

GAO

Report to the Chairman, Subcommittee
on Criminal Justice, Drug Policy and
Human Resources, Committee on
Government Reform,
U.S. House of Representatives

November 2002

MARIJUANA

Early Experiences with Four States' Laws That Allow Use for Medical Purposes



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Accountability * Integrity * Reliability

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Abbreviations

CSA	Controlled Substances Act of 1970
DEA	Drug Enforcement Administration
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
UCR	Uniform Crime Reports



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United States General Accounting Office
Washington, DC 20548

November 1, 2002

The Honorable Mark Souder
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

A number of states have adopted laws that allow medical use of marijuana. Federal law, however, does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession. Debate continues over the medical effectiveness of marijuana, and over government policies surrounding medical use. A bill introduced in the House of Representatives in July 2001 would modify the federal classification of marijuana and allow doctors, in states with medical marijuana laws, to recommend or prescribe marijuana.¹ As the debate continues, so has interest in how state medical marijuana programs are operating, and in the issues faced by federal and state law enforcement officials in enforcing criminal marijuana provisions.²

This report responds to your request that we examine the implementation of medical marijuana laws in selected states. We did not examine the effectiveness of states' or local jurisdictions efforts to administer their programs and did not judge the validity of their approaches for implementing states' laws. As agreed with your staff, we selected Oregon, Alaska, Hawaii, and California because they had medical marijuana laws in effect for at least 6 months and, according to our preliminary work, some

¹States' Rights to Medical Marijuana Act, H.R. 2592, 107th Cong. (2001). Status as of August 5, 2002: Referred to House Energy and Commerce, Subcommittee on Health on July 31, 2001.

²Throughout this report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

data was available on patient and physician participation.³ For these states, we are reporting on (1) their approach to implementing their medical marijuana laws and how these approaches compare, and the results of any state audits or reviews; (2) the number, age, gender, and medical conditions of patients that have had doctors recommend marijuana for medical use in each state; (3) how many doctors are known to have recommended marijuana in each state, and what guidance is available for making these recommendations; and (4) the perceptions of federal and state law enforcement officials, and whether data are available to show how the enforcement of state marijuana laws has been affected by the introduction of these states' medical marijuana laws.

In conducting our work, we examined applicable federal and state laws and regulations and spoke with responsible program officials in Oregon, Alaska, Hawaii, and California. In the four states, we obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors. We also met with various federal, state, and local law enforcement officials—including officials with the Drug Enforcement Administration (DEA) and U.S. Attorneys offices in Washington, D.C., and the four selected states—to discuss data on arrests and prosecutions and views on the impact of the state's medical marijuana laws on their law enforcement efforts.

Results from our review of these states cannot be generalized to other states with state medical marijuana laws, nor are they generalizable across the states selected for review. Similarly, in California, the information from the local jurisdictions we reviewed cannot be generalized to all local jurisdictions in California. We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards. (Appendix I describes our scope and methodology in greater detail.)

³According to *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001), eight states have enacted medical marijuana laws. We selected four of those states based on the length of time the laws had been in place and the availability of data. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Also, at the time of our review, two other states, Maine and Washington, did not have state registries to obtain information on program registrants. Alaska, Oregon, and Hawaii have state registries and had laws in place for at least 6 months. California's law was enacted in 1996. California does not have a participant registry, but based on our preliminary work, some local registry information was available.

Results in Brief

State laws in Oregon, Alaska, Hawaii, and California allow medical use of marijuana under specified conditions. All four states require a patient to have a physician's recommendation to be eligible for medical marijuana use. Alaska, Hawaii, and Oregon have established state-run registries for patients and caregivers to document their eligibility to engage in medical marijuana use; these states require physician documentation of a person's debilitating condition to register. Laws in these three states also establish maximum allowable amounts of marijuana for medical purposes. California's law does not establish a state-run registry or establish maximum allowable amounts of marijuana. Some local California jurisdictions have developed their own guidelines and voluntary registries. Oregon has changed some verification practices and administrative procedures as a result of a review of their medical marijuana program.

Relatively few people had registered to use marijuana for medical purposes in Oregon, Hawaii, and Alaska. As of Spring 2002, about 2,450 people, or about 0.05 percent of the total population of the three states combined, had registered as medical marijuana users. Statewide figures for California are unknown. In Oregon, Alaska, and Hawaii, over 70 percent of registrants were over 40 years of age or older, and in Hawaii and Oregon, the two states where gender information is collected, about 70 percent of registrants were men. Data from Hawaii and Oregon also showed that about 75 percent and more than 80 percent respectively, of the physician recommendations were for severe pain and conditions associated with muscle spasms, such as multiple sclerosis. Statewide figures on gender and medical conditions were not available for Alaska or California.

Hawaii and Oregon were the only two states that had data on the number of physicians recommending marijuana. As of February 2002, less than one percent of the approximately 5,700 physicians in Hawaii and three percent of Oregon's physicians out of about 12,900 had recommended marijuana to their patients. Oregon also was the only state that maintained data on the number of times individual physicians recommended marijuana—as of February 2002, about 62 percent of the Oregon physicians recommending marijuana made one recommendation. Professional medical associations in all four states provided some guidance to physicians. The associations caution physicians about the legal issues facing them, or give advice on practices to follow and avoid. Most state medical board officials said they would only become involved with physicians recommending marijuana in cases where a complaint was filed against a physician for violating state medical practice standards. California's medical board provides informal guidelines on making marijuana recommendations to their patients.

Data were not readily available to measure how marijuana-related law enforcement has been affected by the introduction of medical marijuana laws. To assess the relationship between trends in marijuana-related law enforcement activities and the passage of medical marijuana laws would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as data on other factors that are not easily measured, such as changes in perceptions about marijuana and shifts in law enforcement priorities. Officials from over half of the 37 selected federal, state, and local law enforcement organizations we interviewed in the four states said that the introduction of medical marijuana laws had not greatly affected their law enforcement activities. These officials indicated that they had not encountered situations involving a medical marijuana defense or they had other drug priorities. However, officials with some of the organizations told us that the laws in their states had made it more difficult to prosecute marijuana cases where medical use might be claimed; there was confusion over how to handle seized marijuana; and that, in their view, the laws had softened public attitudes toward marijuana.

In commenting on a draft of this report, the Department of Justice (DOJ) said that we fully described the current status of the programs in the states reviewed. However, DOJ stated that we failed to adequately address some of the serious difficulties associated with such programs. Specifically, DOJ commented that the report did not adequately address issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase “medical marijuana” implicitly accepts a premise that is contrary to existing federal law.

We disagree. We believe the report adequately addresses the issues within the scope of our review. With respect to DOJ’s first issue, our report describes how laws in the selected states and federal law treat the use of marijuana—the opening paragraph of our report specifically states that federal law does not recognize any accepted medical use of marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. With regard to the second and third issues raised by DOJ concerning the potential for facilitating illegal trafficking and the impact on cooperation between federal, state, and local law enforcement officials, respectively, we interviewed federal, state, and local law enforcement officials about their perceptions concerning the impact of state medical marijuana laws on their activities and our report

conveys the views and opinions of those officials. However, based on comments from law enforcement officials on a draft section of this report, we modified our report to discuss some of the issues law enforcement faces when dealing with medical marijuana laws and seized marijuana. Concerning the fourth issue—the lack of data on marijuana’s medical value—our report discusses that a continuing debate exists over the medical value of marijuana, but an analysis of the scientific aspects of this debate was beyond the scope of our review.

Finally, we disagree with DOJ’s comment that our use of the phrase medical marijuana accepts a premise contrary to federal law. The introduction to our report specifically states that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law. Our detailed response to DOJ’s comments is provided on pages 35 to 38 and we have reprinted a copy of DOJ’s comments in appendix V.

Background

The cannabis plant, commonly known as marijuana, is the most widely used illicit drug in the United States. According to recent national survey figures, over 75 percent of the 14 million illicit drug users 12 years or older are estimated to have used marijuana alone or with other drugs in the month prior to the survey.⁴ Marijuana can be consumed in food or drinks, but most commonly dried portions of the leaves and flowers are smoked. Marijuana is widely used and the only major drug of abuse grown within the United States borders, according to the Drug Enforcement Administration.

Marijuana is a controlled substance under federal law and is classified in the most restrictive of categories of drugs by the federal government. The federal Controlled Substances Act of 1970 (CSA)⁵ places all federally controlled substances into one of five “schedules,” depending on the drug’s likelihood for abuse or dependence, and whether the drug has an accepted medical use.⁶ Marijuana is classified under Schedule I,⁷ the classification reserved for drugs that have been found by the federal

⁴U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *National Household Survey on Drug Abuse 2000*. Hashish is included by SAMHSA in the statistic for marijuana use.

⁵21 U.S.C. §§ 801 to 971.

⁶*Id.* § 812(a), (b).

⁷*Id.* § 812(c), Schedule I (c)(10).

government to have a high abuse potential, a lack of accepted safety under medical supervision, and no currently accepted medical use.⁸ In contrast, the other schedules are for drugs of varying addictive properties, but found by the federal government to have a currently accepted medical use.⁹ The CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the other schedules.¹⁰ In particular, the CSA provides federal sanctions for possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project.¹¹

The potential medical value of marijuana has been a continuing debate. For example, beginning in 1978, the federal government allowed the first patient to use marijuana as medicine under the “Single Patient Investigational New Drug” procedure, which allows treatment for individual patients using drugs that have not been approved by the Food and Drug Administration. An additional 12 patients were approved under the procedure between 1978 and 1992. When the volume of applicants tripled, the Secretary of the Department of Health and Human Services (HHS) decided not to supply marijuana to any more patients. According to *Kuromiya v. United States*, HHS concluded that the use of the single patient Investigational New Drug procedure would not yield useful data to resolve the remaining safety and effectiveness issues.¹²

⁸Schedule I includes drugs such as heroin, lysergic acid diethylamide (LSD) and other hallucinogenic substances. 21 C.F.R. 1308.11(c), (d).

⁹*Id.* § 812(b)(2)-(5).

¹⁰*Id.* § 829. DEA rejected petitions in 1992 and 2001 to reschedule marijuana to schedule II. See Notice of Denial of Petition, 66 Fed. Reg. 20038 (2001); Marijuana Scheduling Petition; Denial of Petition; Remand, 57 Fed. Reg. 10499 (1992) (final order affirming the 1989 denial after remand); Marijuana Scheduling Petition; Denial of Petition, 54 Fed. Reg. 53767 (1989).

¹¹*Id.* § 823(f), 841(a)(1), 844.

¹²*See* 78 F. Supp. 2d 367 (E.D.Pa.1999). In the *Kuromiya* case, a group of approximately 160 plaintiffs raised an equal protection challenge to the administration of the “Single Patient Investigational New Drug” program. The plaintiffs contended that they were similarly situated to patients currently receiving marijuana under the program and that the government acted unconstitutionally in denying them access to the same program. The court concluded that the government had a rational basis for its decision not to supply marijuana to the plaintiffs through this program and granted the government's motion for summary judgment.

In 1999, an Institute of Medicine study¹³ commissioned by the White House Office of National Drug Control Policy recognized both a potential therapeutic value and potential harmful effects, particularly the harmful effects from smoked marijuana. The study called for more research on the physiological and psychological effects of marijuana and on better delivery systems. A 2001 report by the American Medical Association's Council on Scientific Affairs also summarized the medical and scientific research in this area, similarly calling for more research.¹⁴

In May 1999, HHS released procedures allowing researchers not funded by the National Institute of Health to obtain research-grade marijuana for approved clinical studies. Sixteen proposals have been submitted for research under these procedures, and seven of the proposals had been approved as of May 2002.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law in 1996 when California voters passed a ballot initiative, Proposition 215 (The Compassionate Use Act of 1996) that removed certain state criminal penalties for the medical use of marijuana.¹⁵ Since then, voters in Oregon, Alaska, Colorado, Maine, Washington and Nevada have passed medical marijuana initiatives, and Hawaii has enacted a medical marijuana measure through its legislature. While state criminal penalties do not apply to medical marijuana users defined by the state's statute, federal penalties remain, as determined by the Supreme Court in *United States v. Oakland Cannabis Buyers' Cooperative*.¹⁶ (Appendix II provides more information on the Supreme Court's decision.)

