STATE OF MICHIGAN

COURT OF APPEALS

PEOPLE OF THE STATE OF MICHIGAN, Plaintiff-Appellee,	FOR PUBLICATION September 14, 2010
v ROBERT LEE REDDEN Defendant-Appellant.	No. 295809 Oakland Circuit Court LC No. 2009-009020-AR
PEOPLE OF THE STATE OF MICHIGAN, Plaintiff-Appellee,	
v TOREY ALISON CLARK Defendant-Appellant.	No. 295810 Oakland Circuit Court LC No. 2009-009020-AR Advance Sheets Version

Before: O'CONNELL, P.J., and METER and OWENS, JJ.

O'CONNELL, P.J. (*concurring*).

I concur with the majority's decision to affirm the circuit court's decision to reinstate the charges against defendants, but write separately because I interpret the statutory defenses at issue more narrowly than does the majority, and also to elaborate on issues raised in the briefs and at oral argument but not fully addressed by the majority opinion.

On November 4, 2008, the Michigan Medical Marihuana Act (MMMA), MCL 333.26421 *et seq.*, was passed by initiative and went into effect soon thereafter. It is without question that this act has no effect on federal prohibitions of the possession or consumption of

marijuana.[1] The Controlled Substances Act, 21 USC 801 *et seq.*, classifies marijuana as a schedule 1 substance, 21 USC 812(c)(10), meaning that Congress recognizes no acceptable medical uses for it, and its possession is generally prohibited. See *Gonzales v Raich*, 545 US 1, 27; 125 S Ct 2195; 162 L Ed 2d 1 (2005); *United States v Oakland Cannabis Buyers' Coop*, 532 US 483, 491; 121 S Ct 1711; 149 L Ed 2d 722 (2001). As a federal court in Michigan recently recognized, "It is indisputable that state medical-marijuana laws do not, and cannot, supercede federal laws that criminalize the possession of marijuana." *United States v Hicks*, 722 F Supp 2d 829, 833 (ED Mich, 2010), citing *Gonzales*, 545 US at 29 ("The Supremacy Clause unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail."), *United States v $186,416.00 in US Currency*, 590 F3d 942, 945 (CA 9, 2010) ("The federal government has not recognized a legitimate medical use for marijuana, however, and there is no exception for medical marijuana distribution or possession under the federal Controlled Substances Act"), *United States v Scarmazzo*, 554 F Supp 2d 1102, 1109 (ED Cal, 2008) ("Federal law prohibiting the sale of marijuana is valid, despite any state law suggesting medical necessity for marijuana"), and *United States v Landa*, 281 F Supp 2d 1139, 1145 (ND Cal, 2003) ("[O]ur Congress has flatly outlawed marijuana in this country, nationwide, including for medicinal purposes."). Accordingly, "the MMMA has no effect on federal law, and the possession of marijuana remains illegal under federal law, even if it is possessed for medicinal purposes in accordance with state law." *Hicks*, 722 F Supp 2d, at 833, citing *Gonzales*, 545 US at 27 ("The [Controlled Substances Act] designates marijuana as contraband for any purpose[.]").

Further, the MMMA does not create any sort of affirmative *right* under state law to use or possess marijuana. That drug remains a schedule 1 controlled substance under the Public Health Code, MCL 333.7212(1)(c), meaning that "the substance has high potential for abuse and has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision," MCL 333.7211. The MMMA does not repeal any drug laws contained in the Public Health Code, and all persons under this state's jurisdiction remain subject to them. Accordingly, mere possession of marijuana remains a misdemeanor offense, MCL 333.7403(2)(d), and the manufacture of marijuana remains a felony, MCL 333.7401(2)(d).

Perhaps surprisingly, the purpose of the MMMA is a bit less revolutionary than one might suspect. MCL 333.26422(b) states as follows:

> 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.

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[1] "Marijuana" and "marihuana" are both acceptable spellings for the name of this drug. The spelling "marihuana" is used in the Public Health Code, MCL 333.1101 *et seq.*, but "marijuana" is the more commonly used spelling and so will be used throughout this opinion.

The MMMA does not codify a *right* to use marijuana; instead, it merely provides a procedure through which seriously ill individuals using marijuana for its palliative effects can be identified and protected from prosecution under state law. Although these individuals are still violating the Public Health Code by using marijuana, the MMMA sets forth particular circumstances under which they will not be arrested or otherwise prosecuted for their lawbreaking. In so doing, the MMMA reflects the practical determination of the people of Michigan that, while marijuana is classified as a harmful substance and its use and manufacture should generally be prohibited, law enforcement resources should not be used to arrest and prosecute those with serious medical conditions who use marijuana for its palliative effects.[2]

Accordingly, the MMMA functions as an affirmative defense to prosecutions under the Public Health Code, allowing an individual to use marijuana by freeing him or her from the threat of arrest and prosecution if that individual meets *all* the requirements of the MMMA, while permitting prosecution under the Public Health Code if the individual fails to meet any of the requirements set forth by the MMMA.[3] See MCL 333.26422(b); MCL 333.26427(e).

The problem, however, is that the MMMA is inartfully drafted and, unfortunately, has created much confusion regarding the circumstances under which an individual may use marijuana without fear of prosecution. Some sections of the MMMA are in conflict with others, and many provisions in the MMMA are in conflict with other statutes, especially the Public Health Code. Further, individuals who do not have a serious medical condition are attempting to use the MMMA to flout the clear prohibitions of the Public Health Code and engage in recreational use of marijuana. Law enforcement officers, prosecutors, and trial court judges attempting to enforce both the MMMA and the Public Health Code are hampered by confusing and seemingly contradictory language, while healthy recreational marijuana users incorrectly view the MMMA as a de facto legalization of the drug, seemingly unconcerned that marijuana use remains illegal under both state and federal law.

In this opinion, I will attempt to cut through the haze surrounding this legislation. In so doing, I note that neither my opinion nor the majority's opinion constitutes an attempt to *make* the law. We are simply interpreting an act passed by the people of this state. It is up to the Legislature to revise this act as it sees fit.[4]

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[2] Again, all individuals who possess, use, or manufacture marijuana in this state, including qualifying patients who have been issued a valid registry identification card and their primary caregivers, are violating the federal Controlled Substances Act and are still subject to arrest and punishment for doing so.

[3] Of course, because the MMMA protects against enforcement of the Public Health Code under only limited circumstances, an individual who is using marijuana must satisfy *all* the requirements of the MMMA or else remain subject to arrest and prosecution for violating the Public Health Code.

[4] I have no doubt that in the minds of some voters in this state, legalizing marijuana would be good public policy. Others who approved this act were under the impression that the act's

I. GUIDANCE IS NEEDED

In light of the majority opinion's resolution of the issues in this case, one might ask why this concurrence is of any importance. The answer is simple: delay and neglect in addressing the proper scope and application of the MMMA invites and perpetuates error. Judges bear the responsibility of applying, interpreting, and shaping the law, and we neglect this responsibility when we fail to explain, with well-reasoned analysis, our agreement or disagreement with pertinent points of law. Failure to engage in the debate hinders our hunt for a statute's intended purpose and generally stifles the formation of sound legal principles. If we all gently withdrew our voices from the arena of competing ideas, then mistakes would go unchallenged, and the process of correction could suffer nearly insurmountable setbacks.

This case proves the rule. At oral argument and in their briefs, both parties raised numerous questions regarding the proper interpretation of the provisions of the MMMA. It was made clear that many provisions of this act are subject to multiple interpretations and that obfuscating words and phrases in the MMMA have caused much confusion on the part of both law enforcement officials and defense attorneys wishing to advise their clients of their rights and protections under the law. Defense counsel was particularly concerned that the law was not specific enough for him to advise his clients on both the strictures of the MMMA and the ramifications of certain provisions. The prosecuting attorney noted that he was unable to advise municipalities, townships, the police, and others regarding whether particular conduct was permitted or prohibited under the act. More generally, in the absence of clear direction from the appellate courts, many citizens believe that the MMMA supports and legitimizes the marijuana business.

As defense counsel emphasized at oral argument this Court could take a case-by-case approach to resolving all the issues found in the MMMA, addressing particular provisions piecemeal and in isolation over years and leaving defendants, prosecutors, law enforcement, entrepreneurs, cities, municipalities, townships, and others in a state of confusion for a very, very long time.[5] Or, in one well-thought-out opinion, it could interpret the essential provisions of this

specific purpose was limited to permitting the medical use of marijuana by registered patients with debilitating medical conditions. Still others voted against this change in the law. Whether decriminalizing the medical use of marijuana is a good or bad idea for this state is a question of public policy for our state legislators, the executive branch, and the citizenry to ponder. It is not for the courts to set public policy. This Court's responsibility is simply to interpret this act. Citizens of this state wishing for revision of the MMMA should take such appropriate action as attending the public hearings on pertinent pending legislation or communicating with their elected representatives.

