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Medical Marijuana: An Overview of Select Resources

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Medical Marijuana: An Overview of Select Resources

THERESE A. CLARKE ARADO AND ANNIE MENTKOWSKI*

The following annotated bibliography provides information in a number of areas. The state laws related to legalizing medical marijuana in effect as of January 2015 are summarized. In addition to the statute summaries, annotations of select articles are provided. The greatest portion of materials annotated involves federalism discussions and employment related issues. Also included, but to a much lesser extent are family law, transportation, and attorney ethics. Additionally, a few articles on state regulatory power and other topics are included. As this bibliography was being created, the U.S. House of Representatives and Senate introduced legislation to reclassify marijuana within the Controlled Substances Act. Those bills are referenced in a section of the bibliography. At the end of the document there are lists of recent newspaper coverage of the medical marijuana laws and debates in the United States. The creators of this bibliography did not attempt to cover the breadth of information available on this topic. These resources are meant to provide a broad picture of the medical marijuana discussion at this time, along with some history of the topic. There is significantly more literature available on medical marijuana and the various legal issues surrounding it. However, this bibliography will give researchers a good start on compiling relevant materials for further study.

STATUTES	462
THE UNITED STATES SUPREME COURT AND MEDICAL MARIJUANA USE UNDER THE CONTROLLED SUBSTANCES ACT	481
RECENT CONGRESSIONAL ACTIONS	481
ARTICLES	482
STATE REGULATORY ACTIONS	499
MISCELLANEOUS.....	501
NEWSPAPER COVERAGE	505

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STATUTES

In this section a summary of all states currently with medical marijuana laws is provided. Illinois is listed first as the focus of the symposium is the newly enacted medical marijuana law in Illinois.

ILLINOIS

The Compassionate Use of Medical Cannabis Pilot Program Act, 410 ILL. COMP. STAT. ANN. 130/1-130/199 (West, Westlaw through P.A. 98-1125 of the 2014 Reg. Sess.).

Under the statute, a four-year pilot program has been established where a registered qualifying patient may possess and use medical marijuana. A qualifying patient is a person who has been diagnosed by a physician as having a debilitating medical condition, and has obtained a written certification from his/her physician, and has followed all the procedures to become registered with the Department of Public Health.

Possession: 2½ ounces

Homegrown: Prohibited

Dispensaries: Yes

Illnesses: Cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's disease, cachexia, muscular dystrophy, severe fibromyalgia, spinal cord disease, including but not limited to arachnoiditis, Tarlov cysts, hydromyelia, syringomyelia, rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post-concussion syndrome, multiple sclerosis, Arnold-Chiari malformation, spinocerebellar ataxia (SCA), Parkinson's, Tourette's, myoclonus, dystonia, reflex sympathetic dystrophy, RSD (complex regional pain syndromes type I), causalgia, CRPS (complex regional pain syndromes type II), neurofibromatosis, chronic inflammatory demyelinating polyneuropathy, Sjogren's syndrome, lupus, interstitial cystitis, myasthenia gravis, hydrocephalus, nail-patella syndrome, residual limb pain, or the treatment of these conditions or any other debilitating medical condition or its treatment that is added by the Department of Public Health.

Caregivers: Must be at least twenty-one years of age, agree to assist with a patient's medical use of marijuana, not convicted of an excluded offense, and may not assist more than one registered qualifying patient at a time.

Agency Website:

<http://www2.illinois.gov/gov/mcpp/Pages/default.aspx>

ALASKA

Medical Uses of Marijuana for Persons Suffering from Debilitating Medical Conditions Act, ALASKA STAT. §§ 17.37.010-17.37.080 (West, Westlaw through Ch. 116 (End) of the 2014 2d Reg. Sess.).

Under the statute, patients who possess a Registry Identification Card for Medical Use of Marijuana may use, possess, and cultivate marijuana for personal use. The Registry is maintained by the Department of Health and Social Services. To be eligible for a card, patients must be placed on the Registry. This requires a signed statement from the patient's physician stating that the patient has been diagnosed with a debilitating medical condition and that "the physician has concluded that the patient might benefit from the medical use of marijuana."

Possession: One ounce of usable marijuana.

Homegrown: Six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time.

Dispensaries: No

Illnesses: Cancer, glaucoma, HIV/AIDS, cachexia, severe pain, severe nausea, seizures, epilepsy, multiple sclerosis, or any other condition approved by the Department.

Caregivers: Must be at least twenty-one years old, have no felony convictions for offenses related to controlled substances, and he/she must be listed by the patient as either the primary caregiver or an alternate caregiver.

Agency Website:

<http://dhss.alaska.gov/dph/VitalStats/Pages/marijuana.aspx>

ARIZONA

Arizona Medical Marijuana Act, ARIZ. REV. STAT. ANN. §§ 36-2801 to -2819 (West, Westlaw through the Second Regular and Second Special Sessions of the Fifty-First Legislature).

Under the statute, a qualifying patient and a designated caretaker may possess or cultivate the requisite amount of marijuana so long as they have properly joined the Arizona Department of Health Services registry. To be considered a qualifying patient, a person must obtain a written diagnosis for a debilitating medical condition from his/her physician. In addition, the law also recognizes "visiting qualifying patient[s]." These are people with valid medical recommendations from other medical marijuana states. However,

the statute does not permit the cultivation of marijuana within twenty-five miles of a state-licensed dispensary.

Possession: 2 ½ ounces of usable marijuana.

Homegrown: Twelve marijuana plants contained in an enclosed, locked facility.

Dispensaries: No

Illnesses: Cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's Disease, Alzheimer's Disease, chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, severe and persistent muscle spasms, including those characteristic of multiple sclerosis, and any other medical condition or its treatment added by the Department.

Caregivers: Must be at least twenty-one years old, have agreed to assist with patient's use, have no excluded felony offense convictions, and assists five or less qualifying patients.

Agency Website: <http://azdhs.gov/preparedness/medical-marijuana/>

CALIFORNIA

Medical Marijuana Program, CAL. HEALTH & SAFETY CODE §§ 11362.7-1136.9 (West, Westlaw through Current with urgency legislation through Ch. 931 of 2014 Reg. Sess.).

Under the statute, eligible patients may possess and cultivate marijuana. Eligible patients are seriously ill Californians whose physicians have deemed marijuana to be an appropriate treatment. To be eligible, patients must present their physicians' written or oral recommendation. In addition, California's Department of Public Health administers a registry, but it is voluntary.

Possession: Eight ounces (or more if doctor recommended).

Homegrown: Six mature plants or twelve immature plants.

Dispensaries: Yes

Illnesses: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis, seizures (including seizures associated with epilepsy), severe nausea, and any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activity as defined in the Americans with Disabilities Act of 1990, or if not stopped may cause serious harm to the patient's safety or physical or mental health.

Caregivers: At least eighteen-years old (unless the primary caregiver is the parent of a minor who is a qualified patient or a person with an identi-

fication card, or is a person otherwise entitled to make medical decisions under state law), designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person.

Agency Website:

<http://www.cdph.ca.gov/programs/mmp/pages/default.aspx>

COLORADO

Medical use of marijuana by persons diagnosed with debilitating medical conditions—unlawful acts—penalty—medical marijuana program cash fund, COLO. REV. STAT. ANN. § 18 to 18-406.3 (West, Westlaw through the Second Reg. Sess. of the Sixty-Ninth Gen. Assemb.).

COLO. CONST. art. XVIII, § 14.

Under Article XVIII and the statute, any patient or primary caregiver in lawful possession of a registry identification card may engage in or assist in the medical use of marijuana. To obtain a registry identification card a patient must reside in Colorado and complete the application process. Patients who do not join the registry and are arrested for possession or cultivation of marijuana may argue an “affirmative defense . . . [of] medical necessity.”

Possession: Two ounces of usable marijuana.

Homegrown: Six plants.

Dispensaries: Yes

Illnesses: Cancer, glaucoma, HIV/AIDS, cachexia, persistent muscle spasms, seizures, severe nausea, and severe pain.

Caregivers: Must be at least eighteen-years old, must not be the patient or the patient’s physician, must have significant responsibility for managing the well-being of a patient who has a debilitating medical condition, and must not have a primary caregiver of his/her own. May register with the Voluntary Caregivers Registry.

Agency Website:

<https://www.colorado.gov/pacific/cdphe/medicalmarijuana>

CONNECTICUT

Palliative Use of Marijuana, CONN. GEN. STAT. ANN. §§21a-408 to 21a-408q (West, Westlaw through the 2014 Feb. Reg. Sess.).

Under the statute, a patient must obtain written certification from his/her physician and register with the Department of Consumer Protection. To be a qualifying patient, he/she must be at least eighteen-years old, a resident of Connecticut, and be diagnosed by a physician as having a debilitating medical condition. This does not include inmates at correctional institutions.

Possession: The combined amount of marijuana possessed by the qualifying patient and the caregiver may not exceed an amount of usable marijuana reasonably necessary to ensure uninterrupted availability for one month. This amount is determined by the Department of Consumer Protection.

Homegrown: Prohibited

Dispensaries: Yes

Illnesses: Cancer, glaucoma, AIDS/HIV, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable, spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, post-traumatic stress disorder, any medical condition, medical treatment or disease approved by the Department of Consumer Protection.

Caregivers: Must be eighteen years old and have agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the palliative use of marijuana.

Agency Website:

http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=503670&dcpNav=|&dcpNav_GID=2109

DELAWARE

The Delaware Medical Marijuana Act, DEL. CODE ANN. tit. 16, §§ 4901a-4926a (West, Westlaw through 79 laws 2014).

Under the statute, medical use of marijuana is permitted with a doctor's recommendation. Qualifying patients must be eighteen years old and they must send their doctor's written documentation to the state Department of Health and Social Services. The department will then issue a mandatory I.D. card. The statute also recognizes qualifying patients from other states. Qualifying patients who do not have an I.D. card may raise an affirmative defense motion to dismiss marijuana possession charges.

Possession: Six ounces of usable marijuana.

Homegrown: Home cultivation is prohibited; only licensed compassion centers may cultivate marijuana.

Dispensaries: Yes

Illnesses: cancer, multiple sclerosis, HIV/AIDS, hepatitis C, ALS, Alzheimer's disease, post-traumatic stress disorder, conditions that cause severe, debilitating pain, wasting syndrome, intractable nausea, and seizures.

Caregivers: Must be at least twenty-one years old and have no felony convictions for violent crimes or drug crimes (state and federal). S/he is permitted to assist up to five patients at a time.

Agency Website:

<http://dhss.delaware.gov/dph/hsp/medmarhome.html>

DISTRICT OF COLUMBIA

Use of Marijuana for Medical Treatment, D.C. CODE §§ 7-1671.01 to 7-1671.13 (West, Westlaw through Nov. 25, 2014).

Under the statute, a qualifying patient or qualifying caretaker may possess and administer medical marijuana. They may also possess and use paraphernalia, only for treatment of a qualifying medical condition or the side effects of a qualifying medical treatment if they have obtained a written and signed recommendation from his/her physician and registered with the mayor.

Possession: Two ounces

Homegrown: Home cultivation is prohibited.

Dispensaries: Yes

Illnesses: Cancer, HIV/AIDS, glaucoma, multiple sclerosis and other muscle spasticity disorders, and any other condition that is "(i) [c]hronic or long-lasting; (ii) [d]ebilitating; (iii) [a] serious medical condition for which the use of medical marijuana is beneficial."

Caregivers: Must be at least eighteen years old, registered with the Department, and cannot serve more than one qualified patient at a time.

Agency Website: <http://doh.dc.gov/service/medical-marijuana-program>

HAWAII

Medical Use of Marijuana, HAW. REV. STAT. §§ 329-121 to 329-128 (West, Westlaw through 2014 Reg. Sess.).