In California, Alaska, and Oregon, where voters passed medical marijuana laws through ballot initiatives, each state provided an official ballot pamphlet, which included the text of the proposed law and arguments

¹³National Academy of Sciences, Institute of Medicine, "Marijuana and Medicine: Assessing the Science Base." 1999.

¹⁴American Medical Association, Council on Scientific Affairs Report: *Medical Marijuana (A-01)*, June, 2001.

¹⁵The medical use exception in the states we reviewed allows growing or possessing marijuana for the purpose of the patient's personal medical use, and does not extend to other state marijuana prohibitions such as distribution outside the patient-caregiver relationship or any sale of marijuana.

¹⁶532 U.S. 483 (2001).

from proponents and opponents. Opponents of the initiatives referred to federal marijuana prohibitions, legal marijuana alternatives, and evidence of the dangers of smoked marijuana. Proponents referred to supportive studies and positive statements from medical personnel. In Hawaii, where the state legislature enacted the medical marijuana measure, law enforcement officials, advocacy groups, and medical professionals made similar arguments for or against the proposed law during the legislative process.

Implementation in Oregon, Alaska, Hawaii, and California

Oregon, Alaska, Hawaii, and California laws allow medical use of marijuana under certain conditions.¹⁷ All four states require a patient to have a physician's recommendation to be eligible for medical marijuana. Consistent with their laws, Oregon, Alaska, and Hawaii also have designated a state agency to administer patient registries—which document a patient's eligibility to use medical marijuana based on the written certification of a licensed physician—and issue cards to identify certified registrants. Also, laws in Oregon, Alaska, and Hawaii establish limits on the amounts of marijuana a patient is allowed to possess for medical purposes. California does not provide for state implementation of its law. In particular, California has not delegated authority to a state agency or established a statewide patient registry. In addition, California law does not prescribe a specific amount of marijuana that can be possessed for medical purposes. In the absence of specific statutory language, some local California jurisdictions have established their own registries, physician certification requirements, and guidelines for allowable marijuana amounts for medical purposes. Only Oregon has reviewed its medical marijuana program, and as a result of that review, has changed some of its procedures and practices, including verifying all doctor recommendations.

States and Some Local California Jurisdictions Maintain Medical Marijuana Registries

To document their eligibility to engage in medical marijuana use, applicants in Oregon, Alaska, and Hawaii must register with state agencies charged with implementing provisions of the medical marijuana laws in those states (hereinafter referred to as registry states). In Oregon, the Department of Human Services is responsible, and in Alaska, the

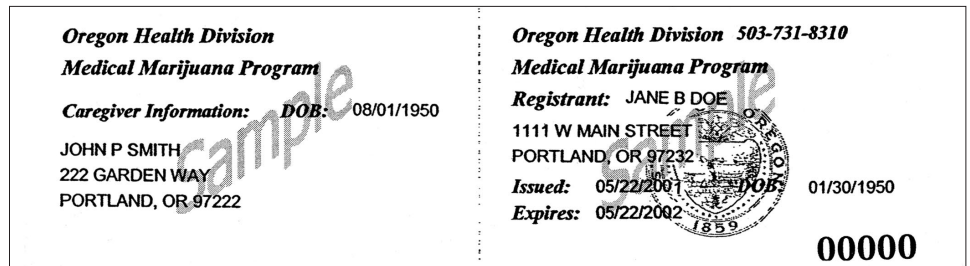
¹⁷The states' medical marijuana laws appear at Alaska Stat. Ann. 11.71.090, 17.37.010 to 17.37.080; Cal. Health & Safety Code Ann. 11362.5; Haw. Rev. Stat. 329-121 to 329-128; and Ore. Rev. Stat. 475.300 to 475.346. Alaska's Hawaii's and Oregon's administrative regulations appear at Alaska Admin. Code, tit. 7, ch. 34; Haw. Admin. R., tit. 23, ch. 202; and Ore. Admin. R., ch. 333, div. 8. There are no regulations under California's law.

Department of Health and Social Services. In Hawaii, the Narcotics Enforcement Division within the Department of Public Safety is responsible for the state's medical marijuana registry. Applicants meeting state requirements are entered into a registry maintained by each state. In California, a number of counties have established voluntary registries to certify eligibility under the state's medical marijuana law.¹⁸

The three registry states, Oregon, Alaska and Hawaii, have similar registry requirements. Potential registrants must supply written documentation by a physician licensed in that state certifying that the person suffers from a debilitating medical condition (as defined by the state statute) and in the physician's opinion would benefit from the use of marijuana. They also must provide information on the name, address, and birth date of the applicant (and of their caregiver, where one is specified) along with identification to verify the personal information. In each state, registry agencies must verify the information in the application based on procedures set in that state's statutes or regulations before issuing the applicant a medical marijuana identification card. All three states allow law enforcement officers to rely upon registry applications in lieu of registry cards to determine whether a medical use exception applies. Figure 1 provides an example of the registry card issued by Oregon. (Appendix III provides examples of registry cards from Alaska and Hawaii.)

¹⁸Under Alaska's and Hawaii's statutes, patients and caregivers must strictly comply with the registration requirement in order to receive legal protection; unregistered persons may not present a medical use defense to a marijuana prosecution in these states. *See* Alaska Stat. Ann. 11.71.090; Haw. Rev. Stat. 329-125. Under Oregon's statute, unregistered patients who have substantially complied with the act may raise such a defense to a marijuana prosecution, while registered persons are excepted from criminal charges, so long as they meet the act's quantity and use restrictions. *See* Ore. Rev. Stat. 475.306, 475.316, 475.319, 475.342. Because California's law does not establish a state-run registry, a medical use defense may be established by any individual meeting the act's substantive requirements, that is, patients whose doctors have recommended marijuana to treat an allowed medical condition and their primary caregivers. *See* Cal. Health & Safety Code Ann. 11362.5; *see also* *People v. Mower*, No. S094490, 2002 Cal. Lexis 4520 (July 18, 2002), in which the California Supreme Court interprets California's medical marijuana act.

Figure 1: Example of Oregon’s Medical Marijuana Registry Card



Source: Oregon Department of Human Services.

Hawaii’s Department of Public Safety requires that doctors submit the completed registry application to the state agency, and if approved, the medical use certification is returned to the doctor for issuance to their patient. By contrast, registry agencies in Oregon and Alaska require that the registry card applicant submit the physician statement as part of the application, and issue the card directly to the patient. Alaska allows registry cards to be revoked if the registrant commits an offense involving a controlled substance of any type, whereas Oregon and Hawaii allow registry cards to be revoked only for marijuana-related offenses, such as sale. Table 1 summarizes registry requirements and verification procedures of the responsible agencies in each registry state as of July 2002.

Table 1: Registry Requirements and Verification Procedures in Oregon, Alaska and Hawaii, as of July 2002

Registry requirements	Oregon	Alaska	Hawaii
Completed application form	x ^a (submitted by applicant)	x (submitted by applicant)	x (submitted by physician)
Written physician documentation	x ^b	x ^c	x ^d
Applicant name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Primary caregiver name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Sworn caregiver statement on department form regarding lack of felony drug conviction, not on probation or parole, and over 21		x	
Address of site where marijuana will be produced	x		x
Annual renewal for registry card	x	x	x
Minors: parents declaration form and agreement to serve as minor's caregiver	x (must be notarized)	x	x
Registration fee	\$150	\$25 first time \$20 renewal	\$25
Registry Verification Procedures			
Doctor has a valid license in state	x	x	x
Verification call or letter sent to doctor re: recommendation	x	x ^e	x
Patient contacted to validate application information	x	x ^e	x
Caregiver contacted to validate application information	x ^e	x ^e	x ^e
Registry checked to assure caregiver only serves one patient		x	

^aA legible written statement with all the form information included will be accepted.

^bAttending physician completes a state declaration form that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the patient's condition, or applicant provides medical records of debilitating condition signed by physician that contains all information required on physician form.

^cSigned physician statement that the patient was examined within bona fide relationship and is diagnosed with a debilitating medical condition, other medications were considered and that patient might benefit from marijuana.

^dSigned statement that in the physician's opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient, OR medical records with same information.

^eAgency officials verify when they believe it is appropriate.

Source: Oregon, Alaska, and Hawaii medical marijuana state statutes, administrative rules and program officials.

California's statute does not establish a state registry or require that a person or caregiver be registered to qualify for a medical use exception. California's law requires that medical use has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana for certain symptoms or conditions. The exception applies based "upon the written or oral recommendation or approval of a

physician.” After the medical marijuana law was passed, the California Attorney General assembled a task force to discuss implementation issues in light of the “ambiguities and significant omissions in the language of the initiative.” The task force recommended a statewide registry be created and administered by the Department of Health Services, among other things, to clarify California’s law.¹⁹ However, a bill incorporating many of the ideas agreed upon by the task force was not enacted by the California legislature.²⁰

Some California communities have created voluntary local registries to provide medical marijuana users with registry cards to document that the cardholder has met certain medical use requirements. Figure 2 provides examples of patient and caregiver registry cards issued by San Francisco’s Department of Public Health. (See the following section for a discussion of caregivers.)

¹⁹Office of the Attorney General, State of California, Department of Justice, *Medical Marijuana Task Force* (July 12, 1999). Other recommendations included requiring that the patient’s personal physician make the marijuana recommendation, and allowing cooperative marijuana cultivation.

²⁰California Senate Bill 187, 2001-2002 Reg. Sess. The bill was introduced by California Senator Vasconcellos on February 7, 2001.

Figure 2: Example of San Francisco's Medical Marijuana Registry Cards



Source: San Francisco Department of Public Health.

According to a September 2000 letter by the California Attorney General, medical marijuana policies have been created in some counties. Local registries have been created in Humboldt, Mendocino, San Francisco, and Sonoma counties. A medical marijuana registry in the city of Arcata, located in Humboldt County, was discontinued, however, the Arcata police department accepts registry cards from Humboldt County. A more recent list of medical marijuana registries operated by a county or city was not available, an official with the Attorney General's office said, because there is no requirement for counties or cities to report on provisions they adopt regarding medical use of marijuana. At least two counties have since approved development of county medical marijuana registries, in San Diego in November 2001, and in Del Norte, in April 2002. Several cannabis buyers' clubs, or cannabis cooperatives may have also established voluntary registries of their members.

(Appendix III provides additional discussion on state registry procedures in Oregon, Alaska, and Hawaii, procedures in selected California county registries, and examples of registry cards.)

Medical Marijuana Patient Primary Caregivers

Laws in Oregon, Alaska, Hawaii, and California allow medical marijuana users to designate a primary caregiver. To qualify as a caregiver in the registry states, persons must be part of the state registry and be issued medical marijuana cards. Registered caregivers may assist registrants in their medical use of marijuana without violating state criminal laws for possession or cultivation of marijuana, within the allowed medical use amounts. Alaska allows registrants to designate a primary and alternate caregiver. Both must submit a sworn statement that they are at least 21 years old, have not been convicted of a felony drug offense, and are not currently on probation or parole. In Hawaii and Alaska, caregivers can serve only one patient at a time. Alaska, however, allows exceptions for patients related to the caregiver by blood or marriage, or with agency approval, such as circumstances where a patient resides in a licensed hospice program. Oregon does not specify a limit to the number of patients one caregiver may serve. Table 2 provides information on definitions and caregiver provisions in Oregon, Alaska, and Hawaii.

