

# **An Open Policy Recommendation to the New York State Legislature Calling for the Legalization of Medical Marijuana in New York**

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## Executive Summary

A number of recent academic, scientific and popular studies suggest that marijuana may have medical value in treating patients with such serious illnesses as Acquired Immunodeficiency Syndrome (AIDS), cancer, multiple sclerosis, epilepsy and chronic pain.<sup>1</sup> Surveys conducted throughout the nation over the past decade indicate that a significant majority of U.S. citizens may favor partial or complete legalization of marijuana when its use, under physicians' supervision, may be medically effective in treating (or at least alleviating the suffering of) seriously ill individuals.<sup>2</sup>

Twelve states (Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont and Washington) currently allow medical marijuana to be legally prescribed by physicians to their patients, and a thirteenth (Maryland) has a medical marijuana affirmative defense law that requires courts to consider a defendant's use of marijuana for medical purposes when prosecuting marijuana related cases in the state's courts.<sup>3</sup> Despite efforts by various elected officials and committees in both the State Assembly and Senate, New York does not currently permit the prescription or use of marijuana for medical purposes.

In point of fact, New York's criminal laws regarding marijuana and other recreational drugs are among the strictest in the nation, and have come under increasing scrutiny and been

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<sup>1</sup> Weiss, Rick. "Research Supports Medical Marijuana: AIDS Patients in Controlled Study Had Significant Pain Relief," *The Washington Post*, February 13, 2007, to cite one prominent recent study.

<sup>2</sup> Wolfe, Elizabeth, "75% in AARP Poll Back Medical Marijuana Use," December 19, 2004 (cited via *The Buffalo News*), to cite one oft-quoted recent survey.

<sup>3</sup> The National Organization for the Reform of Marijuana Laws, *Active State Medical Marijuana Programs*, 2007.

subjected to increasing criticism accordingly, most significantly for the very limited discretion judges are accorded in their sentencing decisions. The combined effect of 1979's so-called "Rockefeller Drug Laws" and Second Felony Offender Laws has been to dramatically increase the number of drug offenders incarcerated in New York State; in 1980, 11% of inmates were drug felons, while by 2002 the number had grown to 38% of New York's prison population.<sup>4</sup> Any attempt to pilot or evaluate medical marijuana programs in New York State must seriously consider the liability to participants given these rigid sentencing guidelines, and the broader issues associated with the prescription and use of medical marijuana must still be evaluated in a legal and political environment built around state, federal and International laws that fully criminalize all possession and sales of marijuana.

This is not to imply that change is impossible or inadvisable. Limited legislative and regulatory steps have already been taken toward reducing penalties associated with possession of small amounts of marijuana for personal use in New York; first and second possessions of 25 grams or less are now treated as civil citations, much like traffic tickets. Furthermore, the New York State Assembly passed a medical marijuana bill (A04867) on June 13, 2007, though it has yet to receive passage through the Senate, which has proposed its own competing bill.<sup>5</sup>

Given the failure of A04867 to be enacted into law during the 2007 legislative season, this policy briefing and recommendation white paper will summarize and review the historic and current issues associated with the prescription and use of medical marijuana in New York State for legislators and others interested in this policy matter, and then provide policy recommendations for the 2008 legislative season.

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<sup>4</sup> Drug Policy Alliance Fact Sheet, *Rockefeller Drug Laws*, Undated.

<sup>5</sup> New York State Assembly Bill Summary, Bill No. A04867A, June 13, 2007.

## The Policy Issue

The root social policy question underpinning the contemporary debate about medical marijuana prescription and use may be framed as follows: do United States citizens have a right to medically use a substance that can enhance their health and well-being, if the recreational sale and possession of said substance has been criminalized? This simply phrased question is doggedly difficult to answer, primarily because the issues it imbues lie at the center of a long-standing, complex tangle of criminal, constitutional, civil and administrative laws, which have political and legal ramifications at the state, federal and International levels.

A brief overview of the legal history of marijuana in the United States is necessary to put contemporary issues related to its medical use in context. The first federal law in the United States limiting or prohibiting recreational drug use was the Harrison Narcotics Tax Act of 1914, which applied to opium and coca plant derivatives, and was largely enacted as a companion-piece to the International Opium Convention of 1912, the world's first multinational attempt to stifle the opium trade. The Harrison Act did not ban cocaine and opiates outright, but rather called for them to be taxed—without providing a mechanism for the collection and administration of said taxes.<sup>6</sup>

After President Franklin Delano Roosevelt signed the similarly-structured Marihuana Tax Act in 1937, the production, distribution and consumption of marijuana were *de facto* treated as criminal acts by the United States Government, which refused to collect the small taxes or create the registry of licensed users and distributors cited in the law, but zealously prosecuted possession and sale of unlicensed marijuana with stiff fines and penalties.<sup>7</sup> While the Marihuana

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<sup>6</sup> Kennedy, Joseph E., "Drug Wars in Black and White." *Law and Contemporary Problems*, Summer 2003, Vol. 66 Issue 3.

<sup>7</sup> Drug Policy Alliance Fact Sheet, *Marijuana: The Facts*, April 10, 2006.

