

# HOW POT BECAME LEGAL

MEDICAL MARIJUANA IS GIVING ACTIVISTS A CHANCE TO SHOW HOW A LEGITIMIZED POT BUSINESS CAN WORK. IS THE END OF PROHIBITION UPON US?

**BY ROGER PARLOFF**  
PHOTOGRAPHS BY ROBYN TWOMEY



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**OVER-THE-COUNTER CULTURE:**  
 A "BUDTENDER" AT OAKLAND'S HARBORSIDE HEALTH CENTER, A MARIJUANA DISPENSARY



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**hen Irvin Rosenfeld, 56,** picks me up at the Fort Lauderdale airport, his SUV reeks of marijuana. The vice president for sales at a local brokerage firm, Rosenfeld has been smoking 10 to 12 marijuana cigarettes a day for 38 years, he says. ¶ That's probably unusual in itself, but what makes Rosenfeld exceptional is that

for the past 27 years, he has been copping his weed directly from the United States government. Every 25 days Rosenfeld goes to a pharmacy and picks up a tin of 300 federally grown and rolled cigarettes that have been sent there for him by the National Institute of Drug Abuse (NIDA), acting with approval from the U.S. Food and Drug Administration. ¶ Rosenfeld smokes the marijuana to relieve chronic pain and muscle spasms caused by a rare bone disease. When he was 10, doctors discovered that his skeleton was riddled with more than 200 tumors, due to a condition known as multiple congenital cartilaginous exostosis. Despite seven operations, he still lives with scores of tumors in his bones.

Rosenfeld is one of four people in the United States whom the federal government supplies with medical marijuana. Each is a living anomaly because, officially, the U.S. Drug Enforcement Administration, NIDA, and the FDA all take the position that marijuana has “no currently accepted medical use.” That’s the only way federal law can continue to classify marijuana, like heroin, as a “Schedule I controlled substance,” forbidden from being prescribed by doctors. (Numerous dangerous, psychoactive, and addictive opium derivatives, by contrast, are more leniently classified as Schedule II drugs, allowing prescription use.)

Over the years the government’s position has become progressively more embattled, if not untenable. Thirteen states now have laws that let residents use marijuana medically, typically to alleviate chronic pain (particularly nerve pain caused

by diabetes, AIDS, and hepatitis); manage movement disorders and muscle spasticity (especially for multiple sclerosis patients); as an anti-nausea and anti-vomiting agent (for those, say, undergoing chemotherapy); and as an appetite stimulant (yes, as in “the munchies”) for those with wasting diseases like AIDS and cancer. Another 15 states are weighing legislation or ballot initiatives that could turn them into medical marijuana states by next year.

The acceptance of medical marijuana has implications that extend far beyond helping those suffering from life-threatening diseases. It is one of several factors—including demographic changes, the financial crisis, and the widely perceived failure of the war on drugs—reopening the country’s 40-year-old on-again, off-again shouting match over whether marijuana should be legalized.

This article is not another polemic about why it should or shouldn’t be. Today, in any case, the pertinent question is whether it already has been—at least on a local-option basis. We’re referring to a cultural phenomenon that has been evolving for the past 15 years, topped off by a crucial policy reversal that was quietly instituted by President Barack Obama in February.

First, some necessary background. Under President George W. Bush (and under President Bill Clinton before him, for that matter), the U.S. Justice Department treated state medical marijuana laws as nullities. Such laws were contradicted and therefore preempted by federal drug laws, the Justice Department reasoned, and the U.S. Supreme Court upheld that position in 2005. Accordingly, the federal government has periodically raided and prosecuted defendants who at least claimed to be complying with state medical marijuana laws, and when it did, defendants were forbidden from telling juries about the existence of those laws.

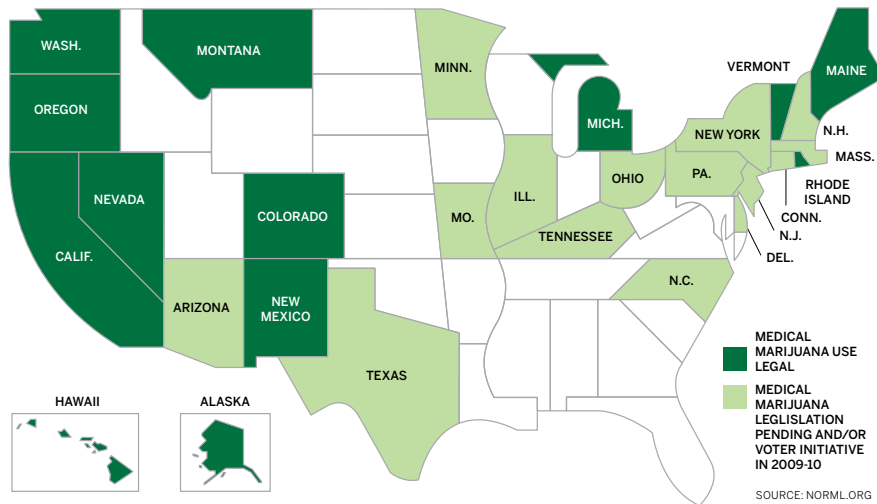
**FDA APPROVED**  
IRV ROSENFELD IS ONE OF FOUR U.S. CITIZENS WHO GET THEIR MEDICAL MARIJUANA FROM THE FEDERAL GOVERNMENT.



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# THE GREENING OF AMERICA

**MORE THAN HALF THE STATES EITHER HAVE OR ARE CONSIDERING LAWS MAKING MEDICAL MARIJUANA LEGAL.**



prescribe it for other, so-called off-label purposes, even though the drug has not yet been certified as safe or effective for them.

Accordingly, California doctors are authorizing patients to take marijuana to relieve such ailments as anxiety, headache, premenstrual syndrome, and trouble sleeping. “You could get it for writer’s block,” comments Allen St. Pierre, the executive director of the National Organization for the Reform of Marijuana Laws.

