STATE OF MICHIGAN
In the SUPREME COURT
On Appeal from the Michigan Court of Appeals

PEOPLE OF THE STATE OF MICHIGAN
Plaintiff-Appellee,

v

No. 143824
Court of Appeals No. 301951
Circuit Court No. 10-008488-CZ

BRANDON McQUEEN, and
MATTHEW TAYLOR, d/b/a
COMPASSIONATE APOTHECARY, LLC,
Defendants-Appellants.
/

ANN ARBOR MEDICAL CANNABIS GUILD, INC.
AMICUS CURIAE BRIEF
In Support of
DEFENDANTS-APPELLANTS

PROOF OF SERVICE

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STATEMENT OF BASIS OF JURISDICTION

This case originated in the Isabella County Circuit Court where the county prosecutor filed a motion for a temporary restraining order, a show cause order, and a preliminary injunction. The trial court ruled in favor of the Defendants on December 16, 2010. The prosecutor appealed that decision to the Court of Appeals who issued an opinion on August 23, 2011 reversing the trial court's decision. Defendants-Appellants filed an application for leave to appeal in this court under MCR 7.302. This Court granted leave to appeal on March 28, 2012. This Court has jurisdiction under MCR 7.301(2).

STATEMENT OF QUESTION INVOLVED

The Michigan Medical Marihuana Act [MMMA] became law as the result of a citizens' initiative petition approved by voters in November 2008. Patient-to-patient transfers/sales of medical grade marijuana fulfill the objectives and intent of the MMMA, which is to facilitate patients' access to this medicine. Was it the intent of the voters in the §3(e) definition of "medical use" to allow patient-to-patient transfers/sales of medical marijuana in compliance with the amounts and frequency specified in the MMMA?

Amicus Ann Arbor Medical Cannabis Guild, Inc. answers: YES

STATEMENT OF INTEREST OF AMICUS CURIAE THE ANN ARBOR MEDICAL CANNIBUS GUILD, INC.

The Ann Arbor Medical Cannabis Guild, Inc. is an organization of non-profit dispensaries whose primary mission is to assist patients in learning about medical cannabis (marijuana). While these dispensaries are all patient friendly and low-key, they appeal to different types of patients and demographics, serving about 15,000 patients per month.

The Guild member dispensaries, which are staffed by registered MMMA caregivers, provide patients with accurate information on the various strains of cannabis based upon current published research. They also help patients find the appropriate strain for their individual situation and give them information on the various methods of ingesting the medicine. The goal is to help registered MMMA patients make informed decisions about using medical cannabis to treat their condition.

The Ann Arbor Medical Cannabis Guild, Inc. supports an interpretation of the definition of "medical use" that includes dispensaries where patients can get accurate information regarding medical marijuana, including the various strains and methods of taking the medicine and where patients can have a safe, controlled environment for patient-to-patient transfers of medicinal marijuana

within the amounts and frequencies specified in the Michigan Medical Marijuana Act.

STATEMENT OF FACTS

Amicus Curiae Ann Arbor Medical Cannabis Guild, Inc. adopts all non-argumentative statements of fact made by Defendants-Appellants in their brief.

STANDARD OF REVIEW

Questions of statutory interpretation are questions of law that are reviewed *de novo*. *People v Nimeth*.[1] The primary goal of judicial interpretation of statutes is to ascertain and give effect to the intent of the Legislature. *People v Williams*.[2] "However, because the MMMA was the result of a voter initiative, our goal is to ascertain and give effect to the intent of the electorate, rather than the Legislature, as reflected in the language of the law itself." *People v Kolanek/King*.[3] Referencing *People v Barbee*,[4] this Court also said that it "must give the words of the MMMA their ordinary and plain meaning as would have been understood by the electorate." *Id*. (footnote omitted).

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[1] 236 Mich.App. 616, 620; 601 NW2d 393 (1999).
[2] 475 Mich. 245, 250; 716 NW2d 208 (2006).
[3] ___ Mich. ___ (MSC Nos. 142695, 142712, 142850, rel'd May 31, 2012). Footnote 31 references *People v Feezel*, 486 Mich. 184, 205; 783 NW2d 67 (2010) and *Schmidt v Dep't of Ed*., 441 Mich. 236, 241-242; 490 NW2d 584 (1992) for this statement.
[4] 470 Mich. 283, 286; 681 NW2d 348 (2004).

The issue before the court is whether the definition of "medical use" contained in MMMA §3(e) encompasses patient-to-patient sales, which are part of the Compassionate Apothecary's dispensary model for providing registered patients access to medical marijuana.

ARGUMENT

The Michigan Medical Marihuana Act [MMMA] became law as the result of a citizens' initiative petition approved by voters in November 2008. Patient-to-patient transfers/sales of medical grade marijuana fulfill the objectives and intent of the MMMA, which is to facilitate patients' access to this medicine. It was the intent of the voters in the §3(e) definition of "medical use" to allow patient-to-patient transfers/sales of medical marijuana in compliance with the amounts and frequency specified in the MMMA.