Tax Act law is often cited as the effective starting point of America's long-term "War on Drugs," in an ironic reversed precursor of the current trend of states challenging federal drug laws, the 1937 law was actually a federal response to a patchwork quilt of state and local marijuana laws dating back to 1914, when the New York City Sanitary Laws were amended to include marijuana among the list of prohibited drugs and substances.<sup>8</sup>

In 1915, Utah became the first state to fully prohibit the production, sale and use of marijuana, largely at the behest of the state's dominant Mormon Church, which prohibited the use of intoxicants or euphorants by its adherents. In 1927, New York passed its first state-wide law banning marijuana usage as part of its broader narcotics statutes, essentially citing what we would now refer to as the "stepping stone" or "pathway" argument, positing that marijuana was an entry level drug that would inexorably lead to abuse of harsher substances. By 1931, several other Northeastern states had passed laws similar to, and largely inspired by, New York's ban. A third group of states, largely in the Southwest, began to criminalize marijuana during the same period as part of a broad spectrum of actions designed to dissuade Mexican immigrants (who had traditionally and culturally smoked marijuana, and carried it with them into the United States) from remaining unmolested in the country. At the time the Marihuana Tax Act of 1937 was passed, 27 states in total had already enacted laws prohibiting or prescribing the use of marijuana.<sup>9</sup>

The Marihuana Tax Act remained in effect until 1969, when the Supreme Court ruled it unconstitutional in the case *Leary v. United States*, in which counter-culture guru Timothy Leary fought a drug bust at the United States-Mexico border all the way to the Supreme Court, arguing

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<sup>8</sup> Whitbread II, Charles H. and Richard J. Bonnie, "The Forbidden Fruit and the Tree of Knowledge: An Inquiry Into the Legal History of American Marijuana Prohibition," *Virginia Law Review*, Volume 56, Number 6, October 1970.

<sup>9</sup> Whitbread II, Charles H., "The History of Non-Medical Use of Drugs in the United States," a speech to the California Judges' Associations' Annual Conference, 1995.

that the Marihuana Tax Act, as structured and implemented, had forced him to incriminate himself in violation of the Fifth Amendment of the Constitution. Associate Justice John Marshall Harlan II wrote in his summary of the Court's ruling that ". . . at the time petitioner acquired marihuana he was confronted with a statute which on its face permitted him to acquire the drug legally, provided he paid the \$100 per ounce transfer tax and gave incriminating information, and simultaneously with a system of regulations which, according to the Government, prohibited him from acquiring marihuana under any conditions. We have found those regulations so out of keeping with the statute as to be *ultra vires*. Faced with these conflicting commands, we think petitioner would have been justified in giving precedence to the higher authority: the statute . . . Any other holding would give rise to additional knotty questions, such as whether petitioner's nonpayment of the transfer tax should be excused because of his actual or assumed reliance upon the erroneous administrative construction of the statute, under which he would not have been permitted to pay."<sup>10</sup>

The reprieve for would-be marijuana users and producers in the aftermath of *Leary v. United States* was brief: in 1970, Title II of the Comprehensive Drug Abuse and Prevention Control Act was enacted as the Controlled Substances Act (CSA). As the Harrison Act of 1914 had dovetailed with the International Opium Convention of 1912, the CSA was also designed to reflect international standards set in the Single Convention on Narcotic Drugs of 1961, which formally terminated the 1912 treaty, and which required signatories of the treaty to implement and maintain drug laws that kept pace with the changing face of the international drug trade and interdictions thereto. As implemented via Title 21, Chapter 13 of the U.S. Code, the CSA provides for central, federal regulation of controlled substances under the auspices of the U.S.

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<sup>10</sup> U.S. Supreme Court, *Leary v. United States*, 395 U.S. 6 (1969), 395 U.S. 6, decided May 19, 1969.

Attorney General, noting that “controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate. Thus, it is not feasible to distinguish, in terms of controls, between controlled substances manufactured and distributed interstate and controlled substances manufactured and distributed intrastate . . . federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic.”<sup>11</sup> As states begin to challenge federal laws related to the production, sale and use of marijuana for medical purposes, they potentially undermine this final provision related to effective control of interstate and international traffic.

The CSA further established five schedules of controlled substances, with marijuana listed on Schedule I, defined thusly: “(A) The drug or other substance has a high potential for abuse. (B) The drug or other substance has no currently accepted medical use in treatment in the United States. (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.”<sup>12</sup> The crux of the medical marijuana debate hinges on the second and third clauses of that definition, as proponents of medical marijuana would argue that the substance may be safely and effectively used under medical supervision, and therefore should be rescheduled.