Some California doctors voluntarily report the breakdown of patient medical conditions for which they have approved marijuana use in the Alameda, Calif., medical newsletter *O’Shaughnessy’s*. They commonly report that more than a quarter of their marijuana authorizations have been prompted by patients suffering from conditions like “anxiety” or “insom-

nia.” (The most common complaint is “chronic pain.”)

In late February, President Obama signaled a new approach. His attorney general, Eric Holder, confirmed at a press conference that he would no longer subject individuals who were complying with state medical marijuana laws to federal drug raids and prosecutions. This understated act—a simple pledge not to act, really—could have enormous consequences. It potentially leads to exactly the same endpoint as the Twenty-First Amendment, which repealed the federal prohibition on alcoholic beverage sales.

As a result, in most of California’s coastal metropolitan areas, marijuana is effectively legal today. Any resident older than 18 who gets a note from a doctor can lawfully buy the stuff, and doctors seemingly eager to write such notes, typically in exchange for a \$200 consultation fee, advertise in newspapers and on websites. There are an estimated 300,000 to 400,000 medical marijuana patients in the state now, and the figure is rapidly growing.

Here’s how. When states make a legal loophole allowing medical use of marijuana, they must grapple with the messy question of what precisely constitutes medical use. After all, doctors regularly prescribe powerful drugs like Valium, Viagra, Prozac, and—give us a break—Botox to patients who are hardly at death’s door.

More astonishingly, there are about 700 medical marijuana dispensaries now operating in California openly distributing the drug. These dispensaries—called “compassionate-care clinics” by the solemn and “pot shops” by the skeptical—are decidedly outpatient facilities, with not a few patients arriving on bicycles, roller skates, or skateboards. (They often get discounts for doing so, because it’s greener than using a fossil-fuel-powered car.)

If a state doesn’t tightly limit what “medical use” means, the camel can get its nose under the tent. That’s what happened in California. Like most medical marijuana states, California permits doctors to “recommend” marijuana use for patients who suffer from specific serious diseases. (Drafters of the law avoided the word “prescribe” in an attempt to sidestep conflict with federal law.) California’s law then adds a catchall provision that lets doctors also approve marijuana use for “any other illness for which marijuana provides relief.” In practice, doctors—largely protected from second-guessing by confidentiality privileges—have been free to make the final call as to which conditions those might be. This is, after all, the norm vis-à-vis medicines. Once a pharmaceutical has been FDA-approved for one use, doctors can lawfully

The dispensaries sell marijuana and its concentrated resin forms, hashish and kif, sometimes alongside a range of enticing, non-inhaled alternatives, including marijuana-imbued brownies, cookies, gelati, honeys, butters, cooking oils (“Not So Virgin” olive oil), bottled cold drinks (“enhanced” lemonade is the most popular), capsules, lozenges, spray-under-the-tongue tinctures, and even topically applied salves. In Los Angeles a high-end three-store chain called the Pharmacy employs a pastry chef to oversee production of all its baked goods. Most dispensaries also sell potted plants and seeds for patients who are either thrifty or entrepreneurial.

All these establishments are engaged in what federal penal stat-

## **CALIFORNIA DOCTORS ARE PRESCRIBING POT FOR ANXIETY, HEADACHES, AND TROUBLE SLEEPING. “YOU COULD GET IT FOR WRITER’S BLOCK,” SAYS ONE ACTIVIST.**

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# “I THINK WE’RE GOING TO HAVE EXACTLY THAT KIND OF LOCAL OPTION WITH MARIJUANA [THAT WE NOW HAVE WITH ALCOHOL]. ONCE THAT HAPPENS, IT WILL BE LIKE GAMBLING.”

utes still humorlessly define as narcotics trafficking. The dispensaries’ affiliated marijuana farms and plant nurseries are sometimes of sufficient size to subject operators to mandatory-minimum five-year federal prison terms. And this, mind you, is a situation that evolved almost entirely during the Bush administration, when the U.S. Drug Enforcement Administration was still routinely threatening dispensary landlords with forfeiture of their premises, periodically raiding clinics and seizing inventories, and criminally prosecuting the most brazenly abusive operators. Luke Scarmazzo, who aired a rap video on YouTube two years ago boasting of all the money and great sex he was getting from running the California Healthcare Collective in Modesto, Calif.—“Fuck the feds!” was one ill-advised lyric—was sentenced in federal court this past December to almost 22 years of imprisonment on a continuing criminal enterprise conviction. (He has appealed.)

While the situation in California is unusual, it’s becoming less so. There are now 15 dispensaries in Colorado, according to weed-maps.com, one of many online marijuana dispensary and physician (“pot-doc”) locator services. In Oregon nearly one in four active physicians has authorized at least one of his patients to grow marijuana for medical use. New Mexico hopes to have the nation’s first state-licensed medical marijuana farm and distributorship up and running by the time this article is published. New Mexico’s law was enacted two years ago, but state officials hadn’t dared implement it until Attorney General Holder blew the all clear in February.

This is the sense in which President Obama’s understated pledge not to interfere with state medical marijuana laws potentially achieves for that intoxicant what the Twenty-First Amendment accomplished for beer, wine, and booze during the Great Depression. Repeal, remember, simply returned to the states the right to decide whether to permit alcoholic beverage sales, and, if so, when and how. If a state permitted sales, it could also enforce minimum age requirements, limit store hours, set zoning restrictions, and levy taxes. If it prohibited sales, it could bask in righteousness but exercise no control over the traffic that would occur anyway. Over time nearly every state fell in line behind the tax-and-regulate model. (During Prohibition, federal law did contain an exception allowing alcoholic beverage sales for medical purposes. Nevertheless the case for medical booze was never

compelling, and after repeal no state chose to condition the legality of alcohol sales upon a showing of medical need.)

“I think we’re going to have exactly that kind of local option with marijuana [that we now have with alcohol],” says Keith Stroup, 65, NORML’s founder, two-time past executive director, and current legal counsel. “Once that happens it will be like gambling.” Initially only Nevada permitted gambling, and then it was just Nevada and New Jersey. “But over a period of time,” Stroup says, “the morality part of the issue kind of dissipated, and there were more and more needs for new revenue, and today almost every state in the country allows legalized gambling.”

