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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

The Arizona Cannabis Nurses Association ("AZCNA"), hereby gives notice that it has filed its additional and supplemental exhibits numbered consecutively following the last exhibit filed by ADHS, as follows:

EX # DESCRIPTION

13. OAH Decision by Judge Shedden in OAH Case No. 2014A-MMR-0254-DHS, dated June 4, 2014 ("PTSD case");

14. Decision of the Director of ADHS in the PTSD case, dated July 9, 2014;

15. Article, "The Discovery of the Endocannabinoid System";

16. Article, "DEA Accused of Obstructing Research on Marijuana Benefits", dated June 14, 2014;

17. Article, "Arizona Medical Association Challenges NIDA Blockade of Medical Marijuana Research", dated June 3, 2012;

18. White Mountain Health, etc. v. County of Maricopa, Maricopa Sup. Ct., CV 2012-053585, dated 12/03/2012, by Judge Michael D. Gordon;

19. Welton v. State of Arizona, Maricopa Sup. Ct., CV 2013-014852, dated

3/21/2014, Judge Kathleen Cooper;

20. Article, "As A Former US Attorney, here's why I support the Medical Marijuana Law", by Melvin McDonald, dated Feb. 15, 2013, Arizona Capitol Times;

21. Article, "Parkinson's disease and Huntington's disease added to the list of medical conditions for which New Mexicans are allowed to seek medical marijuana, etc.", The Daily Chronic, Feb. 2, 2016.

22. Article, "Annual Causes of Death in the United States", Source: US Center for Disease Control, Data from 2013.

23. Article, "Marijuana Overdose Facts".

RESPECTFULLY SUBMITTED:

March 4, 2016

By */s/ Ken Sobel*
Ken Sobel, Esq.
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San Diego, California 92109
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COPY of the foregoing sent via email and/or U.S. Mail on March 4, 2016 to:

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In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 13

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:	No. 2014A-MMR-0254-DHS
Arizona Cannabis Nurses Association,	ADMINISTRATIVE LAW JUDGE
Appellant.	DECISION

HEARING: March 26, May 13, 14 and 15, 2014

APPEARANCES: Kenneth A. Sobel, Esq. for Appellant; Gregory W. Falls, Esq. and Matthew A. Hesketh, Esq. for the Department of Health Services

ADMINISTRATIVE LAW JUDGE: Thomas Shedden

FINDINGS OF FACT

1. On January 29, 2014, the Arizona Department of Health Services ("Department") issued a Notice of Hearing setting the above-captioned matter for hearing at 1:00 p.m. March 26, 2014, at the Office of Administrative Hearings in Phoenix, Arizona.

2. The Notice of Hearing provides that the hearing was set to consider the appeal of the Department's January 14, 2014 denial of the petition to add Post Traumatic Stress Disorder ("PTSD") to the list of debilitating medical conditions set forth in ARIZ. REV. STAT. section 36-2801(3) [1]

[1] Ariz. Rev. Stat. section 36-2801.01 shows that the "denial of a petition is a final decision of the [D]epartment subject to judicial review pursuant to [ARIZ. REV STAT.] title 12, chapter 7, article 6. Jurisdiction and venue are vested in the superior court." Consequently, the undersigned Administrative Law Judge issued an Order directing the parties to file memoranda addressing the Office of Administrative Hearings' ("OAH") jurisdiction to hear this appeal.

The Department filed a memorandum asserting that the OAH has jurisdiction to hear the appeal. Appellant did not file a memorandum. In light of the Department's position, the matter was convened for hearing as scheduled.

Office of Administrative Hearings
1400 West Washington, Suite 101
Phoenix, Arizona 85007
(602) 542-9826

3. Appellant Arizona Cannabis Nurses Association presented the testimony of its president Heather Manus, R.N., Richard Strand, M.D., Edith Lynn Edde, D.O., Gina Mecagni, M.D., Ricardo Pereyda, and Lezli Engelking.

4. The Department presented the testimony of its Deputy Director Cara Christ, M.D. and Doug Campos-Outcalt, M.D.

5. On July 25, 2013, the Department received Appellant's Petition to add PTSD to the list of debilitating conditions for which medical marijuana may be dispensed.

6. The Department determined that the Petition contained the information required by ARIZ. ADMIN. CODE section 9-17-106(A).

7. The Department is required to hold a public hearing on petitions for which the petitioner has provided evidence that: (1) the medical condition impairs a sufferer's ability to accomplish the activities of daily living; and (2) marijuana usage provides a palliative benefit to an individual suffering from the medical condition. For petitions that do not meet these requirements, the Department is required to provide the petitioner the specific reason for the Department's determination and to provide the petitioner with information on obtaining judicial review of the Department's decision. ARIZ. ADMIN. CODE § 9-17-106(B).

8. The Department's Medical Advisory Committee ("Committee") evaluated the Petition and voted to set the Petition for a public hearing.

9. The Department notified Appellant that the Petition would be set for a public hearing, which was conducted on October 29, 2013.[2]

10. At the instant hearing, Dr. Christ testified that the Committee voted to hold a public hearing on the Petition even though the Department had determined that Appellant's Petition did not show that marijuana has a palliative effect on PTSD. At the hearing, the Department acknowledged that by setting the Petition for public hearing it had not properly followed the rules, but Appellant agreed to waive any objection.

11. At the public hearing, the Department accepted public comments and it accepted additional scientific articles related to marijuana's effect on PTSD. The

Department also accepted written public comments, including comments through an internet portal.

12. The Department received about 700 public comments supporting the effort to add PTSD to the list of debilitating conditions, with only two comments opposing the addition. Most of the comments were from PTSD sufferers or their family members who have experienced or seen that marijuana alleviates the symptoms of PTSD.

13. After the public hearing, the Department had the University of Arizona's College of Public Health (the "U of A") conduct an evidence review of the medical literature regarding the benefits and harms of marijuana for treatment of PTSD. The U of A had conducted a similar evidence review in 2012 and its 2013 review was prepared as an update of the 2012 review

14. In December 2013, the U of A produced a report entitled "Medical Marijuana for the Treatment of Post-Traumatic Stress Disorder" summarizing its findings (the "2013 Report"). Dr. Campos-Outcalt was the principal investigator/reviewer and the author of both the 2012 Report and the 2013 Report.

15. Dr. Campos-Outcalt conducted his reviews by searching medical databases for articles reporting on studies of adults with PTSD. The search was restricted to English language studies only. A complete list of the search terms is provided in Exhibits C (2013 Report) and D (2012 Report).

16. Dr. Campos-Outcalt determined that only six studies met all the required search criteria, whereas eighty-eight did not.[3]

17. Dr. Campos-Outcalt assessed the quality of the six studies that met all the search criteria. Dr. Campos-Outcalt's assessment was based on both the type of study (e.g., randomized controlled trial; case series) and by reference to generally accepted principles for the evaluation of scientific studies. *See* Exhibit C, Appendices 2 (Taxonomy of study designs) and 3 (GRADE Method to assess overall quality of

[2] Petitions to add two other conditions were considered at the same public hearing

[3] Exhibit C at Tables 1 and 2 provide Dr. Campos-Outcalt's assessment of the six studies meeting the search criteria and a listing of the studies that did not meet those criteria

evidence); and Exhibits L (Quality Rating Criteria for Case Control Studies) and M (Quality Rating Criteria for Cohort Studies).[4]

18. After receiving the 2013 Report, the Committee determined that because marijuana has not been subjected to any high quality, scientifically controlled testing in humans, there was a lack of evidence to support adding PTSD to the list of debilitating conditions. Consequently, the Committee recommended that the Department's Director deny Appellant's Petition.

19. In its recommendation, the Committee also wrote that there was a growing body of evidence concerning the potential effects of cannabinoids on PTSD that raised valid clinical questions that need to be investigated. They went on to write that given this evidence and that several states have approved medical marijuana for PTSD, the Committee hoped that a randomized, controlled study might be conducted to further investigate this question.

20. Dr. Christ testified that the Committee did not intend its comments to be read as requiring that marijuana be tested in humans or that only randomized, controlled trials would meet the applicable rule. Dr. Christ further explained that the language regarding randomized, controlled studies was added to the Committee's recommendation in an effort to support research being proposed by Dr. Sue Sisley.

21. Eleven states have approved medical marijuana for the treatment of PTSD.

22. In a letter dated January 14, 2014, the Department's Director informed Appellant that its Petition had been denied because there was insufficient evidence to support adding PTSD to the list of debilitating medical conditions.

Dr. Christ's Testimony

23. The Director's decision to deny Appellant's Petition was based on the Department's determination that Appellant had not demonstrated that marijuana provides a palliative benefit to people suffering from PTSD.

24. The Committee agreed that PTSD is a condition that impairs the sufferer's ability to accomplish the activities of daily living.

[4] Similar Quality Rating Criteria exist for other types of studies.

25. The Committee was unanimous in its decision to recommend that Appellant's Petition be denied.

26. Dr Christ testified that the six articles that Dr. Campos-Outcalt determined met the applicable search criteria were not persuasive because the articles were not of sufficient quality or did not actually show that marijuana had a palliative benefit to PTSD sufferers.[5]

27. The Committee consists of eleven doctors (all M D s), with Dr Christ serving as its chair. These doctors have diverse backgrounds covering many disciplines.

28. Many of the Department's decisions are based on scientific or medical evidence using the same method that was applied to Appellant's Petition. The Committee holds regular meetings and it provides advice to the Director on issues in addition to Petitions for the listing of debilitating conditions.

29. Dr. Christ testified that the Department errs on the side of holding a public hearing rather than rejecting petitions that may not meet the applicable rules because holding a public hearing allows more evidence to be considered.

30. The Department wants to be careful before adding any new debilitating conditions to the list because there is no method to take a condition off that list

31. Dr. Christ was of the opinion that the Committee has a good balance of doctors, whereby some are pro-medical marijuana, some against it, and some who want to see the evidence

Dr. Campos-Outcalt's Testimony

32. Dr Campos-Outcalt testified as to the methods he used to locate and assess studies related to marijuana and PTSD and as to the strengths and weaknesses of various types of studies. Dr Campos-Outcalt also provided his opinion as to the quality of each of the six studies that met all the search criteria.

[5] Dr Christ's opinion was that synthetic cannabinoids do not meet the definition of marijuana

33. Dr. Compos-Outcalt's role was limited to locating and assessing these studies and he did not participate in the Department's decision to deny Appellant's Petition [6]

34. Dr. Campos-Outcalt did testify however, that the standards used in evidence based research were not necessarily those used to develop clinical guidelines for standard-of-care determinations. According to Dr. Compos-Outcalt, the preference is to have complete evidence, but there are times when standard-of-care determinations are made on incomplete evidence with those determinations subject to change as more evidence becomes available.

Ms. Manus's Testimony

35. About thirteen years ago, Ms. Manus was attacked and almost killed, resulting in her suffering from PTSD. For five years, Ms. Manus took a "cocktail" of prescription pharmaceuticals that had side effects including a loss of sex drive and leaving her in a "zombie-like" state. These side effects ruined her marriage and left her unable to properly care for her children. Ms. Manus cannot recall years of her children's lives from the time of her "zombie-like blackouts."

36. Ms. Manus made multiple suicide attempts, which would cause her doctor to increase her prescription-drug dosages.

37. Ms. Manus went online where she learned that one of these prescription drugs (Zoloft) carried a warning showing that it increased the risk of suicide. She then decided to get off the prescription drugs, which she did.

38. Ms. Manus uses medical marijuana for chronic pain and that usage effectively eliminates much of her anxiety and "releases [the] stresses" her attack left her with, including a fear of men and anxiety in social settings. The medical marijuana allows her to function, whereas on the prescription medications, she could not get out of bed

39. Ms. Manus provided credible testimony that medical marijuana changed her life for the better and that it has relieved her PTSD symptoms.

[6] Dr. Campos-Outcalt was present at the Committee meeting during which the Petition was considered, but solely to answer any questions the members may have had regarding his work.

40. Ms. Manus wants others who suffer from PTSD, especially veterans, to be able to receive the same benefit that she has received.

41. After learning about the side effects of the prescription drugs she was taking, Ms. Manus went to nursing school and in 2009 became a registered nurse.

42. Ms. Manus worked as a home-health nurse, where she had patients who used marijuana to treat their PTSD. Ms. Manus's clinical experience shows that marijuana helps with the symptoms of PTSD.

43. Ms. Manus's opinion was that the best way to determine whether a drug has a palliative effect is to hear from the patients who are using the drug. Ms. Manus often hears from PTSD sufferers who have found that marijuana provides them a palliative benefit.

44. Ms. Manus's opinion was that the comments received by the Department are important in showing that marijuana provides a palliative benefit those suffering from PTSD.

45. Ms. Manus's opinion was that researchers accept that marijuana provides a benefit to PTSD sufferers and are focusing their studies on determining why it works, with a particular focus on the effect of marijuana on biochemical pathways.

46. Ms. Manus is the medical director for a dispensary in New Mexico, which requires her to stay informed about medical-marijuana issues and current research.

47. Since 2009, medical marijuana has been approved in New Mexico for patients with PTSD, and in 2013, by a unanimous vote New Mexico's medical advisory board denied a petition to remove PTSD from the approved list.

48. Through her work in New Mexico, Ms. Manus has spoken to members of the state's medical advisory board and other nurses, and she knew of no adverse outcomes from the use of medical marijuana in New Mexico.

49. Ms. Manus acknowledged that the sativa strain of marijuana might cause anxiety in a PTSD sufferer, whereas the indica strain does not have that affect.

Dr. Strand's Testimony

50. Dr. Strand completed medical school in 1969 and his residency in 1974. He was the Chairman of the United States Track & Field Substance Abuse, Education

and Testing Committee from 1992 to 2000, and a member of the United States Olympic Team Medical Staff during the 2000 Olympics.

51. Dr. Strand's daughter is an anesthesiologist who recommends medical marijuana for patients with chronic pain and it works for that condition.

52. Dr. Strand, with some other doctors, took part in Arizona's lottery for a dispensary license, but they were not selected

53. PTSD is common and any stressful event can cause it. Most people get over the stressful event, which Dr. Strand characterized as extinguishing the "toxic" memory. Those who do not extinguish these memories can suffer a physical or emotional response to an inappropriate stimulus at a later time.

54. Dr. Strand's review of the medical literature shows that pharmacological treatments for PTSD are not effective for everyone. Selective serotonin reuptake inhibitors ("SSRI") such as Zoloft or Paxil can help, but these have side effects including grogginess and effects on sexual performance. Anti-anxiety medications can also be helpful. But these types of medications can lead to increased suicidal ideations, and there is risk of overdosing.

55. There have been studies on the toxicity of marijuana, and there are no reported cases of overdosing on marijuana, so it is safe from that stand point. And, in New Mexico over 3000 PTSD sufferers have used medical marijuana without any reported adverse effects.

56. Dr. Strand's opinion was that medical marijuana "definitely" has a palliative benefit for PTSD sufferers, which is supported by his review of the recent medical literature on this issue. Dr. Strand acknowledged however that marijuana may not have a palliative benefit for all PTSD sufferers and that "conventional" medicine may work for some PTSD sufferers.

57. Dr. Strand also testified that marijuana also may have a therapeutic effect by helping to extinguishing "toxic" memories and that recent research is showing that the endocannabinoid system may have an important role in the extinction of toxic memories

58. Dr. Strand's opinion was that medical marijuana is reasonably safe, especially when compared to the prescription drugs that are currently being used to treat PTSD.

