PROPOSITION 215:

AN ANALYSIS

DECEMBER 3, 1996

INTRODUCTION

This analysis is an effort to provide guidance as to the meaning of the language used in the initiative statute. As is too often true of initiative-generated legislation, there can be a considerable range of opinion regarding the meaning. Typically, and it is true in this case, those who proposed the initiative tell us what they had in mind when they put the words of the initiative on paper. Unfortunately, the language chosen often goes in very different directions than the authors intended. In this particular instance, the stated intention of the drafters is even more difficult to ascertain because they do not have a unified view of what they intended.

As law enforcement officers and prosecutors, we must look first to the statute itself and interpret it based on the plain meaning of its language in the context in which the words are used. Because it is not a statute that imposes a penalty on persons, it is not a typical criminal statute, however, it still should be strictly construed as are criminal statutes in general.

In those instances in which the words and context of the statute are ambiguous, it is appropriate to examine the official voter's pamphlet (see Appendix I for the language) to determine whether it reveals the "probable intent" of the voters. (*Hill* v. *N.C.A.A.* (1994) 7 Cal. 4th 1, 16.) This examination should include the Legislative Analyst's views to the extent they are persuasive and logical (*San Francisco Taxpayers' Association* v. *Board of Supervisors* (1992) 2 Cal. 4th 571, 579-580.) However, in referring to the first of these sources, the ballot pamphlet arguments, it is important to bear in mind the caveat offered in *Hill, supra*:

> "Ballot arguments often embody the sound-bite rhetoric of competing political interests vying for popular support. However useful they may be in identifying the general evils sought to be remedied by an initiative measure, they are principally designed to win votes, not to present a thoughtful or precise explication of legal tests or standards." (at p. 22, fn. 5.)

In the final analysis, the courts will be the arbiters of the meaning of the words and context as applied to the facts to which this law is applied.

Analysis of Proposition 215

I. General Comments

Health and Safety Code section 11362.5 was added by the initiative process at the November 5, 1996, general election (see Appendix II for the language of the statute). It became effective on November 6, 1996 (see California Constitution, Article 2, section 10 (a)). Because it was added through the initiative process, the section may not be amended by the legislature unless (and only to the extent permitted by its terms) the statute permits Legislative amendment (California Constitution, Article 2, section 10(c))[1].

The intent of the statute is to provide two affirmative defenses (see § 11362.5(c) and (d)) for three classes of persons -- physicians, patients and primary caregivers -- involved in "compassionate use" of marijuana. Because of the language of section 11362.5 (b)(1)(B), some defense counsel will contend that the statute is an exemption from prosecution as to patients and caregivers. This section states an intention of the drafters and must be construed in the context of section 11362.5(d) which is expressed in terms of an affirmative factual defense. To the extent that there is an ambiguity (there does not appear to be an ambiguity here), the ballot arguments are helpful. In their rebuttal to the opponents, the proponents have stated that the statute merely provides a defense in court. (See Rebuttal, p. 61, Appendix I.)

This analysis is an attempt to set out the limits of the statute using the statements of intent its drafters included in the section (§ 11362.5(b)). Since this statute represents a total departure from existing national, California and other state policy[2], there really is little, if any, useful precedent.

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[1]There may be an opportunity to make some legislative changes with respect to the law. This possibility is discussed in Part III, infra.

[2]At the same election, the voters of Arizona passed a somewhat similar statute (see Appendix III for a summary of the Arizona law). Under Arizona law, however, this statue will not take effect for 30 days (December 6, 1996). Also, again because of Arizona's law, their initiative may be amended by the state Legislature regardless the terms of the statute.

II. Analysis

A. Section 11362.5 (c)

1. Language

"Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

2. Persons Who May Assert The Defense

The section does not define the word physician. Section 11362.5 of the Health and Safety Code is contained in the same division of the code as section 11024, which defines the word "physician" as a person licensed to practice as a physician in the state. Under section 11001, this definition governs "unless the context requires" otherwise. There is no indication that the context of section 11362.5 would require otherwise.