[5] Under this piecemeal approach, each case would address a separate, specific issue involving the MMMA. The lower courts of all 83 Michigan counties would then opine on each issue (in some cases arriving at different results). The cases would be appealed to this Court, which would in response issue published opinions binding all trial courts in the state. While this may be an efficient and orderly process for some areas of the law, I suspect that the confusion regarding the circumstances under which an individual using or possessing marijuana is protected from arrest or conviction could result in some citizens losing both their liberty and their property. I am reminded of a statement often attributed to the eighteenth-century British statesman Edmund Burke: "All that is necessary for the triumph of evil is for good men to do nothing." In this case,

act, providing a framework for future application of the new statute and giving fair notice to all regarding the scope of acceptable conduct under the MMMA. Counsel for both parties advised this Court against interpreting the MMMA in a piecemeal fashion because of the confusion that would persist. I agree, and this opinion is my attempt to establish the framework for the law and address those issues not resolved by the majority opinion.

I also agree with counsel that it is the responsibility of this Court to interpret this law in a way that gives fair notice to all concerned regarding what conduct is allowed and what conduct is prohibited under this law. Without some guidance from the appellate courts, the lower courts will continue to stumble about. The system of justice will become hopelessly unpredictable and intolerably frustrating for the people it was established to serve. Right or wrong, we all have the duty to interpret the law to the best of our abilities. Any delay in this process frustrates those citizens who are making a good faith effort to adhere to the law.

II. ONE STATUTE, COMPETING GOALS

Proposal 1 on the 2008 ballot, which presented the MMMA to the people of this state for a vote, described the proposed MMMA as purporting to 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 as may be approved by the Department of Community Health.
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> - Permit registered individuals to grow limited amounts of marijuana for qualifying patients in an enclosed, locked facility.
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> - Require Department of Community Health to establish an identification card system for patients qualified to use marijuana and individuals qualified to grow marijuana.
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> - Permit registered and unregistered patients and primary caregivers to assert medical reasons for using marijuana as a defense to any prosecution involving marijuana.

Yet in its summary of the intended effect of the MMMA, this ballot proposal obfuscated the more confusing and contradictory aspects of the actual legislation. The statutory language creates a maze for the reader, making the statute susceptible to multiple interpretations.

The MMMA is based on model legislation provided by the Marijuana Policy Project (MPP), a lobbying group based in Washington, D. C., and organized to decriminalize both the medical *and* recreational uses of marijuana. The statutory language of the MMMA was drafted

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the evil at issue is the loss of liberty or property suffered by individuals who honestly believe that they are in compliance with the MMMA at the hands of prosecutors and law enforcement officials who honestly believe that they are properly enforcing the clear provisions of the Public Health Code.

by Karen O'Keefe, the director of state policies at the MPP in Washington, D.C.[6] Interestingly, the confusion caused by reading the statute piecemeal and out of context has seemed to work to the advantage of those who share the MPP's wish for outright legalization of marijuana. Taking advantage of the confusion from the MMMA, proponents of liberalized marijuana regulations claim that the MMMA legalizes shops that sell marijuana, collective growing facilities, and the cultivation and sale of marijuana as a commercial crop. Further, those individuals who primarily wish to use marijuana recreationally are taking advantage of "pot docs" who will give them written certifications for the medical use of marijuana without bothering to establish either a bona fide physician-patient relationship or the existence of a terminal or debilitating medical condition.

In looking at the specific provisions of the MMMA, it is important to remember that this act is based on a premise—namely, that marijuana can be used for medical purposes—that is in obvious contravention to the Public Health Code. By classifying marijuana as a schedule 1 controlled substance under the Public Health Code, the people of this state, through their elected representatives, have determined that marijuana "has high potential for abuse and has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision." MCL 333.7211. This clearly contravenes the rationale for the MMMA, which indicates that provisions should be made to permit seriously ill individuals to use marijuana for medical purposes without fear of arrest because "[m]odern medical research . . . has discovered beneficial uses for marihuana in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions." MCL 333.26422(a).

The obvious solution to this problem would simply be to amend the Public Health Code to make marijuana a schedule 2 or schedule 3 controlled substance.[7] With such an amendment, state law would not prohibit a licensed prescriber from prescribing marijuana if, in the prescriber's professional opinion, the drug would effectively treat the pain, nausea, and other symptoms associated with certain debilitating medical conditions. MCL 333.7303a. Curiously, however, the MMMA has no provisions to repeal the contradictory portions of the Public Health Code or to ensure the controlled, monitored distribution of marijuana to seriously ill individuals

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[6] On its website, the MPP advertises its involvement in the ballot initiative, noting, "Michigan passed MPP's ballot initiative to permit terminally and seriously ill patients to use medical marijuana with their doctors' approval . . . ." Marijuana Policy Project, Our History <http://www.mpp.org/about/history.html> (accessed September 10, 2010).

[7] A substance may be included in schedule 2 if the substance has a high potential for abuse and that abuse may lead to severe psychic or physical dependence, but the substance also has "currently accepted medical use in treatment in the United States, or currently accepted medical use with severe restrictions." MCL 333.7213. A substance may be included in Schedule 3 if the substance has a potential for abuse less than a schedule 1 or schedule 2 controlled substance and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence, but the substance also has "currently accepted medical use in treatment in the United States." MCL 333.7215.

in accordance with the well-tested provisions of the Public Health Code.[8] Instead, it creates a new system, untested in this state, in which a physician merely "certifies" that an individual would likely "benefit" from using marijuana to alleviate pain, nausea, or other symptoms, while leaving it to the patient to register under the act and to self-regulate the quality and quantity of marijuana the patient uses.

Accordingly, the confusing nature of the MMMA, and its susceptibility to multiple interpretations, creates an untoward risk for Michiganders.[9] Reading the statute carelessly or out of context could result in jail or prison time for many of our citizens. Until our Supreme Court and the Legislature clarify and define the scope of the MMMA, it is important to proceed cautiously when seeking to take advantage of the protections in it. Those citizens who proceed without due caution will become test cases and may lose both their property and their liberty.[10]

III. THROUGH THE MAZE

The MMMA consists of 10 sections detailing the protections, procedures, and defenses surrounding the medical use of marijuana in this state. However, much of the confusion caused by the MMMA arises from difficulty understanding the interplay among §§ 4, 7, and 8. Section 4 addresses the protections afforded to qualifying patients, caregivers, and others under the act:

> (a) A qualifying patient who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty

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[8] Critics might argue that reclassifying marijuana under the Public Health Code would be ineffective because it would require doctors to ignore federal provisions banning them from prescribing marijuana. Yet it is important to remember that the entirety of the MMMA stands in conflict with federal law. Accordingly, such criticism would less likely stem from a desire to adhere to federal law than from a desire to steer the risk associated with breaking federal law away from those perceived as less willing to take that risk. The Catch-22 here is that doctors would not, and should not, put their medical licenses at risk.

[9] At the preliminary examination in this matter, the learned Judge Robert Turner, a veteran of many years on the bench, stated that the MMMA "is one of the worst pieces of legislation I have ever seen in my life." In interpreting this act, Judge Turner assumed that the sole purpose of it was to set forth the rules and regulations for the medical use of marijuana in Michigan, but it is becoming increasingly clear that the act is being used as a subterfuge to legalize marijuana in Michigan. It is well crafted in its obfuscations, ambiguous language, and confusingly overlapping sections.

[10] Until our Supreme Court provides a final comprehensive interpretation of this act, it would be prudent for the citizens of this state to avoid all use of marijuana if they do not wish to risk violating state law. I again issue a stern warning to all: please do not attempt to interpret this act on your own. Reading this act is similar to participating in the Triwizard Tournament described in J.K. Rowling's *Harry Potter and the Goblet of Fire*: the maze that is this statute is so complex that the final result will only be known once the Supreme Court has had an opportunity to review and remove the haze from this act.

or disciplinary action by a business or occupational or professional licensing board or bureau, for the medical use of marihuana in accordance with this act, provided that the qualifying patient possesses an amount of marihuana that does not exceed 2.5 ounces of usable marihuana, and, if the qualifying patient has not specified that a primary caregiver will be allowed under state law to cultivate marihuana for the qualifying patient, 12 marihuana plants kept in an enclosed, locked facility. Any incidental amount of seeds, stalks, and unusable roots shall also be allowed under state law and shall not be included in this amount.