59. Dr. Strand acknowledged that there are risks associated with marijuana use, but he added that over thousands of years, millions of people have used marijuana and these people are not "dropping dead," whereas the need of PTSD sufferers is great.

Dr. Edde's Testimony

60. Dr. Edde practiced in the area of neonatology and was an Assistant Professor of Pediatrics at the University of Arizona until 2011. While at the University, she conducted plant research, taught, and worked as a clinician.

61. Dr. Edde had reviewed the studies about which Dr. Campos-Outcalt testified and she has done additional research on PTSD.

62. Dr. Edde testified at the Department's public hearing, but was allotted only two minutes for her testimony.

63. Dr. Edde's opinion was that a palliative benefit may be seen by past experience, medical journals, and the patients' reports. For any medication, the doctor needs to listen to the patient and change what does not work, but keep doing what does work.

64. Dr. Edde's opinion was that the public comments received by the Department are evidence that marijuana provides a palliative benefit to those with PTSD and that these comments are of sufficient quality that a doctor would use them.

65. Dr. Edde's opinion was that marijuana provides a palliative benefit for PTSD and that it is safe and effective. But each person is unique, so it varies from patient to patient.

66. According to Dr. Edde, risk versus benefit is huge in medicine, which is especially true for an intensivist such as herself: either something works or it does not work. Neonatology is based on doing what works and there was not time to get studies done. A neonatologist cannot go to the lab first, because the baby will die while waiting for results – they see what works and the controlled studies come later.

67 Dr Edde testified that generally the studies are showing that there is a benefit to the use of marijuana for PTSD and that the benefit outweighs the risks.

68 Dr. Edde was of the opinion that it is not known why marijuana is effective for PTSD sufferers. Most of the current research work is looking at bio-pathways and the trending information shows that this will explain why marijuana works.

69 Dr. Edde was of the opinion that the Committee should not have excluded studies conducted on animals because, although going from a mouse to man is a huge leap, essentially all medical research proceeds along this path and you will not get to man if you do not first look at the mouse.

70 Dr. Edde's opinion was that PTSD should be added to the list of debilitating conditions. The risk is rather low and marijuana is safe and effective when compared to the medications that are now being used to treat PTSD.

Dr. Mecagni's Testimony

71 Dr. Mecagni has been an emergency room doctor for the last ten years and she is also the Medical Director for a marijuana dispensary.

72 There is an epidemic of PTSD among veterans. PTSD is a "horrible" mental illness and the risk extends to the community because PTSD can lead to violence.

73 There are only two FDA approved treatments for PTSD, sertraline (Zoloft) and Paxil, all other treatments, including benzodiazepines, are off-label uses. All of these drugs have bad side effects including a risk of suicide, and Zoloft does not appear to work, especially with combat-related PTSD.

74 Marijuana is a safe plant that does not affect the brain stem so the respiratory system is not affected. There are no reported marijuana overdoses leading to death and there is nothing showing that the risk of suicide goes up. Marijuana's side effects are benign, but the sativa strain is not a good choice for PTSD sufferers.

75 Dr. Mecagni has done research on the cellular biology of the endocannabinoid system (how it works) and on the experiential, observational studies of marijuana in the general population.

76. There are receptors in the hippocampus that control, or are related to, the fight-or-flight response. PTSD comes about from maladaptive responses to the flight-or-fight stimuli and with memory retrieval and dealing with stressful situations. The endocannabinoid system is connected to this part of the brain's neurochemistry and is active in memory retrieval and retention.

77. Dr. Mecagni agreed that whether marijuana works for those with PTSD is not in question and that how it works is the focus of research. Her opinion was that the current research shows that the endocannabinoid system is involved with the aberrant pathways that develop with PTSD in response to stress and that exogenous cannabinoid mitigates that effect.

78. Dr. Mecagni's opinion is that marijuana is safe and that, to a reasonable degree of scientific and medical certainty, observational studies show it is effective for the treatment of PTSD.

79. As a clinician Dr. Mecagni agrees that double blind studies are the best evidence, but there are none for marijuana. Moreover, off-label drug uses are not based on double blind studies, but rather are based on observations showing that the drug is effective for the off-label condition.

Mr. Pereyda's Testimony

80 Mr. Pereyda is a combat veteran of the United States Army, having served as a military policeman in Iraq

81 Mr. Pereyda suffers from PTSD and other maladies including chronic pain Mr. Pereyda holds a patient's qualifying card that was issued based on his chronic pain.

82. Mr. Pereyda had used medical marijuana every day in the four years prior to the hearing and found that using medical marijuana alleviated his PTSD and that it "helped tremendously."

83 Prior to his use of medical marijuana, Mr. Pereyda used prescription medications for his PTSD, including valium, Xanax, and Paxil. These prescription drugs did not alleviate his symptoms and they had side effects that he found to be unpleasant, including lethargy and reduced libido

84. Mr. Pereyda had been "hooked" on these pills, but since he started using medical marijuana he no longer uses the prescription drugs.

85. Mr. Pereyda acknowledged that he still has some issues related to his PTSD and that he has suffered panic attacks since he started using medical marijuana, but these attacks are less frequent and less severe than those that he previously experienced

86 Mr. Pereyda has not suffered any side effects from his medical marijuana use

87. Mr. Pereyda knows other veterans with PTSD for whom medical marijuana has been a tremendous help.

Ms. Engelking's Testimony

88. Ms. Engelking is the executive director of the Bloom Dispensary.

89. Ms. Engelking was a pharmaceutical sales rep for about thirteen years, during which time she interacted with over 600 doctors' offices.

90. Ms. Engelking testified as to the dangers of prescription medications and the operations at Bloom Dispensary.

CONCLUSIONS OF LAW

1 Appellant bears the burden of proof and the standard of proof on all issues in this matter is that of a preponderance of the evidence ARIZ. ADMIN. CODE § 2-19-119.

2 A preponderance of the evidence is:

> The greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact but by evidence that has the most convincing force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other.
>
> BLACK'S LAW DICTIONARY 1301 (9th ed. 2009).

3. "A [rule] is to be given such an effect that no clause, sentence or word is rendered superfluous, void, contradictory or insignificant." *Guzman v. Guzman*, 175 Ariz. 183, 187, 854 P.2d 1169,1173 (App. 1993); *Gutierrez v. Industrial Commission of*

Arizona, 226 Ariz 395, 249 P 3d 1095 (2011)(statutes and rules are construed using the same principles)

4. Among other things, a petitioner to add a new condition must provide the Department with:

> 6. A summary of the evidence that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition; and
> 7. Articles, published in peer-reviewed scientific journals, reporting the results of research on the effects of marijuana on the medical condition or a treatment of the medical condition supporting why the medical condition should be added.
>
> ARIZ. ADMIN. CODE § 9-17-106 (A).

5. The Department's determination that Appellant did not show that marijuana usage provides a palliative benefit to those who suffer from PTSD was based on its review of peer-reviewed articles. By limiting its evaluation to those articles, the Department has interpreted the applicable rules in a manner that leaves ARIZ. ADMIN. CODE section 9-17-106(A)(6) with no significance. Consequently, the Department's interpretation of the rule is not valid.

6. At the hearing, there was substantial evidence showing that PTSD sufferers receive a palliative benefit from marijuana use. There was also substantial evidence showing that medical professionals rely on patients' feedback when determining the appropriate treatments and that the practice of off-label prescribing is predicated on such feedback. In addition, Drs. Strand, Edde and Mecegni, and Ms. Manus all provided credible testimony showing medical marijuana provides a palliative benefit to PTSD sufferers.[7]

7 The preponderance of the evidence shows that marijuana use provides a palliative benefit to those suffering from PTSD.

8. Consequently, Appellant's appeal should be granted and PTSD should be added to the list of debilitating conditions for which marijuana may be dispensed.

[7] Although Dr. Sisley did not testify, in a video clip admitted into evidence, she expressed her opinion that marijuana has a palliative benefit for PTSD sufferers.

ORDER

IT IS ORDERED that Appellant's appeal is granted and that PTSD is added to the list of debilitating conditions for which marijuana may be dispensed

In the event of certification of the Administrative Law Judge Decision by the Director of the Office of Administrative Hearings, the effective date of the Order will be five days after the date of that certification.

Done this day, June 4, 2014.

/s/ Thomas Shedden
Thomas Shedden
Administrative Law Judge

Transmitted electronically to:

William Humble, Director
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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 14

BEFORE THE DIRECTOR OF THE

ARIZONA DEPARTMENT OF HEALTH SERVICES

In the Matter of: ARIZONA CANNABIS NURSES ASSOCIATION, Appellant	Case No.: 2014A-MMR-0254-DHS DECISION

PURSUANT TO the authority granted to me by Arizona Revised Statutes (A.R.S.) § 41-1092.08(B), and in accordance with the above-referenced matter, and

IN CONSIDERATION OF this proceeding, and the recommended decision of the administrative law judge, Thomas Shedden, I hereby make the following decision

NOW, THEREFORE, in that the findings of fact of the appointed administrative law judge, received on June 4, 2014, and incorporated herein by reference, are supported by the greater weight of the credible evidence and they are hereby **ADOPTED** except as amended

NOW, FURTHER, in that conclusions of law numbers 1 through 4, 7, and 8 of the appointed administrative law judge, received on June 4, 2014, and incorporated herein by reference, are supported by the greater weight of the credible evidence, are legally correct, and they are hereby **ADOPTED** except as amended

NOW, FURTHER, in that conclusions of law numbers 5 and 6 of the appointed administrative law judge, received on June 4, 2014, and incorporated herein by reference, are not

supported by the greater weight of the credible evidence, are not legally correct, and they are hereby **REJECTED**

NOW, FURTHER, in that the recommended decision of the appointed administrative law judge, received on June 4, 2014, and incorporated herein by reference, is supported by the greater weight of the credible evidence, is legally correct, and is hereby **ADOPTED** except as amended

FINDINGS OF FACT

Page 2, Findings of Fact, number 6, lines 9 and 10, delete the text after "contained the" and add the following:

> components specified in Arizona Administrative Code ("A A.C ") R9-17-106(A)(1) through (A)(7) The Department's review for administrative completeness of the components submitted for a petition is liberal Dr Christ's testimony, Audio Hearing Record, May 13, 2014, at 4:51 to 4:54; 5:58 to 6:00 Locations on the Audio Hearing Record are given in hours and minutes.

This deletion and addition are made to avoid a conclusory finding on the issue for determination

Page 2, Findings of Fact, number 7, line 14, before "palliative" add "therapeutic or" to correct an omission

Page 2, Findings of Fact, number 7, line 14, after "condition." add "A.A C. R9-17-106(B)(2)." to add the applicable citation

Page 2, Findings of Fact, number 7, line 15, delete "meet these requirements" and add "provide evidence specified in A A C R9-17-106(B)(2)" to make a technical change

20

Page 2, Findings of Fact, number 8, lines 19 and 20, delete the text and add the following:

> The Department's Medical Advisory Committee ("Committee") initially discussed Appellant's Petition at a meeting before the public hearing took place; one-half of the Committee felt that Appellant's Petition did not meet the conditions for going forward with a public hearing However, the Department scheduled a public hearing on Appellant's Petition in order to get more information The Committee also discussed Appellant's Petition at a meeting after the public hearing took place Testimony of Dr Christ, Audio Hearing Record, May 13, 2014, 6:19 to 6:21

This deletion and addition are made for consistency with the record

Page 2, Findings of Fact, number 10, lines 23 to 25, delete the first sentence as inconsistent with Findings of Fact, number 10 as amended herein

Findings of Fact, number 10, line 27, after "objection " add the following:

> Notwithstanding Appellant's waiving any objection, it cannot be shown that affording the Appellant and the public an opportunity for in-person comment on and presentation of additional information for Appellant's Petition caused, or could have caused, any harm

This addition is made for clarification

Page 3, Findings of Fact, number 13, line 11, after "the 2012 review " add the following:

The record established that the U of A fully searched a new database, which had not been available for the 2012 evidence review

This addition is made for consistency with the record.

Page 4, Findings of Fact, number 20, lines 14 to 16, delete the first sentence and add the following:

The record established that Dr. Christ's recommendation letter to the Director just states what the Committee recommended: that marijuana has not been subjected to high-quality, scientifically-controlled testing in humans. This does not mean that only randomized controlled double-blind studies are acceptable; good cohort studies would be acceptable. Dr. Christ's testimony, Audio Hearing Record, May 13, 2014, at 5:24 to 5:27

This deletion and addition are made for consistency with the record.

Page 6, Findings of Fact, line 6, delete "Compos-Outcalt" and add "Campos-Outcalt" to correct a clerical error.

Page 6, Findings of Fact, number 34, line 9, after "as more evidence becomes available," add the following:

Dr. Campos-Outcalt testified that his systematic evidence review excluded animal studies because such studies do not tell very much about the effect in humans; that it is standard practice to exclude animal studies; that animal studies may tell you about basic physiological principles; that solid basic science research on

animals may lead to studies on humans, but doesn't tell you how things are going to work in humans; and that many drugs are researched through animal studies, but less than five percent end up being proven to work in humans Audio Hearing Record, May 13, 2014, at 1:12 to 1:17 Dr Campos-Outcalt further testified his understanding is that the language in A A.C R9-17-106(A)(7) – "reporting the results of research on the effects of marijuana on the medical condition" – means the effect on people Audio Hearing Record, May 13, 2014, at 4:21 to 4:22

This addition is made for consistency with the record

Page 6, footnote 6, line 30, delete "his work" and add "the 2012 and 2013 evidence reviews" for clarity

Page 8, Findings of Fact, number 55, line 20, after "without any reported adverse effects" add the following:

The record established that there have been only anecdotal or media reports of overdosing on marijuana or adverse effects of marijuana *See* the Department's Supplemental Exhibits R and S

This addition is made for consistency with the record

Page 12, line 17, add Findings of Fact, numbers 91 through 95 as follows:

The New Mexico Study[1]

91 The record established that the New Mexico study was published after the Department issued its determination denying

[1] George R Greer M D , Charles S Grob M.D & Adam L Halberstadt Ph D (2014) PTSD Symptom Reports of Patients Evaluated for the New Mexico Medical Cannabis Program, Journal of Psychoactive Drugs, 46:1, 73-77, DOI: 10 1080/02791072 2013 873843

Appellant's petition. Testimony of Dr Campos-Outcalt that the publication date of the New Mexico study was January 16, 2014; Audio Hearing Record, May 13, 2014, at 4:06

92 The record established that the Committee reviewed a manuscript version of the New Mexico study Dr Campos-Outcalt and Dr Christ testified that the manuscript version of the New Mexico study was not a high-quality study Testimony of Dr Campos-Outcalt, Audio Hearing Record, May 13, 2014, at 2:57 to 3:03, 3:24 to 3:27, 4:07 to 4:11; testimony of Dr Christ, Audio Hearing Record, May 14, 2014, at 0:37 to 0:39

93 The New Mexico study included 80 individuals in the New Mexico medical marijuana program who self-described as having PTSD The New Mexico study results indicated more than 75 percent symptom reduction among study subjects during marijuana-use time periods when compared with non-marijuana-use time periods The New Mexico study concluded: "[T]he data reviewed here supports a conclusion that cannabis is associated with PTSD symptom reduction in some patients, "