Under Business and Professions Code section 2050, all physicians and surgeons shall be in one category of license. Section 2051 of that code permits use of appropriate treatments on patients. Only physicians and surgeons in good standing may use the initials M.D. and practice as physicians (compare sections 2054 and 2055, and see section 2065). The definition to be applied is a medical doctor licensed to practice medicine by the California licensing authorities.

Because of the use of the phrase "in this state" to modify "physician", it can he argued that the otherwise qualified "physician" must be practicing in California. There is, of course, the argument that a physician in good standing with California licensing authorities who is out of state but has a relationship with a patient who qualifies under the initiative may recommend. The ballot pamphlet materials do not help resolve this issue. Obviously, doctors not licensed by California authorities do not have authority to recommend. A "physician" who has an active California license but maintains his/her practice in another state may not recommend for persons, not California residents who then come to California to obtain medicine.

An additional limitation is that a "physician" may not recommend to any but California residents. This is because subsection (b)(1)(A) states the intent that the law apply only to "seriously ill Californians." An issue arises as to whether these persons must actually be living in California. If the person is legally domiciled in California or is a legal resident of California he/she probably meets the definition. Note that the defense can only be asserted in California's state courts.

Finally, it is important to note that any otherwise qualified "physician" who approves the use of marijuana by a person already using it does not enjoy the benefit of the defense. The terms "approve" and "recommend" are not defined. The usual definition of approve is to validate an action already taken or proposed to be taken (the initiative coming from the patient to the doctor), while recommend is the act of suggesting taking an action. It seems clear that the proponents did not contemplate that patient elect to use and merely have the physician "rubber stamp" his/her choice. Subsection (c) of 11362.5 only includes recommendations.

By contrast, subsection (d) includes the terms "approval and recommendation" in describing the extent of the defense available to the "patient."

Obviously, if the drafters of the initiative had intended to protect physicians who merely approved self-prescribed use, the term approve would appear in subsection (c). The statement of intent in subsection (b)(1)(A) is also limited to use of the term "recommended" when describing the role of a physician.

3. Substances That May Be Recommended By A Physician

As in the case of the word "physician," the word "marijuana" is not defined by the initiative. Health and Safety Code section 11018 does define marijuana.

Because the section 11018 defines marijuana to include "every . . . mixture or preparation of the plant . . ." including resin, because Health and Safety code section 11006.5 defines "concentrated cannabis" as resin based derivatives and because the schedules of drugs do not mention hashish

separately, it would appear that section 11362.5(d) includes this more concentrated and dangerous form of marijuana.

There is an argument that the use of the word "marijuana" without the term "concentrated cannabis" limits coverage of the defense to marijuana. The statute, however, merely refers to Health and Safety Code section 11357, without excepting subsection (a).

4. Circumstances Under Which A Physician May Recommend

The issue here is whether a qualified physician may make a generalized recommendation to persons without individual examination and evaluation. The clear answer is no.

The intent language offered by the drafters in subsection (b)(1)(A) used the phrase ". . . by a physician who has determined that the person's health would benefit . . . ." (Emphasis added.) This intention is properly expressed by subsection (c)'s reference to ". . . a patient . . . ." Business and Professions Code section 2242 expressly provides that a physician who prescribes, dispenses, or furnishes dangerous drugs without a good faith prior examination, is engaging in unprofessional conduct and may be subject to discipline.

Thus, it is required that a physician examine a person and make the specific determination that the individual's health would benefit.

5. Findings Which A Physician Must Make

Here the issue is what findings a physician must make before he/she can recommend.

The proper beginning point is to point out that all physicians are bound by the Hippocratic Oath which admonishes "First, do no harm." The standard which should be applied is that a physician must act in keeping with generally accepted standards of medical practice.

At the outset, then, the drafters provided that the "section" shall not be construed to ". . . supersede legislation prohibiting persons from engaging in conduct that endangers others . . ."

