UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

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HONORABLE TERRY J. HATTER JR., JUDGE PRESIDING

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UNITED STATES OF AMERICA,

PLAINTIFF(S),

VS.

TODD PATRICK MCCORMICK,

DEFENDANT(S),

NO. CR 97-1724-TJH

REPORTER'S TRANSCRIPT OF PROCEEDINGS

LOS ANGELES, CALIFORNIA

FRIDAY, AUGUST 1, 1997

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LOS ANGELES, CALIFORNIA; FRIDAY, AUGUST 1, 1997

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THE CLERK: Calling case number 97-1724M. U.S.A. versus Todd Patrick McCormick.

Please state your appearances, counsel.

MR. SPERTUS: Good afternoon, your Honor. James Spertus for the United States.

THE COURT: Thank you, Mr. Spertus.

MR. ISAACMAN: Good afternoon, your Honor. Alan Isaacman for Todd Patrick McCormick who is present.

THE COURT: Thank you, Mr. Isaacman. Whom else do you have at counsel table?

MR. ISAACMAN: Joel Isaacson is at counsel table, your Honor.

THE COURT: All right. And he is associated with you?

MR. ISAACMAN: Yes, he is. His name is very close in mine and he happens to have an office near mine as well, so he is associated in this case.

THE COURT: Who is the gentleman here within the bar of the court?

MR. MARGOLIN: Mr. Margolin, your Honor. My name is also on the record, your Honor. Thank you, sir.

THE COURT: All right. Find him a chair so he can be at counsel table.

Who wishes to be heard in this matter? Mr. Spertus?

MR. SPERTUS: Your Honor, on --

THE COURT: Why don't you come to the lectern.

MR. SPERTUS: Thank you, your Honor. On July 30th the defendant Todd Patrick McCormick made his initial appearance in this district before Magistrate Judge McMahon. At that time the government requested that the defendant be detained. The government proffered the facts contained in the Pretrial Services report --

THE COURT: Speaking of that, do we have the Pretrial Services officer here?

MR. SPERTUS: No, your Honor. He is not present in the courtroom.

THE COURT: Did you notify him?

MR. SPERTUS: Yes, your Honor. I spoke this morning to Pretrial Services and I believe they received a -- they were served with a copy of the notice of appeal that was filed with the court.

THE COURT: Miss Kato, would you call upstairs and find out where the Pretrial Services officer is.

(Brief pause in proceedings.)

THE COURT: Go ahead, Mr. Spertus.

MR. SPERTUS: At that time the government requested detention in this case on both -- on two separate bases.

First, that the defendant posed a danger to the community. And second, and most importantly, that the defendant posed a flight risk. In support of that motion the government proffered facts contained in the Pretrial Services report; the facts contained in the affidavit and complaint that has been filed in this case, and the government argued that the defendant should be detained because he is suspected of being involved in a large scale commercial marijuana production conspiracy. And the defendant was arrested at a location where over 4,000 marijuana plants were growing. There was a substantial quantity of marijuana.

The facts contained in the Pretrial Services report illustrate that the defendant had significant assets. The Pretrial Services report also indicated that the defendant had resided very recently in the Netherlands for a year.

THE COURT: Just back up a minute. You say that the Pretrial Services report indicates that he has significant assets? I have looked at the copy that you had and we really ought to have the Pretrial Services officer here. There seemed to me to be a number of inconsistencies. For example, on the cover sheet as I recall, and I have just given it to Miss Kato to make the call so I don't have it before me, but as I recall from it, it indicates that he has been in this community for five years, and yet in the body of the report it says that he has only lived at that address for four months.

Now, it's conceivable that he could have lived somewhere else within the community. But they also indicate that he has lived in San Diego until 1995. And I can remember back probably before you were born when San Diego was a part of this district. But it has not been so for some 30 some years or more. So I don't understand that inconsistency.

I also saw in the face sheet that this defendant makes approximately $300,000 a year. Inside it indicates that he makes $250,000 a year. I don't know which of those is correct if either. Then it further went on to indicate that at the time of arrest he only had $40 on his person. Had $1,000 or so in the bank account and no other assets that I know about. So what are these assets?

MR. SPERTUS: Yes, your Honor. There were several inconsistencies in the report. The report also indicated that the defendant had resided in the Netherlands for a year, and later elsewhere in the report it indicated that the defendant had resided in -- within this district for the past five years. There were several inconsistencies. The government --

THE COURT: Not within the district; within the community.

MR. SPERTUS: Within the community, yes, your Honor. The government is -- the evidence of the significant assets derives from the size and scope of this marijuana production operation; the fact that the defendant stated to

the Pretrial Services officer that his utility bills alone are approximately $2,500 a month. He pays $6,000 a month in rent. We believe that the money for all of these assets derives from distribution of marijuana. When we arrested the defendant sheriff's deputies videotaped, actually videotaped the entire premises which existed at the time of arrest. And you can see from the videotape that this is a highly sophisticated operation with sophisticated lighting and irrigation systems which themselves must have cost some amount of capital to create. Most of the lights are 1,000 watt halogen lighting.

And the government, based on its own internal calculations, it was obvious by the scale of the operation that this is a multi-million-dollar marijuana growing facility.

THE COURT: Who owns the property if your investigation has shown?

MR. SPERTUS: Well, it's owned -- I don't know the name, your Honor, but it's not the defendant. It's somebody who is renting to the defendant. Also at the time of the arrest there was a lease located which does identify the land owner and I'm just not recalling his name.

THE COURT: All right. And I take it that the lease arrangements are proper as far as you know?

MR. SPERTUS: Yes, your Honor.

THE COURT: No arrearage in his rental payments?

MR. SPERTUS: None that we're aware of, your Honor. And the electric bill also as far as we know has been paid on a timely basis.

THE COURT: Has that just been for these four months that he supposedly has lived there?

MR. SPERTUS: To the best of our knowledge yes, your Honor. And this is still -- the investigation is still in a preliminary phase. This is preindictment. And the government -- there is a presumption of both flight risk and danger to the community in a case such as this.

THE COURT: Tell me this, Mr. Spertus, if you know -- I try to avoid these so-called guidelines as much as I can as you know -- but is this 4,044 plants of marijuana -- or should I put it this way, would the penalty for the possession of them be any more than, say, for a gram of crack cocaine?

MR. SPERTUS: Yes, your Honor. I believe the way the guidelines were recently amended and the amendments provide that the quantity of marijuana when you are dealing with a plant should be calculated either as 100 grams marijuana or as the actual weight of the marijuana plant, whichever is greater. So using that calculation which is in Application Note 2 sentencing guideline 2(d)1.2, I personally calculated that the offense level in this case would most probably be 30, the base offense level. Plus it does appear that there were several individuals involved in this operation

which would provide for an offense level enhancement for role in the offense.

THE COURT: So you're getting up around 20 or more years?

MR. SPERTUS: Well, there is a statutory mandatory minimum of ten years, and for purposes of arguing before Judge McMahon I referred to the mandatory minimum of ten years.

THE COURT: I think that's appropriate.

MR. SPERTUS: So in light of the fact that we are talking about a significant amount of time that the defendant faces, the ties to the community have created a substantial and real concern that once the defendant --

THE COURT: Excuse me. Stop the talking in the back of this courtroom.

MR. SPERTUS: Your Honor, the government believes that in light of the substantial connection to the Netherlands, the fact that the defendant in the Pretrial Services report indicates that he has lost his passport which there is a concern that it could miraculously be found, the fact that the defendant appears to have access to substantial amounts of money, and the Pretrial Services report does indicate that the friends of the defendant are pooling resources in order to make bond, the government believes that a $100,000 bond won't even be a blip on the radar screen for the defendant and that as soon as he is released on that

amount of bond the defendant will flee to the Netherlands and be able to pursue his cause.

The defendant is -- this is not in the Pretrial Services report, but the defendant has the knowledge and argument that he does believe in the legalization of marijuana and is a proponent of that cause and that cause can be very effectively carried out as a -- from outside the jurisdiction of this district. And the government is concerned for $100,000 which will be made very easily, the defendant will flee.

THE COURT: What about the full deeding of property of, is it Peter McWilliams? Where is that property located by the way?

MR. SPERTUS: Your Honor, I do not know. The defense counsel could speak to that. Apparently there are two individuals who Judge McMahon approved. One of them is involved with now which is a, I believe a marijuana legalization movement. And the other is a friend of the defendant. Those are the only two people that Judge McMahon approved to post -- to deed property, and I don't know the location of either piece of property.

THE COURT: I would take it that if there were to be this bail that the magistrate judges approved or some that I would approve, that you would want to have a Nebbia hearing in any regard before you would go any further?

MR. SPERTUS: Yes, your Honor.

THE COURT: All right. Anything else?

MR. SPERTUS: Your Honor, the government would proffer the 18-minute videotape showing the size of the operation. The affidavit describes the operation. It's not until I personally saw the videotape that I really realized the sophistication and scope of the operation. But other than the videotape, no, your Honor, the government does not proffer anything else. Thank you.

THE COURT: Fine. I'll hear from defense counsel.

MR. SPERTUS: This last point -- I apologize -- what the government is asking for is detention. In the alternative the government would request a substantial increase in the amount of bail. And the government has requested Judge McMahon to consider a one-million-dollar bond in lieu of detention if the Court won't order detention. Thank you.

THE COURT: All right. Would you repeat your representation, sir?

MR. ISAACMAN: Yes, sir. My name is Alan Isaacman for Todd Patrick McCormick. Your Honor, let me say first of all that this matter was fully considered by Magistrate Judge McMahon on Wednesday. We were in court for hours. There were four defendants in total. He went through a bond setting for each of them. He got into the facts of the case and is

thoroughly familiar with the affidavit, considered it, considered the presentence report, and he had a hearing again this afternoon. So he is -- his decision was a recent decision and it was a thoughtful one. It wasn't a quick one.

THE COURT: When you say that, you also say that he followed the recommendation of Pretrial Services.

MR. ISAACMAN: He did that yes, your Honor. He followed that recommendation as well.

THE COURT: Was the Pretrial Services officer heard from during either of those hearings?

MR. ISAACMAN: He wasn't heard from other than by the written report, your Honor. There was a Pretrial Services officer present. I don't believe it was the one who wrote the report. No questions were asked of him and he made no comments.

THE COURT: I see.

MR. ISAACMAN: Mr. McCormick has not great amount of resources. That is demonstrated actually by his presence still here in custody. This bond or the stay expired yesterday at 5:00 I think it was. He is not --

THE COURT: Before we get into all that, tell me about some of these apparent discrepancies here. How long has he been in this community?

MR. ISAACMAN: Well, he has been --

THE COURT: When I say this community, let's just

confine it to this district.

MR. ISAACMAN: He's been in this district --

THE COURT: It's a large district.

MR. ISAACMAN: Right. It is. I believe since the beginning of this year. So about four or five months in this district. And the five years I believe probably is reference to his living in San Diego County. He lived in San Diego County since 1992.

THE COURT: I would think the people in San Diego would take umbrage to saying that this is their community. You don't have to go that far. In Orange County they take exception and they're in our district. But go ahead.

MR. ISAACMAN: Thank you.

THE COURT: What about this book that he is supposedly writing for which he is being paid supposedly a month grossly income of 25,000?

MR. ISAACMAN: He's getting paid, as he informs me, about $250,000 a year on a monthly basis, and it is for the book services. It is by Prelude Press. I read the Pretrial Services report as indicating that that was one of the facts that was confirmed. I may have misread that. That is just from memory now. But he indicated that very -- several of those statements were verified by the Pretrial Services officer. I never asked him whether he verified that or not. That has never been raised as an issue before this time right

now.

Again, I say that he has not been able to make bail and he does not to my knowledge have the money to post the million-dollar bond by any means. If he has a friend come forward and post his house, that's a substantial inducement to stay here. But even more, we're talking about not somebody who is engaged in the sale of marijuana for profit. There is no evidence of that at all.

THE COURT: He's giving it away?

MR. ISAACMAN: Well, I don't think there is any evidence that he was even giving it away. I mean --

THE COURT: Stockpiling it for his own medicinal purposes?

MR. ISAACMAN: I think the evidence is that he was growing it. He was in the stage, relative stages of growing the marijuana.

THE COURT: Does it get better with age?

MR. ISAACMAN: I don't know. But I think when you're experimenting -- and I'm not an expert on that part -- but when you are experimenting and you have about 40 different strains and you're trying to grow marijuana that would be useful for various kinds of illnesses: brain tumors, different kinds of cancer, that kind of thing, spinal problems, that you are looking for -- first of all, you have to deal with the failure rate. You are going to have a number of these not

grow into marijuana itself. Grow into pods itself.

THE COURT: He is a scientist of some sort or biologist?

MR. ISAACMAN: He's more of an amateur scientist. He's a bright young man who doesn't have a botany degree.

THE COURT: Doesn't even have a high school diploma. He has a GED I understand.

MR. ISAACMAN: That's correct.

THE COURT: So is he collaborating with some medical doctors or at least some scientists somewhere?

MR. ISAACMAN: I think he -- the answer to that is on an informal basis that's true. He is in contact with medical doctors. He has prescriptions or recommendations.

THE COURT: I wasn't thinking about that so much. But if there is indeed some collaboration, and I'm not getting into an alleged conspiracy at all here, but if there is such then I would think that some of these people would want to come forward and help with the bail if there is to be bail.

MR. ISAACMAN: Yes, your Honor. I think that's who would come forward. There is in --

THE COURT: Mr. McWilliams one of these scientists?

MR. ISAACMAN: Mr. Mcwilliams is one of the people who writes a -- he does a medical magazine, your Honor. A medical marijuana magazine. Mr. McWilliams, Mr. Cowen -- Mr. Cowen is present --

THE COURT: Who is the other individual that Pretrial Services indicated that they have been not been able to locate? They refer to another individual.

MR. ISAACMAN: They refer to two. I don't know that they haven't been able to locate him. There is a Mr. Cowen that is referred to as well, I believe, in the Pretrial Services report. He is present in court.

THE COURT: Mr. Harrelson, H-a-r-r-e-l-s-o-n.

MR. ISAACMAN: There is a Mr. Harrelson who is not in California at this time.

THE COURT: Is he a scientist?

MR. ISAACMAN: No, he is not a scientist. Mr. Cowen who is present in court was the executive director of NORML, the National Organization for the Reform of Marijuana Laws for many years.

THE COURT: Is he a scientist?

MR. ISAACMAN: I don't know his educational background. I know he does a lot of work in the marijuana area, both to get it legalized and also in terms of the property aspect of it. And I think that Mr. McCormick --

THE COURT: As we sit here today it is not legalized and there is a presumption here. And how do you intend to overcome that presumption?

MR. ISAACMAN: I think it has been overcome already as far as Magistrate McMahon is concerned.

THE COURT: We're beyond Magistrate Judge McMahon now. How do you overcome it with me?

MR. ISAACMAN: Let me explain that Mr. McCormick is a young man that has no criminal conviction, your Honor.

THE COURT: I understand he has a failure to appear on a matter. That doesn't sit well with me.

MR. ISAACMAN: That was a failure to appear. That was in a traffic matter. It was cleared up and resolved and --

THE COURT: I don't see that in the report. Was it resolve since this report was done?

MR. ISAACMAN: It was. This gentleman right here, by the way, can represent to that. He did it several days ago. He did it before the arrest even occurred. So I might add --

THE COURT: You need to report your findings to the Pretrial Services officer, sir.

MR. ISAACMAN: Magistrate Judge McMahon wasn't aware of that before he made his ruling. This man, Mr. McCormick, has had a long history of illness. He has had cancer for many years. Had spinal fusion of five vertebrae. He has been told that he needs to have a refusion done. He has had symptoms recently again of what he recognizes as cancer growing again. He has had forms of cancer that periodically appear.

He has used marijuana for a long time under doctors' care and under doctors' guidance. He is somebody who was a supporter of Prop 215 and he is at least somewhat of an expert on the properties of marijuana. And I think probably the evidence will show when it comes out at trial, which we don't need to get into a whole lot here, but we'll show that there was medical experimentation going on even though Mr. McCormick is not a doctor. When I say medical experimentation, I really mean that plants were being grown to try to find the strains or combinations of strains that would be medically useful.

There was a statement made that a lot of marijuana was found. I read the affidavit and my impression from that is that there was not a lot of marijuana found. It might have been marijuana plants found but not a lot of marijuana found. And it's my information that the plants were not -- did not have seeds; were not in a position really at that point to be producing marijuana. They were at various heights; some small, some larger. But that doesn't indicate that they are ready to give off marijuana.

But in any event, there was not a lot of marijuana found I'm informed. I think the main thing is that Mr. McCormick is not likely to flee this jurisdiction because he has a very strong interest in this case and he has a very strong interest in the issues concerning this case. I mean he

believes, rightly or wrongly, that Proposition 215 has allowed California citizens, California residents to use marijuana where medically indicated under the guidance of a doctor. Now, the federal laws may not countenance that. And I think that's one of the problems that may exist today between the two systems. But the people of the State of California under 215 have given their view that that should be permitted and it is permitted as far as they're concerned under state law.

And now I don't think there is any evidence that's been presented here to show that he was doing anything other than growing marijuana for that use. People in the movement know him. He is recognized in that sense. He is not a wealthy man and that's the reason he is still here today and hasn't made the bail. If he has a friend put up his house, then I think that's going to be a strong inducement as well as the opportunity to express his views on this subject.

And with that I think, your Honor, I will just say that Magistrate Judge McMahon went through this and his decision should not be changed. There are no new facts being presented to this Court on that. And we would ask the Court to keep the present bail in effect. Thank you, your Honor.

THE COURT: Thank you. Let me indicate for the record that we do have one of our senior supervisors from Pretrial Services. Mr. Williams, would you come over to the lectern please. Is the Pretrial Services officer who is

assigned to this matter unavailable?

MR. WILLIAMS: He is not present in the office today, your Honor.

THE COURT: I see. Does your office still stand by this recommendation with a number of inconsistencies that I see in it? You weren't here earlier when I pointed out several of them from the face sheet to the body of the report, and from items that I have heard from both counsel.

MR. WILLIAMS: Could I have a minute to review the report?

THE COURT: Of course.

MR. WILLIAMS: Thank you.

THE COURT: Let me just point out several of them to you. On the face sheet it indicates monthly gross income of 25,000. Inside they talk about 250,000. Also on the face sheet it says time in community, five years. Inside it talks about his having really only been here four months, evidently counting sometime that he was in San Diego which, of course, is not this community.

MR. WILLIAMS: Okay, your Honor.

(Brief pause in proceedings.)

MR. WILLIAMS: It terms of residence, it appears he has only been here four months. Prior to that he resided in San Diego County from 1992 to 1995 and in Florida from 1991 to 1992.

THE COURT: Yes. And it would appear he has also been in Ohio and he's also been in the Netherlands.

MR. WILLIAMS: That is also correct, your Honor. In terms of the income, let me double check. According to the information he gave us he makes $250,000 annually, not monthly.

THE COURT: Was there any proof of that? Any canceled checks, anything?

MR. WILLIAMS: This was all done by telephone so we did not have an opportunity to look at any verification firsthand. Any other questions or --

THE COURT: Have you had an opportunity to talk to Pretrial Services officer Rieger about this matter?

MR. WILLIAMS: No, your Honor. We were notified about an hour and a half ago of a bail matter so we did not reinterview or make any phone calls. This came as kind of a surprise to us.

THE COURT: I appreciate your coming up here. I know that you are quite busy down there. Thank you.

MR. WILLIAMS: You're welcome, your Honor.

THE COURT: Did you wish to be heard again briefly, Mr. Spertus?

MR. SPERTUS: Yes, very briefly, your Honor. Your Honor, I would just like to emphasize the standard of evidence for proving a flight risk is preponderance of the evidence.

And I want to emphasize the international connection and the apparent frequent travel to the Netherlands.

THE COURT: Yes, that together with this passport that's supposedly lost or stolen concerns me I must say.

MR. SPERTUS: Thank you, your Honor. I want to emphasize those two facts and request that the Court order detention.

THE COURT: All right. Anything further?

MR. ISAACMAN: The house that would be put up, your Honor, is in Morrow Canyon. And in terms of the standard which is required to be found in order to ensure that the safety of the community will be reasonably assured, there must be evidence put forth finding by clear and convincing evidence. That's under section 3142 of Title 18.

THE COURT: What more do we need other than the sheer volume of the items of illegal nature found there?

MR. ISAACMAN: Well --

THE COURT: It's your presumption to begin with. And then we have those items found.

MR. ISAACMAN: That's correct.

THE COURT: The admission that they're there.

MR. ISAACMAN: They are there and there is -- the only indication that's there is that they were being grown for purposes of medical marijuana use, for experimentation. No indication that they were being sold to anybody in the

community. And this is consistent with what the government knows about this man's background as well as what his friends who have come forward to Pretrial Services such as Richard Cowen who is present in the courtroom today, what they know. And what you have is somebody who believes in this issue, who believes that he has a right and others have a right.

THE COURT: I hear you saying that, and I think about someone like Dr. Martin Luther King Jr. who believed in certain issues and he was out front about those and was willing to accept the punishment that came with what turned out to be illegal laws. But here, as I understand it, there was a secret kind of operation going on which seems to just fly in the face of what you say to me. If he believes in all of this, why the secret nature of this?

MR. ISAACMAN: Your Honor, I most respectfully say one of the things that strikes me about what I've seen in this is there is very little secrecy to this whole thing. Apparently there are plants everywhere --

THE COURT: Stop making any kind of signs, otherwise you are going to be removed from the courtroom.

MR. ISAACMAN: Apparently it was almost -- according to the affidavit you could see the plants from the street. They were visible from the hillside. There doesn't seem to be very much secrecy going on in the middle of Bel Air so that one wonders if you are trying to keep that secret, why

would you do that.

And he has been somebody -- when he got stopped in Ohio, by the way, he informed the Court about the marijuana and the Court ended up dismissing it and apparently allowed him while he was in custody, to use marijuana for his medical condition.

THE COURT: And let him go to the Netherlands to further his medical treatment supposedly.

MR. ISAACMAN: That's correct. He was able to do that. But he is back and he is not running. And nobody who is a friend of his thinks he is going to run from this because he really believes in this cause and he is not somebody that has a record of doing that kind of thing.

So I would just say, your Honor, that if you had the evidence in here that this man was making a lot of money off supplying marijuana to people around Los Angeles or other places, that would be one thing, but that hasn't happened here. And all you really have is a large number of plants that - large number of plants that were fairly visible from the street. And when he was originally arrested, he gave his explanation right away that this was for medical experimentation and that it wasn't being for distribution.

And the reason that this man ought to be released on bail is that the presumption of the Bail Reform Act is really that people ought to be released on bail until they're

convicted. Now understanding that, when you are charged with a particularly serious offense and it prescribes a certain amount of punishment, there is a presumption that initially flows from that. But that presumption by the very language of the Bail Reform Act can be overcome and can be rebutted. And the magistrate, Magistrate Judge McMahon went through a full hearing on this and concluded it had been rebutted. He made that finding. Nothing has changed since then in terms of the facts. And if anything, the very fact that this man is still in custody indicates that he is not a big drug dealer or else the money would have obviously been posted earlier and he would be out of custody right now. There is no stay in effect as of this time. Thank you, your Honor.

THE COURT: All right.

MR. ISAACMAN: Also I might say -- I'm sorry. One last thing. He is somebody that is not going to thrive in custody at this point. I mean, he needs to have some medical attention. And I think that since there is a presumption of innocence, and that presumption is specifically recognized in the Bail Reform Act in the very language, and nothing in this act changes that presumption of innocence, that is a factor that I think ought to be considered in allowing this current bail to stand. And if he is able to get out of prison or out of jail temporarily now while the case is pending and until he has his day in court, he can get the treatment that he needs

for a very serious illness, and he has the ability to come in and contest the charges that are here.

The fact that the government has indicated there are very serious penalties that may flow doesn't mean that that's what to end up in this case by a long shot. Thank you, your Honor.

THE COURT: Before you leave the lectern, have you seen a copy of the criminal complaint in this matter?

MR. ISAACMAN: Yes, I have.

THE COURT: You see page 8 where paragraph 21 and several sentences down, "Also seized was cultivation equipment including halogen lights, hoods, and ballasts. Also seized was the cultivation layout, diagrams and expenditures, logbooks, catalogues for cultivation supplies and equipment and documents relating to the techniques for cultivating. Also seized were personal documents including address books, billing statements and phone records."

MR. ISAACMAN: Well, the thing that's kind of confusing -- I read that language. First of all, there is no issue about whether marijuana plants were being grown there and lights being grown there -- being used in that process. When I looked at that I saw the billing statements and I had a question about that. My information is that the kind of statements that are there are utility bills, other kinds of bills that normal households have without regard to the

amounts involved and whether there are any inferences that could be drawn. But it's not billing statements for marijuana sales or anything of that nature. And I would be curious to see if the government has any kind of evidence that that's the kind of billing statement that they're referring to.

THE COURT: I need to know that. Mr. Spertus, what about it?

MR. SPERTUS: Your Honor, the affiant is present in the courtroom. May I have a moment?

THE COURT: You haven't talked to him about this previously?

MR. SPERTUS: No. I have, your Honor. I have talked to him extensively about this case and all the facts contained in the affidavit.

THE COURT: If you need to talk to him further go ahead.

MR. SPERTUS: Just for clarification.

THE COURT: Go right ahead.

(Counsel confers.)

MR. SPERTUS: Your Honor, the specific bill statements that were seized dealt with bill statements from electricians who modified the house to accommodate the lighting system that was necessary and for the hydroponics to irrigate the plants, and there were bills that were for the machinery necessary to create this production facility.

THE COURT: But no bills indicating that these items were being sold to others?

MR. SPERTUS: No. No, your Honor.

THE COURT: That's fairly important.

MR. SPERTUS: Your Honor, with regard whether these items were being distributed to others, there was a significant amount of packaging material that were found, basically baggies. Marijuana was packaged in various quantities. That would tend to show distribution. And scales as well, your Honor.

THE COURT: All right. Go ahead, Mr. Isaacman.

