

1-2-2014

The Other Green Movement: How D.C. Can Sensibly Regulate Medical Marijuana & Why It Matters

Jacob; Rahavi

Robert Ziff

Follow this and additional works at: <http://digitalcommons.wcl.american.edu/hlp>

 Part of the [Health Law Commons](#)

Recommended Citation

Rahavi, Jacob, and Robert Ziff. "The Other Green Movement: How D.C. Can Sensibly Regulate Medical Marijuana & Why It Matters." *Health Law & Policy Brief* 4, no. 1 (2010): 16-19.

This Article is brought to you for free and open access by Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in *Health Law and Policy Brief* by an authorized administrator of Digital Commons @ American University Washington College of Law. For more information, please contact fbrown@wcl.american.edu.

THE OTHER GREEN MOVEMENT: HOW D.C. CAN SENSIBLY REGULATE MEDICAL MARIJUANA & WHY IT MATTERS

Jacob Rahavi* and Robert Ziff†

After years of obstructing home rule in the District of Columbia, the federal government has reversed course on the issue of medical marijuana. First, the Department of Justice released a memorandum advising U.S. Attorneys to avoid prosecuting “individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.”¹ Then, in a critical step, the U.S. Congress repealed the Barr Amendment, which had prevented the District from enacting the Legalization of Marijuana for Medical Treatment Initiative of 1998 (“the Act”). Accordingly, the District of Columbia government (“the District”) must now create a regulatory scheme for the proper cultivation, sale, and distribution of marijuana for medical purposes. To succeed in its task, the District must strike a delicate balance between the patient’s right to access and the threat of abuse. This will require a series of controls designed to prevent non-medical use while ensuring reasonable access for suffering patients.

Regulation of Medical Marijuana in the Fifty States

Doctors have long recognized the medicinal value of marijuana in treating the symptoms of chronic diseases.² While it cannot cure anything, proper marijuana use is considered an effective treatment for, *inter alia*, the nausea, weight loss, and severe pain suffered by many cancer and HIV/AIDS patients. It also appears to mitigate the severe pain and discomfort related to other chronic ailments. Considering the District has the highest per capita rate of HIV/AIDS in the nation,³ it should come as no surprise that 69% of D.C. residents passed the Act by voter initiative in 1998.⁴

The Act grants seriously ill individuals the right to consume marijuana for medical purposes when recommended by a licensed physician.⁵ To facilitate the creation of a legal supply, it also permits D.C. residents

to organize and operate nonprofit corporations for the purpose of cultivating and distributing marijuana to qualified patients.⁶ The District must now create the necessary framework to license and regulate these dispensaries. Though the District may do so in accordance with its existing authority to regulate controlled substances,⁷ recent legislative activity suggests that the D.C. Council intends to amend the Act in order to create a more robust regulatory framework.⁸ Fortunately, D.C. is not the first actor in this arena. It follows a torrent of activity within the states, many of whom have already relaxed the prohibition on use and distribution of marijuana for qualified medical purposes. According to the Marijuana Policy Project, no less than thirty-six states have enacted “favorable” medical marijuana laws in the last thirty years.⁹ While many of these laws are symbolic or ineffectual, fifteen states provide patients with real protections for medical use,¹⁰ and a handful of states have affirmatively regulated the cultivation and distribution of medical marijuana by third parties.¹¹

Marijuana has long been classified as a Schedule I narcotic by act of Congress. This precludes reclassification to a lower schedule except by subsequent act of Congress. Such classification prevents any distribution as a prescription drug through conventional pharmacies.¹² So the states that are home to organized cultivation and distribution efforts — California, Colorado, Maine, Michigan, New Jersey, New Mexico, Oregon, and Rhode Island — permit the formation of marijuana dispensaries for patients who have a doctor’s recommendation. As each state’s regulatory framework is unique, each has addressed the balance between patient need and narcotic control with varying degrees of success. For instance, the law in both Colorado and Michigan does *not* expressly allow for the operation of dispensaries. Yet new for-profit dispensaries are rapidly emerging in both states anyway. Rather than address the issue directly, each state has effectively ignored it.¹³ Meanwhile in California, state law permits the establishment of collectives and cooperatives, but regulation of these establishments is relegated to local governments.¹⁴ Attitudes toward marijuana vary widely throughout California, which has led to varying

* Jacob Rahavi is an attorney licensed in Washington, D.C. and Maryland. He can be reached at JacobRahavi@gmail.com.

