THE COMPASSIONATE USE DEFENSE

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The dozen most frequently asked questions about California's medical marijuana law. The Compassionate Use Act of 1996, enacted as Proposition 215 on November 5th and codified in Health and Safety Code section 11362.5, are;

1. Did the United States Supreme Court declare the law invalid?

NO. In *United States v. Oakland Cannabis Buyers Cooperative* (5-14-01) 532 U.S. __; 149 L.Ed. 2d 722; 121 S.Ct. __, the Court reversed the District Court's modified injunction which permitted OCBC to distribute marijuana to patient-members who demonstrated "medical necessity" because "we hold that medical necessity is not a defense to manufacturing and distributing marijuana," under the federal Controlled Substances Act, 21 U.S.C. 801 et seq., because Congress had determined by putting marijuana in Schedule 1 that "the drug has no currently accepted medical use in the United States, has a high potential for abuse, and has a lack of accepted safety for use under medical supervision."

As pointed out in a concurring opinion by Justice Stevens, joined by Souter and Ginsburg (Breyer recused himself because his brother issued the District Court order appealed), the OCBC cannot claim necessity based on a choice of evils faced by seriously ill patients by electing to become a distributor for such patients. However, the dicta in Justice Thomas' opinion that drew fire from the concurring Justices was his statement casting doubt on whether necessity can ever be a defense to any federal statute that does not explicitly provide for it.
Thus, while the decision puts individual patients in jeopardy of federal prosecution under the CSA, it leaves Health and Safety Code section 11362.5 intact. No California police or prosecuting agency can use the OCBC case as an excuse for not recognizing or accepting section 11362.5. Article 3, Section 3.5 of the California Constitution provides that an administrative agency, including one created by the Constitution or an initiative statute, has no power to refuse to enforce a statute on the basis of it being unconstitutional unless an appellate court has determined that such statute is unconstitutional.

On remand to the District Court, OCBC has contended that the CSA is beyond Congress' commerce clause power as applied to a California organization regulated by a municipality pursuant to the laws of California, which distributes medical cannabis grown in California by California cultivators, wholly within California to California patients for use in California, where such use has been recommended by California physicians. This and related constitutional issues are now in the Ninth Circuit Court of Appeals.

2. Where can I get it? Good question.
OCBC prohibits distribution even by not-for-profit cooperatives that are regulated by municipalities. On October 25, 2001, the DEA raided the LA. Cannabis Resource Center in West Hollywood, seizing computers, financial documents, 400 marijuana plants and medical records of about 3,000 current or former patients. Reports indicate that the DEA has stepped up enforcement activity since the *OCBC* decision.
The patient/caregiver can buy from a dealer, but the dealer is subject to arrest and prosecution under state law. Moreover, state law prohibits transportation (11360), without an explicit exemption under section 11362.5. (This is discussed in part 7 following). State law allows cultivation by a patient^caregiver, but only in amount consistent with current medical use). Whether such patients/caregivers may engage in cooperative efforts and how much they can grow are open questions.

3. Do I need a prescription?
NO. Although synthetic THC delta-9 (Marinol) can be prescribed (Schedule 3), marijuana cannot be prescribed (Schedule 1).
Section 11362.5(d) allows cultivation and possession "for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician."
Sudi Pebbles Trippet was convicted in 1995, before the enactment of the Compassionate Use Act, for transporting two pounds of marijuana in her vehicle. Her motion to dismiss on the ground of "religious necessity" was denied and her "medical necessity" defense was rejected in limine. She appealed in pro. per.
The Court, in *People v. Trippet*(1997) 56 C.A. 4th 1532,1538, recognizing "medical necessity" as a defense and quoting from *People v. Pena* (1983) 149 C.A. 3d Supp. 14, 25-26, said:
"An individual claiming the defense of necessity must establish six required elements: '(1) The act charged as criminal must have been done to prevent a significant evil; (2) There must have been no adequate alternative to the commission of the act; (3) The harm caused by the act must not be disproportionate to the harm avoided; (4) The accused must entertain a good-faith belief that his act was necessary to prevent the greater harm; (5) Such belief must be objectively reasonable under all the circumstances; and (6) The accused must not have substantially contributed to the creation of the emergency.'"
However, the Court held that the defense was properly rejected by the trial judge because: 'There was no evidence that Marinol is ineffective for appellant, causes side effects for her, or is in any way unavailable to her." *{Supra,56* C.A. 4th at p. 1540.)
Trippet's conviction was nevertheless reversed because the Compassionate Act was applied retroactively and it was unclear whether her physician. Dr. Todd Mikuriya, had approved of her cannabis use, noting that "'approval' connotes a less formal act than a 'recommendation.'" *{Id.* at p. 1548.) The trial court was directed on remand to make a factual determination whether Trippet had a recommendation or approval, and:
"(2) if so, whether and to what extent the quantity of marijuana which she possessed was reasonably related to her then-current medical needs; and (3) what quantity of marijuana of which she was then in possession was related to her "religious purposes" usage.. ..
With respect to the section 11360, subdivision (a), conviction, the trier of fact will need to determine: (1) whether any (and if so what amount) of the marijuana appellant was transporting at the time of her arrest was, considering not only the quantity, but the