(b) A primary caregiver who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, for assisting a qualifying patient to whom he or she is connected through the department's registration process with the medical use of marihuana in accordance with this act, provided that the primary caregiver possesses an amount of marihuana that does not exceed:

(1) 2.5 ounces of usable marihuana for each qualifying patient to whom he or she is connected through the department's registration process; and

(2) for each registered qualifying patient who has specified that the primary caregiver will be allowed under state law to cultivate marihuana for the qualifying patient, 12 marihuana plants kept in an enclosed, locked facility; and

(3) any incidental amount of seeds, stalks, and unusable roots.

(c) A person shall not be denied custody or visitation of a minor for acting in accordance with this act, unless the person's behavior is such that it creates an unreasonable danger to the minor that can be clearly articulated and substantiated.

(d) There shall be a presumption that a qualifying patient or primary caregiver is engaged in the medical use of marihuana in accordance with this act if the qualifying patient or primary caregiver:

(1) is in possession of a registry identification card; and

(2) is in possession of an amount of marihuana that does not exceed the amount allowed under this act. The presumption may be rebutted by evidence that conduct related to marihuana was not for the purpose of alleviating the qualifying patient's debilitating medical condition or symptoms associated with the debilitating medical condition, in accordance with this act.

(e) A registered primary caregiver may receive compensation for costs associated with assisting a registered qualifying patient in the medical use of marihuana. Any such compensation shall not constitute the sale of controlled substances.

(f) A physician shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Michigan board of medicine, the Michigan board of osteopathic medicine and surgery, or any other business or occupational or professional licensing board or bureau, solely for providing written certifications, in the course of a bona fide physician-patient relationship and after the physician has completed a full assessment of the qualifying patient's medical history, or for otherwise stating that, in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition, provided that nothing shall prevent a professional licensing board from sanctioning a physician for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

(g) A person shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, for providing a registered qualifying patient or a registered primary caregiver with marihuana paraphernalia for purposes of a qualifying patient's medical use of marihuana.

(h) Any marihuana, marihuana paraphernalia, or licit property that is possessed, owned, or used in connection with the medical use of marihuana, as allowed under this act, or acts incidental to such use, shall not be seized or forfeited.

(i) A person shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, solely for being in the presence or vicinity of the medical use of marihuana in accordance with this act, or for assisting a registered qualifying patient with using or administering marihuana.

(j) A registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States that allows the medical use of marihuana by a visiting qualifying patient, or to allow a person to assist with a visiting qualifying patient's medical use of marihuana, shall have the same force and effect as a registry identification card issued by the department.

(k) Any registered qualifying patient or registered primary caregiver who sells marihuana to someone who is not allowed to use marihuana for medical purposes under this act shall have his or her registry identification card revoked and is guilty of a felony punishable by imprisonment for not more than 2 years or a fine of not more than $2,000.00, or both, in addition to any other penalties for the distribution of marihuana. [MCL 333.26424.]

The unusual structure of this section reflects the intent of the MMMA as set forth in MCL 333.26422(b). Instead of describing an affirmative right to grow, possess, or use marijuana, § 4 simply indicates that registered qualifying patients, primary caregivers, and physicians are protected from arrest, prosecution, or penalty if they meet the specific requirements set forth.[11]

A closer look at the pertinent subsections of § 4 further shows this to be the case. Section 4(a) specifies that a qualifying patient with a registry identification card is not subject to arrest, prosecution, or penalty "for the medical use of marihuana in accordance with this act . . . ." MCL 333.2642(a). MCL 333.26423(h) defines a "qualifying patient" as "a person who has been diagnosed by a physician as having a debilitating medical condition." Accordingly, even if a qualifying patient has a registry identification card, that patient is entitled to protection under the MMMA only if he or she has also been diagnosed with a debilitating medical condition. In order to "diagnose" a patient, a physician must "determine the identity of (a disease, illness, etc.) by a medical examination." *Random House Webster's College Dictionary* (2001). Accordingly, regardless of whether an individual has a registry identification card, that individual is not a "qualifying patient" under the MMMA and, therefore, is not entitled to the act's protections unless a physician has determined that the patient suffers from an identifiable debilitating condition.[12]

Under § 4(a), a qualifying patient may engage in the "medical use" of marijuana without fear of arrest. Interestingly, the term "medical use," as defined by the MMMA, is much broader than one would anticipate. MCL 333.26423(e) defines the term "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 definition of "medical use" is

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[11] Most legislation either grants rights and privileges to citizens by stating that a person may do a certain activity or it makes certain activity illegal. In either circumstance, the statute affirmatively indicates what an individual may or may not do. The MMMA does the opposite; instead of granting a right or implementing a prohibition, the statute leaves the underlying prohibition of the manufacture, possession, or use of marijuana intact and states that individuals meeting certain criteria "shall not be subject to arrest, prosecution, or penalty" for using, possessing, or growing marijuana under specified circumstances. As a result, this state finds itself in the unusual position of having a statute that precludes enforcement, in certain circumstances, of another statute that makes certain activity illegal. Needless to say, this decision to use one statute to undercut the enforceability of another statute, instead of simply redefining the circumstances under which marijuana use and possession are legal in this state, greatly adds to the confusion that surrounds this act.

[12] Thus, an individual is not entitled to protection under the MMMA if a physician has acknowledged only that the individual suffers from *symptoms* of a disease or illness (such as pain, nausea, or anxiety) but has not actually diagnosed that person as having a debilitating disease or illness. Also, the term "medical use" is only employed in specific sections of this act, while the term "use" is employed in other sections, thereby suggesting two separate meanings for the term "use" within the act.

unexpectedly broad: although a qualifying patient may not sell marijuana, just about anything else an individual can do with marijuana would be considered *medical use* under the MMMA.[13]

Section 4(a) also provides that a qualifying patient is not subject to arrest, prosecution, or penalty for the medical use of marijuana if that patient has no more than 12 marijuana plants in an enclosed, locked facility. MCL 333.26424(a). Alternatively, the qualifying patient may designate a primary caregiver to grow up to 12 plants in an enclosed, locked facility. However, because the statute provides that a qualified patient may be in possession of the specified number of marijuana plants only if the patient has not designated a primary caregiver to grow marijuana for him or her, if the qualified patient has made such a designation, the statute provides that qualified patient no protection from arrest if found in the possession of any marijuana plants.

Section 4(b) specifies the circumstances in which a registered primary caregiver is protected from arrest. MCL 333.26424(b). MCL 333.26423(g) defines a "primary caregiver" as "a person who is at least 21 years old and who has agreed to assist with a patient's medical use of marihuana and who has never been convicted of a felony involving illegal drugs." Section 4(b) specifies that a registered primary caregiver may assist *only* a qualifying patient[14] *to whom he or*

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[13] An example of this conflict is § 4(a) and § 7(b)(2) of the act. Section 4(a) allows 18-year-old high school students to grow and use marijuana if they are properly registered with the state. MCL 333.26424(a). Section 4(a) also states that as long as he or she is a qualifying patient who has a registry card, the student "shall not be subject to arrest, prosecution, or penalty in any manner" whatsoever. *Id*. Reading § 4(a) in isolation allows 18-year-old students to possess marijuana in our schools without being subject to arrest, prosecution, or penalty in any manner whatsoever. Conflicting with § 4(a) is § 7(b)(2)(B), which provides that one may not possess marijuana on the grounds of any preschool or primary or secondary school. MCL 333.26427(b)(2)(B).

Sections 4(b) and 7(b)(5) are also in conflict. Section 7(b)(5) states that a person may not use marijuana if that person does not have a serious or debilitating medical condition. MCL 333.26427(b)(5). Section 4(b) allows primary caregivers to assist qualifying patients. MCL 333.26424(b). Nothing in § 4(a) or (b) allows primary caregivers to use marijuana, unless they qualify under § 4(a). The conflict arises because the act allows primary caregivers to grow marijuana, but it prohibits those who are not "qualifying patients" to use marijuana. I note that caregivers receive registration cards under the statute but are not required to have a "written certification" stating they have a debilitating condition. The only logical conclusion is that "primary caregivers" who do not possess a "qualifying patient" registry card are not permitted to use marijuana under the MMMA.