Under the statute, a qualifying patient is permitted the medical use of marijuana if he/she has been diagnosed with a debilitating medical condition by a physician, and the physician has certified in writing that, in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient. Qualifying patients and caregivers must be registered with the Department of Health.

Possession: Four ounces

Homegrown: Seven plants (mature or immature).

Dispensaries: Yes

Illnesses: Cachexia, cancer, chronic pain, Crohn's disease, epilepsy and other conditions characterized by seizures, glaucoma, HIV/AIDS, multiple sclerosis and other muscle spasticity disorders, nausea (other conditions subject to state approval).

Caregivers: "Primary caregiver" means a person who is at least eighteen years old, other than the qualifying patient and the qualifying patient's physician, who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana. In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody.

Agency Website: <http://dps.hawaii.gov/about/divisions/law-enforcement-division/ned/>

MAINE

Maine Medical Use of Marijuana Act, ME. REV. STAT. ANN. tit. 13, §§ 13-3301 to 13-3316 (West, Westlaw through 2014 Reg. Sess.).

Under the statute, qualifying patients may grow and cultivate medical marijuana. To be a qualifying patient one must have been diagnosed with a debilitating medical condition and have a valid written certification pertaining to the use of medical marijuana. A valid written certification is a document signed by a medical provider stating the patient is likely to gain a therapeutic benefit from using medical marijuana.

Possession: 2 ½ ounces

Homegrown: Six marijuana plants (up to three may be mature).

Dispensaries: Yes

Illnesses: Epilepsy and other conditions characterized by seizures, glaucoma, multiple sclerosis and other muscle spasticity disorders, nausea, HIV/AIDS, cancer, hepatitis C, Lou Gehrig's disease, Crohn's disease, Alzheimer's disease, nail-patella syndrome, cachexia, and other conditions subject to state approval.

Caregivers: Must be at least twenty-one years old and have never been convicted of a drug offense.

Agency Website: <http://www.maine.gov/dhhs/dlrs/mmm/index.shtml>

MARYLAND

Natalie M. Laprade Medical Marijuana Commission, MD. CODE ANN., HEALTH §§ 13-3301 to 13-3316 (West, Westlaw through 2014 Reg. Sess.).

Under the statute a qualifying patient, may possess medical marijuana. To be a qualifying patient one must obtain written certification from a treating physician that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient.

Possession: An amount constituting a thirty-day supply. The Commission will determine the amount.

Homegrown: No

Dispensaries: Yes

Illnesses: Chronic or debilitating disease or medical condition that results in a patient being admitted into hospice or receiving palliative care, a chronic or debilitating disease or medical condition or the treatment of a chronic or debilitating disease or medical condition that produces: cachexia, anorexia, wasting syndrome, severe pain, severe nausea, seizures, severe or persistent muscle spasms, and severe conditions or The Commission may approve applications that include any other condition that is severe and for which other medical treatments have been ineffective if the symptoms reasonably can be expected to be relieved by the medical use of marijuana.

Caregivers: A person who has agreed to assist with a qualifying patient's medical use of marijuana. If the qualifying patient is under eighteen years old the caregiver must be a parent or legal guardian.

Agency Website:

<http://dhmh.maryland.gov/SitePages/Medical%20Marijuana%20Commission.aspx>

MASSACHUSETTS

Humanitarian Medical Use of Marijuana, MASS. GEN. LAWS ch. 94C, §§ 1-1 to 1-14 (West, Westlaw through chs. 1 to 505 of the 2014 2d Ann. Sess.).

Protection is provided for health care professionals, qualifying patients, personal care givers, and dispensary agents, for the medical use of

marijuana, who comply with the specification stated in the law. The law shall be administered by the Department of Public Health of the Commonwealth of Massachusetts. Registration cards are issued to qualifying patients and caregivers via the Department. A qualifying patient is “a person who has been diagnosed by a licensed physician as having a debilitating medical condition.” MASS. GEN. LAWS ch. 94C, § 1-2(K).

Possession: Sixty-day supply is equal to ten ounces. A certifying physician may alter this amount by presenting documentation supporting the additional need. 105 MASS. CODE REGS. § 725.004 (2013).

Home Grown: Permitted upon obtaining a hardship cultivation registration. Cultivation is limited to the location specified in the application, registration is valid for one year, and the number of plants is limited to that sufficient to maintain a sixty-day supply solely for the patient’s use. 105 MASS. CODE REGS. § 725.035 (2013).

Dispensaries: Yes

Illnesses: When debilitating the following conditions are included: cancer, glaucoma, HIV positive, AIDS, hepatitis C, ALS, Crohn’s disease, Parkinson’s disease, and MS. Also covered are “other debilitating conditions as determined in writing by a qualifying patient’s certifying physician.” 105 MASS. CODE REGS. § 725.004 (2013).

Caregivers: Must be twenty-one years of age or older. A qualifying patient may designate up to two caregivers. Generally, a caregiver may only provide care to one individual. Caregivers must attest s/he will not divert marijuana elsewhere and acknowledge that the rights of the caregiver are only applicable within the state of Massachusetts. MASS. GEN. LAWS ch. 94C, § 1-2(K); 105 MASS. CODE REGS. § 725.020 (2013).

Agency Website:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/medical-marijuana/>

MICHIGAN

Michigan Medical Marihuana Act, MICH. COMP. LAWS ANN. §§ 333.26421–333.26430 (West, Westlaw through P.A. 2014, No. 572 of the 2014 Reg. Sess. of the Ninety-Seventh Leg.).

Qualifying patients, caregivers, and physicians are protected from arrest, prosecution, penalty, or denial of rights or actions by professional disciplinary boards for the medical use of marihuana in accordance with this Act. The Act is administered by the Department of Licensing and Regulatory Affairs. Registry identification cards are issued to qualifying patients and registered caregivers by the department. MICH. COMP. LAWS ANN. § 333.26423.

Possession: 2 ½ ounces of useable marihuana. If held by a caregiver then 2 ½ ounces per qualifying patient to whom s/he is connected by proper registration. MICH. COMP. LAWS ANN. § 333.26424(a), (b)(1).

Home Grown: Twelve plants. They must be kept in an “enclosed, locked facility.” MICH. COMP. LAWS ANN. § 333.26424(a), (b)(2).

Dispensaries: No

Illnesses: One or more of the following: cancer, glaucoma, HIV positive, AIDS, hepatitis C, ALS, Crohn’s disease, agitation of Alzheimer’s disease, nail-patella. A chronic debilitating disease or condition that results in: cachexia (wasting syndrome), severe and chronic pain, severe nausea, seizures, severe and chronic muscle spasms. And other medical conditions as approved by the department. MICH. COMP. LAWS ANN. § 333.26423(b).

Caregivers: Caregivers must be twenty-one years of age or older, have no felony convictions within the past ten years, have never been convicted of a felony involving illegal drugs or an assaultive crime as defined in the code of criminal procedure, and must have agreed to assist with the patient’s use of medical marihuana. MICH. COMP. LAWS ANN. § 333.26423(b); MICH. ADMIN. CODE r. 333.101(15).

Agency Website: http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869---,00.html

MINNESOTA

Therapeutic Research Act; Medical Cannabis, MINN. STAT. ANN. §§ 152.21–152.37 (West, Westlaw through the 2015 Reg. Sess. through ch. 2).

The provision of medical cannabis to qualifying patients begins July 1, 2015. The process is under the control of the Commissioner of Health. Qualifying patients apply to the commissioner to be enrolled in the registry program and in doing so agree to continue treatment for the qualifying condition, report any changes in the condition, and to obtain medical cannabis only from a registered manufacturer. The law expressly prohibits the smoking of marijuana. MINN. STAT. ANN. §§ 152.22, 152.25, 152.30.

Possession: Thirty-day supply. 39 MINN. REG. 818 (Dec. 15, 2014).

Home Grown: No

Dispensaries: Yes. MINN. STAT. ANN. § 152.29.

Illnesses: Cancer or a terminal illness with a less than one-year life expectancy, if the condition or treatment results in one or more of the following: severe or chronic pain, nausea or severe vomiting or severe wasting, glaucoma, HIV or AIDS, Tourette’s syndrome, ALS, seizures, severe and persistent muscle spasms, Crohn’s disease, and any other medical condition approved by the commissioner. MINN. STAT. ANN. § 152.22.

Caregivers: Must be at least twenty-one years of age and not have any convictions for disqualifying felonies. Registered, designated caregivers are approved by the commission to assist patients who have been identified by health care professionals to be unable to self-administer or acquire cannabis. MINN. STAT. ANN. § 152.22.

Agency Website: <http://www.health.state.mn.us/topics/cannabis/>

MONTANA

Montana Marijuana Act, MONT. CODE ANN. §§ 50-46-301 to -344 (West, Westlaw through the 2013 Sess., and the 2014 Gen. Election).

Provides legal protections for persons covered by the Act who use marijuana to alleviate symptoms associated with a debilitating condition. Also provides protection for those who cultivate, manufacture, deliver, and possess marijuana within the parameters of the Act as well as individuals who assist in some of these activities. The Act establishes reporting requirements and permits local governments to establish standards for the protection of those within their jurisdiction. The Act is administered by the Department of Health and Human Services, which issues registration cards to patients, providers and marijuana infused product providers (MIPPs). The Department also provides for a “Landlord Permission Form,” which permits cultivation on rented property when properly obtained and approved. MONT. CODE ANN. §§ 50-46-301 to 50-46-302; MONT. ADMIN. R. 37.107.110 (2011).

Possession: Registered cardholders may possess twelve seedlings, a seedling being a plant less than twelve-inches tall, four mature plants and one ounce of useable marijuana. <http://dphhs.mt.gov/qad/Licensure/MMP/mmpfaq#159672069-how-many-plants-can-i-have-if-im-on-the-montana-marijuana-registry> (last visited Feb. 28, 2015).

Home Grown: Registered cardholders may possess twelve seedlings, a seedling being a plant less than twelve-inches tall, and four mature plants. *Id.*

Dispensaries: No

Illnesses: Cancer, glaucoma, HIV positive, AIDS, when the condition or disease results in debilitating symptoms; wasting syndrome, severe chronic pain that interferes with daily activities (must be documented by physician), Crohn’s disease, MS, peripheral neuropathy, chronic painful muscle spasms, seizure disorders, hard to control nausea, conditions leading to hospice care, and other conditions as approved by the legislature.

Providers and MIPPs: Must be a Montana resident who is eighteen years of age or older; must not be in the custody of or under the supervision

of the Department of Corrections or a youth court; must not have a felony conviction for a drug offense; must not have fraudulently represented self as a registered cardholder or MIPP under this Act; must not have failed to pay taxes or a judgment to a government agency; must not have defaulted on student loans or have failed to pay child support; must not have failed to remedy outstanding child support or tax judgments; must reapply annually. A provider or MIPP may assist up to three registered cardholders. If the provider or MIPP is also a registered cardholder then s/he may assist only two additional registered cardholders. MONT. CODE ANN. § 50-46-308; MONT. ADMIN. R. 37.107.115 (2011); <http://dphhs.mt.gov/qad/Licensure/MMP/mmpfaq> (last visited Feb. 28, 2015).

NEVADA

Medical Use of Marijuana, 453A NE. REV. STAT. ANN. §§ 453A.010–453A.810 (West, Westlaw through the end of the Twenty-Eighth Spec. Sess. (2014)).