Under the CSA, the Attorney General of the United States is granted authority to add or remove substances to any of the five schedules, or to transfer substances between schedules, but only after requesting that the Secretary of Health and Human Services provide “a scientific and medical evaluation, and his recommendations, as to whether such drug or other substance should be so controlled or removed as a controlled substance . . . the recommendations of the Secretary

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<sup>11</sup> 21 U.S Code § 801, (a)(6)-(7)

<sup>12</sup> 21 U.S Code § 812, (b)(1)

to the Attorney General shall be binding on the Attorney General as to such scientific and medical matters, and if the Secretary recommends that a drug or other substance not be controlled, the Attorney General shall not control the drug or other substance.”<sup>13</sup>

Via the Food and Drug Administration, one of its subsidiary agencies, the Department of Health and Human Services has been clear regarding its opinions on medical marijuana, per the following special inter-agency statement issued in 2006: “A growing number of states have passed voter referenda (or legislative actions) making smoked marijuana available for a variety of medical conditions upon a doctor's recommendation. These measures are inconsistent with efforts to ensure that medications undergo the rigorous scientific scrutiny of the FDA approval process and are proven safe and effective under the standards of the FD&C Act. Accordingly, FDA, as the federal agency responsible for reviewing the safety and efficacy of drugs, DEA as the federal agency charged with enforcing the CSA, and the Office of National Drug Control Policy, as the federal coordinator of drug control policy, do not support the use of smoked marijuana for medical purposes.”<sup>14</sup> Given this stance, it is highly unlikely that, within the current administration, the Secretary of Health and Human Services would recommend to the Attorney General of the United States that marijuana be rescheduled.

On a state level, New York criminalizes the possession, sale and cultivation of marijuana under a sentencing schedule that considers the quantity of marijuana involved, the number of prior offenses by the accused, and whether the marijuana was for private use or sale. Penalties may range from civil citations to Class C felonies, as summarized in the following tables, with

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<sup>13</sup> 21 U.S Code § 811, (b)

<sup>14</sup> U.S. Food and Drug Administration, Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine, FDA Press Office Press Release, April 20, 2006.

certain specific provisions within offense classes, and criminal statutes related to paraphernalia omitted for clarity of presentation:<sup>15</sup>

<b>Possession</b>	<b>Type of Offense</b>	<b>Incarceration</b>	<b>Fine</b>
25 g or less (first offense)	civil citation	none	\$100
25 g or less (second offense)	civil citation	none	\$200
25 g or less (3rd offense)	misdemeanor	5 days	\$250
25 g to 2 oz	misdemeanor	3 months	\$500
2 to 8 oz	class A misdemeanor	1 year	\$1,000
8 to 16 oz	class E felony	1 to 4 years	\$5,000
16 oz to 10 lbs	class D felony	1 to 15 years	\$5,000
10 lbs or more	class C felony	1 to 15 years	\$5,000
<b>Sale or Cultivation</b>	<b>Type of Offense</b>	<b>Incarceration</b>	<b>Fine</b>
2 oz or less gift	class B misdemeanor	3 months	\$500
24 g sale	class A misdemeanor	1 year	\$1,000
25 g to 4 oz	class E felony	1 to 4 years	\$5,000
4 to 16 oz	class D felony	1 to 7 years	\$5,000
16 oz to 10 lbs	class C felony	1 to 7 years	\$5,000
10 lbs or more	class C felony	1 to 15 years	\$5,000
Sale to a minor	class D felony	1 to 7 years	\$5,000

### Potential Policy Responses

In the face of an organized and generally draconian federal, state and International regulatory environment, researchers, physicians, healthcare services and patient advocates have begun to press for formal recognition that marijuana may be useful in selected medical applications. Most medical studies to date have focused on alleviating the suffering of severely, often terminally, ill individuals; the most commonly-cited and researched medical uses of

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<sup>15</sup> New York State Penal Code, Article 221

marijuana include treatment for chronic pain, neurological and movement disorders, the nausea of patients who are undergoing chemotherapy for cancer, AIDS-related cachexia (loss of appetite and weight), and glaucoma.<sup>16</sup> The Dartmouth Medical School's CORK database, an authoritative information bank for substance abuse clinicians, educators and policy makers, cited 115 studies from scholarly journals in its March 2007 update, with a majority reporting or favoring at least further testing for selected medical uses for marijuana, if not findings related to its efficacy.<sup>17</sup>

The formal contemporary challenge to centralized federal control and criminalization of marijuana began to achieve critical mass in 1996, when California voters passed Proposition 215, "The Compassionate Use Act," which allowed terminal patients to legally use marijuana for palliative care.<sup>18</sup> Twelve other states have since passed laws related to the prescription and use of medical marijuana, even though, as noted earlier, the federal Food and Drug Administration (FDA), Drug Enforcement Agency (DEA) and Office of National Drug Control Policy still do not support the use of smoked marijuana for medical purposes.<sup>19</sup>

The thirteen states have taken different approaches to the complexities associated with partially decriminalizing a substance that remains controlled under the terms of the CSA. Differences have generally clustered around the lists of covered medical conditions, authority for medical marijuana program administration, quantities of usable marijuana allowed, number of marijuana plants allowed, and whether participating patients must be registered as users by the states. An executive summary of the different approaches taken by twelve of the states follows;

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<sup>16</sup> United States Department of Health and Human Services, National Institutes of Health Fact Sheet: *Investigating Possible Medical Uses of Marijuana*, May 15, 2002.

<sup>17</sup> CORK Bibliography: Marijuana; Therapeutic Use, Project CORK, Dartmouth Medical School, 2007, cited via [www.projectcork.org](http://www.projectcork.org).

<sup>18</sup> Drug Policy Alliance Fact Sheet, *Marijuana: The Facts*, April 10, 2006.

<sup>19</sup> U.S. Food and Drug Administration, Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine, FDA Press Office Press Release, April 20, 2006.