(§ 11362.5 (b)(2)). Of interest is the fact that the word "legislation" is not defined by the act to limit its meaning to state legislation. There is authority for the proposition that federal law is incorporated into state law absent some express statement to the contrary in the federal statute. (See *People* v. *Barajas* (1978) 81 Cal.App.3d 999, 1006; *People* v. *Arciga* (1986) 182 Cal.App.3d 991, 1000; and *Gonzales* v. *City of Peoria*, 722 F.2d 468, 475 (9th Circ. 1983)

Both state and federal law prohibit physicians from prescribing schedule I controlled substances. D.E.A. has the authority to revoke a physician's registration number which, in effect, eliminates the right to prescribe. (See 21 U.S.C. §§ 823 and 824.)

Given the scientific and medical evidence (see Appendix IV), there is an argument that recommending a habit forming substance (see 21 U.S.C. § 352(b)), which is deemed by both state and federal legislatures as too dangerous to prescribe is ". . . engaging in conduct that endangers others . . .."

Obviously, the drafters would argue that this interpretation is contrary to their intent. It is important, however, to note that the initiative statute does not make the finding that marijuana shall be deemed a medicine. The reason this is so is the same reason the statue does not require a written prescription, that is that the drafters recognized that attempting to declare it medicine or requiring a prescription would conflict directly with 21 U.S.C. section 903 and would be preempted by federal law.

However, it is clear that at the very least the voters intended to make marijuana available to certain persons on a doctor's recommendation. It is clearly the case that some doctors will recommend[3]. Thus, the issue becomes the validity of the particular doctor's recommendation for the specific patient and whether that recommendation is consistent with sound medical practice. It will not be possible to argue that there is no

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[3]Two C.M.A. documents are attached as Appendix V. It is interesting to note that these documents, incorrectly, refer to "immunity" for doctors.

case in which a person could receive marijuana with a doctor's recommendation.

Next, a physician must find that ingestion of marijuana is an appropriate medical use that would benefit the health of the individual patient afflicted with the specifically listed diseases or conditions (cancer, anorexia, AIDs, chronic pain, spasticity, glaucoma, arthritis and migraine). Clearly, this finding must be based on generally accepted medical standards or it would constitute medical malpractice. Further, the physician is obligated to base his/her recommendation on a body of generally accepted scientific evidence specific to the disease. (KELLY/FRYE type standards will apply.)

Therefore, the second finding the physician must make is that there is generally accepted scientific evidence that ingestion of marijuana will benefit the patient's health.

The injunctive phrase, "or any other illness for which marijuana provides relief," is still subject to the same two qualifications. These are, first, that recommending marijuana does not endanger the patient and, second, that generally accepted scientific evidence supports a finding that marijuana will benefit the patient by providing relief from the condition generated by the illness.

6. Conclusion

The key to the availability of the affirmative defense is the ability of the physician to demonstrate that he/she acted in a medically sound manner in recommending marijuana for the specific patient in question.

Given the historic failure to qualify marijuana under F.D.A. rules and the resultant inability of a physician to be assured of the content, purity and potential effects of ingesting marijuana from a specific source, it may be difficult for a physician to find that the recommendation does not endanger others.

Indeed, it would appear that the drafters recognized the problems of content, purity and effect. Subsection 11362.5 (b)(1)(c) states that the drafters want to encourage state and federal

government to provide ". . . safe . . . distribution . . . ."

State and federal governments, however, have already concluded, after numerous studies, that marijuana should be and should remain a schedule I substance[4]. The burden of demonstrating both medical value and lack of danger is on the physician seeking to recommend. At present, there is no accepted scientific/medical evidence which would support such recommendation:

> "One of the very purposes in placing a drug in Schedule I is to raise significant barriers to prevent doctors from obtaining the drugs too easily. D.E.A. regulations required doctors who wish to use such drugs to submit a scientific protocol to the FDA for approval and permit use only in accordance with the protocol. And it insists that a developed scientific study program to be presented in order to gain approval of the protocol." (*Alliance for Cannabis Therapeutics* v. *D.E.A.* (D.C. Cir. 1991) 930 F.2d 936, 940; *Alliance for Cannabis Therapeutics* v. *D.E.A.* (D.C. Cir. 1994) 15 F.3d. 1131, 1133; see e.g. 21 C.F.R. 1301.33(b) and 21 C.F.R. 130.3).