Marijuana activists thought they were close to legalization once before. From 1973 to 1978 activists won decriminalization in 11 states. (“Decriminalization” is a grab-bag term but usually refers to schemes under which first-time possession of small quantities of marijuana becomes a noncriminal violation, akin to a parking ticket. Decriminalization falls short of legalization, in that sale and distribution remain serious felonies.) In 1977, President Jimmy Carter endorsed a federal decriminalization bill. But the bill went nowhere, and soon the movement was all but obliterated by the return swing of the cultural pendulum, now known as the Reagan Revolution. There would be no new state or federal marijuana reforms for the next 16 years.

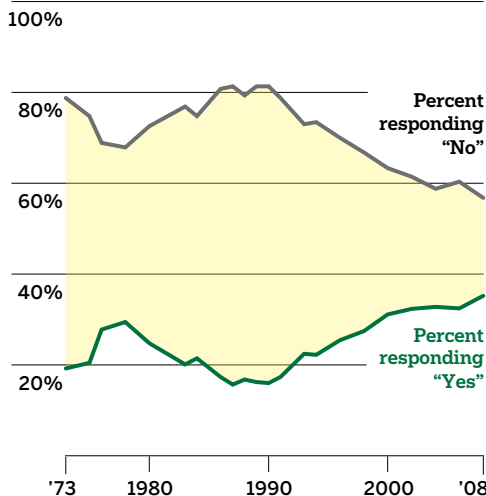
“Here’s what’s different now,” asserts Ethan Nadelmann, the head of the Drug Policy Alliance, which favors marijuana legalization on a tax-and-regulate model. “First, in the late 1970s no more

than 30% of the American public supported making marijuana legal. Now it’s breaking 40%.” That jump reflects an important demographic change, Nadelmann notes. “Back then there was a whole older generation of Americans who didn’t know the difference between marijuana and heroin,” he says. “Now that generation is mostly gone. The people in power are baby boomers, a majority of whom actually smoked marijuana.” The past three Presidents have all more or less admitted trying the drug, Nadelmann continues, and the current one, when asked if he inhaled, famously retorted, “I thought that was the point.”

Beyond the demographic change, there is a perception that after 40 years of blood, sweat, and tears, the war on drugs—formally declared by President Richard Nixon in 1969, a

## OPINION MELLOWS A NATIONAL SURVEY SHOWS ACCEPTANCE OF MARIJUANA IS GROWING.

Poll: “Should marijuana be made legal?”



SOURCE: NATIONAL OPINION RESEARCH CENTER, UNIVERSITY OF CHICAGO

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month before the Woodstock festival—has failed to reduce the availability of illegal drugs, has enriched and empowered organized-crime gangs, and has subjected millions of people to arrest who pose little threat to anyone but themselves.

On top of that, we're now mired in the worst economic environment since the Great Depression, which makes the prospect of collecting taxes on marijuana sales as alluring to contemporary politicians as beer, wine, and liquor taxes looked to President Franklin Delano Roosevelt and his party when they took office in 1933, the year Prohibition was repealed. Assuming a national consumer market for marijuana of about \$13 billion annually, Harvard economist Jeffrey Miron has estimated that legalization could be expected to bring state and federal governments about \$7 billion annually in additional tax revenue, while saving them \$13.5 billion in prohibition-related law enforcement costs.

In California, where the fiscal crisis is so grave that the state has had to issue vendors more than \$1 billion in IOUs, a Field Poll published in April showed that 56% of the state's population favored legalizing marijuana, prompting Gov. Arnold Schwarzenegger to call for an "open debate" on the question. A legalization bill has been introduced in the state legislature, and the state board of equalization has estimated that if passed, it would bring in \$1.4 billion in new revenue, a seemingly conservative estimate.

It's even possible that legalization would reduce national health-care costs, by easing demand for costly pharmaceuticals. In the most recent issue of *O'Shaughnessy's*, one doctor reported that his cannabis patients had either stopped or cut back their use of "analgesics of all kinds [including] Tylenol, aspirin, and opioids; psychotherapeutic agents including anti-anxiety medications, anti-depressants, anti-panic, obsessive-compulsive, anti-psychotic, and bipolar agents; gastrointestinal agents including anti-spasmodics and anti-inflammatory medications; migraine preparations; anticonvulsants; appetite stimulants; immunomodulators and immunosuppressives; muscle relaxants; multiple sclerosis management medications; ophthalmic preparations; sedative and hypnotic agents; and Tourette's syndrome agents."

"Medical marijuana is God's little joke on the [marijuana] prohibitionists," says Richard Cowan, 69, a longtime legalization activist who claims he's smoked almost every day since 1967. "There is clearly



**NO SMOKING**  
THE FARMACY  
STORES IN LOS  
ANGELES  
SELL DRINKS  
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MARIJUANA  
TO PATIENTS.



the medical cannabis newsletter is named). Several well-known pharmaceutical companies, including Eli Lilly, sold cannabis in powdered or tincture forms in the early 20th century as a painkiller, antispasmodic, sedative, and "exhilarant." (For this article *Fortune* asked Eli Lilly for historical details on its cannabis sales, but a spokeswoman responded, "Due to competing priorities, we ... are unable to facilitate your query.")

Though cannabis remained listed in the *U.S. Pharmacopeia*—a standard desk reference for drugs—until 1942, its use in Western medicine began declining in the late 1800s, according to a history of cannabis written by Harvard psychiatrist Lester Grinspoon titled *Marijuana: The Forbidden Medicine*. The decline, Grinspoon writes, was due in part to the rise of more stable and effective pharmaceuticals—though many of them later proved to have grave potential side effects—and because modern hypodermic syringes could deliver faster pain relief using opiates. (Opiates were soluble; cannabis wasn't.)

Then, in the early 1900s, states began outlawing cannabis,

a medical need, and it ranges from minor to life-saving. ... From my perspective, the dividing line between medical and nonmedical should not be decided by the police."