Persons in possession of a valid registry identification card are protected from prosecution for possession, delivery, or production of marijuana as well as possession and delivery of related paraphernalia. Additionally, protection from prosecution is provided for aiding and abetting in the possession or delivery of marijuana or related paraphernalia in connection with a qualifying person. Registration cards are administered by the Division of Public and Behavioral Health of the Department of Health and Human Services. NEV. REV. STAT. ANN. §§ 453A.200, .210.

Possession: 2 ½ ounces in any fourteen-day period; twelve marijuana plants regardless of maturity and the regulatory permissible amount of edible marijuana products. NEV. REV. STAT. ANN. § 453A.200.

Home Grown: No

Dispensaries: Yes. NEV. REV. STAT. ANN. § 453A.115.

Illnesses: AIDS, cancer, and glaucoma. A medical condition or treatment therefore, that for a specific patient, results in: cachexia, persistent muscle spasms, seizures, severe nausea, or severe pain. Any other condition the Division deems chronic or debilitating and a condition approved pursuant to petition. NEV. REV. STAT. ANN. § 453A.050.

Caregivers: Must be eighteen years of age or older and have significant responsibility for the well-being of the person with the qualifying condition. There may be only one designated primary caregiver per person with a qualifying medical condition.

Agency Website: <http://www.health.nv.gov/MedicalMarijuana.htm>

NEW HAMPSHIRE

Use of Cannabis for Therapeutic Purposes, N.H. REV. STAT. ANN. §§ 126-X:1 to -X:11 (Lexis through the 2014 Sess.).

The provisions of this law are administered by the Department of Health and Human Services. Protection is provided to qualifying patients for the possession and use of cannabis for therapeutic use in compliance with the law. Additionally, caregivers possessing an acceptable amount of therapeutic cannabis, as stated in the statute, for a qualifying patient are protected from prosecution. Valid registry cards from other jurisdictions will be honored within the state. Protections are also provided for providers of therapeutic cannabis and alternative treatment centers acting in accordance with the law. Qualifying patients who have custody or visitation rights will not be presumed to be neglectful or endangering the child(ren) when acting in accordance with the law. Additionally, custody or visitation cannot be denied solely based on conduct in connection to the law. N.H. REV. STAT. ANN. §§ 126-X:1, 126-X:2.

Possession: Two ounces of useable cannabis or any amount of unusable cannabis. Caregivers may possess two ounces per qualifying patient for which s/he is a designated caregiver. N.H. REV. STAT. ANN. §§ 126-X:2 (I), (II).

Homegrown: No. N.H. CODE R. Dep't of Health and Human Services He-C 401.02(m).

Dispensaries: No

Illnesses: Cancer, glaucoma, HIV positive, AIDS, hepatitis C when antiviral treatment is being done, ALS, muscular dystrophy, Crohn's disease, agitation associated with Alzheimer's, MS, chronic pancreatitis, spinal cord injuries or diseases, traumatic brain injury, injur(ies) that significantly interfere with daily activity (must be documented by patient's provider), severely debilitating or terminal illness resulting in one or more of the following: elevated intraocular pressure, cachexia, anorexia as a result of chemotherapy, wasting syndrome, constant or severe nausea, moderate to severe vomiting, seizure, severe muscle spasms, and severe pain not responding to other treatments or where treatments have serious side effects. N.H. REV. STAT. ANN. § 126-X:1(IX); N.H. CODE R. Dep't of Health and Human Services He-C 401.02(j).

Caregivers: Must be twenty-one years of age or older. Has agreed to assist a qualifying patient with the use of therapeutic cannabis. Cannot assist more than five qualifying patients. Must have never been convicted of a felony or any felony drug-related offense. Must obtain a valid registry card under this law. N.H. REV. STAT. ANN. § 126-X:1(VI).

Agency Website: <http://www.dhhs.state.nh.us/oos/tcp/>

NEW JERSEY

New Jersey Compassionate Use Medical Marijuana Act, N.J. STAT. ANN. §§ 24:6I-1 to -16 (Lexis through the 216th Ann. Sess., L. 2015, c. 3NJ).

The purpose of the Act is to “protect from arrest, prosecution, property forfeiture, and criminal and other penalties” qualifying patients use of medical marijuana. N.J. STAT. ANN. § 24:6I-2(e). The Act is administered by the Department of Health and covers the medical marijuana activities of qualifying patients who must be provided a certification by a physician with whom s/he has a bona-fide physician-patient relationship. The Department of Health issues registry identification cards to qualifying patients. N.J. STAT. ANN. § 24:6I-2.

Possession: Two ounces per thirty-day period. N.J. STAT. ANN. § 24:6I-10.

Homegrown: No

Dispensaries: Alternative Treatment Centers provide medical marijuana based on a physician’s instructions. N.J. STAT. ANN. § 24:6I-10.

Illnesses: ALS; MS; terminal cancer; muscular dystrophy; inflammatory bowel disease including: Crohn’s disease; terminal illness with a prognosis of less than twelve months to live; one of the following if resistant to existing conventional treatment: seizure disorders, intractable skeletal muscular spasticity, or glaucoma; one of the following when severe or chronic pain, or severe nausea or vomiting or wasting syndrome result: HIV positive, AIDS or cancer; any other condition approved by the Department of Health. N.J. STAT. ANN. § 24:6I-3; N.J. ADMIN. CODE § 8:64-1.2 (2015).

Caregivers: A resident of the state who is eighteen years of age or older, has agreed to assist a qualifying patient with the use of medical marijuana who is neither a primary caregiver to another qualifying patient, nor the patient’s physician, has never been convicted of sale of a controlled dangerous substance unless the conviction was at the federal level and pertained to lawful behavior under this Act, has properly registered and passed the criminal background check and has been designated as primary caregiver on the qualifying patient’s application. N.J. STAT. ANN. § 24:6I-3; N.J. ADMIN. CODE § 8:64-2.3 (2015).

Agency Website: <http://www.state.nj.us/health/medicalmarijuana/>

NEW MEXICO

Lynn and Erin Compassionate Use Act, N.M. STAT. ANN. §§ 26-2B-1 to -7 (Lexis through the end of the Second Reg. Sess. of the Fifty-First Leg.).

The law was enacted to permit the use of medical cannabis to alleviate symptoms of debilitating medical conditions and treatments in a controlled fashion. The Department of Health administers the law. Practitioners, persons licensed to prescribe and administer drugs identified in the Controlled Substances Act, determine a patient's status as a qualified patient. Written certifications are not valid for more than one year. Medical cannabis must be obtained only from in-state sources. Qualified patients must provide their name, address, and birthdate as well as the name, address, and phone number of their practitioner. N.M. STAT. ANN. §§ 26-2B-2, 26-2B-7; N.M. CODE R. § 7.34.2.7 (2015).

Possession: An adequate three-month supply. An adequate supply cannot exceed six ounces of useable cannabis. If a personal production license is held, four mature plants and twelve seedlings are permitted. If treatment is topical, a three-month supply is allowed. Additional amounts may be permitted at the Department's discretion. N.M. CODE R. § 7.34.2.7.

Homegrown: Permitted after obtaining a personal production license. License may also be issued to a primary caregiver. N.M. CODE R. § 7.34.2.7(AA).

Dispensaries: Yes

Illnesses: Cancer, glaucoma, MS, spinal cord damage with objective neurological indication of intractable spasticity, epilepsy, HIV positive, AIDS, hospice care in accordance with rules of department, and any other medical condition, treatment, or disease as approved by the department. N.M. STAT. ANN. § 26-2B-3(B).

Caregivers: Must be a resident of New Mexico who is at least eighteen years of age, and have been deemed necessary to take care of the patient's well-being, by the patient's practitioner, with respect to the medical use of cannabis. N.M. STAT. ANN. § 26-2B-3(F).

Agency Website: <http://nmhealth.org/about/mcp/svcs/>

NEW YORK

Compassionate Care Act, N.Y. PUB. HEALTH §§ 3360–3369-e (Lexis through 2014 released chs. 1-478).

Possession, use, acquisition, delivery, transportation, and transfer of medical marihuana are lawful under this Act when done by a certified patient or designated caregiver holding a valid registry identification card and in accordance with the law. To be certified, patient must be working with a practitioner registered to issue certificates by the commissioner, must have a serious condition documented in medical records, the registered practitioner must be qualified to treat patient's condition, the patient must be under the continuing care of the practitioner, and the practitioner's view is that in looking at past treatments the patient will benefit from the use of medical marihuana. N.Y. PUB. HEALTH §§ 3360(1), 3662.

Possession: A thirty-day supply of the dosage determined by patient's practitioner and that dosage is consistent with regulations by the commissioner. Product must be kept in its original packaging except for that portion being used immediately. N.Y. PUB. HEALTH § 3362.

Homegrown: No

Dispensaries: Yes. N.Y. PUB. HEALTH § 3364.

Illness: Cancer, HIV positive, AIDS, ALS, Parkinson's disease, MS, spinal cord damage with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, and others as added by the commission. Also covered are the following when clinically associated with or a complication of a condition in this section: wasting syndrome or cachexia, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, and other conditions added by the commissioner. Within eighteen months of the effective date of the Act, July 3, 2014, the commissioner will make a determination on the following: Alzheimer's, muscular dystrophy, dystonia, PTSD, and rheumatoid arthritis. N.Y. PUB. HEALTH § 3360(7).

Caregivers: Must be designated by the patient. Additional requirements are likely forthcoming but the regulations related to this Act have not yet been enacted.

Agency Website:

https://www.health.ny.gov/regulations/medical_marijuana/

OREGON

Oregon Medical Marijuana Act, OR. REV. STAT. ANN. §§ 475.300–475.346
(Lexis through the 2014 Sess.).

Provides protection from civil and criminal penalties for patients using medical marijuana on the advice of a doctor and in conformity with stated restrictions in the Act. The Oregon Health Authority oversees the Act. The authority will issue registry identification cards to qualified patients and/or designated primary caregivers.

Possession: Patient or designated primary caregiver may possess twenty-four ounces of useable marijuana, up to six mature plants, and up to eighteen seedlings. A one-ounce limitation is placed on patients having been convicted of certain Schedule I or II controlled substance offenses. Growers may possess the same amounts per patient for whom s/he is a grower. A grower may produce for no more than four qualified patients. OR. ADMIN. R. 333-008-0080 (2015).

Homegrown: Yes

Dispensaries: Yes. OR. REV. STAT. ANN. § 475.314; OR. ADMIN. R. 333-008-1000-, 333-008-1400 (2015).

Illnesses: Cancer, glaucoma, agitation related to Alzheimer's disease, HIV positive, AIDS, or side-effects related to the treatment of the aforementioned conditions. Medical treatments or conditions resulting in cachexia, severe pain, severe nausea, seizures, including those caused by epilepsy, persistent muscle spasms, including those caused by MS, PTSD, or any other condition or side-effect approved by the Authority. OR. REV. STAT. ANN. § 475.302(3).

Caregivers: Designated primary caregivers must be eighteen years of age or older, have the significant responsibility for managing the well-being of a person with a debilitating medical condition, be designated as such on the patient's registry identification application card, and may not be the patient's physician. OR. REV. STAT. ANN. § 475.302(5).

Agency Website:

<https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/index.aspx>

RHODE ISLAND

The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, R.I. GEN. LAWS ANN. §§ 21-28.6-1 to -14 (Lexis through Jan. 2014 Sess.).

The purpose of the Act is to protect from arrest and prosecution, other criminal penalties and property forfeiture, patients with debilitating medical

conditions, their caregivers, and physicians. Protection is also provided for a patient cardholder who grows and sells or distributes marijuana as identified in the Act to a compassion center cardholder. The Act is administered by the Rhode Island Department of Health.

Possession: 2 ½ ounces of useable marijuana and up to twelve mature plants. Plants must be stored indoors. Additionally, up to twelve seedlings may be possessed. R.I. GEN. LAWS ANN. §§ 21-28.6-4(a), (d), and (e).