The balance then is between the voters' desire to permit seriously ill persons to have marijuana, if it would benefit their health, and the physician's justification for finding that benefit outweighs the danger of marijuana ingestion.

B. Section 11362.5(d)

1. Language

> "Section 11357, relating to the possession of marijuana, and section 11358, relating to cultivating marijuana, shall not apply to a patient, or to a patient's primary caregiver,

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[4] A T.H.C. containing drug has been approved for prescription.

who possess or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician."

2. Persons Who May Assert The Defense

Assuming for the purposes of argument that a physician has made a valid recommendation, there are two categories of persons who may assert the defense: patients and primary caregivers. Again, it is important to reiterate that a physician who merely approves a self-prescribed use has no defense.

a. The Patient

This person must be a seriously ill California resident who has been diagnosed as having one of the specifically listed diseases or conditions or who has any other illness as to which there is valid scientific evidence that marijuana ingestion provides relief.

As to a patient who either possesses or cultivates, he/she may only do so for personal medical purposes. The limitation, read in light of section 11362.5(b)(2)'s expression that the section shall not be read to condone diversion for nonmedical purposes, appears to preclude cultivation of any amount greater than necessary to meet the single patient's needs. Thus, a patient who cultivates an amount greater than his/her personal needs does not enjoy the benefit of the defense. This may not be the case if a patient also is a designated primary caregiver for another patient. It further appears that this personal-use limitation would prohibit commercial cultivation and cooperative style possession[5].

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[5] As the flier attached as Appendix VI shows, certain individuals will attempt to use this law as a shield for open sales operations. Such operations simply cannot be legal because they cannot qualify as caregivers. A caregiver is "an *individual*

The proponents appear to support this conclusion. Both segments of their ballot arguments (see pp. 60 and 61, Appendix I) use language that suggests that cultivators who sell (presumably at a profit) are not to be permitted to assert the defense. As the materials in Appendix VI demonstrate, the "Buyers' Clubs" all have some margin of profit incorporated in their structure.

Unfortunately, a person of any age may receive and use, or grow and use, marijuana under this statute. Even more unfortunate is the fact that if a minor designates as a primary caregiver someone who otherwise meets the definition of primary caregiver but isn't a parent, there can be authorization to ingest marijuana without the knowledge or approval of the minor's parents.

b. The Primary Caregiver

This is the single term defined by the statute. A primary caregiver is an individual (that is a real person) designated by the patient.

The primary caregiver must have "consistently assumed responsibility for housing, health or safety" of the patient making the designation. This language requires that a relationship over a meaningful period of time must be demonstrated before a person may be deemed properly qualified as a primary caregiver.

As in the circumstance discussed, *supra*, regarding physicians, section 11362.5(b)(2) comes into play. By way of example, a person who harbored a runaway minor (or minors) who might fall within the category of patients described in 11362.5(b)(1)(A) could be prevented from being a primary caregiver

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. . . who" (emphasis added) has done certain acts for the patient, not a business enterprise.

because the act of harboring would constitute at least the crime of contributing to the delinquency of minors and, almost by definition, is conduct which endangers others.

The primary caregiver definition's use of the word "individual" reinforces the conclusion that clubs cannot assert the defense. Simply put, the definition contemplates a person-to-person relationship inconsistent with the large scale operation of a club serving many patients. Put another way, "clubs" can never be primary caregivers. One caveat is in order in this context, it may be the case that patients, and/or primary caregivers could band together to use a common plot of land to grow, share the work, harvest, and then divide for patient use the marijuana grown. The standard by which the legitimacy of such efforts would be measured is the danger that this type of effort increases the likelihood that surplus will be generated that would be diverted. (See 11362.5(b)(2).)