Medical marijuana is clearly the crowning factor making things different this time. Not only is it changing perceptions of the drug, but it has also given legalization advocates in California a first-ever opportunity to devise and showcase a business prototype. They've been afforded the chance to show a skeptical public that a safe, seemly, and responsible system for distributing marijuana is possible. If they succeed, they'll convince the fence sitters and lead the way to a nationwide metamorphosis.

If they fail, the backlash will be savage. If communities cannot adequately regulate the dispensaries, they'll descend into unsightly, youth-seducing, crime-ridden playgrounds for gang-bangers, and this flirtation with legalization will conclude the way the last one did: with a swift and merciless swing of the pendulum.

**Marijuana, whose botanical name** is cannabis, has been used medicinally—and as an intoxicant, of course—for thousands of years in Eastern cultures. It is believed to have been introduced to Western medicine in the early 19th century by a British doctor, W.B. O'Shaughnessy, who learned about it while stationed in India (and for whom

**“THERE WAS A WHOLE OLDER GENERATION OF AMERICANS WHO DIDN'T KNOW THE DIFFERENCE BETWEEN MARIJUANA AND HEROIN. NOW THAT GENERATION IS MOSTLY GONE.”**

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## ELI LILLY SOLD POWDERED CANNABIS IN THE EARLY 20TH CENTURY. ASKED ABOUT THAT BUSINESS, A SPOKESWOMAN SAYS, “DUE TO COMPETING PRIORITIES ... WE ARE UNABLE TO FACILITATE YOUR QUERY.”

which had become associated in legislators’ minds with violent crime and psychosis. The drug was then being used in the U.S. mainly by Mexican migrant workers in the West and African Americans in the South, so apprehensions about it may have been intertwined with racial and ethnic fears. In 1937 the federal government, over the objections of the American Medical Association, effectively outlawed cannabis.

Modern-day medical assessments of marijuana’s properties have not corroborated the outsize dangers that lawmakers had attributed to the plant. While it is a “powerful drug,” concluded an Institute of Medicine report conducted in 1997 at the behest of the White House Office of National Drug Control Policy, its “adverse effects ... are within the range of effects tolerated for other medications.” Yes, someone who is high on marijuana shouldn’t drive—his motor skills and mental powers are impaired—but that’s true of alcohol and many prescription drugs too. The long-term risks to chronic users appear to center mainly on the generic dangers of smoking (respiratory disease and possibly lung cancer) and upon the “mild and short-lived” withdrawal symptoms that a minority of marijuana users experience, according to the IOM experts. They considered marijuana less addictive than tobacco, codeine, or Valium.

Still, many doctors are squeamish about recommending marijuana to patients—putting aside issues of legal liability. To begin with, most pharmaceuticals consist of a single, purified chemical compound. Such drugs are susceptible to double-blind, placebo-controlled testing, and once they are approved, doctors can prescribe known dosages.

Marijuana, in contrast, consists of the dried, ground-up flowers of a highly variable plant. It is made up of at least 400 compounds, including more than 60 that are unique to cannabis, known as cannabinoids, several of which are believed to have therapeutic effects. The proportions of these compounds vary greatly from plant to plant. A plant may attract harmful molds. Lighting a match to the mix then introduces a whole new set of variables. Finally, smoking—even putting aside its health risks—is an idiosyncratic delivery system. Everyone smokes differently, so one never knows how much of which

compounds the patient is receiving. These factors all make marijuana hard for researchers to test meaningfully and hard for doctors to prescribe confidently.

Accordingly, even those doctors who recognize the therapeutic powers of marijuana often prefer the notion of looking for one or two key active ingredients in it, isolating them, and then devising a delivery system that would not involve smoking.

And that’s been done. In 1986 the FDA approved a synthetic version of what has long been recognized to be the main psychoactive ingredient of marijuana—delta-9-tetrahydrocannabinol, or THC. After rigorous testing, the FDA found THC to be safe and effective for the treatment of nausea, vomiting, and wasting diseases. This lawful, Schedule II drug, trade-named Marinol, is taken orally, by capsule.

The trouble is, for many patients Marinol turns out to be inferior to good old-fashioned pot. Smoked marijuana is much faster

acting and, as a consequence, easier for patients to control in terms of dosage. The patient inhales as much as he needs and then stops. In contrast, with a THC pill the patient can easily ingest more than he can handle. “Oral THC is slow in onset of action but produces more pronounced, and often unfavorable, psychoactive effects that last much longer than those experienced with smoking,” according to a 2008 report published by the American College of Physicians. (Incidentally, the FDA-approved warnings for Marinol—pure THC—do not flatly forbid patients from driving under its

influence. Rather, they simply caution patients not to do so “until it is established that they are able to tolerate the drug and to perform such tasks safely.”) Still, despite the disappointing performance of oral THC, many doctors want to continue exploring faster-acting THC delivery systems, including a skin patch or a suppository.

Meanwhile we’re still awaiting hard proof that smoking marijuana can actually cause lung cancer. That evidence has proved surprisingly elusive, maybe in part because typical marijuana users smoke so much less than typical tobacco smokers. In any case, marijuana users are increasingly turning to a means of inhalation that does not involve smoking known as vaporization.



### HERBAL REMEDIES

JOANNA LAFORCE,  
A PHARMACIST,  
AT THE FARMACY  
IN VENICE BEACH,  
CALIF., WHERE  
ANYONE  
CAN BROWSE



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With a vaporizer—the Volcano brand is the best known—users heat marijuana to a temperature sufficient to vaporize the cannabinoids but insufficient to spark combustion and most of its associated noxious gases. The vapors are captured in a balloon and then inhaled.

**As a teenager Irv Rosenfeld** was a strong opponent of marijuana use. He would sometimes give talks against marijuana at local schools. “I’d hold up bags of my prescription drugs and say, ‘Be thankful you’re healthy,’” he recounts. He was then taking prescription muscle relaxants, sleeping pills, anti-inflammatories, and a range of addictive, debilitating, opioid painkillers, including codeine, Demerol, and Darvon.