Table 2: Definition and Provisions Regarding Caregivers in Oregon, Alaska and Hawaii

	Oregon	Alaska	Hawaii
Definition of Caregiver	“Designated primary caregiver” means an individual eighteen years of age or older who has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition and who is designated as such on that person’s application for a registry identification card or in other written notification to the division. Designated primary caregiver does not include the person’s attending physician.	“Primary caregiver” means a person listed as a primary caregiver (in the state medical use registry) 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. “Alternate caregiver” means a person who is listed as an alternate caregiver (in the state medical use registry).	“Primary caregiver” means a person, other than the qualifying patient and the qualifying patient’s physician, who is eighteen years of age or older, and who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.
Limit to number of caregivers per patient	1	2 (a primary and an alternate)	1
Limit to number of patients per caregiver	Not specified	1 (exceptions may be granted by state agency)	1
Criminal record restriction on serving as caregiver	Not specified	Yes	Not specified

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California’s statute also allows qualified medical marijuana users to designate a primary caregiver. The statute defines “primary caregiver” to mean “the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health or safety of that person.” There is no requirement that the patient–caregiver relationship be registered or otherwise documented, nor is there a specified limit to the number of patients that can designate a particular caregiver.

Physician Recommendation Requirements

In all four states, patients must obtain a physician’s diagnosis that he or she suffers from a medical condition eligible for marijuana use under that state’s statute, and a physician recommendation for the use of marijuana. California does not have a requirement that the diagnosis or recommendation be documented, as the other states do. In the registry states, patients must supply written documentation of their physician’s medical determination and marijuana recommendation in their registry applications. This documentation must conform with program requirements, reflecting that the physician made his or her

recommendation in the context of a bona fide physician-patient relationship.

California's law does not require patients to submit documentation of a physician's determination or recommendation to any state entity, nor does it specify particular examination requirements. According to California's law, marijuana may be used for medical purposes "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana" in treating certain medical conditions; such recommendations may be oral or written.

The physician certification form adopted by Hawaii's Department of Public Safety calls for doctors recommending marijuana to a patient to certify that "I have primary responsibility for the care and treatment of the named patient and based on my professional opinion and having completed a medical examination and/or full assessment of my patient's medical history and current medical condition in the course of a bona fide physician-patient relationship have issued this written certificate." Similarly in Alaska, the recommending physician signs a statement that they personally examined the patient on a specific date, and that the examination took place in the context of a bona fide physician-patient relationship.

Under Oregon's medical marijuana law, the patient's attending physician must supply physician documentation. Oregon's administrative rules defining "attending physician" were amended in March 2002 to more fully describe the conditions for meeting the definition. To qualify, the physician must have established a physician-patient relationship with the patient and must diagnose the patient with a debilitating condition in the context of that relationship.²¹ Agency officials stated that they changed the definition of an attending physician in light of information that one doctor responsible for many medical marijuana recommendations had not

²¹As provided in Ore. Admin. R. 333-008-0010, an attending physician is "a physician who has established a physician/patient relationship with the patient, is licensed under ORS chapter 677, and who, with respect to a patient diagnosed with a debilitating medical condition: (a) Is primarily responsible for the care and treatment of the patient; (b) Is primarily responsible for recognized, medical specialty care and treatment of the patient; (c) Has been asked to consult and treat the patient by the patient's primary care physician; or (d) Has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file. "

followed standard physician-patient practices, such as keeping written patient records. (See physician section.) Under its regulations, the Department of Human Services will contact each physician making a medical marijuana recommendation to assure that the physician is an “attending physician” and, with patient approval, the department may review the physician’s patient file in connection with this inquiry.

Qualifying State Conditions for Use of Medical Marijuana

The laws in all four states we reviewed identify medical conditions²² for which marijuana may be used for medical purposes. Table 3 displays the allowed medical conditions for which marijuana may be used in each state. (See appendix IV for descriptions from general medical sources of the allowable conditions identified by the state laws.)

Table 3: Allowable Conditions for Medical Marijuana Use in Four States

Conditions ^a	Oregon	Alaska	Hawaii	California
Cancer	X	X	X	X
Glaucoma	X	X	X	X
HIV positive status	X	X	X	
AIDS	X	X	X	X
Cachexia	X	X	X	
Wasting syndrome			X	
Anorexia				X
Epilepsy and other seizure disorders	X	X	X	
Multiple sclerosis and other disorders characterized by persistent muscle spasticity	X	X	X	X
Crohn’s disease			X	
Alzheimer’s disease	X			
Arthritis				X
Migraine				X
Severe pain	X	X	X	
Chronic pain				X
Severe nausea	X	X	X	
Any other illness for which marijuana provides relief ^b				X

^aOregon’s, Alaska’s, and Hawaii’s medical marijuana statutes use the term “debilitating medical condition” to encompass the conditions eligible for medical marijuana use. California’s statute does not use this term, but simply lists the eligible conditions.

^bCalifornia’s statute does not define “any other illness for which marijuana provides relief.”

²²For simplicity, we use the general term medical “condition” to encompass, diseases, symptoms, and medical conditions.

Source: California, Oregon, Alaska and Hawaii medical marijuana statutes and Oregon administrative rules.

Allowable Amounts of Marijuana for Medical Use

Statutes in Oregon, Alaska, and Hawaii define the maximum amount of marijuana and the number of plants that an individual registrant and their caregiver may possess under medical marijuana laws, while California’s statute does not provide such definitions. Oregon and Hawaii regulations also provide definitions of marijuana plant maturity. Table 4 provides the definitions of quantity and maturity for each registry state.

Table 4: Permissible Amounts of Medical Marijuana and Plant Maturity in Oregon, Alaska, and Hawaii

	Oregon	Alaska	Hawaii
Allowable amount	A patient and a designated primary caregiver may not individually or collectively possess more than three mature plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant, if present at a location at which marijuana is produced, including any residence associated with that location. If not at a location where marijuana is produced, including any residence associated with that location, the allowable amount is one ounce of usable marijuana. ^a	A patient, primary caregiver or alternate caregiver may not possess in the aggregate more than one ounce of marijuana in usable form; and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time.	“Adequate Supply” means an amount of marijuana jointly possessed between the qualifying patient and the primary caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the express purpose of alleviating the symptoms or effects of a qualifying patient’s debilitating medical condition; provided that the “adequate supply” jointly possessed by the qualifying patient and the primary caregiver not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.
Plant maturity	“Mature plant” means the following: A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.	Not specified	“Immature marijuana plant” means a marijuana plant, whether male or female, that has not yet flowered and which does not yet have buds that are readily observed by unaided visual examination. “Mature plant” means a marijuana plant, whether male or female, that has flowered and which has buds that are readily observed by unaided visual examination.

^aRegistered patients and caregivers in Oregon who exceed the act’s quantity restrictions are not immune from prosecution, but may establish an “affirmative defense” in a marijuana prosecution that the greater amount is medically necessary to mitigate the symptoms or effects of the patient’s debilitating medical condition. Ore. Rev. Stat. 475.306(2).

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California’s statute does not specify an amount of marijuana allowable under medical use provisions; however, some local jurisdictions have established their own guidelines. The statute’s criminal exemption is for “personal medical purposes” but does not define an amount appropriate

for personal medical purposes. The California Attorney General's medical marijuana task force debated establishing an allowable amount but could not come to a consensus on this issue, proposing that the Department of Health Services determine an appropriate amount. Participants did agree that the amount of marijuana a patient may possess might well depend on the type and severity of illness. They concluded that an appropriate amount of marijuana was ultimately a medical issue, better analyzed and decided by medical professionals. In the absence of state specified amounts, a number of the state's 58 counties and some cities have informally established maximum allowable amounts of marijuana for medical purposes. According to the September 2000 summary by the California Attorney General's office, the amount of marijuana an individual patient and their caregiver were allowed to have varied, with a two-plant limit in one area, and a 48 plant (indoors, with mature flowers) limit in another area. In May 2002, Del Norte County raised their limit from 6 plants to 99 plants per individual patient.

Safety and Public Use Restrictions

California, Oregon, Alaska, and Hawaii prohibit medical marijuana use in specific situations relating to safety or public use. Patients or caregivers who violate these prohibitions are subject to state marijuana sanctions and, in the registry states, may also forfeit their registry cards.²³ Table 5 reflects the various states' safety or public use restrictions.

²³Alaska's statute provides a one-year suspension from using or obtaining a registry card; Oregon's statute provides up to a 6-month suspension from using or obtaining a registry card; Hawaii's rules provide for revocation of the registry certificate for an indefinite time.

Table 5: Safety and Public Use Restrictions in Oregon, Alaska, Hawaii and California

	Oregon	Alaska	Hawaii	California
Safety restrictions	Oregon’s medical marijuana statute prohibits driving under the influence of marijuana.	Alaska’s medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of any person.	Hawaii’s medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of another person.	California’s medical marijuana statute provides that, “Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.”
Public use restrictions	Oregon’s medical marijuana statute prohibits patients and caregivers from engaging in the medical use of marijuana in public places as defined in Ore. Rev. Stat. 161.015, ^a or in public view or in a correctional facility as defined in Ore. Rev. Stat. 162.135(2) or youth correction facility as defined in Ore. Rev. Stat 162.135(6).	Alaska’s medical marijuana law prohibits the medical use of marijuana in plain view of, or in a place open to, the general public. The law also states that medical marijuana use need not be accommodated in any place of employment; in any correctional facility, medical facility, or facility monitored by the Alaska Department of Administration; on or within 500 feet of school grounds; at or within 500 feet of a recreation or youth center; or on a school bus.	Hawaii’s medical marijuana statute prohibits the medical use of marijuana in a school bus, public bus, or any moving vehicle; in the workplace of one’s employment; on any school grounds; at any public park, public beach, public recreation center, recreation or youth center; or other place open to the public.	(not specified)

^aAs defined in Ore. Rev. Stat. 161.015, a public place means a place to which the general public has access including, but not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and premises used in connection with public passenger transportation.

Source: California, Oregon, Alaska and Hawaii state statutes.

Management Review Results in Oregon Program Changes

Oregon was the only state of the four we reviewed to have conducted a management review of their state’s medical marijuana program.²⁴ The Oregon Department of Human Services conducted the review after concerns arose that a doctor’s signature for marijuana recommendations had been forged. The review team reported a number of program areas needing improvement, and proposed a corrective plan of action. Most of

²⁴“Oregon’s Medical Marijuana Program: A Management Review” Oregon Department of Human Services, June 11, 2001.

the actions had been completed, as of May 2002. Lack of verification of physician signature was a key problem identified by the team. All physician signatures are now verified. A number of other team findings had to do with program management and staffing. The Program Manager was replaced, additional staff was added, and their roles were clarified, according to officials. Another area of recommendation was the processing of applications and database management, such as how to handle incomplete applications, handling of voided applications, edit checks for data entry, and reducing the application backlog. As of May 2002, some action items were still open, such as computer “flags” for problem patient numbers or database checks on patients and caregivers at the same address.

Few Registrants, Most with Severe Pain or Muscle Spasms

A relatively small number of people are registered as medical marijuana users in Oregon, Hawaii, and Alaska. In those states, most registrants were over 40 years old. Severe pain and muscle spasms (spasticity) were the most common medical conditions for which marijuana was recommended in the states where data was gathered.