94 The issue addressed by the New Mexico study was the palliative (symptom-reduction) effect of marijuana use for PTSD The New Mexico study did not address the issue of any therapeutic (curative) effect of marijuana use for PTSD and cannot provide support for any curative effect derived from marijuana use for

PTSD or other condition The Director finds that the record in this matter did not include credible evidence of a curative effect derived from marijuana use for PTSD or other condition

95 The Director finds that the published version of the New Mexico study, which was not available to or considered by the Department for its review of Appellant's Petition, provides sufficient support for a decision by the Director to add PTSD to the list of debilitating conditions set forth in A.R.S. § 36-2801(3) because its subsequent publication in a peer-reviewed journal gives the study additional credibility Further, the Director finds that a physician's written certification, as defined in A.R.S. § 36-2801(18), for the medical use of marijuana for PTSD is to be specifically limited to palliative, non-therapeutic use

Page 12, line 17, after Findings of Fact, number 95, as added herein, add Findings of Fact, numbers 96 and 97, as follows:

Additional Findings by the Director

96 The record shows that PTSD is a condition for which there are limited effective palliative treatment options, and that there is substantial anecdotal evidence that medical marijuana provides relief to those suffering from this condition

97 The director finds that the new evidence presented at the administrative hearing, including the additional weight that can be given to the New Mexico study, supports the Director's decision to

add PTSD to the list of debilitating conditions as set forth in

A R S § 36-2801(3)

CONCLUSIONS OF LAW

Page 13, Conclusions of Law, number 3, line 2, after "the same principles)." add the following:

> Further, Arizona courts have stated: "Statutory provisions are to read in the context of related provisions and the overall statutory scheme," and "[s]tatutes relating to the same subject matter should be read *in pari materia* to determine legislative intent [or in this case the intent of the voters] and to maintain harmony." *Goulder v Ariz Dep't of Transp*, 177 Ariz 414, 416, 868 P 2d 997, 999 (App 1993), *aff'd*, 179 Ariz 181, 877 P 2d 280 (1994) [2]

This addition is made to correct an omission and for consistency with applicable case law

Page 13, Conclusions of Law, number 4, line 10, delete "§ 9-17-106 (A)" and add "R9-17-106(A)" to make a technical correction

Page 13, Conclusions of Law, numbers 5 through 6, lines 11 5 through 24 5, delete the numbers, the text, and footnote 7 and add new Conclusions of Law, numbers 5 through 6 as follows:

> 5 Under the *in pari materia* rule of statutory construction, when read consistently with A.A.C. R9-17-106(A)(7), subsection (A)(6) must mean that a petition to add a debilitating condition is

[2] Arizona courts apply the same rules in construing both statutes and rules *See Gutierrez v Indus Comm'n of Ariz*, 226 Ariz 395, 396, ¶ 5, 249 P 3d 1095, 1096 (2011); *Smith v Ariz Citizens Clean Elections Comm'n*, 212 Ariz 407, 412, ¶ 18, 132 P 3d 1187, 1192 (2006)

to include a summary of the evidence other than the articles reported in peer-reviewed journals. Articles reported in peer-reviewed journals are to be included under subsection (A)(7). The Department's interpretation gives meaning to both A.A.C. R9-17-106(A)(6) and (A)(7). An agency's interpretation of its rules is generally entitled to great weight and accorded deference by Arizona courts. *See Capitol Castings, Inc. v. Ariz. Dep't of Econ. Sec.*, 171 Ariz. 57, 60, 828 P.2d 781, 784 (App. 1992); *Marlar v. Ariz.*, 136 Ariz. 404, 411-12, 666 P.2d 504, 511-12 (App. 1983); *Metro Mobile CTS, Inc. v. NewVector Commc'ns, Inc.*, 661 F. Supp. 1504, 1512 (D. Ariz. 1987), *aff'd*, 892 F.2d 62 (9th Cir. 1989). The Director concludes that the Department's interpretation of its administrative rule is valid.

6. The record established that the Department reviewed all the material submitted by Appellant for its Petition, all the written/online comments submitted by public, all the comments made and materials submitted at the public hearing, and the U of A systematic evidence reviews. The Committee gave more weight to the evidence (or lack thereof) of articles published in peer-reviewed journals.

This deletion and addition are made for consistency with the Findings of Fact as amended and added herein and with applicable legal authorities.

27

Page 13, Conclusions of Law, number 7, lines 25 and 26, delete the text and add the following:

> Based on the Department's subsequent review of the newly published, peer-reviewed New Mexico study and the additional evidence provided at the administrative hearing, the Director found that this provides sufficient support for a decision by the Director to add PTSD to the list of debilitating conditions set forth in A R S § 36-2801(3). The Director further found that a physician's written certification, as defined in A R S § 36-2801(18), for the medical use of marijuana for PTSD is to be specifically limited to palliative, non-therapeutic use *See* Findings of Fact, number 95 as added herein

This deletion and addition are made for consistency with Findings of Fact, numbers 91 through 95 as added herein.

Page 13, Conclusions of Law, number 8, lines 27 and 28, delete the text and add the following:

> In accordance with the Findings of Fact and Conclusions of Law as amended and added herein, the Director concludes that Appellant's Petition and appeal should be granted, and that PTSD should be added to the list of debilitating conditions for which marijuana may be dispensed for medical use A physician's written certification, as defined in A R S § 36-2801(18), for the medical use of

marijuana for PTSD is to be specifically limited to palliative, non-therapeutic use

This deletion and addition are made as a technical change

Page 14, line 1, before "Order" add "Recommended" to make a technical change

Page 14, Recommended Order, lines 2 and 3, delete the text and add the following:

It is recommended that the Director grant Appellant's Petition and appeal; add PTSD to the list of debilitating conditions for which marijuana may be dispensed for medical use; and require that a physician's written certification, as defined in A R S § 36-2801(18), for the medical use of marijuana for PTSD be specifically limited to palliative, non-therapeutic use

This deletion and addition are made as a technical change

IT IS ORDERED THAT the appeal is granted.

IT IS FURTHER ORDERED THAT Appellant Arizona Cannabis Nurses Association's Petition to add Post-Traumatic Stress Disorder to the list of debilitating medical conditions set forth in A R S § 36-2801(3) is granted

IT IS FURTHER ORDERED THAT Post-Traumatic Stress Disorder is added to the list of debilitating conditions for which marijuana may be dispensed for medical use, from and after January 1, 2015

IT IS FURTHER ORDERED THAT a physician's written certification, as defined in A.R.S. § 36-2801(18), for the medical use of marijuana for Post-Traumatic Stress Disorder is to be specifically limited to palliative, non-therapeutic use

IT IS FURTHER ORDERED THAT a physician's written certification, as defined in A.R.S. § 36-2801(18), for the medical use of marijuana for Post-Traumatic Stress Disorder is to include an attestation that the patient is participating in conventional treatment for Post-Traumatic Stress Disorder

IT IS FURTHER ORDERED THAT the effective date for adding Post-Traumatic Stress Disorder, for palliative use only, to the list of debilitating conditions for which marijuana may be dispensed for medical use is January 1, 2015. This effective date enables physicians to prepare for issuing written certifications in accordance with A.A.C. R9-17-202(F)(5) and (G)(8) and A.A.C. R9-17-204(A)(5) and (B)(4) for best meeting the needs of patients who qualify for the palliative use of medical marijuana for Post-Traumatic Stress Disorder; enables medical marijuana dispensaries to comply with the requirement to develop, document, and implement policies and procedures in accordance with A.A.C. R9-17-310(A)(2) for best meeting the needs of patients who qualify for the palliative use of medical marijuana for Post-Traumatic Stress Disorder; and enables medical directors of medical marijuana dispensaries to comply with requirements to develop and provide training to dispensary agents in accordance with A.A.C. R9-17-313(C), and to oversee the development and dissemination of educational materials and a system for documenting qualifying patients' symptoms in accordance with A.A.C. R9-17-313(D) for best meeting the needs of patients who qualify for the palliative use of medical marijuana for Post-Traumatic Stress Disorder.

PURSUANT TO the requirements of A.R.S. §§ 41-1092.08(H), 41-1092.09, and 12-904, the parties are advised that they have a period of thirty (30) days from the receipt of this decision to file a motion for rehearing or review with the Clerk of the Department, at the address

30

appearing on the distribution list; or a period of thirty-five (35) days after receipt of this decision to file a notice of appeal for judicial review of administrative decision in Superior Court

Dated this 9th day of July, 2014

Will Humble
Director

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 15

The Discovery of the Endocannabinoid System

The National Institute on Drug Abuse inadvertently facilitated a series of major discoveries about the workings of the human brain.

By Martin A. Lee

Up until the late 1980s, Cannabis research remained a rather esoteric field involving a small number of scientists in the United States and abroad. Their efforts were circumscribed by the politicized agenda of the National Institute of Drug Abuse, which subsidized studies designed to prove the deleterious effects of cannabis while blocking inquiry into its potential benefits.

Rather than discrediting cannabis, NIDA inadvertently facilitated a series of major discoveries about the workings of the human brain. These breakthroughs —among the most exciting developments in brain chemistry of our time— spawned a revolution in medical science and a profound understanding of health and healing.

"By using a plant that has been around for thousands of years, we discovered a new physiological system of immense importance," says Raphael Mechoulam, the dean of the transnational cannabinoid research community. "We wouldn't have been able to get there if we had not looked at the plant."

In the two decades following the identification and synthesis of THC by Mechoulam and his colleague Y. Gaoni in Israel in 1964, scientists learned a great deal about the pharmacology, biochemistry and clinical effects of cannabis. But no one really knew how it worked —what it actually did inside the brain on a molecular level to alter consciousness, stimulate appetite, dampen nausea, quell seizures, and relieve pain. No one understood how smoked marijuana could stop an asthma attack in seconds, not minutes. No one knew why it lifted one's mood.

When American researchers at Johns Hopkins University identified receptor sites in the brain capable of binding with opioids (such as morphine and heroin) in 1973, some scientists expected that the discovery of receptor sites for marijuana would soon follow. But 15 years would elapse before a U.S.-government-funded study at the St. Louis University School of Medicine determined that the mammalian brain has receptor sites —specialized protein molecules embedded in cell membranes— that respond pharmacologically to compounds in marijuana resin.

Initially identified by Allyn Howlett and William Devane, cannabinoid receptors turned out to be far more abundant in the brain than any other type of neurotransmitter receptor.

A potent THC analog synthesized by Pfizer (CP55,940) enabled researchers to radioactively tag and begin mapping the precise locations of cannabinoid receptors in the brain. Not surprisingly, they are concentrated in regions responsible for mental and physiological processes: the hippocampus (memory), cerebral cortex (higher cognition), the cerebellum (motor coordination), the basal ganglia (movement), the hypothalamus (appetite), the amygdala (emotions) and elsewhere.

On July 18, 1990, at a meeting of the National Academy of Science's Institute of Medicine, Lisa Matsuda announced that she and her colleagues at the National Institute of Mental Health (NIMH) had achieved a major breakthrough — they had pinpointed the exact DNA sequence that encodes a THC-sensitive receptor in the rat's brain.

Cannabinoid receptors function as subtle sensing devices, tiny vibrating scanners perpetually primed to pick up biochemical cues that flow through fluids surrounding each cell.

People have the same receptor, which consists of 472 amino acids strung together in a crumpled chain that squiggles back and forth across the cell membrane seven times. Cannabinoid receptors function as subtle sensing devices, tiny vibrating scanners perpetually primed to pick up biochemical cues that flow through fluids surrounding each cell.

Matsuda also disclosed that she had successfully cloned the marijuana receptor. This electrifying news was the curtain-raiser for "the Decade of the Brain," as it was proclaimed at the National Academy of Science meeting. During the 1990s, there would be more advances in neuroscience than in all previous years combined.

The cloning of the cannabis receptor was crucial. It opened the door for scientists to sculpt molecules that "fit" these receptors like keys in a slot. Some keys —"agonists"— turned the receptor on, others —"antagonists"— turned it off.

Scientists also developed genetically engineered "knockout" mice that lacked this receptor. When administered to knockout mice, THC had virtually no effect; the THC had nowhere to bind and hence could not trigger any activity. This was further proof that THC works by activating cannabinoid receptors in the brain and central nervous system. Finally, after 50 centuries of medicinal usage, the scientific basis of cannabis therapeutics was coming into focus.

Researchers soon identified a second type of cannabinoid receptor, dubbed "CB2," which is prevalent throughout the immune system and the peripheral nervous system. CB2 receptors are also present in the gut, spleen, liver, heart, kidneys, bones, blood vessels, lymph cells, endocrine glands and reproductive organs.

The CB1 receptor mediates psychoactivity. CB2 regulates immune response. Marijuana does so much and is such a versatile medicine because it acts everywhere, not just in the brain.

Just as the study of opium resulted in the discovery of endorphins, the brain's own morphine-like substance, so, too, marijuana research would lead to the discovery of a natural, internal, THC-like compound, our "inner cannabis," so to speak. In 1992, Raphael Mechoulam, in collaboration with NIMH research fellow William Devane and Dr. Lumir Hanus, found a novel neurotransmitter, a naturally-occurring "endocannabi-noid," which attaches to the same mammalian brain-cell receptors as THC. They decided to call it "anandamide," deriving from the Sanskrit word for bliss.[2]

In 1995, Mechoulam's group discovered a second major endocannabinoid — 2-arachidonoylglycerol, or "2-AG" — that "locks on" to both the CB1 and CB2 receptors.

By tracing the metabolic pathways of THC, scientists stumbled upon a unique and hitherto unknown molecular signaling system that is involved in regulating a broad range of biological functions. Scientists call it "the endocannabinoid system," after the plant that led to its detection. The name suggests that the plant came first, but in fact, as Dr. John McPartland has explained, this ancient, internal signal system started evolving over 600 million years ago (long before cannabis appeared) when the most complex life form was sponges.[1]

Endocannabinoids and their receptors are present in fish, reptiles, earthworms, leeches, amphibians, birds and mammals —every animal except insects. Given its long evolutionary history, scientists surmised that the endocannabinoid system must serve an important and basic function in animal physiology.

The effects of cannabis have drawn scientists to the still unfolding saga of the endocannabinoid system, which has only recently begun to reveal its profound mysteries. Endocannabinoids and their receptors emerged as a hot topic among scientists who shared their findings in highly technical peer-reviewed journals and at annual conclaves hosted by the International Cannabinoid Research Society (ICRS). Formed in 1992, the society and many of its members (mainly university-connected scientists) were supported by U.S government research grants.

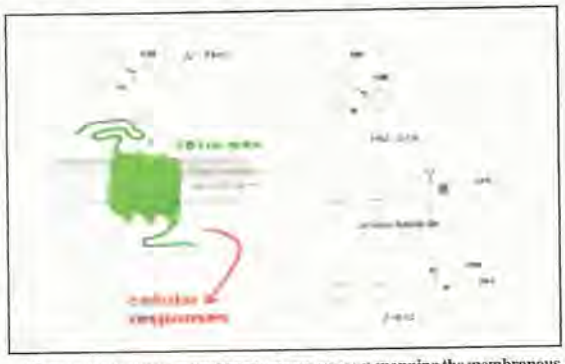
ICRS proceedings piqued the interest of big pharmaceutical firms. Drug company investigators paid close attention to cutting-edge developments in cannabinoid science, which few people outside the scientific community were privy to. Advances in the burgeoning field of cannabinoid studies would pave the way for new treatment strategies for various pathological conditions —cancer, diabetes, neuropathic pain, arthritis, osteoporosis, obesity, Alzheimer's, multiple sclerosis, depression and many other diseases that seemed beyond the reach of conventional cures.