Shortly after Rosenfeld started college at the University of Miami, he caved in to peer pressure and tried pot. “Nothing happened,” he says. (To this day Rosenfeld maintains that he never has been able to get high from marijuana. In my six or so hours with him, during which he drove me from Fort Lauderdale to Miami and back, all the while chain-smoking joints, I never noticed any apparent impact on him, other than an occasional cough.)

Rosenfeld continued smoking socially when others did. “About the 10th time,” he continues, “I was playing chess when I realized that I’d been sitting still for 30 minutes.” Normally he couldn’t do that because his muscles would begin to ache and he’d have to change position. “I hadn’t taken a pill in six hours. Just then someone handed me the joint, and it hit me. The only thing I’d done different was smoke pot.”

Rosenfeld ran repeated experiments, and both he and his surgeon became convinced that marijuana helped him more than

**HIGH-TECH DOSE**  
CAROL KLEIN-MAIER, WHO HAS DEGENERATIVE DISK DISEASE, USES A “VOLCANO” VAPORIZER TO INHALE MARIJUANA WITHOUT BURNING IT.



his prescription drugs, with fewer side effects. In 1971, with the blessing of his doctors and the indulgence of sympathetic police officials, he began smoking marijuana to treat his pain.

Then, in 1976, Rosenfeld learned of the extraordinary case of Bob Randall (now deceased). Randall, who had severe glaucoma, had been prosecuted that year for marijuana possession in the District of Columbia but won acquittal after advancing a “medical necessity” defense. Randall’s doctors had testified that he risked going blind without marijuana to relieve the pressure within his eyeballs. Randall then brought a civil suit against the government. In 1978 a mind-boggling settlement was reached: The government agreed to supply Randall with marijuana for the rest of his life.

The government had the capacity to strike such a deal because since 1968, NIDA had been growing a small quantity of marijuana for research purposes under contract with the University of Mississippi’s pharmacy school. FDA and NIDA officials theorized that the U.S. government could lawfully become Randall’s supplier if they observed the pretense that he was part of a clinical study to investigate a potential new drug. A research “protocol” was drawn up, though the study design called for just one patient: Randall.

Rosenfeld drew up a similar protocol for a clinical study of himself. With the help of supportive doctors and threatening lawyers, Rosenfeld became the second patient to pry his way into what became known as the compassionate-use investigative new drug program.

By 1991 the compassionate-use program had grown to include 13 patients. That year, after Randall counseled AIDS advocacy groups on how to seek admission to the program, it suddenly found itself deluged with 40 new applications. In early 1992, seeing the unworkable direction in which matters were headed, the government shut the program down, though the 13 existing patients were grandfathered in. Today just four are left, including Rosenfeld.

For them, federal marijuana grown at the University of Mississippi is sent to a contractor in Research Triangle Park, N.C., where it is rolled into cigarettes on an old machine obtained from the local tobacco industry. About every five months the contractor sends six tins of the cigarettes to the pharmacy where Rosenfeld picks them up.

Rosenfeld’s weed is hardly connoisseur quality by contemporary California dispensary standards. The government grows its crops only sporadically, so it dries the harvested flowers and places them in cold storage. When I visited him in June, Rosenfeld was smoking marijuana harvested nine years earlier. Because Rosenfeld finds the government’s cigarettes too dry, he unwraps them, rehydrates the marijuana by placing it in a con-

## **DESPITE THE DISAPPOINTING PERFORMANCE OF THC PILLS, MANY DOCTORS WANT TO CONTINUE EXPLORING ALTERNATIVE DELIVERY SYSTEMS, INCLUDING A SKIN PATCH OR A SUPPOSITORY.**

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## HARBORSIDE, WHICH IS ORGANIZED AS A NOT-FOR-PROFIT COLLECTIVE, NOW HAS 30,000 PATIENTS WHOSE PURCHASES OF MEDICINE BRING IN ABOUT \$20 MILLION ANNUALLY IN REVENUE.

tainer with lettuce, and then re-rolls his own joints, he says.

Rosenfeld's cigarettes are also not very potent by contemporary standards. They contain around 3.5% THC, which was about the average strength of dope seized in domestic street busts in 1996, according to NIDA data. By contrast, marijuana seized from such busts in 2007 had an average potency of about 4.8%, while the fresh "manicured bud" available at today's best California dispensaries boast THC content ranging from about 6% to 22%. It's as if Rosenfeld were receiving vanilla ice cream joylessly made in the Soviet Union and stored for decades, when there's fresh Ben & Jerry's Chocolate Chip Cookie Dough for sale just around the corner.

Still, Rosenfeld's not complaining. The government charges him nothing, so his only costs are medical consultations and pharmacists' fees—about \$50 a month. Subpar or not, the 8.3 ounces he receives every 25 days would cost him more than \$2,000 on the street.

**After the compassionate-use program** was shut down, medical marijuana activists had one last hope for changing federal policies. Back in 1972, NORML and other groups had sued the predecessor of the DEA to force the rescheduling of marijuana as a prescribable drug, and incredibly, two decades later, the litigation was still raging.

During 14 days of hearings in 1986 the plaintiffs had presented many anecdotal accounts of nearly miraculous experiences patients had had with marijuana. Rosenfeld testified, as did the psychiatrist and medical historian Grinspoon, who related not only the evidence his research had unearthed but also a personal anecdote. In 1972, Grinspoon's own teenage son, who had leukemia, began undergoing chemotherapy. "He would start to vomit shortly after treatment and continue retching for up to eight hours," as Grinspoon later described the ordeal in his book. "He vomited in the car as we drove home, and on arriving he would lie in bed with his head over a bucket on the floor." Having heard that marijuana could help, Grinspoon's wife proposed that the couple let their son try it, but Grinspoon refused because it was illegal. His wife then defied him, secretly smoking marijuana with the teenager before one of his treatments. This time there was no vomiting, and in fact, on the way home the child asked to stop for

a submarine sandwich. "From then on he used marijuana before every treatment, and we were all much more comfortable during the remaining year of his life," according to Grinspoon's account.

