Michigan's Medical Marihuana Act—Parting the Haze

by

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Introduction

On November 4, 2008, the people of the state of Michigan spoke loudly and clearly to the legislature as well as to the rest of the nation. The message they communicated, via a ballot initiative receiving the support of 63% of registered voters, was that marihuana has medical benefits.[1] As such, the voters made it clear that they supported the legalization of marihuana within the state of Michigan for certain medical uses. To give effect to this popular support, the legislature adopted the proposed version of the Michigan Medical Marihuana Act (MMMA, but hereafter referred to as "the Act" or "the Michigan Act") on December 4, 2008[2]. The Act sets out some of the findings on the benefits that medical marihuana can confer upon a patient, among those being relief from "pain, nausea, and other symptoms associated with a variety of debilitating medical conditions."[3]

However, in getting this issue onto the ballot through the initiative process, the proponents of medical marihuana's availability in Michigan had to submit a draft of the proposed legislation. When such an initiative is passed by a majority of popular votes, the legislature must either pass or reject the legislation as proposed in the initiative without any changes.[4] Whether through problems related to the give-and-take of the political process, a lack of knowledge about how such a program could be effectively administered, or a host of other potential causes, the Act was drafted in such a way that has given rise to several issues. These issues are related in large part to the Act's language, seemingly inconsistent sections, and general ambiguity as to what is expected of patients, physicians, and law enforcement. Michigan Court of Appeals

[1] This is the spelling used by the statute, which I will utilize throughout this paper except within quotes which use the other accepted spelling of "marijuana." This initiative was adopted and codified as MICH. COMP. LAWS §§ 333.26421-333.26430 (2008). The ballot from that November 4th election is available at http://www.michigan.gov/documents/sos/ED-20_11-08_Props_Poster2_251561_7.pdf.
[2] MICH. COMP. LAWS §§ 333.26421-333.26430.
[3] *Id.* at § 333.26422(a).
[4] MICH. CONST. art. II, § 9.

Judge Peter O'Connell stated that reading the Act "carelessly or out of context could result in jail or prison time for many of our citizens."[5] The courts have attempted to deal with these issues, but without clear guidance they have struggled to come up with rulings which balance the competing policy interests at play while still giving effect to the will of the voters in providing access to medical marihuana. Even the general application of the Act and its intersection with the criminal laws of Michigan is somewhat of a conceptual nightmare. As stated in the *People v. King* decision by the Michigan Court of Appeals, "these individuals continue to violate the Public Health Code by using marijuana, the [Act merely] sets forth narrow circumstances under which they can avoid criminal liability."[6] As a result, courts in Michigan have adopted several competing interpretations of the various sections of the Act.

This paper will first analyze the Act as it is currently written. It will discuss some of the main problems, and illustrate these problems using case law from Michigan's courts. Then, it will discuss several issues related to the Federal Government. One of these issues is potential federal preemption of the Michigan Marihuana Act. This issue is very important, because federal pre-emption makes an analysis of how Michigan's Act could be improved an exercise in futility. Another important issue is the federal justice system's treatment of marihuana. Finally, this paper will offer suggestions for improvement via comparisons to the Model Medical Marijuana Bill as well as the Medical Marijuana Act passed by the State of Rhode Island.

Interpretive Issues

Given that marihuana was previously illegal in the State of Michigan for any purpose, a law allowing its use for medicinal purposes raises the question of how a patient is to acquire

[5] Mike Householder & Tim Martin, *Michigan's medical marijuana law shrouded in haze*, THE DAILY TRIBUNE, Dec. 22, 2010, http://www.dailytribune.com/articles/2010/12/22/news/doc4d12d912166e0368260857.prt.
[6] 804 N.W.2d 911, 915 (Mich. Ct. App. 2011).

marihuana. Although each patient is allowed to possess up to 2.5 ounces of usable marihuana, and up to 12 marihuana plants for personal use,[7] the MMMA does not explicitly authorize any method of acquisition for the seeds needed to grow marihuana. Attorney General Bill Schuette touched upon this problem in one of his opinions.[8] Due to this, growing enough to support one's own needs is a problem. One potential solution to this problem is to look to a third-party in order to acquire marihuana, at least initially.

According to that same Attorney General's opinion, the voters who adopted the Act did not contemplate cooperative grow operations involving multiple patients.[9] That opinion recognizes two ways that a patient may lawfully acquire marihuana: by growing for personal use, or by acquiring from a "registered caregiver."[10] The case law developed since adoption of the Act has even questioned patient-to-patient transfers, when both patients are lawfully registered.[11]

The MMMA mentions "primary caregivers" several times.[12] These individuals are allowed to cultivate up to 12 plants per patient, and possess up to 2.5 ounces of usable marihuana per patient. [13] Registered caregivers are allowed to assist up to 5 patients, all of whom must vest their authority to cultivate marihuana in the caregiver and properly register that relationship.[14]

However, case law questions a registered caregiver's requirements under the Act. First, the Act states that primary caregivers as well as individual patients must keep the marihuana which has been cultivated for each registered patient in an "enclosed, locked facility."[15] The Act defines this phrase as a "closet, room, or other enclosed area equipped with locks or other

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[7] MICH. COMP. LAWS at § 333.26424(a).
[8] Att'y Gen. Op. 7259 at 3 (June 28, 2011), http://www.ag.state.mi.us/opinion/datafiles/2010s/op10338.htm.
[9] *Id.*
[10] *Id.*
[11] *Michigan v. McQueen*, 2011 WL 3685642 at 13 (Mich.App.), states that patient-to-patient transfers using a third party business to facilitate the transfers are not within the protection of the Medical Marihuana Act.
[12] The specific section governing primary caregivers is § 333.26424.
[13] MICH. COMP. LAWS at § 333.26424(b)(1)-(2).
[14] *Id.* at § 333.26424(b).
[15] *Id.* at § 333.26424(a).

security devices that permit access only by a registered primary caregiver or registered qualifying patient."[16] The courts have contemplated several times the measures needed to meet the burden of maintaining an "enclosed, locked facility."