method, timing and distance of the transportation, reasonably related to her then-current medical needs; and (2) what quantity of the marijuana she was transporting was related to her "religious purposes" usage." {*Id.* at p. 1551.)

4. Can I get a doctor to sign off after the bust?

Serge Rigo was arrested for cultivating marijuana on election day, the day before the effective date of the Compassionate Use Act of 1996. More than three months later, he got a doctor's approval on a written prescription form for the use of marijuana for gastritis. His conviction by the trial judge on stipulated facts was affirmed because; 'The stipulated facts establish that appellant not only had no prior medical approval or recommendation, but had not even consulted any doctor about his condition since 1994. He failed to seek approval until three and a half months after he was arrested and while his motion for pretrial diversion was pending. Appellant did not seek medical approval until the consequences of the justice system gave him the impetus to do so and did not do so in a reasonable amount of time for reasons independent of his arrest. ... Regardless of whether we can conceive of exigent circumstances under which a contemporaneous or subsequent approval might allow application of the compassionate use defense, those circumstances do not exist in this case.... To allow self-medication in the context of this case would improperly promote non-medically supervised use of marijuana for a variety of subjectively held reasons which would frustrate the intent of the voters in enacting Proposition 215. To sanction the use of marijuana under the facts presented herein would encourage the use of marijuana for any idiosyncratic problem, whether medically valid or not, with an ensuing attempt to seek medical approval after an arrest intervened. Medical marijuana should be prescribed for specific relief for clearly defined medical problems." {*People v. Rigo* (1999) 69 C.A. 4th 409, 413-415).
Nevertheless, if your client really has a medical condition for which a physician will recommend marijuana, it may be helpful in mitigation to get that recommendation/approval, even if it comes too late or if the amount involved seems excessive for personal use.

5. Do I need my/a physician to testily?

That defends on a variety of considerations. The presentation of a "medical necessity" defense would almost certainly require a physician's testimony, whereas a Prop. 215 compassionate use defense might be presented with the physician's written recommendation/approval or the patient's testimony that his/her doctor recommended/approved medicinal use of marijuana. The patient's testimony about the doctor's statement is not hearsay because it is offered to prove the "operative fact" of the recommendation or approval. (See, e.g., Witkin, California Evidence, Section 588 (3d ed. 1986)).

If the defendant's physician is called as a witness, either by the prosecution or the defense, other issues may be presented.

For example, may the prosecution go beyond the recommendation/ approval and inquire as to the defendant's medical diagnosis and history, the performance and results of any examinations or laboratory tests and the appropriateness of the recommendation/

approval? If this is analogous to a prosecution for possessing a drug without a prescription, then the answer is no. The Court does not sit as a Board of Medical Quality Assurance, nor is it equipped to do so.

If the prosecution calls the physician to deny making such recommendation or approval, can you offer evidence to show that the federal government has threatened California Physicians with the loss of license to prescribe medicine and Medicare reimbursement (see *Conant v. McCaffrey,* 172 F.R.D. 681 (N.D. Cal. 1997)) and that the DEA has recently raided the office of a physician known to recommend marijuana and are seeking a court order to review patient files?

6. What medical conditions are covered by the Act?

AIDS, anorexia, arthritis, cancer, chronic pain, glaucoma, migraine, spasticity, "or any other illness for which marijuana provides relief."