This case brings into specific focus the problems encountered by registered medical marijuana patients when they try to gain access to their medicine. The question is whether a business facilitating the acquisition of medical marijuana by registered patients from other registered patients and/or registered caregivers in a controlled environment falls within the definition of the term "medical use" contained in MMMA §3(e). While this is a question of statutory interpretation, it is one where this Court must look to the intent of the electorate and not make a policy judgment on the choice of the electorate to allow a limited group of patients access to medical marijuana.[5] This Court's goal is to "ascertain and give effect to the intent of the electorate, rather than the Legislature, as reflected in

[5] Chief Justice Roberts recently described the role of the court (SCOTUS) as having the authority to interpret the law, not make policy judgments. He further stated that it is "not our job to protect the people from the consequences of their political choices." *National Federation of Independent Business v Sebelius*, ___ U.S. ___; ___ S.Ct. ___ (USSC Nos. 11-393, 11-398, 11-400, slip opinion rel'd June 28, 2012, page 8). 2012 WL 2427810 (U.S.).

the language of the law itself." *King/Kolanek*, supra.[6] The electorate's "intent" for enacting the MMMA can be found in MMMA §2:

> "The People of the State of Michigan find and declare that:
>
> (a) Modern medical research, including as found by the National Academy of Sciences' Institute of Medicine in a March 1999 report, has discovered beneficial uses for marihuana in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions.
> (b) Data from the Federal Bureau of Investigation Uniform Crime Reports and the Compendium of Federal Justice Statistics show that approximately 99 out of every 100 marihuana arrests in the United States are made under state law, rather than under federal law. Consequently, changing state law will have the practical effect of protecting from arrest the vast majority of seriously ill people who have a medical need to use marihuana.
> (c) Although federal law currently prohibits any use of marihuana except under very limited circumstances, states are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law. The laws of Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Vermont, Rhode Island, and Washington do not penalize the medical use and cultivation of marihuana. Michigan joins in this effort for the health and welfare its citizens."

This is consistent with the language in the ballot proposal at the November 2008 election.[7] The Michigan electorate is not alone in its decision to allow the

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[6] ___ Mich. ___ (MSC Nos. 142695, 142712, 142850, rel'd May 31, 2012).

[7] Proposal 08-1 told the voters that the MMMA would do the following: permit physician approved use of marijuana by registered patients with debilitating medical conditions including cancer, glaucoma, HIV, AIDS, hepatitis C, MS and other conditions that may be approved by the Department of Community

medical use of marijuana. Since the enactment of the MMMA in 2008, several more states have either passed or are considering medical marijuana laws, or just decriminalizing the possession of marijuana.[8] The fact that additional states have enacted or are considering medical marijuana laws lends credence to the intent of the Michigan electorate to make medical marijuana accessible to those who need it as medicine.

MMMA §3(e) defines "medical use" as "the acquisition, possession, cultivation, manufacture, use, internal possession, delivery, transfer, or transportation of marihuana or paraphernalia relating to the administration of marihuana to treat or alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the debilitating medical condition." The Compassionate Apothecary presents only one model for how patients can acquire and/or transfer medical marijuana that they need to treat

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Health; permit registered individuals to grow limited amounts of marijuana for qualifying patients in an enclosed, locked facility; require the Department of Community Health to establish an identification card system for patients qualified to use marijuana and individuals qualified to grow marijuana; and permit registered and unregistered patients and primary caregivers to assert medical reasons for using marijuana as a defense to any prosecution involving marijuana. *Kolanek/King*, supra, slip opinion at page 9, footnote 32.

[8] As of early 2012, the states that have decriminalized possession of marijuana or that allow medical marijuana are: California, Oregon, Nevada, Montana, Colorado, Alaska, New Mexico, Nebraska, Minnesota, Michigan, Ohio, Maine, Mississippi, Delaware, and Connecticut. States with existing decriminalization or medical marijuana laws that are considering further reform include: Washington, Arizona, Missouri, Virginia, New Jersey, New York, Massachusetts, Rhode Island, and North Carolina. The states considering decriminalization, legalization, or medical marijuana in 2012 are: Idaho, Kansas, Oklahoma, Iowa, Wisconsin, Illinois, Indiana, Kentucky, Tennessee, Alabama, Florida, Virginia, West Virginia, Pennsylvania, Maryland, and New Hampshire. See Attachment A.

their condition or symptoms. While the language is simple, it has to cover a very complicated situation. The goal of the MMMA is safe consistent access to medicinal quality marijuana for qualifying/registered patients. Obviously this does not mean buying "street dope" on the black market. It is readily apparent that the MMMA was set up to avoid this scenario for patients who use medical marijuana as medicine. And medical marijuana is medicine.

Medical Marijuana is Medicine

Contrary to the beliefs of some people in the law enforcement community, marijuana has medicinal properties that benefit certain types of medical conditions without the devastating side effects of pharmaceutical drugs. We are decades down the road from the time when walking down State Street in Ann Arbor smoking a joint was a $5 fine.[9] In the decades since the 60's and 70's much has changed regarding what is known about the medicinal value of marijuana. As far back as 1999, the California Legislature created The Center of Medicinal Cannabis Research [CMCR], which is based at the University of California, San Diego.[10] The mission of the CMCR is to conduct clinical and pre-clinical studies of cannabinoids to provide evidence one way or another to

[9] Referencing Ann Arbor's $5 fine for marijuana possession in the mid 1970's. Ann Arbor City Charter 16.2 added by election of April 1974. Most recently it was amended by election of November 2, 2004 to include the affirmative defense of medicinal use of marijuana.