The Michigan Court of Appeals stated in *People v. King* that an unlocked closet is not enough to meet this burden, even if protected by the owner and located within a locked home, since the Act requires that marihuana only be accessible to the specific patient for whom it is grown as well as the primary caregiver.[17] In *King*, the homeowner was also growing marihuana within a chain-link dog kennel which was movable and not covered on the top. The Court held that a movable structure with no top covering, despite the fact that it was locked, does not fall within the meaning of "other enclosed area" within the definition of "enclosed, locked area" since it does not share similar characteristics to the other specifically-enumerated types of disclosures.[18] The Court used the doctrine of statutory interpretation referred to as ejusdem generis, meaning that "the scope of a broad general term following a series of items is construed as including 'things of the same kind, class, character, or nature as those specifically enumerated…'"[19] This case illustrates the confusion on the part of registered patients who, while attempting to comply with the Act, are not sure exactly how to do so on a practical level.

Second, whether generalized dispensaries are sanctioned by the MMMA is a hotly-contested issue. Aside from issues arising from federal treatment of these facilities, local authorities are attempting to fill this specific void left by the MMMA.[20] These municipalities,

[16] *Id.* at §333.26423(c).
[17] 804 N.W.2d 911, 917-18 (Mich. Ct. App. 2011).
[18] *Id.* at 916-17.
[19] *Id.* at 917.
[20] *Supra* note 5.

including Lansing, outlawed such dispensary operations in absence of a clear authorization for them in the law.[21]

Without clear authorization for these facilities, access for qualifying patients is harmed. Due to this lack of clear authorization an operation attempting to facilitate patient-to-patient sales of medical marihuana was held not to qualify for protection under section 4 of the Michigan Medical Marihuana Act in *State v. McQueen*.[22] The Michigan Court of Appeals stated in *McQueen* that because patient-to-patient sales were not contemplated by the term "medical use" under the Act, dispensaries do not receive protection.[23]

Third, the compensation allowed by the MMMA for primary caregivers is a fuzzy issue as well. The MMMA authorizes compensation for "costs associated with assisting a registered qualifying patient."[24] Without more guidance, it is unclear whether caregivers may turn a profit or simply cover the costs of growing marihuana for their registered patients. It is unlikely that caregivers would agree to undertake such duties given the uncertainty of the law and the accompanying risk of prosecution, especially if no financial incentive exists. If they do not undertake the duties of registered caregivers, access to marihuana for registered patients will be inhibited and the will of the majority of voters to provide such access in Michigan will be frustrated.

According to the Act a "qualifying patient" must be diagnosed with a debilitating medical condition by a physician.[25] The physician is insulated from any legal or professional punishment at the state level if he determines that a patient is likely to receive therapeutic or palliative benefit

[21] *Id.*
[22] 2011 WL 3685642 at 13 (Mich.App.).
[23] *Id.* at 12-13.
[24] MICH. COMP. LAWS at § 333.26424(e).
[25] *Id.* at §333.26423(h).

in treating or alleviating the symptoms of such a condition.[26] This determination must be in the form of a written certification, in the course of a bona-fide physician-patient relationship, and after the physician completes a full review of the patient's medical history.[27]

The courts are unsure about the meaning of this section as well. First, what is a "bona-fide relationship" within the meaning of the Act? In *People v. Redden*, the Court of Appeals held that Dr. Eisenbud did not create such a relationship with the defendants even after reviewing each of their respective medical histories and determining that they would each receive medical benefit from using medical marihuana.[28] Therefore, the Court did not allow either defendant to rely on the affirmative defense embodied in section 8 of the Act.[29] The Court noted that "the facts at least raise an inference that Defendants saw Dr. Eisenbud not for good faith medical treatment but in order to obtain marihuana under false pretenses."[30] Presumably, this inference in *Redden* rested on the fact that Dr. Eisenbud was not the primary care physician for the Defendants, nor did he treat the underlying condition for which they claimed a medical need for marihuana.

Second, when is the physician required to render an opinion that a patient would receive the required medical benefits from using marihuana? The Court of Appeals stated in *People v. Kolanek* that, in order to rely on the affirmative defense set out in section 8 of the Act, the physician must render the opinion prior to arrest.[31] In *Kolanek*, a search of Defendant's car yielded eight marihuana cigarettes. Defendant had a written medical opinion that he could benefit from the use of marihuana for his chronic Lyme disease, as required by the Act, but did

[26] *Id.* at §333.26424(f).
[27] *Id.* at §333.26424(f).
[28] 799 N.W.2d 184, 196 (Mich. Ct. App. 2010).
[29] *Id.*
[30] *Id.*
[31] 804 N.W.2d 870, 875 (Mich. Ct. App. 2011).

not receive it until after his arrest for possession of the marihuana cigarettes. The Court reasoned that, since the Act was passed as an initiative, the voters "must have intended that the physicians opinion be stated prior in time to some event" due to the language in section 8 of the Act requiring that the physician "has stated" the medical benefit to the patient in his opinion.[32] This is because "[t]he words of an initiative law are to be given their ordinary and customary meaning as would have been understood by the voters."[33] That event, the Court reasoned, has to be prosecution for possession of marihuana—which begins with the arrest.[34] However, in a strange twist, the Court still held that failure to win a pre-trial motion to dismiss did not preclude the Defendant from presenting evidence relating to the section 8 affirmative defense to the fact finder at trial.[35]

The discussions above relating to section 4 and section 8 of the Act create an effective segue into discussion of a related problem. Most of section 4 of the Act deals with how a patient or primary caregiver can comply with the registration requirements of the medical marihuana program. Section 8 specifically sets out the affirmative defense available to such individuals, who possess marihuana and seek to rely on the protections of the Act in subsequent prosecution. One would assume that the registration requirements of Act are a prerequisite to reliance on section 8's affirmative defense. However, courts have differed on this issue.