MR. ISAACMAN: Your Honor, it is my impression, I made the statement earlier that there was no marijuana of any significance found. Now, maybe Mr. Spertus can illuminate us on that, but my impression is they didn't come in and find marijuana in baggies and that kind of a thing, packages ready for sale.

THE COURT: I see. All right. I take it that the matter stands submitted then?

MR. ISAACMAN: Yes, your Honor.

MR. SPERTUS: Yes, your Honor.

THE COURT: There is the presumption that runs with an offense that is alleged such as this. And I think it has been rebutted to some degree. I must say that given the details that I have, and they're still somewhat sketchy

subject to change with more investigation by both sides I would think, I would welcome or to whomever this case is assigned I'm sure would welcome a review of it further. But at this stage with what I do have I'm going to raise the amount of bail in this matter to $500,000 and all of the rest of the conditions that were previously set by Judge McMahon will remain in place other than the appearance bond being raised from 100,000 to 500,000.

There will be the justified affidavit of surety. In addition to the above, there will be the full deeding of property of Peter McWilliams. And further, I will allow the government to have a Nebbia hearing with regard to that property if it cares to do so. There will be intensive pretrial supervision. There will be a surrendering of the passport if it is found or located. Travel will be restricted to the Central District of California. The defendant shall not enter the premises of any airport, seaport terminal which permits exit from the continental United States without Court permission. Further, he shall not enter the premises of any bus, railroad, airport or seaport terminal which permits exit from the area of restricted travel without Court permission.

He shall not use or possess illegal drugs. That includes marijuana. Drug, alcohol testing as deemed necessary by Pretrial Services will be in place. And are there any other conditions that the government is seeking, Mr. Spertus?

MR. SPERTUS: No, your Honor.

THE COURT: All right. That will be the order. As I say, I will further entertain hearing in this matter if there are other facts that come to the attention of either side that either side wishes to present to the Court.

MR. ISAACMAN: Your Honor, as a matter of clarification may I make one inquiry?

THE COURT: Certainly.

MR. ISAACMAN: I think the Court setting the bond at $500,000 is going to have one effect, and that is to make Mr. McWilliams' tendering of his property a futile effort because he doesn't have --

THE COURT: I understand there are other individuals as well.

MR. ISAACMAN: Right. If they're able to get the money together to put up that kind of bond, I take it that would be acceptable?

THE COURT: Of course.

MR. ISAACMAN: Okay. Thank you, your Honor.

THE COURT: Thank you all.

(Proceedings adjourned.)

* * * *

I, MARIA BEESLEY, C.S.R., R.P.R. do hereby certify that the foregoing is a true and correct copy of proceedings in the above-entitled matter.

Dated: 10-14-97

MARIA BEESLEY, C.S.R., R.P.R.
OFFICIAL REPORTER

Exhibit B

Newsweek

February 3, 1997 ; $2.95

EXCERPTS

PERSONAL HISTORY

By Katharine Graham

THE BATTLE OVER MARIJUANA

Is It Medicine?

The Risks of Legalizatio

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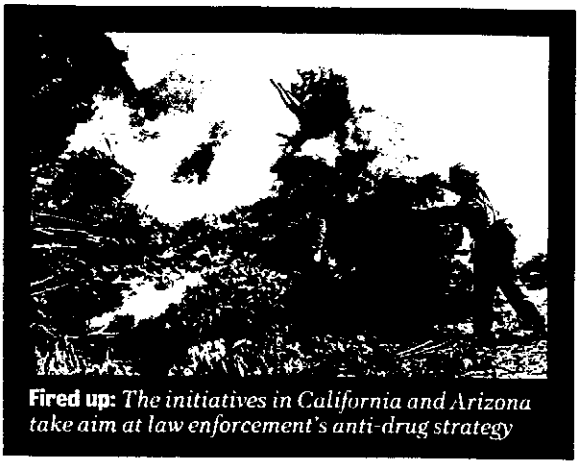
It can be a seductive argument: why not let sick people ease their pain by smoking pot? But drug warriors say 'medical marijuana' could lead to legalization—and the country does not seem ready for that. BY TOM MORGANTHAU

The War Over Weed


ANDRE GROSSMANN

CONSIDERED SOLELY AS AN EXAMPLE OF practical politics, the campaign for Proposition 215 was brilliant. It was fought and won in California, a bellwether state whose law on ballot initiatives makes it uniquely open to grass-roots political movements. It attacked a policy, the U.S. drug war, about which many opinion leaders have large doubts. It mobilized a politically potent interest group—doctors—to defend their right to practice their profession as they see fit, and it appealed to voters' compassion for people with cancer, AIDS and other deadly diseases. It used the federal government as a scapegoat and made cops and prosecutors look like dolts. On Election Day, Prop 215 scored a clean kill, 56 percent to 44. Now the fun begins.

Simply put, Prop 215 and Proposition 200, a similar measure passed in Arizona last fall, pose a frontal challenge to the American prohibition against drugs—which is exactly what some, though not all, backers of these initiatives wanted to do. By convincing voters there are humane reasons to relax current laws against marijuana use, a Hungarian-born billionaire named George Soros (page 24) and his helpers created a muddle that may take years to sort out. Like many political controversies, this one is headed for the courts. After the initiative passed, Gen. Barry McCaffrey, the drug czar, publicly warned doctors not to break federal law by prescribing marijuana. That prompted a group of California physicians to file suit claiming that their rights to advise their patients were being infringed. The policy issue is, who controls America's drug laws—the federal government or the voters of California and Arizona? The political issue is whether we Americans, fighting what seems to be a endless war, want to move toward greater tolerance of marijuana and other drugs. That is not overstatement: the Arizona law permits the use of heroin, LSD and methamphetamines if a user gets prescriptions from two doctors.


WENDY ANN ZIMA

Fired up: *The initiatives in California and Arizona take aim at law enforcement's anti-drug strategy*

Marijuana is the soft spot in the national opposition to drugs. Millions have tried it at some point in their lives and found that it was pleasurable and not particularly addictive. To that reservoir of latent tolerance, the backers of Prop 215 shrewdly added the irresistible notion of helping people in pain—people like 77-year-old Hazel Rodgers of San Francisco, who regularly smokes pot to relieve the symptoms of glaucoma and her anxiety about having been diagnosed with breast cancer. Drug warriors like McCaffrey (page 27)

Pain relief: *At 77, Hazel Rodgers smokes to ease her glaucoma*

RICHARD MORGENSTEIN

are thus forced into the no-win position of trying to deny the weed to thousands of patients who say it makes them feel better. Never mind the fact that current medical research (right) suggests pot doesn't do anything for glaucoma, or that other prescription drugs alleviate pain and anxiety. And never mind the fact that the fine print in the California law makes it a sham. Though sold to the voters as a way of helping people with terrible illnesses, the law specifically permits pot use for almost any complaint—even migraine headaches. It sidesteps federal law by specifying that pot use is legal if a doctor merely "recommends" it orally. That may mean doctors will not lose their licenses because they didn't *prescribe* the drug. It also means there will be no paper trail for narcs to follow.

Considering the fact that poll after poll reveals no sign that U.S. voters want to legalize pot or any other drug, this outcome is arguably perverse. It greatly disturbs groups like the Partnership for a Drug-Free America, which points out that marijuana use among teenagers is rising steadily and that the California law contains no age restrictions. The theory here is that marijuana is a "gateway" to harder drugs. That isn't Reefer Madness alarmism: reliable research shows that virtually all heroin and cocaine addicts started out with pot.

What worries drug warriors now is the possibility that would-be users will find friendly doctors to give them oral approval and then buy the weed on the black market or at so-called cannabis buyers' clubs, which serve as middlemen between illicit growers and their middle-class clientele. That will surely create large problems for cops trying to suppress the underground pot trade, and it could produce a new class of criminal defendants who could claim their doctors said pot was a good thing to do. Ultimately, it may lead to a test case in which some prosecutor will press charges against an old lady like Hazel Rodgers. "The sense of frustration here is just huge," says a U.S. Justice Department official. "The dilemma is that in trying to look tough [to deter pot use], we wind up looking draconian."

What we have here, thanks to the voters of California and Arizona, is a nightmare for drug warriors everywhere—and a small but potentially significant breach in the national resolve against drugs. Earnest appeals by McCaffrey and many others failed to stop these slippery proposals at the ballot box, and it is time for clear leadership from the top—from Bill Clinton, the man who didn't inhale. Should we legalize pot, or not? That question is clearly implied in the controversy over medicinal marijuana. It is an issue that all Americans, ready or not, must confront honestly and resolve.

With MATT BAI *and* PATRICIA KING *in San Francisco and* DANIEL KLAIDMAN *in Washington*

GERRY GROPP—SIPA

On the edge: *Ken Estes, a paraplegic, works at Oakland's Cannabis Buyers Club, part of a*

Can Marijuana Be Medicine?

The claims are unproven, but many patients say the drug helps them. BY GEOFFREY COWLEY

SUSAN NELSON SPENT most of 1978 watching her husband, Don, retch almost constantly. His body fought so hard to expel the chemicals used to treat his testicular cancer that, after 18 months, his battered esophagus ripped, causing tissue damage that has plagued him ever since. A decade later, it was Susan's turn. She developed lymphoma in 1989, and she, too, underwent chemotherapy. But in four months of treatment, she vomited only once. Instead of heading for the bathroom when she felt a surge of nausea, she took matters into her own hands: she fired up a joint.

Susan Nelson is no dopehead. She grew up in a military family, and never even experimented with pot as a '60s teenager. But she wasn't about to relive her husband's experience. The anti-nausea drug her doctor prescribed did wonders for her digestion, but it also lowered her inhibitions, causing inexplicable urges to throw plates and roll burning logs on the living-room floor. Smoking marijuana may have broken the law (she bought it from fellow patients), but it didn't break her dishes. "When I smoked it," she recalls, "you could still trust me."

Americans may frown on recreational pot smoking, but as recent votes in California and Arizona make clear, a lot of people favor leaving folks like the Nelsons alone. The states' initiatives won't have much practical effect (they free doctors to recommend marijuana without creating legal supplies of the drug). Still, the measures have revived an important and long-neglected question: does pot ever make good medi-

underground network that supplies the sick

cine? Federal drug-enforcement officials say the drug is both useless and dangerous. They're challenging the new initiatives in court and vow to punish doctors who prescribe pot to their patients. But proponents claim marijuana can help control glaucoma, forestall AIDS-related wasting, ease the nausea brought on by cancer chemotherapy and counter the symptoms of epilepsy and multiple sclerosis. The claims are largely unproven, but they warrant some serious attention.

Marijuana's basic mode of action is well known. Several years ago, researchers discovered that the body makes a chemical closely resembling THC, the main active ingredient in cannabis, and that the brain has receptors designed specifically to receive it. The receptors are concentrated in the brain regions responsible for motor activity, concentration and short-term memory. As anyone who ever inhaled will attest, marijuana can disrupt all those functions.

The question is whether it can do anything else. For nearly three decades the government has listed marijuana as a "schedule I" drug, a designation reserved for substances with no apparent medical value and a high potential for abuse. Barry McCaffrey, director of the Office of National Drug Control Policy, stoutly defends that ruling, saying there is "no convincing scientific evidence" that marijuana offers benefits that a person can't get from approved prescription drugs.

Where glaucoma is concerned, McCaffrey has a point. It's well known that smoking marijuana can reduce pressure within the eye, a hallmark of the disease. But the drug may also reduce the blood supply to the optic nerve—the last thing a glaucoma sufferer needs—and it doesn't seem to prevent blindness. Even if marijuana could save eyes, smoking it enough would take extraordinary effort. "In order to substantially reduce eye pressure," says Dr. Harry Quigley of Johns Hopkins University's Wilmer Eye Institute, "you'd have to be stoned all the time." When researchers tried dissolving THC in eye drops, they succeeded only in irritating people's eyes, but other compounds proved more useful. As a result, glaucoma patients can now choose from a number of potent topical treatments. The latest, a once-a-day eye drop called Xalatan, is virtually free of major side effects.

Marijuana may not cure glaucoma, but it

SOURCE: NORML

States with medical-marijuana laws

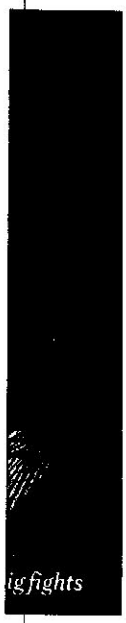
The Medical Bottom Line

Though largely illegal since 1937, marijuana may prove an effective alternative to more commonly prescribed drugs for some diseases. California, Arizona and Massachusetts are leading the fight to make marijuana more readily available. They aren't alone: 26 states and the District of Columbia have passed various laws and resolutions establishing therapeutic-research programs, allowing doctors to prescribe marijuana, or asking the federal government to lift the ban on medical use.

CONDITION	MARIJUANA TREATMENT	CONVENTIONAL TREATMENT
Cancer chemotherapy Often causes extreme nausea and vomiting	• Active ingredient THC reduces vomiting and nausea, alleviates pretreatment anxiety	• Marinol (synthetic THC): Commonly used but can cause intoxication. Pill form only, hard to swallow if you're vomiting. • Serotonin antagonists such as Zofran (ondansetron): Can be taken intravenously but more expensive than Marinol
AIDS-related wasting Low appetite, loss of lean (muscle) mass	• Improves appetite	• Marinol: Boosts appetite, but smokable marijuana allows better dose control • Megase (megestrol acetate): Stimulates appetite and may reduce nausea. Currently being compared to Marinol for cancer patients.
Pain and muscle spasms Associated with epilepsy and multiple sclerosis	• Reduces muscle spasms; may ease incontinence of bladder and bowel and relieve depression	• Dantrium (dantrolene sodium): Capsules or injection can relax nerves and muscles to calm spasms. Can cause liver damage. • Lioresal (bactofen): Tablet alleviates spasticity but also causes sedation. Sudden withdrawal can cause hallucinations and seizures.
Glaucoma A progressive form of blindness due to increased pressure inside the eyeball	• When smoked, it reduces pressure within the eye. But it may also reduce blood flow to the optic nerve, exacerbating the loss of vision.	• Xalatan (latanoprost): Once-a-day eye drop. Low rate of side effects. Changes eye color in some users. • Beta-blocker eye drops: Can cause lethargy and trigger asthma attacks • Miotic eye drops: Allow eye to drain faster but constrict the pupil, dimming vision • Carbonic anhydrase inhibitors: Decrease production of fluid in the eye, but can cause numbness and weight loss

has other claims to respectability. People have used it for centuries to stimulate appetite, and an unknown number now use it to combat the wasting associated with AIDS. No one knows how much good it's doing—the drug-control agencies have recently thwarted studies intended to answer that question—but some experts suspect the benefits are modest. The wasting syndrome doesn't stem solely from a lack of appetite, says Dr. Donald Kotler, an immunologist at New York's St. Luke's–Roosevelt Hospital. The patient may have an intestinal infection that blocks the absorption of nutrients, or a neck tumor that interferes with swallowing.

Skeptics also note that the FDA has already approved several effective remedies for wasting. To stimulate appetite, patients can take Marinol, a synthetic version of THC that comes in pill form, or Megace, a derivative of the hormone progesterone. In premarketing studies, AIDS patients who took Megace for 12 weeks gained an average of 11 pounds, while those getting a placebo lost 21. Since AIDS takes a particular toll on muscle tissue, the FDA has also approved several muscle-building steroids (testosterone and its kin) as AIDS treatments. Patients with good insurance can also get synthetic human-growth hormone, a bone-and-muscle builder that costs $1,000 a month.



igfights

Yet as many patients have discovered, plain old pot may still have a valuable role. Keith Vines, a 46-year-old San Francisco prosecutor, considers himself a stalwart in the war on drugs. As an assistant district attorney, he has spent years putting street dealers in jail. As an AIDS patient, he has seen his body threaten to disintegrate. "Three years ago my ribs were protruding," he says. "I was terrified to get on the scale." He wanted to enroll in a study of human-growth hormone, but participants had to eat three meals a day, and he could hardly force down one. He tried several drugs—including Marinol, which often left him too blasted to function—but nothing worked until he joined a local buyers' club and started smoking pot. Once he took that leap, he qualified for the human-growth-hormone study, put on 45 pounds and managed to salvage his job. "Without marijuana," he says earnestly, "I would be dead."

Like AIDS-related wasting, the nausea from cancer chemotherapy is readily treated by prescription drugs. But those drugs are expensive, they don't always work and

they're not always harmless. Their warning labels are littered with phrases like "hives," "impotence," "difficulty breathing," "tremors and rigidity" and "leukopenia" (a drop in white blood cells). Marijuana isn't risk-free—its smoke contains a number of carcinogens—but it's less toxic than many prescription drugs. There is no recorded instance of a death from overdose. And because people consume it one puff at a time, feeling the effects as they go, they can easily tailor their intake to their needs.

That's a big advantage for people with chronic pain or with spastic disorders such as multiple sclerosis. Whereas prescription drugs may zonk them out for the whole day, marijuana lets them respond directly to their symptoms. No one has conducted trials to gauge marijuana's genuine therapeutic effect on pain and spasms. But that doesn't much concern 39-year-old Andrew Hasenfeld, who was diagnosed with multiple sclerosis in 1980. He tried the prescription drug bactofen, but it never relieved the spasms, the stiffness, the sensation of "being all locked up." He resorted to marijuana six months ago, at the urging of fellow sufferers in Amherst, Mass., and the result was dramatic. "There's no comparison with any drug I could buy in a pharmacy," he says.

Few people would argue that Andrew Hasenfeld, Keith Vines or Susan Nelson belongs behind bars. ("I'm already in a wheelchair," says Hasenfeld. "Isn't that enough?") And though recreational pot smokers can get involved with harder drugs, it's hard to see how easing one's nausea, wasting or muscle spasms could cause what the drug office describes as "a downward spiral of self-destruction." Still, federal regulatory policy can't rest entirely on individual testimonials. As McCaffrey argues in a forthcoming "myths and truth" position paper, "drug policy must be based on science, not ideology." Approving marijuana as a prescription drug would require organizing clinical trials, identifying appropriate uses and finding ways to regulate its cultivation and sale. Those aren't insurmountable obstacles; morphine has been used medically for years. But federal policy has long discouraged clinical research with marijuana. The drug-control office is now pledging that "any serious marijuana research request will be considered." Perhaps that will begin to clear the smoke.

With MARY HAGER *in Washington,* ADAM ROGERS *in New York,* CLAUDIA KALB *in Boston and* PATRICIA KING *in San Francisco*

Exhibit C

A SURVEY OF STATE MARIJUANA-RELATED STATUTES

California is not alone in allowing medical use of marijuana. A total of nine states currently have laws allowing for medical marijuana usage:

Arizona: Ariz. Rev. Stat. Ann. §13-3412(A)(9) and §3412.01 (1997)(law approved Nov. 5, 1996). The law allows allows physicians to prescribe marijuana if existing research supports the medical efficacy, and a second medical doctor concurs in writing.

California: Cal. Health & Safety Code §11362.5(a) (West 1997)(law approved Nov. 6, 1996). The law is known as the Compassionate Use Act.

Connecticut: Conn. Gen. Stat. §21a-246 and §21a-253 (1997). The law allows physicians licensed by the commissioner of Consumer Protection to prescribe marijuana, and allows patients to possess the marijuana obtained by prescription.

District of Columbia: D.C. Code Ann. §33-522 (1997)(law approved Aug. 1981). Reschedules cannabis as Schedule V when used for medicinal purposes.

Iowa: Iowa Code §124.204 and §124.206 (1996)(law approved on June 1, 1979). The law reschedules marijuana and THC as Schedule II when used for medicinal purposes.

Louisiana: La. Rev. Stat. Ann. §40:1021 (West 1997)(law approved Aug. 21, 1991). The law allows physicians to prescribe marijuana in accordance with regulations promulgated by the Secretary of Health and Hospitals.

New Hampshire: N.H. Rev. Stat. Ann. §318-B:9 (1996) (law approved April 23, 1981). The law allows physicians to prescribe and pharmacists to provide marijuana for medical purposes.

Vermont: Vt. Stat. Ann. tit. 18 §4471 (1997)(law approved April 27, 1981). The law is administered by the Department of Health and allows physicians to prescribe cannabis.

Virginia: Va. Code Ann. §18.2-250.1 and §18.2-251.1 (Michie 1997) (law approved Mar. 27, 1979). The law allows physicians to prescribe, and pharmacists to dispense, marijuana and THC.

Further, other states are actively considering laws that will make medical use of marijuana legal. For example, Colorado and Maine have ballot initiatives up for voting in 1998. Arkansas, Florida and the District of Columbia are all petitioning to get such a law on the ballot. Medical Marijuana Initiatives Filed for 1998 in Maine, Colorado, 1 Legislative Bulletin 3 , National Organization for the Reform of Marijuana Laws, Fall 1997, at 3.

Beyond this, at least ten other states have legislatively approved medical marijuana research programs.

Alabama: Ala. Code §20-2-110 (1997) (law approved July 30, 1979). The law creates a therapeutic research program for approved cancer, chemotherapy, and glaucoma patients.

Georgia: Ga. Code Ann. §43-34-120 (1997) and Rules and Regs. Ch. 360-12 (law approved on Feb. 22, 1980). The law creates a therapeutic research program for approved cancer and glaucoma patients and their physicians and pharmacies. A Patient Qualification Review Board determines who is approved.

Illinois: Ill. Rev. Stat. ch. 720, para. 550/11 (1997)(law approved Sept. 9, 1978). The law allows persons "engaged in research" to use marijuana when authorized by a physician, and approved by the Department of Mental Health and Developmental Disabilities.

Massachusetts: Mass. Gen. L. ch. 94D, § 2 (1997)(law approved Dec. 1991) The law established a therapeutic research program for patients suffering from cancer, chemotherapy, radiation therapy, glaucoma, and asthma.

Minnesota: Minn. Stat. §152.21 (1997) (law approved April 1980). Created a research program for use of marijuana for cancer chemotherapy.

New Mexico: N.M. Stat. Ann. § 26-2A (Michie 1997) (law approved on Feb. 21, 1978). The law reschedules marijuana and THC to Schedule II when used for medicinal purposes.

New York: N.Y. Pub. Health Law §3397 and §3328 (1997) (law approved June 30, 1980). The law establishes a therapeutic research program for patients with glaucoma, cancer and other life-threatening diseases. Patients must be approved by the Commissioner of the Department of Health.

South Carolina: S.C. Code Ann. §44-53-610 (Law. Co-op. 1997) (law approved Feb. 28, 1980). The law allows patients approved by the Commissioner of the Department of Health to use marijuana and THC. Coverage applies to glaucoma, cancer, chemotherapy, radiation, and other disease and treatment groups.

Texas: Tex. Health & Safety Code Ann. §481.111 and §481.201-205 (West 1997) (law approved June 14, 1979). The law establishes a therapeutic research program for glaucoma and cancer patients.

Washington: Wash. Rev. Code §69.51.(1997) (law approved Mar. 27, 1979). The law rescheduled marijuana and its compounds. On March 30, 1996 Washington also created two medicinal marijuana research projects: one for tamper-free cultiviation methods, and the other for studying the therapeutic benefits of marijuana.

Medical marijuana initiatives filed for 1998 in Maine, Colorado, elsewhere

Voters in Colorado and Maine will have the opportunity to decide whether the use of medical marijuana under a physician's supervision should be legal under state law.

Medical marijuana proponents in both states recently filed ballot initiatives to put the issue to a public vote in 1998. Americans for Medical Rights (AMR), the California-based group that spearheaded the successful passage of Proposition 215 in California, is coordinating the two state campaigns.

"Next year is going to be a defining moment in the battle for legal access to medical marijuana," NORML Director R. Keith Stroup predicted. "Federal legislators are looking to the states to take the lead on this issue."

Colorado's reform effort seeks to amend the state's constitution to allow anyone holding a state-issued identification card to legally possess up to an ounce of marijuana. Patients would also be able to cultivate marijuana for medical use with a physician's recommendation. Cultivation limits are set at six plants, with no more than three plants producing usable marijuana at any one time.

A state health agency would keep a confidential registry of patients who possess valid doctor's recommendations. Those who obtain marijuana for medical use would be prohibited from using it in public places, selling or distributing the drug, or "endangering the health and well-being" of other people by its use.

A similar proposal filed in Maine would limit the use of marijuana to patients suffering from AIDS, glaucoma, multiple sclerosis, seizures, or undergoing cancer chemotherapy. As in Colorado, the proposal allows patients to grow up to six marijuana plants.

"It's pretty clear that this was written to ensure that [opponents] could not claim that this law would 'open the door' to other uses of marijuana," said Attorney Ron Kreisman, who drafted the initiative.

"It's been clear for years that there is broad and deep support for permitting medical use of marijuana among Maine [citizens]," explained Dave Fratello, spokesman for AMR. Stephanie Hart, a former Congressional aide who is now coordinating the statewide effort, agrees. "We know from everything we've heard that Maine people will come forward" to support the medical marijuana drive, she said.

Historically, Maine has been on the forefront of the medical marijuana issue. In 1979, Maine was one of the first states to approve legislation creating a therapeutic research program. The law was extended in 1983, but expired in 1987. Maine legislators addressed the issue again in 1991 and passed a law re-establishing the program and allowing licensed pharmacies to distribute marijuana to certified patients. Unfortunately, then-Gov. John McKernan vetoed the bill. Between 1995 and 1997, three separate medical marijuana bills were introduced, but none gathered majority support in the Legislature.

Stroup sees parallels between Colorado and Maine, and anticipates both initiatives efforts to be successful in 1998. "In both instances, you have states where voters have shown strong support for the issue, but the Legislature has failed to convert the voters' sentiment into law," he said. "Proponents have no choice but to bypass the Legislature and go directly to the voters."

Besides Colorado and Maine, grassroots petition drives are also taking place in Alaska, Arkansas, Florida, and the District of Columbia. Both Florida's and Washington D.C.'s initiatives are modeled after California's Proposition 215, while Alaska and Arkansas' language propose broader drug-law reforms.

Americans for Medical Rights said that they may back additional state initiatives in 1998.

