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March 26, 2001

Hon. Mayor and Members of the City Council
Berkeley, CA

Re: Medical Marijuana Ordinance

Dear Mayor and Councilpersons:

I write to urge you to adopt the considered recommendations of the Community Health Commission regarding Berkeley's Medical Marijuana Ordinance, considered for Council action on March 20, 2001, and to reject the City Manager's position on this proposed legislation. I do so jointly in my official capacity as Director of Legal Affairs for The Lindesmith Center-Drug Policy Foundation, in my personal capacity as a proud resident of Berkeley.

The Community Health Commission's recommendations regarding the amount of plants for individuals and collectives, for outdoor and indoor cultivation, and amount of dried cannabis if grown outdoors are far more grounded in both medical and horticultural reality than are those of the City Manager. I say this based on my experience over the past four and one-half years examining these very issues as a central part of my law practice. Specifically, I co-authored the medical marijuana laws for the states of Oregon, Washington, Maine and Alaska; serve as a consultant to the city of Seattle and the Department of Public Safety for Hawaii; am counsel of record in a federal class action lawsuit on behalf of all California physicians who recommend, and all California patients who need, medical marijuana, see *Conant v. McCaffrey*, 2000 U.S. Dist. LEXIS 13024 (N.D. Cal. 2000) (recognizing physicians' First Amendment rights to recommend medical marijuana to patients and striking down as unconstitutional federal government threats against California physicians who recommended marijuana); am lead counsel in the United States Supreme Court in the Oakland Cannabis Buyers' Cooperative case for the American Public Health Association, the California Nurses Association, the American Medical Women's Association and four patients who receive marijuana from the federal government, who, as *amici curiae*, set forth for the Court the medical and scientific support for medical cannabis (the brief is available at www.drugpolicy.org); and am a member of the legal team that persuaded the Ontario Court of Appeals to strike down Canada's marijuana laws for not adequately recognizing medical use, see *Regina v. Parker* [2000] 75 C.R.R. (2d) 233.

As part of my legal duties, I have interviewed hundreds of physicians and patients across the continent regarding medical marijuana, reviewed scores of studies and government documents on the subject, and worked with various state and local officials

from both public health and law enforcement on issues regarding presumptively appropriate amounts of marijuana for patients. Berkeley's Community Health Commission offers the more accurate and workable of the two recommendations before the Council.

The Community Health Commission's recommendations draw principally from the federally administered IND program for medical marijuana through which the U.S. government has, for the past 20 years, cultivated, processed and distributed medical marijuana to certain patients around the country. Under the federal program, the government provides patients one pound of useable marijuana every sixty days, or **six pounds per year**.¹ This amount accords with the amount used by seriously ill patients who are not fortunate enough to be part of the federal IND program, including several of the named patient plaintiffs in the Conant case, declarants in the Oakland Cannabis Buyers' Cooperative case, and numerous defendants in unsuccessful marijuana prosecutions. See e.g., *Regina v. Parker, supra*; [2000] 75 C.R.R. (2d) 233; *People v. Trippet*, 56 Cal. App. 4th 1532 (1997) (patient exonerated by jury for possessing more than two pounds of medical marijuana for personal use). This federally authorized amount is very the amount recommended by the Community Health Commission and adopted by the Oakland City Counsel.² By stark contrast, however, the City Manager, relying on the calculations of a single physician, repudiates the federally recognized amount and contends that Berkeley residents should make do with substantially less medicine (2.5 pounds per year) or risk arrest and prosecution, or at the very least, confiscation of part of their medical supply.

Pursuant to the federal IND program, the City should presume that a qualifying patient or their primary caregiver is acting lawfully under California law if they possess a total of one pound or less of dried marijuana for each 60-day period of use, or a total of six pounds per year. As a standard rule of thumb, 20 outdoor or 30 indoor medical-grade mature female plants will yield the one-pound IND-baseline of dried marijuana.³ Although the City Manager purports to undertake a careful analysis of plant yields for both indoor and outdoor cultivations, the City Manager neglects to account for a simple fact that gardeners know all too well: crop failure. Specifically, cultivators of medical grade marijuana stand to lose roughly half their planted seeds before the plants reach maturity. Thus, a second rule of thumb: patients or caregivers generally need to plant

¹ This figure is derived from data reported by the Research Triangle Institute, which processes, packages and distributes medical marijuana cigarettes for the IND program. 300 cigarettes, each weighing between .64 and .86 grams, are packaged in sealed tin containers. The total weight of dried marijuana in these containers averages 7.8 ounces, or approximately one half pound. See Research Triangle Institute Data Sheet (1996) at 1; see also National Institute on Drug Addiction, General Information at 1 (reporting that government-issued marijuana cigarettes each weigh .9 grams and are packaged in 300 cigarette tins.) These containers are sent to patients every month. See Oakland Liberalizes Pot Rules, in The Sacramento Bee (July 9, 1998). See also D. Baum, Smoke and Mirrors (1997) at 314 (reporting that IND patients in the medical marijuana program receive 300 government-issued marijuana cigarettes each month.); Testimony of Elvy Musikka to Berkeley City Council, March 20, 2001.