The case of *People v. Redden* is an example of how these two sections operate in relation to one another according to the Michigan Court of Appeals.[36] That case involved a warrant search where the police discovered a large amount of usable marihuana and plants. At one point during the search, the Defendants turned over signed statements from Dr. Eisenbud stating that

[32] *Id.*
[33] *Id.* at 873.
[34] *Id.* at 875.
[35] *Id.* at 878.
[36] 799 N.W.2d 184 (Mich. Ct. App. 2010).

they were likely to receive therapeutic or palliative benefit from the use of medical marihuana. They did not, however, possess a valid registry card. During the preliminary examination, they asserted the affirmative defense embodied in section 8 of the Act. In *Redden*, the Court observed that "individuals may either register and obtain a registry identification card under [section] 4 or remain unregistered and, if facing criminal prosecution, be forced to assert the affirmative defense in [section] 8."[37] So, according to that interpretation, both avenues exist independently for a person seeking to use marihuana for medical purposes and receive protection from the Act.

Conversely, the same Court reached a somewhat contradictory conclusion in *People v. King* less than a month later.[38] There, the Court denied the Defendant use of the affirmative defense embodied in section 8, due to his failure to comply with the locked and enclosed growing facility requirement of section 4.[39] The Court stated that compliance with all other sections of the Act is required in order to rely on section 8, which is clear due to section 8's reference to section 7 and its mandate that "the medical use of marihuana is allowed under state law to the extent that it is carried out in accordance with the provisions of this act."[40] These competing results show how difficult it is to navigate the maze that is the Michigan Medical Marihuana Act. If the Court of Appeals of Michigan has trouble determining what the Act requires of individual citizens, how are the citizens themselves (without the benefit of a legal education and years of judicial experience) supposed to make such determinations?

One final issue is whether the Michigan Medical Marihuana Act has retroactive effect, providing protection to individuals who had been prosecuted for marihuana-related offenses prior to passage of the Act on December 4, 2008. The Court of Appeals stated in *People v.*

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[37] *Id.* at 193.
[38] 804 N.W.2d 911, 915 (Mich. Ct. App. 2011).
[39] *Id.*
[40] *Id.*

Campbell that the Act does not have retroactive effect to a defendant whose case began a year prior and was still pending when the Act was passed.[41] In *Campbell*, the Defendant faced several charges stemming from a search of his vehicle and home in late 2007, about a year before the Medical Marihuana Act became effective. However, the lower court in Tuscola County reached the opposite result, stating that the correct application of the Act was to apply it retroactively to cases which were still pending when the Act became effective.[42] These two Courts were struggling over the meaning of the same text. It is likely that several lower courts reached conflicting rulings before the Court of Appeals finally spoke on the issue in *Campbell*.

These interpretive issues illustrate the shortcomings of the Michigan Medical Marihuana Act. It was the will of the majority of the voters of the State of Michigan to legalize marihuana for medicinal purposes. By poorly drafting the bill that would give effect to this will, neither the minority nor the majority of voters is satisfied.

Both sides, in effect, lose because their stance on the issue did not result in consistent legislative action. The supporters in the majority have not seen legal protection for citizens of the state who seek to use marihuana for approved medical reasons. The dissenting minority do not get their wish that marihuana remain illegal across the board. Perhaps a careful tight-rope walk between these two camps, and an effort to please both, was the motivation behind the current version of the Act. Either way, the Act is not effective as it is currently written. It needs re-working, and aside from the fact that the legislature is the most qualified and able entity to do so, its most basic job is to represent the will of the people. The people have spoken, and it is time that the legislature listens.

[41] 798 N.W.2d 514 (Mich. Ct. App. 2010).
[42] *Id.* at 515.

Federal Issues

Before time is spent and ink spilled on potential solutions to these statutory shortcomings, it is important to analyze the relationship between the Michigan Medical Marihuana Act and federal law. Problems of this kind relate both to case law from federal courts as well as administrative and enforcement actions by federal authorities. The most important of these issues is federal preemption. If preempted by federal law, the Act has no legal effect regardless of how well it is written.

The first issue is whether the federal government has the authority to regulate medical marihuana. In our federalist system, Congress has limited jurisdiction. All else is reserved to the states to be regulated. The Commerce Clause is the nexus through which the federal government derives the authority to regulate many activities. As shown in the historic case of *Wickard v. Filburn*, the Commerce Clause allows regulation of such an act as growing wheat for consumption on one's own farm.[43] This is because of the ripple effect that private growth and consumption has on the demand for wheat in interstate commerce.[44] If one grows wheat for his own needs, he will not need to go to the market and buy from others.