[14] The act uses both the terms "qualifying patient" and "patient." While qualifying patients enjoy greater protections under § 4 than patients do under § 8, both qualifying patients and patients must follow all the provisions of the act, including the requirement that all patients growing marijuana do so in an enclosed, locked facility. Growing marijuana in the backyard thus subjects the grower and the homeowner to the penalties found in the Public Health Code. This requirement is consistent with the language of the ballot proposal. Whether each patient's 12 marijuana plants must be grown in a separate locked facility is an issue best left for another day. Those caregivers who commingle various patients' plants in one facility may look forward to becoming test cases. Primary caregivers may have only five patients and, if the qualifying

she is connected through the registration process with the medical use of marijuana. Accordingly, a primary caregiver may not assist *any* qualifying patient in the acquisition, possession, cultivation, manufacture, use, internal possession, delivery, transfer, or transportation of marijuana unless *that* caregiver is connected to *that* qualifying patient through registration with the Department of Community Health (DCH). Section 6(d) specifies that "each qualifying patient can have no more than 1 primary caregiver, and a primary caregiver may assist no more than 5 qualifying patients with their medical use of marihuana." MCL 333.26426(d). Accordingly, no primary caregiver who wishes to benefit from the protections offered by the

MMMA may assist more than five qualifying patients in acquiring, possessing, cultivating, manufacturing, using, internally possessing, delivering, transferring, or transporting marijuana, presuming that the five qualifying patients in question are connected to that caregiver through the department's registration process.[15] Any assistance that any primary caregiver provides on behalf of any qualifying patient to whom that caregiver is *not* connected by the registration process is not subject to the protections of the MMMA.

Similarly, a primary caregiver may not possess more than "12 marihuana plants kept in an enclosed, locked facility" for each qualifying patient to whom the caregiver is connected through the registration process and who has that patient's permission to cultivate the allotment of marijuana plants. MCL 333.26424(b)(2). MCL 333.26423(c) defines an "enclosed, locked facility" as "a closet, room, or other enclosed area equipped with locks or other security devices that permit access only by a registered primary caregiver or registered qualifying patient." Although it is unclear from the statute whether each grouping of 12 plants must be in a separate enclosed, locked facility,[16] it *is* clear that under no circumstances may a primary caregiver be in

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patient designates him- or herself as his or her own caregiver, then that caregiver is allowed only four additional patients. MCL 333.26426(d).

[15] Many Michiganders are faced with the often unwelcome intrusion of medical-marijuana dispensaries in their communities, and local governments are faced with the difficult task of determining whether they are obliged to allow such dispensaries to operate in their communities. Yet, interestingly, under a proper reading of § 4(b), the operation of a dispensary would make little economic sense, because in order to abide by the provisions of the MMMA, the dispensary would have to be operated entirely by one individual, and could have, at most, five customers. This is because, first, the MMMA has no provision for the sale of marijuana and, second, a primary caregiver is permitted to receive compensation only for the costs associated with assisting a qualifying patient to whom he or she is connected through registration with the DCH.

[16] Anyone growing more than 12 plants in one separate enclosed, locked facility should not complain or be surprised when or if a federal drug enforcement agent appears. Again, under federal law, cultivating marijuana is illegal. Growing large quantities of marijuana in an enclosed, locked facility is the same as waving a red flag in front of a 3,000-pound bull. Any questions in this regard are quickly answered by reading the Gus Burns article in the April 22, 2010, *Saginaw News, Federal agents and sheriff's deputies say seized marijuana in Saginaw County was illegal and not medicine*. <http://www.mlive.com/news/saginaw/index.ssf/2010/04/federal_agents_and_sheriffs_de.html> (accessed September 13, 2010). Caregivers who do not want to become a test case should proceed with caution. No clear, reliable, or lasting resolution to this conflict between state and federal law seems in view.

possession of more than a total of 60 marijuana plants, presuming that the primary caregiver acts in that capacity for the statutory maximum of five qualifying patients, all of whom have given the caregiver the authority to cultivate marijuana for them. Because a qualified patient who has designated a primary caregiver to cultivate marijuana for him or her may not him- or herself have possession of any marijuana plants, the primary caregiver is the only individual permitted to be in possession of the qualifying patient's marijuana plants under this circumstance. Accordingly, this means that each set of 12 plants permitted under the MMMA to address the purported medical needs of a particular qualifying patient must be kept in an enclosed, locked facility that can only be accessed by one individual, either the qualifying patient or the qualifying patient's primary caregiver; any other individual with access to the marijuana plants designated for a particular qualifying patient would be considered in possession of marijuana and subject to arrest and prosecution for violating the Public Health Code.[17]

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[17] It is important to remember that under the laws of this state, "[a] person need not have actual physical possession of a controlled substance to be guilty of possessing it. Possession may be either actual or constructive." *People v Wolfe*, 440 Mich 508, 519-520; 489 NW2d 748 (1992). "Constructive possession exists when the totality of the circumstances indicates a sufficient nexus between the defendant and the controlled substance." *People v Meshell*, 265 Mich App 616, 622; 696 NW2d 754 (2005). The "essential" element is that a defendant has "dominion or right of control over the drug with knowledge of its presence and character." *People v McKinney*, 258 Mich App 157, 165; 670 NW2d 254 (2003) (quotation marks and citation omitted). "Because it is difficult to prove an actor's state of mind, only minimal circumstantial evidence . . . and the reasonable inferences that arise from the evidence" are required to prove that a defendant had constructive possession. *People v Brown*, 279 Mich App 116, 136-137; 755 NW2d 664 (2008). Accordingly, an individual who places himself in the proximity of marijuana is at risk of being charged with possession of the substance.

In light of these rules concerning what constitutes possession, the MMMA places the entire burden of cultivating a particular qualifying patient's marijuana plants on one individual (either the qualifying patient or his or her primary caregiver). No other individual can legally even water the plants or enter the enclosed, locked facility to turn on a grow light without risking arrest and prosecution for violating the Public Health Code. This means that primary caregivers and qualifying patients cannot legally form a cooperative and grow marijuana in a shared facility without violating the MMMA and thus being subject to arrest and prosecution under the Public Health Code.

Presumably the drafters affiliated with the Marijuana Policy Project agree. Diane Byrum, a spokesperson for the proposal indicated that "[t]he Michigan proposal wouldn't permit the type of cooperative growing that allows pot shops to exist in California. Those kinds of operations are what have faced federal crackdowns." Satyanarayana, *Is Marijuana Good Medicine?* Detroit Free Press, October 25, 2008, available at <http://www.freep.com/article/20081025/NEWS15/810250341/Is-marijuana-good-medicine> (accessed September 10, 2010). Accordingly, before the November 2008 vote on this ballot proposal, even the drafters of the MMMA were unequivocal that the statute would not permit marijuana growing cooperatives in Michigan.

Section 4(e) permits a registered primary caregiver to receive compensation for the costs associated with assisting a registered qualifying patient in the medical use of marijuana. MCL 333.26424(e). However, under § 4(b), a registered primary caregiver may assist only a registered qualifying patient to whom he or she is connected through registration with the DCH. MCL 333.26424(b). Accordingly, §§ 4(b) and 4(e) can only be reconciled by concluding that the primary caregiver's "compensation for costs associated with assisting a registered qualifying patient in the medical use of marihuana" will come from only a registered qualifying patient to whom he or she is connected through the department's registration process.[18] MCL 333.26424(e). Because a primary caregiver may assist only the five or fewer qualifying patients to whom the caregiver is connected through the registration process, there is no circumstance under the MMMA in which the primary caregiver can provide assistance to any *other* qualifying patient, and receive compensation in exchange, without being subject to arrest and prosecution under the Public Health Code.[19]

In addition, a primary caregiver may receive compensation for only the *costs* associated with assisting a registered qualifying patient in the medical use of marijuana. *Id*. This simply means that the primary caregiver may receive reimbursement for monetary expenses incurred in the course of assisting the qualifying patient in the medical use of marijuana. The statute does not authorize compensation for the labor involved in cultivating marijuana or for otherwise assisting the qualifying patient in its use, nor does it indicate that the primary caregiver may profit financially from this role.

Section 4(f) protects a physician from arrest for providing written certifications *if* the certifications were provided in the course of a bona fide physician-patient relationship *and* if the

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[18] Stated another way, only the person the qualifying patient names as his or her primary caregiver on the registration form can receive compensation for associated costs, and that compensation can only be received from the "qualifying patient to whom he or she is connected through the department's registration process . . . ." MCL 333.26424(b).