† Robert Ziff is an attorney licensed in New York and Washington, D.C. He is currently studying for his Master of Laws (LLM) at the London School of Economics. He can be reached at Robert.Ziff@gmail.com.

interpretation of the governing law, confusion among dispensary operators and law enforcement alike, and a heated ongoing debate.¹⁵ Consequently, a patchwork of varying and ineffective practices — the blind-eye approach in Michigan/Colorado and the local approach in California — have created unnecessary and potentially consequential ambiguities.

On the opposite end of the spectrum, New Jersey and Rhode Island are currently implementing the most conservative plans for the establishment of dispensaries. Prospective applicants in Rhode Island are required to establish a number of qualifying factors (capability to run a nonprofit, capability to provide the necessary amount of marijuana, existence of a secure facility, *et cetera*) before winning one of a limited number of licenses.¹⁶ In New Jersey, dispensary applicants must undergo extensive background checks and are subject to strict monitoring and regulation by the government.¹⁷ The current proposal before the D.C. City Council — the Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010 (the “Amendment”)¹⁸ — falls within the more restrictive end of the spectrum.

A Proposal for Effective and Manageable Regulation in the District

While the Justice Department has reversed policy and stated that it will not prosecute individuals who comply with state law, the current environment in some states leaves open the possibility of criminal sanctions. In states where no clear regulatory framework exists, who can say what “unambiguous compliance” actually is? Contemporaneously, the lack of a robust regulatory framework raises the real possibility of abuse. While the level of abuse is currently unknown, such allegations have already spurred moratoriums on new dispensaries in some local communities in California, Colorado, and Michigan.¹⁹ Thus, the District would be wise to create a regulatory system that is both pointed and well defined without being overly burdensome to legitimate distributors and patients. A clearly defined set of regulations would allow dispensaries to follow the law and avoid severe federal penalties. Meanwhile, a serious attempt at regulation with emphasis on verifiability would minimize the real potential for abuse of the system. In this manner, the District can properly balance patients’ need for access with its desire for autonomy and security.

The Act, which was passed by the voters in 1998, was among the first wave of medical marijuana laws. Consequently, it lacks the benefits of the previous decade’s experience; and significant issues related to record keeping, verification, and security go largely

unaddressed. For that reason, the District should focus on filling these regulatory gaps in order to meet contemporary standards. Otherwise, the District risks further congressional interference²⁰ or criminal sanctions against its residents by the Department of Justice.²¹ As at least one council member has noted, “The more professional and controlled and evidence-based our system is, the greater likelihood it will be sustained going forward.”²²

A. Verification of Doctor Recommendations

The most effective way to balance patient need for access against the need for controlled distribution is the creation of a government-run registration system with identification cards for qualified patients. Although it is not called for in the Act, nearly every state with an effective medical marijuana regime maintains such a registry and the District would be wise to follow suit.²³ Indeed, the proposed Amendment would create just such a registry.²⁴ Identification cards benefit all interested parties by providing verifiable evidence of lawful possession. Specifically, they protect patients from unlawful arrest and serve as reliable evidence of the right to purchase from dispensaries.

The Act, in its current form, permits oral recommendations from physicians.²⁵ California is the sole state that permits this practice.²⁶ The inherent difficulty of verifying oral recommendations presents a substantial challenge for the District and may ultimately draw the ire of Congress. Perhaps for this reason, the proposed Amendment would require that all recommendations be written.²⁷ Since patients are already required to obtain a physician’s recommendation, obtaining it in written form should not be overly burdensome.

Implementation of the Act will necessitate the accumulation of records and patient privacy is a legitimate concern; and not everyone wants to be on a government sponsored list of marijuana users. This is especially true in a city full of federal government employees. For that reason, all patient records should be treated in the strictest of confidences. The database should be securely managed and access should be restricted to the limited number of persons who are expressly tasked with managing it. In this manner, the current Amendment is perhaps most deficient. It makes no reference to the confidential treatment of patient records.

B. Presumptive Quantity Restrictions

All medical marijuana states limit the quantity of usable marijuana and/or the number of plants that qualified patients may lawfully possess.²⁸ Knowing

Implementation of the Act will necessitate the accumulation of records and patient privacy is a legitimate concern; and not everyone wants to be on a government sponsored list of marijuana users.