Homegrown: Permitted. R.I. GEN. LAWS ANN. § 21-28.6-4(a) (possession includes mature and immature plants).

Dispensaries: Yes, as Compassion Centers. R.I. GEN. LAWS ANN. § 21-28.6-3(2)(i); 14-035 R.I. CODE R. § 1.2.

Illnesses: Cancer; glaucoma; HIV positive; AIDS; hepatitis C and treatments thereof. Chronic debilitating diseases, medical conditions or treatments thereof that result in: cachexia; severe debilitating, chronic pain; severe nausea; seizures, including but not limited to those associated with epilepsy; sever or persistent muscle spasms, including but not limited to those associated with MS or Crohn's disease; agitation of Alzheimer's disease; or any other condition or treatment approved by the department. R.I. GEN. LAWS ANN. § 21-28.6-3(3).

Caregivers: A natural person must be twenty-one years old or older and may assist no more than five qualifying patients at once. Caregivers may also be compassion centers registered under R.I. GEN. LAWS ANN. § 21-28.6-12 who have been designated as a primary caregiver by a qualified patient. R.I. GEN. LAWS ANN. §§ 21-28.6-3(2)(i), (9); 14-035 R.I. CODE R. §§ 1.2, 1.12.

Agency Website:

<http://www.health.ri.gov/healthcare/medicalmarijuana/>

VERMONT

Therapeutic Use of Cannabis, VT. STAT. ANN. tit. 18, §§ 4471–4474m
(Lexis through the 2013 adjourned Sess.).

Provides protection from arrest or prosecution for registered patients and their registered caregivers, health care professionals who have participated in the patient's application process. To qualify as a registered patient, one must be diagnosed with a debilitating disease or condition by a physician with whom the patient has a bona-fide healthcare professional-patient relationship. The Act is administered by the Department of Public Safety.

Possession: Two ounces of useable marijuana, up to two mature marijuana plants, and seven immature plants may be possessed collectively by the patient and caregiver. VT. STAT. ANN. tit. 18, § 4472(10).

Homegrown: Permitted.

Dispensaries: Yes. VT. STAT. ANN. tit. 18, §§ 4474e–4474i.

Illnesses: Cancer, MS, HIV positive, AIDS or the treatment of the aforementioned conditions if the disease or treatment thereof results in severe, persistent, and intractable symptoms; chronic or debilitating diseases resulting in cachexia, severe pain, severe nausea, or seizures. VT. STAT. ANN. tit. 18, § 4472(4); 28-003 VT. CODE R. § 3.

Caregivers: Must be twenty-one years of age or older, never been convicted of a drug related crime, been issued a registration card by the Department of Public Safety, and has agreed to be responsible for the medical marijuana use related well-being of a registered patient. VT. STAT. ANN. tit. 18, § 4472(11); 28-003 VT. CODE R. § 1.12.

Agency Website: http://vcic.vermont.gov/marijuana_registry

WASHINGTON

Medical Cannabis, WASH. REV. CODE ANN. §§ 69.51A.005–69.51A.903
(Lexis through the 2014 Reg. Sess. and the 2014 Gen. Election).

Provides protection from arrest, prosecution, or other state criminal or civil consequences when lawfully using medical marijuana in compliance with the law. Also protected are designated providers and health care professionals working within the parameters of the medical marijuana laws. Qualifying patients must be residents of the state of Washington at the time of the diagnosis of their terminal or debilitating medical condition.

Possession: No more than fifteen cannabis plants; twenty-four ounces of useable cannabis; cannabis product only in an amount that could be made with twenty-four ounces of cannabis, or a combination of useable cannabis and cannabis product. A person who is both a qualifying patient and a designated provider may possess two times the aforementioned amounts. WASH. REV. CODE ANN. § 69.51A.040.

Homegrown: Yes. WASH. REV. CODE ANN. § 69.51A.040.

Dispensaries: Yes. WASH. ADMIN CODE §§ 314-55-005 through 314-55-540 (2015).

Illnesses: Cancer, HIV, MS, epilepsy or other seizure disorder, spasticity disorders, intractable pain (pain that is not relieved by standard treatments), glaucoma (pain form which is not relieved by standard treatments), Crohn's disease (debilitating symptoms of which are not relieved by standard treatments), hepatitis C (where debilitating nausea or intractable pain are not relieved by standard treatment), diseases, where symptoms are not relieved by standard treatment, including nausea from anorexia, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity, and any other medical condition approved by the Washington State Medical Quality Assurance Commission. WASH. REV. CODE ANN. § 69.51A.010(4).

Caregivers: Is eighteen years of age or older, designated in writing by the patient to be the designated provider, is prohibited from consuming the medical marijuana that is intended for medical use by the patient, and may be a designated provider for only one patient. WASH. REV. CODE ANN. § 69.51A.010(1).

Agency Website:

<http://www.doh.wa.gov/YouandYourFamily/Marijuana/MedicalMarijuanaCannabis>

THE UNITED STATES SUPREME COURT AND MEDICAL MARIJUANA USE
UNDER THE CONTROLLED SUBSTANCES ACT

Gonzales v. Raich, 545 U.S. 1 (2004).

The United States Supreme Court in *Gonzales v. Raich* determined that the Comprehensive Drug Abuse Prevention and Control Act of 1970 (commonly referred to as the Controlled Substances Act) had constitutional supremacy over state laws allowing medical marijuana use. Thus, individuals using medical marijuana were not protected from federal prosecutions. The case arose out of California. The respondents in the case were California residents suffering from serious medical conditions. In order to alleviate symptoms associated with these conditions they were using medical marijuana under the California Compassionate Use Act. *Gonzales*, 545 U.S. at 6. Respondent Monson cultivated her own marijuana and Respondent Raich was provided with medical marijuana by two registered caregivers. *Id.* at 7. In August 2002, federal agents seized and destroyed the marijuana plants in Monson's home. *Id.* at 8. Raich's home was never entered by federal agents, however she feared this could happen at any time. *Raich v. Ashcroft*, 248 F. Supp. 2d 921 (N.D. Cal. 2003). The United States Supreme Court stated the issue as follows: "whether Congress' power to regulate interstate markets for medicinal substances encompasses the portions of those markets that are supplied with drugs produced and consumed locally." *Gonzales*, 545 U.S. at 9. While the Court acknowledged the "troubling facts" of the case at hand, it found that the Controlled Substances Act was a "valid exercise of federal power." *Id.* at 9.

RECENT CONGRESSIONAL ACTIONS

The U.S. House and Senate both recently introduced bills that would end the long-standing conflict between state and federal laws with respect to medical marijuana. The Regulate Marijuana Like Alcohol Act, H.R.

1013, 114th Cong. (2015), introduced in the United States House of Representatives on February 20, 2015, and The Compassionate Access, Research Expansion and Respect States Act, S. 683, 114th Cong. (2015), introduced in the United States Senate on March, 10, 2015, would reschedule marijuana from Schedule I classification to Schedule II under the Controlled Substances Act, thus recognizing it for medical use.

ARTICLES

The following materials represent a select group of articles addressing medical marijuana in different areas including employment, federalism, family law, and transportation. Also included in this section is a summary of the Department of Justice's memorandums addressing federal enforcement issues. Intermixed are additional statutory and case law summaries when connected to the article topics.

FEDERALISM AND MEDICAL MARIJUANA

Gerald Caplan, *Medical Marijuana: A Study of Unintended Consequences*, 43 MCGEORGE L. REV. 127 (2012).

This Article highlights the evolution of medical marijuana laws in Colorado, California, and Michigan. Noted is that the initial applications for use in these states were on the low end with numbers increasing dramatically after the 2009 statement from the Obama administration. The statement was interpreted as stating individuals in compliance with state law would not be arrested under federal law. For example, in Colorado, from January 2009 to January 2010, there was an 871% increase in registrants for medical marijuana use under the state law. Also noted is the lack of consistency in some jurisdictions with respect to certain aspects of the laws. In California, the amount of medical marijuana that a person may possess varies by county. State law says up to eight ounces may be possessed; yet a significantly higher amount is allowed in some counties. In Michigan, as in other states, the author notes that a small number of physicians certify a significant number of patients for medical marijuana use. Mr. Caplan stated that the original thought with respect to medical marijuana was that a small number of older adults with debilitating conditions would use medical marijuana. Very few patients would be under the age of forty, and marijuana use would not be permitted for conditions that were hard to verify such as stress and anxiety. The author however indicates that this has not been the practice in many jurisdictions, and in some areas, physicians are in practice only to see patients wanting to qualify for medical marijuana use. He indicates

how this practice is very different from the usual doctor-patient relationship. The author also discussed the increased number of dispensaries and how many are very involved in marketing their businesses. Mr. Caplan ends with a discussion of law enforcement issues related to the new medical marijuana programs and the broader effects of additional states legalizing the recreational use of marijuana.

Erwin Chemerinsky et al., *Cooperative Federalism and Marijuana Regulations*, 62 UCLA L. REV. 74 (2015).

The authors propose a solution to the federalism issue with respect to the Controlled Substances Act and marijuana. The proposed solution involves permitting states wishing to legalize marijuana an opportunity to opt-out of Controlled Substances Act provisions related to marijuana as long as the states meet specified criteria. The history of marijuana is covered starting with some states criminalizing the drug in the 1910s through the recent Department of Justice's response to Colorado and Washington legalizing the recreational use of marijuana. The authors then proceed to address the problems that the federal criminalization of the drug poses to businesses and those seeking to use marijuana legally. Topics covered include the need for a marijuana business to be cash only due to banking laws that threaten prosecution for money laundering. Also covered is the problem with federal taxes and the exorbitant amounts that must be paid by "illegal" entities. A provision of the Internal Revenue Code requires an entity operating in violation of federal drug laws to pay a tax that creates a significant disadvantage to the entity—*e.g.*, not being able to deduct business expenses from income. A third challenge covered is the availability of lawyers able and willing to provide services. Fourth, the authors look at the consequences of those using legalized marijuana, in an employment situation, individuals on parole and with a probation status, and in family law situations. The next area analyzed is the federal preemption law with respect to the Controlled Substances Act and the anti-commandeering doctrine of the Tenth Amendment. Section 903 of the Controlled Substances Act is discussed in that the authors indicate it shows Congress's intent not to completely preempt the regulation of controlled substances in the Controlled Substances Act. Lastly, the authors discuss crafting federal laws to work with state marijuana laws by employing cooperative federalism.

Todd Grabarsky, *Conflicting Federal and State Medical Marijuana Policies: A Threat to Cooperative Federalism*, 116 W. VA. L. REV. 1 (2013).

The author intends to explain the zone in which marijuana related activities can be both legal and illegal. In doing so he states that the enforcement of federal drug laws in an unpredictable manner can threaten the ef-

fectiveness and cooperative efforts of federal and state authorities in enforcing “dual-ban” drug laws. Mr. Grabarsky summarizes the Department of Justice memorandums and the changing landscape in legalized marijuana with two states recently voting to legalize its recreational use. His main focus though is on the conflict between federal law and California’s Compassionate Use Act. The author summarizes the California law and the state case law that evolved in relation to the Act. He then discusses the Controlled Substances Act and Congress’s and the Drug Enforcement Agency’s inaction in rescheduling marijuana. In a section on de jure constitutional authority, the author discusses commandeering, preemption, and conditional spending. He also addresses the obstacles to the federal enforcement of marijuana violations. The author next discusses the change in federal enforcement and the crackdown on medical marijuana entities profiting from the sale of medical marijuana whereby distributors in California were closed and dispensaries received cease and desist letters. The author discusses how these activities threatened cooperative federalism and also addresses the idea with respect to those states authorizing recreational use of marijuana. The author next discusses the idea of creating an exemption for persons and entities complying with state laws and the viability of such a system.