*For more information, please contact the **NORML** national office. **Americans for Medical Rights** may be contacted @ (310) 394-2952*

STOP

"Journey for Justice II" culminates in introduction of medical marijuana bill

Legal medical marijuana patient George McMahon of Iowa displays a tin of government grown marijuana at a September 18 press conference in Madison, WI, culminating the end of "Journey for Justice II." Patients trekked 210 miles across Wisconsin to bring attention to the plight of medical marijuana users nationwide. The week long event ended with a pledge from state representative Frank Boyle (D-Superior) to introduce legislation protecting patients who use marijuana under a physician's supervision from state criminal charges. NORML was the chief sponsor of the event, which Executive Director R. Keith Stroup, Esq. called a "truly inspirational protest."

Exhibit D

ON 7-24-97, I (DET. NORDSKOG) WAS CONTACTED BY A PERSON REGARDING A LARGE SCALE INDOOR MARIJUANA GROW. THE PERSON WHO CONTACTED ME, KNOWN ONLY AS "INFORMANT", IS UNTESTED AND WISHED TO REMAIN ANONYMOUS. I KNOW FROM PAST CONTACTS HOWEVER, THAT THE INFORMANT IS HIGHLY KNOWLEDGEABLE REGARDING MARIJUANA CULTIVATION. ON THAT DATE, THE INFORMANT TOLD ME THAT A MALE NAMED TODD MCCORMICK (M/W-25-30) HAD A MASSIVE MARIJUANA GROW IN THE "CITY" OF BEL AIR. THE INFORMANT (WHO HAS NOT PERSONNALY SEEN THE GROW) SAID THAT MCCORMICK IS BEING FINANCED BY AN AUTHOR AND SOME OTHER PERSONS ACTIVELY INVOLVED IN THE MARIJUANA LEGALIZATION MOVEMENT. THE INFORMANT STATED THAT MCCORMICK HAS RECENTLY BEEN FEATURED IN "HIGH TIMES" AND HAS PAST ARRESTS FOR MARIJUANA TRAFFICKING.

THE INFORMANT STATED THAT HIS/HER INFORMATION IS SECOND HAND FROM A FRIEND WHO VISITED THE GROW LOCATION. THE INFORMANT STATED THAT THE LOCATION IS DESCRIBED AS A "CASTLE", HAS 4-5 FLOORS, AND HAS AN ELEVATOR. THE INFORMANT DID NOT KNOW THE ADDRESS, BUT SAID IT WAS IN AND EXCLUSIVE CANYON IN BEL AIR. THE INFORMANT SAID THE GROW WAS SUPPOSED TO EXCEED SEVERAL HUNDRED PLANTS IN AN INDOOR HYDROPONIC CONFIGURATION. THE INFORMANT ALSO SAID THAT THE GROW LOCATION WAS "VERY OBVIOUS". THE INFORMANT IS NOT BEING COMPENSATED FOR THIS INFORMATION IN ANY WAY. THE INFORMANT WAS JUST PASSING ON A "RUMOR" TO US.

I CONTACTED S/A TONY ZAVACKY OF THE LOS ANGELES DRUG ENFORCEMENT ADMINISTRATION, REGARDING THIS INFORMATION. HE BEGAN A COMPUTER SEARCH FOR TODD MCCORMICK. ON 7-28-97, HE RE-CONTACTED ME AND SAID THAT VIA NORMAL COMPUTER SOURCES, HE HAD LOCATED A TODD MCCORMICK AT THE ADDRESS OF 1605 STONE CANYON ROAD, BEL AIR. HE SAID THAT COMPUTER RECORDS SHOW THAT IT IS THE SAME TODD MCCORMICK THAT HAD PAST MARIJUANA SALES ARRESTS IN OHIO AND SAN DIEGO. THIS INFORMATION IS CONSISTENT WITH THE ARTICLE FEATURING MCCORMICK IN THE DECEMBER 1995 "HIGH TIMES". HE FURTHER SAID THAT TODD MCCORMICK IS THE UTILITIES SUBSCRIBER AT THAT LOCATION.

ON 7-28-97, S/A ZAVACKY DROVE TO THAT LOCATION AND SAW THAT THE HOME WAS VERY UNIQUE AND VERY MUCH RESEMBLED A CASTLE IN APPEARANCE. AT THIS TIME, HE SAW NUMEROUS PLANTS ON THE VISIBLE BACK BALCONY/PATIO THAT POSSIBLY APPEARED TO BE MARIJUANA PLANTS. S/A ZAVACKY SAID THAT A FEMALE WHITE WAS MOVING THE PLANTS THAT APPEARED TO BE ON LARGE TRAYS.

ON 7-29-97, I (NORDSKOG) ALONG WITH DETECTIVES VELAZQUEZ, CATER, AND DET. SGT. DICKEY DROVE TO THAT SAME LOCATION. WE SAW THAT THE LOCATION STRONGLY RESEMBLED A CASTLE IN APPEARANCE, AND WAS 4-5 STORIES IN HEIGHT. A NEARBY LONG TIME RESIDENT ALSO TOLD US THAT THE BUILDING HAD AN INTERNAL ELEVATOR. AT THAT TIME, WE SAW THE POST OFFICE DELIVER A PACKAGE TO A MALE NAMED TODD MCCORMICK AT THAT LOCATION.

FURTHER, FROM SEVERAL LEGAL VANTAGE POINTS, ALL FOUR OF US COULD CLEARLY MAKE OUT SEVERAL HUNDRED MARIJUANA PLANTS RANGING IN SIZE FROM 1 FOOT TO 5 FEET IN HEIGHT. THE PLANTS WERE VISIBLE FROM THE ROAD, A CITY CATCH BASIN ALONGSIDE THE HOME, CITY PROPERTY ACROSS THE STREET, AND FROM AT LEAST ONE NEIGHBOR'S HOME. THESE PLANTS WERE ALL GROWING ON THE REAR PATIO IN LARGE POTS OR ON TRAYS. THE PLANTS APPEARED TO BE WELL WATERED AND WELL CARED FOR. SEVERAL OF THE PLANTS WERE IN THE MATURE STAGE OF DEVELOPMENT AND WERE READY FOR HARVEST. WE IMMEDIATELY NOTED THAT THE LARGE NUMBER OF PLANTS VISIBLE WAS CLEARLY INDICATIVE OF A MAJOR COMMERCIAL GROWING OPERATION.

WE COULD SEE A MALE WHITE WORKING INSIDE OF THE HOME. FURTHER, WE SAW A VAN DRIVE TO THE LOCATION, PICK-UP A FEMALE FROM INSIDE AND THEN DRIVE AWAY.

IT APPEARED THAT THE SECOND HAND INFORMATION PROVIDED BY THE INFORMANT IS EXTREMELY ACCURATE. BASED ON THIS ACCURACY, WE BELIEVE THAT WE WILL PROBABLY FIND EVEN MORE PLANTS INSIDE THE LOCATION IN A HYDROPONIC GROW SETTING.

WE REQUEST THIS WARRANT IN ORDER TO SEIZE THE MARIJUANA PLANTS WE OBSERVED AND TO FIND FURTHER EVIDENCE OF THIS LARGE COMMERCIAL OPERATION.

IT SHOULD BE NOTED THAT DESPITE THE WARNING SIGNS, THERE WAS NO EVIDENCE OF AN ATTACK OR GUARD DOG PRESENT. FURTHER, A NEIGHBOR SAID HE DID NOT BELIEVE THERE WERE ANY GUARD DOGS PRESENT.

U.S. Department of Justice
Drug Enforcement Administration

REPORT OF INVESTIGATION Page 1 of 2

1. Program Code	2. Cross File / Related Files	3. File No. [redacted]	4. G-DEP Identifier [redacted]
5. By: Anthony J. Zavacky, S/A At Los Angeles, CA		6. File Title MCCORMICK, Todd	
7. ☐ Closed ☐ Requested Action Completed ☐ Action Requested By:		8. Date Prepared 08/04/97	

9. Other Officers: S/A's Chris Schlichter, J. Todd Scott, Cinda Lutz

10. Report Re: Case Initiation

DETAILS

1. Date of Initiation : July 24, 1997.

2. Basis of Investigation : Based on information received by S/A Cinda Lutz from a Task Force Agent in the San Diego, CA area, and forwarded to S/A Chris Schlichter, S/A Anthony Zavacky and S/A J. Todd Scott initiated an investigation concerning a possible indoor marijuana cultivation near Culver City, CA [redacted]. During the investigation, S/A Zavacky requested the assistance of Los Angeles County Sheriff's (LASO) Det. Edward Nordskog. Det. Nordskog obtained a state search warrant which was executed on 07/22/97 by deputies from the LASO and agents from Group 2 of the Los Angeles Field Division. The search revealed 515 marijuana plants, 1.6 kilos of cocaine and $6,439 U.S. Currency. Two suspects were arrested by the LASO. The United States Attorney's office declined to prosecute. S/A Zavacky opened summary case number [redacted].

On 07/24/97, based on interviews with the previous suspects, S/A Zavacky received information from Det. Nordskog regarding an indoor marijuana cultivation of MCCORMICK, Todd, in the Bel-Air area of Los Angeles, CA. Det. Nordskog stated that the house was described as a "castle" with 4 floors and an elevator. Det. Nordskog said that an article in High Times magazine stated that MCCORMICK had been arrested previously for trying to enter the country with marijuana for medicinal use, and a search warrant had been served at his residence in San Diego, CA. On the same date, S/A Zavacky obtained an address for MCCORMICK at 1605 Stone Canyon Rd., Los Angeles, CA, which is in the Bel-Air area.

3. Targets : MCCORMICK, Todd Patrick and all co-conspirators

11. Distribution: Division / District / Other [redacted]	12. Signature (Agent) Anthony J. Zavacky, S/A	13. Date 08/06/97
	14. Approved (Name and Title) Anthony [illegible] Group Supervisor	15. Date 8/6/97

DEA Form -6 (Aug. 1994) AJ2

DEA SENSITIVE
Drug Enforcement Administration

1-Prosecutor

Previous edition dated 5-90 may be used.

U.S. Department of Justice
Drug Enforcement Administration

REPORT OF INVESTIGATION

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5. By: Anthony J. Zavacky, S/A At: Los Angeles, CA	[redacted]	6. File Title MCCORMICK, Todd	
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DEA Form -6 (Aug. 1994) AJ2

DEA SENSITIVE
Drug Enforcement Administration

1-Prosecutor

Previous edition dated 5/91 may be used.

004308

D-109

U.S. Department of Justice
Drug Enforcement Administration

REPORT OF INVESTIGATION (Continuation)	1. File No. [redacted]	2. G-DEP Identifier [redacted]
4. Page 2 of 2	3. File Title MCCORMICK, Todd	
5. Program Code	6. Date Prepared 08/04/97	

4. Objectives : To identify MCCORMICK, to identify all of MCCORMICK's co-conspirators and to confirm that MCCORMICK resides in the house in Bel-Air and determine if there is marijuana being cultivated on the property.

[redacted]

Afflicted with a rare form of cancer at age two, Todd McCormick spent most of his early childhood in and out of hospitals and operating rooms. At nine, with his doctor's approval, he began smoking marijuana to relieve the pain and nausea of radiation treatments. In December 1994, while in Amsterdam for the Cannabis Cup, a friend suggested he get a prescription for medical marijuana, which he uses for his chronic pain. He did, and subsequently discovered that the preamble to the United Nations' Single Convention Treaty, which outlawed cannabis around the world, contains a special provision to allow people to carry and use prescription drugs internationally that are illegal in some countries but legal in the country in which they are prescribed. In March of this year McCormick tested his prescription when he brought 900 grams of cannabis through Customs in Denver.

In July, while en route from San Diego to Rhode Island to help launch a cannabis buyers' club, he, along with his companion, Natalie Byrd, was arrested in Ohio and spent 52 days in jail. Now out on bond, McCormick faces 30 years for trying to deliver medicine to sick people.

HIGH TIMES: Before we get into your prescription for marijuana and the charges you're facing, tell us something about your cancer and how you discovered using marijuana as medicine in the first place.

TODD McCORMICK: When I was two years old I was diagnosed with a cancer called histiocytosis-X. It's pretty rare. I've had nine operations for it. I had it in my spine, and from there it went to my skull, from my skull to my right ear and from my right ear to my left hip twice. I was in a wheelchair for a year when I was about eight, and then it went from my hip to between my lung and my heart, which was the first time it hit soft tissue.

The cancers were coming machine-gun style. I was in the hospital every week, all the time, constantly. And I was in a lot of pain. My first five vertebrae and my spine were fused together when I was two, and they were giving me painkillers and all sorts of different drugs since I was a little kid. You wouldn't believe the fucking plethora of drugs I was on as a child.

Were you bedridden?

Actually, I was a very active child. I started taking judo at age ten and had my first motorcycle at age eight, my second at age 12. My stepfather was a biker, so I was hitting Sturgis and all the rendezvous, camping in Keene, New Hampshire, all those things. Very biker lifestyle. And bikers are really good people when you're one of 'em. So I was taken care of rather well.

How did you start using cannabis for your disease?

I got it from my mom when I was nine. We were in our car going home one day after a radiation treatment. She put up the windows, turned on the AC and lit a joint, and the secondhand smoke just took my dizziness and nausea away.

When we got home she didn't know what she had done to me, because I felt fine. I wanted to go out and play, and usually when we got home I was sick, just lying down, half dead. So she thought maybe the dope had done something bad, and called my doctor. He told her my reaction was typical, and that she should let me smoke. So she did, then called him back and told him I was hungry. My doctor approved, so they kept it up during my radiation sessions.

Radiation sucks. But at least with pot it was a lot less painful. Being able to smoke before or after radiation was an incredible relief.

And you've been smoking ever since?

I stopped smoking for maybe a year because I got over the cancer and I was feeling OK. B

when I was 12 years old I needed something for the pain in my neck. What was happening, and is still happening, is that my spinal fusion is eroding the base of my skull, and it was causing me a lot of pain and anguish. I couldn't even sleep.

Anyway, my doctor told me it was an irreversible condition and that I was going to have to learn to deal with it. He said he wouldn't prescribe anything that would make me psychologically or physically dependent or compromise my health. He told me to smoke pot. Well, I didn't want to be a pothead. I believed a lot of myths about marijuana and so forth. But he just said pot was not my worst option. So I've been using cannabis regularly since then.

Have you had any cancers since you were nine?

I went into a kind of spontaneous remission from age 10 to 15. And then right around 15-and-a-half, I got it in my left arm, in my bone. That was the quickest I ever went through treatment. I was constantly smoking and going to radiation, and it healed really fast. Of course, the cancer can come back at any time.

Have you had any negative effects from cannabis?

Getting busted. My lungs are still clean, if that's what you mean. I've been doing deep-breathing exercises and studying karate and everything, so I don't have any trouble breathing.

Where did you get the ingenious idea to get a prescription for marijuana in Holland?

My companion, Natalie Byrd, and I were in Amsterdam for last year's Cannabis Cup, and we stayed on after it for a few weeks. The whole time we were there Dion Montgraff, who used to be a partner in Cannabis in Amsterdam, kept urging me to get a prescription. I kept asking what good it would do me but he'd say, "What good wouldn't it do you? You'd have it. Just having it could be really useful."

In March 1995 I brought back about 900 grams, two pounds [of medical marijuana]. The airline even let me smoke on the plane.

While I was there I also met with James Burton of the Stichting Institute of Medical Marijuana. He told me about Dr. Troisel, the head of the Preventative Medicine Center in Rotterdam, who was the doctor who'd prescribed his cannabis medication. So I gave him a call and explained my medical history and told him I use cannabis for my pain. He was sympathetic, but he didn't know what he could do for me. But when he found out I was in Holland, he asked if I could come in for a visit. So I went to Rotterdam the next morning and he looked me over, injected novocaine in my back to make certain it was nerve and structural damage I was dealing with and not just muscle pain, then he wrote me out a prescription for 10 grams of medical cannabis daily. He told me the script would be good in any country that had signed onto the United Nations' Single Convention Treaty.

Did you bring any cannabis back with you at that time?

No, I wasn't sure if it was legal. I did ship myself 300 grams, and it made it. But then I did it with another package and that got stopped at Dutch Customs. It had my full legal address and my prescription in it, but they said they couldn't ship it to America.

How did you determine that it was legal to actually carry it back with you?

Well, I came back after the Cup on December 15, and three days later I was heading up to L.A. to see Jack Herer when I got stopped at the checkpoint between San Diego and L.A. by federal agents. They were doing their little immigration drug thing. I showed them my passport, and then one of the agents asked if there was anything else I'd like to show them before they searched my car. So I showed him my prescription.

The chief was eventually called over and he looked at my prescription, then looked at my passport and shook his head. Then they allowed me to get back in my car and drive away.

How did you feel?

I went up to Jack's tripping out! I couldn't believe it. Then I went to the Sacramento Law Library, did some research and reviewed it with Chris Conrad. We were particularly interested in the Single Convention Treaty and the legalities surrounding the prescription, and we both came to the conclusion that it was legal. The preamble of the Single Convention Treaty says that no country shall prohibit legitimate use of narcotics. And because cannabis is classified as a Schedule I narcotic drug in this country, that makes it a narcotic. And then the treaty talks about cannabis and its use as medicine. And I've since learned that international human-rights laws established by the United Nations, as well as the Food and Drug Administration's ruling on personal use of foreign-prescribed drugs, both stipulate that Americans who go to Europe, or Europeans that come to America with prescriptions, will not be harassed. On an individual basis, they will not stop you from utilizing foreign-prescribed drugs.

So when did you actually come into the United States with your prescription medicine?

In March 1995. I brought back about 900 grams, two pounds. The airline even let me smoke on the airplane.

It did?

When I was making arrangements for my flight, the lady said smoking or nonsmoking? And I was like, "Oh, it's a smoking flight?" I told her I had a prescription for cannabis and she acted as if, well, if you have a prescription I'm sure it's not a problem at all. So she put me in the smoking section and they let me smoke my cannabis there.

Coming back on that flight, did you think you were going to have a problem?

I felt really like I was in the right. I wasn't trying to hide it. Everybody on the plane could smell it. They were all talking about it, bussing my balls, asking me if they should bring me extra food.

So I wasn't scared so much as I was wondering how I was going to deal with things. But I'd been through so much as a child, I've been a prisoner in my own body for so very long, what could they really frighten me with? I was willing to see what they were willing to do. And nothing was what they were basically willing to do. So that was that.

What happened at Customs?

I noted on my Customs declaration that I'd been in Holland for a doctor's visit. The agent asked me why I didn't go to an American doctor. I said I'd had cancer nine

times in eight years and doctors here can't prescribe cannabis.

So you walked into Customs in March with 800 grams of pot and nothing happened?
I walked into Customs and as soon as they punched my name into the computer, the agent just looked at me, punched up more information, read the screen, wrote PC, personal check, on my little slip, and said, "You have to go over there." I was the only person off the flight that had to go to secondary inspection. Of course, I was the only person on the flight smoking cannabis, and I did smell like it. But the Customs agent was really nice to me. He X-rayed my things, went through one of my bags, and that was pretty much the end of my interrogation. They let me leave.

What did you do to the cannabis to keep it from being stopped at Customs as vegetation?
I didn't really know anything about that the first time. I just brought through raw cannabis. But I was speaking to someone at the International Hemp Association who said what they could do was gamma-irradiate it, which is what they do to food. What that does is kill all biological forms of life. The IHA has just done an experiment with that and they found that while it killed all the microorganisms in the plant, they found no loss in THC, CBN, CBDs. It was just as potent, just as useful. And actually it was better in a way, because it was dead.

The whole scenario is fascinating, using the Single Convention Treaty, which the US government is always touting as superseding local laws, to your advantage.
It's great. Dr. John Morgan, when he talked to my mother while I was in jail recently, was really wowed by the whole idea. He said that this had been done with other drugs, but no one had ever thought about doing it with cannabis. He said he thinks this could be the key to really unlock a lot of cannabis research.

Have you thought about helping others to get scrips in Holland?
Some of us were thinking we'd try to get a charter flight and group going. Imagine if we had 100 patients on a plane, and I had national coverage—I mean, CNN and the major networks would want to cover something like that. We'd come through and they're waiting on the other side. Either they would see 100 patients get cuffed as they attempted to bring their foreign-prescribed drugs back into America, or 100 patients would make it through with their cannabis prescriptions. I think that sort of action covered by the media would make a huge impact in the Berlin Wall of medical-pot prohibition here in America.

Do you have to keep returning to get your prescription filled?
Yes. That's the one drawback to this.

How much can you pick up at once?
That's debatable. My prescription is for 10 grams a day, and people bring back up to six months' prescription from a foreign country rather commonly. That's nearly two kilos.

Is the pharmacy you get your medicine from licensed to hand over cannabis?
There is only one active pharmacy doing it.

Is anyone here asking where you filled your prescription?
Yeah, the Ohio state troopers, after my bust. I told them it was from Amsterdam, that I brought it back through Customs—in Colorado. They thought that was the most preposterous thing.

Tell us about the bust. When, where and how did it happen?
Natalie and I were arrested by Ohio state troopers on July 18, around 2:30 in the afternoon on interstate 80, Ohio. We were headed to Rhode Island, to help launch a cannabis buyers' club there, so we had 30 pounds of buds with us.

courtesy of Ryan McGuirk

Why Rhode Island?
That's where I grew up. That's where the majority of my friends died, and where I spent most of my life in Rhode Island Hospital. The club is going to open up in a church there and I wanted to help get it going by bringing them some medicine.

Why were you pulled over?
They said it was because my hemp curtains on my 1987 van were closed. Actually, at first I thought it was just a general stop, but Natalie thinks they were waiting for us because there were three cars that pulled us over for our curtains being closed. She may be right, and it might have been the San Diego DEA who tipped them off, since they knew we were traveling with marijuana.

At first they just asked who was smoking the pot? I showed them my prescription, and I gave them my passport. Then a female trooper started questioning me about my prescription, and then this Officer Stevens came along, telling me his father had cancer and he didn't give a shit about my condition. We got into a little debate about things, and then he went over to Natalie and asked to see the prescription. She showed him the vial I brought back from Europe, which had about 60 grams in it, and as soon as that happened, they just opened up the vehicle and started going through our groceries, looking for, whatever. They arrested us for my prescription before they even found the 30 pounds, which was in a trash bag, with stickers on it that said "Not For Sale; Cannabis provided free by members of the Cannabis Buyers' Club." It was all buds, all very good quality.

What happened next?
They had Natalie drive the vehicle to a municipal place up the highway, where they handcuffed us and just started ripping our van apart. We were held there for about two hours, and then I was brought to the Correctional Center for Northwest Ohio, a regional prison. Our bond was set at $150,000 each.

What did they charge you with?
We're both charged with a first-degree felony of corrupt activity (a racketeering charge), a third-degree felony of drug trafficking,

The judge said he would even consider letting me have my prescription for marijuana in jail if I could get an American doctor to validate it.

two fourth-degree felony drug-abuse charges and one other felony. The prosecutor, William Bish, says we're facing 30 years if convicted.

At my arraignment the judge, Anthony Gratick, was phenomenal. He let me speak for about 20 minutes, and I discussed my health situation, the San Diego medical-marijuana resolutions that have passed, the San Diego buyers' club that I run. That's when the judge made a comment saying that he would not be responsible for my health while I was in jail, and ordered the prosecutor to secure my cannabis from the state police. The prosecutor was dumbfounded.

The judge said he would even consider letting me have my prescription in jail if I could get one American doctor to validate it. As soon as he said that, Don Wirtshafter of the Ohio Hempery, who's helped out a lot, got on the horn and called Drs. Lester Grinspoon, Tod Mikuriya and John Morgan, and three letters of validation were on the judge's desk within 18 hours.

Was the issue of giving you your medicine inside a prison simply too hot for the system to handle?

I had a feeling the judge would be more willing to release me on a low bond than let me smoke in jail. I don't think he expected me to get validating doctors so quickly. So they lowered my bond and I raised the money and left.

I also now believe my prescription is more valid than I even thought. Five felonies and I'm out on $2,000? They must have checked the prescription, found out it was valid and realized they'd have to let me smoke in jail. So they lowered the bond. But they're still holding my passport and my medicine, so they're forcing me to go to the illegal market.

How did Natalie take to being busted with you?

We share the same conviction. To say we're like-minded would be an understatement. All the time she was in jail, not one whimper. She was just like, let's get by it, the truth will set us free.

How many days were you inside?

Natalie was in for 28 days before her bail was lowered to $100,000 and the judge agreed to accept a 10 percent cash bond, which her father posted. I was in for 52 days before my bail was lowered. And without my medicine it got really painful. I could hardly move my head. They tried to give me Motrin, double the safe dose, but I wouldn't take it. I'm not a lab animal. I've already got a prescription that works.

Has any date been set for trial?

No. My lawyer, John Schaefer, a court-appointed attorney, feels that this isn't going to make it to trial. Since the beginning he's said this was a violation of the Fourth Amendment on search and seizure.

What about the raid on your house in San Diego three days after the bust? How did that go down?

The DEA, with no assistance from the city police, who know about the buyers' club, went and raided my house on August 21st. I wasn't even told it had happened. I just found out by accident when I called from jail and the Fede answered the phone.

They talked with me for about 15 minutes, trying to get me to implicate the four people that were at my house in criminal activity. I told them everything was mine, that the others were just answering the phone and taking care of things while I was away.

But as soon as I hung up, I called my mother and had her call my friend Diane in San Diego, who called the press. And within 20 minutes of me calling, Channel 10, the most conservative news station in San Diego, was there with cameras rolling, covering the "raid." The DEA promptly uncuffed the people that were there and tried to close the blinds. But the blinds wouldn't close, the cameras were in the windows; I mean, it got really ugly for them.

Was anyone arrested?

No, and the DEA got a massive amount of bad press out of it. All they found in the house was less than two ounces of pot, some seeds, lots of books.

Did they find growing equipment? Plants?

They didn't find anything, because there wasn't anything to find.

What have they done with the house?

Nothing. In fact, within six days of the raid they returned 90 percent of what they took. They're still holding my mortgage and some paperwork which they're saying is "evidence," but they haven't filed any charges or initiated any proceedings at all.

Can they go back on that and file charges if they want?

I've been wondering if there are any secret indictments floating around, or what they've got up their sleeve. It's obvious to me why they didn't want to get me into a federal court. If I were to go into a federal court and show my prescription, that would set precedents from sea to sea. And I don't think they want to deal with that.