“To ensure the sustainability of D.C.’s medical marijuana laws, the District should amend the Act to include authority to collect fees, so dispensaries will bear the burden of their own regulation.”

both the number of patients and presumptive per patient quantities enables regulators and suppliers to limit the amount of marijuana produced without causing supply interruptions. Here in D.C., the Act requires that “patients have access to a *sufficient quantity* of marijuana to assure that they can maintain their medical supply without any interruption.”²⁹ As such, the Act appears to permit reasonable restrictions on quantity. Other states to address this issue have implemented regulations that generally include presumptive caps on per patient quantities.³⁰ A typical presumptive limit is around two ounces and a handful of plants per patient. Similar regulations should be adopted by the District and incorporated into the registration process. The Amendment, if passed, would expressly create quantity restrictions.³¹ Where patients have a medical need for higher quantities — a situation that sometimes occurs where patients can only eat the medicine — their registration card should so indicate.

C. Dispensary Licensing Scheme

The District should also create a licensing scheme for dispensaries that is designed to provide an uninterrupted supply for patients while protecting the safety of the community. An effective licensing scheme would allow the District to mandate compliance with sound policies and conduct reasonable inspections and enforcement proceedings, administered by the D.C. Department of Health. Thus, dispensaries would be regulated in much the same way as pharmacies.

A number of sound regulations seem appropriate. Among other things, proper dispensary regulations in D.C. might address the character of board members and employees. For example, Rhode Island prohibits felons (with limited exception) from serving in any capacity at a dispensary.³² Also, a firewall should be created between dispensaries and recommending physicians in order to avoid any conflict of interest that may raise the suspicion of federal investigators. And dispensaries should maintain accessible audit-friendly records on inventories, sales, personnel, policies, and financial transactions. These records will assist the District’s regulatory efforts and demonstrate a dispensary’s strict adherence to local laws. Accordingly, dispensaries should expect to retain compliance counsel to ensure sufficient training of staff and record keeping, and to assess the appropriateness of internal policies and course corrections.

Dispensaries should also comply with a variety of reasonable restrictions directed toward the safety, security, and general well being of the community. These may include limited hours of operation, plenty

of outdoor lighting, and professional on-site security guards. Most importantly, all facilities should be monitored, securely constructed, and inaccessible to unauthorized persons.

The District may seek to prevent dispensaries from opening within certain proximity to schools. The proposed Amendment, for example, would prevent dispensaries from opening anywhere within 1000 feet of schools and youth centers.³³ However, the District should proceed cautiously. Due to, *inter alia*, the proliferation of charter schools, D.C. is bursting with school facilities. Consequently, businesses seeking alcohol distribution licenses in D.C. have already found it difficult to comply with similar restrictions. Overly regulating the location of dispensaries may relegate them to the outskirts of the city where they will be inaccessible to many patients. If the District’s aim is to prevent marijuana from being unintentionally marketed to minors, it could achieve a superior result through reasonable restrictions on signage and other advertising.

D. Funding of Regulatory Efforts

Administering D.C.’s medical marijuana regime will require funding to cover costs associated with licensing, inspections, and enforcement actions. However, the citizen drafted Act specifically exempts nonprofit dispensaries from paying sales taxes, use taxes, income taxes, and other local taxes. In addition, it makes no mention of fees specifically associated with dispensary regulations. To ensure the sustainability of D.C.’s medical marijuana laws, the District should amend the Act to include authority to collect fees, so dispensaries will bear the burden of their own regulation. The proposed Amendment addresses this issue by implementing a licensing fee for dispensaries and a sliding-scale registration fee for patients.³⁴ This seems wise so long as fees are kept at a reasonable level. Excessive fees may impact the ability of patients to purchase marijuana at a reasonable price.

Conclusion

Medical marijuana is an evolving area of law that has withstood fits and starts over the last decade. Due to the District of Columbia’s role as our nation’s seat of power, implementation of the Act may be its greatest challenge yet. But despite various arguments against implementation, nothing prevents the District from succeeding. After all, pharmacies have been filling prescriptions for dangerous and addictive substances without controversy for decades. Under the Act, marijuana would be just another medication in the physician’s toolbox. When effectively employed, it relieves some of the severe pain and suffering of the

chronically ill. Unlike the fifty states, however, D.C. remains subject to congressional oversight and control. Consequently, more permissive societal norms that exist in some states are unworkable in D.C.; and an overly lax and easily abused regulatory regime may persuade Congress to repeal the Act altogether. But if physicians, patients, and dispensaries work together in good faith with the District, there is no doubt that a sensible policy is attainable.