Maryland is not included, as it does not have an active medical marijuana program, but rather only allows a medical marijuana affirmative defense in marijuana-related prosecution:<sup>20</sup>

State	Year	Conditions Allowed	Amount Allowed	Registry/defense Provisions
Alaska	1999	Cachexia, cancer, chronic pain, seizures, glaucoma, AIDS, MS, nausea.	One ounce usable, six marijuana plants, no more than three mature.	Confidential, with ID cards; unregistered may not claim affirmative defense.
California	1996	Arthritis, cachexia, cancer, chronic pain, AIDS, seizures, migraine, MS.	Eight ounces usable, six mature or twelve immature plants.	Voluntary registry mandated, but not widely implemented.
Colorado	2001	Cachexia, cancer, chronic pain, seizures, glaucoma, AIDS, MS, nausea.	Two ounces usable, six plants.	Confidential, with ID cards, affirmative defense allowed.
Hawaii	2000	Cachexia, cancer, chronic pain, Crohn's, seizures, glaucoma, AIDS, MS, nausea.	One ounce usable, seven plants, no more than three mature.	Mandatory, confidential with ID cards, affirmative defense allowed.
Maine	1999	Seizures, glaucoma, MS, nausea as a result of AIDS or cancer chemotherapy.	2.5 ounces usable, six plants, no more than three mature.	No registry, affirmative defense allowed.
Montana	2004	Cachexia, chronic pain, nausea, seizures, MS, Crohn's.	Six marijuana plants	Yes, confidential with ID cards.
Nevada	2001	AIDS, cancer, glaucoma, cachexia, seizures, nausea, chronic pain.	One ounce usable, seven plants, no more than three mature.	Confidential with ID cards, affirmative defense allowed.
New Mexico	2007	To be determined; rulemaking in process.	To be determined; rulemaking in process.	Confidential; defense provisions to be determined.
Oregon	1998	Alzheimer's, cachexia, cancer, chronic pain, seizures, glaucoma, AIDS, MS, nausea.	24 ounces usable, 18 plants, no more than six mature.	Confidential with ID cards, affirmative defense allowed.
Rhode Island	2006	Cachexia, cancer, glaucoma, Hepatitis, chronic pain, nausea, seizures, MS, Crohn's, Alzheimer's.	2.5 ounces usable, 12 plants.	Mandatory, confidential, ID cards, affirmative defense allowed.
Vermont	2004	AIDS, cancer, MS, cachexia, chronic pain, nausea, seizures.	Two ounces usable, seven plants, two mature.	Yes, mandatory, confidential with ID cards.
Washington	1998	Cachexia, cancer, AIDS, seizures, glaucoma, chronic pain, MS, Crohn's, hepatitis C.	60 day supply.	No registry, affirmative defense allowed.

The most significant federal challenge to the policy options represented by these 12 states' medical marijuana laws has been the 2005 Supreme Court ruling in the *Gonzalez v. Raich* case. Angel McClary Raich is a permanently disabled California woman who had found

<sup>20</sup> The National Organization for the Reform of Marijuana Laws, *Active State Medical Marijuana Programs*, 2007

significant palliative benefits for over five years from medical marijuana prescribed under the Compassionate Care Act. In 2002, county sheriffs and federal Drug Enforcement Agency (DEA) agents seized and destroyed six plants at the home of Diane Monson, the supplier of Raich's medical marijuana. Raich and Monson sued to stop the federal government from future raids and prosecution of medical marijuana users in California, where the Compassionate Care Act made possession and use legal. They won their case before the Ninth Circuit Court of Appeals, but their victory was overturned on government appeal by the United States Supreme Court.<sup>21</sup>

The Supreme Court ruled that under the Commerce Clause of the United States Constitution and per the terms of the CSA, the federal government can prosecute medical marijuana users, even in states where the drug had been legally prescribed by a physician. Associate Justice John Paul Stevens wrote the opinion of the court, which centered on two key determinations, as follows: "First, the fact that marijuana is used 'for personal medical purposes on the advice of a physician' cannot itself serve as a distinguishing factor. The CSA designates marijuana as contraband for *any* purpose; in fact, by characterizing marijuana as a Schedule I drug, Congress expressly found that the drug has no acceptable medical uses. Moreover, the CSA is a comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner. Indeed, most of the substances classified in the CSA 'have a useful and legitimate medical purpose' . . . Second, limiting the activity to marijuana possession and cultivation 'in accordance with state law' cannot serve to place respondents' activities beyond congressional reach. The Supremacy Clause unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail. Just as state acquiescence to federal regulation cannot expand the bounds of the

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<sup>21</sup> "Up in smoke," *Economist*, 00130613, 6/11/2005, Vol. 375, Issue 8430.