How many people were you seeing at the club?

Under 20. It only opened this year. But my house is right next to a house for HIV-positive and AIDS men, and they were going to be my main focus.

Do you plan to continue with the club?

Oh yeah, full balls. I couldn't imagine not doing it. I would not want to die not having tried to change things. And there's no way that anything the police can do will stop me from continuing.

You know, when I was a teenager, I was afraid to mention the word marijuana. I was afraid to fuckin' draw a little pot leaf on my pad in high school, because I didn't want to be charged with it. We live in such a state of fear, what good is that? So yeah, I plan on going home.

What about the Rhode Island club that you were bringing the 30 pounds to? Is that still going to open?

Yeah, my mother's been working on it. She's turned into quite the little activist since I got arrested. She's always been feisty and adamant, but in the past year that I've been running around publicly, she's been saying I'm going to get busted, and I've been saying, so be it. I'm *already* busted, Mom. I'm already livin' in the fuckin' society that considers itself free when it isn't. I do not want to embrace these lies. And it's going to end, so let it end now. ■

Exhibit E

CRIMINAL COMPLAINT

COPY

UNITED STATES DISTRICT COURT	CENTRAL DISTRICT OF CALIFORNIA
UNITED STATES OF AMERICA v TODD PATRICK MCCORMICK, DAVID WAYNE RICHARDS, RENEE DANIELLE BOJE, ALEKSANDRA KRISTIN EVANGELIDI, and JOHN DOE	DOCKET NO. 971724 M MAGISTRATE'S CASE NO. 97-

Complaint for violation of Title 21, United States Code § 846

NAME OF MAGISTRATE JUDGE	UNITED STATES MAGISTRATE JUDGE	LOCATION
JAMES W. MCMAHON		Los Angeles, CA

DATE OF OFFENSE	PLACE OF OFFENSE	ADDRESS OF ACCUSED (IF KNOWN)
7/29/97	Los Angeles County	

COMPLAINANT'S STATEMENT OF FACTS CONSTITUTING THE OFFENSE OR VIOLATION:

Beginning at a date unknown and continuing to on or about July 29, 1997, in Los Angeles County, within the Central District of California, defendants TODD PATRICK MCCORMICK, DAVID WAYNE RICHARDS, RENEE DANIELLE BOJE, ALEKSANDRA KRISTIN EVANGELIDI, and JOHN DOE conspired and agreed to knowingly manufacture more than 1,000 marijuana plants, a Schedule I controlled substance, and to knowingly possess with intent to distribute more than 1,000 marijuana plants.

BASIS OF COMPLAINANT'S CHARGE AGAINST THE ACCUSED:

(See attached affidavit which is incorporated as part of this Complaint)

SIGNATURE OF COMPLAINANT

ANTHONY JAMES ZAVACKY

OFFICIAL TITLE

Special Agent - DEA

Sworn to before me and subscribed in my presence,

DATE

July 30, 1997

REC: DETENTION (for all defendants)

AFFIDAVIT

I, Anthony James Zavacky, being duly sworn according to law, declare and state:

1. I have been employed as a Drug Enforcement Administration (DEA) Special Agent (SA) for approximately one (1) year. I have been assigned to investigate large-scale narcotics trafficking organizations as a member of the Los Angeles Field Division (LAFD), Enforcement Group 2, since November 25, 1996. During my employment with the DEA, I have participated in approximately six large narcotics investigations, including physical surveillance, execution of search warrants, and arrests of numerous drug traffickers. I also have spoken on numerous occasions with informants, suspects, and other experienced narcotics investigators concerning the methods and practices of drug traffickers. I also worked about seven months as a border patrol agent.

2. This affidavit is made in support of a complaint charging TODD PATRICK MCCORMICK, DAVID WAYNE RICHARDS, RENEE DANIELLE BOJE, ALEKSANDRA KRISTIN EVANGELIDI and JOHN DOE with conspiracy to knowingly manufacture more than 1,000 marijuana plants, a Schedule I controlled substance, and to knowingly possess with intent to distribute more than 1,000 marijuana plants in violation of Title 21, United States Code, Section 846.

BACKGROUND CONCERNING INDOOR GROWS OF MARIJUANA

3. I am aware through training and experience, participation in narcotics investigations, and discussions with

other SAs and law enforcement officers of the following:

a. Marijuana is a Schedule I controlled substance which is produced in the United States as well as abroad. Marijuana grown in the United States is generally regarded as higher quality and sells for $1,500.00 to $5,000.00 per pound in California.

b. Marijuana cultivators usually conceal their gardens in remote areas that are not easily accessible to the public in order to avoid detection.

c. Indoor marijuana cultivators often use complex irrigation systems to water their crops. The systems typically consist of pumps, timers and a drip system.

d. Indoor marijuana cultivators consume an excessive amount of electricity and often divert electricity in order to conceal their illegal activity.

e. Some growers also import, usually from the Netherlands, marijuana seeds and sell or trade seeds with other growers.

INVESTIGATION

4. As detailed below, federal and state law enforcement agents have pursued this investigation in Los Angeles, California. I have served as the co-case agent for the Drug Enforcement Administration portion of the investigation. My knowledge of the facts alleged in this affidavit arises from my participation in the investigation as well as conversations with other law enforcement agents and deputies involved in this

investigation. Further, I have worked closely with DEA SA Christopher Sclichter, the other co-case agent for the Los Angeles portion of the case and Detective Ed Nordskog from the Los Angeles County Sheriff's Department Narcotics Unit.

5. I am informed by SA Chris Sclichter of the following:

a. This investigation was initiated from a duty phone call from a Source of Information (SOI) in San Diego, California. The SOI stated that two (2) women in the Los Angeles, California area have been cultivating marijuana in two (2) different residences.

b. The names the SOI provided were Susan Korski and another individual. The addresses the SOI provided were 4244 Mildred Avenue, Los Angeles, California and 3707 Ocean View Avenue, Los Angeles, California.

c. A utilities request at those addresses revealed the subscriber at 4244 Mildred Avenue as Susan Korski.

d. A comparison of usage at the residence for the previous year revealed the average monthly electric bill was $575. The average usage for five (5) other residences on the same street was $58 per month.

6. SAs Todd Scott, Chris Sclichter and I began conducting surveillance at 4244 Mildred Avenue, Los Angeles, California. I observed vehicles, later determined to be registered to Korski and another individual, at the residence. SA Sclichter observed Korski drive to the 3707 Ocean View Avenue address and enter the residence.

7. I contacted Detective Ed Nordskog of the Los Angeles Sheriff's Office, Narcotics Unit, who has conducted numerous indoor marijuana cultivation investigations. Detective Nordskog began conducting surveillance to include a thermal imagery of the 4244 Mildred property. Detective Nordskog informed me that he had observed Korski at the 4244 Mildred Avenue address. Detective Nordskog informed me that he had found clippings of marijuana plants in the trash, and that he would by obtaining a state search warrant for both locations. A state search warrant was signed and served July 22, 1997 at both locations by deputies from the LASO and agents from Group 2, DEA.

8. The search of these two locations recovered 515 marijuana plants growing indoor and outdoor, 1.6 kilos of cocaine, 15 pounds of processed marijuana and approximately $5,000 U.S. Currency.

9. Prior to being advised of her rights under Miranda Susan Korski provided information on other possible marijuana cultivation sites in the Southern California area. Detective Nordskog informed me that one of the names Susan Korski provided was TODD MCCORMICK who lived in a "castle type" house in Bel Air, California.

10. I am informed by DEA analyst Mike Carter, who conducted a computer search on the name MCCORMICK and social security number for TODD MCCORMICK, that his computer search revealed an address of 1605 Stone Canyon Road, Los Angeles, California, (the "Castle") located in the Bel Air area of Los Angeles, as being a

location that TODD MCCORMICK has used for the receipt of mail. SA Burke drove by the Castle on July 24, 1997. The Castle resembles a large castle type residence. A photocopy of the Castle is attached as Exhibit A. SA Burke observed two vehicles parked at the residence which are registered to Pamela Jeanne Lindsay and Tiffany Neumann.

11. I drove by the castle on July 25, 1997 and observed a vehicle registered to DAVID RICHARDS parked outside the gate.

12. I conducted surveillance at the Castle on July 28, 1997. I saw a white female moving what looked like trays of small plants around the patio area located around the side of the Castle.

13. I informed Detective Nordskog of all the previous information. Detective Nordskog stated that he and other deputies would be conducting surveillance at the residence on July 29, 1997. At approximately 3:00 p.m., Detective Nordskog contacted me and stated that he and other deputies observed a large quantity of marijuana plants growing around the patio area of the Castle. Detective Nordskog stated that he and the other deputies used a high power spotting scope, while they were standing across the street on public property, to view the Castle.

14. On July 29, 1997, a state search warrant was issued and executed for 1605 Stone Canyon Road., Los Angeles, California.

15. On July 29, 1997, Detective Nordskog informed me that deputies from LASO observed the vehicle registered to RICHARDS

arrive and park outside the gate. Detective Nordskog stated that Deputy John Cater observed a male he later identified as RICHARDS carry a cylindrical object, later identified as a hash sifter, into the Castle. I know from my training and speaking with other agents that a hash sifter is a round metal cylinder with a filter across the middle of it. It is used to filter the resin containing THC (active ingredient in marijuana) from the marijuana leaves. Hashish, the product of this process, is also a controlled substance. He also heard RICHARDS yell from the Castle words to the effect of "I'm so stoned." I am informed by Detective Nordskog that after RICHARDS was arrested and Mirandized, he stated that he was a frequent visitor to the Castle but he said he was not involved in the growing.

16. Detective Nordskog informed me of the following:

a. On July 29, 1997, Deputies from LASO stopped a vehicle leaving the residence.

b. The vehicle was occupied by RENEE DANIELLE BOJE and ALEKSANDRA KRISTIN EVANGELIDI.

c. These two women, before being Mirandized, stated that they just watered the plants. They also stated that MCCORMICK was at the Castle.

d. On July 29, 1997, Deputies had observed BOJE and EVANGELIDI watering and tending to the marijuana plants on the patio area.

17. I was present later the same day when Detective Nordskog later Mirandized BOJE and EVANGELIDI. After being

Mirandized, I am informed by Detective Nordskog that these two women said that they were told by MCCORMICK that growing the marijuana was legal for medical purposes, that MCCORMICK had a contract to supply a buyer's club in San Francisco, and that MCCORMICK was still located inside the Castle. After being Mirandized, BOJE and EVANGELIDI also admitted that they watered the plants and moved trays of plants.

18. Detective Nordskog informed me that deputies from LASO stopped another vehicle leaving the residence. This vehicle was occupied by MCCORMICK and RICHARDS. Both before and after being Mirandized, MCCORMICK stated that he was growing the marijuana for his medical condition and that he does not sell marijuana but provides it to people for medical experimentation. MCCORMICK also stated that there was one (1) male at the residence.

19. When the state search warrant was served by deputies from the LASO and DEA SAs on July 29, 1997, the deputies arrested a number of individuals including an individual who refused to give his name who is therefore referred to herein as JOHN DOE. I am informed by Detective Nordskog that he and Deputy Velazquez saw this same white male with red hair and a green-dyed goatee, identified herein as JOHN DOE and booked as JOHN DOE, on the patio carrying a tray of small plants. When I searched the Castle, I saw such trays and they contained numerous marijuana plants. There were no trays of any other kinds of plants present except marijuana plants.

20. I am informed by Detective Nordskog that when JOHN DOE

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was arrested, he gave his name as "Fuck you" and refused to provide any booking or identifying information about himself. I have listened to JOHN DOE speak, and he speaks with some sort of Germanic accent.

21. I am informed by Detective Nordskog that in the search of the Castle on July 29, 1997, deputies recovered approximately 4,044 marijuana plants growing indoors and on the grounds of the Castle. Also seized was cultivation equipment including halogen lights, hoods and ballast. Also seized was a cultivation lay out, diagrams and expenditures, log books, catalogs for cultivation supplies and equipment, and documents relating to the techniques for cultivating. Also seized were personal documents including address books, billing statements and phone records. I observed that one of the documents seized was a newspaper story received at MCCORMICK's fax machine in his office that stated substantially as follows: "In a telephone conversation with Todd McCormick from the Northern Ohio Correctional Institution, McCormick said 'when I get out of jail, I am going to go nuts and have plants growing in my front yard. If they want to come and get me, let them.'" Also seized was a computer and disks. I observed that the 4,044 marijuana plants were growing in locations throughout the Castle and grounds and were found in the living room, bathrooms, MCCORMICK's office, bedrooms, closets and the elevator.

22. Based on the foregoing, I believe there is probable cause to believe that TODD PATRICK MCCORMICK, DAVID WAYNE

RICHARDS, RENEE DANIELLE BOJE, ALEKSANDRA KRISTIN EVANGELIDI and JOHN DOE conspired and agreed together to knowingly manufacture more than 1,000 marijuana plants, a Schedule I controlled substance, and to knowingly possess with intent to distribute more than 1,000 marijuana plants, in violation of Title 21, United States Code, Section 846.

Anthony J. Zavacky
Special Agent
Drug Enforcement Administration

Sworn to and subscribed to before me this _____ day of July, 1997.

UNITED STATES MAGISTRATE JUDGE

Exhibit F

Hearings on H.R. 1782 (Medical Use of Marijuana Act) Before the Crime Subcomm. of the H.R. Judiciary Comm., 105th Cong., 1st Sess. (Oct. 1, 1997)(testimony of Dr. Lester Grinspoon, Associate Professor of Psychiatry, Harvard Medical School).

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before you this morning to share my views on the use of marihuana as a medicine.

In September 1928 Alexander Fleming returned from vacation to his laboratory and discovered that one of the petri dishes he had inadvertently left out over the summer was overgrown with staphylococci except for the area surrounding a mold colony. That mold contained a substance he later named penicillin. He published his finding in 1929, but the discovery was ignored by the medical establishment, and bacterial infections continued to be a leading cause of death. Had it aroused the interest of a pharmaceutical firm, its development might not have been delayed. More than 10 years later, under wartime pressure to develop antibiotic substances to supplement sulfonamide, Howard Florey and Ernst Chain initiated the first clinical trial of penicillin (with six patients) and began the systematic investigations that might have been conducted a decade earlier.

After its debut in 1941, penicillin rapidly earned a reputation as "the wonder drug of the '40s." There were three major reasons for that reputation: it was remarkably non-toxic, even at high doses; it was inexpensive to produce on a large scale; and it was extremely versatile, acting against the microorganisms that caused a great variety of diseases, from pneumonia to syphilis. In all three respects cannabis suggests parallels:

(1) Cannabis is remarkably safe. Although not harmless, it is surely less toxic than most of the conventional medicines it could replace if it were legally available. Despite its use by millions of people over thousands of years, cannabis has never caused an overdose death. The most serious concern is respiratory system damage from smoking, but that can easily be addressed by increasing the potency of cannabis and by developing the technology to separate the particulate matter in marihuana smoke from its active ingredients, the cannabinoids (prohibition, incidentally, has prevented this technology from flourishing). Once cannabis regains the place in the U.S. Pharmacopoeia that it lost in 1941 after the passage of the Marihuana Tax Act (1937), it will be among the least toxic substances in that compendium. Right now the greatest danger in using marihuana medically is the illegality that imposes a great deal of anxiety and expense on people who are already suffering.

(2) Medical cannabis would be extremely inexpensive. Street marihuana today

costs $200 to $400 an ounce, but the prohibition tariff accounts for most of that. A reasonable estimate of the cost of cannabis as a medicine is $20 to $30 an ounce, or about 30 to 40 cents per marihuana cigarette. As an example of what this means in practice, consider the following. Both the marihuana cigarette and an 8 mg ondansetron pill -- cost to the patient, $30 to $40 -- are effective in most cases for the nausea and vomiting of cancer chemotherapy (although many patients find less than one marihuana cigarette to be more useful, and they often require several ondansetron pills). Thus cannabis would be at least 100 times less expensive than the best present treatment for this symptom.

(3) Cannabis is remarkably versatile. Let me review briefly some of the symptoms and syndromes for which it is useful.

Cancer Treatment

Cannabis has several uses in the treatment of cancer. As an appetite stimulant, it can help to slow weight loss in cancer patients . It may also act as a mood elevator. But the most common use is the prevention of nausea and vomiting of cancer chemotherapy. About half of patients treated with anticancer drugs suffer from severe nausea and vomiting, which are not only unpleasant but a threat to the effectiveness of the therapy. Retching can cause tears of the esophagus and rib fractures, prevent adequate nutrition, and lead to fluid loss. Some patients find the nausea so intolerable they say they would rather die than go on. The antiemetics most commonly used in chemotherapy are metoclopramide (Reglan), the relatively new ondansetron (Zofran), and the newer granisetron (Kytril). Unfortunately, for many cancer patients these conventional antiemetics do not work at all or provide little relief.

The suggestion that cannabis might be useful arose in the early 1970s when some young patients receiving cancer chemotherapy found that marihuana smoking reduced their nausea and vomiting. In one study of 56 patients who got no relief from standard antiemetic agents, 78% became symptom-free when they smoked marihuana. Oral tetrahydrocannabinol (THC) has proved effective where the standard drugs were not. but smoking generates faster and more predictable results because it raises THC concentration in the blood more easily to the needed level. Also, it may be hard for a nauseated patient to take oral medicine. In fact, there is strong evidence that most patients suffering from nausea and vomiting prefer smoked marihuana to oral THC.

Oncologists may be ahead of other physicians in recognizing the therapeutic potential of cannabis. In the spring of 1990, two investigators randomly selected more than 2,000 members of the American Society of Clinical Oncology (one-third of the membership) and mailed them an anonymous questionnaire to learn their views on the use of cannabis in cancer chemotherapy. Almost half of the recipients responded. Although the investigators acknowledge that this group

was self-selected and that there might be a response bias, their results provide a rough estimate of the views of specialists on the use of Marinol (dronabinol, oral synthetic THC) and smoked marihuana.

Only 43 % said the available legal antiemetic drugs (including Marinol) provided adequate relief to all or most of their patients, and only 46% said the side effects of these drugs were rarely a serious problem. Forty-four percent had recommended the illegal use of marihuana to at least one patient, and half would prescribe it to some patients if it were legal. On average, they considered smoked marihuana more effective than Marinol and roughly as safe.

Glaucoma

Cannabis may also be useful in the treatment of glaucoma, the second leading cause of blindness in the United States - In this disease, fluid pressure within the eyeball increases until it damages the optic nerve. About a million Americans suffer from the form of glaucoma (open angle) treatable with cannabis Marihuana causes a dose-related, clinically significant drop in intraocular pressure that lasts several hours in both normal subjects and those with the abnormally high ocular tension produced by glaucoma. Oral or intravenous THC has the same effect, which seems to be specific to cannabis derivatives rather than simply a result of sedation . Cannabis does not cure the disease, but it can retard the progressive loss of sight when conventional medication fails and surgery is too dangerous.

Seizures

About 20% of epileptic patients do not get much relief from conventional anticonvulsant medications. Cannabis has been explored as an alternative at least since 1975 when a case was reported in which marihuana smoking, together with the standard anticonvulsants phenobarbital and diphenylhydantoin, was apparently necessary to control seizures in a young epileptic man. The cannabis derivative that is most promising as an anticonvulsant is cannabidiol. In one controlled study, cannabidiol in addition to prescribed anticonvulsants produced improvement in seven patients with grand mal convulsions; three showed great improvement. Of eight patients who received a placebo instead, only one improved. There are patients suffering from both grand mal and Partial seizure disorders who find that smoked marihuana allows them to lower the doses of conventional anticonvulsant medications or dispense with them altogether .

Pain

There are many case reports of marihuana smokers using the drug to reduce pain: post-surgery pain, headache, migraine, menstrual cramps, and so on. Ironically, the best alternative analgesics are the potentially addictive and

lethal opioids. In particular, marihuana is becoming increasingly recognized as a drug of choice for the pain that accompanies muscle spasm, which is often chronic and debilitating, especially in paraplegics, quadriplegics, other victims of traumatic nerve injury, and people suffering from multiple sclerosis or cerebral palsy. Many of them have discovered that cannabis not only allows them to avoid the risks of other drugs, but also reduces muscle spasms and tremors; sometimes they are even able to leave their wheelchairs.

One of the most common causes of chronic pain is osteoarthritis, which is usually treated with synthetic analgesics. The most widely used of these drugs -aspirin, acetaminophen (Tylenol), and nonsteroidal antiinflanunatory drugs (NSAIDs) like ibuprofen and naproxen -- are not addictive, but they are often insufficiently powerful. Furthermore, they have serious side effects. Stomach bleeding and ulcer induced by aspirin and NSAIDs are the most common serious adverse drug reactions reported in the United States, causing an estimated 7,000 deaths each year. Acetaminophen can cause liver damage or kidney failure when used regularly for long periods of time; a recent study suggests it may account for 10 % of all cases of end-stage renal disease, a condition that requires dialysis or a kidney transplant. Marihuana, as I pointed out earlier, has never been shown to cause death or serious illness.

AIDS

More than 300,000 Americans have died of AIDS. Nearly a million are infected with HIV, and at least a quarter of a million have AIDS. Although the spread of AIDS has slowed among homosexual men, the reservoir is so huge that the number of cases is sure to grow. Women and children as well as both heterosexual and homosexual men are now being affected; the disease is spreading most rapidly among intravenous drug abusers and their sexual partners. The disease can be attacked with anti-viral drugs, of which the best known are zidovudine (AZT) and protease inhibitors. Unfortunately, these drugs sometimes cause severe nausea that heightens the danger of semi-starvation for patients who are already suffering from nausea and losing weight because of the illness -- a condition sometimes called the AIDS wasting syndrome.

Marihuana is particularly useful for patients who suffer from AIDS because it not only relieves the nausea but retards weight loss by enhancing appetite. When it helps patients regain lost weight, it can prolong life. Marinol has been shown to relieve nausea and retard or reverse weight loss in patients with HIV infection, but most patients prefer smoked cannabis for the same reasons that cancer chemotherapy patients prefer it: it is more effective and has fewer unpleasant side effects, and the dosage is easier to adjust.

These are the symptoms and syndromes for which cannabis is most commonly used today, but there are others for which clinical experience provides

compelling evidence. It is distressing to consider how many lives might have been saved if penicillin had been developed as a medicine immediately after Fleming's discovery. It is equally frustrating to consider how much suffering might have been avoided if cannabis had been available as a medicine for the last 60 years. Initial enthusiasm for drugs is often disappointed after further investigation, but this is hardly likely in the case of cannabis, since it is not a new medicine at all. Its long medical history began 5,000 years ago in China and extended well into the twentieth century. Between 1840 and 1900, more than one hundred papers on its therapeutic uses were published in American and European medical journals. It was recommended as an appetite stimulant, muscle relaxant, analgesic, sedative, anticonvulsant, and treatment for opium addiction. As late as 1913, the great Sir William Osler cited it as the best remedy for migraine in a standard medical textbook.

In the United States, what remained of marihuana's medical use was effectively eliminated by the Marihuana Tax Act of 1937, which was ostensibly designed to prevent nonmedical use but made cannabis so difficult to obtain that it was removed from standard pharmaceutical references. When the present comprehensive federal drug law was passed in 1970, marihuana was officially classified as a Schedule I drug: a high potential for abuse, no accepted medical use, and lack of safety for use under medical supervision.

But in the 1970s the public began to rediscover its medical value, as letters appeared in lay publications from people who had learned that it could relieve their asthma, nausea, muscle spasms, or pain and wanted to shared that knowledge with readers who were familiar with the drug. The most effective spur to the movement for medical marihuana came from the discovery that it could prevent the AIDS wasting syndrome. It is not surprising that the Physicians Association for AIDS Care was one of the medical organizations that endorsed the California initiative prohibiting criminal prosecution of medical marihuana users. The mid-1980s had already seen the establishment, often by people with AIDS, of cannabis buyers' clubs, organizations that distribute medical marihuana in open defiance of the law. These clubs buy marihuana wholesale and provide it to patients at or near cost, usually on the written recommendation of a physician. Although a few of the clubs have been raided and closed, most are still flourishing, and new ones are being organized. Some of them may gain legal status as a result of the initiative.

Until the recent vote in California, efforts to change the laws had been futile. In 1972 the National Organization for the Reform of Marijuana Laws (NORML) entered a petition to move marihuana out of Schedule I under federal law so that it could become a prescription drug. It was not until 1986 that the Drug Enforcement Administration (DEA) finally agreed to the public hearings required by law. During two years of hearings, many patients and physicians testified and thousands of pages of documentation were introduced. In 1988 the DEA's

Administrative Law Judge, Francis L. Young, declared that marihuana fulfilled the requirement for transfer to Schedule II. In his opinion he described it as "one of the safest therapeutically active substances known to man." His order was overruled by the DEA.

Nevertheless, a few patients have been able to obtain medical marihuana legally in the last twenty years. Beginning in the 1970s, thirty-five states passed legislation that would have permitted medical use of cannabis but for the federal law. Several of those states actually established special research programs, with the permission of the federal government, under which patients who were receiving cancer chemotherapy would be allowed to use cannabis. These projects demonstrated the value of both smoked marihuana and oral THC. The FDA then approved oral THC as a prescription medicine, but ignored the data that suggested that smoked marihuana was more useful than oral THC for some patients. With the approval of Marinol, this research came to an end. In 1976, the federal government introduced the Individual Treatment Investigational New Drug program (commonly referred to as the Compassionate IND), which provided marihuana to a few patients whose doctors were willing to undergo the paperwork-burdened and time-consuming application process. About three dozen patients eventually received marihuana before the program was discontinued in 1992, and eight survivors are still receiving it -- the only persons in the country for whom it is not a forbidden medicine. It is safe to say that a significant number of the more than ten million American citizens arrested on marihuana charges in the last thirty years were using the drug therapeutically. The Schedule I classification persists, although in my view and the view of millions of other Americans, it is medically absurd, legally questionable, and morally wrong.