[10] California SB 847, signed in 1999.

answer the question "does marijuana have therapeutic value?" As of 2010 the CMCR had approved fifteen clinical studies, including seven clinical trials, of which five had been completed and two were in progress. Four CMCR-funded studies demonstrated that cannabis had analgesic effects in pain conditions secondary to injury (e.g. spinal cord injury) or disease (e.g. HIV disease, HIV drug therapy) of the nervous system. Three of these studies utilized cannabis as an add-on treatment for patients who were not getting adequate benefit from a wide range of standard pain-relieving medications. The CMCR believes that the results of these studies suggest two things: 1) that cannabis may provide a treatment option for patients who do not respond well to currently available therapies; and 2) that there may be a novel mechanism of action not fully exploited by current therapies. One of the pre-clinical studies provided evidence that cannabis did not interfere with the function of blood cells involved with immunity [important because any therapeutic use would be in persons with chronic illnesses]. A special issue of the journal *Neuropharmacology* (2005) published the research presented at the CMCR hosted workshop: "Future Directions in Cannabinoid Therapeutics II: From the Bench to the Clinic." The 2010 report to the California legislature concluded that as a "result of this program of systematic research, we now have reasonable evidence that cannabis

is a promising treatment in selected pain syndromes caused by injury or diseases of the nervous system, and possibly for painful muscle spasticity due to multiple sclerosis."[11] While the State of California has the only legislatively funded research to determine the medical efficacy of medicinal marijuana, it is by no means alone in believing that there is sufficient evidence to warrant the research and use of medical marijuana.

Organizations devoted to HIV/AIDS research and issues have taken positions supporting the availability of medical marijuana for persons who have HIV/AIDS.[12] Nursing associations support the availability and use of medicinal marijuana.[13] The British Medical Association said that: "[P]resent evidence indicates that [cannabinoids] are remarkably safe drugs, with a side-effects

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[11] Center for Medicinal Cannabis Research, Report to the Legislature and Governor of the State of California, prepared February 11, 2010, UC San Diego, p. 4. See Attachment B for the complete report.

[12] AIDS Action Council, November 15,1996 "Resolution in Support of Access to Medical-Use Marijuana;" AIDS Treatment News, January 23, 1998, "*AIDS Treatment News*, #287; Maine AIDS Alliance, December 30, 1997, *Bangor Daily*; San Francisco Mayor's Summit on AIDS and HIV, January 27, 1998, preliminary report on the "Mayor's Summit on AIDS & HIV".

[13] California Nurses Assn., letter from CAN President Kurt Laumann, RN, to Gov. Pete Wilson (September 21, 1995); Colorado Nurses Assn., 1995 Conventional Directory and Book or Reports; Congress of Nursing Practice, Motion passed by CNP, May 31, 1996; National Nurses Society on Addictions, "Position Paper: Access to Therapeutic Cannabis," approved by the NNSA Board of Directors, May 1, 1995; New York State Nurses Assn., "Position Statement on Medicinal Marijuana," passed by the NYSNA Board of Directors, June 7, 1995; North Carolina Nurses Assn., "Position Statement on Therapeutic Use of Cannabis," adopted by the NCNA, October 15, 1996; Virginia Nurses Assn., Resolution passed by the VNA Delegate Assembly, October 7, 1994.

profile superior to many drugs used for the same indications."[14] A representative from Health Canada stated: "[T]here is no problem, basically, with marijuana as medicine."[15] The Australian National Task Force on Cannabis found that: "First, there is good evidence that THC is an effective anti-emetic agent for patients undergoing cancer chemotherapy… Second, there is reasonable evidence for the potential efficacy of THC and marijuana in the treatment of glaucoma, especially in cases which have proved resistant to existing anti-glaucoma agents… Third, there is sufficient suggestive evidence of the potential usefulness of various cannabinoids as analgesic, anti-asthmatic, anti-spasmodic… and anti-convulsant agents to warrant basic pharmacological and experimental investigation and… clinical research into their effectiveness."[16] And finally, in 2009, the American Medical Association issued a policy statement on medical marijuana calling for "further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggest possible efficacy and the application of such results to the understanding and treatment of disease." In the same policy statement, the AMA urged the National Institutes of Health to

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[14] BMA Report: "Therapeutic Uses of Cannabis" November 1997.

[15] Statements of Health Canada spokesman Dann Michols to the *Ottawa Citizen*, December 19, 1997.

[16] Australian National Task Force on Cannabis: "The health and psychological consequences of cannabis use," March 1994.

"implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana." There is now a significant amount of information that there is a solid basis for believing that medical grade marijuana is medicine.

Medical Marijuana is Needed by Patients

Not only is medical grade marijuana medicine, it is a medicine that is needed by legitimate patients who are registered through the MMMA system. Only through understanding why patients need medical marijuana can this Court realize that the electorate's intent in defining "medical use" as it did was to aid rather than hinder the acquisition and transfer of medical marijuana to registered patients.