Troy E. Grandel, *One Toke Over the Line: The Proliferation of State Medical Marijuana Laws*, 9 U. N.H. L. REV. 135 (2010-2011).

Mr. Grandel approaches his article acknowledging that he is making the assumption that there are valid medicinal qualities associated with marijuana. He provides a discussion of the changing view toward marijuana in the 1930s from a medicinal product to one associated with drug use and deviance. He then summarizes the start of the “war on drugs” in the 1970s and the Comprehensive Drug Abuse Prevention and Control Act. A brief look is taken at the 1980s action creating a drug czar. The author then begins a look at California in the 1990s and other states, in subsequent years, enacting medical marijuana laws. Mr. Grandel summarizes the votes in each state legalizing medical marijuana. He also identifies the condition/diseases for which medical marijuana can be used. Other issues addressed are the problem employees may face in the workplace when properly using medical marijuana and the fact that marijuana is an agricultural crop having a stand-alone value.

Robert A. Mikos, *Preemption Under the Controlled Substances Act*, 16 J. HEALTH CARE L. & POL’Y 5 (2013).

The author identifies the significant confusion and various interpretations of courts relating to states’ adoptions of the legalization of medical,

and in some instances recreational, marijuana use. He notes that states have differed on issues such as the ability to license marijuana distributors noting that even courts within a single state have reached different conclusions on this issue. In this Article, Mr. Mikos proposes a direct conflict test where “state law is preempted only if it requires someone to violate federal law.” He provides a general discussion of preemption, including field preemption, direct conflicts, and obstacle conflicts. Additionally, preemption with respect to the Controlled Substances Act is addressed and the language of section 903 is evaluated and its application in cases where the courts interpreted it to mean the Controlled Substances Act preempted all state law conflicts. In discussing the reasons the obstacle conflict preemption rule is too broad, the author covers differences between legalization and regulation and why that distinction is important in the medical marijuana discussion. Another factor presented by the author is the concept that Congress intended to preempt the creation of regulations that promote rather than restrict marijuana activities. He uses examples such as state subsidies for medical marijuana being preempted as such action would drive the cost down and thus promote marijuana use, whereas licensing, taxing or requiring registration would add to the cost of marijuana, at least minimally, thus restricting the activities. The author goes on to argue the benefits of a direct conflict rule, starting with how such a rule would help courts avoid the commandeering trap, permit them to not preempt regulations that place restrictions on the marijuana market, and to permit state laws that are only indirectly affecting the actions of Congress. Mr. Mikos proceeds to analyze state laws that may pose a direct conflict to the Controlled Substances Act and separates these laws into those legalizing marijuana related activities as well as those that promote marijuana related activities. He indicates in his analysis that only a few states have laws that are in direct conflict with the Controlled Substances Act.

Michael D. Ramsey, *American Federalism and the Tragedy of Gonzales v. Raich*, 31 U. QUEENSLAND L.J. 203 (2012).

The author states that the decision in *Gonzales v. Raich* was the “U.S. Supreme Court’s worst modern decision.” *Id.* at 203. In support of his stance, he identifies four propositions: 1) the shocking implausibility of *Gonzales v. Raich*; 2) *Gonzales v. Raich* involves “a matter . . . that is core to the U.S. constitutional system . . .” *Id.* at 203; 3) *Raich* came at a time of reinvigoration of federalism and offered the opportunity for expansion of judicial protection of federalism; and 4) *Raich* undercut the attempt to return to stronger federalism. In his essay, Mr. Ramsey provides a history of federalism beginning with the birth of the United States. He continues with a revival of it in the 1990s with the case of *Gregory v. Ashcroft*, 501 U.S. 452 (1991). The author notes his observation of a movement away from

federalism as intended in the Constitution but prior to *Raich* saw a movement to “rectify the constitutional departures.” *Id.* at 224. The author notes changes in the Court once again affected the federalism issue and its direction.

David S. Schwartz, *Presidential Politics as a Safeguard of Federalism: The Case of Marijuana Legalization*, 62 *BUFF. L. REV.* 599 (2014).

Mr. Schwartz discusses the movement of the Court between the non-deferential and deferential review of federalism, noting that the non-deferential view in the *Lochner* era and the deferential view applied in the 1930s and early 1940s as a “substantial effects” test. Also covered is the use of the Tenth Amendment in the federalism discussions. The author addresses the “political safeguards of federalism” theory and the idea that Congress and the President are better situated to strike a national versus local regulatory balance. The origin of the phrase “political safeguards of federalism” and Professor Herbert Wechsler’s article are discussed. He follows with a discussion of weaknesses in the theory noted by Professor Larry Kramer. A position the author notes, of Kramer, is that state autonomy is protected by party politics. The author also references the 2013 article by Robert Mikos discussing the “under-enforcement” of the federal law and hypothesizes that the actual policy of the Obama administration leads to this under-enforcement. Mr. Schwartz identifies marijuana regulation as “one of the most complex regulatory problems in the history of federalism.” In discussing this problem the author covers state’s legalization of marijuana and then addresses the Controlled Substances Act, the Supremacy Clause indicating state laws may not supersede federal laws (preemption), and the impact of state legalization on federal law enforcement. Additionally, he addresses the lack of action on behalf of Congress or the Attorney General to re-schedule marijuana. The author moves into a discussion of the Electoral College and swing state votes when a group of swing states hold a political or social idea that is different from the national policy view on the same topic. Of the twenty states with legalized medical marijuana the author identifies thirteen of them as potential swing states. He then proceeds to discuss drug policies and presidential campaigns followed by an analysis of what each branch of government can do to protect federalism in some instances.

Vijay Sekhon, *Highly Uncertain Times: An Analysis of the Executive Branch’s Decision to not Investigate or Prosecute Individuals in Compliance with State Medical Marijuana Laws*, 37 *HASTINGS CONST. L.Q.* 553 (2009-2010).

The author addresses the efficacy of President Obama and Attorney General Eric Holder's position to not enforce federal drug laws against the legalized use of medical marijuana in light of the Separation of Powers clause of the United States Constitution. The author states that the enforcement policy is in direct conflict with the Controlled Substances Act (CSA), and the decision to not enforce in these instances must be drawn from prosecutorial discretion. He indicates this is supported by a memorandum from the Deputy Attorney General of the United States Department of Justice. In his analysis he looks at the *Wayte* case and identifies why the concerns regarding judicial review in that case are not the same when applied to the decision not to enforce federal laws in medical marijuana cases. Because of the doctrine of sovereign immunity the author cautions against being too comfortable with safety from compliance with state laws thus resulting in protection based on the Executive Branch's stated enforcement policy. He writes that an individual citizen cannot sue the government without the government's permission—the government has qualified immunity—thus an individual qualified in his or her state to use medical marijuana cannot challenge the Executive Branch's enforcement position if that individual is arrested and charged under federal drug laws. However, Congress is not prohibited from suing to remove the enforcement policy. In order to remove the uncertainties faced by those operating under the rights given to them by state law, the author urges Congress to pass and the President to sign legislation codifying the enforcement policy regarding the use of medical marijuana in compliance with state laws.

EMPLOYMENT ISSUES ASSOCIATED WITH MEDICAL MARIJUANA

Francine Bailey, *Reefer Madness: Lighting Up in the Dairyland*, WIS. LAW., Nov. 2014, at 24.

This Article examines whether or not Wisconsin employers may terminate employees for using recreational marijuana in states where recreational marijuana is permitted. The author argues that Wisconsin currently does not permit the use of recreational marijuana or provide protections for medical marijuana users; given the drug's popularity, it is highly likely that many Wisconsin employees are using marijuana when off duty. She notes that Wisconsin courts have not addressed either medical marijuana or legalized recreational marijuana. However, she explores the legislation in Colorado and Washington that permit the recreational use of marijuana. She also discusses the growth in "pot tourism" in these states. Finally, she looks at current case law with regards to medical marijuana in the workplace, and how a Wisconsin court might rule in an employment case involving legal

recreational marijuana. She concludes that it is likely a court would use the reasoning courts have adopted in the medical marijuana cases. Therefore, it is unlikely that a Wisconsin employee would prevail in an employment case where the employee is terminated for using legal recreational marijuana in another state.

Jay S. Becker & Saranne E. Weimer, *Legalization of Marijuana Raises Significant Questions and Issues for Employers*, N.J. LAW., Dec. 2014, at 66.

This Article examines employers' potential obligations in states where medical marijuana is legal. First, the Article discusses the legal conundrum that will exist so long as the federal government continues to classify marijuana as an illegal drug. In addition, the Article looks at whether or not employers must provide medical marijuana users an accommodation under the Americans with Disabilities Act. It concludes that under federal law there is no requirement. However, under some state statutes, the answer is not as simple. The Article provides case examples from around the country where different courts have examined this issue. It also discusses the challenges of providing an accommodation as well as issues associated with medical marijuana and workers' compensation and health insurance.

Lori A. Bowman & Jonathan S. Longino, *Taking the High Road-The Healthcare Provider's Duty to Accommodate Employees' Medical Marijuana Use*, 5 J. HEALTH & LIFE SCI. 34 (2012).

This Article examines the legal landscape for healthcare providers when it comes to accommodating bona fide medical marijuana users who also happen to be healthcare providers. Here, the authors trace the growth of the medical marijuana industry. Then, they look at the inconsistencies between state and federal law with regards to medical marijuana and protection from criminal prosecution. Next, they shift to the employment law arena by looking at whether there is a duty to accommodate medical marijuana users under the Americans with Disabilities Act (ADA). They ultimately conclude that there is not, since the ADA is directly tied to the Controlled Substances Act (CSA). They turn to state laws and look at two approaches—the no accommodation approach and the no discrimination approach. The no accommodation approach refers to state medical marijuana laws that make a specific reference in the statute that employers are not required to accommodate medical marijuana. For this discussion they examine the California, Oregon, and Washington statutes. The no discrimination approach refers to state medical marijuana laws that provide protections to employees who are bona fide medical marijuana users. For this discussion they examine the Rhode Island, Maine, and Arizona statutes.

Finally, they examine the special health and safety issues that a healthcare provider faces when it comes to medical marijuana and its employees. They conclude with several recommendations for health care provider employers.

John Campbell, *Coats v. Dish: A Chance to Clear the Legal Haze Surrounding Medical Marijuana*, 91 DENV. U. L. REV. ONLINE 79 (2014).

This Article examines the history of medical marijuana in Colorado and the current state of the law. It explains that while the medical marijuana statute has been on the books for ten years, the Colorado Supreme Court has not weighed in on medical marijuana's lawfulness. It suggests that this is likely to change in 2015, because the Court has agreed to hear an employment case (*Coats v. Dish Network LLC*) where it is likely to determine whether or not medical marijuana is indeed lawful in Colorado. The rest of the Article examines Colorado's law, the case law associated with the law, the facts and status of the *Coats* case, and how the case could be decided.

Holli L. Hartman, *Legalized Marijuana and the Workplace: Preparing for the Trend*, 38 EMP. REL. L.J. 4, Spring 2013, at 72.

This Article examines the legal landscape for employers located in states with medical marijuana statutes. Ultimately, the author recommends taking a proactive approach by reviewing and revising employment policies and handbooks. The author discusses the decriminalization of medical marijuana on the state level as well as the federal government's current approach to criminal enforcement. She explores the fact that the federal approach has largely affected the state courts' approach to medical marijuana in the workplace. She provides a brief analysis of current case law. Then, she concludes with recommendations for employers. She argues for employers to clearly state their approach to medical marijuana in employment policies and procedures. She suggests that this may cut down on litigation because employees will know up front where they stand with regards to their employment and the use of medical marijuana.