Small Number of Medical Marijuana Registrants

Relatively few people are registered as medical marijuana users in Alaska, Hawaii and Oregon. In these states, registry data showed that the number of participants registered was below 0.05 percent or less of the total population of each respective state. Data doesn't exist to identify the total population of people with medical conditions that might qualify for marijuana use because not all the conditions specified in the state's laws are diseases for which population data is available. For example, a debilitating condition of “severe pain” may be a symptom for a number of specific medical conditions, such as a back injury, however not all patients with back injury suffer severe pain. Table 6 shows the number of patients registered in Oregon, Hawaii, and Alaska, at the time of our review as compared to the total population from the U.S. Census Bureau population projections for 2002.

Table 6: Medical Marijuana Registrants in Oregon, Hawaii, and Alaska, by Projected 2002 State Population

State	State population	Number of registrants	Percent of registrants by state population
Oregon	3,488,000	1,691	0.05
Hawaii	1,289,000	573	0.04
Alaska	672,000	190	0.03
Totals	5,449,000	2,454	0.05

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Oregon, Hawaii, and Alaska state medical marijuana registries and U.S. Bureau of the Census population projections for 2002.

There is no statewide data on participants in California because the medical marijuana law does not provide for a state registry. We obtained information from four county registries in San Francisco, Humboldt, Mendocino and Sonoma counties.²⁵ In each of these registries, participation was 0.5 percent or less than the respective county’s population. However, because the local registries are voluntary it is unknown how many people in those jurisdictions have received medical recommendations from their doctors for marijuana but have not registered.

Table 7 shows the number of patients registered in four California counties and as a percent of the population for those counties, since each registry was established.

²⁵Sonoma County does not maintain a “registry” of approved medical marijuana users, but is included because it does have records of county patients whose doctors have recommended marijuana using Sonoma County Medical Association peer review process.

Table 7: Registrants in Four California Counties by County Population

Registrant source	County population	Number of registrants	Percent of registrants by county population
San Francisco Department of Public Health	793,729	3551	0.44
Sonoma County Medical Association	468,754	435	0.09
Humboldt County Department of Public Health	127,754	182	0.14
Mendocino County	87,273	430	0.49

Note: San Francisco and Sonoma county data as of July 2002, Humboldt county data as of January 2002, and Mendocino county data as of April 2002.

Sources: California State Association of Counties (as of January 2002), and California medical marijuana county registries.

Medical Marijuana Registrant Demographics

Most medical marijuana registrants in Hawaii and Oregon—the states where both gender and age data were available—were males over 40 years old. Hawaii and Oregon were the only states that provided gender information; in both cases approximately 70 percent of registrants were men. In Alaska, Hawaii, and Oregon state records showed that over 70 percent of all registrants in each state were 40 years of age or older. Only in one state was there a person under the age of 18 registered as a medical marijuana user. Table 8 shows the distribution of registrants by age in the registry states.

Table 8: Registrant Age in Alaska, Hawaii and Oregon

(Percent in each age category)

Age	Alaska	Hawaii	Oregon
Under 18	1 (1%)	0	0
19-29	10 (5%)	16 (3%)	145 (9%)
30-39	42 (22%)	70 (12%)	247 (15%)
40-49	84 (44%)	197 (34%)	613 (36%)
50-59	42 (22%)	216 (38%)	550 (33%)
Over 60	11 (6%)	74 (13%)	136 (8%)
Total	190	573	1691

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Medical Marijuana registries in Alaska, Hawaii and Oregon.

In California, none of the local jurisdictions we met with kept information on participants' gender, and only Sonoma County Medical Association provided information on their registrants' age. The age of medical association registrants was similar to participants in the state registries, only slightly younger. Over 60 percent of participants that have had their records reviewed by medical associations were 40 years or older.

Medical Marijuana Registrant Conditions

Most medical marijuana recommendations in states where data are collected have been made for applicants with severe pain or muscle spasticity as their medical condition. Conditions allowed by the states' medical marijuana laws ranged from illnesses such as cancer and AIDS, to symptoms, such as severe pain. Information is not collected on the conditions for which marijuana has been recommended in Alaska or California. However, data from Hawaii's registry showed that the majority of recommendations have been made for the condition of severe pain or the condition of muscle spasticity. Likewise, data from Oregon's registry showed that, 84 percent of recommendations were for the condition of severe pain or for muscle spasticity. Table 9 shows the number and percentage of patients registered by types of conditions in Oregon and Hawaii.

Table 9: Registrant Conditions in Oregon and Hawaii

	Oregon		Hawaii	
	Number of recommendations per condition	Percent with condition	Number of recommendations per condition	Percent with condition
Cancer	43	3	9	2
Glaucoma	31	2	10	2
HIV positive status or AIDS	47	3	66	12
Cachexia	18	1	-	-
Cachexia or wasting syndrome	-	-	9	2
Epilepsy and other seizure disorders	43	3	5	1
Multiple Sclerosis and other disorders characterized by persistent muscle spasms, or spasticity	459	28	240	43
Alzheimer's disease	1	Under 1	-	-
Severe pain	915	56	172	31
Severe nausea	83	5	12	2
Severe nausea/severe pain	-	-	31	6
Total	1640^a		554^b	

Note: Oregon data as of February 2002, Hawaii data as of March 2002.

^aInformation on 51 cases not available.

^bThe number of registrants for Hawaii differs in tables 8 and 9 due to differences in the reporting dates.

Source: Oregon and Hawaii medical marijuana registries.

On the basis of records from the Oregon registry, we reviewed the information provided by doctors for additional insight into the conditions for which registrants use marijuana. The Oregon registry keeps track of secondary conditions in cases where the recommending doctor specified more than one condition. We examined the pool of secondary conditions associated with severe pain²⁶ and muscle spasms,²⁷ the two largest condition categories. About 40 percent of those with severe pain reported muscle spasms, migraines, arthritis, or nausea as a secondary medical condition. The most common secondary conditions reported by those with

²⁶Of the 915 registrants that reported severe pain as their primary condition, over half reported only one secondary condition, some included up to five secondary conditions. The percentages reported here include those with only one secondary condition.

²⁷Of the 459 registrants that reported spasms as a primary condition over 40 percent reported only one secondary condition, some included up to four secondary conditions. The percentages reported here include those with only one secondary condition.

spasms were pain, multiple sclerosis, and fibromyalgia,²⁸ accounting for 37 percent of the secondary conditions for spasms. A variety of other secondary conditions were identified in the Oregon data, such as acid reflux, asthma, chronic fatigue syndrome, hepatitis C, and lupus.

Few Physicians Make Marijuana Recommendations; Some Guidance Available

In the two states, Hawaii and Oregon, where data on physicians is maintained, few physicians have made medical marijuana recommendations. Of the pool of recommending physicians in Oregon, most physicians made only one to two recommendations. Over half of the medical organizations we contacted provide written guidance for physicians considering recommending marijuana.

Low Physician Participation

Only a small percentage of physicians in Hawaii and Oregon were identified by state registries as having made recommendations for their patients to use marijuana as medicine. These two states maintain information on recommending physicians in their registry records. No information was available on physician participation in California and Alaska. In Hawaii, at the time of our review, there were 5,673 physicians licensed by the state's medical board. Of that number, 44 (0.78 percent) physicians had recommended marijuana to at least one of their patients since the legislation was passed in June 2000. In Oregon, at the time of our review, 435 (3 percent) of the 12,926 licensed physicians in the state had participated in the medical marijuana program since May 1999.

Both Hawaii and Oregon's medical marijuana registration programs are relatively new, which may account for the low level of participation by physicians in both states. Oregon's program has operated for a year longer than Hawaii's, however physician participation overall is low in both states. A Hawaii medical association official told us that he believes physicians consider a number of factors when deciding whether to recommend marijuana as medicine, such as the legal implications of recommending marijuana, lack of conclusive research results on the drug's medical efficacy, and a doctor's own philosophical stance on the use of marijuana as medicine.

²⁸Fibromyalgia: Chronic pain, stiffness, and tenderness of muscles, tendons, and joints without detectable inflammation. Fatigue and sleep disorders are common in fibromyalgia patients.

The lower federal courts are divided in terms of whether doctors can make medical marijuana recommendations without facing federal enforcement action, including the revocation of doctors' DEA registrations that allow them to write prescriptions for federally controlled substances. In one case, the district court for the Northern District of California held that the federal government could not revoke doctors' registrations, stating that the de-registration policy raised "grave constitutional doubts" concerning doctors' exercise of free speech rights in making medical marijuana recommendations.²⁹ In the other case considering this issue, the district court for the District of Columbia ruled that the federal government could revoke doctors' registrations, stating that "[e]ven though state law may allow for the prescription or recommendation of medicinal marijuana within its borders, to do so is still a violation of federal law under the CSA," and "there are no First Amendment protections for speech that is used 'as an integral part of conduct in violation of a valid criminal statute.'"³⁰

Oregon is the only state we reviewed which has registry records that identify recommendations by doctor. Few Oregon physicians made recommendations to use medical marijuana to more than two patients. According to registry data, 82 percent of the participating physicians made one or two recommendations, and 18 percent made three or more recommendations. Table 10 shows a breakdown of the frequency by which physicians made marijuana recommendations.

²⁹See *Conant v. McCaffrey*, No. C-97-00139, 2000 U.S. Dist. LEXIS 13024 at *19 (N.D. Cal. Sept. 7, 2000) (permanent injunction granted); see also *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (preliminary injunction granted). On October 29, 2002, the Ninth Circuit Court of Appeals affirmed, finding that the district court convincingly explained how the government's professed enforcement policy threatened to interfere with doctors' First Amendment rights. See *Conant v. Walters*, No. 00-17222, 2002 U.S. App. LEXIS 22942 at *2 (9th Cir. Oct. 29, 2002)

³⁰See *Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 121 (D.D.C. 2001).

Table 10: Number of Marijuana Recommendations Made by Oregon Physicians, as of February 2002

Number of recommendations	Number of physicians making recommendations	Percentage of recommending physicians
1	269	61.8
2	87	20.0
3	33	7.6
4	22	5.1
5	8	1.8
6	2	0.5
7	2	0.5
9	2	0.5
10	1	0.2
11	1	0.2
12	1	0.2
13	2	0.5
14	1	0.2
18	1	0.2
23	1	0.2
38	1	0.2
823	1	0.2

Source: Oregon Department of Human Services.

State or law enforcement officials in Oregon, California, and Hawaii indicated that they were each aware of a particular physician in their state that had recommended marijuana to many patients.³¹ In Alaska, a state official knew of no physician that had made many recommendations. In Oregon and California the state medical boards have had formal complaints filed against these physicians for alleged violations of the states' Medical Practices Acts, which establish physician standards for medical care. The complaints charge the physicians with unprofessional conduct violations such as failure to conduct a medical examination, failure to maintain adequate and accurate records, and failure to confer with other medical care providers. In Oregon, the physician

³¹Program officials in the registry states verify that a physician recommendation has been made in accordance with program requirements, and that the physician is licensed; they are not authorized to determine whether a doctor's recommendation is medically appropriate.

recommending marijuana to over 800 patients was disciplined.³² The California case was still pending. At the time of our review, there was no medical practice complaint filed against the Hawaiian doctor known to have made many marijuana recommendations.

Physician Guidance for Making Medical Marijuana Recommendations

In all four states, professional medical associations provide some guidance for physicians in regards to recommending marijuana to patients. State medical boards, in general, have limited involvement in providing this type of guidance. Table 11 indicates the type of guidance available from these medical organizations in each state.