Patients use medical marijuana to treat a variety of illnesses and symptoms, which are described in the MMMA. MCL 333.26423(a) defines a "debilitating medical condition" as one or more of the following:

> "(1) cancer, glaucoma, positive status for human immunodeficiency virus,[17] acquired immune deficiency syndrome,[18] hepatitis C, amyotrophic lateral sclerosis,[19]

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[17] HIV (Human Immunodeficiency Virus).

[18] AIDS (Acquired Immune Deficiency Syndrome).

[19] Amyotrophic lateral sclerosis (ALS, a/k/a Lou Gehrig's disease) is a classic motor neuron disease. Motor neuron diseases are progressive chronic diseases of the nerves that come from the spinal court responsible for supplying electrical stimulation to the muscles. This stimulation is necessary for the movement of body parts.

> Chron's (sic) disease,[20] agitation of Alzheimer's disease, nail patella,[21] or the treatment of these conditions.
> (2) a chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: cachexia[22] or wasting syndrome;[23] severe and chronic pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis.
> (3) any other medical condition or its treatment approved by the department, as provided for in section 5(a)."

Real people in Michigan suffer from most if not all of the diseases, conditions, and symptoms, which fall under the definition of a "debilitating medical condition." The people who use medical marijuana to relieve their symptoms come from all walks of life including a person raised in a drug free Christian home where everyone has at least a bachelor's degree,[24] a railroad construction worker,[25] a physician,[26] a graduate student,[27] a Vietnam veteran,[28] and a

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[20] Crohn's disease is a chronic inflammatory disease primarily involving the small and large intestine, but which can affect other parts of the digestive system as well. Common symptoms are abdominal pain, diarrhea, vomiting, fever, and weight loss.

[21] Nail patella is an hereditary condition characterized by abnormally formed or absent nails and under developed or absent knee caps (patella). It can also include abnormalities of the elbows, which interfere with the range of motion and kidney disease.

[22] Cachexia is a general physical wasting with loss of weight and muscle mass due to a disease.

[23] Wasting Syndrome is a gradual loss (e.g. weight), deterioration, or emaciation from a wasting disease.

[24] Stephanie Annis, letter at pages C-1 and C-2, Attachment C.

[25] Dave Messmann, letter at pages C-3 and C-4, Attachment C.

[26] Mitchell Elkiss, statement at page C-5, Attachment C.

[27] Marin Turk, letter at page C-6 and C-7, Attachment C; Laura Jadwin, letter at page 12, Attachment C.

[28] Dennis Reott, letter at pages C-8 to C-10, Attachment C.

university researcher.[29] All of them turned to medical marijuana after conventional treatments did not work for them or caused such unpleasant side effects that their quality of life was substantially reduced to an unacceptable level. What follows are synopses of letters received from real medical marijuana patients by the Legislature at hearings this Spring and by the attorneys. The complete letters can be found in Attachment C.

Chronic Pain

Chronic pain is the most prevalent condition that responds to medical marijuana treatment. Unless you have had to live with chronic pain either personally or through a family member or friend, it is impossible to imagine the overwhelming need to control the pain. Most diseases and/or conditions that cause chronic pain are not curable, so the only alternative is to manage the pain. And managing the pain becomes the paramount goal in these patients' lives.

Dave Messmann severely injured his back while working in railroad construction at the young age of 25. This caused him to have disc degenerative disease resulting in constant pain that in his words: "can never be removed, only managed." "The ER doctors shot me full of pain relievers, performed tests, and prescribed more pain relievers. The specialists performed still more tests and

[29] Anne Murphy, letter at page C-11, Attachment C.

prescribed still more pain relievers. I took them. I took them all. I listened to their advice, followed their exercises. But the pain did not stop. The pain relievers only masked the pain and masked my life along with it. I was losing my life to the drugs. They caused violent dreams, depression and turned me into a zombie who was unable to take care of my two year old son." (emphasis added). Dave knew he could not live like this, and so he stopped taking the "nerve pills, the pain pills, and the stomach pills [he] took to combat the nerve pills and the pain pills; and [he] began using cannabis." He is now able to work and care for his family and as he says, "I am operational and cognitively aware." He gladly traded the cannabis side effects of "the munchies" and the slight euphoria for the awful side effects that included "the suicidal thoughts, the blurry vision, the chest pain, the loss of balance, or the abnormal mood swings caused by the Neurontin...or the shallow breathing, the ringing in [his] ears, the nausea, the anxiety, or the confusion caused by the Vicodin."[30]

Marin Turk a 26-year-old graduate student at the University of Michigan suffers from interstitial cystitis. Interstitial cystitis is a disease that involves inflammation or irritation of the bladder wall. This inflammation can lead to scarring and stiffening of the bladder, and even ulcerations and bleeding. Since

[30] See Dave Messmann's complete letter in Attachment C at pages C-3 to C-4.

the doctors do not know what causes interstitial cystitis, the treatments are aimed at relieving symptoms. By the time she was in graduate school, Marin was in chronic pain ranging from moderate to excruciating, and suffering from severe insomnia. "The side-effects of marijuana are shockingly few compared to those of more conventional drugs. My hospitalization and suicidal ideation episode were partly a side-effect (with, of course, a significant precedent) of a drug called Detrol, an anti-spasmodic my physician had prescribed to me the day before. My 10 month experience with Pamelor, a second-generation anti-depressant often prescribed for chronic pain sent me into a severe depression and masked the symptoms of an infection. Valium turned me into a zombie. Trazodone, which I took for insomnia, is similarly numbing and creates a constant mental fog." She uses medical marijuana to diminish her pain, control her bladder spasms, and insomnia. Marin has returned to graduate school, gotten all A's, "delivered a conference paper alongside prominent academics in my field and was a successful graduate student instructor." She has found medical grade marijuana to have "highly effective anti-spasmodic, anti-insomnia, analgesic, and anti-anxiety properties."[31]

[31] See Marin Turk's letter in Attachment C at pages C-6 to C-7.