This same tenuous connection was used in *Gonzalez v. Raich*, a much more recent case and one directly on point with this discussion.[45] In that case, the United States Supreme Court followed the logical lead of *Wickard* in holding that the federal government may criminalize the personal production and use of marihuana, even privately in the home and when state law has approved it for medical use.[46] The Court again used the argument that private growth and

[43] 317 U.S. 111, 127-28 (1942).
[44] *Id.*
[45] 545 U.S. 1 (2005).
[46] *Id.* at 32-33.

consumption has an impact on the national market, and determined that intrastate regulation is necessary to effective regulation of the national market for marihuana.[47]

With federal authority to regulate medical marihuana settled, it is important to take a look at how this authority has been put to use. When it comes to prosecution of drug-related offenses by federal authorities, the main law is the Federal Controlled Substances Act of 1970.[48] This federal act lists drugs in one of five schedules based on their medical value, potential for abuse, and the likelihood that their use could lead to psychological or physical dependence.[49] Marihuana is currently listed under Schedule I, meaning that it has a high potential for abuse, no recognized medical value, and no safe way exists to use the substance even with medical supervision.[50]

Marihuana's status as a Schedule I controlled substance is problematic for those seeking legal protection for the medical use of marihuana. A Federal District Court stated in *Raich v. Ashcroft* that placement on Schedule I precludes any defense based on medicinal use of marihuana, and indicates a finding by Congress that the substance has no accepted medicinal value.[51] The Supreme Court ruled in an earlier case that the common law defense of medical necessity was also precluded by the Controlled Substances Act, and the placement of marihuana under Schedule I.[52]

In the face of all this federal authority, the State of Michigan still passed the Medical Marihuana Act. In fact, the text of the Act recognizes the general prohibition of marihuana under federal law.[53] However, as the Act also points out, 99 out of every 100 marihuana-related

[47] *Id.* at 31-32.
[48] 21 U.S.C.A. § 812 (West 1970).
[49] *Id.* at § 812(b).
[50] 21 C.F.R. § 1308.11(d)(23) (2012).
[51] 248 F.Supp.2d 918, 929 (N.D. Cal. 2003).
[52] *U.S. v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).
[53] MICH. COMP. LAWS at § 333.26422(c) (2008).

arrests in the United States are under state law.[54] Since it remains illegal under federal law despite the passage of this Act, the level of federal enforcement is a key issue.

At the top level, Attorney General Eric Holder has the authority under federal law to add, remove, and change the schedule under which a drug is listed in the Federal Controlled Substances Act.[55] This section provides only that the Attorney General must first order a scientific and medical evaluation of the drug from the Secretary of Health & Human Services, and any recommendations made by the Secretary are binding upon the Attorney General.[56] That the Attorney General has yet to alter the classification of marihuana despite immense political pressure to do so, and political statements made by states such as Michigan in passing statutes legalizing the substance for medical purposes, does not bode well for its legalization at the federal level in the near future.

The so-called "Ogden Memo" was a directive from then-Deputy Attorney General David W. Ogden, issued less than a year after President Obama took office, directing federal law enforcement agencies not to focus federal resources on people who were acting in "clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."[57] This directive also seemed to place a low priority on caregivers, instead directing attention toward those who were trafficking for profit.[58] This left dispensaries, perhaps the activity with the most questionable legality under the Michigan Act, in a very precarious position. This precarious position was later affirmed when Deputy Attorney General James M. Cole sent out a

[54] MICH. COMP. LAWS at § 333.26422(b).
[55] 21 U.S.C.A. § 811 (West 2005).
[56] *Id.* at § 811(b).
[57] David W. Ogden, *Investigations and Prosecutions In States Authorizing the Medical Use of Marijuana*, Memorandum for Selected United States Attorneys (2009), available at http://blogs.usdoj.gov/blog/archives/192.
[58] *Id.*

memo in June of 2011 "clarifying" the Ogden Memo.[59] This circulation instructed federal agencies to maintain pressure on dispensaries and related marihuana grow-and-sell operations, stating that such operations are in clear violation of the Controlled Substances Act.[60] This memo clarified the Ogden Memo by stating that the latter only meant to dissuade expenditure of federal resources on individuals with serious medical conditions, or their caregivers, who were in possession and using marihuana under color of state law.[61]

Dispensaries and related operations have felt the sting of federal enforcement in recent years. According to Americans for Safe Access, an organization which believes in access to medical marihuana for patients who can benefit from it, there were well over 100 raids of such operations in the first two and a half years of Obama's presidency.[62] This is compared to about 200 during President George W. Bush's eight year presidency,[63] before the Ogden Memo and before several state statutes legalizing medical marihuana were passed. So, despite the findings of the Michigan Legislature that federal arrest and prosecution for marihuana-related offenses is negligible compared to that of state authorities, the federal government has not made it any easier for those seeking to provide and use marihuana as authorized by the Michigan Medical Marihuana Act.