[19] A familiar example may help clarify how the provisions of the MMMA are connected to each other. Michigan has statutory qualifications for persons entering into a state of matrimony. See MCL 551.1 (restricting marriage to couples of opposite gender); MCL 551.3 (disqualifying couples who are of specified, close degrees of familial affinity). There is also a registration requirement in the form of a marriage license. MCL 551.2. Married couples have many statutory rights and duties. See, e.g., MCL 205.93(3)(a) (the right to transfer property and free from use tax); MCL 600.2162 (the right to not testify against a spouse); MCL 552.7 (authorizing actions for separate maintenance). The registration, or licensing, requirement inheres in all statutory references to marriage, and thus there is no need to repeat it with each statutory mention. For example, MCL 206.311(3) authorizes the filing of joint tax returns by "husband and wife," but does not reiterate that this concerns couples licensed to marry each other. To conclude that any married person, qualified and registered under the laws of this state, may file jointly with any other married person, so qualified and registered, would be nonsensical and lead to an absurd result. As the statutory registration, or licensing, requirement carries through all marriage law, so should the registration requirement of the MMMA be understood as carrying through all provisions of that act.

physician first completed a full assessment of the qualifying patient's medical history. MCL 333.26424(f). Unfortunately, the statute does not indicate how the existence of an authentic physician-patient relationship can be discerned. However, a fact-finder might wish to ask certain questions when determining whether the physician-patient relationship was authentic, including (a) whether the physician signing the written certification form was the patient's primary caregiver, (b) whether the patient had an established history of receiving medical care from that physician, (c) whether the physician diagnosed a particular debilitating medical condition instead of simply stating that a patient's reported symptoms must be the result of some such unidentified condition, (d) whether the physician was paid specifically to sign the written certification, and (e) whether the physician has a history of signing an unusually large number of certifications. Needless to say, those doctors hired specifically to sign certification forms are suspect and deserve special scrutiny by prosecutors, the DCH, and the legislative oversight committees of both the House and Senate.[20]

Section 4(f) also indicates that

> [a] physician shall not be subject to arrest . . . for otherwise stating that, in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition . . . ." [MCL 333.26424(f)]

This provision does not create an alternative scenario under which a physician may issue a written certification to a patient in the absence of a bona fide physician-patient relationship with that patient or a full assessment of the patient's medical history. Instead, this provision merely provides a physician with additional protection from legal penalties, or disciplinary action by a professional licensing board if the physician opines in general that an individual might benefit from the medical use of marijuana.

Section 4(i) provides that "[a] person shall not be subject to arrest . . . solely for being in the presence or vicinity of the medical use of marihuana in accordance with this act, or for assisting a registered qualifying patient with using or administering marihuana." MCL 333.26424(i). In a possible attempt at chicanery, the drafters of the act thus slipped into this

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[20] The DCH should keep track of the number of certification forms each doctor signs. If it is determined that certain doctors are collecting money for routinely signing the forms, those doctors should be disqualified from participation in the Michigan medical marihuana program. It is beyond question that one doctor treating 100, 500, or 1,000 terminally ill patients in the course of 10-minute examinations has *not* been acting pursuant to bona fide physician-patient relationships. A revolving-door, rubber-stamp, assembly-line certification process does not constitute activity "in the course of a bona fide physician-patient relationship," especially when the doctor fails to set any medical boundaries for his or her patients and fails to monitor the patient's progress on a regular basis.

subsection the term "*person*," instead of discussing the protections and responsibilities of a "caregiver" or "qualifying patient." Reading § 4(i) in isolation could cause one to conclude that it constitutes a nullification of all provisions in the Public Health Code that punish individuals who come in contact with marijuana. However, when reading § 4(i) in context, it is clear that it is not, and is not intended to function as, a permission slip to manufacture or sell marijuana in Michigan. First, because the MMMA does not grant *rights* to anyone, the use of the word "person" instead of the more specific terms "qualifying patient" and "primary caregiver" does not constitute an expansion of any rights. Instead, although a "person" may not be subject to arrest under § 4(i) for "assisting a registered qualifying patient with using or administering marihuana," it is clear that this protection does not extend to assisting a registered qualifying patient in the *medical use* of marijuana as defined by MCL 333.26423(e). Instead, this protection from arrest only extends to providing assistance in "using or administering" marijuana, which is much more limited. Such assistance would be in the nature of holding or rolling a marijuana cigarette, filling a pipe, or preparing marijuana-laced brownies for the qualifying patient suffering from a terminal illness or a debilitating condition. Section 4(i) does not protect persons generally from arrest for acquiring, possessing, cultivating, manufacturing, delivering, transferring, or transporting marijuana on behalf of the qualifying patient.

Finally, § 4(k) imposes a penalty on those registered qualifying patients or registered primary caregivers who sell marijuana to "someone who is not allowed to use marihuana for medical purposes under this act . . . ." MCL 333.26424(k). The penalty is severe: a violator faces up to two years in prison or a fine of up to $2,000, or both. However, that this subsection specifies a particular punishment for a specific type of violation does not mean that, by default, the sale of marijuana to someone who *is* allowed to use marijuana for medical purposes under this act is permitted. The MMMA does *not* give any individual permission to sell marijuana in the state of Michigan for any purpose. Instead, the MMMA merely identifies circumstances under which qualifying patients and primary caregivers are protected from arrest and prosecution for the "medical use" of marijuana. If the drafters of this statute had wanted to legalize the sale of marijuana to qualifying patients from primary caregivers or other qualifying patients, they would have included the term "sale" in the definition of "medical use." MCL 333.26423(e). They did not and, therefore, the sale of marijuana is not a permitted activity under § 4.[21] Stated differently, the MMMA does not legalize the sale of marijuana to any individual, even one registered as a qualifying patient.[22]

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[21] As explained earlier, § 4(e) permits a primary caregiver to receive compensation for the *costs* associated with assisting a registered qualifying patient to whom he or she is connected through the DCH's registration process. Again, this means that the primary caregiver may receive reimbursement for monies paid in the course of assisting the qualifying patient in the medical use of marijuana, but may not receive compensation or otherwise profit from the labor involved in cultivating marijuana or otherwise assisting the qualifying patient in its medical use.

[22] Accordingly, I can find no circumstance under which the MMMA *legalizes* the sale of marijuana by medical-marijuana dispensaries. The statute simply does not permit that activity.

Section 7 of the act is very specific about use of marijuana for medical purposes. It provides as follows:

> (a) The medical use of marihuana is allowed under state law to the extent that it is carried out in accordance with the provisions of this act.
>
> (b) This act shall not permit any person to do any of the following:
>
> (1) Undertake any task under the influence of marihuana, when doing so would constitute negligence or professional malpractice.
>
> (2) Possess marihuana, or otherwise engage in the medical use of marihuana:
>
> (A) in a school bus;
>
> (B) on the grounds of any preschool or primary or secondary school; or
>
> (C) in any correctional facility.
>
> (3) Smoke marihuana:
>
> (A) on any form of public transportation; or
>
> (B) in any public place.
>
> (4) Operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marihuana.
>
> (5) Use marihuana if that person does not have a serious or debilitating medical condition.
>
> (c) Nothing in this act shall be construed to require:
>
> (1) A government medical assistance program or commercial or non-profit health insurer to reimburse a person for costs associated with the medical use of marihuana.
>
> (2) An employer to accommodate the ingestion of marihuana in any workplace or any employee working while under the influence of marihuana.
>
> (d) Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marihuana to avoid arrest or prosecution shall be punishable by a fine of $500.00, which shall be in addition to any other penalties that may apply for making a false statement or for the use of marihuana other than use undertaken pursuant to this act.
>
> (e) All other acts and parts of acts inconsistent with this act do not apply to the medical use of marihuana as provided for by this act. [MCL 333.26427.]

When interpreting § 7, it is important to remember that an individual acquires protection from arrest and prosecution under this act only if suffering from serious or debilitating medical condition. A person without such a condition, as defined by the act and diagnosed by a physician, is prohibited from using marijuana and remains subject to the penalties set forth in the Public Health Code. Section 7(b)(5) acts as an affirmative defense to a prosecution under the Public Health Code, meaning that the defendant has the responsibility of establishing that he or she was suffering from a serious or debilitating medical condition as a prerequisite to establishing a medical-marijuana defense. Once the defendant has presented sufficient evidence to establish the existence of a sufficiently serious medical condition, the prosecution may seek to rebut it, including by cross-examination of the defendant's physician regarding whether the defendant had a serious or debilitating medical condition. Of course, the prosecution may also call medical expert witnesses to rebut the defendant's evidence.

A defendant asserting the medical-marijuana defense bears the burden of establishing the existence of a qualifying medical condition; a mere assertion is not sufficient.[23] Further, it logically follows that a defendant resorting to that defense by placing into evidence his or her medical condition necessarily waives any physician-patient privilege that would otherwise limit a prosecutor's prerogative to question the defendant's physician or examine pertinent medical records.