Opponents of medical marihuana often object that the evidence of its usefulness, although strong, comes only from case reports and clinical experience. It is true that there are no double-blind controlled studies meeting the standards of the Food and Drug Administration, chiefly because legal, bureaucratic, and financial obstacles have been constantly put in the way. The situation is ironical, since so much research has been done on marihuana, often in unsuccessful efforts to show health hazards and addictive potential, that we know more about it than about most prescription drugs. In any case, individual therapeutic responses are often obscured in group experiments, and case reports and clinical experience are the source of much of our knowledge of drugs. As Dr. Louis Lasagna has pointed out, controlled experiments were not needed to recognize the therapeutic potential of chloral hydrate, barbiturates, aspirin, insulin, or penicillin. Nor was that the way we learned about the use of propranolol for hypertension, diazepam for status epilepticus, and imipramine for enuresis. All these drugs had originally been approved for other purposes.

In the experimental method known as the single patient randomized trial, active and placebo treatments are administered randomly in alternation or

succession. The method is often used when large-scale controlled studies are inappropriate because the disorder is rare, the patient is atypical, or the response to treatment is idiosyncratic. Several patients have told me that they assured themselves of marihuana's effectiveness by carrying out such experiments on themselves, alternating periods of cannabis use with periods of abstention. I am convinced that the medical reputation of cannabis is derived partly from similar experiments conducted by many other patients.

Some physicians may regard it as irresponsible to advocate use of a medicine on the basis of case reports, which are sometimes disparaged as merely "anecdotal" evidence which counts apparent successes and ignore apparent failures. That would be a serious problem only if cannabis were a dangerous drug. The years of effort devoted to showing that marihuana is exceedingly dangerous have proved the opposite. It is safer, with fewer serious side effects, than most prescription medicines, and far less addictive or subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics.

Thus cannabis should be made available even if only a few patients could get relief from it, because the risks would be so small. For example, as I mentioned, many patients with multiple sclerosis find that cannabis reduces their muscle spasms and pain. A physician may not be sure that such a patient will get more relief from marihuana than from the standard drugs baclofen, dantrolene, and diazepam -- all of which are potentially dangerous or addictive -- but it is almost certain that a serious toxic reaction to marihuana will not occur. Therefore the potential benefit is much greater than any potential risk.

During the past few years, the medical uses of marihuana have become increasingly clear to many physicians and patients, and the number of people with direct experience of these uses has been growing. Therefore the discussion is now turning from whether cannabis is an effective medicine to how it should be made available. It is essential to relax legal restrictions that prevent physicians arid patients from achieving a workable accommodation that takes into account the needs of suffering people. H.R. 1782 (the Medical Use of Marihuana Act) is a worthwhile move in that direction because it gets the federal government out of the way and allows the states to experiment with their own solutions to the problem. I strongly urge that you pass this law.

gislative Bulletin

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e to current and pending marijuana legislation from the ional Organization for the Reform of Marijuana Laws

Dr. Lester Grinspoon, others testify before Congress in favor of medical marijuana

NORML board member Dr. Lester Grinspoon of Harvard Medical School testified in favor of legalizing marijuana for medical use at a special Congressional hearing before the House Judiciary Committee, Subcommittee on Crime. He was joined by proponents Dennis Peron, Director of the San Francisco Cultivator's Club, and Roger Pilon, Director for Constitutional Studies at the Cato Institute in Washington, D.C.

Lester Grinspoon, M.D. testifies before the Subcommittee on Crime

Appearing on the other side of the issue were witnesses Barry McCaffrey of the Office of National Drug Control Policy (ONDCP), National Institute on Drug Abuse (NIDA) Director Alan Leshner, Ronald Brooks of the California Narcotics Officer's Association, Community Anti-Drug Coalitions of America (CADCA) President James Copple, Maricopa County Arizona Attorney Richard Romley, and Dr. Janet Lapey of Concerned Citizens for Drug Prevention. The October 1 hearing marked the first time since voters in California and Arizona approved initiatives allowing the use of medical marijuana under a doctor's supervision.

see **Republicans,** *page 4*

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NORML Testifies

Continued from page 1

that Congress has allowed testimony from medical marijuana proponents.

"During the past few years, the medical uses of marijuana have become increasingly clear to many physicians and patients, and the number of people with direct experience of these uses has been growing," testified Grinspoon before members of the Subcommittee and approximately 150 spectators. "Therefore the discussion is now turning from whether cannabis is an effective medicine to how it should be made available. It is essential to relax legal restrictions that prevent physicians and patients from achieving a workable accommodation that takes into account the needs of suffering people." Grinspoon also voiced his support for H.R. 1782, legislation introduced by Rep. Barney Frank (D-Mass.) in June which would remove federal restrictions that currently prevent physicians from legally prescribing marijuana.

Proposition 215 co-author Dennis Peron (middle) speaks his mind

Frank -- who attended the hearing, but does not sit on the Subcommittee -- used the opportunity to ask for Congressional support for his measure. Presently, six members of Congress -- Reps. Brian Bilbray (R-Calif.), Zoe Lofgren (D-Calif.), John Olver (D-Mass.), Nancy Pelosi (D-Calif.), Peter Stark (D-Calif.), and Lynn Woolsey (D-Calif.) -- are co-sponsors of the legislation. Frank also chided House Republicans for objecting to federal efforts to study marijuana's medical potential. H.R. 1782 mandates the federal government to provide marijuana for all research projects that are FDA approved.

"People must feel that by studying marijuana, it will undermine their position [against the drug.]" he said.

Subcommittee members Bob Barr (R-Ga.) and Asa Hutchinson (R-Ark.) repeatedly told witnesses, including NIDA's Dr. Alan Leshner, that they opposed any efforts by the National Institutes of Health (NIH) to conduct scientific trials on marijuana's medical potential. Their charges came in response to a recent NIH report urging the federal government to play an active role in facilitating clinical evaluations of medical marijuana as well as testimony from Drug Czar Barry McCaffrey endorsing additional research.

Barr and Hutchinson called such proposals "inconsistent" with the administration's position that marijuana lacks medical value. The representatives further warned that federal efforts to study marijuana's medical value would send a harmful message to children.

"That certain Republicans are vocally opposed not only to medical marijuana, but also to medical marijuana research demonstrates a surprising and unfortunate willingness to play politics at the expense of legitimate science and the health of seriously ill Americans," said **NORML** Executive Director R. Keith Stroup, Esq.

Subcommittee chair Rep. Bill McCollum (R-Fla.), a former two-time co-sponsor of medical marijuana legislation in 1981 and 1983, voiced little support for the use of marijuana as a medicine and urged federal officials to campaign against a potential 1998 initiative in Florida. Witness Roger Pilon attacked such federal efforts to persuade voters as well as override existing state medical marijuana laws. "Clearly, this is a blatant effort by the federal government to impose a national policy on the people in the states in question, people who have already elected a contrary policy," he said. "[This] effort cannot be justified under the 14th Amendment, for the states have not enacted a policy that runs rough-shod over the privileges or immunities of their citizens or denies them due process or equal protection under the laws."

see **NORML Testifies**, *page 8*

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(Minority members are listed on page eight.)

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they're not always harmless. Their warning labels are littered with phrases like "hives," "impotence," "difficulty breathing," "tremors and rigidity" and "leukopenia" (a drop in white blood cells). Marijuana isn't risk-free—its smoke contains a number of carcinogens—but it's less toxic than many prescription drugs. There is no recorded instance of a death from overdose. And because people consume it one puff at a time, feeling the effects as they go, they can easily tailor their intake to their needs.

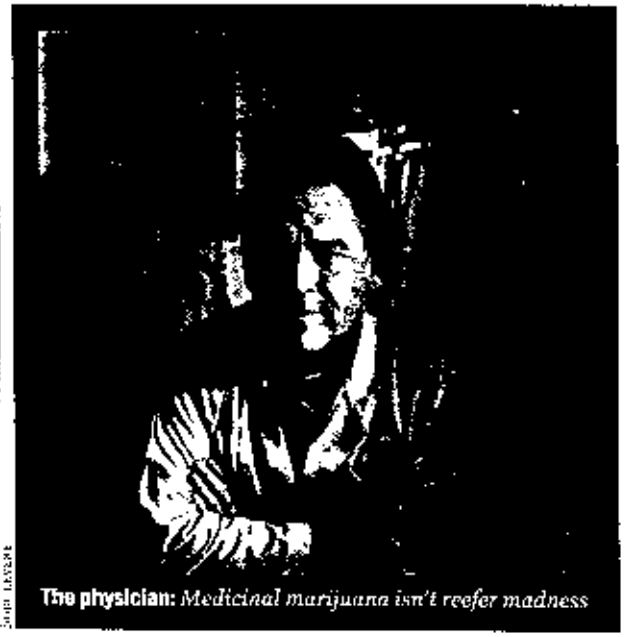
That's a big advantage for people with chronic pain or with spastic disorders such as multiple sclerosis. Whereas prescription drugs may zonk them out for the whole day, marijuana lets them respond directly to their symptoms. No one has conducted trials to gauge marijuana's genuine therapeutic effect on pain and spasms. But that doesn't much concern 39-year-old Andrew Hasenfeld, who was diagnosed with multiple sclerosis in 1980. He tried the prescription drug baclofen, but it never relieved the spasms, the stiffness, the sensation of "being all locked up." He resorted to marijuana six months ago, at the urging of fellow sufferers in Amherst, Mass., and the result was dramatic. "There's no comparison with any

This Is Smart Medicine

A doctor argues that marijuana can ease patients' suffering in ways nothing else can. BY MARCUS CONANT

ANYONE WHO HAS EVER smoked marijuana will tell you he gets hungry afterward. That kind of anecdotal evidence led doctors and patients to experiment with marijuana as a treatment for extreme nausea, or wasting syndrome. I have seen hundreds of AIDS and cancer patients who are losing weight derive almost immediate relief from smoking marijuana, even after other weight-gain treatments—such as hormone treatments or feeding tubes—have failed. But it's not just individuals who have recognized the medicinal benefits of marijuana. No less an authority than the FDA has approved the use of Marinol, a drug that contains the active ingredient in marijuana.

The problem with Marinol is that it doesn't always work as well as smoking marijuana. Either you take too little, or 45 minutes later you fall asleep. Even though insurance will pay for Marinol—which costs about $200 a month—some patients spend their own money, and risk breaking the law, for the more effective marijuana. That's fairly good evidence that smoking the drug is superior to taking it orally. How would we keep patients from giving their prescribed marijuana to friends? The same way we keep people from abusing other prescription drugs: by making patients understand the dangers of giving medication to other people. A physician who prescribes marijuana without the proper diagnoses should be held up to peer review and punished. There are drugs available at the local pharmacy—Valium, Xanax, Percodan—that are far more mood-altering than marijuana. They aren't widely abused. It's not important that a few zealots advocate the wholesale legalization of marijuana. The federal government can't craft policy based on what a few irrational people say. This is a democracy, and what the people of California voted for was to make marijuana available for medical use for seriously ill people.



JOHN LEYBA

The physician: *Medicinal marijuana isn't reefer madness*

For skeptics, a study devised at San Francisco General Hospital would test the benefits of smoking marijuana once and for all. It, too, was endorsed by the FDA - but the federal government won't provide the marijuana for the study. Washington recently offered to fund a $1 million review of literature on medical marijuana, but it refuses to allow a clinical trial, which is what's really needed.

When citizens even speak up in favor of legalizing marijuana for medicinal use, as happened this fall in California and Arizona, the government tries to stop them. Gen. Barry McCaffrey and the Justice Department have threatened to revoke the prescription-drug licenses of doctors who prescribe marijuana. This is a truly dangerous step. The government has no place in the examination room. Our society has long felt that certain relationships require privileged communication, such as those between a priest and a parishioner or a lawyer and a client. If a patient wants to discuss marijuana, I don't want to have the responsibility of reporting him, and I have to feel comfortable that the patient will not report me. This is a First Amendment issue of freedom of speech between doctor and patient.

Perhaps the most persuasive argument for medicinal marijuana I've encountered came two years ago, when the California Assembly was debating a medical-marijuana bill. One GOP assemblyman said he had had a great deal of trouble with the issue. But when a relative was dying a few years before, the family had used marijuana to help her nausea. That story helped the bill pass. Wouldn't it be awful if people changed their minds only after someone close to them had died?

CONANT, a doctor at the University of California, San Francisco, has treated more than 5,000 HIV-positive patients in his private practice.

F-94

Exhibit G

Lungren Backs Medical Pot Study

Attorney general does about-face on marijuana research

By Robert B. Gunnison
Chronicle Sacramento Bureau

Sacramento

After leading the charge against use of marijuana as a medicine and ordering the arrest of the state's most outspoken pot pharmacist, Attorney General Dan Lungren announced yesterday that it is time to study whether marijuana has healing properties.

Republican Lungren, a candidate for governor next year, said at a Capitol press conference he will support a bill by Senator John Vasconcellos, D-San Jose, that would order a three-year study of the efficacy and safety of marijuana as a treatment.

While declaring that Proposition 215, which legalized use of pot for patients, is a "dumb idea," Lungren said, "California needs a definitive study. This bill will fill the many information gaps that have made it difficult for ordinary Californians to know whether marijuana has a medicinal value."

The attorney general's announcement marks a truce of sorts with Vasconcellos, who long has supported use of marijuana for people suffering from AIDS, cancer and glaucoma.

Lungren had opposed Vasconcellos' bill to order a study by the University of California. But with the Senate-passed measure pending in the Assembly Appropriations Committee, the attorney general and the lawmaker made a deal on how the study would be conducted.

By doing so, Lungren took a step toward blurring his differences with supporters of Proposition 215, who won 56 percent support for their measure in November.

Lungren has been the state's most vocal and visible opponent of medical marijuana, filing both civil and criminal cases against Dennis Peron, co-author of Proposition 215, who has announced he will run against Lungren for the GOP gubernatorial nomination.

Peron's Cannabis Cultivators Club in San Francisco was raided a year ago by state narcotics agents, and he was charged with possessing and cultivating marijuana. Those raids earned Lungren mention in a series of Doonesbury cartoons as an overzealous crusader.

A spokesman for Governor Pete Wilson, however, sounded less than enthusiastic about the agreement.

"We are a little skeptical at this point," said Ron Low, a Wilson spokesman. "There have already been a number of studies that show marijuana has no medical value, but the governor respects the opinion of the attorney general and will be taking a long, hard look at the bill."

Attorney General Dan Lungren opposed the pot initiative

Lungren and Vasconcellos agreed the bill will set standards to guarantee that researchers will be objective, and require them to comply with rules to be developed by the National Institutes of Health.

The attorney general agreed to supply the marijuana for the study if the federal government fails to do so.

The measure will also state that the research is not intended to condone nonmedical uses of pot.

G-95

Exhibit H

Uncle Sam Is the Pot Supplier

BY ASSOCIATED PRESS

Irvin Rosenfeld and seven other U.S. patients receive their pot from the government

Associated Press

Miami

The small silver canister that looks like a cookie tin arrives promptly once a month for Florida stockbroker Irvin Rosenfeld.

Its contents: 300 tightly rolled marijuana joints.

His supplier: the U.S. government.

"The quality is satisfactory," Rosenfeld says appreciatively. "And I don't have to buy it on the street."

The 44-year-old suffers from a rare bone disease and is one of eight people legally supplied with marijuana under the federal government's long-standing "compassionate use" program.

It's run by the same health and drug agencies that condemn marijuana as part of the national war on drugs. And this fall, top government officials from those agencies campaigned against ballot measures in California and Arizona to legalize marijuana for medical purposes. The issues passed in both states, although the courts likely will determine their fate.

"Research shows that marijuana is harmful to one's brain, heart, lungs and immune system," wrote Health and Human Services Secretary Donna Shalala in a recent statement. "Any law premised on the notion that marijuana or these other illicit drugs are medically useful is suspect."

So why does the government continue supplying it?

"When we have a compassionate-use situation, out of feeling for the patient, we don't take that away," says Don McLearn, a spokesman for the Food and Drug Administration. "We just don't add to it."

The federal marijuana program started in the 1970s and was discontinued in 1992 — partly because of a huge increase in applications from AIDS patients. The 13 people already receiving monthly pot shipments were allowed to continue. Five have since died.

for Sick Florida Stockbroker

The others will be supplied — at taxpayer expense — for as long as they want.

They suffer from cancer, glaucoma, multiple sclerosis and rare genetic diseases.

Marijuana, they say, helps control nausea and muscle spasms, ease eye pressure and pain and stimulate appetites. Pot patients insist it works better than other drugs, including the highly expensive Marinol, a pill form of marijuana that has the same active ingredient, THC.

The government crop is harvested on a 7.5-acre pot farm at the Research Institute of Pharmaceutical Sciences at the University of Mississippi. From there, the marijuana is shipped to Raleigh, N.C., where the cigarettes are rolled by machine, packed in canisters and delivered to medical centers for the eight patients to pick up.

The entire operation costs about $200,000 a year.

It's a tiny — but thorny — sum for the agencies involved: the FDA, which administers the program, and its parent, the Department of Health and Human Services; the National Institute on Drug Abuse, which acts as supplier; and the Drug Enforcement Administration, which must approve the use of any controlled substance.

The official position of these agencies today is that marijuana is more likely to cause health problems than ease them.

"We still have a federal law that says marijuana has no medical value, and that it is against the law to grow it, distribute it and prescribe it as medicine," says President Clinton's drug czar Barry McCaffrey.

H-96

Exhibit I

San Francisco Chronicle

BAY AREA AND CALIFORNIA

U.S. Drug Czar Eases Stand on Medical Marijuana

Says rigorous tests needed on pot's value

By Edward W. Lempinen
Chronicle Staff Writer

President Clinton's drug czar yesterday softened the administration's hard-line opposition to California's new medical marijuana law, saying there's "an open door" to approval for any substance that provides proven therapeutic benefits.

Just two weeks ago, top Clinton officials pledged to prosecute doctors who prescribed or recommended marijuana. But in San Francisco yesterday, federal drug policy director Barry McCaffrey deflected questions about the get-tough policy and abandoned the administration's confrontational rhetoric.

Instead, he stressed the need to put pot through rigorous health studies before permitting its use as a legal drug.

"What American doctors want is effective medicine," McCaffrey told reporters. "They want something to manage pain that handles the nausea of chemotherapy. ... There is an open door to any substance that claims it's a medicine. But it has to pass medical-scientific evaluation.

"This is a medical-scientific issue, not an ideological issue."

After voters in Arizona and California approved "compassionate care" measures in November to permit the medical use of marijuana, the Clinton administration rallied against the votes. After intensive discussion at the White House, officials announced that doctors who recommend marijuana would be barred from Medicare and Medicaid programs and, in some cases, be subject to criminal prosecution.

A number of establishment medical organizations have backed the White House, including the American Medical Association and the American Cancer Society.

But in California, a host of prominent doctors, researchers and medical groups have insisted that marijuana is effective pain re-

DRUG CZAR: Page A20 Col. 1

S.F. looks at restricting sales of cleaners

By Henry K. Lee
Chronicle Staff Writer

A San Francisco supervisor yesterday called for a city ordinance that would bar the sale of certain engine cleaning products to minors, saying many teenagers have been inhaling what they call "chemo" to get a very dangerous high.

Supervisor Susan Leal asked the city attorney's office to draft legislation that would prevent the sale of octane boosters and carburetor cleaners to anyone under 18. The ordinance would also require merchants to store such products behind counters.

Authorities said the abuse of "chemo" (pronounced CHAY-mo), the street term for the euphoria-producing compounds, is especially of concern in the Mission District, where teenagers purchase the cheap chemicals from auto part shops and gas stations.

"What kids will do is buy the stuff for three bucks a bottle, put it on a rag and then a paper bag and inhale it that way," said Bill Ambrunn, Leal's legislative assistant. "It's really become a problem in the Mission."

The use of petroleum-based products to get high has been a problem for decades, but the use of chemo is a new twist.

The practice of "huffing" with chemo appears to be in the experimental phase, said Phil Ramarez, a health educator with Horizons Unlimited, a youth substance abuse center in the Mission District.

Although dabbling with the substance has been "cross-cultural and cross-gender," Ramirez said, "chemo abusers tend to be Latino and Native

CLEANERS: Page A20 Col. 1

DRUG CZAR: Medicinal Pot

From Page A13

lief and boosts the appetite of patients who are wasting away from AIDS or cancer. That, they say, prolongs lives.

One group that backed California's Proposition 215, Americans for Medical Rights, is expected to file suit in federal court today against McCaffrey, Attorney General Janet Reno and other top Clinton officials, charging that their threats to punish doctors violate the doctors' First Amendment right to free speech.

McCaffrey's comments came at a symposium in San Francisco about increasing medical casualties and violence associated with the use of methamphetamine. But outside the Presidio conference, protesters denounced the Clinton administration's stand against medical marijuana. Inside, it was clear that McCaffrey, California Attorney General Dan Lungren and others are preoccupied with the dilemma presented by Prop. 215.

When asked about the federal threat to prosecute doctors, McCaffrey dodged the question and stressed a new administration plan to spend up to $1 million on studies of pot's possible medical value.

"We don't expect there to be anything out of the federal government but an attitude of support for the American medical community," the retired general said. "I do not expect there to be a problem with U.S. doctors violating the law."

Lungren, too, seemed caught in an uneasy situation. While Prop. 215 will send a dangerous signal to children, he told reporters, "we will enforce the law under 215 as it is required to be enforced."

But, he added: "We will still make sure that we do everything we can to not allow 215 to be an excuse for the commercialization of marijuana in California, nor that it is legalized for juveniles."

A minor milestone in the medical marijuana movement is expected tomorrow, when the Cannabis Buyers' Club reopens in San Francisco. The club was shut down by state narcotics agents last summer, but a San Francisco Superior Court judge last week cleared the way for its reopening.

Lungren said yesterday that he may appeal the judge's ruling to clarify what is permitted by Prop. 215.

I-97

S.F. Study of Marijuana, AIDS Patients Is Approved

Key to debate over medicinal use

By Sabin Russell
Chronicle Staff Writer

San Francisco researchers have won approval for the first federally sponsored study of the medical effects of marijuana on AIDS patients.

With $1 million from the National Institutes of Health, doctors at San Francisco General Hospital will spend two years studying how the drug interacts with the latest AIDS medicines.

The results of the study are certain to play a central role in the debate over medical use of marijuana, not only for AIDS patients, but for sufferers of numerous other diseases. It is a debate that led California voters last year to legalize the medical use of pot, and has since become a major issue in the wrangling over national drug policy.

In the San Francisco study, each of 63 volunteers will be confined to the hospital for 25 days during the experiment. Because of limited space at the hospital, only three or four patients will be stud-

MARIJUANA: *Page A16 Col. 1*

MARIJUANA: AIDS Study

From Page 1

ied each month.

The grant was a significant victory for Dr. Donald Abrams, the San Francisco AIDS doctor who has fought an uphill battle for federal approval of a serious scientific examination of marijuana's effects on patients.

"I'm happy we've evolved to the point where we can ask some very important scientific questions," said Abrams. "In all honesty, I think we've learned a lot during this process. The study we've proposed this time is really the best."

Advocates of medical use of marijuana contend that it promotes appetite and suppresses nausea — making it a potential lifesaver for patients undergoing chemotherapy for cancer or battling the wasting syndrome caused by the human immunodeficiency virus.

"I know this experiment will work, because I know marijuana gives you the munchies. Now, let's prove our point," said Dennis Peron, director of Californians for Compassionate Use, a group that helped win passage of Proposition 215, which legalized the use of marijuana in California for medical purposes.

The stated purpose of the San Francisco General Hospital study will be to determine whether or not marijuana therapy is safe for patients taking the new protease inhibitor drugs, which in combination with older AIDS drugs such as AZT and 3TC have caused dramatic improvements in many patients.

Abrams said that because marijuana is metabolized by the same liver enzymes that process protease drugs, there is a chance that pot consumption could render the new drugs either dangerous or ineffective.

Accordingly, all the patient volunteers must be HIV-positive and be taking a protease inhibitor drug.

Test subjects will have to live in special, ventilated rooms at San Francisco General Hospital currently used for study of tobacco smoking. One-third of the subjects will be asked to smoke three rolled marijuana cigarettes each day. Researchers will weigh the unsmoked portions each day to measure consumption.

A second group of patients will take instead the approved prescription drug Marinol, which contains the active ingredient of marijuana, THC. A third group will be given a dummy pill that resembles Marinol, but contains no medication.

Patients in all three groups will each be paid $1,000 for their time. But they will have to endure frequent blood tests that researchers will use to determine the effects of the experiment on their blood chemistry.

Abrams said that, although the study will measure factors like increase in appetite and weight gain, it will take a larger study than this to prove or disprove such effects. The proposed research will determine, however, whether it is safe to conduct such a large-scale trial.

Peron said that he is convinced that even the small-scale trial will quickly show the beneficial effects of pot on HIV-positive people. "They will have to shorten the study as soon as it starts looking good," said Peron. "They will watch the placebo person die, and as moral people, they will say this isn't right."

The issue of medical testing of marijuana's effectiveness has created some strange political bedfellows. Attorney General Dan Lungren, a staunch opponent of Proposition 215, threw his support behind a bill by Senator John Vasconcellos, D-San Jose, last month that would have provided state money to study the effects of marijuana. "Past studies of marijuana notwithstanding, California needs a definitive study," he argued.

Lungren spokesman Matt Ross said yesterday that the attorney general had not yet heard about the National Institutes of Health approval of Abrams' study. "His point all along is he wants to see a study to see the true effects of marijuana. He said that before 215, and he called for it after 215," said Ross.

T-9R

Exhibit J

U. S. Department of Justice

Drug Enforcement Administration
Office of Chief Counsel
Diversion/Regulatory Section

December 19, 1997

Simone Monasebian, Esq.
Law Offices of Michael Kennedy
425 Park Avenue, 26th Floor
New York, New York 10032

Re: Petition of Jon Gettman and Trans-High Corporation

Dear Ms. Monasebian:

Please be advised that the above-referenced petition, which requests initiation of proceedings for a repeal of the rules or regulations that place marijuana and THC in Schedule I and dronabinol product and nabilone in Schedule II of the Controlled Substances Act, has been forwarded to the Acting Assistant Secretary for Health of the Department of Health and Human Services (DHHS) for review pursuant to 21 U.S.C. § 811(b) and 21 C.F.R. § 1308.43(d). In accordance with these provisions, the Acting Assistant Secretary has been requested to provide a scientific and medical evaluation of the available data and to provide a scheduling recommendation for the substances at issue in the petition. Once the DEA receives the requested evaluation and recommendation from DHHS, and after consideration of that and all other relevant information, a decision will be made whether to initiate proceedings as requested by the petitioners. You will then be notified of such decision.