CB1 and CB2 receptors recognize and respond to three kinds of cannabinoid agonists (turn-on keys): endogenous-fatty-acid cannabinoids; phyto-cannabinoids concentrated in the oily resin on the buds and leaves of the marijuana plant; and synthetic cannabinoids concocted in university and drug company laboratories.

For Big Pharma, cannabinoid research became a tale of knockout mice and men. Using genetically-engineered rodents that lacked CB receptors, researchers were able to prove that cannabinoid compounds can alter disease progression and attenuate experimentally-induced symptoms.

An "animal model" of osteoporosis, for example, was created in normal mice and in knockout mice lacking CB receptors. When a synthetic cannabinoid drug was given to both groups of osteoporatic mice, bone damage was mitigated in the normal mice but had no effect on rodents sans CB receptors —which means that CB receptors are instrumental in regulating bone density.

continued on next page



CANNABINOIDS ACT BY BINDING TO RECEPTOR PROTEINS spanning the membranous surface of cells and encoded by either the CB1 or CB2 receptor genes. Activation of the CB receptors changes cellular function, including gene expression and electrical excitability of cell membranes, by triggering intricate cascades of intracellular signaling molecules. The chemical structure of delta 9-THC, the classic and prototypical cannabinoid of the cannabis plant, has been modified to create synthetic analog drugs like HU-210, which is many times more potent an agonist (chemical activator) of the CB1 receptor.

Such potent drugs have been very useful experimentally because they drive the receptor more intensely than do THC or the endocannabinoids. While this property (being a "high-efficacy full agonist") can create more readily observable results when compared to a partial agonist like THC, such experiments are frequently and inaccurately publicized as revealing a specific effect of marijuana. Anandamide and 2-AG are CB receptor agonists that evolved in the natural world many millions of years before the cannabis plant itself, and are innate chemical regulators within possibly every animal and in most tissues of the human body (even in insects that lack the CB receptors, 2-AG is present and acts at different targets). The chemical structures of the endocannabinoids are quite different from the phytocannabinoids, although there is evidence that they may fold in a way that resembles THC in 3-D space.

Adapted from a chapter in Martin Lee's forthcoming social history of marijuana, "Mellow Mayhem," which he is writing for Scribner's. Lee is the author of "Acid Dreams" *and an associate editor of* O'Shaughnessy's.

Illustrations are from Gerdeman, G.L and Schechter, J.B., 'Endocannabinoids and the molecular physiology of cannabis," in "The Pot Book: A Complete Guide to the Risks and Benefits of Cannabis" *(Inner Traditions), in press. Captions by Gregory Gerdeman, assistant professor of Biology at Eckerd College.*

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 16

print

CRIME & DRUGS (/TOPIC/CRIME-DRUGS)

DEA Accused of Obstructing Research on Marijuana Benefits

By Mary Emily O'Hara (/contributor/mary-emily-ohara)

June 14, 2014 | 6:25 am

This Monday, the Drug Policy Alliance and the Multidisciplinary Association for Psychedelic Studies released a report titled "The DEA: Four Decades of Impeding and Rejecting Science (http://www.drugpolicy.org/sites/default/files/DPA-MAPS_DEA_Science_Final.pdf)." Using case

studies from 1972 to the present, the report argues the ways the US Drug Enforcement Administration (https://news.vice.com/topic/dea) has suppressed research on the positive benefits of marijuana for medical use.

The crux of the report is this: The DEA has worked to paint marijuana into an inescapable corner by both repeatedly (and falsely) stating that marijuana has no proven medical use and by systematically impeding clinical research that would prove such medical benefit. This refusal to either acknowledge or study the drug allows it to continue being classified as a Schedule I drug, the most heavily regulated illegal substance.

Schedule I drugs, according to the DEA itself (http://www.justice.gov/dea/druginfo/ds.shtml), are those with no medical use and "the most dangerous" with "potentially severe psychological or physical dependence."

Marijuana is classified as Schedule I along with heroin, LSD, ecstasy, and peyote. But drugs that are classified as Schedule II and considered to have "less abuse potential" include cocaine, methamphetamine, and opium.

Legal pot in the US is crippling Mexican drug cartels. Read more here. (https://news.vice.com/search?query=DEA)

The Drug Policy Alliance/MAPS report recommends taking the power to schedule and classify drugs away from the DEA, a criminal justice agency, and instead giving jurisdiction to a health or science based division of government.

"It's like giving the Highway Patrol the ability to set speed limits," Sean Dunagan, a former DEA senior intelligence research specialist, told VICE News.

Dunagan, a member of Law Enforcement Against Prohibition, said DEA culture is vehemently anti-drug and "stuck in the 1980's rhetoric" of the war on drugs.

> *"It's like giving the Highway Patrol the ability to set speed limits."*

"The DEA is never going to approach scheduling decisions on the basis of science," said Dunagan. "It's necessarily skewed in one direction."

The end of weed prohibition is still a long way off. Read more here. (https://news.vice.com/article/the-end-of-weed-prohibition-is-still-a-long-way-off)

Scheduling doesn't affect the way a drug's criminality is enforced, Dunagan explained. Cocaine busts usually bring harsher sentences than pot offenses, but the fact that marijuana remains in the Schedule I category is part of the DEA's ongoing defense against legalization.

So why is cocaine classified as a less dangerous, Schedule II drug? Because it was once used as a topical anesthetic for surgery — a use that has long been out of fashion in surgical wards across the US.

In 2009, the American Medical Association (AMA) reversed its previously anti-pot stance and declared that clinical trials had evidenced the use of cannabis in reducing neuropathic pain, reducing spasms in multiple sclerosis patients, and improved appetite in those suffering from nausea and loss of muscle mass.

The AMA recommended that marijuana's Schedule I status "be reviewed with the goal of facilitating clinical research and development of cannabis-based medicines and alternate delivery systems."

Drug Policy Alliance says schedule classifications aren't even the main thing getting in the way of research. The organization's Jag Davies told VICE News that the biggest problem facing clinical researchers is the fact that the government is the only place where you can get legal, research-grade marijuana.

"The only federally approved provider of marijuana is the National Institute on Drug Abuse (NIDA), which is part of Health and Human Services. But they are very politically motivated and aren't interested in its medical research," Davies said.

"If you want to do a study on any drug, you have to get FDA approval, a DEA license to possess the drug, and then you purchase the drug from a manufacturer that has a DEA license to produce the drugs," he explained. "Say I'm doing a study on heroin, meth, or LSD — I can purchase that from a federally licensed private facility."

He said marijuana is the only drug not produced for research by any third party drug manufacturer. In order to study marijuana's clinical benefits, a research team must be approved by Health and Human Services (HHS), who then recommends that NIDA give them the drug.

"HHS agencies have approved and funded hundreds of research projects (intramural, extramural, and independently funded) on adverse effects and therapeutic uses for marijuana," an HHS spokesperson told VICE News. "There has not been any government blockade of research on the potential medical benefits of marijuana, and in fact there has been significant research conducted over the last few years."

According to the report, the DEA refuses to license any other drug manufacturer to grow marijuana for scientific research. So the only place researchers can go to get it is a government agency that states in its very name the perception that all drug use is abuse.

Marijuana is the only drug, said Davies, not produced for research by any third party drug manufacturer.

A NIDA spokesperson told VICE News the agency supplies a variety of drugs to researchers, including several classes of cannabidinoids, hallucinogens, and other controlled substances like methamphetamine. A full catalog of the government drug supply for researchers is available online.

Though the NIDA catalog states that the drugs are available to "research investigators working in the area of drug abuse, drug addiction, and related disciplines," the spokesperson informed VICE News that there are currently almost 30 active NIDA-funded studies on marijuana's therapeutic benefits.

However, a glance at the list of active NIDA-funded marijuana studies (http://www.drugabuse.gov/drugs-abuse/marijuana/nida-research-therapeutic-benefits-cannabis-cannabinoids) shows that only 12 have a primary focus on therapeutic benefit, while the other 13 focus on withdrawal and addiction.

Only 15 independent studies (http://www.drugabuse.gov/drugs-abuse/marijuana/independently-funded-studies-receving-research-grade-marijuana-1999-to-present) since 1999 have received research-grade marijuana through NIDA.

This March, MAPS finally got a letter of approval (http://www.maps.org/mmj/HHS-CoverLetter-Doblin-electronic-14Mar14.pdf) to run a clinical marijuana trial after what they say was a 12-year battle. But in May, NIDA informed MAPS that despite being the only source for the drug, they just didn't have particular strain needed for the study.. In fact, NIDA would have to start growing some pot plants from scratch, saying they might be ready by this fall.

MAPS published a timeline (http://www.maps.org/research/mmj/) of its longstanding struggles to get marijuana approved for various clinical trials. Currently the only organization in the world funding clinical trials using MDMA as therapy to treat PTSD in veterans, MAPS slammed NIDA for its lack of marijuana availability, saying "NIDA is required under the Controlled Substances Act of 1970 to provide a "continuous and uninterrupted supply" of marijuana for research, which they have now admitted to failing to provide."

"The DEA basically protects NIDA's monopoly by refusing to issue licenses to anyone else," Davies told VICE News, "The DEA's blockage of research on marijuana is really the hidden story behind the medical marijuana movement of the past couple decades. It doesn't make sense to many in the medical profession that we would regulate drugs at the state level, but because the process at the federal level has been blocked for so many decades, we've turned to state regulations."

As long as the agencies continue to block federally funded clinical studies that could prove marijuana's medical benefits, doctors have no choice but to recommend legally prescribeable drugs from Schedule II and beyond, such as opiates like oxycodone.

If doctors choose to recommend medical marijuana, even in states that legalized the drug, they face getting their federal licenses taken away – such as when DEA agents recently showed up at the homes of several Massachusetts doctors, (http://www.bostonglobe.com/metro/2014/06/05/drug-enforcement-administration-targets-doctors-associated-with-medical-marijuana-dispensaries-physicians-say/PHsP0zRlaxXwnDazsohIOL/story.html) threatening them with ultimatums.

"This is an important issue beyond just marijuana," Dunagan said. "There are so many other drugs that have so much medical potential and aren't being used. You have to wonder what drugs people are taking instead when they aren't given access to this."

Image via Flickr (https://www.flickr.com/photos/milkwhitegown/4607818422/in/photolist-82bgTd-ndTJbw-ndTwLq-383jvz-5voWPC-nw4mt7-ndTwGZ-9VBtUS-NTmqU-a11MR-89xTFR-38828C-ngA38Z-aH42Ca-fhJXw-BFk4e-383pMK-9hwwTs-387XS5-bhRSDv-387HWf-383nJB-383m1F-383k4B-387STs-387Sbb-383fBM-9VyC58-387RyC-8yxyWo-383mTv-3881am-383aVD-3883rL-387QDo-387Qd3-383dvF-387Mh7-4uNTBk-383ePz-383h6r-383cCT-2bF4a-csY9D9-EpyyL-8vWmZd-9VBuk1-9VBu8E-9VBsNb-gS6S4)

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 17

(http://www.maps.org)

Arizona Medical Association Challenges NIDA Blockade of Medical Marijuana Research

Written on June 3, 2012.

On June 2, 2012, the Arizona Medical Association (ArMA) House of Delegates unanimously adopted a resolution (/mmj/MCMS_RES2_ENDNIDAMonopoly2012_1_.pdf) (pdf) challenging the National Institute on Drug Abuse's blockade of medical marijuana research. ArMA's resolution is yet another pressure point on the federal government's obstruction of medical marijuana research. ArMA resolved that "once the protocol for privately-funded marijuana research has been reviewed and approved by the Food and Drug Administration and relevant Independent Review Board and the practitioner has obtained registration from the Drug Enforcement Administration, the National Institute of Drug Abuse shall, without further evaluation of the research protocol, supply marijuana for the research, at cost, upon the practitioner's proper application."

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 18

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2012-053585

12/03/2012

HONORABLE MICHAEL D. GORDON

CLERK OF THE COURT
M. MINKOW
Deputy

WHITE MOUNTAIN HEALTH CENTER INC JEFFREY S KAUFMAN

v.

COUNTY OF MARICOPA, et al. PETER MUTHIG

CHARLES A GRUBE
KEVIN D RAY
KELLY J FLOOD

UNDER ADVISEMENT RULING AND WRIT OF MANDAMUS

A. Introduction

The controversy before the Court arises out of the passage and application of Arizona's Medical Marijuana Act (AMMA). The AMMA, originally known as Proposition 203, was enacted by voter initiative on November 2, 2010 and has been codified under Arizona law. *See* Ariz. Rev. Stat. Ann. §§ 36-280 to 36-2819 (2012). The AMMA decriminalizes, under State law, the possession, use, cultivation and sale of marijuana for medical use. The AMMA provides for highly State-regulated dispensary and cultivation sites. *Id.*

The AMMA grants rule-making authority to the Arizona Department of Health Services (ADHS). *See* Ariz. Rev. Stat. Ann. § 36-136(F) (2012). The regulations subsequently promulgated are embodied in Arizona's Administrative Code. *See* Ariz. Admin. Code R9-17-101 to R9-17-323 (2012). The regulations divide Arizona into 126 separate "Community Health Care Analysis Areas" ("CHAA") and each CHAA may have only <u>one</u> medical marijuana dispensary.

The regulations also provide that an entity seeking to become a dispensary or cultivation site must first file an application for a Registration Certificate (Registration Certificate) with the ADHS. *See* Ariz. Admin. Code R9-17-305 (2012). Once having obtained a Registration Certificate, the applicant must then submit an application with the certificate to ADHS for approval of the site.

The regulations further provide that the applicant must submit documentation to ADHS stating that its proposed site meets all applicable zoning restrictions or, alternatively, there are none that need to be met. *See* Ariz. Admin. Code. R9-17-304(6) and R9-17-305(A)(2) (2012). It is that requirement that precipitated the extant lawsuit.

B. This lawsuit

Plaintiff White Mountain Health Center Inc. seeks to operate a dispensary under the AMMA, the Sun City CHAA No. 49 and it is the only applicant in this CHAA. On about May 25, 2012, Plaintiff filed an application for a Registration Certificate with ADHS. Plaintiff alleges that it was unable to obtain documentation from Defendants Maricopa County and/or County Attorney William Montgomery (collectively referred to as the "County Defendants") stating that its proposed site either met County zoning restrictions or, alternatively, that there were no such restrictions. Plaintiff further alleges that ADHS issued a "Notice of Deficiencies" advising Plaintiff of the defect with the application. Plaintiff alleges that the County Defendants categorically refused to provide the necessary zoning documentation.

Thus, on June 19, 2012, Plaintiff filed a Complaint followed by a First Amended Complaint, filed on September 7, 2012.[1] Plaintiff seeks the following relief:

- Count 1 (Declaratory Judgment): Declaring, among other things, that there are no local or Maricopa County zoning restrictions for its proposed dispensary in the Sun City CHAA No. 49 and/or, in the alternative, the proposed site is in compliance with the Maricopa County Zoning Ordinance and regulations relating to where a dispensary may be located and/or, in the alternative, Maricopa County has not enacted reasonable restrictions with respect to CHAA No. 49;

- Count 2 (Injunctive Relief): Enjoining the ADHS and its Director Will Humble (Humble) *pendente lite* and permanently from "withdrawing" and/or rejecting Plaintiff's application for a Registration Certificate;

[1] The First Amended Complaint was filed in order to correct technical deficiencies.