In the present case, both defendants contend that they are entitled to assert an affirmative defense under § 8 of the MMMA. Section 8 addresses affirmative defenses for patients and caregivers under the act. It reads as follows:

> (a) Except as provided in section 7, a patient and a patient's primary caregiver, if any, may assert the medical purpose for using marihuana as a defense to any prosecution involving marihuana, and this defense shall be presumed valid where the evidence shows that:
>
> (1) A physician has stated that, in the physician's professional opinion, after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms of the patient's serious or debilitating medical condition;

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[23] Although most qualifying patients and primary caregivers apparently believe that they are immune from arrest or prosecution if they possess registry identification cards, the MMMA makes no such provision. Instead, the act leaves a qualifying patient or primary caregiver subject to criminal proceedings for any conduct not for the purposes of alleviating the qualifying patient's debilitating medical condition or its symptoms. MCL 333.26424(a) and (b); MCL 333.26427(b)(5). In my opinion, all certification forms should include a warning that, even though the patient has a registry identification card, the patient could still be prosecuted for conduct that is not in strict accordance with the provisions of the MMMA.

(2) The patient and the patient's primary caregiver, if any, were collectively in possession of a quantity of marihuana that was not more than was reasonably necessary to ensure the uninterrupted availability of marihuana for the purpose of treating or alleviating the patient's serious or debilitating medical condition or symptoms of the patient's serious or debilitating medical condition; and

(3) The patient and the patient's primary caregiver, if any, were engaged in the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of marihuana or paraphernalia relating to the use of marihuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms of the patient's serious or debilitating medical condition.

(b) A person may assert the medical purpose for using marihuana in a motion to dismiss, and the charges shall be dismissed following an evidentiary hearing where the person shows the elements listed in subsection (a).

(c) If a patient or a patient's primary caregiver demonstrates the patient's medical purpose for using marihuana pursuant to this section, the patient and the patient's primary caregiver shall not be subject to the following for the patient's medical use of marihuana:

(1) disciplinary action by a business or occupational or professional licensing board or bureau; or

(2) forfeiture of any interest in or right to property. [MCL 333.26428.]

In this section, the act speaks for the first time in terms of a patient instead of a qualifying patient. The purpose of § 8 is to establish an affirmative defense for those marijuana users and growers who are not registered with the state. Read out of context and with a limitless imagination, one could conclude that qualifying patients, patient caregivers, physicians, or persons in general may not be arrested or prosecuted for any actions involving marijuana, i.e., the act in essence legalizes marijuana in Michigan. But, as I have previously stated, the language of the ballot proposal and a contextual reading of the act belie this premise.

In order for defendants to assert an affirmative defense under § 8(a)(1), they must first establish that Dr. Eric Eisenbud, the physician who signed their medical-marijuana authorizations, treated them *in the course of a bona fide physician-patient relationship*, and they must further establish under § 7(b)(5) that they have a *serious or debilitating condition*. Both defendants have failed to establish either prerequisite to asserting a § 8 affirmative defense.

At issue is the phrase, "in the course of a bona fide physician-patient relationship." This phrase has three components: *physician-patient relationship*, *bona fide*, and *in the course of*. When construing a statute, a court should presume that every word has some meaning; a construction rendering some part nugatory or surplusage should be avoided. *People v Seiders*, 262 Mich App 702, 705; 686 NW2d 821 (2004). "Physician-patient relationship" clearly means that a patient must have the traditional doctor-patient relationship. Use of the qualifier "bona fide" indicates that the drafters of this act were concerned about such doctors as the one in

Livingston County described in part IV of this opinion who routinely sell written certifications for profit, rather than provide them for any genuine medical reason. Any such doctor is not engaging in the good-faith practice of medicine, and any such certifications must be disallowed under this act.[24] "In the course of" clearly means that the bona fide relationship has been in existence beyond just one occasion. An individual who visits a doctor for the first time for the sole purpose of obtaining certification for the medical use of marijuana, especially after an arrest on drug charges, does not satisfy the requirement that the certification come about *in the course of a bona fide physician-patient relationship*. Conversely, a primary-care physician who has long been treating a patient suffering from a terminal illness or a serious or debilitating condition is certainly acting *in the course of a bona fide physician-patient relationship*.

Certain protocols must be adhered to, or elements met, before a bona fide physician-patient relationship can be established. Among these are the following: the physician must create and maintain medical records; the physician must have a complete understanding of the patient's medical history; specific medical issues must be identified and plans developed to address each; treatment must be conducted in a professional setting; the physician must, when appropriate, set boundaries for the patient; and the physician must monitor the patient's progress. Important for the treatment of most medical conditions, especially those involving chronic pain, is continuity of treatment. Some chronic-pain patients with serious or debilitating conditions need constant monitoring for their own safety. I note that, in the present case, while some of these protocols or elements were present in Dr. Eisenbud's treatment of defendants, others were lacking in both substance and process.

In order to have a bona fide physician-patient relationship, a legal duty must be established between the physician and his or her patient. If no duty arises from the relationship, then no legally recognizable physician-patient relationship exists. Only once a physician-patient relationship is established and a treatment plan is instituted may a physician be held liable for malpractice under Michigan law. However, by insulating a physician from "prosecution, or penalty in any manner," including "civil penalty" in connection with that physician's certification of a patient for the medical use of marijuana, § 4(f) leaves a physician so acting unaccountable in the matter to society and to his or her patient. MCL 333.26424(f). It is problematic to classify as bona fide a physician-patient relationship when the physician has no enforceable duties to the patient. In my opinion, because physicians such as Dr. Eisenbud, in the course of approving written certifications for the medical use of marijuana, do not establish a

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[24] Some seek marijuana for treatment of depression and anxiety disorders. At the very least, the progress of such treatments should be carefully monitored by a doctor. But the MMMA appears to discard the concept of any monitoring within the "bona fide" physician-patient relationship. If monitoring of patients is not taking place, how can the physician-patient relationship be a bona fide one? Should the medical profession step forward on this issue? I note that the medical profession generally opposed the MMMA because, as one official put it, "'it's not in the public health interest to see people smoke.'" Satyanarayana, n 17 *supra*, quoting Donald Allen, director of the Office of Drug Control and Policy.

legally binding physician-patient relationship in the matter, such relationships, in the eyes of the law, are not bona fide.

In this regard, the Catch-22 for patients is found in §§ 4(f) and 8(a). Section 4(f) provides that "a physician shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty . . . ." MCL 333.26424(f). But § 8(a) of the act states that a patient can assert a medical-marijuana defense if *in the course of a bona fide physician-patient relationship* the physician makes certain statements and authorizes the patient to use marijuana. MCL 333.264248(a). It would be unusual, if not outright peculiar, for the law to recognize a physician-patient relationship if no potential liability attached to the actions of the treating physician. Because one part of the MMMA provides that no civil liability, and thus no potential malpractice liability, attaches to physicians who authorize the medical use of marijuana, while another part of the act states that a physician must have a bona fide physician-patient relationship to assert the affirmative medical-marijuana defense, the act presents a seemingly irreconcilable internal conflict.

Adding to the confusion in this case is that, according to the record, *all* of Dr. Eisenbud's patients visited him for a single treatment plan and for no other purpose. In each instance then, the patient is not only directing the treatment plan, but setting his or her own boundaries and monitoring his or her own progress. It strains credibility to suggest that a treatment plan has already been established before the doctor has examined the patient. The confusion is resolved by simply concluding that a one-stop shopping event to obtain a permission slip to use marijuana under § 8 does not meet the requirement of § 8(a)(1) that the authorization occur in the course of a bona fide physician-patient relationship. Stated another way, a § 8 affirmative defense is not available unless the testifying physician is the patient's treating physician for the underlying serious or debilitating condition. Dr. Eisenbud was not either defendant's treating physician, and therefore the § 8 affirmative defense was not available to them.