Stacy A. Hickox, *Drug Testing of Medical Marijuana Users in the Workplace: An Inaccurate Test of Impairment*, 29 HOFSTRA LAB. & EMP. L.J. 273 (2012).

This Article examines the use of urinalysis tests to take adverse employment actions against employees who are impaired in the workplace. She argues that the reliance on this type of testing is inaccurate and unreliable when it comes to bona fide medical marijuana users. The author gives an overview of the existing medical marijuana statutes and the fact that most of these statutes provide language specifying that employers do not

have an obligation to accommodate medical marijuana in the work place. But, many of those statutes do not contemplate off-duty legal medical marijuana use. Then, she explores research discussing marijuana's effect on users and the fact that there is no clear guidance for when a medical marijuana user should be protected from termination based on intoxication or impairment. Next, she examines whether traditional drug tests are appropriate for determining whether or not an employee is impaired or intoxicated in the workplace. Finally, she offers two solutions to the problem of inaccurate results. She suggests adopting either the approach that criminal courts take with regard to intoxication, or the approach that is used in worker's compensation cases. Essentially, she argues that when employers take adverse actions based on impairment, employers should look at whether or not the employee is truly affected by marijuana while on duty, not the results of a urinalysis test.

Matthew D. Macy, *Employment Law and Medical Marijuana—An Uncertain Relationship*, 41 COLO. LAW. 57 (2012).

This Article examines how medical marijuana laws have created new issues in the employment law arena and some uncertainty for employers. It explores the split between federal and state law. Then, it looks at how the case law is slowly developing in states with medical marijuana statutes. The author points out that while there is relatively little case law, the case law that does exist seems to favor employers. He explores several different arguments that have been brought and have failed. He looks at the Americans with Disabilities Act and then surveys related state laws in Colorado and Oregon. Next, he explores Colorado's anti-discrimination and lawful acts statutes. He concludes that these statutes also will not likely protect an employee who is also a bona fide medical marijuana user. Finally, he explores the strength of public policy arguments in wrongful discharge claims and concludes that these arguments will also likely fail. The underlying cause of all these arguments failing is the split between federal and state law with regards to how marijuana is classified. He also argues that the state statutes were intended to protect people from criminal prosecution, and the employment law ramifications were either not contemplated or legislatures did not intend to grant that type of protection.

McGuire Woods, *But I have a Prescription!—Employee Drug Tests in the Age of Medical Marijuana*, THE SOC'Y FOR HUMAN RES. MGMT. (July 1, 2010), <http://www.shrm.org/legalissues/stateandlocalresources/pages/buihaveaprescription.aspx>.

This Article examines ADA considerations that must be made when an employer issues discipline to its employees for using medical marijuana. The Article points out that the ADA does not protect employees from the “illegal use of drugs.” However, if there is an adverse employment action associated with a qualified individual with a disability using medical marijuana, the employer must be able to show the motivating factor for the adverse action was not the employee’s disability. In addition, the Article provides a list of recommendations for employers to take to minimize their risks for lawsuits.

Michael D. Moberly & Charitie L. Hartsig, *Smoke—And Mirrors? Employers and the Arizona Medical Marijuana Act*, ARIZ. ATTORNEY, July-Aug. 2011, at 30.

This Article examines the managerial and legal problems Arizona employers face in light of the state’s medical marijuana statute. First, the authors explore the state level decriminalization of medical marijuana. They point out that nearly all the medical marijuana statutes are silent to the employment issues associated with this decriminalization. However, Arizona’s statute provides specific language prohibiting employers from discriminating against medical marijuana users in hiring, promotion, or other terms and conditions of employment. The authors discuss some of the potential issues this statute creates because it fails to define “impairment.” They explore the problem with complying with federal laws and regulations, such as the Occupational Health and Safety Administration’s regulations governing workplace safety. They argue that until Arizona’s Department of Health Services defines “impairment” employers will be operating in an uncertain area and should proceed with caution.

Amy Komoroski Wiwi & Nicole P. Crifo, *The Unintended Impact of New Jersey’s New Medical Marijuana Law on the Workplace*, 36 EMP. REL. L.J., Summer 2010, at 33.

This Article examines the implications of New Jersey’s medical marijuana statute on New Jersey workplaces. The New Jersey statute is similar to many of the other state statutes in that it decriminalizes medical marijuana use, but it is silent as to workplace implications such as drug testing and drug use policies. However, the statute does provide that employers are not required “to accommodate the medical use of marijuana in any workplace.” The Article pays particular attention to employers considering accommodating medical marijuana. The authors suggest that there are three important things to consider: whether an accommodation is appropriate for the particular workplace, whether an accommodation will trigger liability under anti-disability discrimination laws, and whether there is an ability to verify

registry status. Finally, the authors provide a list of recommendations for employers who opt to accommodate medical marijuana in the workplace.

STATE STATUTES THAT PROVIDE PROTECTION TO EMPLOYEES USING MEDICAL MARIJUANA

The following is a sampling of state statutes that provide protection to employees using medical marijuana. The first state to pass this type of anti-discrimination statute was Rhode Island. The state's medical marijuana statute specifically prohibits employers from penalizing employees for being medical marijuana cardholders. Maine also prohibits employers from discriminating against employees who are registered medical marijuana users. Arizona and Delaware's statutes use stronger language. The Arizona law implies that employers will be barred from disciplining employees for using or limiting use of off-duty medical marijuana, while the Delaware statute states that employers may not discriminate against medical marijuana users in hiring, terminating, or in other terms or conditions of employment. Moreover, an employer may not terminate a medical marijuana user for a positive drug test, unless the employee was using on the job.

R.I. GEN LAWS § 21-28.6-4(b) (West, Westlaw through chapter 555 of the Jan. 2014 Sess.).

ME. REV. STAT. tit. 22, § 2423-E(3) (West, Westlaw through 2015 First Reg. Sess. of the 127th Leg.).

ARIZ. REV. STAT ANN. § 36-2813(B) (West, Westlaw through legis. effective Feb. 24, 2015 of the First Reg. Sess. of the Fifty-Second Leg.).

DEL. CODE ANN. tit. 16, § 4905A(a)(3) (West, Westlaw through 80 Laws 2015).

THE STATE COURTS WEIGH IN ON MEDICAL MARIJUANA AND THE WORKPLACE

Coats v. Dish Network, L.L.C., 303 P.3d 147 (Colo. App. 2013), *cert. granted*, No. 13SC394, 2014 WL 279960 (Colo. Jan. 27, 2014).

In this case, the court examined whether an employer is prohibited from discharging employees for off-the-job use of medical marijuana. Here, Coats filed suit after he was terminated for violating Dish Network's drug policy. Coats, a quadriplegic, was a licensed Colorado medical marijuana

user. He used marijuana within the limits of the license and he was never under the influence at work. However, he tested positive for marijuana and this constituted a violation of Dish Network's policy.

To make its decision, the court examined Colorado's "Lawful Activities Statute." Under the statute, employers are prohibited from terminating employees for engaging in lawful activities off hours. Here, the court had to decide whether medical marijuana was considered "unlawful." After examining the legislative history, the court ultimately concluded that the statute did not contemplate protections for a federally prohibited off-the-job activity. Therefore, employers are not barred from enforcing drug policies with regards to medical marijuana.

The Colorado Supreme Court has granted certiorari and will hear the case sometime this year.

Roe v. Teletech Customer Care Mgmt., 257 P.3d 586 (Wash. 2011).

In this case, the court looked at whether or not the Washington State Medical Use of Marijuana Act protects employees from adverse employment actions with regards to employee use of medical marijuana. Here, Roe was a bona fide medical marijuana user, who only ingested marijuana in her home during off-duty hours. In 2006, Roe was offered a position with Teletech contingent on the results of a drug-screening test. Roe informed the company of her medical marijuana use and took the drug test. After taking the test, she began her employment training. Shortly thereafter the company received the results of the drug test, which she failed. Upon receiving the results, Roe was terminated.

To make its decision, the court examined the state's medical marijuana statute. The court noted that the only reference to employment was "nothing in this chapter requires any accommodation of any on-site medical use of marijuana in any place of employment." Looking at the statutory language, on its face, the court concluded that the statute was not intended to protect an employee from discharge because of medical marijuana use—even if the use occurred off-duty. Employers were still entitled to use mandatory drug tests as a condition of employment. The court also noted that Washington patients have no legal right to use marijuana under federal law, therefore a public policy argument fails because the activity is illegal.

Emerald Steel Fabricators v. Bureau of Labor & Indus., 230 P.3d 518 (Or. 2010).

In this case, the court examined whether under the state's disability statute employers had an affirmative duty to accommodate medical marijuana. Here, the employee in question began using medical marijuana in 2002. The employee complied with all the provisions in the state's medical

marijuana statute. In 2003, Emerald Steel Fabricators (Emerald) hired employee on a temporary basis. During this time, employee continued to ingest medical marijuana off-duty. Knowing that Emerald was considering making the position permanent, the employee told his supervisor about his medical marijuana use. One week later, the employee was terminated.

To make its decision, the court considered how the federal laws intersected with the state laws. Ultimately, the court concluded that there is no duty to confer with a disabled employee about his marijuana use, because under federal law marijuana use is illegal. Moreover, the court concluded that the federal Controlled Substances Act preempts the state's disability statute.

Ross v. RagingWire Telecomm., Inc., 174 P.3d 200 (Cal. 2008).

In this case, the court considered whether under the state's medical marijuana statute employers are required to permit its employees to use medical marijuana, and whether employers must accommodate medical marijuana use. Here, Ross was a bona fide medical marijuana user. He ingested marijuana to alleviate pain from injuries he sustained during active military duty. However, he was terminated from his new position at RagingWire Telecommunications (RagingWire) for failing a pre-employment drug test.

To make its decision, the court considered that the state's medical marijuana statute required RagingWire to permit Ross to continue his medical marijuana use. First, the court determined that the state's medical marijuana statute only applied to criminal protections. Second, the court determined that the statute only specifically addressed on-site accommodations, and the statute was silent to off-site use, therefore it did not cover off-site use and accommodation.

THE FEDERAL COURTS WEIGH IN ON MEDICAL MARIJUANA AND THE WORKPLACE

Casias v. Wal-Mart Stores, Inc., 695 F.3d 428 (6th Cir. 2012).

In this case, the court considered whether or not Michigan's medical marijuana statute prevented Michigan employers from terminating employees for testing positive for marijuana in violation of a company drug policy. Here, Casias was a bona fide medical marijuana user. He ingested marijuana to alleviate the pain associated with his cancer. In 2009, he was injured on the job. This injury was not associated with his marijuana use. Due to the on-the-job injury, Casias was required to take a drug test before returning to work. He informed the testing staff that he was a registered medical

marijuana user. Then he took the drug test and failed it. Upon receiving the results, Wal-Mart terminated his employment.

The court ultimately decided that the statute did not prevent employers from enforcing their drug policies. The court reasoned that the statute was intended to protect against criminal prosecution, not adverse employment actions.

THE DEPARTMENT OF TRANSPORTATION WEIGHS IN ON MEDICAL MARIJUANA AND THE WORKPLACE

DOT Office of Drug and Alcohol Policy and Compliance Notice (Oct. 22, 2009), http://www.dot.gov/sites/dot.dev/files/docs/ODAPC_medicalmarijuana_notice_0.pdf.

The Department of Transportation issued a notice informing employers that state medical marijuana laws do not supersede federal law. Therefore, employers in the trucking, railroad, airline and transit system industries must follow the federal regulations with regards to drug testing. And, if an employee who uses medical marijuana tests positive, the employer is still required to follow the agency regulations with regards to the positive drug test.