- Count 3 (Mandamus Relief Issuing a Writ of Mandamus): Requiring County Defendants to provide Plaintiff and ADHS with a sworn statement and/or other materials declaring that Maricopa County has not adopted any restrictions upon the location of medical marijuana dispensaries in the CHAA No. 49 and that Plaintiff's proposed location is therefore in compliance with zoning requirements;

- Count 4: Seeking a Writ of Mandamus requiring ADHS to issue a Registration Certificate and to allow Plaintiff to open a medical marijuana dispensary after Plaintiff has constructed improvements regardless of whether Maricopa County has issued the zoning compliance certification; and

- Awarding Plaintiff its attorney's fees.

On July 23, 2012, after a hearing, the Court entered a preliminary injunction that enjoined ADHS and Humble from withdrawing, denying or otherwise rejecting Plaintiff's application for a Registration Certificate based on the Plaintiff's putative failure to comply with Ariz. Admin. Code R9-17-304(6) (regulation requiring the dispensary applicant to provide documentation confirming zoning certification). The Court found that the County Defendants were effectively foreclosing the possibility of Plaintiff's full compliance. The Court also found Plaintiff had applied for a Registration Certificate but Maricopa County refused to examine whether Plaintiff's proposed site met zoning requirements or if there were any zoning requirements at all.

The defendants filed timely Answers to the First Amended Complaint, including the State of Arizona (Intervenor), who intervened.[2] Intervenor also affirmatively counterclaimed for declaratory relief asserting that portions of the AMMA were preempted by federal law under the Controlled Substances Act (CSA). *See* U.S.C. §§801-971 (2012).[3]

Pending before the Court are: (1) Plaintiff's Motion for Partial Summary Judgment (deemed filed 9/7/12);[4] (2) County Defendants' (Maricopa County, William Montgomery) Cross Motion

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[2] On August 23, 2012, the State moved to intervene. The Court granted the Motion on September 10, 2012 to the Intervenor.

[3] Intervenor and the County disagree on one point. The County Defendants argue the CSA preempts the AMMA in its entirety and the State argues that the AMMA's provision that directs the ADHS to issue medical marijuana cards is not preempted.

[4] Although denominated a motion for summary judgment, Plaintiff seeks limited relief, either: (i) a court order directing County Defendants to issue its documentation or (ii) a Court order deeming that its application for a permit satisfies Ariz. Admin. Code R9-17-304(6). Therefore, it is a motion for partial summary judgment.

for Summary Judgment (filed 8/23/12); and (3) The Intervenor's Motion for Summary Judgment (filed 8/23/2012).

Other procedural motions include Plaintiff's Motion for Leave to file Plaintiff's Response to County Defendants' Separate Statement of Facts in Support of Cross Motion for Summary Judgment (filed 10/10/12) (granted by minute entry dated 10/18/12 and on the Record) and Plaintiff's request to strike memorandum decisions cited by County Defendants. *See Plaintiff's Joint Response to County Defendants' Cross Motion for Summary Judgment and Intervenor's Motion for Summary Judgment*, n.7 (9/27/12).[5]

The crux of the parties' dispute lies with the County Defendants and the Intervenor's argument that the United States Constitution preempts the AMMA and, therefore, the AMMA is unconstitutional. The Court turns to this argument first.

C. Preemption

Federal law proscribes the "manufacture, distribution or possession of marijuana" under the CSA. In 2005, the United States Supreme Court held that California's medical marijuana laws do not provide any impediment to federal prosecution of the CSA and previously held there is no exception for medical necessity under the CSA. *Gonzales v. Raich*, 545 U.S. 1 (2005); *United States v. Oakland Cannabis Buyers' Co-op*, 532 U.S. 483 (2001). The *Raich* Court did *not* address the issue presented to this Court, that is, whether federal law preempts State law, which permits the use of medical marijuana. *Id.* Rather, the Court addressed Congress' power under the Commerce Clause to prohibit the local cultivation and use of medical marijuana. *Id.*

The question before this Court is the flip side of the *Raich* coin. Does Congressional passage of the CSA preempt Arizona's attempt to authorize, under State law only, the local cultivation, sale and use of medical marijuana? In other words, does the CSA preempt the AMMA?

Early in this preemption analysis, the Court acknowledges two fundamental principles underlying the examination of preemption. First, preemption is a question of Congressional *intent* or *purpose*. *See, e.g., Wyeth v. Levine*, 555 U.S 555, 565-66 (2009); *Gade v. National Solid Waste Management Ass'n,* 505 U.S. 88 (1992). Where, as here, Arizona is operating under its historic police powers, this Court is directed to "assume that 'the historic police powers of the States' are *not* superseded unless that was *the clear and manifest purpose* of Congress." *Arizona v. United States,* 132 Ariz. S. Ct. 2492, 2501 (2012) (addressing Arizona's immigration statutes

[5] *See Ariz. R. Sup. Ct.* 111(c) (2012). While the Court reviewed those cases, the Court they did not impact the Court's decision. The request is, therefore, deemed moot.

that were preempted by federal law) (emphasis added); *see also Gonzales v. Oregon,* 546 U.S. 243, 270 (2006).

Second, once preemption of State law is clearly demonstrated to be a Congressional purpose, this Court must respect the right of Congress to impose laws that supersede State law. Congress' power to do so arises from the Supremacy Clause of the United States Constitution which provides, in part, that the "[l]aws of the United States. . . shall be the supreme law of the land." U.S. Const. Art. VI, cl. 2.[6]

With that groundwork, the Court must measure whether Congress intended to have the CSA preempt State law. There are four ways to measure congressional purpose in terms of preemption: (1) expressed preemption; (2) field preemption; (3) obstacle preemption; and (4) physical impossibility.

Addressing the first, Congress may expressly set forth its intent to prohibit State involvement in a statutory scheme. *See, e.g., Chamber of Commerce of U. S. v. Whiting*, 131 S. Ct. 1968 (2011) (holding that Arizona's employer sanctions against those who hire undocumented workers were not preempted by federal law). In this case, the parties acknowledge that when Congress enacted the CSA, there was no such expression of purpose.

Addressing the second, Congress may preempt State legislation if Congressional legislation so fully occupies the field that its intent to preempt State law is obvious. *See Gade v. National Solid Wastes Management Ass'n,* 505 U.S. 88, 115 (1992) (Souter, J., dissenting) (acknowledging the doctrine). Often referred to as "field preemption," it is a measure of Congressional intent. Like express preemption, the parties in this case agree that the CSA does not require preemption of the AMMA under this rubric.[7]

Addressing the third, preemption may occur when States enact legislation that stand as an "obstacle" to the full purposes and objectives of Congress. *See Hines v. Davidowitz*, 312 U.S. 52 (1941). This type of preemption is implied. *Id.* at n.20.

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[6] This principle, of course, is tempered by the Tenth Amendment that expressly provides that the "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U. S. Const. Amend. X.

[7] Like the federal government, Arizona expressly regulates and/or criminalizes the unlawful use of and distribution of controlled substances. *See, e.g.,* Ariz. Rev. Stat. Ann. §§ 13-3401 to 3461 (2012); *see also* Ariz. Rev. Stat. Ann. §§ 36-2501 to 2611 (Arizona's "Controlled Substance Act").

Finally, preemption may arise when it is "physically impossible" to comply with both State and Federal law. *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963).[8] Like obstacle preemption, physical-impossibility preemption is implied. *Id.*

In this case, Intervenor and County Defendants claim that AMMA fails under obstacle preemption and as physical-impossibility preemption. They argue the AMMA is therefore unconstitutional. The Court disagrees.

1. Obstacle Preemption

The Intervenor and County Defendants argue that the AMMA stands as an obstacle to the accomplishment of the full purposes of the CSA. "What is a sufficient obstacle is matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects." *Crosby v. National Foreign Trade Council,* 530 U.S. 363, 373 (2000). The Court must determine whether State law "undermines the intended purpose and 'natural effect'" of the CSA. *Id*; *see also Willis v. Winters*, 253 P.3d 1058, 1064 (Or. Sup. Ct. 2011).

The CSA's objectives are: (1) combating drug abuse; and (2) controlling the legitimate and illegitimate traffic in controlled substances. *See Gonzales v. Oregon*, 546 U.S. at 249 (2006); *Gonzales v. Raich*, 545 U.S. at 12. With these objectives in mind, the Court finds that the AMMA, while reflecting a very narrow but different policy choice about medical marijuana, does not undermine the CSA's purposes.

Clearly, the mere State authorization of a very limited amount of federally proscribed conduct, under a tight regulatory scheme, provides no meaningful obstacle to federal enforcement. No one can argue that the federal government's ability to enforce the CSA is impaired to the slightest degree. Indeed, the United States Supreme Court has been unequivocal on this point. *See generally Gonzales v. Raich.*

Instead of frustrating the CSA's purpose, it is sensible to argue that the AMMA furthers the CSA's objectives in combating drug abuse and the illegitimate trafficking of controlled substances. The Arizona statute requires a physician to review a patient's medical circumstances prior to authorization of its use. The statute also provides the ADHS with full regulatory authority. The ADHS, in turn, has exercised that authority with appropriate care to ensure that licensed dispensaries operate only within the confines of the AMMA. The detailed regulations ensure the marijuana is used for medical purposes only. *See*, *e.g.*, n.13, *infra.*

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[8] Courts frequently characterize physical impossibility and obstacle preemption as subsets of "conflict preemption." *See, e.g., Gade v. National Solid Waste Management Ass'n*, 505 U.S. at 115) (Souter, J., dissenting).

Moreover, the AMMA provisions should not be viewed in isolation when evaluating whether it frustrates the purposes of the CSA. The AMMA did not remove Arizona's categorical prohibition of marijuana for recreational use or any use other than medical use. Arizona's adoption of the Uniform Controlled Substances Act remains intact and unlawful possession and sale remain felonies that carry with them the possibility of long prison terms. *See, e.g.*, Ariz. Rev. Stat. Ann. § 13-3405 (2012). It should not be lost on anyone that using the AMMA as a subterfuge for prohibited possession and sale poses serious and meaningful consequences. *Id.* Consistent with the CSA objectives, these criminal provisions act in concert with the AMMA and Arizona's Uniform Controlled Substance Act in controlling the legitimate and illegitimate traffic in controlled substances.

To be sure, there is no universal agreement on this analysis. The Oregon Supreme Court, for example, held that federal law preempted Oregon state law that otherwise would have required accommodation for employees who used medical marijuana. *See Emerald Steel Fabricators, Inc. v. Bureau of Labor and Industries*, 230 P.3d 518 (Or. Sup. Ct. 2010).

The *Emerald Steel* Court held that Oregon's statutory scheme was preempted because it "affirmatively authorized the very conduct that federal law prohibited." *See Emerald Steel*, 230 P.3d at 529. The court found that "to the extent [Oregon law] affirmatively authorizes the use of medical marijuana," it was "without effect." *Id.*[9]

The majority in *Emerald Steel*, however, faced a vigorous dissent. The dissenters, in this Court's view, correctly focused on the objectives and goals of the CSA. The dissenters noted that the Oregon statute did not undermine the accomplishment and execution of the CSA. *Id.* at 542. The only difference between the Oregon statute and the CSA, posited the dissenters, was "Oregon's differing policy choice and the lack of respect it signifies." Concluding that *Emerald Steel* majority incorrectly yielded Oregon's right to make its own decisions that furthered the same goals as the CSA, the dissenters stated that they could not:

> join in a decision by which we, as state court judges, enjoin the policies of our own state and preclude our legislature from making its own

[9] The *Emerald Steel* Court analogized to hypothetical Congressional enactments prohibiting drivers under 21 years old to drive or alcohol sales to those under 21. State laws to the contrary would "stand[ ] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress" (keeping everyone under the age of 21 off the road) and would be preempted. 230 P.3d at 530.

> independent decisions about what conduct to criminalize.

Emerald Steel, 230 P.3d at 544-45.

Notably, the *Emerald* Court majority stands virtually alone when it suggested that almost any State statute that affirmatively authorizes federally conflicting conduct is preempted. *See* n. 9, *supra.* Most courts, like this Court, more closely examine the purposes of the federal statute and would permit conflicting State law that not does directly undermine federal law. *See, e.g., Ter Beek v. City of Wyoming,* __N.W.2d__, 2012 WL 3101758 (Mich. App.) (July 31, 2012); *Willis v. Winters,* 253 P.3d at 1065-66 (holding that the Oregon law that permitted concealed gun permits was not preempted by federal law); *County of San Diego v. San Diego NORML*, 81 Cal. Rptr. (Cal. App. 2008) (California State law permitting marijuana identification cards is not preempted).

Finally, the Court will state the obvious: The AMMA affirmatively provides a roadmap for federal enforcement of the CSA, if it wished to so. Dispensaries are easily identified. They are, in fact, ready targets for federal prosecution under the CSA, should federal authorities deem it appropriate.

For all these reasons, the Court finds that obstacle preemption is inapplicable.

2. Physical Impossibility.

The Intervenors and County Defendants argue that it is physically impossible for its employees and agents to comply with both AMMA and the CSA. *See Wyeth v. Levine*, 444 U.S. 555 (2009). Stated another way, they argue that the State and County employees must violate the CSA by issuing the requested documentation and otherwise complying with the AMMA's regulatory scheme. Specifically, they argue that these workers necessarily commit the federal crime of aiding and abetting the possession and sale of marijuana in violation of 18 U.S.C. § 2.[10]

This precise issue is not well settled. *Compare Pack v. Superior Court*, 132 Cal. Rptr. 3d 633 n.27 (Cal. App. 2012) (*review granted previously but later vacated due to mootness*) *with*

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[10] The Intervenor and County Defendants do not argue that others who use or dispense marijuana under State law support their argument for physical-impossibility preemption. There is nothing in the AMMA that requires these persons to engage in the activity. It is not physically impossible to comply with logically inconsistent statutes where a person can simply refrain from doing the activity that one statute purports to permit and that the other statute purports to proscribe. *See Ter Beek, supra* (*citing Barnett Bank v. Nelson,* 517 U.S. 25, 31 (1996)).

Garden Grove v. Superior Court, 68 Cal. Rptr. 3d 656 (Cal. App. 2007). Nonetheless, physical-impossibility preemption is rarely used and has been described as "vanishingly narrow." *See* Nelson, *Preemption,* 86 Va. L. Rev. 225, 228 (2000).