Given this split between state and federal law, an obvious question arises as to whether Michigan's Legislature may pass such a statute despite the Controlled Substances Act. If an activity is solely within the authority of the federal government, then any state legislation purporting to regulate that activity is preempted—meaning it has no legal effect. The Supreme

[59] Mike Riggs, *Obama Administration Overrides 2009 Ogden Memo, Declares Open Season on Pot Shops in States Where Medical Marijuana Is Legal*, REASON MAGAZINE, June 30, 2011, http://reason.com/blog/2011/06/30/white-house-overrides-2009-mem.
[60] *Id.* at 1.
[61] *Id.* at 2.
[62] *Id.* at 3.
[63] *Id.*

Court set out a test for preemption in *Pennsylvania v. Nelson*.[64] This test looks to: 1) whether the federal regulatory scheme is pervasive; 2) whether federal interests in the field are so dominant that the federal system must be assumed to preclude enforcement of state laws on the same subject; and 3) whether there is danger of conflict between state laws and the administration of federal programs.[65]

While this test does not lend much predictability to circumstances such as the one confronted here, courts have repeatedly recognized the usage of the 50 states as little laboratories. The Supreme Court acknowledged in *Engle v. Isaac* that states have "primary authority for defining and enforcing the criminal law."[66] While federal cases interpreting the potential preemption of a piece of legislation like the Michigan Medical Marihuana Act differ greatly in opinion, a Federal District Court has stated that nothing in the Constitution forbids the making of local penalties for drug possession less stringent than federal penalties.[67] The Michigan Medical Marihuana Act does just that by not legalizing marihuana, but simply allowing a narrow class of users to avoid criminal liability.[68]

Looking at the factors from *Nelson*, there is a chance that the Michigan Act passes the test and avoids preemption. The Controlled Substances Act is quite pervasive. It lists several substances and makes a determination as to whether they have any medical benefit. However, the scientific research that the Attorney General relies upon to make such a determination could change at any time. New studies could emerge which find medical benefits in the use of marihuana. Aside from that, it cannot be said that federal interests in regulating marihuana are so dominant that enforcement of related state laws should be precluded. The use and cultivation

[64] 350 U.S. 479 (1956).
[65] *Id.* at 480-82.
[66] 456 U.S. 107, 128 (1982).
[67] *Turner v. District of Columbia Bd. Of Elections and Ethics*, 77 F.Supp.2d 25, 34 (D.D.C. 1999).
[68] *People v. King*, 804 N.W.2d 911, 915 (Mich. Ct. App. 2011).

of marihuana is not an area that must be regulated by the federal government for practical reasons, unlike channels of interstate commerce. Also, little danger of conflict exists between state laws and the administration of federal programs. A state's decision not to pursue a narrow class of marihuana users does not interfere with the ability of the federal government to regulate marihuana as it sees fit. As mentioned earlier, the Act does not legalize marihuana. It shields from state criminal liability a certain narrow class of users. If it legalized marihuana, there would be a bona fide conflict between the Act and federal law. As it stands, a federal court could find that the two laws are able to co-exist.

While the preemption issue is still very much open,[69] and has not been touched upon conclusively by a high federal court seeking to lend finality to the issue, the goal for the Michigan Legislature should remain the same. Worrying about potential preemption, while citizens are arrested for failing to understanding the statutory maze that is the current Medical Marihuana Act, amounts to an abdication of responsibility. It makes little sense to leave the Act in its current state of disarray, when the issue of federal preemption is not conclusively answered. When and if preemption is found, the Act will be useless to the citizens of Michigan. Until then, it has the potential to fulfill its purpose by shielding certain users of marihuana from criminal liability under state law. This was the intent of the voters when they approved the ballot initiative. With that issue out of their minds, the legislature needs to undertake its most important task—refining the language of the Act so that the will of the voters may be given the appropriate and intended effect under Michigan Law.

[69] A quick check of a secondary source relating to the preemption of state-level legislation of medical marihuana reveals a slew of case law that reaches rulings on both sides of the issue. *See* 60 A.L.R. 6th 175.

Revising the Michigan Medical Marihuana Act

Revising the Michigan Marihuana Act's language necessarily involves the preliminary inquiry of how to do so procedurally. According to the Michigan Constitution, amending a bill passed by ballot initiative requires another submission to the voters or a vote of three-fourths of the legislators serving in each house.[70] It would seem, due to the media attention given to the Act's troublesome language and the difficulties that many have faced in exercising their rights under the Act, that the voters would have little opposition to accepting an amended version of the Act. However, predicting voter behavior more than three years after the initiative was approved is fraught with uncertainty.

The other option is to pass the amended version of the bill through both houses of the Michigan Legislature with the approval of three-fourths of those serving in each house. The initial version of the Act was passed by ballot initiative, so predicting legislator voting behavior is also difficult. Politically, at least for many of those holding seats in either house, it would be wise for them to follow the actions of their constituency from the initiative vote. Due to the initiative passing by popular vote, it is hard to tell if the requisite number of legislators would allow an amended version of the Act to pass. It would be wise for them to pass the bill either way, according to the logic of the earlier discussion regarding the lose-lose situation presented by a poorly drafted version of the Act.

Moving on from the more speculative question of whether an amended version of the Medical Marihuana Act could make its way through the legislature, the next question is what could be changed to improve the language of the Act? The first resource that provides valuable guidance is the Model State Medical Marijuana Act (hereafter, the "Model Act") created by the

[70] MICH. CONST. art. II, § 9.

Marijuana Policy Project.[71] According to this organization, in the sixteen states which have enacted legislation authorizing medical marihuana there has not been one documented case of a patient being convicted in federal court for the possession of a small amount of marihuana.[72] Also, as mentioned earlier, the Cole Memo discourages federal prosecutors from pursuing marihuana-related charges against those with serious illnesses in states which have passed medical marihuana laws.[73] This underscores the importance of drafting an Act that clearly spells out the rights and obligations of a patient, and provides him with certainty under state law. The other resource which will provide helpful guidance is the Medical Marijuana Act from Rhode Island (hereafter, the "Rhode Island Act"), a fairly recent law.[74]