DEPARTMENT OF JUSTICE APPROACH TO MEDICAL MARIJUANA

Memorandum from David W. Ogden, Deputy Attorney General, For Selected U.S. Attorneys (Oct. 19 2009), available at <http://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf>.

This is the first memorandum issued by the Department of Justice with regards to medical marijuana. It explains that the Department is adopting a policy where it will focus enforcement activity on “significant traffickers and trafficking networks,” not individuals suffering from debilitating diseases, such as cancer.

Memorandum from James M. Cole, Deputy Attorney General, For U.S. Attorneys (Jun. 29, 2011), available at <http://www.mpp.org/assets/pdfs/library/Cole-memo.pdf>.

This is the second memorandum issued by the Department of Justice with regards to medical marijuana. Here, the Department takes the position

that it is still committed to enforcing the Controlled Substances Act. This memo outlines that it was not the Department's intention to protect large-scale cultivators from federal prosecution. Rather, the first memorandum was merely intended to protect users of medical marijuana, and to ensure that federal resources were directed to large-scale operations.

Memorandum from James M. Cole, Deputy Attorney General, For U.S. Attorneys (Aug. 29, 2013), available at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

This is the third memorandum issued by the Department of Justice with regards to medical marijuana. Here, the Department once again reiterated its priorities with regards to medical marijuana and enforcing the Controlled Substance Act. The memorandum outlines several areas that the Department is interested in, such as large scale trafficking and the sale of marijuana to minors. The Department expressed that it was not interested in pursuing individual medical marijuana users.

Robert A. Mikos, *A Critical Appraisal of the Department of Justice's New Approach to Medical Marijuana*, 22 STAN. L. & POL'Y REV. 633 (2011).

This Article examines the true impact of the Department of Justice's (DOJ) new approach to prosecuting medical marijuana at the federal level—the non-enforcement approach. The author argues that on its face the approach appears to be groundbreaking and ceding power to the states to regulate medical marijuana. However, upon closer examination the non-enforcement approach does not really do anything. First, the author provides a brief history on state and federal medical marijuana laws and the federal government's enforcement response. Next, the author looks at whether the DOJ's approach actually stops criminal prosecutions. He concludes that it does not for two reasons. First, because the DOJ did not create an enforceable right, and second, the DOJ does not have the power to monitor and sanction its own employees for failing to comply with the new approach. Next, the author explores some of the civil actions that may be taken by other federal agencies, private citizens, and state officials. Finally, the author concludes that if criminal prosecutions are truly going to be curbed the federal government must legalize marijuana.

FAMILY LAW AND MEDICAL MARIJUANA

David Malleis, Comment, *The High Price of Parenting High: Medical Marijuana and its Effects on Child Custody Matters*, 33 U. LA VERNE L. REV. 357 (2012).

In this Article, the author addresses the challenges faced in permitting the medicinal use of marijuana in connection with family and custody issues. The author notes that several states permit the use of medical marijuana without producing a negative impact on the medical marijuana user's parental rights. Mr. Malleis summarizes the history of marijuana use ranging from recreational to religious to medicinal. A brief overview of state law and the Controlled Substances Act is provided along with a brief discussion of *Gonzales v. Raich* and U.S. Attorney General Eric Holder's guidelines concerning the enforcement of federal law in medical marijuana use instances. In addressing family law issues, the author presents three approaches in child custody cases. The approaches identified are: 1) "The Best Interest of the Child;" 2) "The Hybrid Conduct Standard," which provides for the protection of parental rights "unless the person's conduct creates an unreasonable danger" (the author notes that some states have legislated this position while others have arrived there through judicial action); and 3) "The Per Se Probative Standard." The author applies the two latter standards to a custody issue and discusses the possible outcomes. He also compares pros and cons of the standards concluding the "Hybrid Conduct Standard" is superior.

ATTORNEY ETHICAL ISSUES AND MEDICAL MARIJUANA

Sam Kamin & Eli Wald, *Marijuana Lawyers: Outlaws or Crusaders?*, 91 OR. L. REV. 869 (2013).

The authors address the issues faced by attorneys representing people and entities in the lawful use and provision of medical marijuana, and in some states legal recreational use, businesses. Much of the conflict arises due to the fact that at the federal level marijuana is an illegal drug. In their discussion of federalism the authors note that the Controlled Substances Act clearly does not preempt regulation of marijuana. The Department of Justice memorandum regarding enforcement is discussed and it is suggested that the memo does not state that enforcement will not occur in states having adopted medical marijuana laws. The second Department of Justice memorandum on topic, the authors indicate, supports the view that the first memorandum was misinterpreted. Highlighting this misinterpretation were acts of the United States Attorney's office indicting marijuana cooperatives and sending cease and desist letters to dispensaries. Additional issues arise, for example, where residents in public housing indicate that they will not violate criminal laws, or parolees who agree to not use controlled substances yet the states in which they reside permit medical marijuana use and in some instances recreational use. In covering the representation of medical

marijuana, client issues such as accomplice and coconspirator liability are discussed. The authors provide an analysis of actions where attorneys were found to be aiding criminal clients and they also identify the chilling effect such actions can have on the effective representation of criminal clients. With respect to the Controlled Substances Act and coconspirator or accomplice liability the authors indicate that there needs to be shown a mens rea of true intent. Also covered are ethical considerations when representing marijuana clients. The authors look at ABA Model Rule of Professional Conduct 1.2(d) in the discussion of ethical concerns. The rule, the authors indicate, permits an attorney to discuss medical marijuana and explain the potential Controlled Substances Act issues, but does not allow the drafting of documents related to the client's business. The differing ethical application stances in Arizona and Maine are also covered. An attorney's status as a medical marijuana patient is looked at in the ethical considerations as well. Financial activities in the medical marijuana industry by lawyers, as well as, legal services that may be permitted to be provided by attorneys in the area are addressed. There are also sections on questionable and prohibited legal services.

Alec Rothrock, *Is Assisting Medical Marijuana Dispensaries Hazardous to a Lawyer's Professional Health?*, 89 DENV. U.L. REV. 1047 (2012).

The author examines Colorado Rule of Professional Conduct 1.2(d) in light of an attorney providing legal services to a medical marijuana dispensary. While doing so is not a violation of Colorado law, the author notes it is a violation of federal law and thus creates a conflict with this rule. He also identifies ethics opinions from Maine and Arizona that reach opposite conclusions in their interpretation of Rule 1.2(d) with respect to medical marijuana activities. The author provides a discussion of good faith arguments and provides examples outside the medical marijuana realm. Mr. Rothrock identifies other prohibitions from Rule 1.2(d) including counseling and assisting. He also discusses the knowledge requirement of the rule. He states that no Colorado lawyers have been publicly disciplined; however, under the rule it is possible and no disciplinary action thus far does not mean it will not happen.

MODEL RULES OF PROFESSIONAL CONDUCT R. 1.2

Client-Lawyer Relationship

Scope of Representation and Allocation of Authority between Client and Lawyer

(a) Subject to paragraphs (c) and (d), a lawyer shall abide by a client's decisions concerning the

objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer may take such action on behalf of the client as is impliedly authorized to carry out the representation. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision, after consultation with the lawyer, as to a plea to be entered, whether to waive jury trial and whether the client will testify.

(b) A lawyer's representation of a client, including representation by appointment, does not constitute an endorsement of the client's political, economic, social or moral views or activities.

(c) A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent.

(d) A lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent, but a lawyer may discuss the legal consequences of any proposed course of conduct with a client and may counsel or assist a client to make a good faith effort to determine the validity, scope, meaning or application of the law.

STATE REGULATORY ACTIONS

Peter J. Cohen, *Medical Marijuana 2010: It's Time to Fix the Regulatory Vacuum*, 38 J.L. MED. & ETHICS 654 (2010).

The author starts by discussing the roadblock to effective research on the medicinal uses of marijuana imposed by its classification as a Schedule I drug in the Controlled Substances Act. He provides examples of the Drug Enforcement Agency and the National Institute of Drug Abuse not permitting access to marijuana by university researchers, thus hampering their abilities to develop scientific information on the efficacy of medical marijuana. Also discussed is the attempt in the 1990s by scientists to have the Drug Enforcement Agency permit such research. In 1999 the National Academies of Sciences' Institute of Medicine proceedings included materials indicating that marijuana had beneficial effects in dealing with chemo-

therapy related nausea, AIDS, wasting syndrome, and some types of spasticity among other conditions. Yet, these findings were not considered by the agencies. He indicates that the American Medical Association even recommended a review of the Schedule I classification of marijuana in order to allow for a relaxation on access to cannabis for research purposes. All of the scientific and medical groups that supported a scientific evaluation of the potential use of marijuana for medical purposes were not heeded by the federal entities able to affect the start of a change. The author provides a discussion of marijuana as a gateway drug. Mr. Cohen provides an overview of state attempts at regulating marijuana and focuses on California and Colorado. He then proposes revisions to state regulations to better oversee the practices related to medical marijuana. Among those is the participation of physicians as “therapeutic gatekeepers” and state boards of medicine providing oversight. He concludes by reiterating the need for scientific evidence to be the basis of approval of any drug for medicinal use and indicates such evidence exists with respect to marijuana.

Robert A. Mikos, *On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime*, 62 VAND. L. REV. 1421 (2009).

The author looks at the strong position of the states to legalize activities that are banned by the federal government. While his Article focuses on medical marijuana he also indicates this approach is possible in other areas as well. A basis for this argument is that the states are permitting behavior (not acting with respect to it) that is banned by the federal government. Mr. Mikos provides an overview of state laws at the time of writing and the Controlled Substances Act and its constitutionality. Despite the holding in *Gonzales v. Raich*, the author does not find federal law to preempt the states' legalization of medical marijuana. He provides an explanation for this by looking at the anti-commandeering doctrine and how it constrains the preemption power, and the congressional intent seen in the Controlled Substances Act limiting the preemptive powers of the Act. Additionally, the author looks at five types of state statutes with respect to legalized medical marijuana and discusses why these laws are likely not preempted. Mr. Mikos also looks at ways Congress can try to alter the state laws and whether these methods are appropriate or realistic. The author also provides a discussion of why people obey laws and how that factors into this area.

Karen O'Keefe, *State Medical Marijuana Implementation and Federal Policy*, 16 J. HEALTH CARE L. & POL'Y 39 (2013).

The author in looking at efforts to “reschedule marijuana under federal law,” looks at state marijuana laws and the interaction of state policies and

federal law in the states that have legalized marijuana. Ms. O'Keefe addresses the Schedule I Controlled Substances Act classification of marijuana and the unwillingness over the years of the Drug Enforcement Agency and the Food and Drug Administration, with support from the federal courts, to change the classification. She notes this resistance in the face of much research showing the effectiveness and safety of marijuana. She looks at early state legislative attempts to recognize the value of medical marijuana. Such laws permitted marijuana as a prescription, but doctors could not prescribe marijuana without potential sanctions and pharmacies could not fill such prescriptions under federal law. Other laws provided federal approval for small-scale programs. She covers more recent actions to legalize medical marijuana starting with California's 1996 law that did not rely on any help or consent from the federal government. She summarizes the California law as well as identifies other states that subsequently enacted medical marijuana laws. Also identified are instances where states chose not to enforce federal laws. Ms. O'Keefe moves on to discuss the growth of dispensaries and federal impediments to these entities. She then discusses the start of regulated dispensaries with the 2008 New Mexico law and subsequent states legalizing medical marijuana and regulating its distribution to some extent. She concludes by identifying ways to more closely align federal and state policies.