Notwithstanding the very limited scope of this type of preemption, the California Court of Appeals in *Pack* held that state employees may well be subject to federal prosecution in support of its decision that the CSA preempted a city ordinance and California's medical marijuana laws. That ordinance required medical marijuana to be analyzed by an independent laboratory and required permits for marijuana collectives. The *Pack* court held that state workers would likely violate the CSA but was equivocal—acknowledging another California court's decision to the contrary. *Pack at id.* (referring to *City of Garden Grove v. Superior Court, supra*). The *Pack* court was concerned that the earlier decision was "too narrow." *Id.*

In *Garden Grove*, the California Court of Appeals arrived at the opposite conclusion. The *Garden Grove* court found that California medical marijuana laws were not preempted under the physical-impossibility doctrine. The *California Grove* court affirmed a lower-court order that directed law enforcement to return a user's medical marijuana after it was determined he lawfully possessed the substance. The *Garden Grove* court expressly rejected the City's argument that compliance with the lower-court order required law enforcement officers to violate federal law.[11] After examining whether such conduct violating the federal aiding and abetting statute, the court found prosecution to be "unlikely." *See Garden Grove*, 60 Cal. Rptr. 3d at 663 - 665. The *Garden Grove* court observed:

> [H]olding the City or individual officers responsible for any violations of federal law that might ensue from the return of [defendant's] marijuana would appear to be beyond the scope of either conspiracy or aiding and abetting. No one would accuse the City of willfully encouraging the violation of federal laws were it merely to comply with the trial court's order. The requisite intent to transgress the law is so clearly absent here that the argument is no more than a straw man.

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[11] Construing 21 U.S.C. § 885(d), the court also concluded that the officers likely had federal immunity because they were acting within the official duties. *See Garden Grove*, 157 Calif. Rptr. 3d at 664. *See also State v. Kama*, 39 P.3d 866 (Or. Ct. App. 2001) (noting that federal law immunizes law enforcement officers who possess marijuana in the performance of their official duties).

Garden Grove, 60 Cal. Rptr. 3d at 663.

A similar issue was presented to the Oregon Supreme Court in *Willis v. Winters*, *supra*. In *Winters*, two Oregon county sheriffs refused to issue a concealed-handgun license (CHL) to medical-marijuana users. The *Winters* court rejected the sheriffs' two-pronged preemption argument, including an argument that providing a CHL required the sheriffs to violate federal law.

The sheriffs were positing what was in reality a physical-impossibility preemption argument.[12] Specifically, the sheriffs argued that issuing the CHL would in essence be providing "deceptive" information to gun dealers—and would violate 18 U.S.C. § 922(a)(6) which prohibits persons from providing false information to federally licensed gun dealers. Like the *Garden Grove* court, the *Winters* court juxtaposed the state actor's conduct with federal law and found the conduct did not violate federal law. *See Winters*, 253 P.2d at 1066-68.

Finally, the Ninth Circuit Court of Appeals addressed a similar issue in *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) but under First Amendment principles. The *Conant* court rejected the federal government's argument that it could prevent a physician from "recommending" marijuana. That recommendation was a statutory predicate to lawful possession of marijuana under California State law. The federal government contended that the physician's recommendation constituted aiding-and-abetting the violation of CSA or constituted conspiracy.[13] The *Conant* court rejected that argument and held that the doctor's "anticipation" of patient conduct was insufficient to establish liability under either the aiding-and-abetting or the conspiracy statutes.

Turning to the arguments presented here, this Court addresses the limited issue of whether the AMMA requirements that direct the County Defendants to confirm zoning compliance constitutes aiding and abetting thereby creating physically-impossible preemption. Aiding and

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[12] The *Winters* court also rejected the obstacle preemption argument as well. *See Winters*, 253 P.2d at 1064-66.

[13] The AMMA, like California law, does not require a "prescription." The AMMA requires a "physician's written certification" attested and signed by a licensed physician that confirms, among other things, diagnosis of a qualifying debilitating condition, an in-person physical examination, a review of the patient's medical records, an explanation of the potential risks of marijuana use, and the physician's opinion that the patient is likely to receive therapeutic or palliative benefit. *See Ariz. Admin. Code* R9-17-202(F)(5)(2012).

abetting requires: (1) these employees have specific intent to facilitate the substantive offense; (2) these employees have the requisite intent of the underlying substantive offense; (3) these employees assist or participate in the commission of the underlying offense; and (4) someone commits the underlying offense. *See Conant*, 309 F.3d at 635.

While the Court does not go so far as calling the argument a "straw man" claim, *Garden Grove, supra,* the Court finds that the employees are not violating federal law. Their specific intent is to perform their administrative tasks. They have no interest in whether the dispensary opens, operates, succeeds or fails. They are wholly unconnected to and separate from the person(s) or entity that will purportedly be completing the substantive offense. Like the physicians in *Conant* and the employees in *Garden Grove,* these employees cannot be held accountable for conduct that they anticipate will occur but could care less if it actually does.

Thus, in the final analysis, the Court finds that federal law does not preempt the AMMA. In so doing, the Court notes that Arizona, if it had wished to do so, could have *fully decriminalized* the possession, use and sale of marijuana under State law. In its wisdom, Arizona took a far narrower and deliberative course opting to allow only the chronically ill access to it and only after a licensed physician certified that it might well relieve its citizens of suffering.

It is of considerable consequence that it is Arizona's attempt at partial decriminalization with strict regulation that makes the AMMA vulnerable under the impossibility-preemption doctrine. This view, if successful, highjacks Arizona drug laws and obligates Arizonans to enforce federal proscriptions that categorically prohibit the use of all marijuana. The Tenth Amendment's "anti-commandeering rule" prohibits Congress from charting that course. *See Printz v. United States,* 521 U.S. 898 (1997); *Tar Beek, supra; Winters, supra.* Because this Court finds that the AMMA is not preempted, it need not decide this 10th Amendment issue but notes other courts have ruled this way. *Id.*

D. Remedy

Having found the AMMA constitutional, the Court finds that it is appropriate to grant Plaintiff's Motion for Partial Summary Judgment, grant mandamus relief, and deny Intervenor's and County Defendants' cross-motions for summary judgment.

In so doing, the Court rejects the Intervenor and County Defendants' argument that the AMMA violates public policy simply because marijuana use and possession violate federal law. Eighteen States and the District of Columbia have passed legislation permitting the use of marijuana in whole or in part. *See National Conferences of State Legislatures,* http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx (November 2012).

This Court will not rule that Arizona, having sided with the ever-growing minority of States and having limited it to medical use, has violated public policy.

The Court makes the following conclusions of law:

- Defendants ADHS and its director Will Humble have the lawful authority to withdraw, deny or reject Plaintiff's application for a dispensary registration certification.

- ADHS regulations impose a requirement that the local jurisdiction provide documentation confirming zoning compliance. That requirement falls on the County Defendants.

- County Defendants' categorical refusal to examine whether Plaintiff's proposed site meets zoning requirements and comply with Ariz. Admin. Code R9-17-304(6) is unlawful.

- Plaintiff has no adequate remedy at law and will suffer irreparable harm absent a mandamus requiring the County Defendants to comply with the ADHS regulations. This is because Plaintiff loses the right to continue to pursue a dispensary license during this cycle of applications. This is an important fact given that Plaintiff is the only applicant in CHAA No. 49. Thus, if Plaintiff is otherwise qualified, Plaintiff would be the only applicant for this CHAA.

IT IS THEREFORE ORDERED that the County Defendants shall provide Plaintiff with documentation from the local jurisdiction that:

a. There are no local zoning restrictions for the dispensary's location, or
b. The dispensary's location is in compliance with any local zoning restrictions.

IT IS FURTHER ORDERED that County Defendants shall comply no later than 10 days from the date of this Order.

IT IS FURTHER ORDERED that pursuant to Rule 54(b) of the Arizona Rules of Civil Procedure, no just cause exists to delay entry of judgment and therefore the Court signs this minute entry as a final order.

/s/ Michael D. Gordon

MICHAEL D. GORDON
JUDGE OF THE SUPERIOR COURT

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2012-053585 12/03/2012

ALERT: The Arizona Supreme Court Administrative Order 2011-140 directs the Clerk's Office not to accept paper filings from attorneys in civil cases. Civil cases must still be initiated on paper; however, subsequent documents must be eFiled through AZTurboCourt unless an exception defined in the Administrative Order applies.

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 19

Michael K. Jeanes, Clerk of Court
*** Electronically Filed ***
03/24/2014 8:00 AM

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2013-014852

03/21/2014

HONORABLE KATHERINE COOPER

CLERK OF THE COURT
D. Harding
Deputy

JACOB WELTON, et al.

DANIEL J POCHODA

v.

STATE OF ARIZONA, et al.

J KENNETH MANGUM
JOSEPH N ROTH

MINUTE ENTRY

The Court has reviewed the following:

- Plaintiffs' Motion for Preliminary Injunction, filed November 13, 2013;
- Defendant William Montgomery's Response to Plaintiffs' Motion for Preliminary Injunction and Motion for Judgment on the Pleadings per Ariz. R. Civ. P. 12(C), filed December 2, 2013;
- Plaintiffs' Response to Defendant Montgomery's Motion for Judgment on the Pleadings and Reply in Support of Plaintiffs' Application for Preliminary Injunction, filed January 7, 2014; and
- Defendant William Montgomery's Reply in Support of Motion for Judgment on the Pleadings per Ariz. R. Civ. P. 12(C), filed January 28, 2014.

On February 14, 2014, the Court heard oral argument and took under advisement Plaintiffs' claim for declaratory judgment.[1] The issue is one of statutory interpretation: Does Arizona's Medical Marijuana Act ("AMMA") allow medical marijuana to be consumed in extract form? As set forth below, the Court concludes it does and that Plaintiffs are entitled to an

[1] The Court denied Defendant's Motion for Judgment on the Pleadings on February 14, 2014.

order that decriminalization of marijuana for medicinal purposes includes extracts adapted from marijuana.

Having reached this conclusion, the Court believes that Plaintiffs' request for injunctive relief is moot. Pursuant to the Court's declaratory judgment in favor of Plaintiffs, they are now protected from arrest and prosecution for giving their son, Zander, CBD oil, a marijuana extract. Unless Plaintiffs have a basis for fearing that Defendant Montgomery may prosecute them regardless of the Court's ruling, an injunction against Defendant is not warranted.

Declaratory Judgment Action

Plaintiffs seek an order pursuant to Arizona's Declaratory Judgment Act, A.R.S. § 12-1832. The Act provides that" [a]ny person…whose rights, status or other legal relations are affected by a statute…may have determined any question of construction or validity arising under the [statute] and obtain a declaration of rights, status or other legal relations thereunder." It is a remedial statute intended to "settle and to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations." *Planned Parenthood Ctr. of Tucson, Inc. v. Marks*, 17 Ariz. App. 308, 310, 497 P.2d 534, 536 (1972). Declaratory judgment must be based on an actual controversy. *Id.*

A real, justiciable controversy requiring clarity exists here. Plaintiff's Complaint and Application for Preliminary Injunction present a prima facie case for the medical treatment of nine-year-old Zander with medical marijuana administered in a form of plant material combined with extracted CBD in oil form. The State contends that the AMMA did not decriminalize plant extracts which, therefore, are still unlawful under state law.

The controversy is ripe. The law does not require Plaintiffs to be arrested and to face criminal prosecution to obtain declaratory relief. *Planned Parenthood,* 17 Ariz. App. at 312, 497 P.2d at 538 ("To require statutory violation and exposure to grave legal sanctions; to force parties down the prosecution path, in effect compelling them to pull the trigger to discover if the gun is loaded, divests them of the forewarning which the law, through the Uniform Declaratory Judgments Act, has promised.") Whether or not the County Attorney intends to prosecute Plaintiffs is not the issue. Plaintiffs are entitled to a determination of their rights under the AMMA.

Statutory Interpretation

In interpreting a voter initiative, the court's "'primary purpose is to effectuate the intent of those who framed it and the electorate that adopted it.'" *State ex rel. Montgomery v. Woodburn ex rel. County of Maricopa*, 231 Ariz. 215, 216, 292 P.3d 201, 202 (App. 2012)

(citations omitted). The court first considers the statutory language, "the best and most reliable index of a statute's meaning." *Janson v. Christensen,* 167 Ariz. 470, 471, 808 P.2d 1222, 1223 (1991); *see also Zamora v. Reinstein,* 185 Ariz. 272, 275, 915 P.2d 1227, 1230 (1996). "[W]here the language is plain and unambiguous, courts generally must follow the text as written." *Canon Sch. Dist. No. 50 v. W.E.S. Constr. Co.,* 177 Ariz. 526, 529, 869 P.2d 500, 503 (1994). Courts give effect to each word or phrase and apply the "usual and commonly understood meaning." *Bilke v. State,* 206 Ariz. 462, 464–65, 80 P.3d 269, 271–72 (2003). Unless clear indication of legislative intent to the contrary exists, courts do not "construe the words of a statute to mean something other than what they plainly state." *Canon Sch. Dist. No. 50,* 177 Ariz. at 529, 869 P.2d at 503.

The AMMA

In November, 2010, Arizona voters passed the AMMA for "the purpose of . . . protect[ing] patients with debilitating medical conditions, as well as their physicians and providers, from arrest and prosecution, criminal and other penalties and property forfeiture if such patients engage in the medical use of marijuana." Prop. 203 § 2(G) (codified at A.R.S. § 36-2801 et seq.). The AMMA decriminalizes, under state law, certain activities associated with the medical use of marijuana for patients and caregivers to whom ADHS has issued identification cards. It also decriminalizes activities associated with cultivating, packaging, and selling medical marijuana for individuals to whom ADHS has issued appropriate licenses. *Id.*

The AMMA defines "marijuana" as "all parts of any plant of the genus cannabis whether growing or not, and the seeds of such plant." A.R.S. § 36-2801(8). It defines "'[u]sable marijuana" as "the dried flowers of the marijuana plant, *and any mixture or preparation thereof,* but does not include the seeds, stalks and roots of the plant and does not include the weight of any non-marijuana ingredients combined with marijuana and prepared for consumption as food or drink." A.R.S. § 36-2801(15). (Emphasis added.)

In applying the plain language of the statute to the rules of statutory interpretation, the Court concludes that nothing in the statute limits the form in which patients may use medical marijuana. The AMMA applies equally to the plant and to CBD oil.

First, the definition of "usable marijuana" does not limit the medicine to just the dried flowers. It includes "any mixture or preparation" of the dried flowers of the marijuana plant. The plain and ordinary meaning of the AMMA's text is reflected in the Merriam-Webster Dictionary definitions of these words:

- "Usable" is defined as "a convenient or practicable use." http://www.merriam-webster.com/dictionary/usable.

- "Any" is all-inclusive and defined as "every; one, some, or all of indiscriminate quantity." http://www.merriam-webster.com/dictionary/any.
- "Mixture" is the "combination of different things." http://www.merriam-webster.com/dictionary/mixture.
- Importantly in this case, "preparation" means "the activity or process of making something ready or to become ready for something;" http://www.merriam-webster.com/dictionary/preparation; "[t]hat which is prepared, made, or compounded by a certain process or for a particular purpose; a combination" including "a medicinal substance made ready for use." http://www.webster-dictionary.net/definition/ preparation.
- "Prepared" is to be "made fit or suitable; adapted." http://www.webster-dictonary.net.definition/Prepared.

The effect of these words is to allow patients to employ "certain process[es]" to "adapt[]" marijuana "for a particular purpose" and a "convenient and practicable use."

Second, the drafters included the phrase "and any mixture or preparation thereof." These words expand the allowable manipulation of the plant. To conclude that patients can only use unmanipulated plant material would render the phrase meaningless. Basic statutory interpretation prohibits such a result. Each word and phrase is given meaning. *Bilke, supra. See Williams v. Thude,* 188 Ariz. 257, 259, 934 P.2d 1349, 1351 (1997) (when interpreting a statute, a court presumes the legislature intended each word and clause to have meaning). Had the drafters wanted to limit legal use to the plant form only, they did not need this phrase and would have omitted it.