Table 11: Doctor Guidance Provided by Selected State Medical Organizations

State Medical Organizations	Guidance provided	Description
Oregon State Board of Medical Examiners	No	
Oregon Medical Association	Yes	The association has a document informing members of the legal issues facing doctors and advising them on doctor-patient discussions and documentation concerning the use of marijuana for medicine, and actions to avoid.
Alaska State Medical Board	No	
Alaska Medical Association	Yes	Those inquiring about recommending marijuana are directed to seek legal counsel.
Hawaii State Board of Medical Examiners	No	
Hawaii Medical Association	Yes	Those inquiring about recommending marijuana are informed of the association's official position against medical marijuana and advised of the legal implications involved.
Medical State Board of California	Yes	The board has a document that describes the standards physicians recommending marijuana should apply to their practice and advises them on how to best protect themselves.
California Medical Association	Yes	The association provides a document covering the legal issues facing doctors, doctor-patient discussions and documentation concerning the use of marijuana for medicine, actions to avoid, and other topics under the law that may be of concern to physicians.

Note: Guidance provided as of the time of our review.

Source: State Medical Boards and Medical Associations in Oregon, Alaska, Hawaii, and Oregon.

The guidance to physicians considering recommending marijuana to a patient in Oregon, for example, includes avoiding engaging in any

³²The April 2002 order by the Oregon Board of Medical Examiners reprimanded the physician, fined him \$5,000, suspended his license for 90 days, and specified conditions under which any future marijuana recommendations would be made, and other disciplinary actions.

discussions with a patient on how to obtain marijuana, and to avoid providing a patient with any written documentation other than that in the patient's medical records. The medical association also advises physicians to clearly document in a patient's medical records conversations that take place between the physician and patient about the use of marijuana as medicine. Oregon's medical association notes that until the federal government advises whether it considers a physician's medical marijuana recommendation in a patient chart to violate federal law, no physician is fully protected from federal enforcement action.

Most of the state medical board officials we contacted stated that the medical boards do not provide guidance for physicians on recommending marijuana to patients. The medical boards do become involved with physicians making marijuana recommendations if a complaint for violating state medical practices is filed against them. Once a complaint is filed, the boards investigate a physician's practice. Any subsequent action occurs if the allegations against a doctor included violations of the statutes regulating physician conduct.

California medical board's informal guidance states that physicians recommending marijuana to their patients should apply the accepted standards of medical responsibility such as the physical examination of the patient, development of a treatment plan, and discussion of side effects. In addition, the board warns physicians that their best legal protection is by documenting how they arrived at their decision to recommend marijuana as well as any actions taken for the patient.

Difficult to Measure the Impact of State Medical Marijuana Laws on Law Enforcement Activities

Data are not readily available to show whether the introduction of medical marijuana laws have affected marijuana-related law enforcement activities. Assessing such a relationship would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as other measures that may influence law enforcement activities. It may be difficult to identify the relevant measures because crime is a sociological phenomena influenced by a variety of factors.³³ Local law enforcement officials we spoke with about trends in marijuana law enforcement noted several factors, other than medical marijuana laws, important in assessing trends. These factors included changes in general perceptions about marijuana, shifts in funding for various law

³³According to the FBI introduction to users of Uniform Crime Report data.

enforcement activities, shifts in local law enforcement priorities from one drug to another, or changes in emphasis from drugs to other areas, such as terrorism. Demographics might also be a factor.

The limited availability of data on marijuana-related law enforcement activity illustrates some of the difficulties in doing a statistically valid trend analysis. To fully assess the relationship between the passage of state's medical marijuana laws and law enforcement, one would need data on marijuana related arrests or prosecutions over some period of time, and preferably an extended period of time. Although state-by-state data on marijuana-related arrests is available from the FBI Uniform Crime Reports (UCR), at the time of our review, only data up to the year 2000 was available. Yearly data would be insufficient for analytic purposes since the passage of the medical marijuana initiatives or law in three of the states—Oregon (November 1998), Alaska (November 1998), and Hawaii (June 2000)—is too recent to permit a rigorous appraisal of trends in arrests and changes in them.³⁴ Furthermore, although California's law took effect during 1996 providing a longer period of data, it is also important to note that the FBI cautions about UCR data comparisons between time periods because of variations in year-to-year reporting by agencies.³⁵

Similar data limitations would occur using marijuana prosecutions as a measure of trends in law enforcement activity. Data on marijuana prosecutions are not collected or aggregated at the federal level by state. At the state level, for the four states we reviewed, the format for collecting the data, or time period covered also had limitations. For example in California, the state maintains "disposition" data that includes prosecutions, but reflects only the most serious offenses, so that marijuana possession that was classified as a misdemeanor would not be captured if the defendant was also charged with possession of other drugs, or was involved with theft or other non-misdemeanor crimes. Further, the data is grouped by the year of final disposition, not when the offense

³⁴Programs to implement the laws in Oregon, Alaska and Hawaii were developed somewhat later. Alaska's registry was established in June 1999, Oregon's program began operating in May 1999, and Hawaii issued its first card in January 2001.

³⁵As described in the methodology section of UCR's annual publication, *Crime in the United States* (2000) UCR excludes trend statistics if the reporting units have not provided comparable data for the periods under consideration, or when it is ascertained that unusual fluctuations, such as improved record keeping or annexations are involved. Although most law enforcement agencies submit crime reports to the UCR program, data are sometimes not received for complete annual periods. If data on other factors was available for California to analyze the relationship of its medical marijuana law and arrests, one would also need to assess the comparability of arrest data from different time periods.

occurred. Hawaii does not have statewide prosecution data. At the time of our review, prosecution data from Oregon's statewide Law Enforcement Data System was only available for 1999 and 2000.

Perceptions of Officials with Selected Law Enforcement Organizations Regarding the Impact of Medical Marijuana Laws

We interviewed officials from 37 selected federal, state, and local law enforcement organizations in the four states to obtain their views on the effect, if any, state medical marijuana laws had on their law enforcement activities. Officials representing 21 of the organizations we contacted indicated that medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons, including very few or no encounters involving medical marijuana registry cards or claims of a medical marijuana defense. For example:

- The police department on one Hawaiian island had never been presented a medical marijuana registry card, and only 15 registrants lived on the island.
- In Alaska, a top official for the State Troopers Drug Unit had never encountered a medical marijuana registry card in support of claimed medical use.
- In Oregon, one district attorney reported having less than 10 cases since the law was passed where the defendant presented a medical marijuana defense.³⁶
- In Los Angeles County, an official in the District Attorney's office stated that only three medical marijuana cases have been filed in the last two years in the Central Branch office, two of the cases involving the same person.

Some of the federal law enforcement officials we interviewed indicated that the introduction of medical marijuana laws has had little impact on their operations. Senior Department of Justice officials said that the Department's overall policy is to enforce all laws regarding controlled substances, however they do have limited resources. Further, the federal process of using a case-by-case review of potential marijuana prosecutions has not changed as a consequence of the states' medical marijuana laws. These officials said that U.S. Attorneys have their own criteria or guidelines for which cases to prosecute that are based on the Department's overall strategies and objectives.

³⁶The District Attorney noted that they had won these cases because the defendants were not operating within the parameters of the state medical marijuana law.

Law enforcement officials in the selected states also told us that, given the range of drug issues, other illicit drug concerns, such as rampant methamphetamine abuse or large-scale marijuana production are higher priorities than concerns about abuse of medical marijuana. In at least one instance, this emphasis was said to reflect community concerns—in Hawaii, one prosecuting attorney estimated that one-third to one-half of the murders and most hostage situations in the county involved methamphetamines. He said businesses ask why law enforcement is bothering with marijuana when they have methamphetamines to deal with.

Although many of the officials with other organizations we contacted did not clearly indicate whether medical marijuana laws had, or had not, had major impact on their activities, officials with two organizations said that medical marijuana laws had become a problem from their perspective. Specifically, an official with the Oregon State Police Drug Enforcement Section said that during 2000 and 2001, there were 14 cases in which the suspects had substantial quantities of processed or growing marijuana and were arrested for distribution of marijuana for profit, yet were able to obtain medical marijuana registry cards after their arrests. Because the same two defense attorneys represented all the suspects, the police official expressed his view that the suspects might have been referred to the same doctor, causing the official to speculate about the validity of the recommendations. In Northern California—an area where substantial amounts of marijuana are grown³⁷—officials with the Humboldt County Drug Task Force³⁸ told us that they have encountered growers claiming to be caregivers for multiple medical marijuana patients. With a limit of 10 plants per person established by the Humboldt County District Attorney, growers can have hundreds of plants officials said, and no documentation to support their medical use claims is required.³⁹

Over one-third of officials from the 37 law enforcement organizations told us that they believe that the introduction of medical marijuana laws have, or could make it, more difficult to pursue or prosecute some marijuana

³⁷According to the senior DEA official for the area, three northern counties are the source region for much of the domestically produced marijuana in the United States, and this production is a major contributor to the local economies.

³⁸Headed by a Commander from the California Bureau of Narcotics and staffed by officers from local law enforcement.

³⁹The 10 plant limit can be exceeded if the grower claims to grow 10 plants for patient A, 10 plants for patient B, and so on. Documentation of caregiver status is not required under the state's law.

cases. In California, some local law enforcement officials said that their state's medical marijuana law makes them question whether it is worth pursuing some criminal marijuana cases because of concerns about whether they can effectively prosecute (e.g., with no statutory limit on the number of marijuana plants allowed for medical use, the amount consistent with a patient's personal medical purposes is open to interpretation). In Oregon, Hawaii, and Alaska where specific plant limits have been established, some law enforcement officials and district attorneys said that they were less likely to pursue marijuana cases that could be argued as falling under medical use provisions. For example, one Oregon District Attorney stated that because they have limited resources the District Attorneys might not prosecute a case where someone is sick, has an amount of marijuana within the medical use limit, and would probably be approved for a card if they did apply. Officers in Hawaii reported reluctance of a judge to issue a search warrant until detectives were certain that cultivated marijuana was not being grown for medical use, or that the growth was over the 25-plant limit qualifying for felony charges.

Less concrete, but of concern to law enforcement officials were the more subtle consequences attributed to the passage of state medical marijuana laws. Officials in over one-fourth of the 37 law enforcement organizations we interviewed indicated they believe there has been a general softening in public attitude toward marijuana, or public perception that marijuana is no longer illegal. For example, state troopers in Alaska said that they believe that the law has desensitized the public to the issue of marijuana, reflected in fewer calls to report illegal marijuana activities than they once received. Hawaiian officers stated that it is their view that Hawaii's law may send the wrong message because people may believe that the drug is safe or legal.

Several law enforcement officials in California and Oregon cited the inconsistency between federal and state law as a significant problem, particularly regarding how seized marijuana is handled. According to a California Attorney General official, state and local law enforcement officials are frequently faced with this issue if the court or prosecutor concludes that marijuana seized during an arrest was legally possessed under California law, and law enforcement is ordered to return the marijuana. To return it puts officials in violation of federal law for dispensing a Schedule I narcotic, according to the California State Sheriffs' Association, and in direct violation of the court order if they don't return it. The same issue has arisen in Portland, Oregon, officials said, when the Portland police seized 2.5 grams of marijuana from an individual. After the state dismissed charges, the court ordered the return of the marijuana to

the individual, who was a registered medical marijuana user. The city of Portland appealed the court order on grounds that its police officers could not return the seized marijuana without violating federal law, but the Oregon court of appeals rejected this argument in *Oregon v. Kama*.⁴⁰ Oregon officials said that DEA then obtained a federal court order to seize the marijuana from the Portland police department. The Department of Justice stated in comments on a draft of this report that they believe conflicts between federal and non-federal law enforcement over the handling of seized marijuana has been and will continue to be a problem.

Law enforcement officials in all four states identified areas of their medical marijuana laws that can hamper their marijuana enforcement activities because the law could be clearer or provide better control. In California, key issues were lack of a definable amount of marijuana for medical use, and no systematic way to identify who qualifies for the exemption. In Oregon, officers were concerned about individuals registering as medical marijuana users after they have been arrested, and timely law enforcement access to the registry information. Officials with about one-fourth of the law enforcement organizations in Hawaii, California and Oregon shared the concern about the degree of latitude given to physicians in qualifying patients for medical use.