If you have any questions or comments, please do not hesitate to contact me at (202) 307-8010.

Very truly yours,

Mary Kate Whalen

Mary Kate Whalen, Esq.

CC: Frank Sapienza, Chief
Office of Drug Evaluation

J-99

Exhibit K

U.S. Department of Justice

Drug Enforcement Administration

Washington, D.C. 20537

JUL 27 1995

Mr. Jon Gettman
Rt. 1 Box 25
Lovettsville, Virginia 22080

Dear Mr. Gettman:

Reference is made to your petition dated July 10, 1995, requesting the Drug Enforcement Administration (DEA) to initiate proceedings to issue a rule or regulation pursuant to § 201 of the Controlled Substances Act (CSA) to repeal the rules placing marihuana in Schedule I (21 C.F.R. § 1308.11(d)(18)), tetrahydrocannabinols in Schedule I (21 C.F.R. § 1308.11(d)(26)), dronabinol in Schedule II (21 C.F.R. § 1308.12(f)(1)) and nabilone in Schedule II (21 C.F.R. § 1308.12(f)(7)), remove these drugs from their respective schedules, and reschedule these drugs on the basis of evaluation by the Department of Health and Human Service and in accordance with existing law. The Attorney General has delegated authority under the CSA to the Administrator of DEA. 28 C.F.R. § 0.100. Pursuant to 28 C.F.R. § 0.104, the Administrator, in turn, has redelegated his authority under this section to the Deputy Administrator. Because your petition complies with the requirements of 21 C.F.R. § 1308.44(b), DEA hereby accepts this petition for filing.

The DEA shall determine within a reasonable period of time whether there are sufficient grounds to justify removing marihuana and tetrahydrocannabinols from Schedule I and removing dronabinol and nabilone from Schedule II. 21 C.F.R. § 1308.44(c). If DEA finds that sufficient grounds do not exist to initiate proceedings, it shall deny the petition. Otherwise, should DEA determine that there are sufficient grounds, then it must request a medical and scientific recommendation from the Secretary of the Department of Health and Human Services. The Secretary's recommendation shall be binding on DEA as to medical and scientific findings and to the extent that the Secretary recommends that a substance not be scheduled or controlled. 21 C.F.R. § 1308.44(d). Only after this process is completed may DEA initiate proceedings for rulemaking.

Should you have any questions, please contact the Office of Chief Counsel at (202) 387-5010.

Sincerely,

Stephen H. Groome
Deputy Administrator

cc: Elizabeth Murphy
Office of Chief Counsel

Exhibit L

F.A.S.

FEDERATION OF AMERICAN SCIENTISTS
307 Massachusetts Avenue, N.E.
Washington, D.C. 20002 (202) 546-3300

MEDICAL USE OF WHOLE CANNABIS:

Statement of the Federation of American Scientists

SUMMARY

The federal government, particularly through the Drug Enforcement Administration, has strongly resisted research on therapeutic uses of whole cannabis, though there is good prima facie evidence that it might make valuable contributions to the treatment of a variety of significant problems. Moreover, despite its illegality, whole cannabis is in clinical use; thus even negative results would have practical use. The federal government should remove legal barriers to research, provide direct or indirect financial support for such research and, in the meantime, allow continued and expanded use of the drug under a compassionate research program for patients who doctors prescribe whole marijuana.

BACKGROUND

While a synthetic version of delta-9 tetrahyrocannabinol (THC), the main psychoactive agent in Cannabis (marijuana), is legally available in he United States for medical use, the plant material itself, and all of its other active agents, remain forbidden[1]. Even the Compassionate Investigational New Drug program, under which a handful of patients receive government-produced whole cannabis for the treatment of various conditions, has been closed to new applicants[2].

Anecdotal accounts testify to the potential value of whole cannabis in a wide range of conditions, including appetite enhancement for the wasting syndrome of AIDS, control of nausea and vomiting associated with cancer chemotherapy, relief of spasticity and pain associated with multiple sclerosis, and control of migraine headaches and epileptic seizures[3]. A substantial proportion of practicing oncologists regard cannabis as a safe and effective anti-nausea agent[4].

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[1] In June 1985, FDA approved the synthetic drug for marketing under the chemical name dronabinol, and the trade name Marinol. In April 1986, DEA rescheduled synthetic THC to Schedule 2.

[2] The program was closed to new applicants during the Bush Administration by Assistant Secretary of Health James Madison. Dr. Philip Lee, the current Assistant of Health, reviewed the decision by his predecessor and in July, 1994 decided to keep the Compassionate program closed on that grounds that the program "is not the type of clinical trial that would produce useful scientific information." Letter from Dr. Lee to Rep. Barney Frank.

[3] Grinspoon, D L and Bakalar, J. *Marijuana, The Forbidden Medicine*, *Yale University Press. New Haven, CT. 1993*

[4] Doblin R, Kleiman MAR. Marijuana as antiemetic medicine: A survey of oncologists' experiences and attitudes. *J Clin Oncol. 1991;9:1314-1319.*

Facsimile (202) 675-1010 Email: fas@igc.apc.org

If indeed whole smoked cannabis has greater efficacy or lesser side effects than oral delta-9 THC for some patients or conditions – one careful, though non-randomized, clinical study with chemotherapy patients has shown greater efficacy[5] – that might be due either to the advantages of inhaled over oral administration (speed of action plus more reliable bioavailability[6]) and the consequent ability of patients to self-titrate dosage) or to the action of one or more of the dozens of active agents in whole cannabis, or their interactions with each other and with delta-9 THC. One study with healthy volunteers showed that a combination of THC with cannabidiol, another chemical in whole cannabis, tends to be less anxiety-provoking than THC alone[7].

Despite its illegality, whole cannabis is in clinical use. In a survey of practicing oncologists, more than four in ten reported having recommended the material for use by one or more patients[8]. A substantial number of AIDS patients reportedly use whole cannabis, either smoked or orally, as an appetite enhancer, and some of the "buyers' clubs" which legally acquire non-FDA-approved medicines for such patients apparently are now handling illegal cannabis as well[9]. Even at black-market prices, whole cannabis is substantially less expensive per bioavailable milligram of THC than is the legal synthetic, sold under the trade-name Marinol.

An unknown number of persons growing cannabis for their own medical use or distributing it for medical use by others have been arrested, prosecuted, and had homes and other assets seized and forfeited to the government. In a few well-publicized cases, charges of marijuana production or distribution have been dropped or convictions overturned based on the defense of "medical necessity;" at least one such defendant has subsequently been re-arrested[10].

The absurd and obscene spectacle of physicians sending patients to black-market drug dealers for medicine, and other producers and consumers of a therapeutic agent risking arrest, must end.

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[5] Vinciguerra V, Moore T, Brennen E. Inhalation marijuana as an antiemetic for chemotherapy. *NY State J Med*, 1988; 88:525-527.

[6] Ohlsson A, Lindgren JE, Wahlen A, et al. Plasma d-9-THC concentrations and clinical effects after oral and intravenous administration and smoking. *Clin Pharmacol Ther. 1980;28:409-416.*

[7] Zuardi AW, Shirakawa E, Finkelfarb E, Karniol IG. Action of cannabidiol on the anxiety and other effects produced by Δ9-THC in normal subjects. *Psychopharm* 1982;76:245-250.

[8] Doblin R, Kleiman MAR. Medical Use of Marijuana *Annals Int Med.* 1991;114:809-810.

[9] Simmers, Tim. Many Chronically Ill Find Relief in Marijuana Shop, *Oakland Tribune*, September 18, 1994. p.D1.

[10] Vallarie Corral is the person arrested twice. She is both a marijuana patient and a grower/distributor to other patients.

End ban on pot, doctors demand

S.F. Medical Society president leads protest for controlled use

By Lisa M. Krieger
EXAMINER MEDICAL WRITER

San Francisco doctors gathered Wednesday to urge the federal government to rescind its ban on the medical use of marijuana, asking that it be treated the same as morphine, Demerol and other carefully controlled drugs.

"Fear of prosecution is something we cannot tolerate," said Dr. Dexter Louie, president of the San Francisco Medical Society, representing 1,300 practicing doctors in The City.

At a news conference called to protest the ban, the physicians proposed that qualified doctors be able to prescribe marijuana to certain patients with serious diseases. A federal gag order has stifled doctors from prescribing, or even discussing, marijuana use with patients, they said.

They also want to open the door to further research on the therapeutic use of the drug, without political or legal obstruction.

Finally, they challenged the government's assertion that a $1 mil-

[See MARIJUANA, A-14]

◆ *MARIJUANA from A-1*

S.F. doctors want feds to allow pot

lion, 18-month literature search was needed to review the risks and benefits of marijuana.

What is needed, they said, is a large and scientifically credible clinical trial that can address, once and for all, the possible role of marijuana in doctors' arsenal of anti-cancer and anti-AIDS therapies.

Until then, doctors should be able to prescribe it without fear of legal repercussions, said the group, which included Louie, oncologist and former California Medical Association President Dr. Laurens White and AIDS Drs. Jay Lalezari, Steve Follansbee and Ricardo Alvarez.

Many AIDS medications, including the new anti-viral protease inhibitors, are being licensed and released while testing is still under way, said Follansbee, chief of staff at Ralph K. Davies Medical Center in San Francisco.

Journal supports pot

Also Wednesday, an editorial in the New England Journal of Medicine said doctors should be allowed to prescribe marijuana for medical purposes and called the threat of government sanctions "misguided, heavy-handed and inhumane."

Under a new federal policy, physicians who recommend or prescribe marijuana could lose their federal authority to write drug prescriptions, be excluded from Medicare and Medicaid programs and possibly face criminal charges.

The get-tough administration policy followed the passage of California's medical marijuana initiative, Proposition 215, and is widely regarded by the proposition's proponents as an attempt to nullify the election results.

It means many San Francisco doctors — particularly those who need to write narcotics prescriptions for AIDS and cancer patients — give marijuana at the risk of losing their jobs.

"We have to fear the implications of the law on our license and livelihood," Alvarez said. Added Dr. Thomas O'Connell, a recently retired thoracic surgeon, "It is ironic that laws designed to protect patients have transferred the risk to doctors."

Dr. Ivan Silverberg, a cancer specialist, said that under the new federal policy doctors feel threatened and intimidated. Steve Heilig of the San Francisco Medical Society agreed: "A lot of doctors — the 'silent majority' — are afraid to talk about it."

Schedule 1 drugs are those with high potential for abuse and no therapeutic value, such as MDMA or Ecstasy. Schedule 5 drugs are those with low abuse potential and high therapeutic value, like aspirin.

Support for its use

As a Schedule 2 drug, marijuana use could be restricted — but not banned.

"Marijuana is not a panacea in any sense of the word, but it may make the difference whether a patient can tolerate (cancer) therapy or not," White said. "We need restrictions on its use ... but it will not destroy the fabric of society."

The doctors urged support for legislation, soon to be proposed by state Sen. John Vasconcellos, D-San Jose, chairman of the Senate Criminal Procedure Committee, to create a state-run supply of marijuana for a California-based research project.

Scientific research has been held up because of the unwillingness of the federal Drug Enforcement Administration to supply the drug for testing purposes.

Some physicians have also filed a lawsuit seeking to enjoin the administration's policy, saying it violates the freedom of speech of doctors and patients to discuss the potential risks and benefits of medical use of marijuana.

"If we followed 'zero tolerance' drug policy to an extreme," Follansbee said, "there would be no pain medications, there would be no sedatives."

Medical Journal Blasts U.S. on Marijuana for the Sick

Unhappily, Virginia Finds It OKd Medical Pot First

By Louis Freedberg
Chronicle Washington Bureau

Alexandria, Va.

When California voters passed Proposition 215 in November, supporters proudly declared the state to be in the vanguard of the medical marijuana movement.

In fact, at least one other state got a head start — by nearly two decades.

Without a whiff of controversy, the Virginia Legislature passed a law in 1979 allowing doctors to prescribe marijuana to treat glaucoma and to help cancer patients cope with the side effects of chemotherapy.

The law was passed as a small part of a sweeping over-

VIRGINIA: *Page A8 Col. 1*

Editorial calls drug policy 'misguided'

By Glen Martin
Chronicle Staff Writer

The debate over medical marijuana took an unexpected turn yesterday when the respected New England Journal of Medicine announced an editorial excoriating federal pot policy and calling for a reclassification that would allow physicians to prescribe it.

The editorial by editor-in-chief Dr. Jerome Kassirer calls federal policy that prohibits physicians from prescribing marijuana "misguided, heavy-handed and inhumane."

Kassirer lambasted Secretary of Health and Human Services Donna Shalala, Attorney General Janet Reno and drug czar General Barry McCaffrey for their comments against medical marijuana after voters passed initiatives in California and Arizona allowing physicians to prescribe pot.

IN OPINION

■ Text of the New England Journal of Medicine's editorial

PAGE A19

Also yesterday, a group of Bay Area doctors contradicted McCaffrey's assertion that there is no

POT: *Page A8 Col. 1*

POT: Federal Policy Blasted

From Page 1

proof of the drug's benefits.

In the editorial being published today, Kassirer said it is "hypocritical" of the federal government to allow physicians to prescribe potentially dangerous drugs such as morphine and Demerol while forbidding marijuana.

"With (morphine and Demerol), the difference between the dose that relieves symptoms and the dose that hastens death is very narrow," Kassirer wrote. "By contrast, there is no risk of death from smoking marijuana."

It is also hypocritical of federal officials to demand documented evidence of marijuana's therapeutic value before loosening legal strictures, Kassirer wrote. What counts, he said, is whether a patient feels relief.

The editorial also calls for changing marijuana's federal classification from Schedule I to Schedule II. Schedule I drugs — such as heroin — are illegal under all circumstances and may not be used in medicine or research. Schedule II drugs, such as morphine, cocaine and amphetamines, are considered dangerous but may be prescribed and used in sanctioned experiments.

McCaffrey's office released a statement yesterday reiterating opposition to medical marijuana.

"We respectfully disagree with the proposition that marijuana should be available for medical purposes now," the statement says. "We must continue to protect our nation's youth from drugs and motivate them to live healthy, drug-free lives."

The statement emphasized that proposals to license all new drugs — including marijuana — must be submitted to the National Institutes of Health and the National Institute on Drug Abuse.

"Selective use of anecdotal data does not make the scientific case," the statement says. "Perhaps marijuana (might be approved) — but up to this point, smoke is not a medicine. Other treatments have been deemed safer and more effective."

The editorial in the New England Journal of Medicine resonates far beyond the insular world of medical publications.

The journal is arguably the most prestigious medical magazine in the world, the traditional forum where ground-breaking therapies are revealed and revolutionary theories are propounded.

By firmly identifying marijuana use by the sick as a medical rather than social issue, the journal deals a blow to the federal argument that marijuana is a wholly dangerous drug without any redeeming value.

"The journal does not take these issues lightly," said Steve Heilig, director of public health and education for the San Francisco Medical Society.

"I believe that (the editorial) reflects a majority in the medical community that was silent until now," Heilig said.

Heilig said he has been amazed at the number of physicians who have publicly and privately supported medical marijuana.

"The most significant recommendation in the editorial is the call for rescheduling," said Heilig. "I think there is great sentiment in the medical community that this needs to go forward. And if it is not rescheduled immediately, then there should at least be guarantees that doctors will not be prosecuted for prescribing marijuana to their patients."

In a related development, the San Francisco Medical Society held a press conference yesterday to unveil a study that concludes marijuana is a valuable asset in the national pharmacopoeia.

Several prominent Bay Area physicians attended to show their support of the study, including Dr. Laurens White, former president of the California Medical Association, and Dr. Dexter Louie, a head and neck surgeon and president of the San Francisco Medical Society.

Kevin Zeese, an attorney and author of the study, said it demonstrates that federal marijuana policy is bankrupt.

"We based the study completely on peer-reviewed medical articles, and all our research came to the same conclusion — that marijuana is a safe and effective medicine," said Zeese. "McCaffrey said there is not a shred of evidence to prove that marijuana works, and we've shown that the evidence amounts to much more than a shred. The federal government is losing control over this issue."

"There can be harmful effects," said White. "It is not a panacea. But it may make all the difference where certain cases are concerned. I've seen it work like a charm (for nausea and anorexia associated with AIDS and cancer therapies) where other drugs failed."

Exhibit M

Anthony Lewis, Medicine and Politics, N.Y. Times, Oct. 13, 1997, at A15.

The medical use of marijuana remains a poisonous idea in political Washington. Williams Weld's support for it was one of Senator Jesse Helms's stated reasons for blocking his nomination as Ambassador to Mexico, and no one in Washington wanted even to discuss it.

But in the scientific and medical world, there is increasing support for the use of marijuana as an aid to treatment -- or at least for open-minded testing.

The National Institutes of Health in August issued a report by an eight-member committee calling for N.I.H. tests of marijuana's efficacy in four medical areas. The chairman of the committee, William Beaver of Georgetown University, said: "For at least some potential indications marijuana looks promising enough to recommend that there be controlled studies."

In The New England Journal of Medicine dated Aug. 7 a strongly worded article by George J. Annas condemned political interference in the question -- in particular, the Clinton Administration's threat to prosecute any California doctors advising marijuana use after the state's voters overwhelmingly approved the idea in a referendum last year.

"Doctors are not the enemy in the 'war' on drugs," Mr. Annas said; "Ignorance and hypocrisy are. Research should go on, and while it does, marijuana should be available to all patients who need it to help them undergo treatment for life-threatening illnesses."

The best popular discussion I have seen of the scientific-medical issues appeared in The Economist on Aug. 16. It described four kinds of illnesses in which patients have found marijuana helpful.

One is glaucoma. The increased pressure in the eyeball that the disease causes is eased by smoking marijuana. Indeed, the Food and Drug Administration allowed its use when other glaucoma treatments were unavailing until 1991 -- when it may have given way to anti-marijuana hysteria.

A second medical area is neurological diseases. Sufferers from multiple sclerosis, for instance, find relief in marijuana from burning sensations in their arms and legs.

Third, there is what The Economist called "marijuana's well-known ability to stimulate the appetite." This is reportedly of crucial help to AIDS sufferers.

Finally, The Economist said, marijuana is "of undoubted benefit in

suppressing the nausea suffered by many people on anti-cancer therapy."

One patient who reported being greatly helped in that way is Prof. Stephen Jay Gould, the esteemed Harvard paleontologist, who was driven to near despair by nausea when under treatment for abdominal mesothelioma. (He is one of the first people, ever, to survive the disease.) Marijuana, he said, "was the greatest boost I received in all my year of treatment, and surely the most important effect upon my eventual cure."

President Clinton's drug czar, retired Gen. Barry McCaffrey, has scoffed at the idea that marijuana is medically indicated. It is unnecessary, he wrote last month, because its active ingredient, THC, is synthesized and available as a prescription drug, Marinol. "The argument that this chemical needs to be smoked . . . doesn't make sense."

But numerous patients who have tried Marinol and found it ineffective report having benefited from marijuana. It may be that the vapor form of THC is more readily absorbed by the body, or that the smoke contains other ingredients not yet known.

Disquiet is growing more broadly in the medical community about the punitive nature of American drug policy. In July a new organization was formed called Physician Leadership on National Drug Policy. Dr. Lonnie Bristow, former president of the American Medical Association, said: "The current criminal justice-driven approach is not reducing, let alone controlling, drug abuse in America."

And last month another new group of scientists, officials and drug experts called for discussion of drug policy in practical terms -- what actually works. Open debate is now inhibited, they said, by the treatment of critics as traitors.

The Economist put it succinctly in its article on medical use of marijuana. "Some drugs are known to induce paranoia through chemical action," it said. "Marijuana, it seems, can do it through political action."

Exhibit N

Ongoing Briefing

December 1997

A Publication of the National Organization for the Reform of Marijuana Laws

International Medical Groups Tout Marijuana's Effectiveness As A Medicine As 1997 Comes To A Close

Prestigious medical associations in America and abroad recently announced their support for efforts to legalize certain active chemicals in marijuana for medical purposes. The Society for Neuroscience in Washington, D.C. and the British Medical Association in London came out publicly in support of new evidence demonstrating that cannabinoids -- active chemical compounds in marijuana -- provide safe and effective therapeutic relief for a number of serious health conditions. Combined, the associations represent the interests of approximately 140,000 physicians and researchers worldwide.

In New Orleans, several of the nation's top researchers in pain management announced that new scientific studies indicate certain cannabinoids to be safe and effective analgesics to patients suffering from chronic or severe pain. (*Please see Pot Pourri, November 1997, for full details.*) Scientists from the University of California at San Francisco, the University of Texas, Brown University, and elsewhere presented their findings at the 27th annual meeting of the Society for Neuroscience on October 26, 1997.

"Present evidence indicates that [cannabinoids] are remarkably safe drugs, with a side-effects profile superior to many [conventional] drugs."

-- British Medical Association

"Cannabinoids, at least in animal models, can reduce pain," said Dr. Ian Meng, a pharmacology expert at the University of California at San Francisco. Meng noted that the effectiveness of specific cannabinoids as pain relieving agents appeared comparable to those of opiate-based drugs like morphine. Researchers added that the use of cannabinoids like THC and other chemical compounds found in marijuana did not appear to carry the risks associated with the use of opiates, such as addiction and tolerance.

Researchers from the University of Texas reported that the localized injection of anandamide -- a cannabinoid-like chemical present in the brain -- greatly relieved the inflammation associated with arthritis. An additional team of scientists from the University of Minnesota found that certain cannabinoids can also block the

see **Cannabinoids,** *page 4*

AMA Okays Doctor's Right To Discuss Medical Marijuana With Patients, Urges Research

The American Medical Association (AMA) backed a doctor's right to discuss marijuana therapy with a patient, and urged the federal government to facilitate medical marijuana research studies, at a December 9, 1997, policy-making meeting in Dallas.

"The AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions," the organization's House of Delegates resolved. Earlier this year, federal officials threatened to arrest physicians who recommended the use of marijuana to seriously ill patients under state law.

The AMA delegates also urged the federal government to provide "sufficient funding" for clinical research on medical marijuana, and "access for qualified investigators to adequate supplies of marijuana" for the studies. This recommendation parallels a conclusion reached by a National Institute of Health (NIH) working group in August.

Throughout the mid 1990's, many medical marijuana proponents -- including **NORML** -- have criticized the federal government for blocking research to better determine marijuana's medical value. A 1992 proposal comparing the effectiveness of inhaled marijuana with that of synthetic THC as a treatment for the weight loss associated with the AIDS wasting syndrome was rejected on three separate occasions by federal officials. NIH finally approved a revised version of the protocol in 1997, but only after researchers agreed to focus on determining the potential short-term *harmful* effects of marijuana on HIV-positive patients. Similarly, two recent state proposals submitted by the Massachusetts and Washington state boards of health regarding medical marijuana research have been delayed indefinitely while awaiting federal approval. Earlier this year, NIH officials rejected a scientific proposal submitted by a team of researchers from the Western Montana Clinic in Missoula to examine the use of marijuana in acute migraine

see **AMA Resolutions,** *page 2*

AMA Resolutions

continued from page 1

treatment. (*Please see **Ongoing Briefing, November 1997**, for full details.*)

"Hopefully, the AMA's call for medical marijuana research will not go unheard by those in Washington currently impeding such studies from taking place," **NORML Foundation** Executive Director Allen St. Pierre said.

The AMA Council on Scientific Affairs also released a report on Tuesday acknowledging that scientific clinical data exists demonstrating marijuana's medical utility in the treatment of serious diseases like AIDS wasting syndrome and spasticity disorders. The report also maintained that "smoked marijuana may allow individual patients to self-titrate their dosage to the point of therapeutic benefit, while minimizing the undesirable psychoactive effects." Researchers speculated that, in some cases, the inhaled route of administration could offer advantages over oral THC capsules.

However, a member of the AMA's board of trustees, John Nelson, said that the organization does not expect to advocate the legalization of medical marijuana until additional clinical research is conducted.

Regardless, **NORML** Executive Director R. Keith Stroup called the AMA resolutions "powerful steps in the right direction."

"These statements from the AMA are the most supportive since the organization testified before Congress against the Marihuana Tax Act of 1937 out of concern that it would stifle future investigations into the drug's potential medical uses," Stroup said. "It is also critical that the AMA now admits that 'anecdotal, survey, and clinical' data support the use of marijuana as a therapeutic agent for the treatment of some illnesses. This key admission may have significant implications politically for the future of the medical marijuana movement."

The AMA represents more than 40 percent of the 675,000 doctors in the United States.

*For more information, please contact the **NORML** national office. A listing of medical organizations that favor clinical medical marijuana research and/or legal access appears on page three.*

Doctors Seek OK to Discuss Pot Use, Los Angeles Times, Dec. 10, 1997, at A17.

The American Medical Assn. proposed that doctors be allowed to discuss with their patients the potential benefits of using marijuana to treat some diseases without risk of criminal charges. Delegates at a meeting of the AMA's policy-making committee in Dallas approved a resolution that recommends allowing free discussion between doctors and patients about marijuana use for treatment of such diseases as AIDS and multiple sclerosis. But the AMA delegates made no recommendation on whether doctors should actually be allowed to advise their patients to use marijuana.

Exhibit O

George J. Annas, Reefer Madness -- the Federal Response to California's Medical-Marijuana Law, 337 N. Eng. J. Med. 435-439 (Aug. 7, 1997).