Commerce Clause, so too state action cannot circumscribe Congress' plenary commerce power.”<sup>22</sup>

Associate Justice Sandra Day O’Connor wrote the dissent for *Gonzalez v. Raich*, largely basing her perspective on the value and legitimacy of states’ rights to serve as incubators for experimental laws and policies. She concluded her dissent by noting: “Relying on Congress’ abstract assertions, the Court has endorsed making it a federal crime to grow small amounts of marijuana in one’s own home for one’s own medicinal use. This overreaching stifles an express choice by some states, concerned for the lives and liberties of their people, to regulate medical marijuana differently. If I were a California citizen, I would not have voted for the medical marijuana ballot initiative; if I were a California legislator I would not have supported the Compassionate Use Act. But whatever the wisdom of California’s experiment with medical marijuana, the federalism principles that have driven our Commerce Clause cases require that room for experiment be protected in this case.”<sup>23</sup>

While states may still permit the prescription and use of medical marijuana and allow for affirmative defense in cases of marijuana prosecutions under state laws, the ruling of *Gonzalez v. Raich* ensures that the United States’ government maintains the right and privilege to prosecute medical marijuana consumers and producers under federal statutes. This raises significant administrative and regulatory challenges with regard to securing and ensuring the privacy of medical marijuana consumers, especially in states with mandatory registries, where such forced self-enrollment being required to acquire a product in express violation of federal law could be interpreted as self-incrimination, much per the principles in the earlier *Leary v. United States* case. It is unclear to date how aggressive the federal government will be in pursuing medical

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<sup>22</sup> U.S Supreme Court, *Alberto Gonzales, Attorney General, et al. v. Angel McClary Raich, et al.* 545 U.S. 1; decided June 6, 2005.

<sup>23</sup> *IBID.*

marijuana prosecutions in the long term, and worth noting that two states (Rhode Island and New Mexico) have implemented medical marijuana programs even after the *Gonzalez v. Raich* ruling, perhaps recognizing the current value and possible future legal heft of Justice O'Connor's dissenting opinion.

Despite this continued expansion of state medical marijuana programs, given the current body of federal case law and regulations, state policy-makers must carefully and clearly evaluate questions of jurisdictional authority on behalf of their citizens when evaluating proposed medical marijuana laws, even in the face of popular referenda in support of such legislation. States must also realistically consider the political retaliatory power of the federal government when its elected and appointed leaders are of different parties and espouse different philosophical views on the medical marijuana debate than state leadership. While a dozen states have active medical marijuana programs, federal prosecution and intervention under conservative, Republican Attorneys General John Ashcroft and Alberto Gonzalez has largely been directed at liberal California and Oregon, while conservative Alaska, Montana and Nevada go largely unmolested.<sup>24</sup> Should New York pass a medical marijuana law and implement related programs, it is certainly more likely to be grouped with liberal, cosmopolitan California in the eyes of the Federal government than with the small (population-wise), more libertarian Rocky Mountain states.

Finally, it is also illustrative to note that legal resistance to state medical marijuana laws has not come only from the federal level. At the other end of the spectrum, zoning laws have been used in such seemingly progressive California cities as San Francisco to shutdown medical marijuana clubs for lack of applicable permits or for proximity to schools or churches. While

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<sup>24</sup> Schrag, Peter. "Getting the Blues: The Administration Appears Bent on Teaching Liberal States a Lesson." *The Nation*, August 4/11, 2003, p22-26.

voters may favor medical marijuana policies in the abstract, the reality of visibly, terminally or chronically ill patients congregating on community “pot clubs” has quickly raised “not in my backyard” concerns and reactions among home- and business-owners who view such traffic as detrimental to property values and public order.<sup>25</sup> State policymakers must certainly be sensitive to these tendencies among the voters who elect them, as home- and business-owners generally have greater social and economic capital than the individuals that medical marijuana policies are designed to serve.

### Recommendation

Having completed the more factual, objective background on the historic and current state of law and policy related to marijuana’s medicinal use and trade, we may now evaluate and recommend, in a more subjective and analytical fashion, the specific policy options available to Legislative members as they look to the 2008 season. In addition to finding a balance between current federal laws and regulations and any proposed state legislation, any potential policy responses must be crafted with the recognition that there would also be significant administrative complexities associated with regulating the production, distribution and consumption of medical marijuana, establishing a mechanism for enforcing such regulations, and prosecuting violators thereto.

For example, physicians are licensed to practice by the state, and legislation allowing them to prescribe medical marijuana must not be incompatible with the terms and conditions of their licenses, or the licenses issued to the hospitals and medical groups associated with them.<sup>26</sup> Furthermore, once medical marijuana has been prescribed, patients will then be presented with the challenge of acquiring it, since there is currently no legal mechanism for commercial or

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<sup>25</sup> Beato, Greg, “Pot Clubs in Peril.” Reason; Feb 2007, Vol. 38 Issue 9, p26-36.

<sup>26</sup> New York State Education Law, Title 8, Article 131, Sections 6520-6529.

pharmaceutical cultivation or sale of marijuana within New York. The infrastructure needed to support such programs could potentially be complex and expensive, with costs borne either directly (e.g. via taxes) or indirectly (e.g. via increased costs passed back to patients by physicians or insurers) by the state’s citizens. While the committees drafting health policy are not directly responsible for the rulemaking and administration associated with any proposed legislative policies, it is imperative that they ensure legislation be carefully crafted to facilitate successful implementation of any new state laws related to this controversial area.