² Oakland City Council Report, pp. 1, 4.

³ Oakland Report, p. 4.

twice as many seeds or seedlings than the number of mature plants needed to yield a necessary supply of medical marijuana.⁴

In light of these principles, it follows that:

1. A patient or caregiver who cultivates outdoors and harvests once a year will need to plant roughly 240 seedlings in order to harvest a total of 120 mature female plants to yield a sixty day / one pound supply of dried marijuana in accordance with the federal government's IND program. This annual harvest will yield a total six pounds of dried marijuana (or one pound for every 60 day period).
2. A patient or caregiver who cultivates indoors will need to plant roughly 360 seedlings, 180 of which can be expected to yield six pounds of medical grade marijuana per year.
3. A patient or caregiver who cultivates indoors and harvests quarterly, will need to plant 90 seedlings in order to harvest 45 medical-grade females to yield one and one-half pounds of dried marijuana every three months, or one per pound 60 day period.

For these reasons I urge the Council to adopt the documented, sensible, and medically appropriate recommendations advanced by the Community Health Commission. In so urging, I do not suggest that every patient with a physician's recommendation will need or should have six pounds of marijuana per year. Indeed, a patient's need for a particular type of medication or therapy is determined by multiple factors, including the type, severity and stage of illness or condition,⁵ the unique physiological make-up of the individual patient, and the strength or potency of medication.⁶

I am not insensitive to the concerns of law enforcement and residents about issues of community safety and security. But it is well within the power of the City Council to address such issues directly, by requiring special security precautions and/or accounting

⁴ Oakland Report, p. 4.

⁵ See e.g., Randall, Glaucoma: A Patient's View, in Cannibis in Medical Practice (M. Mathre, ed., 1997) at 98-100 (relief for glaucoma requires a significant amount of medical marijuana, upwards of ten marijuana cigarettes per day); W. Krampf, AIDS and the Wasting Syndrome, in Cannibis in Medical Practice (M. Mathre, ed., 1997) at 88-91 (AIDS patients using medical marijuana as an appetite stimulant to combat wasting syndrome may require smaller or less frequent doses of medical marijuana, e.g. only at meal times); D. Dansak, As an Antiemetic and Appetite Stimulant for Cancer Patients, in Cannibis in Medical Practice (M. Mathre, ed., 1997) at 73, 75-79 (patients using medical marijuana to combat the severe nausea of chemotherapy often have fluctuating use patterns due to the unpredictable frequency and intensity of the chemical-induced symptoms); Krampf at 87 (antiemetic use of medical marijuana by AIDS/HIV patients undergoing AZT treatment); D. Petro, Spasticity and Chronic Pain, in Cannibis in Medical Practice (M. Mathre, ed., 1997) at 115-21.

⁶ Numerous studies have documented the variable levels of THC and other cannabinoids in marijuana. See e.g., M. Brazis and M. Mathre, Dosage and Administration of Cannabis, in Cannibis in Medical Practice (M. Mathre, ed., 1997) at 145-147; National Institute on Drug Addiction, General Information on Marijuana Cigarettes from NIDA and their use in Therapeutic Programs, at 2-4; J. Morgan and L. Zimmer, Marijuana Myths, Marijuana Facts (1997) at 134-141.

measures to be undertaken by collectives or individuals who cultivate in excess of a specified amount, whether indoors or outdoors. Indeed, I offer my office's services *pro bono* to the City of Berkeley to assist with the crafting workable regulations that would accomplish this objective. The Council should not, however, enact a badly flawed ordinance that falls far short of federal government standards that will either deprive seriously ill patients of an appropriate amount of their physician-recommended medication, and/or force such patients or their caregivers to live in fear of arrest or prosecution for having a medically appropriate amount of marijuana.

In closing, I wish to add that there is considerable benefit in cohering Berkeley's medical marijuana ordinance to that of the City of Oakland. The two cities are contiguous within the same county, with residents of each city frequently commuting to other for work and pleasure. Enacting drastically disparate standards between these two communities is likely to create confusion and may prompt patients residing in the more restrictive jurisdiction to circumvent the law by cultivating or storing medical marijuana in the less restrictive jurisdiction. While this result may appeal to city officials whose concerns stop at the city's boundaries, it advances neither the interests of patients nor of law enforcement.

In sum, I respectfully urge you to accept the recommendations of the Community Health Commission and adopt a policy founded in sound medical and public health data. Please feel free to contact me if I can be of further assistance in this matter.

Sincerely,

Daniel N. Abrahamson
Director of Legal Affairs
The Lindesmith Center