The first problem discussed earlier was the initial acquisition of marihuana or seeds to begin the use of medical marihuana. Michigan's Act does not explicitly authorize an avenue of initial acquisition for seeds or other required materials, only mentioning that a patient or his caregiver may cultivate marihuana for the patient's use.[75] This is a commonly-recognized problem.[76] The Model Act authorizes patients to grow their own marihuana,[77] designate a primary caregiver to do so for them,[78] or to acquire usable marihuana through a registered compassion center[79]. In the explanation provided by the organization for their Model Act, the importance of clear language authorizing acquisition of usable marihuana or seeds from the

[71] Model Medical Marijuana Bill, http://www.mpp.org/legislation/model-medical-marijuana-bill.html (last visited Jan. 30, 2012).
[72] Overview and Explanation of MPP's Model State Medical Marijuana Bill, available at http://www.mpp.org/legislation/model-state-bill.html (then click on "PDF version" under the title) (last visited Jan. 30, 2012).
[73] *Id.*
[74] R.I. GEN. LAWS § 21-28.6-1 (2009).
[75] MICH. COMP. LAWS § 333.26424 (2008).
[76] A writer from Reason Magazine touches upon this issue in the context of a discussion relating to the legally unstable situation of dispensaries in Michigan. Shikha Dalmia, *Michigan's Medical Marijuana Law Stoned to Death*, REASON MAGAZINE, August 26, 2011, http://reason.com/blog/2011/08/26/michigans-medical-marijuana-law/print
[77] Model Medical Marijuana Bill § 4(a)(2).
[78] *Id.* at § 4(b)(1)(B).
[79] *Id.* at § 4(i).

criminal market is discussed.[80] After all, patients may do so anyways if faced with immense difficulties in trying to acquire seeds or usable marihuana. A clear authorization would allow them to do so under the protection of the law, although it would provide criminal operations with revenue and potentially expose patients to dangerous situations in buying from such operations or individuals.

The Rhode Island Act follows the Model Act in authorizing so-called "compassion centers."[81] These are non-profit entities regulated under specific sections in each Act, which have the primary purpose of dispensing marihuana, supplies, and educational materials to registered patients who designate the center as one of their primary caregivers. If Michigan were to authorize such centers, and provide that they could dispense seeds as well, patients would no longer be faced with the dilemma of how to acquire marihuana. Along with a clear authorization of self-growing and primary caregiver designation, plenty of options would be provided so that patients could safely acquire enough to cover their needs. In addition, patients would not have to resort to the criminal market.

The Model Act also authorizes patient-to-patient or caregiver-to-caregiver exchanges, provided that no compensation is paid or the exchange does not cause the recipient to possess more than the authorized amount of marihuana.[82] The absence of a clause authorizing this type of transfer is another shortcoming of the Michigan Act. If this type of transfer was authorized in the amended version of the Act, perhaps allowing a fair rate of remuneration for the patient giving the marihuana, patients would benefit from another safe avenue of acquisition. What is the purpose of an Act authorizing the use of marihuana for medical use if acquisition of

[80] Overview and Explanation of MPP's Model State Medical Marijuana Bill, p.2.
[81] R.I. GEN. LAWS at § 21-28.6-12.

[82] Model Medical Marijuana Bill at § 4(e)(4).

marihuana is nearly impossible? Implementing these changes would take care of this initial problem.

In addition, the authorization of compassion centers provides a more easily regulated alternative to the dispensary. Some dispensary operations, such as the one described in *State v. McQueen*, were held to violate the strictures of the Act because they facilitated patient-to-patient sales.[83] With compassion centers, a steady stream of marihuana and supplies will be available to patients who find it impractical or impossible to grow their own or to find a caregiver willing to do so.

These centers are heavily regulated under both the Model Act and the Rhode Island Act, are to be non-profit, and have to be approved for their area of operation. This helps to prevent congestion like what Lansing experienced on certain areas of Michigan Avenue. However, to prevent the legal limbo that such operations experienced in places such as Lansing, the Model Act sets out in section 18 a restriction on local ordinances which ban compassion center operation altogether or make it unreasonably impracticable in the jurisdiction.[84] Including such a clause in the Michigan Act would be a necessary companion to an authorization of compassion centers.

The definition section of the Model Act provides similar guidance to the Michigan Act when determining what constitutes an "enclosed, locked facility." The Model Act provides that an "enclosed, locked facility means a closet, room, greenhouse, building, or other enclosed area that is equipped with locks or other security devices that permit access only by the cardholder allowed to cultivate the plants or, in the case of a registered compassion center, the compassion

[83] 2011 WL 3685642 at 13 (Mich.App.).
[84] Model Medical Marijuana Act at § 18.

center agents working for the registered compassion center."[85] This spells out the expectations in a similar way to the Michigan Act, with slightly more detail. Adopting a more substantive definition to replace the one used in the Michigan Act could prevent a good deal of litigation and uncertainty. Including an example or two of what does not constitute an enclosed, locked facility under the Act could further reduce uncertainty. For example, providing that a common growing area for multiple patients which is accessible by more than one patient would be a violation of the Act (except in the context of a compassion center) could be helpful. Also, clarifying that a locked home alone cannot meet the requirements of the Act would be useful guidance.

The compensation issue also needs to be fixed in the Michigan Act. The Rhode Island Act suffers from the same problem, allowing "reimbursement for costs associated with assisting" a patient but stopping short of spelling out a profit can be realized by charging for labor.[86] The Model Act follows suit in allowing "compensation for costs associated with assisting a registered qualifying patient's medical use of marijuana."[87] If labor costs are legal, how much can be charged? A flat rate rather than an hourly rate would seem to be a more workable standard, perhaps in the form of a maximum percentage markup over an amount fixed in the Act to be the presumptive cost of growing marihuana. Making the amount presumptive would allow it to be rebuttable in exceptional circumstances and provide a level of flexibility for the courts. Labor costs would provide an incentive for caretakers to aid patients, and further increase the avenues for safe access available to patients.