In 1988 the administrative law judge hearing the case ruled in NORML's favor. "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man," Judge Francis Young concluded. Young was referring to the fact that it is almost impossible to overdose fatally on marijuana, a circumstance that distinguishes it from virtually any other drug. "By any measure of rational analysis," Young concluded, "marijuana can be safely used within a supervised routine of medical care."

In one of those maddening circularities of federal administrative law, however, the DEA's appeal from Judge Young's ruling was heard by John C. Lawn, then administrator of the DEA itself. Not surprisingly, in 1989, Lawn overturned all of Young's findings.

Lawn gave short shrift to anecdotes like Grinspoon's and Rosenfeld's. "These stories of individuals who treat themselves with a mind-altering drug ... must be viewed with great skepticism," he wrote. "Many of these individuals had been recreational users of marijuana prior to becoming ill. These individuals' desire for the drug to relieve their symptoms, as well as a desire to rationalize their marijuana use, removes any scientific value from their accounts."

Lawn also stressed the absence of any controlled clinical studies proving marijuana's safety or efficacy. He was right; such studies didn't exist (at that time), both because of the inherent difficulties of performing them on a whole plant and the unique difficulties of performing them on an illegal plant. To even obtain marijuana for such tests, researchers would have had to first win approval from three federal bureaucracies—the DEA, the FDA, and NIDA—a daunting task even assuming the best of good will on everyone's part.

As for the controlled studies showing that marijuana's chief psychoactive ingredient—THC, in the form of Marinol—was safe and effective for treating certain medical conditions, Lawn saw them as simply proving conclusively that there could be no conceivable excuse for smoking marijuana. To whatever extent THC might be helpful, patients could use Marinol.



**CANNA-BUSINESSMAN**  
STEPHEN DE-ANGELO FOUNDED HARBORSIDE TO SHOW THAT A MARIJUANA DISPENSARY COULD MAKE A POSITIVE CONTRIBUTION TO A COMMUNITY.



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In 1994 the federal court of appeals for the District of Columbia upheld Lavn's decision, and the activists' last hope for achieving reform at the federal level died.

So they turned to state government. In 1996 a group of marijuana activists in California got enough signatures to put a legislative initiative on the ballot known as Proposition 215. It called for permitting medical marijuana patients or their "primary caregivers" to possess marijuana on the "recommendation or approval" of a physician.

The measure passed with a 56% majority, and California became the first medical marijuana state. Precisely what that meant, though, remained totally unclear. Prop. 215 did not specify how much pot patients could possess, and it said nothing about the way patients would obtain it. Nothing in the initiative explicitly legalized sales or distribution of any kind.

Nevertheless, a few intrepid souls opened dispensaries.

"In the immediate wake of passage of Prop. 215 in 1996," recalls Stephen DeAngelo, who would later open what is now Oakland's largest dispensary, "local governments tended to take a hands-off attitude toward medical cannabis." They wouldn't explicitly license dispensaries to open, he says, but they also didn't instruct the police to go shut them down. "Dispensaries were tolerated but not sanctioned."

Even those local politicians who supported the goals of Prop. 215 were reluctant to regulate in the area, because any such effort would have had to begin with dispensary operators filling out forms providing incriminating information about themselves. Any such documents could then have been subpoenaed by federal prosecutors and used to shut the operators down or put them in prison.

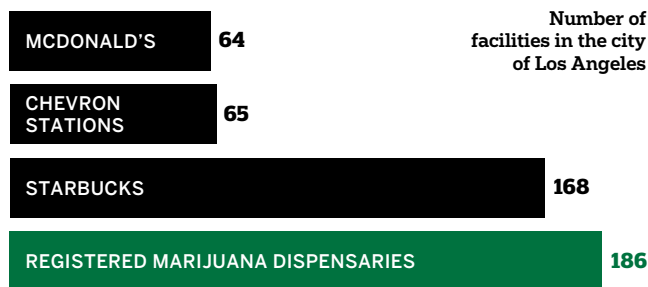
DeAngelo, now 51, was then a longtime marijuana activist but also a businessman. From 1990 to 2000 he founded and headed the industrial hemp company known as Ecolution. (Hemp, from which rope and other products are made, is a non-psychoactive strain of cannabis. Hemp products are legal in this country, but growing hemp is not.) Excited by the medical cannabis phenomenon in California, DeAngelo moved there in 2001, when the legal environment was still extremely gray.

He found two main types of dispensary managers operating at that time, he recalls. "The best of them were the well-motivated activists who brought really good intentions ... but had, for the most part, no business experience whatsoever and no capital to invest. Despite that, they managed to thrive, simply because they were the only game in town.

"This engendered a second wave of operators, who were attracted by the money, as opposed to the cause," DeAngelo continues. "A whole new wave of dispensaries got thrown up, which I refer to as 'thug dispensaries.' These were operations run by people who had a background in illicit activities, whether it was

## A CROWDED MARKET

### SLOW TO REGULATE, LOS ANGELES HAS SEEN CLINICS BLOOM.



selling cannabis or other drugs on the street, or trading in illegal firearms, or in the porn industry or gambling industry—people comfortable operating in the gray zone. Very rapidly you began to see some big problems. Several armed robberies. You had a spate of stories about operators being arrested.

"As a patient," says DeAngelo—he uses marijuana to relieve pain from a degenerative disk disease—"I was profoundly unhappy about it. As an activist I became concerned because these types were really hurting the public image of medical cannabis."

In an effort to improve the Wild West atmosphere, the California legislature then passed Senate Bill 420 ("420" is a slang term for pot), which took effect in 2004. This law fleshed out a bit more about the way Prop. 215 would work, requiring counties to issue identification cards to patients who sought them (to help them in their interactions with the police) and setting up minimum guidelines for how much marijuana patients could possess: eight ounces of dried marijuana plus either six mature plants or 12 immature plants. (Counties could allow higher amounts.)