Marijuana is unique among illegal drugs in its political symbolism, its safety, and its wide use. More than 65 million Americans have tried marijuana, the use of which is not associated with increased mortality. n1 Since the federal government first tried to tax it out of existence in 1937, at least partly in response to the 1936 film Reefer Madness, marijuana has remained at the center of controversy. Now physicians are becoming more actively involved. Most recently, the federal drug policy against any use of marijuana has been challenged by California's attempt to legalize its use by certain patients on the recommendation of their physicians. The federal government responded by threatening California physicians who recommend marijuana to their sick patients with investigation and the loss of their prescription privileges under Drug Enforcement Administration (DEA) regulations. n2

The editor-in-chief of the Journal suggested that prohibiting physicians from helping their suffering patients by suggesting that they use marijuana is "misguided, heavy-handed, and inhumane." n3 He recommended that marijuana be reclassified as a Schedule II drug and made available by prescription without the usual requirement of controlled clinical trials. Many states, including Massachusetts, had previously passed laws that permitted their citizens to use marijuana for medicinal purposes under some circumstances. n4 California's law seems to have engendered a uniquely harsh federal response because California is a large, trend-setting state; because its new marijuana law is very broad as compared with others; and because the law was passed by popular referendum. In this article I will discuss the new California law and its implications for physicians.

The California Proposition

In the fall of 1996, California voters approved the Medical Marijuana Initiative (Proposition 215) by a vote of 56 to 44 percent. The act is entitled the Compassionate Use Act of 1996, and its purpose is to give Californians the right to possess and cultivate marijuana 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 the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuan provides relief." n5 Nothing in the act permits persons using marijuana for medical purposes to engage in conduct that endangers others (such as driving while under its influence), condones "the diversion of marijuana for nonmedical purposes," or permits the buying or selling of marijuana. n5 The two operative

sections of the law are as follows:Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. Existing California law relating to the possession of marijuana and the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver the person who has consistently assumed responsibility for the patient's housing, health, or safety who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician. n5

The primary purpose of this law is to provide a specified group of patients with an affirmative defense to the charge of possession or cultivation of marijuana, the defense of medical necessity. To use this defense, the patient must be able to show that his or her physician recommended or approved of the use of marijuana, either orally or in writing. Obviously, a note from a physician is better evidence than a simple assertion that "my doctor said this would be good for me," and most patients will want a written statement to help protect them from problems with the police. Nothing in this law changes current law against buying or selling marijuana or affects federal law; it merely provides that qualified patients and their primary care givers can possess and cultivate their own marijuana for personal medicinal purposes, without violating state drug laws.

Compassion and the Use of Unapproved Drugs

The federal government has been in the business of regulating drugs for almost a century, and few exceptions have ever been made to the basic rules of the Food and Drug Administration (FDA), even for patients with cancer or AIDS. In 1979, for example, the FDA was successful in convincing a unanimous U.S. Supreme Court that Congress intended no exception for terminally ill patients who sought to take laetrile, an unapproved drug, for cancer. The FDA's primary rationale was that the use of this unapproved and useless drug could prevent patients from seeking conventional treatments for cancer that offered them at least some chance of a cure. n6 Under President Ronald Reagan, however, the FDA responded with a great deal more flexibility to the AIDS epidemic and permitted the use and sale of drugs not yet approved (but in use in ongoing clinical trials) if, among other things, "the drug was intended to treat a serious or immediately life-threatening disease." n7 More surprisingly, the FDA also permitted individual patients to import unapproved drugs from other countries for their personal, medical use. n8 These regulations were almost purely political, had no scientific basis, and tended to conflate treatment and research and to undermine the very purpose of clinical trials. n8 The theory used to justify these exceptions to federal drug laws was the very one rejected by the Supreme Court: terminally ill patients have "nothing to lose" and should not be deprived of the hope (even the false hope) that they might escape death. n6 n8

Given this history, it is not surprising that the advocates of the medicinal use of marijuana concentrate their reform efforts on helping patients with cancer ameliorate the adverse effects of chemotherapy and helping patients with AIDS counteract weight loss and fight their disease. Virtually no one thinks it is reasonable to initiate criminal prosecution of patients with cancer or AIDS who use marijuana on the advice of their physicians to help them through conventional medical treatment for their disease. Anecdotal evidence of the effectiveness of smoked marijuana abounds. n9 Perhaps the most convincing is the account of Harvard professor and author Stephen Jay Gould, one of the world's first survivors of abdominal mesothelioma. When Gould started intravenous chemotherapy, he writes: Absolutely nothing in the available arsenal of anti-emetics worked at all. I was miserable and came to dread the frequent treatments with an almost perverse intensity. I had heard that marijuana often worked well against nausea. I was reluctant to try it because I have never smoked any substance habitually (and didn't even know how to inhale). Moreover, I had tried marijuana twice in the 1960s ... and had hated it.... Marijuana worked like a charm.... The sheer bliss of not experiencing nausea -- and not having to fear it for all the days intervening between treatments -- was the greatest boost I received in all my year of treatment, and surely the most important effect upon my eventual cure. n10

Similarly, in patients with AIDS, marijuana has been credited with counteracting such side effects of treatment as severe nausea, vomiting, loss of appetite, and fatigue, as well as with stimulating the appetite to help prevent weight loss.

The White House Press Conference

Had the California proposition been limited to the use of marijuana for terminal illnesses such as cancer and AIDS, it would probably have caused much less concern. Arizona passed a much broader initiative that permitted physicians to prescribe any drug on Schedule I, but in April 1997, the Arizona legislature amended the law to apply only to drugs approved by the FDA, thus effectively repealing it. n11 The California law applies only to marijuana but makes it available for a wide range of medical conditions, including anorexia, pain, spasticity, glaucoma, arthritis, migraine, "or any other illness for which marijuana provides relief." n5 This very broad definition of the potential medicinal uses of marijuana seemed an explicit endorsement of the drug itself, which the Clinton administration and others believed to be sending the wrong message to America's youth. After thinking about the issue for approximately two months, the Clinton administration announced that it would vigorously oppose the implementation of the California proposition and the Arizona law. n2

Barry McCaffrey, director of the Office of National Drug Control Policy, announced at a White House news conference on December 30, 1996, that "nothing has changed. Federal law is unaffected by these propositions." n2 McCaffrey expressed concern about marijuana as a "gateway drug" and about the potential impact of the law on children. As for the potential medicinal uses of marijuana, he said:This is not a medical proposition. This is the legalization of drugs that we're concerned about. Here's what the medical advisor in the state of California saw as the potential uses of marijuana. Here McCaffrey showed a slide. ... It includes recalling forgotten memories, cough suppressants, Parkinson's disease, writer's cramp. This is not medicine. This is a Cheech and Chong show. And now what we are committed to doing is to look in a scientific way at any proposition that would bring a new medicine to the assistance of the American medical establishment. n2

Secretary of Health and Human Services Donna Shalala said that the initiatives reinforced the growing belief among Americans that marijuana is not harmful, whereas the administration remained "opposed to the legalization of marijuana because all available research has concluded that marijuana is dangerous to our health." n2 Nonetheless, she did say that the National Institutes of Health (NIH) would continue to support and review "peer-reviewed" and "scientifically valid" research on "the possible usefulness of smoked marijuana in the limited circumstances where available medications have failed to provide relief for individual patients." n2

Finally, Attorney General Janet Reno announced that physicians who followed the terms of the California law would be the new targets of federal law enforcement (instead of drug dealers) and threatened physicians with loss of their registrations with the DEA and with exclusion from participation in Medicare and Medicaid. She stated:Federal law still applies.... U.S. attorneys in both states will continue to review cases for prosecution and DEA officials will review cases as they have to determine whether to revoke the registration of any physician who recommends or prescribes so-called Schedule I controlled substances. We will not turn a blind eye toward our responsibility to enforce federal law and to preserve the integrity of medical and scientific process to determine if drugs have medical value before allowing them to be used. n2

Doctor-Patient Conversations

Two basic issues are raised by the administration's position. One involves government regulation of doctor-patient conversations, and the other the quality of evidence necessary to make marijuana available by prescription. A group of California physicians filed suit against McCaffrey, Reno, and Shalala, arguing that the threats of prosecution against physicians for talking to their patients violate their First Amendment rights and interfere with their ability as physicians to use "their best medical judgment in the context of a bona fide

physician-patient relationship." n12

In the only comparable case to reach the U.S. Supreme Court, the Court narrowly upheld a gag rule related to discussing abortion in a federally funded Title X family-planning clinic. n13 The Court upheld the gag rule because Congress could reasonably limit the types of medical services available at a federally funded facility. n14 The Court was able to sidestep the First Amendment issue because patients (at least in theory) had access to other doctors who had an obligation to furnish them with full information, and the doctor-patient relationship in a Title X clinic was characterized as not "all-encompassing" but, rather, as limited only to preconception counseling:The Title X program regulations do not significantly impinge upon the doctor-patient relationship. Nothing in them requires a doctor to represent as his or her own any opinion that he or she does not in fact hold. Nor is the doctor-patient relationship established by expectation on the part of the patient of comprehensive medical advice. The program does not provide post-conception medical care, and therefore a doctor's silence with regard to abortion cannot reasonably be thought to mislead a client into thinking that the doctor does not consider abortion an appropriate option for her. n13

Even if one accepts this unconvincing rationale, it is impossible to apply it to California physicians who believe that marijuana would be beneficial for their patients and who are providing their overall health care. Patients receiving care for cancer or AIDS rightfully and reasonably expect and are entitled to full disclosure and discussion of available treatment options. The California physicians are on strong legal ground with their lawsuit, and they should prevail. In early April, U.S. District Court judge Fern M. Smith granted a preliminary injunction prohibiting the DEA from carrying out its threats against California physicians and encouraged the litigants to try to work out a settlement of the dispute. n15

In response to the lawsuit and the growing opposition to its threats to physicians, the administration issued a clarifying letter, essentially stating that physicians may discuss marijuana with their patients so long as they do not recommend its use. n16 This provides no guidance at all. Of course doctors can talk to patients; the question is what they can tell them. The real subject of dispute remains whether physicians can "recommend" marijuana (and thereby grant their patients immunity from state prosecution), as the California proposition provides. Would, for example, telling a patient with cancer that other physicians have reported that marijuana has given their patients relief from nausea constitute a "recommendation"?

Judge Smith made it clear that the First Amendment protects physician-patient communications and that the government has no authority to determine the content of physicians' speech. n15 She also concluded that the federal statements

regarding threatened prosecution were vague and thus could lead to physicians' censuring their own speech to avoid possible federal prosecution. On the other hand, she noted (correctly) that the First Amendment does not protect "speech that is itself criminal because the speech is too intertwined with illegal activity." n15 Under federal drug laws, which cannot be affected by legislation in California, it remains a crime for physicians to aid, abet, or conspire -- by speech or action -- to violate federal criminal statutes. Thus, it is not a violation of the First Amendment for the federal government to prosecute or threaten to prosecute physicians who specifically intend to aid, abet, or conspire with their patients to violate federal drug laws.

Judge Smith could have added that to prevail in such a case the government will have to prove more than simply that the physician recommended marijuana as worth trying for a medical condition. The "more" will include evidence that the physician "associated himself with the venture" of illegally purchasing marijuana "as something he wished to bring about and sought by his actions to make succeed." n17 This should require at least that the physician identify a source of the marijuana, and some connection between that source and the physician. n18 It is only speech short of this that the injunction covers. Of course, this formulation still leaves it uncertain exactly how far physicians may go in recommending marijuana use before the federal government is justified in prosecuting them for criminal behavior. Judge Smith concluded with an understatement: "This injunction does not provide physicians with the level of certainty for which they had hoped." n15

Marijuana as Medicine

Attempts to have marijuana reassigned from Schedule I to Schedule II began almost immediately after Congress passed the Uniform Controlled Substances Act of 1970, which established the current system of drug classification. The following findings must be made to place a drug on Schedule I: "(A) The drug... has a high potential for abuse; (B) The drug... has no currently accepted medical use in treatment in the United States; and (C) there is a lack of accepted safety for use of the drug under medical supervision." Part A for Schedule II drugs is identical; the other requirements are "(B) The drug... has a currently accepted medical use in treatment in the United States... and (C) Abuse of the drug... may lead to severe psychological or physical dependence."

In 1988, after two years of hearings, DEA administrative-law judge Francis Young recommended shifting marijuana to Schedule II on the grounds that it was safe and had a "currently accepted medical use in treatment." n19 Specifically, Judge Young found that "marijuana, in its natural form, is one of the safest therapeutically active substances known to man.... At present it is estimated that marijuana's LD-50 median lethal dose is around 1:20,000 or 1:40,000. In layman's terms... a smoker would theoretically have to consume 20,000 to 40,000

times as much marijuana as is contained in one marijuana cigarette... nearly 1500 pounds of marijuana within about fifteen minutes to induce a lethal response." As for medical use, the judge concluded, among other things, that marijuana "has a currently accepted medical use in treatment in the United States for nausea and vomiting resulting from chemotherapy treatments." n19 The administrator of the DEA rejected Young's recommendation, on the basis that there was no scientific evidence showing that marijuana was better than other approved drugs for any specific medical condition. Further attempts to get the courts to reclassify marijuana have been unsuccessful.

Reacting to a DEA suggestion that only a "fringe group" of oncologists accepted marijuana as an antiemetic agent, a survey of a random sample of the members of the American Society of Clinical Oncology was undertaken in 1990. n20 More than 1000 oncologists responded to the survey, and 44 percent of them reported that they had recommended marijuana to at least one patient. n20 Marijuana was believed to be more effective than oral dronabinol (Marinol) by the respondents: of those who believed they had sufficient information to compare the two drugs directly, 44 percent believed marijuana was more effective, and only 13 percent believed dronabinol was more effective. n20 Of course, nothing in the FDA regulations requires a drug to be more effective than an existing one for it to be approved. Nonetheless, in the current anti-marijuana climate, the NIH has consistently refused to fund research on marijuana. In the wake of the California proposition, this position is no longer tenable.

An NIH panel, after a two-day workshop in February, recommended research on marijuana in the areas of wasting associated with AIDS, nausea due to cancer chemotherapy, glaucoma, and neuropathic pain. n21 This list seems reasonable, especially since objective criteria such as weight gain, intraocular pressure, and the frequency of vomiting can be used to determine the drug's effectiveness.

Such research may be difficult to do, but it is possible to compare orally administered dronabinol with smoked marijuana. Some argue that because the symptoms of nausea are so subjective and "extremely difficult to quantify in controlled experiments," marijuana should be available as a prescription drug on a compassionate basis. n3 In fact, current FDA regulations provide the authority for making marijuana available on a compassionate basis while such studies are proceeding. Other support for its compassionate use would appear to come from the Clinton administration's solicitor general, Walter Dellinger, who argued before the Supreme Court less than two weeks after the McCaffrey-Reno press conference that the administration believed that Americans had a weak constitutional right "not to suffer." Although Dellinger said he did not believe this right was broad enough to prohibit the states from making physician-assisted suicide for terminally ill patients a crime, it should certainly be broad enough to prohibit the federal government from denying

patients with cancer and AIDS access to drugs that could help them withstand potentially life-saving treatments.

What About the Children?

The final argument that the administration makes against any medical use of marijuana is that this would send the "wrong message" to children, who would then use this "gateway drug" and get hooked on much more harmful substances, such as cocaine and heroin. There are two responses to this argument. The first is provided by Boston Globe columnist Ellen Goodman, who asks, "What is the infamous signal being sent to children ?... If you hurry up and get cancer, you, too, can get high?" n22

The second response relates to the "gateway" issue itself. A 1994 survey found that 17 percent of current marijuana users said they had tried cocaine and only 0.2 percent of those who had not used marijuana had tried cocaine. n23 One way to interpret these data is that children who smoke marijuana are 85 times as likely as others to try cocaine; another is that 83 percent of pot smokers, or five out of six, never try cocaine. n23 Honesty is likely to make a greater and more lasting impression on our children than political posturing and hysteria. Many people want to make marijuana legal for everyone. But opposition to the legalization of marijuana generally is not a good reason to keep it from patients who are suffering. Making marijuana a Schedule II drug does not make it widely acceptable or available any more than classifying medicinal cocaine as a Schedule II drug made it acceptable or available.

Conclusions

Doctors are not the enemy in the "war" on drugs; ignorance and hypocrisy are. Research should go on, and while it does, marijuana should be available to all patients who need it to help them undergo treatment for life-threatening illnesses. There is certainly sufficient evidence to reclassify marijuana as a Schedule II drug. Unlike quack remedies such as laetrile, marijuana is not claimed to be a treatment in itself; instead, it is used to help patients withstand the effect of accepted treatment that can lead to a cure or amelioration of their condition. As long as a therapy is safe and has not been proved ineffective, seriously ill patients (and their physicians) should have access to whatever they need to fight for their lives.

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Exhibit P

Workshop on the Medical Utility of Marijuana

Report to the Director,
National Institutes of Health,
by the Ad Hoc Group of Experts

Introduction

On February 19 and 20, 1997, the National Institutes of Health (NIH) held a meeting concerning the potential medical uses of marijuana. Recent (November 1996) ballot initiatives in California and Arizona had sparked a public health and policy debate on the medical utility of marijuana and the desirability of allowing healthcare providers to prescribe, and patients to receive, marijuana for medicinal purposes.

For some years the principal psychoactive ingredient of marijuana, delta-9-tetrahydrocannabinol (Δ9-THC), has been available to healthcare providers in an oral form as dronabinol (trade name Marinol) for the treatment of emesis associated with cancer chemotherapy and for appetite stimulation in the treatment of AIDS wasting syndrome. The current debate centers primarily on the potential for other treatment indications and the claims that, when smoked, marijuana offers therapeutic advantages over the currently available oral form. As the Federal Government's principal biomedical research agency, the NIH believed that the public debate could benefit from an impartial examination of all the data available to date concerning these issues. As the claims for benefits were wide ranging, 10 major components of the NIH participated in the planning for the conference.

The NIH planning group focused the meeting on the following four questions concerning marijuana as a potential therapeutic agent:

Question 1 - What research has been done previously and what is currently known about the possible medical uses of marijuana?

Question 2 - What are the major unanswered scientific questions?

Question 3 - What are the diseases or conditions for which marijuana might have potential as a treatment and that merit further study?

Question 4 - What special issues have to be considered in conducting clinical studies of the therapeutic uses of marijuana?

The meeting was formatted as a scientific workshop. It was not an attempt to render a consensus. Therefore, it was structured so that speakers with experience in the relevant therapeutic areas would present to a group of eight expert consultants who possessed broad expertise in clinical studies and

therapeutics and who had no public positions on the potential use of marijuana as a therapeutic agent. Each presentation was followed by a session for questions and answers from the Expert Group. The second day was allotted for the public to present their views and for discussion by the Expert Group. This report represents a compilation of the views of the Expert Group. Since this report was not intended as a general review of the literature on marijuana and THC, only a few selected references from among the thousands that exist are cited. Each of the members in the Expert Group chose those references relevant to their own contributions to the report.

Clinical Pharmacology of Marijuana

The Pharmacology of Natural Products

It is important to keep in mind that marijuana is not a single drug. Marijuana is a mixture of the dried flowering tops and leaves from the plant cannabis sativa (Agurell et al. 1984, Graham 1976; Jones 1987; Mechoulam 1973). Like most plants, marijuana is a variable and complex mixture of biologically active compounds (Agurell et al. 1986; Graham 1976; Mechoulam 1973). Characterizing the clinical pharmacology of the constituents in any pharmacologically active plant is often complicated, particularly when the plant is smoked or eaten more or less in its natural form. Marijuana is not unusual in this respect. Cannabis sativa is a very adaptive plant, so its characteristics are even more variable than most plants (Graham 1976; Mechoulam 1973). Some of the seeming inconsistency or uncertainty in scientific reports describing the clinical pharmacology of marijuana results from the inherently variable potency of the plant material used in research studies. Inadequate control over drug dose when researching the effects of smoked and oral marijuana, together with the use of research subjects who vary greatly in their past experience with marijuana, contribute differing accounts of what marijuana does or does not do.

The Plant

Marijuana contains more than 400 chemicals. Approximately 60 are called cannabinoids; i.e., C21 terpenes found in the plant and their carboxylic acids, analogs, and transformation products (Agurell et al. 1984, 1986; Mechoulam 1973). Most of the naturally occurring cannabinoids have been identified. Cannabinoids appear in no other plant. Cannabinoids have been the subject of much research, particularly since the mid 1960s when Mechoulam and his colleagues first isolated delta-9-tetrahydrocannabinol (Δ9-THC) (Mechoulam 1973; Mechoulam et al. 1991). THC in the scientific literature is termed Δ9-THC or Δ1-THC depending on whether the pyran or monoterpinoid numbering system is used.

Cannabinoids of Importance

THC, the main psychoactive cannabinoid in marijuana, is an optically active resinous substance. THC is not soluble in water but is extremely lipid soluble (Agurell et al. 1984, 1986; Mechoulam 1973) Varying proportions of other cannabinoids, mainly cannabidiol (CBD) and cannabinol (CBN), are also

present in marijuana, sometimes in quantities that might modify the pharmacology of THC or cause effects of their own. CBD is not psychoactive but has significant anticonvulsant, sedative, and other pharmacologic activity likely to interact with THC (Adams and Martin 1996; Agurell et al. 1984, 1986, Hollister 1986*a*).

The concentration of THC and other cannabinoids in marijuana varies greatly depending on growing conditions, plant genetics, and processing after harvest (Adams and Martin 1996; Agurell et al. 1984, Graham 1976; Mechoulam 1973). In the usual mixture of leaves and stems distributed as marijuana, concentration of THC ranges from 0.3 percent to 4 percent by weight. However, specially grown and selected marijuana can contain 15 percent or more THC. Thus, a marijuana cigarette weighing 1 gram (g) might contain as little as 3 milligrams (mg) of THC or as much as 150 mg or more.

Potency of Tetrahydrocannabinol

THC is quite potent when compared to most other psychoactive drugs. An intravenous (IV) dose of only a milligram or two can produce profound mental and physiologic effects (Agurell et al. 1984, 1986; Fehr and Kalant 1983; Jones 1987). Large doses of THC delivered by marijuana or administered in the pure form can produce mental and perceptual effects similar to drugs usually termed hallucinogens or psychomimetics. However, the way marijuana is used in the United States does not commonly lead to such profound mental effects. Despite potent psychoactivity and pharmacologic actions on multiple organ systems, cannabinoids have remarkably low lethal toxicity. Lethal doses in humans are not known. Given THC's potency on some brain functions, the clinical pharmacology of marijuana containing high concentrations of THC, for example greater than 10 percent, may well differ from plant material containing only 1 or 2 percent THC simply because of the greater dose delivered.

Some Limitations of Previous Marijuana Research

Unfortunately, much of what is known about the human pharmacology of smoked marijuana comes from experiments with plant material containing about 2 percent THC or less, or occasionally up to 4 percent THC. In addition, human experiments typically are done in laboratory settings where only one or two smoked doses were administered to relatively young, medically screened, healthy male volunteers well experienced with the effects of marijuana. Females rarely participated in past marijuana research because of prohibitions (now removed) against their inclusion. Thus the clinical pharmacology of single or repeated smoked marijuana doses given to older people or to people with serious diseases has hardly been researched at all in a controlled laboratory or clinic setting. Some of the very few reports of experiments that have included older or sicker people, particularly patients less experienced in using marijuana, suggest the profile of adverse effects may differ from healthy student volunteers smoking in a laboratory experiment (Hollister 1986*a*, 1988*a*).

THC administered alone in its pure form is the most thoroughly researched cannabinoid. Much of what is written about the clinical pharmacology of marijuana is actually inferred from the results of experiments using only pure THC. Generally, in experiments actually using marijuana, the assumed dose of marijuana was based only on the concentration of THC in the plant material. The amounts of cannabidiol and other cannabinoids in the plant also vary so that pharmacologic interactions modifying the effects THC may occur when marijuana is used instead of pure THC. Only rarely in human

experiments using marijuana was the content of CBD or other cannabinoids specified or the possibility of interactive effects between THC and other cannabinoids or other marijuana constituents actually measured.

The result of this research strategy is that a good deal is known about the pharmacology of THC, but experimental confirmation that the pharmacology of a marijuana cigarette is indeed entirely or mainly determined by the amount of THC it contains remains to be completed. The scientific literature contains occasional hints that the pharmacology of pure THC, although similar, is not always the same as the clinical pharmacology of smoked marijuana containing the same amount of THC (Graham 1976; Harvey 1985; Institute of Medicine 1982). Proponents of therapeutic applications of marijuana emphasize possible but not well documented or proven differences between the effects of the crude plant and pure constituents like THC (Grinspoon and Bakalar 1993).

Route-Dependent Pharmacokinetics

Route of administration determines the pharmacokinetics of the cannabinoids in marijuana, particularly absorption and metabolism (Adams and Martin 1996; Agurell et al. 1984, 1986). Typically, marijuana is smoked as a cigarette (a joint) weighing between 0.5 and 1.0 g, or in a pipe in a way not unlike tobacco smoking. Marijuana can also be baked in foods and eaten, or ethanol or other extracts of plant material can be taken by mouth. Some users claim marijuana containing adequate THC can be heated without burning and the resulting vapor inhaled to produce the desired level of intoxication. This has not been studied under controlled conditions. Pure preparations of THC and other cannabinoids can be administered by mouth, by rectal suppository, by IV injection, or smoked. IV injection of crude extracts of marijuana plant material would be quite toxic, however.

Marijuana Smoking and Oral Administration

Smoking plant material is a special way of delivering psychoactive drugs to the brain. Smoking has different behavioral and physiologic consequences than oral or IV administration. What is well known about tobacco (nicotine) and coca (cocaine) clinical psychopharmacology and toxicity illustrates this point all too well. When marijuana is smoked, THC in the form of an aerosol in the inhaled smoke is absorbed within seconds and delivered to the brain rapidly and efficiently as would be expected of a very lipid-soluble drug. Peak venous blood levels of 75 to 150 nanograms per milliliter (ng/mL) of plasma appear about the time smoking is finished (Agurell et al. 1984, 1986; Huestis et al. 1992*a*, 1992*b*). Arterial concentrations of THC have not been measured but would be expected to be much higher initially than venous levels, as is the case with smoked nicotine or smoked cocaine.

Oral ingestion of THC or marijuana is quite different than smoking. Maximum THC and other cannabinoid blood levels are only reached 1 to 3 hours after an oral dose (Adams and Martin 1996; Agurell et al. 1984, 1986). Onset of psychoactive and other pharmacologic effects is rapid after smoking but much slower after oral doses.