Allowing only non-profit compassion centers to cultivate marihuana, aside from patients and registered caregivers, would be preferable in order to shield them from federal enforcement activity to the greatest extent possible. The Cole and Ogden Memos, as discussed earlier, advise

[85] Model Medical Marijuana Bill at § 3(h).
[86] R.I. GEN. LAWS at § 21-28.6-4(f).
[87] Model Medical Marijuana Bill at § 4(b)(2).

federal authorities to target operations who sell marihuana for a profit.[88] Also, allowing for-profit entities to supply marihuana to patients would put them into competition with the criminal market. The costs associated with running a safe and legal operation would make it difficult to compete with a common street dealer. As non-profit entities, heavily regulated and perhaps aided by state funding as well as private donations, compassion centers can remain cheaper and safer than the criminal market.

The next set of problems deals with the physician-patient relationship, and the relationship required before marihuana can be legally recommended to a patient. Also, when must the recommendation occur for the patient to avoid prosecution? Careful drafting in this area of the Michigan Act could prevent a whole slew of problems. As stated earlier, the Michigan Act requires that the physician "has stated" that the patient "is likely to receive therapeutic or palliative benefit from the medical use of marihuana."[89] The courts in this state found that the consultation and recommendation must have occurred prior to any arrest in order for the section 8 affirmative defense to be applicable.[90]

However, this is quite an extension from the language of the Act. When a court's interpretation goes so much farther than the language of the statute, it results in confusion on the part of those who rely on the statute and do not have the legal training needed to read and interpret subsequent case law. It also vests quasi-legislative authority in the judicial branch, when the legislative branch has the ability to resolve the ambiguity. The Rhode Island Act employs an almost identical statement, requiring that a physician "has stated that…the potential

[88] David W. Ogden, *Investigations and Prosecutions In States Authorizing the Medical Use of Marijuana*, Memorandum for Selected United States Attorneys (2009), available at http://blogs.usdoj.gov/blog/archives/192; Mike Riggs, *Obama Administration Overrides 2009 Ogden Memo, Declares Open Season on Pot Shops in States Where Medical Marijuana Is Legal*, REASON MAGAZINE, June 30, 2011, http://reason.com/blog/2011/06/30/white-house-overrides-2009-mem.
[89] MICH. COMP. LAWS at § 8(a)(1).
[90] *See People v. Kolanek*, 804 N.W.2d 870, 875 (Mich. Ct. App. 2011).

benefits of using marijuana for medical purposes would likely outweigh the health risks for the qualifying patient."[91] The Model Act follows suit in setting forth essentially the same requirement for its affirmative defense.[92] Michigan's Act should take a lesson from the litigation over the past few years and set forth explicitly when the consultation and recommendation from a physician must occur. For example, stating that "the opinion from a physician who recommends the use of marihuana must be given prior to any arrest for the possession or use of such in order for the defendant to have the opportunity to assert the affirmative defense authorized herein" would put an end to any potential uncertainty.

A related problem is confusion as to what constitutes a "bona fide physician-patient relationship" under the Michigan Act. As stated in *People v. Redden*, "a one-stop shopping event to obtain a permission slip to use marijuana under [section] 8 does not meet the requirements of [section] 8(a)(1) that the authorization occur in the course of a bona fide physician-patient relationship."[93] However, the language of the Michigan Act, Rhode Island Act, and the Model Act are all the same in requiring a "bona fide" relationship without describing (even in their respective definitions sections) exactly what constitutes such a relationship. Michigan's Act requires that the statement be given "after having completed a full assessment of the patient's medical history and current medical condition,"[94] but without more guidance it is unclear why Dr. Eisenbud's "one stop shop" in *Redden* was not enough. He reviewed each patient's full medical history and current condition before recommending marihuana.

[91] R.I. GEN. LAWS at § 21-28.6-8(a)(1).
[92] Model Medical Marijuana Act at § 14(a)(1).
[93] 799 N.W.2d at 216 (O'Connell, P.J., concurring).
[94] MICH. COMP. LAWS at § 8(a)(1).

It would be helpful for the Michigan Act to be much clearer in explaining what constitutes a "bona fide" relationship. First, it could spell out that any such opinion given by a physician stating that a patient's use of marihuana would be helpful to his condition should be given by the physician who is treating the underlying condition. *Redden* read this requirement into the statute,[95] but it should be explicitly stated in the Act to avoid confusion and debate in the future. Second, there should be a tracking system instituted by the state to monitor the number of such opinions given by each physician practicing within the state.[96] This way, if the number is inordinately high the state can choose to perform additional investigation into the nature of the consultations which have been undertaken prior to the giving of such opinions. Finally, to avoid opinions like the one given in *Redden* by a traveling physician without ties to the state, the legislature could choose to include a residency requirement for physicians seeking to render opinions to their patients about the use of medical marihuana.