It is also the case that one individual might serve as a primary caregiver for more than one patient. However, given the need for there to be an historic, consistent relationship it is not likely that a primary caregiver could properly handle a large number of patients.

3. Circumstances In Which The Defense May Be Asserted

By its terms, the subsection applies to only two sections, Health and Safety Code section 11357 and section 11358. This reference is the basis for the proponents' representations that this is a narrowly-drawn statute.

However, section 11362.5(b)(1)(B), the intent section, states that patients and caregivers who otherwise comply with the act are "not subject to criminal prosecution or sanction."

When read in light of the broad intent, the impact on a number of Health and Safety code sections other than 11357 and 11358 seems clear (see Appendix VII.).

This "opening of the floodgates" hinges on the recommendation of a physician. As was discussed in the analysis of section 11362.5(c), a physician acting in a manner consistent with appropriate standards of practice has much to consider before making a good faith recommendation. If a physician does make a recommendation, then, as to primary caregivers and patients, the initiative statute could well be deemed to provide an affirmative defense against nearly all marijuana offenses.

Because federal law is not affected by Proposition 215, there is no affirmative defense available to anyone who possesses or cultivates on federal property.

County and state operated correctional facilities are generally deemed to be responsible for insuring that persons committed to custody receive proper and necessary medical care. This duty carries with it the right to independently evaluate the medical condition of an inmate and to determine the appropriate treatment. Thus, it would appear that a physician working for the facility may independently determine whether any inmate has a right to use marijuana as medicine[6].

Schools present a particularly sensitive problem because Health and Safety Code section 11357 (d) and (e) both deal with marijuana and school issues. In the ballot

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[6]Mere disagreements between treating physicians, or between an inmate and his treating physician, about the kind of medical care that is adequate or necessary in his case fails to state a constitutional violation and thus, a cause of action under § 1983 of the Federal Civil Rights Act. (see *Sanchez* v. *Vild*, 897 F.2d 240, 242 (9th Circ. 1989); *Franklin* v. *Oregon*, 662 F.2d 1337, 1344 (9th Circ. 1981).

pamphlet the opponents expressly raised the issue of availability to children and the proponents chose not to rebut or even address the issue.

Because of the significant safety and dissemination issues, it seems clear that use at school should not be permitted; however, the express reference to section 11357 without qualification and the failure to place age restrictions on the category of "patient" makes this a significant issue. Agencies should meet with school officials to establish policies and protocols.

III. Legislation

The statute, as previously noted, does not permit amendment. There is, however, "anti-supersession" language in section 11362.5 (b)(2):

> Nothing in this section shall be construed to supersede legislation *prohibiting persons from engaging in conduct that endangers others*, nor to *condone the diversion of marijuana for nonmedical purposes*." (Emphasis added.)

This language means that existing statutes dealing with conduct that endangers others is not set aside. It means that the Legislature can probably continue to legislate with respect to conduct that implicates marijuana use and danger to others.

Existing statutes that are aimed at prevention of dissemination of marijuana are not affected except to the extent that they might be used to defeat the "medical" uses permitted by the initiative. Legislation that seeks to prevent dissemination and that does not conflict with "medical" uses permitted by the initiative statute would, hopefully, be appropriate.

IV. Civil Liability

The liability rules that apply to search and seizure situations will apply in this area. Thus, a detention based on reasonable suspicion and a search or seizure based on probable cause or on good faith reliance on a properly issued warrant will insulate the officer against liability.

This issue, however, should be discussed with the city attorney or county counsel advising the agency.

Addendum to Page 9, last paragraph of subsection a.

(New paragraph)

Because the act failed to place any limit on age, the physician's duty to use caution before recommending marijuana is much more stringent in the case of minors. As has already been pointed out in the analysis of section 11362.5 (c) (pages 2-7), it should not be an easy matter for a physician to recommend marijuana for an adult. There are simply no studies, not even anecdotal, that support use of marijuana by children for any medical benefit. Clearly, any case in which a minor is involved as a patient should be viewed with suspicion; it may not be too strong to assume that the physician is <u>not</u> complying with standards of sound medical practice.