MISCELLANEOUS

D. Mark Anderson, Benjamin Hansen, & Daniel I. Rees, *Medical Marijuana Laws, Traffic Fatalities, and Alcohol Consumption*, 56 J.L. & ECON. 333 (2013).

This Article examines the impact of legalized medical marijuana on road fatalities. In addition, the authors look at whether or not legalized medical marijuana works as a replacement for overall alcohol consumption. First, the authors provide a brief history of marijuana in the United States; they begin with the introduction of marijuana in the early 1660s and end with the 1996 passage of California's medical marijuana statute. Next, the authors briefly discuss driver impairments associated with alcohol or marijuana use. The authors concluded that while marijuana does impair drivers, alcohol impaired drivers tend to take more risks and underestimate their level of impairment. The authors also discuss the impact medical marijuana laws have on the marijuana market. The authors conclude that medical marijuana laws lead to a substantial decrease in the price of high-grade marijuana. In addition, the demand for high-grade medical marijuana steadily increases, especially among users who are under the legal age limit to consume alcohol. The authors argue that this has a direct impact on the drop in

traffic fatalities for this age group. They assert that users in this age group replace alcohol with marijuana and this in turn leads to fewer fatalities because marijuana users are better drivers than their counterparts using alcohol. They also assert that alcohol use tends to take place at restaurants and bars, requiring people to drive impaired, whereas marijuana users tend to consume it in the home.

Peter J. Cohen, *Medical Marijuana: The Conflict between Scientific and Political Ideology*, 2009 UTAH L. REV. 35 (2009).

Mr. Cohen provides an overview of the FDA and its role in investigating drugs for the legal drug market. Within that overview he identifies issues such as the difference in purpose and effect of medicinal and recreational use of marijuana. He also addresses arguments regarding the negative side effects and risks associated with marijuana use while also showing similar, and in some instances, greater risks existing with other authorized controlled substances used in medicine. Mr. Cohen spends some time speaking to risks such as the connection between smoking marijuana and pulmonary cancer, the possibility that marijuana use leads to the use of other illegal drugs—the “Gateway Hypothesis,” and uses related legal and scientific materials to support his arguments. Additionally, the author provides a summary of the history of medical marijuana’s use prior to the passage of legislation making it an illegal substance and recent studies showing its medicinal applications and benefits. In the latter part of the Article he addresses the struggles faced due to differing scientific and political perceptions of the use of marijuana as a medicine, including its designation as a Schedule I controlled substance and how that affects its designation for use in medical situations, especially when smoked. Mr. Cohen also presents information on the use of Dronabinol and Sativex™ and compares their use and effects to smoked marijuana.

Moira Gibbons, *The Cannabis Conundrum: Medication v. Regulation*, HEALTH LAW, Dec. 2011, at 1.

The author educates the readers on the make-up of cannabis and the ways in which the marijuana plant is used. She also explains cannabinoids and among them THC. Ms. Gibbons explains how a medicine is chosen for treatment and the lack of studies on medical marijuana to assist in it fitting into that choice process. She identifies an Institute of Medicine report often cited by the Drug Enforcement Agency to justify keeping the ban on marijuana. She also identifies new drugs developed to help in areas such as chemotherapy-induced nausea. She indicates though that the efficacy of these compared to medical marijuana has not been compared. She states that research on plant and synthetic cannabinoids needs to continue. Some

of the barriers to these are the roadblocks to obtaining marijuana via government systems and the lack of consistency in the marijuana used. The author proceeds to provide an overview of the federal stance on medical marijuana followed by a summary of state actions in this area.

John Dwight Ingram, *Medical Use of Marijuana*, 33 OKLA. CITY U. L. REV. 589 (2008).

The author summarizes briefly *Gonzales v. Raich*. He then addresses actions in the states regarding medical marijuana pointing out language from the California law. He then moves on to discuss the Controlled Substances Act and the federal government's "war on drugs." A more in-depth discussion of *Gonzales v. Raich* is followed by a discussion of legalizing medical marijuana. He suggests several possible ways to do so. These include: 1) rescheduling marijuana; 2) amending the Controlled Substances Act; or 3) bringing a new case before the U.S. Supreme Court that changes the stance taken in *Gonzales v. Raich*.

Sam Kamin, *The Limits of Marijuana Legalization in the States*, 99 IOWA L. REV. 39 (2014).

This Article explores the pitfalls of medical marijuana with regards to running a business. The author traces this back to the core federalism issue—the states are trying to legalize something that is not in their power to legalize. The Article not only briefly maps out the federalism issue and explores how the Department of Justice Memorandums muddy the issue, but it also explores several legal and business areas that are particularly affected by this issue. These areas are: employment law, probation/parole rules, contracting, and banking. The author argues that until the federalism issue is resolved in a meaningful way, medical marijuana will never be able to become a legitimate tax generating part of the economy.

Linda Simoni-Wastila & Francis B. Palumbo, *Medical Marijuana Legislations: What We Know - and Don't*, 16 J. HEALTH CARE L. & POL'Y 59 (2013).

In this Article the authors review medical marijuana policies and laws and provide suggestions for the evaluation of medical marijuana laws and their implementation. Also covered are the known and unknown health outcomes as well as the identification of knowledge gaps in areas such as social outcomes, dispensary models, and data collection. The data collection limitations are highlighted by the authors who indicate their belief that the best course would be a database analyzing medical marijuana on a number of levels including medical, social, and criminal, among others. The

authors recommend further study of best models for dispensaries and provide potential models. The authors discuss Risk Evaluation and Mitigation Strategies of the Food and Drug Administration and indicate that medical marijuana would be a good candidate for this. Also provided is a discussion of participation in drug monitoring programs.

William Vertes & Sarah Barbantini, *Caught in the Crossfire: The Dilemma of Marijuana "Medicalization" for Healthcare Providers*, 58 WAYNE L. REV. 103 (2012-2013).

The authors provide a history of marijuana use dating back to 1500 B.C., when the Chinese used it for medicinal purposes. They also point to its inclusion in the United States Pharmacopeia in the 1950s. The change in perception of marijuana and its move to a controlled substance is chronicled. The classification of substances as "drugs" and the categories into which drugs fall under the Comprehensive Drug Abuse Control Act is reviewed along with whether medical marijuana falls within the second category. The Controlled Substances Act is discussed with a summary of the process for modification of a drug placed within the Controlled Substances Act's five schedules. Additionally, the authors discuss what a medicine is and whether separate from being a drug is marijuana a medicine. A discussion is also presented on the benefits and pitfalls to both sides if marijuana were reclassified or remained on Schedule I of the Controlled Substances Act. For example, the current models do not involve licensed pharmacists, but rather medical marijuana is self-grown, obtained from a caregiver, or through a dispensary, whereas reclassification as a prescription would involve working through a pharmacist. A significant portion of the work focuses on the Michigan Medical Marijuana Act. In discussing the Michigan Act the authors note the requirement of a physician's evaluation for a registry card and the fact that a physician cannot prescribe marijuana because of its lack of recognition for medical use. Also noted is the Act's requirement of a bona-fide physician-patient relationship without defining the term, however they note subsequent legislation was introduced to help clarify this area. Additionally, the requirements of the Board of Health Professionals with respect to physicians certifying patients for medical marijuana use provide clarification.

Michael Vitiello, *Why the Initiative Process is the Wrong Way to Go: Lessons We Should Have Learned from Proposition 215*, 43 MCGEORGE L. REV. 63 (2012).

The author provides a history of California's Proposition 215, which legalized medical marijuana use in the state, from before its enactment when the federal government had the Compassionate Use Program in effect

to its passage and subsequent legislative and judicial actions. The author covers what he terms “drafting problems” with the initiative. Among those he includes the lack of information on where to obtain marijuana, the ambiguous definition of terms such as “primary caregiver,” and the initiative’s lack of defenses for actions such as transporting marijuana. He indicates how, over the years, courts and the legislature have had to address issues not originally addressed by the proposition such as defining a physician’s recommendation or approval and defining a caregiver. The author summarizes the 2004 Medical Marijuana Program Act and how it resolved some of the initial issues presented by Proposition 215. He also covers 2008 guidelines from the state Attorney General that provided guidance the author indicates was needed twelve years earlier, including regulation guidelines for dispensaries. In addressing his main contention that the initiative process is not the way to bring about laws, the author identifies the following concerns: 1) the proposition resulted from a manipulation of the initiative process rather than through true debate; 2) the initiative process limits the ability of the legislature to reform the law if the proposed legislation is not consistent with the initiative; and 3) in the case of Proposition 215 the “chaos” of the previous fifteen years had led to human and economic costs. In discussing whether it is worthwhile to continue a discussion of the legalization of medical marijuana he identifies the strong support for doing so, which is unlike support for any other drug. Another factor he looks at is the positive economic effect legalization might have in many jurisdictions, while also identifying additional possible costs that will come about from legalization. Also identified by the author as tipping the scale toward legalization is the large number of persons incarcerated in the United States for drug related offenses. He then provides a look at the possible means by which to legalize marijuana.

NEWSPAPER COVERAGE

The following section provides a brief list of newspaper articles from the last year addressing various aspects of the medical marijuana debate.

RECENT NEW YORK TIMES ARTICLES

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Los Angeles County voted to ban marijuana delivery services. A judge in the Los Angeles County Superior Court issued a preliminary injunc-

tion against the developers of an app that provided delivery of marijuana.

Medical Marijuana a Challenge for Legal Pot States, N.Y. TIMES (Jan. 2, 2015), <http://www.nytimes.com/aponline/2015/01/02/us/ap-us-rethinking-pot-a-year-later.html>.

Looks at the challenges of states with legalized recreational use and the issues with taxes and “black market sales.”

Princeton Worker Put on Leave over Medical Pot, N.Y. TIMES (Sept. 2, 2014), <http://www.nytimes.com/aponline/2014/09/02/us/ap-us-princeton-marijuana-ultimatum.html>.

Ian Lovett, *Berkley Pushes a Boundary on Medical Marijuana*, N.Y. TIMES (Sept. 2, 2014), <http://www.nytimes.com/2014/09/03/us/03berkeley.html>.

The article discusses the effort in Berkley to provide medical marijuana to low income residents.

STATES DIFFERENT ACTIONS ON MEDICAL MARIJUANA

Florida Medical Marijuana Backers Seek Law, Ballot Drive in 2016, N.Y. TIMES (Jan. 9, 2015), <http://www.nytimes.com/reuters/2015/01/09/us/politics/09reuters-usa-florida-marijuana.html>.

Illinois Legalizes Medical Marijuana for Children with Seizures, N.Y. TIMES (July 20, 2014), <http://www.nytimes.com/reuters/2014/07/20/us/20reuters-usa-illinois-cannabis.html>.

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Hunter Stewart, *Minnesota Wants to Legalize Medical Marijuana, But Police Agencies are in the Way*, HUFFINGTON POST (Feb. 24, 2014), http://www.huffingtonpost.com/2014/02/24/minnesota-marijuana_n_4847825.html.

Gary Stein, *God Becomes a Passive Lobbyist for Medical Marijuana*, HUFFINGTON POST (Feb. 24, 2014), http://www.huffingtonpost.com/gary-stein/god-becomes-a-passive-lobbyist_b_4824659.html.

The 420 Times, *Washington Lawmakers Vote to Revise Medical Marijuana Regulations*, HUFFINGTON POST (Feb. 20, 2014), http://www.huffingtonpost.com/the-/washington-lawmakers-vote_b_4821108.html.

Matt Ferner, *Epilepsy Group Announces Support for Medical Marijuana*, HUFFINGTON POST (Feb. 20, 2014), http://www.huffingtonpost.com/2014/02/20/epilepsy-foundation-medical-marijuana_n_4825734.html.

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