Though SB 420 was still silent on the issue of dispensaries, it did contain a provision that protected patients or caregivers who "associate ... in order collectively or cooperatively to cultivate marijuana for medical purposes." Accordingly, nearly all the dispensaries in California now claim to be patient "collectives" or "cooperatives," protected under this provision.

At the same time another provision of SB 420 seemed to cut against the idea that dispensaries were legal—at least as many of them were (and still are) being run. It said that nothing in the law should be construed to "authorize any individual or group to cultivate or distribute marijuana for profit."

"In my opinion," says Bill Panzer, a criminal-defense lawyer and marijuana legalization advocate who helped draft Prop. 215, "the vast, overwhelming majority [of dispensaries] are not legal,

**"MARIJUANA, IN ITS NATURAL FORM, IS ONE OF THE SAFEST THERAPEUTICALLY ACTIVE SUBSTANCES KNOWN TO MAN," AN ADMINISTRATIVE LAW JUDGE RULED IN 1988.**

SOURCES: CITY OF LOS ANGELES; CHEVRON; MCDONALD'S; STARBUCKS STORE LOCATOR.

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## THE PATIENT-GROWN MARIJUANA IS INSPECTED FOR QUALITY, EXAMINED FOR MOLD, AND TESTED WITH A GAS CHROMATOGRAPH MASS SPECTROMETER TO DETERMINE ITS THC CONTENT.

because they're not collectives or cooperatives. If somebody owns the store, sells marijuana, and at end of day takes the extra money and puts it in his pocket and goes home, that's not a collective."

DeAngelo opened the Harborside Health Center dispensary in Oakland in October 2006 as a proof-of-concept that might show the rest of the nation how such an establishment could provide top-flight patient services, adhere to the letter of the law, and interact with the surrounding community beneficially.

His clinic, across from a scenic stretch of Oakland harbor, is identified only by its address—a large, block-letter "1840" painted on the façade of an inconspicuous, gray-blue one-story building on Embarcadero Drive. On the inside it's a spacious, wood-trimmed, tastefully appointed room that blends clean, contemporary lines with sparingly employed Eastern medicinal themes: a laughing Buddha here, a dancing goddess statuette there. The mood is broken only by the metal detector at the door and the multiple casino-style cameras embedded in the ceiling. Oakland has a high crime rate, and precautions must be taken. There are at least three security guards inside the facility at all times, as well as two more outside, patrolling Harborside's 100-car parking lot.

"Whenever a patient comes into the clinic for the first time," explains DeAngelo, "they sign a collective cultivation agreement. They authorize

all the other patients in the collective to grow medical cannabis on their behalf. That sets up a 100% closed-loop distribution system that isolates my patients from any contact with the illicit market."

But that doesn't mean that every member of the collective actually knows what a hoe looks like. "For a variety of very valid reasons," DeAngelo continues, "most patients are unable to grow their own medicine. We act as a clearinghouse between patients who are able to grow and patients who aren't able to grow."

Harborside now has 30,000 patients registered in its database, and their purchases of medicine bring in about \$20 million annually in revenue, according to DeAngelo. "I'd rather not discuss my specific salary," he says. "I can tell you if I was working in any other industry and showed the kind of financial returns that this business has shown, I'd be paid three or four times as much as I'm making at Harborside."

First-time patients, upon stepping through the metal detector at Harborside, immediately undergo a thorough paperwork check. The patient produces his doctor recommendation, the clinic verifies its authenticity with the doctor, and then the clinic also verifies the doctor's credentials with the state medical board.

About 600 patients come to Harborside each day, according to DeAngelo, most to buy marijuana, a few to supply it. Suppliers can bring in as much as three pounds at a time. (Bay Area police generally allow patients to transport this much, DeAngelo says.) The patient-grown marijuana is inspected for quality, examined for molds and fungi, and tested with a gas chromatograph mass spectrometer to determine its THC content.

At Harborside, there are eight selling stations along a long counter, each near a glass case displaying the wide array of medicines available, labeled as to strain and THC content. "Our most popular strains are our purple strains," says DeAngelo, "like Purple Urkle or Granddaddy Purple. The purples tend to be heavy indicas"—one of the two main varieties of psychoactive cannabis—"with a very strong, relaxing effect. They have a characteristically sweet, almost candy-like flavor.

"Another popular family of strains is the Kush family," he continues. "That



**SUNDAY ERRAND**  
SHOPPERS AT  
THE HARBORSIDE  
CLINIC, PICKING UP  
MEDICATIONS



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would include OG Kush, Baba Kush, and Pure Kush. The Kushes tend to be more sativa-dominant,” referring to the other main variety of cannabis, which is said to produce a more cerebral, “daytime appropriate” high, with less body impact. “They have a pungent flavor as opposed to a sweet flavor.”

At Harborside, I experienced a mild personal epiphany: I realized that I never really knew before what fresh marijuana smelled like. Though I had easily recognized, from East Coast college days 30 years back, the smell of smoked marijuana inside Rosenfeld’s SUV, I had never before smelled the sweet, herbal fragrance suffusing Harborside. At first I incorrectly assumed it was some sort of incense being artificially introduced to mask the odor I was familiar with.

As I further inspected Harborside’s medicines, I also realized that I had never really known before what fresh, high-quality marijuana looked like. I remembered baggies half-filled with crushed brown twigs, leaves, stems, and even seeds. But the dispensaries sell only fresh “bud,” which looks like cute, plump, fuzzy caterpillars curled in a ball.

After my education at Harborside I went on to explore some of the other approaches that marijuana entrepreneurs and activists are experimenting with as they try to rise to the proof-of-concept

cine stores under the management of registered pharmacist JoAnna LaForce, with marijuana being sold inconspicuously alongside scores of uncontroversial, legal plant products with putative healing powers. At these stores all members of the public, of any age, are welcome to enter, and only those who ask about marijuana are required to produce paperwork. “That way, a young mother with children can come into a store and not feel like a criminal,” LaForce explains.