In an attempt to explain and help this Court interpret the protections contained in the MMMA, Karen O'Keefe, who was identified in part II of this opinion as director of state policies at the MPP in Washington, D.C., filed an affidavit in this case. In the affidavit, Ms. O'Keefe stated, in paragraph 4, that she was the "principal drafter of Michigan's medical marijuana ballot initiative." In paragraph 7 she stated, "We intended for both Michigan law and MPP's model legislation to include two levels of protection," i.e., defenses, with § 4 providing the greater level of protection and § 8 a lesser level of protection. While that affidavit might assist this Court in separating those two types of protection, it does not address any protections under either § 4 or § 8 concerning the sale of marijuana in Michigan. What it does accomplish is to confirm that the MMMA was intended to provide defenses from arrest and prosecution for the use of small amounts of marijuana for medical purposes. But neither the affidavit nor the act itself asserts that the MMMA provides any protections for the sale of marijuana in Michigan. To have authorized the sale of marijuana in Michigan, the MMMA would have had to specifically make such provision. It did not. I further note that the language of the ballot proposal did not mention

that the sale of marijuana was included in the act. It is therefore clear that neither § 4 nor § 8 of the MMMA affords any protections for the sale of marijuana in Michigan.[25]

IV. WHAT MUST BE INCLUDED IN THE WRITTEN CERTIFICATION AND HOW DOES ONE OBTAIN A WRITTEN CERTIFICATION FROM A QUALIFIED PHYSICIAN?

Through no fault on the part of legitimate patients and caregivers who are taking pains in good faith to comply with the law and conduct themselves accordingly, the current written certification process reflects badly on them. The process also reflects badly on legitimate physicians who honestly believe that marijuana would assist their patients.

Section 3(*l*) of the MMMA defines "written certification" as

> a document signed by a physician, stating the patient's debilitating medical condition and stating that, in the physician's professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. [MCL 333.26424(*l*).]

In the present case, defendants' written certification forms fail to set forth their respective debilitating medical conditions and therefore are invalid on their faces. I further regard the process used to obtain the written certification under the current administrative rules as suspect and opine that § 3(*l*) is clearly the most abused section in the MMMA.[26]

I do not direct my critical comments toward those qualifying patients who do in fact have a serious debilitating condition and seek some therapeutic or palliative solace in marijuana. This act was intended to help those individuals. My comments are directed at those who are currently abusing the written certification process, i.e., the majority of the persons who are becoming

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[25] The MMMA contains a number of Catch-22 situations for the unsuspecting. The act allows someone who is properly registered to possess marijuana, but anyone receiving compensation for the marijuana from someone other than the registrant's primary caregiver may be prosecuted. The act also allows caregivers and patients to grow marijuana, but then provides that this must be done in an enclosed, locked facility. Anyone growing marijuana in his or her backyard can thus be prosecuted under the Public Health Code. Another peculiarity is that patients or their caregivers may grow marijuana, but there is no provision for the legal purchase of marijuana seeds or plants in the first instance. The act also includes no caregiver-reporting requirement, which raises the questions, How much may a caregiver charge his or her qualifying patient and how does a caregiver report the income on tax returns? Another oddity is that the act allows a patient or primary caregiver to possess 2.5 ounces of marijuana and 12 plants. MCL 333.26424(a) and (b). What is the legal consequence if the plants are all harvested at the same time and they happen to produce more than 2.5 ounces?

[26] I reiterate that, even with a registry identification card, a qualifying patient can be prosecuted for uses of marijuana exceeding the scope of the statutory defenses. See MCL 333.26424(d)(2).

certified at this time. My comments are also directed at those who are charged with the oversight of the administrative process.

At oral argument, it was revealed that a certain Livingston County doctor was selling written certifications for $50. Apparently all one had to do to obtain a written certification to use marijuana was to show up at this doctor's house and slip $50 under the door. This history of the written certification process may in fact jeopardize the entire medical-marijuana process for those who are legitimately entitled to use it. New checks and balances on this process are certainly necessary to resolve this problem.[27]

I will set forth the histories of the MMMA and its written certification process in parts V and VI of this opinion and leave readers to form their own opinions whether the written certification process is serving its legitimate purpose or is being abused. It is within the province of our legislative and executive officials to retain or change that process. But I reiterate that in the present case both defendants' written certifications[28] did not comply with the statute and were therefore invalid *ab initio*.[29] The balance of this opinion will address issues concerning the

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[27] There currently exist no checks and balances on physicians signing the written certification forms. A simple revision of the form that requires a doctor under penalty of perjury to attest that each patient has a serious or debilitating condition and name that condition might clean up the process. Doctors who are indiscriminately selling written certifications could then be penalized by the courts for issuing false certificates. This would work an important reform, given that § 4(f) appears to immunize even physicians who intentionally sign false certifications. Limiting the number of certifications one doctor may sign might further deter fraudulent certifications.

[28] In the present case, Dr. Eisenbud testified that he met with each defendant for about a half-hour, spending 5 minutes reviewing the medical records and about 10 minutes on the physical examination, while also interviewing them. On those bases, Dr. Eisenbud then certified that he was treating both defendants "for a terminal illness or a debilitating condition." Such foolishness is so obvious on its face as to deserve no more than a footnote in this opinion to expose it, although I note that even Dr. Eisenbud's certifications appear to be more credible than the Livingston County doctor described in the previous paragraph.

[29] The certification forms at issue here stated:

> I, Eric Eisenbud, MD, am a physician, duly licensed in the State of Michigan. I have completed a full assessment of this patient's medical history, and I am treating this patient for a terminal illness or a debilitating condition as defined in Michigan's medical marijuana law. I completed a full assessment of this patient's current medical condition. This assessment was made in the course of a bona fide physician-patient relationship. I have advised the patient about the potential risks and benefits of the medical use of marijuana. I have formed my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh any health risks for the patient. This patient is LIKELY to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate a serious or debilitating medical condition or symptoms of the serious or debilitating medical condition.

written certification process, which the Legislature or the DCH are free to change if persuaded that a problem exists.

V. THE HISTORY OF THE MMMA

The MMMA has a noble purpose, i.e., providing an avenue for improving the health or comfort of those afflicted with a serious or debilitating medical condition.[30] One supposes that most citizens voting for the MMMA envisioned that those individuals suffering from such conditions would visit their regular doctors, obtain prescriptions for marijuana, and then have the prescription filled at a licensed pharmacy. Citizens would rightly expect such a process because the drug-delivery system in Michigan has always dispensed drugs in this manner.[31]

The DCH is the agency charged with regulating this new industry. Under the act, the DCH was required to draft within 120 days administrative rules to implement the act. MCL 333.26425(a). The Governor oversees administrative agencies such as the DCH, and the Legislature also plays a role, maintaining checks and balances to ensure that administrative agencies function properly. Under the normal process, those elected or appointed officials would maintain sufficient control of the process to assure that a schedule 1 drug would not be sold, distributed, or otherwise transferred to the public without a legitimate process in place to regulate the use, sale, and delivery of that drug.

Further, in legitimate medical practice, doctors would observe their ethical duties to sign their names to written certification forms only if their patients were actually suffering from terminal illnesses or serious or debilitating medical conditions, as the act specifies.[32] No ethical

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I note that Dr. Eisenbud attempted to specify neither what the ailment was, nor whether it constituted a terminal illness or a debilitating condition.

[30] Some assert that marijuana is not a bad thing, especially in light of current research, and that those thinking otherwise are illogical prudes. Then there is the view of the National Institute on Drug Abuse, which maintains that marijuana smoke contains 50 to 70 percent more carcinogenic hydrocarbons than tobacco smoke. *NIDA InfoFacts: Marijuana* <http://www.nida.nih.gov/infofacts/marijuana.html> (accessed September 10, 2010). The Partnership for a Drug Free America similarly reports that "[s]tudies show that someone who smokes five joints per week may be taking in as many cancer-causing chemicals as someone who smokes a full pack of cigarettes every day." *Drug Guide* <http://www.drugfree.org/portal/drug_guide/marijuana> (accessed September 10, 2010). While each of these views is legitimate, for the purposes of this opinion I am not concerned with which view the law should reflect. This Court's job is to interpret statutes as they are written. Public policy is determined by the other branches of government.

[31] A question that arises is, Why is there the need for a specialized medical-marijuana business, instead of dispensing through pharmacies as is the case of other legal prescription drugs, if the marijuana is for medical purposes? The answer, in many cases, is that the medical purpose is mere pretext.

[32] In proper medical practice, when a doctor prescribes a drug, that doctor carefully monitors the patient to see if the drug is working, if there are side effects, etc. Shouldn't doctors similarly monitor their patients' use of marijuana, including determining and prescribing proper dosages, monitoring side effects, etc.? Does giving the okay for a marijuana card create an ongoing

doctor would advertise for sale to unqualified patients his or her signature on those forms. Doctors with the personal integrity demanded of that profession would not examine a patient for just several minutes, opine from that short examination that the patient has a terminal illness or a serious or debilitating condition, and then certify that the patient would benefit from the use of a schedule 1 drug. Or would they? Given that these practices have become widespread in Michigan, either I, or the doctors engaging in that practice, should review the question of what integrity and ethics in the medical profession entail.