Whether patients in Michigan may rely on the affirmative defense set out in section 8 without complying with the requirements set out in section 4 is another hazy question. As discussed earlier, this question has also given rise to its fair share of litigation. The Rhode Island Act, similar to the Michigan Act, only requires that a physician has given an opinion to the patient in the course of a bona fide relationship and that an amount of marihuana was not possessed in excess of that authorized by the Act.[97] The Model Act goes one step further in that it clearly spells out the availability of the affirmative defense to those who are not in possession of a valid registry card: "an individual is not required to possess a registry identification card to

[95] 799 N.W.2d at 216.
[96] *Id.* at 211 n.20 (O'Connell, P.J., concurring). Judge O'Connell suggests that the Department of Community Health could keep track of physician opinions, and a certain number could be set above which any opinion rendered by that physician is presumptively invalid.
[97] R.I. GEN. LAWS at § 21-28.6-8(a).

raise the affirmative defense set forth in this section."[98] It also requires that the patient comply with the "enclosed, locked facility" requirement if the affirmative defense is to be properly asserted.[99] As stated earlier, this was a problem in *People v. King* when the affirmative defense was denied to the defendant after he failed to comply with the "enclosed, locked" requirement set out in section 4 of the Michigan Act.[100]

Michigan's Act could essentially mimic the Model Act in these respects, and prevent a good deal of confusion on the part of patients and prosecutors throughout the state. First, the legislature could determine whether the affirmative defense should be available to those who do not comply with the requirements of section 4 or who do not possess a registration identification card. This should involve polling the citizenry, since they may have to vote on and approve any changes to the Act. Second, it should clearly state in section 8 whether or not the affirmative defense stands alone, as the Model Act does. Third, any requirement for reliance on section 8's affirmative defense should be spelled out, much like the Model Act did with the "enclosed, locked facility" requirement. As of now, there is a great deal of confusion not only as to whether the defense stands alone, but more specifically how much of the Act need be complied with in order for the defense to be properly asserted. These changes would solve that problem, as long as the authorization for the defense to stand alone (if that is the decision of the legislature or people) clearly states that compliance with no other requirement of the Act is required for proper assertion of the affirmative defense. As with any of the other potential changes discussed herein, clarity is the goal.

A final interpretive issue is whether the Michigan Act is intended to have any retroactive effect. While the presumption is normally that a piece of legislation will have only prospective

[98] Model Medical Marijuana Act at § 14(c).
[99] *Id.* at § 14(a)(4).
[100] 804 N.W.2d 911, 915 (Mich. Ct. App. 2011).

effect, primarily due to common sense concerns about notice to citizens, this question has nonetheless led to a slew of contradictory rulings. The Model Act states that it will have effect upon the date of its approval.[101] The Rhode Island Act does not even explicitly set out an effective date.

Michigan should go further than either of these two Acts, and devote a section specifically to its effective date. It should clearly state an effective date, as well as stating whether cases pending at that time are covered by any or all of the Act's sections. It should also state clearly whether or not prior cases, decided before the effective date, may be reopened due the defendant's inability to get a medical marihuana card at that time. While the answer to that inquiry may seem to be answered most readily using common sense, erring on the side of too much detail is a good practice for the legislature to employ. In the interest of predictability, the revised version of the Michigan Act should simply state that the Act only has prospective application to those who possess, use, or cultivate marihuana in compliance with the Act after December 4, 2008. Those who were arrested prior to December 4, 2008 should not receive protection from the Act, since they possessed, used, or cultivated marihuana when it was still an illegal activity for any purpose.

Conclusion

Many pages and steps of analysis later, there is only one solid conclusion. That conclusion: the current version of Michigan's Medical Marihuana Act is a lose-lose situation for all stakeholders, and needs to be amended. The District Court judge in *People v. Redden* even went so far as to say the Act "is probably one of the worst pieces of legislation [he has] ever seen

[101] Model Medical Marijuana Act at § 27.

in [his] life."[102] Whether the legislature agrees with or disagrees with the authorization of medical marihuana is irrelevant. The people have spoken. It is now incumbent upon those legislators to give effect to that statement by the people, even if only for political reasons.

With the media attention given to the current version of the Act, both proponents and opponents of medical marihuana are upset with the legislature. Despite this Act's likely place below several other important (and perhaps meritorious) decisions made by each legislator during their respective careers, the spotlight is shining directly upon this issue. Each legislator can benefit politically from an affirmative contribution toward a re-tooling of the Act's language. Even legislators from districts that are opposed to this legislation can benefit from trying to resolve ambiguities and conserve precious resources for law enforcement, administrative bodies, and the courts trying to make sense of the current mess that is the Michigan Medical Marihuana Act.

The drafting process at the State Legislature is probably not a simple one. Even when the legislation is approved (as it was in this case) the fight still continues. In order to avoid drawing the ire of both sides of the dispute, the process needs to be undertaken very carefully. The committee drafting the new version should accept input from judges such as Peter O'Connell from the Michigan Court of Appeals, who has heard numerous cases resulting from the defective first version of the Act. Prosecuting attorneys should also have a place at the table. They would greatly benefit from a refined version of the Medical Marihuana Act. Last, but not least, some of the medical experts who have published the findings upon which this Act as well as the multitude of others around the country are based should have input. We need to know how such a program can be administered effectively, at minimum cost, and with maximum certainty for the patients while still providing the intended benefits.

[102] 799 N.W.2d 184, 189 (Mich. Ct. App. 2010).

The suggestions offered herein are based, in-part, on existing statutes (both real and model), but some go beyond existing legislation. Common sense should be a part of the revision process, as it was in creating some of these suggestions. Each drafter should try to word the provisions as precisely as possible, anticipating and preventing confusion. If the Act is not re-written, there will be hundreds of angry judges and law enforcement officials around the state. Users of medical marihuana will continue to struggle in attempting to understand the current version of the Act, and their mistakes could even result in jail time. Most importantly, the current version of the Act will continue to frustrate the intent of the voters to make medical marihuana available to any citizen who can benefit from its use.