At the simplest level, the policy options available in New York range from “do nothing” to “propose legislation to legalize medical marijuana.” The “do nothing” option is potentially the safest from a national political standpoint, at least until the states have a better sense of how vigorous federal medical marijuana prosecutions may be in the aftermath of *Gonzalez v. Raich*, and whether states which implemented medical marijuana programs after that ruling are challenged. The legislative option, on the other hand, is potentially the most popular and viable from a “street level” political standpoint.

In response to Assembly Bill A04867, a series of polls conducted in July 2007 by Mason-Dixon Polling & Research, Inc. of Washington, DC, revealed the following results from voters polled in a random selection of New York State Senate Districts in response to the question “Do you support or oppose allowing seriously and terminally ill patients to use and grow a limited amount of medical marijuana if their doctors recommend it?”<sup>27</sup>

<b>District</b>	<b>Support</b>	<b>Oppose</b>	<b>Undecided</b>
5th	76%	13%	11%
6th	70%	19%	11%
15th	63%	23%	14%

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<sup>27</sup> “New York Poll Results,” Marijuana Policy Project, July 2007, cited via [www.mpp.org](http://www.mpp.org).

22nd	73%	16%	11%
38th	69%	18%	13%
59th	61%	18%	21%

Another question in the same poll asked “Which position do you agree with more: Allowing medical marijuana sends the wrong message, or Medical marijuana should be allowed to the seriously ill?” The results of this poll were as follows:<sup>28</sup>

<b>District</b>	<b>Should Be Allowed</b>	<b>Sends Wrong Message</b>	<b>Undecided</b>
5th	76%	15%	9%
6th	68%	23%	9%
15th	68%	22%	10%
22nd	69%	20%	11%
38th	74%	18%	8%
59th	71%	19%	10%

*(Note for both tables: The 5<sup>th</sup> and 6<sup>th</sup> Districts are on Long Island, the 15<sup>th</sup> and 22<sup>nd</sup> are in New York City, the 38<sup>th</sup> is in the Hudson Valley, and the 59<sup>th</sup> is in Western New York)*

We can safely infer from these and other Statewide surveys that a majority of voters in New York State would favor a relaxation of criminal laws associated with medical marijuana in cases where it could mitigate the suffering of seriously or terminally ill individuals. Given this fact, the “do nothing” option seems not worth considering further, as it would represent a retreat and retrenchment from an important social policy of national import. New York has traditionally taken a leadership role in similar historical matters that have risen to vex the national consciousness, including abolition, voting rights for women, civil rights for minorities, consumer and environmental protection and reproductive rights. If the people of New York desire a similar

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<sup>28</sup> “New York Poll Results,” Marijuana Policy Project, July 2007, cited via [www.mpp.org](http://www.mpp.org).

progressive role in this current matter of national debate, it is incumbent upon the state's lawmakers to engage the issue in a productive fashion.

A cautious and conservative (and hence more likely to succeed) approach to legalizing medical marijuana in New York could be crafted by combining the most limiting provisions of the twelve states with legal prescription and palliative use programs in effect. Such an approach would result in a broad set of functional requirements as follows:

- Conditions for which medical marijuana may be prescribed: Cachexia, seizures, chronic pain, nausea associated with AIDS, Cancer, Hepatitis, Multiple Sclerosis, Crohn's Disease or Alzheimer's Disease.
- Amounts allowed: One ounce usable, six plants, with no more than three mature.
- Registry provisions: Mandatory confidential registry with issued ID cards.
- Affirmative defense provisions: affirmative defense allowed for individuals on the state registry, but not for individuals who do not register.

Within this general menu of options, policy proposals must be clearly crafted to provide effective guidelines for all elements of lawmaking, rulemaking and implementation, including:

- Robust legislative language that can satisfy both the Assembly and the Senate;
- Regulatory guidance on how to translate law into action by crafting the terms and conditions under which the legislative response will be enacted;
- Enforcement guidance to ensure that laws and regulations are fairly and consistently interpreted and executed at "street level;"
- Administrative guidance to assist in establishing responsibilities for permitting, licensing or other state-sanctioned actions to control the trade of medical marijuana.

Given the fact that the proposed medical marijuana bill A04867 passed in the Assembly in 2007, but was not endorsed by the Senate, which has since drafted its own medical marijuana bill, a side-by-side evaluation of the language in the two bills could help in developing a compromise bill with a higher probability of passing through both houses of the State Legislature. The following table presents the summary language from the 2007 Assembly and Senate bills, sorted by functional elements to allow ready review of similarities and differences:

<b>Element of Legislation</b>	<b>Assembly Bill A04867<sup>29</sup></b>	<b>Senate Bill S06303<sup>30</sup></b>
What is legalized?	Legalizes the possession, manufacture, use, delivery, transfer, transport or administration of marihuana by a certified patient or designated caregiver for a certified medical use;	Legalizes the possession, manufacture, sale, administration, delivery, dispensing and distribution of marihuana in connection with medical use thereof for certified patients;
Who medically prescribes marijuana and to whom?	prescribes procedures for such possession, manufacture, etc. including certification of patients by their practitioner, and that, in the practitioner`s professional judgment, the serious condition should be treated with the medical use of marihuana;	prescribes procedures for such possession, manufacture, sale, etc. including certification of patients by their physician, for a specified period, not to exceed one year (to the effect that the patient has a serious condition, and that the patient is under the practitioner`s care for such condition, and that, in the physician`s medical judgment, the condition can and should be treated with the medical use of marijuana);
From whom will medical marijuana users acquire the drug?	<i>(No analogous text)</i>	permits registered organizations to sell, administer, deliver, etc. marijuana to certified patients or the caregiver of a certified patient for certified medical use, and permits caregivers of a certified patient to sell, administer, deliver, etc. marijuana to a certified patient for a medical use, and also permits any federal, state or local law enforcement agency to sell, deliver, distribute, etc. marijuana to a registered organization;

<sup>29</sup> New York State Assembly Bill Summary, Bill No. A04867A, June 13, 2007.