Laura Jadwin has fibromyalgia and insomnia caused by the severe constant pain. Fibromyalgia is a disease characterized by chronic pain, stiffness, and tenderness of muscles, tendons, and joints, without detectable inflammation. Ninety percent of patients with fibromyalgia are plagued with undue fatigue as well as sleep disorders. Last August, Laura pinched her sciatic nerve, which caused a chain reaction of inflammation and muscle spasms. Medical marijuana enabled her to avoid going back on morphine, which she had been prescribed in an attempt to control her pain, but experienced "severe side effects and still did not receive complete relief." Medical marijuana allowed Laura to control the pain while leaving her mentally clear enough to finish her Masters Degree in Public Health at the University of Michigan.[32]

A former researcher, lecturer, advisor, and advocate for students with mental health problems at the University of Michigan, 58-year-old Anne Murphy is in "considerable chronic pain from advanced osteoarthritis." After years of treatments she describes as "futile" Anne tried medical marijuana. It has allowed her to function well enough to live independently. "The operative word is function. No medication has been as helpful for improving the function of daily living, nor has any been as benign." [33]

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[32] See Laura Jadwin's letter in Attachment C at page C-12.
[33] See Anne Murphy's letter in Attachment C at page C-11.

Stephanie Annis was raised in a Christian home where education was a priority and drugs were forbidden. She has Crohn's colitis, which is a chronic life-long illness and in Stephanie's case "it is severe with many complications." Her "main struggle was always with weight until November 2008." After being discharged from the hospital weighing only 98 lbs., she used medical marijuana to help her gain weight. "Within two months [she] gained 25 lbs., which was a miracle because prior to this [she] had struggled and was unable to get her weight above 121 lbs." [34]

James Kenyon got regular, chronic migraine headaches "triggered, primarily, by disc and vertebrae deterioration and inflammation in vertebrae 4, 5, and 6 of [his] cervical spine." After two referrals to the University of Michigan spine clinic, physical and occupational therapy, the doctors could still not pinpoint the underlying source of his problem. The doctors prescribed narcotic pain killers and muscle relaxers along with his migraine medication. The migraine medications left him "unable to concentrate, generally lethargic and did not allow [him] to function normally." Midrin -- the only reasonably effective migraine relief drug with limited side effects -- is no longer available. The substitute drug, Imitrex, caused James to be nervous, "unable to 'stay on task'"

[34] See Stephanie Annis's letter in Attachment C at pages C-1 to C-2.

and costs $35.00 per dose out-of-pocket. He was in constant pain in his cervical spine and shoulders and "suffered from at least one debilitating migraine every two weeks." "Since beginning medical marihuana treatment in May of last year, I have not suffered a debilitating migraine, have been able to manage the neck and shoulder pain and have, as a result, been more productive at work."[35]

Dennis Reott from Munith is a 61-year-old Vietnam veteran who worked as a Journeyman Inside Wireman and is now permanently disabled. He experiences constant bone pain, nerve pain, and frequent muscle spasms. His pain odyssey began in the early 1990's when Dennis had problems with a very sore right knee that progressed from medications to a total knee replacement, which had to be performed twice. After the second surgery, "Therapy and pain killers became my way of life." A third surgery followed at the University of Michigan to try to correct the problem, but it got worse and Dennis was put on Oxycontin and oxycodone for the pain. The extreme shooting pain along the tibia up to the knee cap "was constant and unrelenting." "Due to the drugs, my entire body was in a mess and my mind was totally messed up." He had no will to live and describes his brain as seeming "like mush with no interconnecting thoughts." A pain clinic doctor suggested he get off the drugs and search for an

[35] See James Kenyon's letter in Attachment C at pages C-13 to C-14.

alternative pain management therapy. Eventually he tried medical marijuana, which allowed him to quit taking the drugs and feel like he had "regained [his] life." After using medical marijuana in an oil for several months, Dennis says that he has no more pain in his stomach, no more constipation, and that his blood pressure is normal along with good oxygen and cholesterol levels.[36]

Another person suffering from fibromyalgia as well as degenerative disc disease is Sheila Bird from Roscommon. The discs in her neck as well as her back have degenerated, causing pain and she developed Irritable bowel syndrome (IBS). After she was hospitalized for an overdose of Tylenol because her liver could not process it along with the pain medications she was taking, she decided to try medical marijuana. She ingests the marijuana in food and has been able to get off the drugs and sleeping pills. Her pain from the IBS is gone and the neck/back pain is manageable.[37]