Agency Comments and Our Evaluation

We provided a copy of a draft of this report to the Department of Justice for review and comment. In a September 27, 2002 letter, DOJ's Acting United States Assistant Attorney General for Administration commented on the draft. DOJ's comments are summarized below and presented in their entirety in appendix V.

In its comments, DOJ noted that the report fully described the current status of the programs in the states reviewed. However, DOJ stated that the report failed to adequately address some of the serious difficulties associated with such programs. Specifically, according to DOJ, the report

⁴⁰39 P.3d 866 (Or. Ct. App. 2002); *rev. den.*, 47 P.3d 484 (Or. S. Ct. 2002). In *Kama*, the city argued that, because marijuana is a Schedule I controlled substance, its police officers would commit the federal crime of delivering a controlled substance if they returned seized marijuana. The court of appeals disagreed, reasoning that the federal Controlled Substances Act, 21 U.S.C. 885(d), confers immunity on state or local law enforcement officials "lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances." The court concluded that, because the officers were required to return the seized marijuana under Oregon's medical marijuana act, Or. Rev. Stat. 475.323(2), federal law granted them immunity for doing so.

does not adequately address, through any considered analysis, issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase “medical marijuana” implicitly accepts a premise that is contrary to existing federal law.

In regard to the first issue—state laws that permit the use of marijuana and federal laws that do not—DOJ pointed out that the most fundamental problem with the report is that it failed to emphasize that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. We disagree, and believe that we have clearly described federal law on the use of marijuana. On page 1 of our report, we specifically state that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws.

In other comments about state and federal laws, DOJ also pointed out that our report failed to mention that state medical marijuana laws undermine (1) the closed system of distribution for controlled substances under the Controlled Substances Act and (2) the federal government’s obligations under international drug control treaties which, according to DOJ, prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. As discussed in our report, the legal framework for our work was the Supreme Court’s opinion in *United States v. Oakland Cannabis Buyers Cooperative*, 532 U.S. 483 (2001) which held that the federal government can enforce marijuana prohibitions without regard to a medical necessity defense, even in states with medical marijuana laws. During our review, we saw no reason to expand our analysis beyond that set forth in the Supreme Court’s decision. This is especially true since the scope of our work was to examine how the selected states were implementing their medical marijuana laws—not the issues raised in DOJ comments.

Regarding the second issue concerning the potential for illegal trafficking, DOJ commented that our report did not mention that state medical marijuana laws are routinely being abused to facilitate traditional illegal trafficking. DOJ also highlighted the lack of guidance provided by the California state government to implement its medical marijuana law as contributing to the problem in California. Our report discusses the views

of law enforcement officials representing 37 organizations in the four states—including federal officials—regarding the impact of state medical marijuana laws on their law enforcement efforts. Our report presented the views they conveyed to us. Thus, in those instances where law enforcement officials, including representatives of DEA and U.S. Attorneys’ offices, discussed what they considered instances of abuse or potential abuse, we discussed it in our report. During our review, none of the federal officials we spoke with provided information to support a statement that abuse of medical marijuana laws was routinely occurring in any of the states, including California. DOJ further asserted that we should include information on the “underlying criminal arena,” on homicides related to marijuana cultivation, and on illegal marijuana production and diversion. These issues were beyond the scope of our work.

In regard to its third comment pertaining to cooperation among federal, state, and local law enforcement officials, DOJ stated that our report did not reflect DEA’s experience—a worsening of relations between federal, state, and local law enforcement. DOJ’s comments provided specific examples of incidents involving conflicts between DEA and non-federal law enforcement officials, but these examples were not provided to us during our fieldwork. In comments on a summary of law enforcement opinions, some of the non-federal law enforcement officials we interviewed also stated we should discuss the conflict between state medical marijuana laws and federal laws as it related to seized marijuana.⁴¹ We modified our draft to include a discussion of these concerns, and have likewise included DOJ’s comment. It is also important to note, however, that contrary to DOJ’s suggestion, our report included a discussion about the concerns of the law enforcement officials regarding a “softening” of the public perception about marijuana. Finally, DOJ’s point that Oregon’s medical marijuana law negatively impacts federal seized asset sharing was an issue outside the scope of our review.

In regard to the fourth issue—lack of data on the medicinal value of marijuana—DOJ stated that our discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. We believe our report adequately discusses that a continuing debate exists. The overall objective of our review was to examine the implementation of state medical marijuana laws, and an analysis of the

⁴¹A summary of law enforcement opinions was sent to those we spoke with for their comments.

scientific aspects of the medical marijuana debate was beyond the scope of our work. We do, however, footnote various studies so that readers can access additional information on the studies if they desire.

Finally, we disagree with DOJ's comment that our use of the term medical marijuana accepts a premise contrary to federal law, given that we specifically defined the term in relation to state, not federal, law. As mentioned earlier, our report specifically states that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. Furthermore, the introduction to the report clearly points out that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

DOJ also provided technical comments, which we have included in this report, where appropriate. In addition, as mentioned earlier, some of the representatives of state law enforcement organizations provided comments on the section of the report dealing with their perceptions, and we have made changes to the report, where appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Ranking Minority Member, Subcommittee on Criminal Justice, Drug Policy and Human Resources, and the Chairman and Ranking Minority Member, House Committee on Government Reform; the Chairman and Ranking Minority Member of the House Judiciary Committee; the Chairman and Ranking Minority Member of the Senate Judiciary Committee; the Attorney General; and the Director, Office of Management and Budget. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions on this report, please contact me or John Mortin on (202) 512 -8777. Key contributors are acknowledged in appendix V.

Sincerely yours,

A handwritten signature in black ink that reads "Paul L. Jones". The signature is written in a cursive style with a long, sweeping underline.

Paul Jones
Director, Justice Issues

Appendix I: Objectives, Scope, and Methodology

Objectives

Our overall objectives were to provide fact-based information on how selected states implement laws that create a medical use exception to specified state marijuana prohibitions, and to document the impact of those laws on law enforcement efforts. Specifically, for selected states, our objectives were to provide information on (1) their approach to implementing their medical marijuana laws and how they compare, and the results of any state audits or reviews, (2) the number of patients that have had doctors recommend marijuana for medical use in each state, for what medical conditions, and by age and gender characteristics, (3) how many doctors are known to have recommended marijuana in each, and what guidance is available for making these recommendations, and (4) perceptions of federal and state law enforcement officials, and whether data are available to show how law enforcement activities have been affected by the exceptions provided by these states' medical marijuana laws.

We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards.

Scope and Methodology: State Selection and Data

Eight states have enacted medical marijuana statutes.¹ We selected four of those states based on the length of time the laws had been in place, the availability of data, and congressional interest. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Another two states, Maine and Washington, were not selected because they do not have state registries to obtain information on program registrants. Alaska, Oregon and Hawaii do have state registries and had laws in place for at least 6 months. California's law was enacted in 1996; however, the state does not have a participant registry. We included it because some local registry information was available, and the requestor specifically requested information on California and Oregon. Our sample consists of these four states: California, Oregon, Alaska, and Hawaii.

We conducted on-site data collection and interviews with senior officials at state registries in Oregon and Hawaii, county offices in selected California counties, and the senior official in Alaska by phone and email. We examined applicable federal and state laws and regulations and

¹These eight states were identified in the Supreme Court's decision in *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001).

obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors.

Data Reliability

State and California county officials voluntarily supplied data on medical marijuana program registrants and some provided data on physician participation. Officials did not provide names to protect participants' confidentiality. We reviewed the data for reasonableness and followed up with appropriate individuals about any questions concerning the data. Given the confidentiality of the information, we could not check the data back to source documents. We also interviewed knowledgeable state and county officials to learn how the data was collected and processed, and to gain a full understanding of the data. We determined the data was reliable enough for the limited purposes of this report. However, the data only reflects those that have registered with state and county programs. No estimate is available on the number of medical marijuana users that have not registered with a program. Additionally, data from the three state registries are not representative of participation in other states for which we did not collect data. Similarly, data from select California counties only reflect each county, not other counties where we did not conduct audit work.

Scope and Methodology: Law Enforcement Opinions

We used a nonprobability sample to select law enforcement representatives to provide examples of the policies, procedures, experiences, and opinions of law enforcement regarding state medical marijuana laws. Our selection of these law enforcement representatives was not designed to enable us to project their responses to others, in this case, other law enforcement officials. Feedback was requested from officials at law enforcement organizations we visited, and incorporated where appropriate.

We discussed state medical marijuana laws with federal, state and local law enforcement officials in the states of California, Hawaii, Oregon and Alaska. On-site interviews were conducted in all but Alaska.² Federal officials in each state included representatives from the office of the U.S. Attorney and the Drug Enforcement Administration (DEA). The specific

²As a result of phone discussions with law enforcement officials in Alaska, and the low number of registrants in Alaska's medical marijuana program, we decided that interviews could be conducted by email and phone.

U.S. Attorney and DEA office and officials we met with were selected by the Department of Justice as the most knowledgeable on the subject. For a statewide perspective, we interviewed representatives from the Attorney General's office and at least one statewide association in California and Oregon representing law enforcement officials. This included representatives from the following:

Oregon Attorney General
Oregon Association of Chiefs of Police
California Attorney General
California District Attorney Association
California State Sheriff's Association
Hawaii Attorney General
Hawaii Department of Public Safety
Alaska Attorney General
Alaska State Troopers

For a local law enforcement perspective, we interviewed district attorney and local police department officials. Selection was judgmental and based on a number of factors, including: suggestions by federal or state officials, jurisdictions where trips were planned to interview state medical marijuana registry program officials or state officials, or large portions of the state population were covered by the department. Local law enforcement representatives included the following:

Marion County Oregon District Attorney
Portland Oregon District Attorney
Portland Oregon Bureau of Police
Oregon State Police
Oregon Association of Chiefs of Police (Dallas Oregon Police Chief participated)
Clackamas County Oregon Sheriff's Office
Los Angeles California District Attorney
Los Angeles California Police Department
San Bernardino California Police Department
Orange California Police Department
Eureka California Police Department/ Humboldt (state) Drug Task Force
Arcata California Police Department
San Francisco California Police Department
Hawaii County Hawaii Prosecuting Attorney
Honolulu County Hawaii Prosecuting Attorney
Hawaii County Hawaii Police Department
Honolulu Hawaii Police Department

Maui Hawaii Police Department
Anchorage Alaska District Attorney
Anchorage Alaska Police Department
Juneau Alaska Police Department

We requested comments from DOJ on a draft of this report in August 2002. The comments are discussed near the end of the letter and are reprinted as appendix V. DOJ also provided technical comments on the draft of this report and we incorporated DOJ's comments where appropriate. In addition, we requested comments from the law enforcement officials we interviewed pertaining to the section of this report dealing with their perceptions and included their comments where appropriate. Finally, we verified the information we obtained on the implementation of state medical marijuana laws with the officials we contacted during our review.

Appendix II: The Supreme Court's Decision in *United States v. Oakland Cannabis Buyers' Cooperative*

Under the federal Controlled Substances Act of 1970 (CSA), marijuana is classified as a Schedule I controlled substance, a classification reserved for drugs found by the federal government to have no currently accepted medical use. 21 U.S.C. 812(c), Schedule I (c)(10).

Consistent with this classification system, the CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the less restrictive drug schedules. *Id.* 829. In particular, the CSA prohibits all possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project. *Id.* 823(f), 841(a)(1), 844.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law, when, in 1996, California voters passed a ballot initiative, Proposition 215, which removed certain state criminal penalties for the medical use of marijuana.