Third, the statute provides that medical marijuana can be prepared "for consumption as food or drink." Marijuana preparations that are consumed as food or drink may involve marijuana extracts. Ex. 2 to Plaintiffs' Application, ¶ 9. An extract is a method of removing material from the plan, usually cannabinoids. Extractions facilitate proper dosing and, in some cases, make it feasible for patients who cannot consume the medicine in plant form to receive it another way. *Id.* at 11. Again, the statute itself contemplates patients preparing marijuana in a manner, including extract form to meet their medical needs.

Defendant Montgomery acknowledges that the AMMA means that "flowers can be crushed or ground up and added to other foods to be consumed" (Response, p. 9). However, he contends that there is a "prohibition on concentrating the chemicals in the marijuana flower" in the AMMA. (Response, p. 10.) Where? The Court finds no such "prohibition" in the statute.

Montgomery further contends that the AMMA does not permit extracts because "any mixture or preparation thereof" simply means that plant material may be mixed with food. As

Plaintiffs' Reply states, this argument collapses "mixture" with "preparation" into a single definition, i.e., mixed with food. With this view, the meaning of the word "preparation" disappears. That is not what the statute says. It broadly states "mixture or preparation," not "mixture or preparation as long as it remains in plant form and then only when mixed with food." "Mixture" is separate and distinct from "preparation." The drafters included both terms. Statutory construction requires that the Court construe the law as it is written: "usable marijuana" includes "any mixture or preparation" made from the dried plant flowers. A.R.S. § 36-2801(15).

Protective Purpose

It is undisputed that medical marijuana is intended to be used by patients to treat chronic, debilitating, and/or painful conditions. The statute identifies them: cancer, glaucoma, positive status for human immuno-deficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, agitation of Alzheimer's disease, and chronic or debilitating medical conditions or treatments that produce cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis. A.R.S. § 36-2801(3).

It makes no sense to interpret the AMMA as allowing people with these conditions to use medical marijuana but only if they take it in one particular form. Such an interpretation reduces, if not eliminates, medical marijuana as a treatment option for those who cannot take it in plant form, or who could receive a greater benefit from an alternative form.

Constraining patients' medical marijuana options contradicts the stated purpose of the AMMA -- to "protect patients with debilitating medical conditions . . . from arrest and prosecution, criminal and other penalties and property forfeiture if such patients engage in the medical use of marijuana." Prop. 203 § 2(G).

Proponents' and Voters' Intent

A statutory interpretation permitting the use of extracts is consistent with voters' intent in enacting the AMMA. Ballot materials demonstrate that proponents and voters did not intend patients to be prosecuted for using medical marijuana in the form that is the most beneficial to them. For example:

- The Descriptive Title voters read before casting their vote on the AMMA stated that the law "allows the use of marijuana for people with debilitating medical conditions who obtain a written certification from a physician and [it] establishes

a regulatory system governed by the Arizona Department of Health Services for establishing and licensing medical marijuana dispensaries."

- The November 2, 2010 ballot further stated that "[a] 'yes' vote shall have the effect of authorizing the use of marijuana for people with debilitating medical conditions who obtain a written certifications from a physician and [of] establishing a regulatory system governed by the Arizona Department of Health Services for establishing and licensing medical marijuana dispensaries. A 'no' vote shall have the effect of retaining current law regarding the use of marijuana."

Nothing in these materials suggests that patients should or would be limited to using un-manipulated plant material for their medical needs.

Conclusion

Defendant Montgomery's concern that an order in this case will impact his ability to prosecute people for using other types of extracts is irrelevant. The Court is solely concerned with the interpretation of the AMMA as written. The language of the AMMA and its ballot materials make clear that proponents and votes intended the AMMA to provide access to medicine for debilitating medical conditions without fear of criminal prosecution. The AMMA does not limit the form in which that medicine can be administered. Nor does it prohibit the use of extracts, such as CBD oil.

Accordingly,

IT IS HEREBY ORDERED that the AMMA authorizes qualifying patients to use extracts, including CBD oil, prepared from the marijuana plant.

IT IS FURTHER ORDERED vacating the evidentiary hearing on Plaintiffs' Application for Preliminary Injunction on April 21, 2014. As stated above, this Declaratory Judgment Order means that Plaintiffs may treat Zander with medical marijuana in extract form and are entitled to the same protections under the AMMA that other medical marijuana patients enjoy. An injunction precluding prosecution is no longer warranted absent a showing that Defendant may attempt to prosecute in spite of this ruling.

The Court did receive Plaintiffs' request for a telephonic conference to address the April 21, 2014 hearing. In view of the foregoing, the Court declines to set a status conference at this time.

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BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 20

ARIZONA CAPITOL TIMES
Your Inside Source for Arizona Politics, Government and Business

As a former U.S. attorney, here's why I support the Medical Marijuana law

By: Guest Opinion February 15, 2013 , 8:37 am

Medical marijuana is packaged for sale in 1-gram packages at the Northwest Patient Resource Center medical marijuana dispensary, Wednesday, Nov. 7, 2012, in Seattle. After voters weighed in on election day, Colorado and Washington became the first states to allow possession of up to 1 oz. of legal pot for recreational use, but they are likely to face resistance from federal regulations. (AP Photo/Ted S. Warren)

I was a prosecutor with the Maricopa County Attorney's Office from 1970-1974.

I served seven years as a Maricopa County Superior Court judge after leaving the County Attorney's Office.

In 1981, I was appointed by President Ronald Reagan to serve as U.S. attorney in Arizona. The top priority of my office from 1981-1985 was fighting the drug war. While serving as U.S. attorney, I was a member of the Advisory Committee to U.S. Attorney General William French Smith and was involved in setting national policies and priorities.

It would be natural, based on my background, to assume that I would oppose Arizona's voter-approved medical marijuana law, which allows people with certain medical conditions to have access to medical marijuana through state-licensed regulated dispensaries. But sometimes it takes extraordinary circumstances to get people to see ordinary truths. And that is the case with me.

So here is my story.

In 1997, my 14-year-old son was hit by a car and thrown 125 feet across a busy intersection in Gilbert. He sustained severe and permanent brain damage. After the near-fatal accident, the brain injury evolved into frequent and massive epileptic seizures. These seizures have been regular occurrences for the past 16 years.

One of his many seizures has left him with uncontrollable shaking in his left arm. Some of the world's finest neurologists and neurosurgeons have prescribed various combinations of approximately 30 different mediations. His condition has been evaluated and treated by some of the top experts in the country, from UCLA Medical Center to the Mayo Clinic in Scottsdale to Barrow's Neurological Institute in Phoenix.

In 2003, the seizure condition became so severe that my wife and I and our son agreed to have a portion of his brain removed in hopes this might stop his agony. We were told it had a two-thirds chance of working. Unfortunately, we were in the one-third.

In the early years following the accident, my son was in a state of constant nausea and would go days at a time without eating. Nothing worked, not even the prescription drug Marinol.

We learned early on that despite the significant doses of various medications, nothing stopped the seizures and nothing stopped the nausea, which arose from both the seizures and the medications. His weight dropped from 180 pounds to 119 pounds because of the severe nausea and lack of eating.

Nothing worked until a friend with severe pain issues gave him some marijuana, which proved to be the only substance that would curtail the nausea. This was prior to Arizona's medical marijuana law.

So there I was – the man appointed by President Reagan to head the drug war in Arizona – with pot being used to help my son find some peace and to have some semblance toward a quality of life.

My wife had to be resourceful to gain access to marijuana. But if you are a parent, if you are a mother, is there anything you won't do to aid your ailing child? The choice for her was brutally harsh – find ways to give your son

life-saving marijuana so he could eat and diminish the nausea, knowing that her loving help for our son could potentially result in criminal prosecution.

When Arizona voters approved medical marijuana in 2010, our family rejoiced. Now, our son could purchase higher quality and effective marijuana for what is truly a legitimate reason. My wife could drive him to state approved dispensaries and purchase medically approved marijuana cultivated for that precise medical need – nausea.

Now my wife and son are faced with the possibility of returning to the underground, to those days of uncertainty, his medical purgatory, a hellish quality of life. There is a bill in the Legislature that aims to revote and repeal the medical marijuana law. They say the jury is still out on marijuana's medical benefits, that there are too many problems with the program.

To those proponents of repeal I say – come and see and speak with our family and my son. Tell him there are no benefits. Tell his mom and dad. In 16 years, with the greatest medical and pharmaceutical minds in the country, no one has found a plant that diminishes the nausea like marijuana.

There are plenty of folks in Arizona like me – who don't fit the profile of a medical marijuana advocate. We are here and we will use our voices to fight for people like my son. Because to take away my son's marijuana would be like taking insulin away from a Type 1 diabetic, or taking pain medications away from a cancer patient because there are some out there who abuse pain medications.

Reform the system where it should be, but do not condemn my family and my son to a life of desperation rather than decency. Don't criminalize behavior of my wife, other mothers and fathers, or patients, who seek only to use the one plant that gives them some quality of life. To take the one healing plant from the medically needy and criminalize their desperate need for relief provided my professionally cultivated marijuana would be the real crime.

— A. Melvin McDonald served as an U.S. attorney, Maricopa County Superior Court judge and in the Maricopa County Attorney's Office.

10 COMMENTS

jammerk65
February 15, 2013 , 10:19 am at 10:19 am

and what about all those peoples lives you ruined putting them in jail for marijuana!

Gary Chandler
February 15, 2013 , 11:03 am at 11:03 am

Cheers to Mr. McDonald's truth and courageous stance. May god bless his entire family and others in similar circumstances. This is a patient rights issue and we need legislators and leaders at all levels to level the playing field, open access to effective treatments, and quit tilting the table for pharmaceuticals, tobacco and alcohol.

Concerned Citizen
February 15, 2013 , 1:01 pm at 1:01 pm

This award-winning documentary should be a civil duty for all to watch. It will clearly explain where we find ourselves today as a nation — the U.S. #1 Jailer in the World. A shameful statistic. Arizona must STOP the building NEW prisons the state does not need. It is also shameful to house inmates from others states and countries — human trafficking for $$'s. This create a liability for the taxpayers as well.

"THE HOUSE I LIVE IN" Sundance award-winning documentary by Eugene Jarecki. Four decades of failed government policy that is addicted to drugs itself and the $$$'s. Official Trailer #1 (2012) YouTube. The full documentary is available on itunes, netflix, etc.

Concerned Citizen
February 15, 2013 , 2:29 pm at 2:29 pm

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EXHIBIT 21

Marijuana Program Adds Conditions, Addresses Supply Shortage&summary=&source=The Daily Chronic) (http://pinterest.com/pin/create/button/?url=http://www.thedailychronic.net/2014/27756/nm-medical-marijuana-program-adds-conditions-addresses-supply-shortage/&media=http://i2.wp.com/www.thedailychronic.net/wp-content/uploads/2013/06/marijuana-grow-indoors.jpg?resize=150%2C150&description=NM Medical Marijuana Program Adds Conditions, Addresses Supply Shortage) (mailto:?subject=The%20Daily%20Chronic%20%3A%20NM%20Medical%20Marijuana%20Program%20Adds%20Conditions%2C medical-marijuana-program-adds-conditions-addresses-supply-shortage%2F)

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Parkinson's disease and Huntington's disease added to the list of medical conditions for which New Mexicans are allowed to seek medical marijuana; Department of Health to increase number of plants patients can grow and licence additional dispensaries

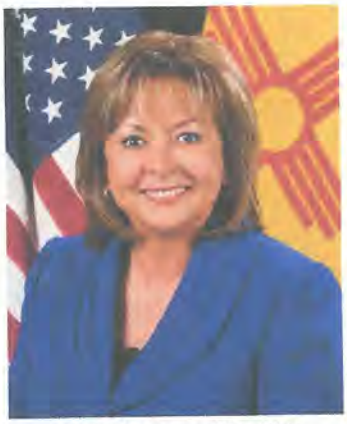
SANTA FE: New Mexico's Secretary of Health Retta Ward has announced the Martinez Administration's decision to approve adding Parkinson's disease and Huntington's disease to the list of medical conditions for which New Mexicans are allowed to seek medical marijuana.

Last fall, activists from the Drug Policy Alliance petitioned the Department of Health (DOH) to add these two neurological conditions in addition to traumatic brain injury. The Drug Policy Alliance previously petitioned to add Huntington's disease in 2010, however at that time the petition was denied.

"Friday's announcement demonstrates the response from the Martinez administration we have been seeking for a long time," said Emily Kaltenbach, New Mexico Director of the Drug Policy Alliance, the organization that spearheaded the passage of New Mexico's medical cannabis law.

"It appears the Martinez Administration's position on medical marijuana is evolving in support of increased access to medical marijuana," added Kaltenbach. "However, we will not rest until the Martinez Administration

continues to demonstrate, as they did on Friday, that they will not turn their backs on medical marijuana patients."



After vowing to repeal the state's medical marijuana law in 2010, is New Mexico Gov. Susana Martinez (http://www.thedailychronic.net/topics/susa martinez/), a former prosecutor, finally evolving her position on medical marijuana?

During her 2010 gubernatorial campaign, Gov. Susana Martinez (http://www.thedailychronic.net/topics/susana-martinez/)(R), a former prosecutor, vowed to repeal New Mexico's medical marijuana law.

The inclusion of Parkinson's disease and Huntington's diseases are consistent with the intent of the Lynn & Erin Compassionate Use Act. Both are chronic and debilitating neurologic diseases that marijuana may play a beneficial role in mitigating.

However, the Department of Health did not approve adding traumatic brain injury (TBI) to the medical marijuana program.

Reverend Gerald White and his wife Judy, whose son has suffered multiple severe traumatic brain injuries are disheartened that TBI was rejected.

"Our son's neuropsychiatrist, a leading expert in the state, supports recommending medical cannabis as a treatment for him. Health care decisions should be made by doctors and their patients. It's a shame we are not able to seek the medicine his doctor suggests," said Judy White, a 25 year veteran advocate who was part of the original Brain Injury Taskforce for New Mexico.

Traumatic brain injury is a frequent combat-related injury that is also commonly seen in other settings of head injury.

"Many veterans are finding it difficult to access effective and safe treatments for their conditions including traumatic brain injury."

said Jessica Gelay, Policy Coordinator for the Drug Policy Alliance who presented the petitions last November. "Veterans and others suffering from traumatic brain injuries deserve the freedom to choose the medication that works for them."

The Department of Health also announced a plan to address the supply shortage of medical marijuana (http://www.thedailychronic.net/2013/26447/new-mexico-medical-marijuana-short-supply/). The DOH's formal announcement to pursue increasing the allowable number of plants and to license more non-profit producers comes several months after the Department's own survey determined that producers are only able to supply enough medicine to meet 20% (http://www.thedailychronic.net/2013/26447/new-mexico-medical-marijuana-short-supply/) of what is needed for the patient base, which now totals more than 10,000 active qualified patients.

The Department's plan to increase the plant count could potentially double the amount of medicine the current producers are able to provide to their patients. Since increasing the plant count requires a public hearing, the announcement by the DOH does not immediately allow licensed non-profit producers to ramp up production.

Once the new rule is instated more medicine should be available within three months.