Jenine Kemp, who lives in Lansing, has neuropathy caused from a combination of lupus and an injury sustained while lifting a heavy patient. "The damage is permanent and the pain is continuous and severe." One of the many prescriptions she was given was Norco, which is an addictive narcotic. "My physician prescribed them by the hundred." "I was fearful of addiction to the

[36] See Dennis Reott's letter in Attachment C at pages C-8 through C-10.
[37] See Sheila Bird's letter in Attachment C at page C-15.

narcotics, and also of the kidney and liver damage they would cause." Jenine discovered medical marijuana was one of the best treatments for neuropathy. Thanks to medical marijuana she has been narcotic free for almost two years.[38]

All of these folks have one thing in common: they are using medical marijuana because standard medical treatments have failed or the drugs have such debilitating side effects that their quality of life was not tolerable. It is a well known medical fact that narcotic pain relievers can be addicting and that anti-inflammatory drugs cause long term damage to the kidneys and digestive system.[39] Medical marijuana provided these people an alternative to the known dangers of narcotic pain killers and anti-inflammatory drugs. But chronic pain is not the only condition that is ameliorated by medical marijuana.

Cancer

This insidious disease in its many forms has touched virtually everyone's life. Whether it is a family member, a friend, or even you who have had to cope with a diagnosis of cancer, it is a disease that is devastating physically,

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[38] See Jenine Kemp's letter in Attachment C at pages C-16 to C-17.

[39] Side effects of narcotic pain killers include: constipation, nausea, respiratory depression, vomiting, drowsiness, dizziness, weakness, dry mouth, confusion, difficulty urinating, itching, and addiction. See http://www.qualityhealth.com/pain-articles/managing-side-effects-narcotic-pain-killers. Side effects of anti-inflammatory drugs on the gastrointestinal system include nausea, vomiting, bloating, heartburn, stomach pain, constipation, diarrhea, and gas; bleeding, particularly in the digestive tract; fluid retention, kidney disorders, kidney failure; increased risk of stroke and blood clots in the legs; and reduced immune function. See http://www.livestrong.com/article/86146-antiinflammatory-medication-side-effects.

emotionally, and financially. Conventional cancer treatments cause horrible side effects that at times are worse than the disease itself.

Erin Love has incurable stage-4 cancer, which started in her breast and then spread to her bones. When she was first diagnosed in 2008, she was told morphine was all they could give her, but it made her sick. After switching doctors, she became a registered medical marijuana patient and has found relief. The medical marijuana "makes [her] feel hungry" which is important because she has to keep her weight up.[40]

John Henry Kaiser used to weigh 224 pounds when he was a firefighter for 25 years and training firefighters. He now has cancer caused by asbestos exposure. He has "tumors all over the place." His weight dropped to 137 pounds before he reluctantly tried medical marijuana to help him eat. He is now up to 153 pounds. John Henry eats medical marijuana in cookies so that he has less pain in his body, eats better, sleeps better, and helps him keep his spirits up. It also helps him manage the pain and stress.[41]

Dennis Alsop, who lives in Lakeport, has recurrent bladder cancer. He was given one intravenous chemo treatment that "literally destroyed [his] bladder." According to the doctors, he was one of the 1% of people who have

[40] See Erin Love's letter in Attachment C at pages C-18 to C-19.
[41] See John Henry Kaiser's letter in Attachment C at page C-20.

an adverse reaction to the drug. He says, "I almost died from the treatment, not the disease." Medical marijuana has helped the bladder heal and put his bladder cancer in remission.[42]

It is no secret that cancer treatments cause horrible side effects, especially nausea, vomiting, and a lack of appetite.[43] It is also no secret that medical marijuana has a place in ameliorating these side effects as evidenced by the findings of the various nursing organizations and the British Medical Association. A significant issue for cancer patients is consistent and timely access to medical grade marijuana. Cancer patients often don't have the time to wait for a crop to mature and be harvested. Nor do they have time to experiment with the different strains to find the one that relieves their symptoms the best. They need safe, timely access to their medicine.

Safe Access to Medical Marijuana

In 2008 over sixty percent of Michigan voters recognized that those people with certain medical conditions should have access to a known natural source of treatment. Thus Michigan allows registered patients to have access to medical marijuana. It is that access to the medicine, which they are allowed to have, that

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[42] See Dennis Alsop's letter in Attachment C at page C-21.

[43] Chemotherapy side effects include: hair loss, nausea, vomiting, mouth sores, constipation, diarrhea, pain, numbness and tingling, forgetfulness, inability to concentrate, reproductive and sexual side effects. See http://www.chemotherapy.com/side_effects/other_side_effects/other-side_effects.html.

is at the heart of this case. In the words of medical marijuana patients, safe controlled access is an enormous problem.[44] No legitimate patient wants to use "street dope" and no one can say that the electorate intended that patients have to seek their medicine on the streets. If anything, the voters intended just the opposite -- that patients have safe access to affordable, consistent medication.