Marijuana Smoking Behavior and Dose Control

As with any smoked drug (e.g., nicotine or cocaine), characterizing the pharmacokinetics of THC and other cannabinoids from smoked marijuana is a challenge (Agurell et al. 1986; Heishman et al. 1989; Herning et al. 1986; Heustis et al. 1992*a*). A person's smoking behavior during an experiment is difficult for a researcher to control. People differ. Smoking behavior is not easily quantified. An experienced marijuana smoker can titrate and regulate dose to obtain the desired acute psychological effects and to avoid overdose and/or minimize undesired effects. Each puff delivers a discrete dose of THC to the body. Puff and inhalation volume changes with phase of smoking, tending to be highest at the beginning and lowest at the end of smoking a cigarette. Some studies found frequent users to have higher puff volumes than did less frequent marijuana users. During smoking, as the cigarette length shortens, the concentration of THC in the remaining marijuana increases; thus, each successive puff contains an increasing concentration of THC.

One consequence of this complicated process is that an experienced marijuana smoker can regulate almost on a puff-by-puff basis the dose of THC delivered to lungs and thence to brain. A less experienced smoker is more likely to overdose or underdose. Thus a marijuana researcher attempting to control or specify dose in a pharmacologic experiment with smoked marijuana has only partial control over drug dose actually delivered. Postsmoking assay of cannabinoids in blood or urine can partially quantify dose actually absorbed after smoking, but the analytic procedures are methodologically demanding, and only in recent years have they become at all practical

After smoking, venous blood levels of THC fall precipitously within minutes, and an hour later they are about 5 to 10 percent of the peak level (Agurell et al. 1986; Huestis et al. 1992*a*, 1992*b*). Plasma clearance of THC is quite high, 950 milliliters per minute (mL/min) or greater; thus approximating hepatic blood flow. However, the rapid disappearance of THC from blood is largely due to redistribution to other tissues in the body rather than simply because of rapid cannabinoid metabolism (Agurell et al. 1984, 1986). Metabolism in most tissues is relatively slow or absent. Slow release of THC and other cannabinoids from tissues and subsequent metabolism makes for a very long elimination half-time. The terminal half-life of THC is estimated to be from about 20 hours to as long as 10 to 13 days, though reported estimates vary as expected with any slowly cleared substance and the use of assays with varied sensitivity.

Cannabinoid metabolism is extensive with at least 80 probably biologically inactive but not completely studied metabolites formed from THC alone (Agurell et al. 1986; Hollister 1988*a*). 11-hydroxy-THC is the primary active THC metabolite. Some inactive carboxy metabolites have terminal half-lives of 50 hours to 6 days or more and thus serve as long persistence markers of prior marijuana use by urine tests. Most of the absorbed THC dose is eliminated in feces and about 33 percent in urine. THC enters enterohepatic circulation and undergoes hydroxylation and oxidation to 11-nor-9-carboxy-delta-9-THC (9-COOH-Δ9-THC). The glucuronide is excreted as the major urine metabolite along with about 18 nonconjugated metabolites. Frequent and infrequent marijuana users are similar in the way they metabolize THC (Agurell et al. 1986; Kelly and Jones 1992).

Route of Use Bioavailability and Dose

THC bioavailability, i.e., the actual absorbed dose as measured in blood, from smoked marijuana varies greatly among individuals. Bioavailability can range from 1 percent to 24 percent with the fraction absorbed rarely exceeding 10 percent to 20 percent of the THC in a marijuana cigarette or pipe

(Agurell et al. 1986; Hollister 1988*a*). This relatively low and quite variable bioavailability results from significant loss of THC in sidestream smoke, from variation in individual smoking behaviors, from incomplete absorption from inhaled smoke, and from metabolism in lung and cannabinoid pyrolysis. A smoker's experience is probably an important determinant of dose actually absorbed (Herning et al. 1986; Johansson et al. 1989). Much more is known about the dynamics of tobacco (nicotine) smoking. Many of the same pharmacokinetic considerations apply to marijuana smoking.

Oral bioavailability of THC, whether given in the pure form or as THC in marijuana, also is low and extremely variable, ranging between 5 percent and 20 percent (Agurell et al. 1984, 1986). Great variation can occur even when the same individual is repeatedly dosed under controlled and ideal conditions. THC's low and variable oral bioavailability is largely a consequence of large first-pass hepatic elimination of THC from blood and due to erratic absorption from stomach and bowel. Because peak effects are slow in onset and variable in intensity, typically at least an hour or two after an oral dose, it is more difficult for a user to titrate dose than with marijuana smoking. When smoked, THC's active metabolite 11-hydroxy-THC probably contributes little to the effects since relatively little is formed, but after oral doses the amounts of 11-hydroxy-THC metabolite may exceed that of THC and thus contribute to the pharmacologic effects of oral THC or marijuana.

* * *

Analgesia

1. What research has been done and what is known about the possible medical uses of marijuana?

A number of studies have been conducted on the antinociceptive or analgesic effect of tetrahydrocannabinol (THC) or marijuana in both animals and human subjects; the results have been conflicting. Of interest is the recent identification of cannabinoid receptors as well as an endogenous ligand, anandamide. There is some evidence that they are part of a natural pain control system distinct from the endogenous opioid system. Recognizing that some studies have demonstrated an antinociceptive (analgesic) effect of THC and related compounds in rodents, it may be useful to identify what specific kinds of pain may be relieved by marijuana or THC.

Animal studies on the analgesic effect of marijuana have produced inconsistent results. Whereas one study shows that delta-9-tetrahydrocannibinol (Δ9-THC) is equipotent to morphine in rats (tailflick test), and more potent than morphine in mice (hotplate test), other studies showed that Δ9-THC was less potent than morphine in both mice and rats. Cannabinoids have been shown to be possibly analgesic in animal models of neuropathic pain.

There have been a few studies of marijuana/Δ9-THC employing different models of experimentally induced pain in volunteer subjects, and these studies have also yielded conflicting results. Raft and colleagues (1977) found that, in oral surgery patients, premedication with intravenous Δ9-THC was less effective than diazepam or placebo in reducing two kinds of experimentally induced pain. Another study showed that smoked marijuana increased pain tolerance, while others showed either no effect or a lowering of pain threshold after oral or intravenous dosing with Δ9-THC or smoking marijuana. The current "FDA Guideline for the Clinical Evaluation of Analgesic Drugs" (FDA 1992) notes that "Evidence is still inadequate to establish that any experimental pain model will consistently and accurately predict the clinical efficacy of new analgesics, . . . [and] they cannot substitute for controlled trials in patients with pathologic pain [naturally occurring pain caused by disease or tissue injury] in producing substantial evidence of analgesia . . ." This is also the overwhelming consensus of investigators who conduct controlled clinical trials of analgesic efficacy. Therefore, the above studies contribute little information about the analgesic efficacy of marijuana/Δ9-THC in patients with pain.

There appear to be no controlled analgesic studies of smoked marijuana in patients with naturally occurring pain. However, Noyes and his colleagues conducted two studies of oral Δ9-THC in inpatients with cancer pain. Both of these studies used the same standard single-dose analgesic study methodology and met the criteria for well-controlled clinical trials of analgesic efficacy, but with small sample sizes. Both were randomized, double-blind, crossover comparisons employing a full-time nurse-observer, who collected hourly subjective ratings of pain intensity and pain relief. Observed and reported side effects were recorded, as were the responses to an 11-item subjective effects questionnaire.

The first study in 10 cancer patients compared a placebo and 5, 10, 15, and 20 mg doses of Δ9-THC over a 6-hour observation period (Noyes et al. 1975*a*). The slope of the dose-response curve for pain relief was significant, as was a pairwise comparison of pain relief after the two lower doses combined versus the two higher doses combined. There was also a clear dose-response relationship for sedation, mental clouding, and other central nervous system (CNS) related side effects. Because of sedation, the 20-mg dose was judged to be "of limited value for most patients."

The second study in 36 cancer patients compared placebo, 10, and 20 mg of Δ9-THC and 60 and 120 mg of codeine over a 7-hour observation period (Noyes et al. 1975*b*). Codeine 120 mg and Δ9-THC 20 mg were similar to each other and significantly superior to placebo for the sum of the pain intensity differences and total pain relief, while other pairwise contrasts were not significant. Relative potency analysis was not performed.

The time-effect curves for both doses of codeine and for Δ9-THC, 10 mg, peaked at the third hour. As in the first study, the 20 mg dose of Δ9-THC peaked at the fifth hour, which probably reflects the delayed absorption of oral THC. "Patients receiving 20 mg of THC were heavily sedated and even at 10 mg reported considerable drowsiness. Other dose limiting side effects included dizziness, ataxia and blurred vision" (Noyes et al. 1975*b*). Mental clouding, thinking impairment, disconnected thought, disorientation, slurred speech, and impaired memory were much more prominent after both doses of Δ9-THC than after codeine administration, and patients expressed particular concern over their "loss of control" over thought and action. Five patients experienced very unpleasant psychic effects after Δ9-THC, three patients said they felt as if they were dying, one patient experienced depressed mood, and one patient suffered paranoid ideation. In two patients, the adverse mood effects persisted 3 or 4 days.

These studies indicate that Δ9-THC has some analgesic activity in humans. They also indicate that there is, at best, a very narrow therapeutic window between doses that produce useful analgesia and those that produce unacceptable adverse CNS effects.

2. What are the major unanswered scientific questions?

Since oral Δ9-THC has some analgesic activity, it is highly likely that smoked marijuana has some analgesic activity in some kinds of clinical pain. Because Δ9-THC from smoked marijuana is absorbed directly into the pulmonary circulation, this route of administration results in a Δ9-THC blood level curve much more like that produced by an intravenous injection than that after oral administration. It is therefore likely that smoked marijuana potentially allows a more precise titration to effect than oral administration of Δ9-THC with its delayed, poor, and erratic bioavailability. Theoretically, smoked marijuana or inhaled THC potentially has some of the characteristics of a patient-controlled analgesia (PCA) pump. It is therefore possible that some pain patients could use smoked marijuana to titrate themselves into the therapeutic window of adequate pain relief while avoiding unacceptable adverse effects. Although the above scenario is pharmacologically reasonable, only properly designed controlled clinical analgesic studies can determine if it actually works and is practically useful. For example, it is also possible that the minimum blood level of Δ9-THC that produces useful analgesia also usually produces a level of sedation, mental clouding, and thinking impairment that is unacceptable to most patients.

There are currently available a great variety of both opioid and nonsteroidal anti-inflammatory drug (NSAID) analgesics in various dosage formulations suitable for many routes of administration. Adroit use of these can manage most acute pain and even chronic cancer pain satisfactorily. If marijuana is to be a useful analgesic, healthcare providers need to know how it compares in efficacy and safety to at least a few of the standard analgesics that would be used in managing a particular kind of pain.

3. What are the diseases or conditions for which marijuana might have potential as a treatment and which merit further study?

Neuropathic pain represents a treatment problem for which currently available analgesics are, at best, marginally effective. Since Δ9-THC is not acting by the same mechanism as either opioids or NSAIDs, it may be useful in this inadequately treated type of pain. Evaluation of cannabinoids in the management of neuropathic pain, including HIV-associated neuropathy, should be undertaken. A few animal studies support this idea. Another potentially useful role for marijuana/Δ9-THC might be as an adjuvant when added to a regimen of standard analgesics.

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Exhibit Q

Robert Lee Hotz, Chemicals in Pot Cut Severe Pain, Study Says, Los Angeles Times, Oct. 27, 1997, at A1.

Adding new fuel to the controversy over medical uses of marijuana, researchers reported Sunday that active chemicals found in the plant could serve as an effective remedy for the millions who suffer serious pain each year, without the unwanted side effects of more traditional morphine-like drugs.

New animal studies by research groups at UC San Francisco, the University of Michigan and Brown University show that a group of potent chemicals known as cannabinoids, which include the active ingredient in marijuana, relieve several kinds of pain, including the kind of inflammation associated with arthritis, as well as more severe forms of chronic pain.

The scientists said they believe that the new research opens the way for a new class of drugs to control pain.

Marijuana's painkilling properties have long been an unheralded --and unconfirmed--staple of medical folklore. But now, sophisticated animal studies of the active biochemicals in marijuana, presented Sunday in New Orleans at a meeting of the Society for Neuroscience, for the first time demonstrate that they have a direct effect on pain signals in the central nervous system and other tissues.

Unlike the current crop of painkillers based on opiates, the new class of chemicals is not addictive, nor does it appear to carry the risk that patients may develop tolerance for it and require increasing doses, the new animal research indicates.

"Cannabinoids, at least in animal models, can reduce pain," said UCSF pharmacology expert Ian Meng, who is studying the painkilling properties of several synthetic cannabinoids.

To discover how these substances regulate pain, researchers traced the tortuous biochemical pathway that pain signals follow, from the site of an injury, through the spinal cord and to the brain. In their experiments, they used both the active ingredient in marijuana--a chemical called delta-9-THC--and an array of more powerful synthetic creations.

Scientists discovered that molecular receptors to which the chemicals can bind are so widely present that researchers at the Medical College of Virginia now suspect that naturally occurring cannabinoids may govern the body's basic threshold of pain.

Marijuana is the newest of nature's analgesic compounds to attract scientific attention. From aspirin and willow bark, to opium and poppy flowers, most modern painkillers are derived originally from plants.

Indeed, people have been writing about the painkilling properties of marijuana since the 1830s, and a century ago, patent medicines based on cannabis compounds were a staple of pharmacy shelves. As stringent drug control laws were adopted at the turn of the century, the folk remedies were abandoned.

Nonetheless, until recently, most evidence suggesting that marijuana could relieve pain was anecdotal, and serious research efforts have been clouded by the politics of drug control in California and other states that have passed measures legalizing the medical use of marijuana despite federal laws banning the plant.

"There is a long history of human use of cannabis to control pain; science has lagged behind for a lot of reasons," said psychologist J. Michael Walker at Brown University, who is investigating how synthetic cannabinoids block pain signals from reaching the brain.

"They stop pain before it ever enters the spinal cord," he said.

Working in animals, Kenneth Hargreaves at the University of Texas reported Sunday that the marijuana-like chemical can relieve the inflammation associated with arthritis when injected directly at the site of an injury. And Donald Simone at the University of Minnesota reported that the chemicals also can block the onset of an extreme sensitivity to pain called hyperalgesia, which flares up during nerve diseases and spinal cord injuries.

"These results suggest that local administration of the cannabinoid to the site of injury may be able to both prevent pain from occurring and reduce pain which has already occurred without producing side effects," Hargreaves said.

A number of neuroscientists said Sunday that marijuana's newly confirmed utility as a painkiller would inevitably broaden the drug's appeal beyond those seriously ill patients who seek it out today to stimulate appetites destroyed by wasting diseases like AIDS or to alleviate the nausea of chemotherapy.

"People who have serious illnesses will take the steps they feel they have to take; certainly the new research you are hearing about here would lead people in that direction," Walker said.

That, in turn, may spur broader federal support for research into marijuana's analgesic effects, scientists said Sunday. Over the long run, however, they believe that their work will result not in a new generation of pot smokers, but in a range of new pills, topical ointments and injectable

pain-control drugs based on the natural chemistry of marijuana.

"If you have pain, we certainly don't suggest you drink willow bark tea, although willow bark certainly has the natural products that would inhibit it by having aspirin-like effects," Hargreaves said. "Instead we suggest that you turn to your drugstore where you can get the more synthetic and more potent agents to produce the effect.

"And I think the same thing would be true here," he said, "that if we could fund more research in this area, we would have a greater opportunity to take drugs that are more selective and more potent."

Exhibit R

William S. Eidelman, M.D.
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Oct 25, 1997

Patient: Todd McCormick
Date of Birth: 10/7/70

Patient Summary

Todd McCormick is a 27 year old man with a well-documented complex medical history which dates back to when he was 18 months old. At that time, Todd was diagnosed with histiocytosis x, a type of cancer. This was treated with surgery and chemotherapy.

This cancer recurred at age 3, age 4, age 5,age 6, age 7, age 8, age 9, age 10, age 12 and age 15. Each time he was treated with surgery and either radiation or chemotherapy. He has experienced many of the typical side effects associated with these types of therapies.

His chief problem in the past fifteen years has been pain as a result of the multiple surgeries, particularly spinal fusions. When the pain first began, he was treated with narcotic pain medications, which caused a variety of side effects. He also was required to take larger and larger doses in order to obtain relief from the pain.

He suffers from pain in the neck region, the upper back, the lower back, and the hips. He also suffers from fear of recurrence of the cancer. He can't sleep, as he wakes up throughout the night with neck pain. His appetite is decreased secondary to fatigue from lack of sleep. He is depressed.

His primary way of dealing successfully with the pain has been to smoke marijuana. He began smoking marijuana at age twelve. At age fifteen, he was forced to desist smoking it, following which he had another recurrence of the cancer.

He received a prescription for medical marijuana from Dr. R.T. Trossel of Rotterdam, Holland, on 7/31/95, and a letter from John P. Morgan, M.D., of CUNY Medical School supporting his use of medical marijuana.

Physical examination reveals a young man with multiple surgical scars. He is tender to palpation in the cervical region and in the lower back. He has diminished range of motion of the neck and head and of the legs. These movements all cause pain.

Diagnosis: Status/Post Recurrent Histiocytosis X
Chronic pain secondary to surgeries
Depression secondary to pain

Prognosis: Poor for relief of his pain
Guarded as to recurrence of cancer

Plan: Given the fact that narcotic medications have been decreasingly effective over the years, and that Todd is in such severe pain, and that marijuana provides the only relief of the pain, it seems rational for him to use marijuana under the guidance of a physician, in line with the California-Compassionate Use Act.

William S. Eidelman, M.D.

R-135

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August 18, 1995

Judge Anthony L. Gretick
Williams County
Court of Common Pleas
Bryan, Ohio

Dear Judge Gretick:

I am a physician licensed in New York State. I am certified by the American Board of Internal Medicine and currently am a Professor of Pharmacology at the City of New York Medical School and Adjunct Professor of Pharmacology and Medicine at the Mt. Sinai School of Medicine in New York City. I have long been interested in the clinical pharmacology of marijuana and the potential application of marijuana as a Medicinal Agent.

I am familiar with the case of Todd McCormick and actually met him briefly during a "Medical Marijuana Day" in Washington, D.C. last year. I have recently read two letters from R.T.M.K. Troosel M.D., a Dutch physician who prescribed marijuana to treat Todd's cervical pain and muscle spasms. This chronic pain is secondary to the unusual neoplasm, histiocytosis X. This illness, which was diagnosed in Todd at age 2, has provoked multiple chemotherapeutic, radiotherapeutic, and surgical interventions. The chronic neck pain and muscle spasm relates to bone deformities in the neck and skull secondary to the primary illness and surgical treatment.

Todd's use of marijuana as a treatment for pain and muscle spasm was certified by a prescription for marijuana, to be filled in a Rotterdam pharmacy. Not only do I agree that this treatment by Dr. Troosel is medically correct, but Todd's employment of this medicine in the United States is almost certainly legal. The FDA permits use by American citizen of drug products approved abroad and not here, under a compassionate-exemption rule. I spoke to a FDA official today who confirmed this policy in broad terms.

I support Mr. McCormick's use of marijuana under prescription by Dr. Troosel and think it to be entirely medically appropriate.

Sincerely,

John P. Morgan

John P. Morgan, M.D.
Professor of Pharmacology

Harvard Medical School
Department of Psychiatry

Massachusetts Mental Health Center
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August 18, 1998

Judge Anthony L. Gretick
Williams County Court of Common Pleas
Bryan, Ohio 43506

Re: Todd McCormick

Dear Judge Gretick:

I am a physician who has been studying cannabis since 1967. I have been particularly interested in the medicinal utilities of cannabis and two years ago co-authored a book on the subject (Lester Grinspoon and James B. Bakalar: Marihuana, the Forbidden Medicine, Yale University Press, 1993). (See enclosed article from the Journal of the American Medical Association and my curriculum vitae.)

I met Todd McCormick this past March and had an opportunity to review his medical use of cannabis for the relief of the symptoms secondary to his cervical lesions (and fusion). He suffers from the chronic pain and muscle spasm which so often accompany damage to nerves and muscles. These patients suffer chronic, unremitting pain for which they are usually prescribed one or more of three classes of drugs: (1) synthetic opiates, to which they often develop tolerance to or dependence on (addiction); (2) non-steroidal anti-inflammatories (NSAIDs), which over the long haul invariably lead to gastrointestinal problems and often to liver toxicity; or (3) acetaminophen (Tylenol), which, according to a recent study published in the New England Journal of Medicine, leads to End Stage Renal Disease (ESRD) in an alarming proportion of people who must regularly take this drug for pain relief.

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I have seen a number of patients who suffer from this kind of pain and believe that by far the best approach to this particular pain is cannabis. It is safer and more effective than the above-mentioned three classes of drugs.

When I met Todd McCormick I reviewed the treatment of his pain with him. I shared with him the belief that this was the most effective approach. I completely agree with Dr. Tressél's assessment; if Todd McCormick were my patient and it were legally possible for me to write a prescription for cannabis for the relief of his pain, I would not hesitate to do so.

I hope this letter is helpful to you. If I can answer any questions, please don't hesitate to call (417-235-1368).

Sincerely yours,

Lester Grinspoon

Lester Grinspoon, M.D.

LG/pa

Enclosures

Tod H. Mikuriya, M.D.
Claremont Hotel
41 Tunnel Road
Berkeley, CA 94705-2429
510-843-1188 Fax 843-5187

To: Don Wirtshafter, Attorney
John Shaeffer, Attorney

re: Todd P. McCormick DOB 10-7-70

I have personally interviewed the above-captioned individual who suffers from a rare auto immune illness, Histiocytosis X. He described significant relief from cannabis which he self-administers through the smoked route.

Cannabis, while little utilized by the smoked route, was routinely prescribed for certain types of pain and muscle spasm for a hundred years before being improperly removed from prescriptive availability in 1937 by the Marihuana Tax Act. It is my clinical opinion that Mr. McCormick has independently "rediscovered" the medicinal utility of cannabis for himself personally despite widespread ignorance among the medical profession secondary to a "disuse atrophy" of knowledge that sadly exists today.

In my personal detailed interviews of 57 members of the Cannabis Buyers' Club in San Francisco a significant number were medicating themselves for similar symptoms.

It is my clinical opinion that Mr. McCormick is using a medication consistent with what is known about the medicinal properties of cannabis based upon scientific fact. I am in agreement with the Dutch physician who prescribed him the drug.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Tod H. Mikuriya, M.D.

Tod H. Mikuriya, M.D. *Biographical Data*

A graduate of Reed College and Temple University Medical School, Philadelphia, he served a rotating internship at Southern Pacific General Hospital, San Francisco. He specialized in psychiatry at the Oregon State Hospital in Salem and completed his training at Mendocino State Hospital. His status is "eligible" by the American Board of Psychiatry and Neurology.

In private practice in Berkeley and the east bay, he was an attending psychiatrist at Gladman Hospital from 1970 until 1991. He was 1993-4 chair of the Department of Psychiatry, Eden Medical Center, Castro Valley, and attending psychiatrist at Vencor, Fairmont, and San Leandro Hospitals.

He is former director of marijuana research for the National Institute of Mental Health Center for Narcotics and Drug Abuse Studies.

A planner for Project Eden community drug abuse treatment program he set up the first methadone maintenance program in Alameda County.

Member of the California Medical Association, American Psychiatric Association, American Society of Addiction Medicine (Certified Medical Review Officer), California Society of Addiction Medicine (Certified) and the Alameda-Contra Costa Medical Association, he serves on the ACCMA Chemical Addictions Committee.

Mikuriya is the editor and publisher of Marijuana Medical Papers 1839-1972 and numerous papers on therapeutic cannabis and drug control policy. He is the editor of Indian Hemp Drugs Commission Centennial Commemorative Volume 1994.

17 August, 1995

PMC
3012 HR ROTTERDAM
JOOST BANCKERTSPLAATS 24-26
TEL: 010-414 39 32 FAX 010-414 78 87

Rotterdam, 31-07-1995

Second medical statement by R.T.H.K. Trossël

Mr.Todd P. McCormick, date of birth October 7th, 1970, address 1556 Thomas Avenue, San Diego, has been treated by us as a severe cancer case from December 13th, 1994 onward. His condition has resulted in many cancer operations including spinal and cervical scul-lessions. On top of this he has been treated with severe chemotherapy and radiotherapy.

Treatment consisted of orthomolecular foodsupplements and diet advice, Vitamin B12 injections and melatonin before sleeping. He also uses Cannabis sativa on my prescription and delivered by the pharmacy in Rotterdam as the only effective musclerelaxant and painreliever. Although we realise it is not commonly prescribed as a herbal medicin, we do see that this is the only drug having an effective result on his present condition. Therefore I am willing to extend his prescription of 10 grams medical Cannabis sativa for 6 weeks, eventually extended to 12 week periods.

I hope this will make it possible through international law and also the FDA ruling on personal use of foreign prescribed drugs to continue his therapy which he needs very urgently.If any futher questions are of need, please do not hesitate to contact me at my office in Rotterdam.

Sincerely,

R.T.H.K. Trossël, M.D

A4 to A4

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PMC

3012 HB ROTTERDAM
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TEL: 010 - 414 76 33, FAX: 010 - 414 76 80

Fax nr: 4195827330 (office)

Fax nr: 419428282119

MEDICAL STATEMENT

Rotterdam, 19-7-1995

Mr. Todd P. Mc. Cormick, born: 07-10-1970 uses Marihuana on my prescription to relieve his severe pain caused by cancer (therapy). Other painmedication isn't sufficient to relieve the pain. He needs 10 grams Marihuana per day for an acceptable effect.

R.T.H.K. Trossël, M.D.

R.T.H.K. TROSSËL, arts
Lid A.B.N.G.
Preventief-Medisch Centrum
Joost Banckertplaats 24-28
3012 HB Rotterdam
Tel. 010 - 414 76 33
Consult volgens afspraak

13.12.94
datum

Rp/ Medical grade marijuana
- dtel. 300 grams.
S/ 10 gr max/dag.

Todd Patrick McCormick
1666 Thomas Avenue
San Diego Cal USA

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