<sup>30</sup> New York State Senate Bill Summary, Bill No. S06303, June 17, 2007.

<b>Element of Legislation</b>	<b>Assembly Bill A04867<sup>31</sup></b>	<b>Senate Bill S06303<sup>32</sup></b>
How much may users and their caregivers possess?	provides that possession or manufacture of marihuana shall be lawful under these provisions provided that the marihuana possessed does not exceed twelve plants and a total aggregate weight of two and a half ounces;	provides that possession or manufacture of marijuana shall not be lawful under these provisions if it is consumed or displayed in a public place or if the aggregate weight of the preparation, compound, etc. exceeds 8 ounces, excluding the weight of any food;
Who has regulatory oversight of the program?	directs the department of health to monitor such use and promulgate rules and regulations for registry identification cards;	directs the department of health to monitor such use and promulgate rules and regulations;
Who reports on the program, and to whom?	provides for reports by the department of health to the governor and legislature on the medical use of marihuana;	provides for reports by physicians and evaluation and reporting by the department.
Does this proposal impact other laws?	further provides for application to other laws.	<i>(No analogous text)</i>

The most encouraging aspect of this side-by-side analysis is the fact that both houses of the Legislature are, in fact, willing to consider some form of medical marijuana program in accordance with the wishes of the majority of the state's voters, and even the more conservative elements of each proposal are generally more permissive than the 12-state aggregate cautious proposal posited above. It is also encouraging to note that both the Assembly and the Senate language incorporate the regulatory, enforcement and administrative elements that will play a crucial role during rulemaking and implementation of such programs.

As to philosophical differences, the Assembly's bill was more attuned to patients' rights, placing more ownership of the process in the hands of consumers and prescribing physicians, while the Senate bill was more institutionally oriented, applying time limits and a more

<sup>31</sup> New York State Assembly Bill Summary, Bill No. A04867A, June 13, 2007.

<sup>32</sup> New York State Senate Bill Summary, Bill No. S06303, June 17, 2007.

restrictive operational procedure for acquiring and using medical marijuana. Surprisingly, the generally more conservative Senate allows for a larger quantity of usable marijuana to be held by consumers, but places restrictions on where they can use it and their ability to grow their own marijuana plants. Both houses place regulatory responsibility in the hands of the State Department of Health, though only the Assembly version explicitly cites user identification cards. The first priority in the Assembly language seems to be a desire to allow seriously ill New York citizens to receive care that may alleviate their suffering. The first priority in the Senate language seems to be a desire to ensure that medical marijuana laws don't inject additional street marijuana into the criminal underworld in the state.

In summary, on a broad basis, it is less a matter of contention between the Assembly and the Senate as to whether medical marijuana should be allowed in the state, but rather a matter of how it should be regulated, and how much independence and freedom patients, their caregivers and physicians should have to control their access to and use of marijuana. Given this fact and the prevailing political winds that will be blowing in 2008, there are two basic options available to members of the Assembly's Health Committee:

- Propose the same Assembly language in 2008, recognizing that it has no greater likelihood of passage than it did in 2007, but also recognizing that patients' rights must stand as the cornerstone to this or any other medical proposal, and that the state should not needlessly be party to private health related transactions between doctors and their patients, nor dictate where, how and for how long patients should receive treatment;
- Propose compromise language that incorporates selected elements of the Senate bill; while the provisions related to how long patients may use medical marijuana seem to

violate the sanctity of the physician-patient relationship, there may be room to yield on the process for acquiring marijuana, since there are legitimate concerns about small growers in the community either voluntarily sharing their prescribed marijuana, or falling victim to criminals or predators who would use the plants for criminal purposes.

The second option would have a higher likelihood of success in 2008, while the first option may be most likely to succeed in 2009, especially if the Democratic Party manages to wrest control of the Senate from the Republicans, or if a still-Republican Senate sees other states passing pro-medical marijuana referenda or laws in and around the 2008 electoral season. While in an idealized world, medical and legal decisions like those posed by the medical marijuana policy question would be addressed and resolved outside the rancor of the political process, in the real world, a key to political success is knowing when and how to deploy your best legislative efforts—with patience and a long view sometimes standing as the most useful virtues for policymakers.

My recommendation in light of all the factors presented above is that the Chair of the Assembly's Health Committee propose language essentially identical to A04867 in the 2008 legislative season, and be prepared to propose it again in 2009. If, by that time, the partisan political splits between the Assembly and Senate are unchanged, then revisions to legislative language that may cause some erosion of the ideal patient privacy protection provisions could become necessary. The bottom lines for New York's lawmakers are these: the majority of your voters want to see medical marijuana made available to severely ill state citizens, and the only way that federal laws related to medical marijuana are going to change in the long term is if

states continue to demand and use the “room for experimentation” that Justice O’Connor cited in her dissenting opinion to *Gonzalez v. Raich*.