The primary mechanism for obtaining medical marijuana specifically described in the MMMA is the private caregiver system or a patient grow-your-own system. But in practice, the private caregiver system is not always reliable and many patients are too sick to grow their own plants. The difficulty of the caregiver system is best described by Laura Jadwin, a fibromyalgia patient who said that she had "no access to an individual caregiver" and did not "know where [she] could find one." "There is no system to match patients with caregivers, and since you must register your caregiver with the state there is no legal way to "shop around" to find a caregiver that meets your needs."[45] Daniel Taylor of Zeeland once had a caregiver, "but that person stopped growing because of concerns with Federal law." He just wants "to be able to obtain safe-lab tested cannabis from a dispensary for [his] condition."[46]

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[44] See Attachment C generally.
[45] See Laura Jadwin's letter in Attachment C at page C-12.
[46] See Daniel Taylor's letter in Attachment C at page C-22.

Growing your own medicine is often not possible for most patients. Jenine Kemp is allowed to grow her own medical marijuana, "but crops fail due to bugs, mold, temperature and many other factors" and that it is "difficult to have a successful grow."[47] Others like Daniel Taylor are "not able to grow cannabis because of [their] illness."[48] As a social worker providing home health care services to disabled people, Miriam Halprin observed that these individuals are "the personification of the most vulnerable patient populations with the most obvious conditions and the greatest discomfort." Just because a patient gets a MMMA card, there is "no guidance with regard to accessing safe, affordable, consistent medication." There is no access to viable edibles and tinctures, which are measurable, and vaporizing, which is reportedly significantly less toxic than smoking…"[49] Patients have been ripped off by caregivers and been unable to gain access to their medicine as a result of crop failures or a caregiver just quitting. [50] This leaves patients without the medicine that has allowed them to get off narcotic pain killers, reduce or eliminate anti-inflammatory drugs that cause kidney damage, or has enabled them to survive chemotherapy.

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[47] See Jenine Kemp's letter in Attachment C at pages C-16 to C-17.
[48] See Daniel Taylor's letter in Attachment C at page C-22.
[49] See Miriam Halprin's letter in Attachment C at page C-23.
[50] See Attachment C generally.

While the dispensary method of helping patients gain access to medicinal grade marijuana is not explicitly provided for in the MMMA, it has to be implicit in the definition of "medical use" because dispensaries fulfill the objectives and intent of the MMMA. Stephanie Annis likes the dispensaries because they "provide information, knowledge, and advice from professionals who know the various strains and can match the patient with a particular symptom or need to a particular strain, edible, oil, or concentrate."[51] Unlike an individual growing their own medicine or a single caregiver, a dispensary facilitating a patient-to-patient transfer can help a patient find the right strain of marijuana for their particular condition. Anne Murphy cogently summed up the reasons why the MMMA should be interpreted broadly enough to allow dispensaries, who facilitate transfers of medical marijuana to registered patients. According to Anne, obtaining her medical marijuana from a dispensary has allowed her to try different strains to get the most pain control and to find it in edible form so that she does not have to smoke it:

> "It is a science to grow marijuana for medical use and beyond my current acumen. But I am learning. I know caregivers so I would be able to find a caregiver. However, this would not be in my best therapeutic interests. Caregivers can only grow so many strains. They may not have edible forms. Cannabis is a particularly good therapeutic agent

[51] See Stephanie Annis's letter in Attachment C at pages C-1 to C-2.

> because it is a varied species, and different strains have different therapeutic effects. Since using a dispensary I have been able to explore and find the best strains suitable for my needs. It has greatly increased the therapeutic effect. Just recently I found an edible form that decreased my pain better than anything I have tried previously."[52]

Anne is not the only one who has benefitted from being able to try different strains. Laura Jadwin pointed out that having a caregiver does not provide her with access to many different strains of cannabis so that she could try different types to find the one that worked the best for her. She was able to sample different strains of marijuana at a dispensary.[53]

Another reason that the definition of medical use should include dispensaries is that a dispensary is capable of creating different forms of cannabis so that it can be ingested in ways other than smoking it.[54] Dave Messmann was able to find an edible concentrated tincture that is a very effective pain reliever for him only at a dispensary. Laura Jadwin prefers edible cannabis because it is more effective and avoids the negative health effects of smoking marijuana. Other patients use topical creams in addition to edible or vaporized marijuana. A dispensary helps patients have access to the medicine by providing options for how to use medical marijuana for the maximum benefit with the least risk.

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[52] See Anne Murphy's letter in Attachment C at page C-11.
[53] See Laura Jadwin's letter in Attachment C at page C-12.
[54] See Attachment C generally for the various non-smoking methods for ingesting medical marijuana.

The "good farmer" problem

Another area that is not specifically addressed in the MMMA is what do a patient and/or caregiver do with medical grade marijuana in excess of what he/she is allowed to possess. While every cannabis grower wishes he/she had the "problem" of an abundant crop, it presents a dilemma. What does a caregiver or patient do with an overage due to a better than average harvest, good farming, or just plain good luck? What does a caregiver or patient do with medical marijuana from a strain that does not work effectively for their particular problem? They can't throw it out – that puts it in the public domain and would subject the person to criminal sanctions for "delivering" marijuana [MCL 333.7401(1)]. They can't burn it in most places because of no-burn ordinances and the fact that the smell would attract law enforcement personnel from every corner of the county. Burying it is not necessarily a practical alternative because of the risk that any seeds might sprout and then the patient/caregiver would be subject to criminal sanctions for manufacturing marijuana outside of the constraints of the MMMA [MCL 333.7401(1)]. And just keeping it is illegal because then the patient/caregiver would possess an amount over the limits set by the MMMA [MCL 333.7401(1) or MCL 333.7403(1)]. Allowing patient-to-patient transfers,

whether by gift or sale, is a practical way to solve the "good farmer" problem in a way that is consistent with the MMMA and the electorate's intent.