¹ Memorandum from David W. Ogden, Deputy Attorney General, to Selected United States Attorneys (Oct. 19, 2009), *available at* <http://www.justice.gov/opa/documents/medical-marijuana.pdf>.

² Report 3 from American Medical Association Council on Science and Public Health (1-09), *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/443/csaph-rep3-a09.pdf>.

³ Dept. of Health and Human Services HIV/AIDS Surveillance Report Vol. 19, Table 16, *available at* www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf.

⁴ District of Columbia November 3, 1998 Election Results on Initiative Measure #59, *available at* www.dcboee.org/election_info/election_results/elec_1998/ini59_98.htm.

⁵ Legalization of Marijuana for Medical Treatment Initiative of 1998 § 1. *Id.* at § 7.

⁶ D.C. CODE § 48-903.01 *et. seq.* (2010).

⁷ District of Columbia Legalization of Marijuana for Medical Treatment Initiative Temporary Amendment Act of 2010, B18-0663 (Delaying the implementation of the Act until the effective date of the Amendment.); District of Columbia Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, B18-0622. This article was submitted for publication while B18-0622 was under consideration by the D.C. City Council. Subsequent amendments to the bill are likely. *See* Martin Austermuhle, *Changes to Medical Marijuana Legislation Likely Next Week*, DCIST, Mar. 24, 2010, *available at* http://mobile.dcist.com/2010/03/changes_to_legislation_that_would.php.

⁸ Marijuana Policy Project, *State by State Medical Marijuana Laws: How to Remove the Threat of Arrest*, 2 (2008) *available at* www.mpp.org/legislation/state-by-state-medical-marijuana-laws.html.

⁹ *See, e.g.*, AK, CA, CO, HI, MA, MD, MI, MT, NJ, NM, NV, OR, RI, VT, and WA.

¹⁰ *See, e.g.*, CA, MA, NJ, NM, OR, and RI.

¹¹ 21 U.S.C. § 812(b).

¹² Colorado Department of Public Health and the Environment statement on Medical Marijuana Registry, *available at* www.cdphe.state.co.us/hs/Medicalmarijuana/Dispensaries%202.pdf; Michigan Department of Community Health, Frequently Asked Questions on Medical Marijuana Program, *available at* www.michigan.gov/mdch/0,1607,7-132-27417_51869_52140_---,00.html.

¹³ CAL. HEALTH & SAF. CODE, § 11362.775 (2010).

¹⁴ John Hoeffel, *Confusion About Marijuana Sales Traced to California Law*, LOS ANGELES TIMES, Jan. 6, 2010.

¹⁵ Office of Health Professionals Regulation, Medical Marijuana Program, *available at* www.health.ri.gov/hst/mmp/index.php.

¹⁶ New Jersey Compassionate Use Medical Marijuana Act, § 7 (2010).

¹⁷ District of Columbia Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, B18-0622.

¹⁸ *See, e.g.*, Genevieve Bookwalter, *Pot dispensary moratorium approved in Santa Cruz*, Santa Cruz Sentinel.

¹⁹ D.C. CODE § 1-206.01.

²⁰ *See* 21 USC § 841.

²¹ Sam Jewler, *Medical Marijuana Finally Heads for D.C.*, TIME, Jan. 27, 2010, *available at* www.time.com/time/nation/article/0,8599,1956673,00.html?iid=tsmodule.

²² *See* AK, CA, CO, HI, MA, MI, MT, NM, NV, OR, RI, and VT.

²³ B18-0622, Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 10, D.C. Council (D.C. 2010).

²⁴ The Act, § 5(a).

²⁵ CAL. HEALTH & SAF. CODE, § 11362.5(d).

²⁶ District of Columbia Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 2, R18-0622.

²⁷ *See* AK, CA, CO, HI, MA, MI, MT, NM, NV, OR, RI, VT, and WA.

²⁸ Legalization of Marijuana for Medical Treatment Initiative of 1998, § 5(a) (emphasis added).

²⁹ *See, e.g.*, MICH. COMP. LAWS §§ 333.26421–333.26430 (2008) (noting that Michigan, permits individual patients to have up to 2.5 ounces of usable marijuana and up to twelve plants in an enclosed and locked facility).

³⁰ District of Columbia Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 10, B18-0622.

³¹ The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, § 21-28.6-12(i)(4) (Rhode Island, 2006).

³² District of Columbia Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 10, B18-0622.

³³ *Id.*