In the wake of Proposition 215, various cannabis clubs formed in California to provide marijuana to patients whose physicians had recommended such treatment. In 1998, the United States sued to enjoin one of these clubs, the Oakland Cannabis Buyers' Cooperative, from cultivating and distributing marijuana. The United States argued that, whether or not the Cooperative's actions were legal under California law, they violated the CSA. Following lower court proceedings, the U.S. Supreme Court granted the government's petition for a writ of certiorari to review whether the CSA permitted the distribution of marijuana to patients who could establish "medical necessity." *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

Although the tension between California's Proposition 215 and the broad federal prohibition on marijuana was the backdrop for the *Oakland Cannabis* case, the legal issue addressed by the Supreme Court did not involve the constitutionality of either the federal or state statute. Rather, the Court confined its analysis to an interpretation of the CSA and whether there was a medical necessity defense to the Act's marijuana prohibitions. The Court held that there was not. While observing that the CSA did not expressly abolish the defense, the Court stated that the statutory scheme left no doubt that the defense was unavailable for marijuana. Because marijuana appeared in Schedule I, it reflected a determination that marijuana had no currently accepted medical use for purposes of the CSA. The Court concluded that a medical necessity defense could not apply under the CSA to a drug determined to have no medical use.

**Appendix II: The Supreme Court's Decision in
United States v. Oakland Cannabis Buyers'
Cooperative**

The *Oakland Cannabis* case upheld the federal government's power to enforce federal marijuana prohibitions without regard to a claim of medical necessity. Thus, while California (and other states) exempt certain medical marijuana users and their designated caregivers from state sanctions, these individuals remain subject to federal sanctions for marijuana use.

Appendix III: Medical Marijuana Registries in Oregon, Alaska, Hawaii, and Select California Counties

How states implemented registry requirements in the three registry states, such as which agency administers the registry or the number of staff to manage it, varied in some ways and were similar in other ways. Similarly, the county-based registries in California had some differences and commonalities.

Oregon

In Oregon, the Department of Human Services is designated to maintain the state medical marijuana registry. A staff of six is responsible for reviewing and verifying incoming applications and renewals, including following up on those that are incomplete, and input and update of the database. Recommending physicians are sent, and must respond to a verification letter for the application to be approved. By statute in Oregon, an applicant can be denied a card for only two reasons—submitting incomplete or false information. According to the State Public Health Officer, the scope of the Department of Human Services responsibility is to see to that there is a written determination of the patient’s condition by a legitimate doctor, and includes an attending physician recommendation that the patient might benefit from using marijuana. He stated that the staff does not question a doctor’s recommendation for medical marijuana use. The law is clear, he said. It is up to the physician to decide what is best.

The Oregon Department of Human Services also considers the addition of new conditions to the list of those acceptable for medical use of marijuana, as authorized by Oregon’s medical marijuana statute. At the time of our review, only one of the eight petitions that had been reviewed by the Department had been approved—agitation due to Alzheimer’s disease. Most of the petitioned conditions have had a psychological basis, the State Public Health Officer said.

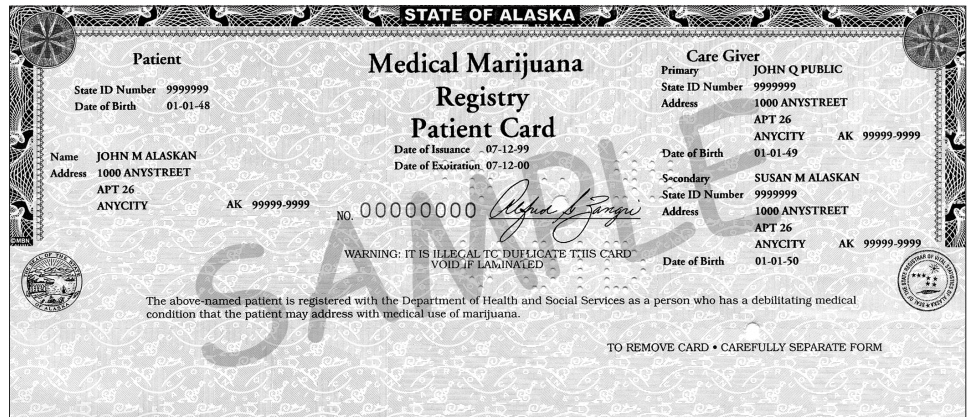
Alaska

Alaska’s statute designates the Department of Health and Social Services to manage the state medical marijuana registry. The full time equivalent of one half-time person is responsible for registry duties, including checking applications for accuracy and completeness and entering the information into the registry. The physician’s license is checked for approval to practice in Alaska, and if a caregiver is designated the registry is checked to assure they are only listed as a caregiver for one person unless otherwise approved by the Department. Patients, physicians and caregivers are also contacted to verify information as appropriate. If all Alaska statutory requirements are met, a medical marijuana registry identification card is issued (see fig. 4). Registry cards are denied in Alaska

Appendix III: Medical Marijuana Registries in Oregon, Alaska, Hawaii, and Select California Counties

if the application is not complete, the patient is not otherwise qualified to be registered, or if the information in the application is found to be false.

Figure 3: Example of Alaska’s Medical Marijuana Certification Card



Source: Alaska Department of Health and Social Services.


Alaska’s statute allows the Department to add debilitating medical conditions to the approved list for use of marijuana. A procedure for requesting new conditions is outlined in state regulations. To date, there have been no requests to consider new conditions and none have been added.

Hawaii

The medical marijuana law passed by the Hawaiian legislature designates the state Department of Public Safety to administer the Hawaiian medical marijuana registry. One person within Public Safety’s Narcotics Enforcement Division staffs the registry. This person is responsible for reviewing and approving applications and renewals as complete, inputting applicant information into the database, and responding to any law enforcement inquiries. Verification procedures in Hawaii are similar to those followed in other states. See figure 4 for an example of Hawaii’s registry card.

Appendix III: Medical Marijuana Registries in Oregon, Alaska, Hawaii, and Select California Counties

Figure 4: Example of Hawaii's Medical Marijuana Registry Card

 **State of Hawaii
Department of Public Safety
Narcotics Enforcement Division
Medical Marijuana Registry
Patient Identification Certificate**

Patient: ALOHA, LEI
789 Malihini Street
Honolulu, HI 96816

DOB: 12/31/2000
Patient ID No.: 123-12-1234

Caregiver: PALANI KING
567 Date Street
Honolulu, HI 96870
Caregiver ID No.: H0006789

Location of Marijuana:

Physician: JOHN A APPLEWAY, md

Physician's Signature

Expiration Date: 1/31/2003
Registration No.: **MJ50000**

Division Administrator

**WARNING: IT IS ILLEGAL TO DUPLICATE THIS CARD
LLAW 0225 (12-00)**

Source: State of Hawaii Department of Public Safety.

California

Registration application requirements and procedures for the voluntary California registries we reviewed were unique to each county, but shared some procedures with the programs established in the registry states.

In Humboldt County, the patient must submit an application and physician recommendation to the county Department of Health and Human Services, with a \$40.00 fee. Applicants are interviewed, photographed, and their county residency documents are checked during an in-person interview. To protect the confidentiality of doctors, after the physician recommendation has been verified, the physician portion of the application is detached and shredded. Applications are denied if the patient is not a county resident, the physician is not licensed in California, or there is not a therapeutic relationship between the patient and physician.

The San Francisco Medical Cannabis ID Card Program applications are made available through the city's Department of Public Health, where the registry is maintained, and also from clinics, doctor's offices and medical cannabis organizations that have requested them. Applicants must bring a physician's statement form, or form documenting that an oral recommendation was received, medical records release form, proof of identification and residence in San Francisco and the fee. For an applicant the fee is \$25.00, plus \$25.00 for each primary caregiver, up to a maximum of three caregivers. Registry cards are valid for up to 2 years, based on a physician's recommendation. After verifying the application documents to its satisfaction, the Department returns the entire application package to the applicant, and issues cards to the applicant and caregivers. The department does not copy the materials, or keep the name of registrants. Information kept on file is limited to the serial number of the cards issued, the serial number of the identification card submitted, the date the registry card was issued, and when it expires.

The Mendocino County Public Health Department and the Sheriff's office jointly run the County Pre-identification Program for county residents. The Health Department accepts the applicant's Medical Marijuana Authorization forms, which includes patient and caregiver information, and a section for the physician to complete. The physician section requires checking "yes" or "no" to a recommendation, and the expiration length for the recommendation in months, years or for the patient's lifetime. No condition information is requested. After verifying the physician recommendation, that section is destroyed, and the approved authorization sheet is sent to the Sheriff's office. The Sheriff's office interviews registrants and caregivers, requiring that they sign a declaration

as to the caregiver's role in patient care. Program identification cards with photographs of patients and caregivers are issued by the Sheriff's office.

In Sonoma County, the Sonoma County Medical Association, in conjunction with the Sonoma County District Attorney, developed a voluntary process for the medical association to provide peer review of individuals' medical records and physician recommendations for medical use of marijuana. Based on the review, the patient's physician is sent a determination regarding whether the patient's case met criteria established regarding the patient-physician relationship, whether marijuana was approved of, and whether the condition is within the California state code allowing medical marijuana use. Upon receiving the determination from their doctor, patients decide whether to voluntarily submit the results to the District Attorney for distribution to the appropriate police department or to the sheriff's office. According to the medical association director, some patients will go through the process but prefer to keep the letter themselves rather than have their name in a law enforcement database.

Appendix IV: Descriptions of Allowable Conditions under State Medical Marijuana Laws

Medical marijuana laws in California, Oregon, Hawaii and Alaska identify medical conditions or symptoms eligible for medical marijuana use, but do not specifically define the conditions or symptoms. The following descriptions are based on definitions in the Merriam Webster Medical Dictionary and selected other sources.

Alzheimer's Disease: Alzheimer's is a brain disease that usually starts in late middle or old age. It is characterized as a memory loss for recent events spreading to memories for more distant events and progressing over the course of five to ten years to a profound intellectual decline characterized by impaired thought and speech and finally complete helplessness.

Anorexia: Anorexia is a lack, or severe loss of appetite, especially when prolonged. Many patients develop anorexia as a secondary condition to other diseases.

AIDS: Acquired Immune Deficiency Syndrome is a severe disorder caused by the human immunodeficiency virus, resulting in a defect in the cells responsible for immune response that is manifested by increased susceptibility to infections and to certain rare cancers.

Arthritis: Arthritis refers to the inflammation of joints, usually accompanied by pain, swelling, and stiffness.

Cachexia: Cachexia is a general physical wasting and malnutrition usually associated with chronic disease, such as AIDS or cancer.

Cancer: Cancer is an abnormal growth that tends to grow uncontrolled and spread to other areas of the body. It can involve any tissue of the body and can have many different forms in each body area. Cancer is a group of more than 100 different diseases. Most cancers are named for the type of cell or the organ in which they begin.

Crohn's Disease: Crohn's disease is a serious inflammatory disease of the gastrointestinal tract, it predominates in parts of the small and large intestine causing diarrhea, abdominal pain, nausea, fever, and at times loss of appetite and subsequent weight loss.

Epilepsy: Epilepsy is a disorder marked by disturbed electrical rhythms of the central nervous system and typically manifested by convulsive attacks, usually with clouding of consciousness.

Glaucoma: Glaucoma is a disease of the eye marked by increased pressure within the eyeball that can result in damage to the part of the eye referred to as the blind spot and if untreated leads to gradual loss of vision.

HIV: Human Immunodeficiency Virus is a virus that reduces the number of the cells in the immune system that helps the body fight infection and certain rare cancers, and causes acquired immune deficiency syndrome (AIDS).

Migraine: A migraine is a severe recurring headache, usually affecting only one side of the head, characterized by sharp pain and often accompanied by nausea, vomiting, and visual disturbances.