Allowing patient-to-patient transfers would further the intent of the electorate when it approved the MMMA by making medicinal grade marijuana available to patients who are not able to grow it or get it from their caregiver because they had a crop failure, or quit growing it. These transfers would allow cancer patients to have timely access to medical marijuana when they need it most – during chemotherapy or other cancer treatments – without having to wait for a crop to be grown and harvested for them. The advantages of having a place such as Compassionate Apothecary facilitate the transfer are that it controls the amount and frequency of transfers to patients to ensure compliance with the limits in the MMMA; it provides that the storage of medical marijuana is in accordance with the MMMA; and it provides a safe place for patients to acquire their medicine. Consistent with the MMMA and the intent of the voters, it separates medical marijuana from "street dope" and patients from recreational users.

Conclusion

This Court is faced with deciding whether the MMMA's definition of "medical use" includes patient-to-patient transfers of medical marijuana facilitated through dispensaries. Even though the MMMA does not specifically provide for patient-to-patient transfers, it does not prohibit them. Nor does it prohibit a "dispensary" from facilitating patient-to-patient transfers. The voters could have prohibited patient-to-patient transfers and they could have prohibited dispensaries, but they did not. Their silence indicates intent to allow whatever is necessary for legitimate patients to have access to medical marijuana.

While the caregiver and grow-your-own models for access to medical marijuana, which are delineated in the MMMA, appeared to be a good idea in 2008, experience has shown that these models can and do fail to provide needed medicine to those who most need it. The MMMA has language in it that is broad enough to be interpreted to allow other access models that fulfill the goals of the MMMA while still restricting that access to legitimate patients. A broader interpretation to allow patient-to patient transfers, with or without dispensary facilitation, solves the problems that have arisen with the caregiver and grow-your-own models.

This broader interpretation would allow patients to be able to find the strain of medical marijuana that best helps their condition. It would help patients find the right caregiver for them and their condition. Cancer patients who need timely access to medical marijuana can receive it without the delay occasioned by having to wait for their marijuana to grow and be harvested. It would provide a safety net for patients to have access to their medicine when caregivers either cannot provide the medical marijuana or decide to not grow it. The same is true when a patient's efforts to grow their own fail to produce the medicine they need. It would make access to medical marijuana safer for the patients, many of whom are seriously compromised by their conditions. The bottom line is that the interpretation of MMMA §3(e) advocated in this brief achieves the MMMA's overarching goal to ensure that legitimate patients be able to obtain medical marijuana.

Moreover, interpreting "medical use" to include patient-to-patient transfers would solve the "good farmer" problem in a way that benefits all patients consistent with the whole point of the MMMA. Patients and/or patients facilitated by a dispensary would have an outlet for excess medical marijuana that keeps it out of the public domain and provides medicine for patients who cannot afford it otherwise.

By giving a voice to the people who otherwise would not be heard, the Ann Arbor Medical Cannabis Guild, Inc. hopes that this brief helps this Court understand the real problems facing actual registered patients when they need access to their medicine. These patients are the reason why over 60% of the electorate decided to approve the MMMA. An interpretation of MMMA §3(e) allowing patient-to patient transfers of medical marijuana in compliance with the limits described in the Act [amount and how often] would be in line with the intent of the voters and the intent of the MMMA.

RELIEF

Amicus Curiae Ann Arbor Medical Cannabis Guild, Inc. respectfully requests that this Honorable Court hold that the definition of "medical use" in MMMA §3(e) includes patient-to-patient transfers of medical marijuana, whether they are facilitated by a dispensary or not, because that interpretation is consistent with the intent of the voters and the MMMA.

Further Amicus Curiae Ann Arbor Medical Cannabis Guild, Inc. respectfully requests that this Honorable Court reverse the Court of Appeals decision in this case.

Respectfully Submitted,

27 July 2012

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STATE OF MICHIGAN
In the SUPREME COURT

PEOPLE OF THE STATE OF MICHIGAN
Plaintiff-Appellee,

v

No. 143824
Court of Appeals No. 301951
Circuit Court No. 10-008488-CZ

BRANDON McQUEEN, and
MATTHEW TAYLOR, d/b/a
COMPASSIONATE APOTHECARY, LLC,
Defendants-Appellants
/

STATE OF ARIZONA }
} ss
COUNTY OF PIMA }

PROOF OF SERVICE

On the date below I mailed 2 copies of ANN ARBOR CANNIBUS GUILD'S AMICUS CURIAE BRIEF IN SUPPORT OF DEFENDANTS- APPELLANTS and ATTACHMENT TO:

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I declare that the above statements are true to the best of information, knowledge, and belief.

Date: 27 July 2012

ROSEMARY GORDON PÁNUCO