It should be the physician's judgment and the patient's informed consent that determines what illnesses are included under the Act, with the physician bearing in mind the historical and current uses of medicinal cannabis. (See Marijuana, The Forbidden Medicine, by Lester Grinspoon, M.D/ and James Bakala.r, as well as Marijuana: Medical Papers, by Todd Mikuriya, M.D.) The patient and her physician need not prove that the treatment is efficacious.

7. What marijuana offenses are/are not covered by the Act?

The Act provides that Section 11357 (possession) and section 11358 (cultivation) shall not apply to a qualified patient or caregiver. *Trippet, supra,* indicates that transportation (section 11360) reasonably related to current medical need is implicitly covered by the Act and we can assume that having marijuana in a vehicle (V.C. section 23222(b)), possessing paraphernalia (Health and Safety Code section 11364) and utilizing space for cultivation, processing or storage of cannabis (section 11366.6) are implicitly exempted if reasonably related to medical use.

As seen in *Trippet,* however, even a qualified patient may be convicted for religious, recreational or commercial use of cannabis.

Does the Act cover the medicinal use of hashish? See the attached Memorandum of Points and Authorities.

8. Who is a "primary caregiver?"

The Act defines the primary caregiver as: "The *individual designated* by the person exempted under this section who has *consistently* assumed responsibility for the housing, health or safety of that person." (Section 11362.5 (e)(emphasis added). Thus, the patient may designate an individual, but not a large dub. (See *People ex re/. Lungren v. Peron* (1997) 59 C.A.4[01] 1383).

There is no reason why a caregiver cannot service more than one patient or why patients cannot engage in cooperative assistance. Moreover, the disjunctive allows the patient some latitude in selection, so long as the caregiver is a consistent individual. Can the

patient designate as primary caregiver someone who consistently assumes responsibility for the patient's health by furnishing medical cannabis to the patient?

?. How much marijuana can a patient/caregiver have in possession or under cultivation?

Tr/ppet, supra., indicates that the amount must be reasonably related to the patient's current medical needs. Some cities and counties have adopted limits and formal or informal guidelines. The City of Oakland based its standards on the amount that the Food and Drug Administration provides patients approved for medical marijuana by the federal government: 300 cigarettes per month, each weighing .9 grams, or approximately 1/2 pound per month. It allowed a three month supply, or 1 and 1/2 pounds.

If the patient/caregiver is an outdoor cultivator and thus has only a single crop per year, he/she would need 30 flowering plants to produce six pounds, but would be allowed to plant 60 plants and maintain them until 30 flowered.
Indoor cultivators are allowed 48 plants to yield 1 and 1/2 pounds every three months. They may grow 96 plants until 48 flower but the remainder must be destroyed. However, a new cycle of 98 can be established, making a total of 144 plants in various stages.

Some counties have sought to arbitrarily establish lower limits, as few as two outdoor plants or six indoor plants (three flowering and three vegetating), or 1.33 pounds of processed marijuana. Most cities and counties, however, have no guidelines and the practice of prosecutors and the verdicts of jurors set the standard.

10. Who has the burden of proving or disproving the compassionate use defense?

If a person were charged with violating Health and Safety Code section 11350 and raised the defense of prescription, the jury would be instructed as follows: "To establish this defense the burden is on the defendant to raise a reasonable doubt as to his/her guilt of the possession of a controlled substance without a prescription." (CALJIC No. 12.30.1)

In a medical marijuana case, however, CAUIC places the burden of proof on the defendant. CALJIC No. 12.22.5 (2001 revision) states:
'The defendant has the burden of proving by a preponderance of the evidence all of the facts necessary to establish the elements of the compassionate use defense." CALJIC is supported by footnote 17 in *Trippet, supra.,* which states at 56 C.A^ page 1551: "Because the statute provides a limited affirmative defense, the burden is, of course, on the defendant to raise the defense and prove its elements. (See *People v. Cardenas* (1997) 53 C.A^ 240, 244-246 ... and cases cited therein.)"

But the Act provides far more than a "limited affirmative defense," It calls for an exemption from prosecution, not unlike the exemption granted the holder of a prescription from a physician. Certainly, the accused has the burden of raising the defense of prescription/recommendation/approval, but the Act is silent as to the