For my aesthetic taste, the most inviting dispensary I toured was the immaculate Peace in Medicine facility in Sebastopol. Here, patients enter a handsome, freshly painted house—the former sales office for a Ford dealership—and come to what looks like a cheery doctor’s waiting room. After taking care of the paperwork, patients are summoned into the dispensary. There, I mention to Robert Jacobs, 32, Peace in Medicine’s idealistic young executive director, how enticing the fresh medicine smells. “If it smells good, the body probably wants it,” he responds, smiling a bit and sounding like Eve in the Garden of Eden.

I then notice a journalistic hole opening up in my reporting. Until now I had assumed that my haphazard, stale, youthful experiences with marijuana would need no refreshing in order for me to write a thorough article about medical cannabis. Now I’m not

## **OAKLAND’S REGULATIONS FORBID DISPENSARY OPERATORS FROM EARNING “EXCESSIVE” PROFITS, WHICH HAS BEEN UNDERSTOOD TO IMPLY THAT SOME PROFIT MUST BE PERMISSIBLE.**

challenge. Pioneering canna-businessman Richard Lee, also in Oakland, has opened his Blue Sky Café dispensary as a coffee shop, taking his cue from Amsterdam. Lee acknowledges that he runs the Blue Sky as a for-profit business, a situation that the City of Oakland authorities have at least tacitly endorsed, notwithstanding SB 420’s apparent prohibition of “for profit” distribution. In 2004 the city, seeking to avoid being overrun by dispensaries, passed municipal regulations limiting the permissible number to four. Those regs required that dispensary operators not earn “excessive” profits, which has been understood to imply that some profit must be permissible. Lee was granted one of the city’s four permits.

Lee has also opened an array of affiliated businesses in the immediate neighborhood of the Blue Sky, several of the few bustling businesses in Oakland’s otherwise depressed downtown. The best-known is Oaksterdam University, which trains medical cannabis entrepreneurs to navigate the business and legal challenges. It also teaches trades to those who seek jobs as, say, a medical cannabis cultivator or “bud-tender,” i.e., the quasi-pharmacist sales clerk who helps customers choose their medicine. Oaksterdam has now opened branches in Los Angeles and Sebastopol, Calif., about an hour north of Oakland, and stages conferences in Ann Arbor.

The most open dispensaries I saw were two branches of the Farmacy chain in Los Angeles. They are full-service herbal medi-

so sure. Unfortunately, most dispensaries are intransigent about serving only California residents, and I am not one. I explain my quandary to Jacobs. Listening back upon my words as they hang in the air, I realize that it sounds as if I’ve just asked him to break the law. He very politely declines.

**In the early days of dispensaries** the California Board of Equalization, which collects state and local sales tax, refused to issue seller’s permits to dispensaries that sought them—the necessary prelude to paying sales tax in the state. The board viewed such establishments as certainly illegal under federal law, and possibly illegal under state law. In October 2005 the board changed tack and began allowing dispensaries to pay sales taxes if they wanted, and in 2007 it completed the reversal by requiring them to pay sales taxes and demanding that they do so retroactively to October 2005. The board assured the dispensaries in a February 2007 letter that it would now issue seller’s permits even if the dispensary refused to answer portions of the standard application—identifying the product sold, for instance, or listing suppliers—due to “concerns about confidentiality or self-incrimination.”

Since sellers’ permits do not require establishments to identify themselves as medical marijuana dispensaries, the board has no hard records on sales taxes collected from them. Unless there is extremely poor compliance by dispensaries, however, the

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numbers should be robust. Harborside alone reported about \$15 million in sales in 2008, for instance, and DeAngelo estimates that the average revenue for each of California's 700 dispensaries probably ranges from \$3 million to \$4 million annually. If so, gross statewide medical cannabis sales are approaching \$2.5 billion, generating taxes of around \$220 million. That does not include the state and federal income taxes that dispensaries and their employees also pay, and employee payroll taxes.

In addition some localities, like Oakland, have begun imposing their own taxes. Each of Oakland's four dispensaries pays the city \$30,000 annually for its license, plus a business tax on gross sales (over and above state or local sales tax). This past July, Oakland increased that business tax 15 times over, from \$1.20 to \$18 for every \$1,000 in sales. Tellingly, the increase had been sought by the dispensary owners themselves, who well understand the importance of being seen as good citizens and becoming indispensable to the city's revenue supply.

Has medical cannabis been a good thing for Oakland? "I think so," says Ignacio De La Fuente, Oakland's current deputy mayor and, from 1998 to 2008, president of its city council. "I was not one of the initial supporters," he concedes, and he still doesn't favor legalizing marijuana for recreational purposes. "But I became educated about the medicinal value of cannabis" over the years of debate, De La Fuente explains. "You kind of make a decision of, Is this measure worth the risk to help the people that really need it?" On balance he believes it was, though he urges other localities considering legalizing medical marijuana to "do their homework about how they want to regulate establishments, so they don't become a problem or a nuisance."

"It's not working," says Councilman Dennis Zine of Los Angeles, a city that began regulating its dispensaries late, and is now overrun. "Too many of these places have become distribution places for recreational purposes under the guise of medical," he says. In 2007 the city set a deadline after which no new dispensaries would be permitted. A staggering 186 establishments met the cutoff, yet another 736 filed late applications, citing a "hardship" exception, and many of those opened too. Zine estimates that there are about 600 dispensaries in his city. He seeks tougher regulations, plus assistance from city, state, and federal authorities to help shut down any operator whose intent is "profit-making" as opposed to "compassionate" distribution for "medical purposes."

"I think the next five or six years are going to be incredibly exciting for this issue," says Stroup, who founded the National Organization to Reform Marijuana Laws 39 years ago. "I honestly believe we'll stop arresting individual smokers in almost all states and start to see the first one or two states experiment with a legalization bill."

Although Stroup originally wanted the "R" in NORML to stand for "Repeal," he was later talked into softening it to "Reform" by cooler, more politically savvy advisers. Now he thinks society might finally be closing in on his original goal.

Could be. Just watch out for those swinging pendulums. ■

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