Drug Policy Alliance

(http://www.facebook.com/drugpolicy)

(http://www.drugpolicy.org/)

(http://www.thedailychronic.net/author/dpa/)

The Drug Policy Alliance (DPA) is the nation's leading organization of people who believe the war on drugs is doing more harm than good. DPA fights for drug policies based on science, compassion, health and human rights.

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EXHIBIT 22

Annual Causes of Death in the United States

Related Chapter:
Overdose
For facts about specific drugs, here's a list of Controlled Substance sections.

1. ***(Annual Causes of Death, By Cause)***

Cause of death (Data from 2013 unless otherwise noted)	Number
All Causes	2,596,993
Major Cardiovascular Diseases [MCD]	796,494
Cerebrovascular Diseases [subset of MCD]	128,978
Essential Hypertension and Hypertensive Renal Disease [subset of MCD]	30,770
Malignant Neoplasms [Cancer]	584,881
Chronic Lower Respiratory Diseases	149,205
Accidents (Unintentional Injuries) [Total]	130,557
Motor Vehicle Accidents [subset of Total Accidents]	35,369
Alzheimer's Disease	84,767
Diabetes Mellitus	75,578
Influenza and Pneumonia	56,979
Nephritis, Nephrotic Syndrome and Nephrosis	47,112
Drug-Induced Deaths[1]	46,471
Intentional Self-Harm (Suicide)	41,149
Septicemia	38,156
Chronic Liver Disease and Cirrhosis	36,427
Alcoholic Liver Disease [subset of Chronic Liver Disease]	18,146
Injury by Firearms	33,636
Alcohol-Induced Deaths	29,001
Parkinson's Disease	25,196
Pneumonitis Due to Solids and Liquids	18,579
Homicide	16,121
Viral Hepatitis	8,157
Human Immunodeficiency Virus (HIV) Disease	6,955
All Illicit Drugs Combined (2000)[2]	17,000[2]
Cannabis (Marijuana)[3]	0

2014 Data Detailing Drug-Induced Deaths, Breaking Out Specific Data for Prescription Analgesics and Heroin, as Reported by the CDC[4]	
Drug Overdose Total	47,055
Prescription Analgesics Total	18,893
Heroin Overdose Total	10,574

- Mandatory Minimums and Sentencing Guidelines
- Marijuana
- Medicinal Marijuana
- Methadone, Buprenorphine, and Opioid Substitution Therapy
- Methamphetamine (Meth) & Amphetamine-Type Stimulants
- Militarization
- Netherlands Compared with the US
- New Psychoactive Substances (NPS) & "Legal Highs"
- Overdose
- Pain Management and Prescription Drugs
- Pregnancy
- Prevention
- Prisons & Jails Overview
  - Prisons & Drug Offenses
  - Race & Prison
- Supervised Injection Facilities & Drug Consumption Rooms (SIFs & DCRs)
- Syringe Service Programs/SEPs/NEPs
- Tobacco and Nicotine
- Treatment
- Women

International Sections

Australia
Austria
Belgium
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Colombia
Czech Republic
Denmark
Eastern Europe and Central Asia (EECA)
European Union
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Germany
Greece
Hungary
Ireland
Mexico
The Netherlands
Norway
Poland
Portugal
Romania
Russian Federation
Scotland
Spain
Sweden
Switzerland
United Kingdom

Navigation

- Drug War Facts Podcast
- Table of Contents

2010 Drug Overdose Mortality Data In Detail, Reported By Paulozzi et al.[5]	
Drug Overdose Total	38,329
Pharmaceutical Drugs	22,134
Pharmaceutical Opioid Analgesics	16,651

1 "Drug" includes both legal and illegal drugs.

2 Mokdad, Ali H., PhD, James S. Marks, MD, MPH, Donna F. Stroup, PhD, MSc, Julie L. Gerberding, MD, MPH, "Actual Causes of Death in the United States, 2000," Journal of the American Medical Association, (March 10, 2004), G225 Vol. 291, No. 10, 1242.

3 No recorded cases of overdose deaths from cannabis have been found in extensive literature reviews, see for example Gable, Robert S., "The Toxicity of Recreational Drugs," American Scientist (Research Triangle Park, NC: Sigma Xi, The Scientific Research Society, May-June 2006) Vol. 94, No. 3, p. 207.

4 CDC/NCHS, National Vital Statistics System, Mortality File, 2015, last accessed Dec. 11, 2015.

5 Paulozzi et al analyzed mortality figures and found that of 38,329 drug overdose deaths then reported in 2010, pharmaceutical drugs accounted for 22,134 deaths, of which 16,651 were opiod analgesic overdoses. The data were apparently revised slightly between the time the research letter was published in JAMA (February 2013) and release of the CDC's Deaths: Final Data for 2010 publication report, officially dated May 8, 2013.

Source: *"2013 Mortality Multiple Cause Micro-data Files," US Centers for Disease Control (Atlanta, GA), December 2014, Table 10, pp. 19-23.*
http://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm
http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
CDC/NCHS, National Vital Statistics System, Mortality File, 2015, last accessed Dec. 11, 2015.
http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving...
Hedegaard H, Chen LH, Warner M. Drug poisoning deaths involving heroin: United States, 2000 –2013. NCHS data brief, no 190. Hyattsville, MD: National Center for Health Statistics. 2015.
http://www.cdc.gov/nchs/data/databriefs/db190.pdf
http://www.cdc.gov/nchs/data/databriefs/db190.htm
Chen LH, Hedegaard H, Warner M. Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011. NCHS data brief no. 166.
Hyattsville, MD: US Department of Health and Human Services, CDC; 2014, p. 1.
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2. ***(Estimated Drug-Induced Mortality in the US, 2013, by Gender and Race/Ethnicity)*** "In 2013, a total of 46,471 persons died of drug-induced causes in the United States (Tables 10, 12, and 13). This category includes deaths from poisoning and medical conditions caused by use of legal or illegal drugs, as well as deaths from poisoning due to medically prescribed and other drugs. It excludes unintentional injuries, homicides, and other causes indirectly related to drug use, as well as newborn deaths due to the mother's drug use. (For a list of drug-induced causes, see Technical Notes; also see the discussion of poisoning mortality that uses the more narrow definition of poisoning as an injury in the preceding "Injury mortality by mechanism and intent" section.)
"In 2013, the age-adjusted death rate for drug-induced causes for the total population increased significantly, 5.8%, from 13.8 in 2012 to 14.6 in 2013 (Internet Tables I–3 and I–4). For males in 2013, the age-adjusted death rate for drug-induced causes was 1.6 times the rate for females. The age-adjusted death rate for black females was 46.5% lower than for white females, and the rate for black males was 30.0% lower than for white males. The rate for drug-induced causes increased 5.9% for males and 3.7% for females in 2013 from 2012.
"Among the major race-sex and race-ethnicity-sex groups, the age adjusted death rates for drug-induced causes increased significantly in 2013 from 2012 for white males (5.3%), white females (5.0%), black males (12.0%), Hispanic males (7.5%), non-Hispanic white males (5.1%), non-Hispanic white females (5.1%), and non-Hispanic black males (13.3%)."

Source: *Xu JQ, Murphy SL, Kochanek KD, Bastian BA. Deaths: Final data for 2013. National vital statistics reports; vol 64 no 2. Hyattsville, MD: National Center for Health Statistics. February 16, 2016, pp. 10-11.*
http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

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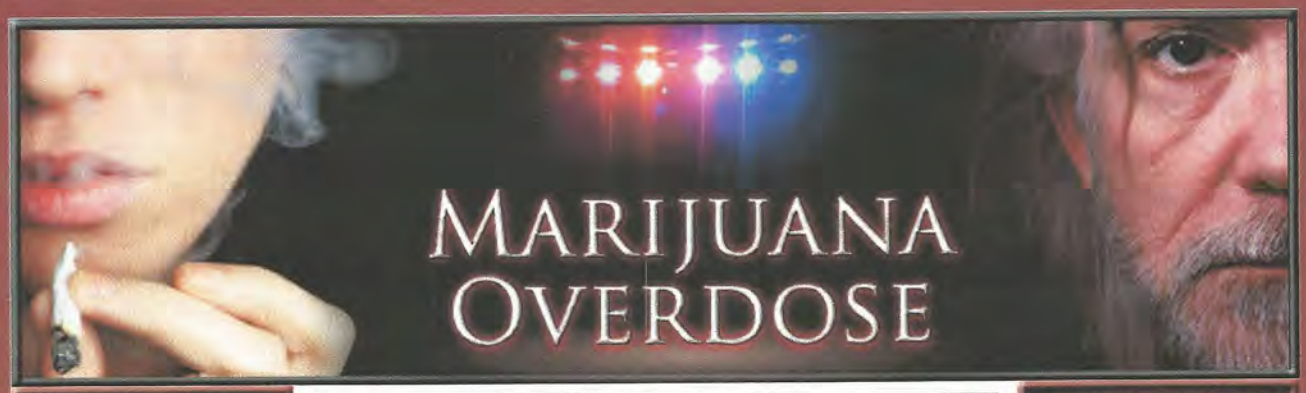
BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of ARIZONA CANNABIS NURSES ASSOCIATION, Appellant.	Case No. 2016-MMR-0176-DHS **NOTICE OF FILING AZCNA EXHIBITS** (Parkinson's Disease) (Assigned to Hon. Dorinda M. Lang)

EXHIBIT 23



MARIJUANA OVERDOSE

Marijuana Overdose

A **marijuana overdose** is uncommon among even the most habitual users. When a person ingests too much marijuana they often feel very tired and sense the need to lie down. If one ingests a large amount of hashish, occasionally they will get sick to their stomach. The Drug Awareness Warning Network Annual Report, published by the US federal government, contains a statistical compilation of all drug deaths which occur in the United States. According to this report, there has never been a death recorded from the use of marijuana by natural causes. Unlike opiates, barbiturates, or amphetamines there seems to be little risk of **marijuana overdose** even with large amounts of marijuana. However, research shows that marijuana users are much more likely to use other illegal drugs than non marijuana users. These other drugs in combination with blurred mental perceptions while using marijuana may make the drug just as deadly as the other commonly abused illegal drugs.

Marijuana Overdose - Lethal Marijuana Overdose Amount

In order for a human to consume enough marijuana to be fatal, they would have to consume nearly 40,000 times the amount of THC required to intoxicate them. In contrast, it only requires about 5 to 10 times the amount of alcohol required for intoxicate to be fatal. For example, if it requires 3 beers to intoxicate you, it only requires 15 to 30 beers to kill you. However, if it takes you 3 'hits' of marijuana to intoxicate you, it would require 120,000 hits to kill you. Thus, it is virtually impossible to die of a **marijuana overdose**.

According to current research, the lethal dose of marijuana is about one-third your body weight consumed all at once. In one research experiment, ingestion of enormous doses of Delta 9 THC and concentrated marijuana extract by mouth were unable to produce death or organ pathology in large mammals but did produce fatalities in smaller rodents due to profound central nervous system depression.

The non-fatal consumption of 3000 mg/kg of THC by a dog or monkey would be comparable to a 154-pound human eating approximately 46 pounds (21 kilograms) of 1%-marijuana or 10 pounds of 5% hashish at one time. In addition, 92 mg/kg THC intravenously produced no fatalities in monkeys. These doses would be comparable to a 154-pound human smoking almost three pounds (1.28 kg) of 1%-marijuana at one time or 250,000 times the usual smoked dose, and over a million times the minimal effective dose assuming 50% destruction of the THC by smoking.

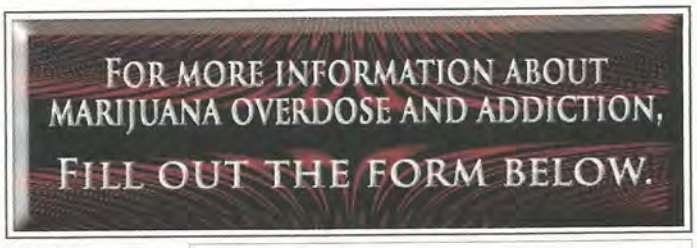
Thus, evidence from animal studies and human case reports appears to indicate that the ratio of lethal dose to effective dose is quite large. This ratio is much more favorable than that of many other common psychoactive agents including alcohol and barbiturates (Phillips et al. 1971, Brill et al. 1970).

Marijuana Overdose Facts:

- The record on marijuana encompasses 5,000 years of human experience. Marijuana is now used daily by enormous numbers of people throughout the world. Estimates suggest that from twenty million to fifty million Americans routinely, albeit illegally, smoke marijuana without the benefit of direct medical supervision. Yet, despite this long history of use and the extraordinarily high numbers of social smokers, there are simply no credible medical reports to suggest that consuming marijuana has caused any deaths.
- Nearly all medicines have toxic, potentially lethal effects. However, there is no record in the extensive medical literature describing a proven, documented cannabis-induced fatality. However, side effects such as lung cancer associated with marijuana use may indeed cause death in users.
- In strict medical terms, marijuana by itself is far safer than many foods we commonly consume. For example, eating ten raw potatoes can result in a toxic response. By comparison, it is physically impossible to eat enough marijuana to induce death.
- Drugs used in medicine are routinely given what is called a LD-50. The LD-50 rating indicates at what dosage fifty percent of test animals receiving a drug will die as a result of drug induced toxicity. A number of researchers have attempted to determine marijuana's LD-50 rating in test animals, without success. Simply stated, researchers have been unable to give animals enough marijuana to induce death.
- At present it is estimated that marijuana's LD-50 is around 1:20,000 or 1:40,000. In layman terms this means that in order to induce death a marijuana smoker would have to consume 20,000 to 40,000 times as much marijuana as is contained in one marijuana cigarette. NIDA-supplied marijuana cigarettes weigh approximately .9 grams. A smoker would theoretically have to consume nearly 1,500 pounds of marijuana within about fifteen minutes to induce a lethal response.

MARIJUANA OVERDOSE

- Another common medical way to determine drug safety is called the therapeutic ratio. This ratio defines the difference between a therapeutically effective dose and a dose which is capable of inducing adverse effects. A commonly used over-the-counter product like aspirin has a therapeutic ratio of around 1:20. Two aspirins are the recommended dose for adult patients. Twenty times this dose, forty aspirins, may cause a lethal reaction in some patients, and will almost certainly cause gross injury to the digestive system, including extensive internal bleeding.
- The therapeutic ratio for prescribed drugs is commonly around 1:10 or lower. Valium, a commonly used prescriptive drug, may cause very serious biological damage if patients use ten times the recommended (therapeutic) dose.
- There are, of course, prescriptive drugs which have much lower therapeutic ratios. Many of the drugs used to treat patients with cancer, glaucoma and multiple sclerosis are highly toxic. The therapeutic ratio of some of the drugs used in antineoplastic therapies, for example, are regarded as extremely toxic poisons with therapeutic ratios that may fall below 1:1.5. These drugs also have very low LD-50 ratios and can result in toxic, even lethal reactions, while being properly employed. By contrast, marijuana's therapeutic ratio, like its LD-50, is impossible to quantify because it is so high.
- In practical terms, marijuana cannot induce a lethal response as a result of drug-related toxicity.
- If you or someone you care about is feeling as though they are suffering from a **marijuana overdose** or are overwhelmed by the drugs effect here is something you can do: drink any liquid high in vitamin C. The vitamin C will counteract the effects of the THC in the marijuana within 20 to 30 minutes. The antioxidants in juices also help break down the cannabinoids and help the user feel better.



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