It was a ragged composite of inconsistent state laws that were cobbled together in the early 20<sup>th</sup> Century in order to criminalize marijuana for any medical purposes on a national basis. Perhaps it will be a similar patchwork quilt of state laws allowing medical marijuana that will ultimately lead to the overturning of that nearly-century old ban. If that is to be the case, New York should join with California and the other 11 states with current medical marijuana provisions to demonstrate that such programs can be administered effectively, efficiently and safely, in accordance with the wills of their people. Your continued leadership on this issue is recommended and important—not only in New York State, but in our Nation at large.

## SOURCES CITED OR USED IN THIS PAPER

- [Anon]. Last resorts and fundamental rights: The substantive due process implications of prohibitions on medical marijuana. *Harvard Law Review* 118(6): 1985-2006, 2005.
- Beato, Greg. "Pot Clubs in Peril." *Reason*; Feb2007, Vol. 38 Issue 9, p26-36.
- Bleich, J. and Friedland, M. "The Supreme Court on dope: A balancing act between two doctrines." *The Oregon State Bar Bulletin* 65: 15-17, 2005.
- Breen, B. "The Cannabis Conundrum: Medical marijuana could be the next big thing in biotech, but not in the United States." *Fast Company*. 5 February 2004. 5 pp.
- CORK Bibliography: Marijuana; Therapeutic Use, Project CORK, Dartmouth Medical School, 2007, cited via [www.projectcork.org](http://www.projectcork.org).
- Drug Policy Alliance Fact Sheet, *Marijuana: The Facts*, April 10, 2006 (referenced via [www.drugpolicy.org](http://www.drugpolicy.org)).
- Drug Policy Alliance Fact Sheet, *Rockefeller Drug Laws*, Undated (referenced via [www.drugpolicy.org](http://www.drugpolicy.org)).
- Drug Policy Research Center. "How State Medical Marijuana Laws Vary: A Comprehensive Review." RAND, 2005.
- Joy, Janet E., Stanley J. Watson, Jr., and John A. Benson, Jr., editors. *Marijuana and medicine: assessing the science base*; Division of Neuroscience and Behavioral Health, Institute of Medicine. Washington, D.C.: National Academy Press, 1999.
- Kennedy, Joseph E., "Drug Wars in Black and White." *Law and Contemporary Problems*, Summer 2003, Vol. 66 Issue 3.
- The National Organization for the Reform of Marijuana Laws, *Active State Medical Marijuana Programs*, 2007 (referenced via [www.norml.org](http://www.norml.org)).
- New York State Assembly Bill Summary, Bill No. A04867A, June 13, 2007.
- New York State Senate Bill Summary, Bill No. S06303, June 17, 2007.
- New York State Education Law, Title 8, Article 131, Sections 6520-6529.
- "New York Poll Results," Marijuana Policy Project, July 2007, cited via [www.mpp.org](http://www.mpp.org).

- Pacula, Rosalie et al., "State Medical Marijuana Laws: Understanding the Laws and Their Limitations," *Journal of Public Health Policy*, Vol. 23, No. 4, 2003, pp. 411-437.
- Pongratz, M. Medical marijuana and the medical necessity defense in the aftermath of *United States v. Oakland Cannabis Buyers' Cooperative*. *Western New England Law Review* 25: 147-191, 2003.
- Schrag, Peter. "Getting the Blues: The Administration Appears Bent on Teaching Liberal States a Lesson." *The Nation*, August 4/11, 2003, p22-26.
- U.S. Department of Health and Human Services, National Institutes of Health Fact Sheet: *Investigating Possible Medical Uses of Marijuana*, May 15, 2002.
- U.S. Food and Drug Administration, *Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine*, FDA Press Office Press Release, April 20, 2006.
- U.S. House of Representatives. Report to the Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, *MARIJUANA: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*. United States General Accounting Office November 2002.
- U.S Supreme Court, *Alberto Gonzales, Attorney General, et al. v. Angel McClary Raich, et al.* 545 U.S. 1; decided June 6, 2005.
- U.S. Supreme Court, *Timothy Leary v. United States*, 395 U.S. 6 (1969), 395 U.S. 6.
- Ward, Robert W., *New York State Government: What It Does, How It Works*. Rockefeller Institute Press, 2002.
- Weiss, Rick. "Research Supports Medical Marijuana: AIDS Patients in Controlled Study Had Significant Pain Relief," *The Washington Post*, February 13, 2007.
- Whitbread II, Charles H. and Richard J. Bonnie, "The Forbidden Fruit and the Tree of Knowledge: An Inquiry Into the Legal History of American Marijuana Prohibition," *Virginia Law Review*, Volume 56, Number 6, October 1970.
- Whitbread II, Charles H., "The History of Non-Medical Use of Drugs in the United States," a speech to the California Judges' Associations' Annual Conference, 1995.
- Wolfe, Elizabeth, "75% in AARP Poll Back Medical Marijuana Use," December 19, 2004 (cited via *The Buffalo News*).