Multiple Sclerosis: Multiple Sclerosis is a disease of the central nervous system marked by patches of hardened tissue in the brain or the spinal cord causing muscular weakness, loss of coordination, speech and visual disturbances, and associated with partial or complete paralysis and jerking muscle tremor.

Nausea: Nausea refers to a stomach distress with distaste for food and an urge to vomit. Severe Nausea refers to nausea of a great degree.

Pain: Pain refers to an unpleasant sensation that can range from mild, localized discomfort to agony. Pain has both physical and emotional components. The physical part of pain results from nerve stimulation. Pain may be contained to a discrete area, as in an injury, or it can be more diffuse, as in disorders that are characterized as causing pain, stiffness, and tenderness of the muscles, tendons, and joints. Severe pain refers to pain causing great discomfort or distress. Chronic pain is often described as pain that lasts six months or more and marked by slowly progressing seriousness.

Spasticity: Spasticity is a condition in which certain muscles are continuously contracted. This contraction causes stiffness or tightness of the muscles and may interfere with gait, movement, and speech. Symptoms may include increased muscle tone, a series of rapid muscle contractions, exaggerated deep tendon reflexes, muscle spasms, involuntary crossing of the legs, and fixed joints. The degree of spasticity varies from mild muscle stiffness to severe, painful, and uncontrollable muscle spasms.

**Appendix IV: Descriptions of Allowable
Conditions under State Medical Marijuana
Laws**

Wasting Syndrome: A condition characterized by loss of ten percent of normal weight without obvious cause. The weight loss is largely the result of depletion of the protein in lean body mass and represents a metabolic derangement frequent during AIDS.

Appendix V: Comments from the Department of Justice



U.S. Department of Justice

Washington, D.C. 20530

SEP 27 2002

Mr. Paul Jones
Director
Justice Issues
U.S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Jones:

On August 26, 2002, the General Accounting Office (GAO) provided the Department of Justice (DOJ) copies of its draft report entitled "MEDICAL MARIJUANA: Early Experiences With Four States' Laws." While we note that the report fully describes the current status of the programs in the states reviewed, we are concerned that it fails to adequately address some of the serious difficulties associated with such programs. The DOJ believes the report does not adequately address, through any considered analysis, issues related to the 1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; 2) potential for facilitating illegal trafficking; 3) impact of such laws on cooperation among federal, state, and local law enforcement; and 4) lack of data on the medicinal value of marijuana. Further, the GAO's continued use of the term "medical marijuana" implicitly accepts the fact that there is a 1) proven medicinal value to marijuana and 2) legitimate exception to federal law for this use. Neither of these premises are true. Finally, we note that the GAO fails to consider what the existence of state "medical marijuana" laws communicates. We believe such laws send society the wrong message.

Conflict Between Laws

The most fundamental problem with the draft GAO report is that it fails to emphasize the fact that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. Further, the GAO fails to even mention that state laws purporting to approve marijuana for medical use undermine the closed system of distribution for controlled substances established by the Controlled Substances Act (CSA). The time-proven safeguards that have made the medical drug supply in the United States the safest in the world are lacking. State medical marijuana legislation does not and could not require the cultivators and distributors of marijuana to comply with the federal requirement that all manufacturers and distributors of Schedule I controlled Substances be registered with the Drug Enforcement Administration (DEA). The registration process and record-keeping requirements established by federal law and administered by DEA are critical components of DEA's

Mr Paul Jones

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effort to restrict abuse of marijuana and other controlled substances. In this regard, there is no analysis nor comparison of state controls of marijuana subject to state "medical marijuana" laws with federal and state controls of other prescribed medicines covered by the CSA. The regulation of the production and distribution of prescribed medicines is a critical component in preventing the diversion of controlled substances that are properly prescribed for medical use. A comparison of DEA's controls of other legitimately prescribed controlled substances would highlight the lack of proper oversight of marijuana as a "medicine."

The registration process is also an important aspect of the United States Government's implementation of international drug control treaties. These treaties obligate the federal government to prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. The treaties also obligate the federal government to control the distribution of marijuana. This is required even if the federal government determines that marijuana has an accepted medical use. Any state legislation purporting to authorize medical use of marijuana is inconsistent with the CSA as none of these state laws require the cultivation of marijuana that is federally licensed and supervised by the federal government. These state laws undermine the ability of the federal government to meet its obligations under international law. The GAO Draft Report makes no mention of this critical issue.

Abuse of State Laws to facilitate Illegal Drug Trafficking

The GAO Draft Report does not mention that state "medical marijuana" laws are routinely being abused to facilitate traditional illegal marijuana trafficking and use. Information acquired by DEA during its investigations of cannabis clubs would provide specific examples of this abuse. The report focuses exclusively on so-called medical use of marijuana and omits any mention of the abuse of state "medical marijuana" laws. The report fails to reflect the underlying criminal arena in which marijuana is produced and consumed and the significant profitability that drives the marijuana market. Because of that factor, there is a blurred line between medical and illegal commercial markets. Further, some U.S. Attorney's Offices have indicated that in their district violent crimes associated with marijuana cultivation (such as homicides) create significant law enforcement and social issues. Without addressing the illegal production and diversion of marijuana, the GAO Draft Report provides an incomplete analysis of the impact of the "medical" marijuana laws on the enforcement of drug control laws.

The passage of Proposition 215 in California and similar legislation in other states has created unfortunate circumstances for state and local law enforcement officers. The state initiatives also have provided legal loopholes for drug dealers and marijuana cultivators to avoid arrest and prosecution. This is due in part to California state government's lack of guidance as to the implementation of the law and their seeming unwillingness to enforce state drug laws against traffickers who claim to be involved with marijuana under the state "medical marijuana" law. Further, those counties that have taken a public position on proposition 215 have contributed to the dilemma now being experienced by state and local law enforcement. The vague guidelines established throughout the counties in California sends a message to many that anyone who has a "recommendation" from a doctor is permitted to grow and possess certain (varying) amounts of marijuana.

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Impact on Law Enforcement Operations and Cooperation

The GAO Draft Report states that "[s]ome of the federal law enforcement officials we interviewed indicated that the introduction of state "medical marijuana" laws has had little impact on their operations." This statement does not accurately reflect DEA's experience in addressing state "medical marijuana" laws. One of the major effects of the states legislation is the worsening of relations between federal, state, and local law enforcement.

As a result of these circumstances the most significant issue that now appears to be occurring is the recognizable rift that the laws have created between state and local law enforcement and federal drug agents, who are mandated to enforce the federal law. There have been and undoubtedly will continue to be instances that occur in the affected states where local officers working joint investigations with DEA have been ordered or instructed not to seize contraband plants and/or marijuana by their district attorney or state's attorney office. In some cases, DEA has been required to obtain Federal warrants to seize marijuana being held by local police agencies to prevent the return of the marijuana to persons pursuant to State court orders. This conflict has lead to several heated incidences on the West Coast.

For example, in one recent case, where federal agents were cooperating with local officers to serve a state search warrant at a residence, the District Attorney of Butte County, California, advised a Butte County detective to arrest a DEA Special Agent if the agent confiscated six marijuana plants that were found during the operation. The District Attorney asserted that under California's "medical marijuana" law the plants were lawfully possessed; however, such possession violates federal law. The plants were seized and submitted to the DEA laboratory for destruction without incident only after negotiations between the U.S. Attorney, the District Attorney, and DEA representatives to resolve the issue. In another instance, the Oakland Police Department referred to the DEA a shooting incident involving the theft of a pound of marijuana because the city of Oakland prohibits its officers from pursuing any investigation of marijuana that may be claimed to be subject to the state "medical marijuana" law. In this instance the "victim" of the robbery was a marijuana recipient under the state "medical marijuana" law who was attempting to sell the marijuana he had to his robbers. Such conflicts over individual mandates have required frequent intervention by DEA's Office of Chief Counsel and the DOJ due to the clear lack of a coordinated drug law enforcement policy.

Because state and local law enforcement cannot work on certain marijuana cases under these laws, federal seized asset sharing has been negatively impacted. In the state of Oregon, the state legislation prevents the federal government from sharing seized assets directly with state/local law enforcement entities in cases involving asset seizure without criminal prosecution initiated following marijuana grow seizures.

It is much more difficult for federal and state officials to prosecute marijuana cases where medicinal use can be claimed. There is growing local sentiment that because of these laws, federal law enforcement resources should not be devoted to marijuana prosecutions. This sentiment also manifests itself in jury

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trials where prosecutors have jury nullification concerns (as a result of softened public attitudes towards marijuana).

In these states, the perception that marijuana is accepted by the public has significantly impacted law enforcement. According to Oregon State Police authorities, outlaw motorcycle gang members are now applying for marijuana caregiver status, believing that this will officially authorize their marijuana grow operations. Marijuana grow operations have always presented problems to law enforcement, and marijuana potentially subject to state "medical marijuana" laws only serve to further confuse the general public on this drug. Public perception on this issue appears to be further softened as a result of strong marketing strategies by pro-legalization/medicinal use advocates. Groups supporting the legalization of marijuana in Alaska are now preparing new proposals to legalize all marijuana. The public confusion on this issue can be demonstrated by the fact that the voters in these states approved the medical use of marijuana but *do not allow use in public places* (Oregon) or in *medical facilities*, or nearby school grounds, recreation centers or youth centers (Alaska). This sends a mixed message to the public as no other medicines are restricted in this way.

Marijuana As Medicine

The GAO Draft Report's discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. The draft states that "[t]he potential medical value of marijuana has been a continuing debate." It fails to mention, however, that smoked marijuana has never been approved as medicine by the Food and Drug Administration (FDA) and has never been proven safe and effective in sound scientific studies. Further, at its 2001 Annual Meeting, the American Medical Association (AMA) adopted the following as its policy on the medicinal use of marijuana:

"The AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease; (2) The AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) The AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. . . . (4) The AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana."

We also believe the GAO Draft Report should at least reference DEA final orders concerning petitions to reschedule marijuana published in 1992 and 2001. These reports contain a comprehensive explanation of the scientific and legal bases for keeping marijuana in Schedule 1.

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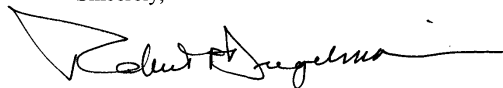
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In addition, the GAO Draft Report fails to mention that medical "marijuana" is legally available in the prescription drug Marinol. A pharmaceutical product, Marinol is widely available by prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch, The active ingredient in Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients. Unlike smoked marijuana—which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke—Marinol has been studied and approved by the medical community and the FDA. Information about Marinol is necessary to understand the debate over medical use of marijuana.

There is no mention in the report on the prescription of Marinol in these states, or more specifically the doctors identified in the study, as compared to doctors not prescribing marijuana under state "medical marijuana" laws versus their prescriptions authored for Marinol, if any. Although the information concerning the prescription of Marinol may not yet be available, it would be available through a longer term study by DEA Office of Diversion Control. It would be informative to determine if Marinol is sold in any quantity to pharmacies in these states by distributors for the manufacturer, both before and after state "medical marijuana" legislation was passed.

As noted by the above comments, we believe that the report falls short by not adequately addressing these significant issues. I urge you will consider our concerns in preparing the final GAO report on this important subject. If you have any questions regarding the Department's comments, you may contact Vickie L. Sloan, Director, Audit Liaison Office, on (202) 514-0469.

Sincerely,



Robert F. Diegelman
Acting Assistant Attorney General
for Administration

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

Paul Jones (202) 512-8777
John Mortin (202) 512-8777

Staff Acknowledgments

Tanya Cruz, Christine Davis, Francisco Enriquez, Evan Gilman, and Monica Kelly made key contributions to this report.

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Jeff Nelligan, managing director, NelliganJ@gao.gov (202) 512-4800
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