The ballot proposal was not intended to legalize marijuana in the state of Michigan. It was intended to protect "from arrest the vast majority of seriously ill people who have a medical need to use marihuana." MCL 333.26422(b). It was not intended to protect those individuals who are fraudulently obtaining written certifications.

VI. THE HISTORY OF THE WRITTEN CERTIFICATION PROCESS

Shortly after the MMMA was passed, advertisements began appearing in the print media. These notices advertised that, for a price, one could visit the marijuana doctor and get certified for the use of marijuana. One such ad in the *Petoskey News Review*, June 22, 2010, p A2, reads as follows:

Soon thereafter, a billboard appeared on I-75 advertising that, with a phone call, one could be certified for the medical use of marijuana in Michigan. Radio spots then began to advertise that the marijuana doctor would be in Saginaw on Monday, in Bay City on Tuesday, and Midland on Wednesday. With a quick visit to the doctor one could become certified to use, grow, and possibly sell marijuana.

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physician-patient relationship and obligate the physician to keep abreast of the situation? Under the MMMA and the current rules, however, doctors are not required to set boundaries for their patients or to inquire into the effectiveness or adverse side effects of the marijuana use. In reality, what have resulted are faux physician-patient relationships.

In California, where a similar law has been on the books for a few years, these doctors have taken the process one step further. They have actually set up tents on the beaches and posted signs in front of them advertising easy access to medical-marijuana certification:

College students typically patrol in front of the tents and on the beach, encouraging all passersby to enter the tent and get certified for using marijuana. Doctors in California are now advertising that they will refund the certification fee to anyone for whom they cannot find a marijuana-worthy medical ailment.[33]

The Hemp and Cannabis Foundation advertises on its website that the organization has offices in Detroit/Southfield, Grand Rapids, Kalamazoo, Flint, Saginaw, Marquette, Traverse City, and Lansing and lists six doctors, none of whom resides in Michigan and only one of whom, the aforementioned Dr. Eisenbud, is licensed to practice in this state. <http://www.thc-foundation.org/> (accessed September 10, 2010).

The Michigan Medical Marijuana Certification Center advertises electronic filing on its website, providing a form that can be filled out online to start the certification process. <http://www.mmmcc.net/locations/> (accessed September 10, 2010). One can even electronically file one's signature on the form.

According to the DCH, it had issued 27,755 patient registrations as of September 3, 2010, and has been struggling to manage the rate of applications coming in. Michigan Medical

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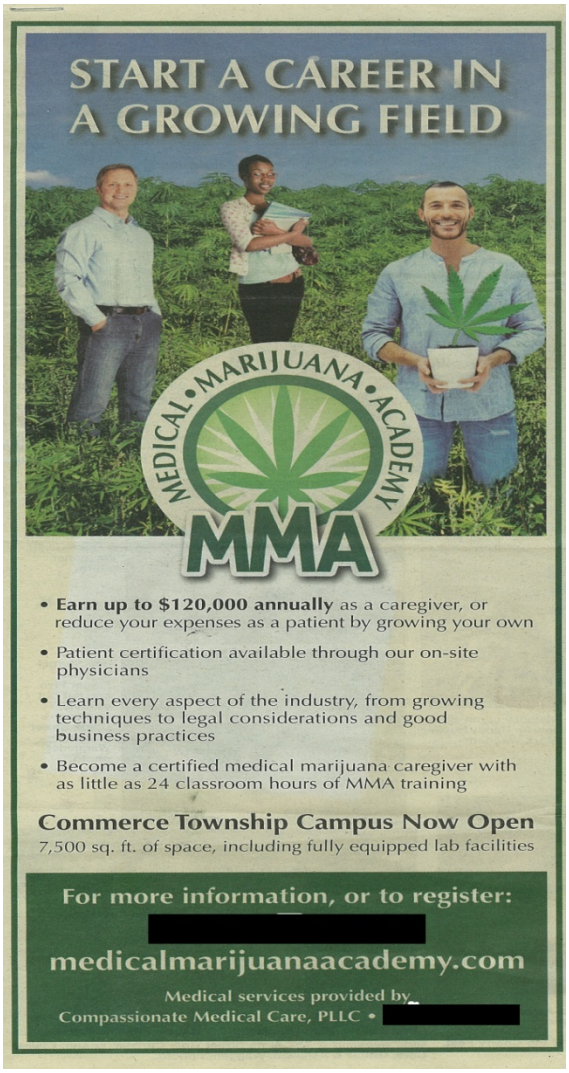
[33] The sale of written certifications has become a very profitable industry in California, as I fear it will soon become here in Michigan. See Mortensen, *California and Uncle Sam's tug-of-war over Mary Jane is really harshing the mellow*, 30 J Nat'l Ass'n Admin L Judiciary 126, 151 (2010) (identifying an "enormous administrative and regulatory void" in connection with medical use of marijuana in California, reporting that it is being filled primarily by "free market principles and by the discretion of marijuana-friendly California doctors who have made a healthy profit off of medical 'recommendations,'" and opining that such "void-fillers do not have the health, safety, and welfare of Californians in mind").

Marihuana Program <http://www.michigan.gov/mdch/0,1607,7-132-27417_51869-202669--,00.html> (accessed September 10, 2010).

Because of the backlog of applications, House Bill 5902, introduced by Representative George Cushingberry and reported out of the House Committee on Appropriations, proposes to privatize the issuance of registry identification cards to the public. That legislation would require the DCH to contract with a third party to take over the issuance of medical-marijuana registry cards. In essence, this bill proposes to turn over regulation to the persons regulated—an arrangement that, under normal circumstances, would be deemed highly suspect.

Even advertisements for new careers are beginning to appear in the newspapers. One such advertisement appeared in the July 19, 2010, *Northern Express Weekly*:



That someone is spending money to run such an ad well proves that confusion runs rampant concerning what is, and is not, subject to prosecution under the MMMA.

Unfortunately, the administrative rules associated with the MMMA do not provide for any checks and balances on the accuracy of the medical certifications signed by these doctors.

At 1,000 new registry applicants a week,[34] Michigan will soon have more registered marijuana users than unemployed individuals—an incredible legacy for the Great Lakes State. And soon we will even have graduates from the Medical Marijuana Academy.

What has been lost in the rush to implement the MMMA is a comprehensive set of administrative rules. Under MCL 333.26425(a), the DCH only had 120 days to draft the administrative rules that are currently in effect.[35] As demonstrated by the rules that did come into being, this was a totally unreasonable time limit for such a task.[36]

No system of regulation can succeed without a clear set of rules. Those wishing to use marijuana need to know when, how, and under what conditions they can legally do so. Providers need to know under what conditions they can legally grow, harvest, and distribute their product, and the operators of the new medical-marijuana clinics that appear to be springing up on every corner need to know if they are in fact set up to dispense marijuana to the public legally. Until today, the DCH, the Legislature, and the appellate courts have answered very few of these questions. Pressure and confusion results from trying to operate under a system in which no one has stepped forward and stated specifically what actions are legal and what actions are not. It appears that most elected officials, including my colleagues, understand the political nature of this controversy and simply choose to address the MMMA only to the extent that a particular occasion requires. I, on the other hand, right or wrong, prefer giving some notice to those concerned *before* they are deprived of their liberty and property.[37]

What is clear from reading the lower court record in this case is that no one has set out a comprehensive plan to implement the new MMMA. The job of setting public policy should not be handed to the courts as a consequence of the inaction of legislative or administrative officials. Those elected and appointed officials can choose to remain silent and allow the courts to interpret this act piecemeal or on a case-by-case basis. Or the statute can be revised, or the pertinent administrative rules revised, to provide a clear direction to all citizens, including the judges of the courts, who are affected by this act.

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[34] See Yung, *Even in a poor economy, the pot industry grows*, Detroit Free Press, June 21, 2010, p 4A.

[35] Mich Admin Code, R 333.101 *et seq*.

[36] The current administrative rules include no reporting requirements, no log-keeping requirements, and no directions for school officials or law enforcement officers on how to regulate the new medical-marijuana industry. The DCH should continue the rule-making process, taking pains to hear from all interested parties. At oral argument, the attorneys for both sides expressed their approval of a negotiated rule-making process. The goal would be to set boundaries for all activities and persons associated with the MMMA.

[37] I am reminded of Shakespeare's sentiments, "Yet the first bringer of unwelcome news / Hath but a losing office," (*The Second Part of King Henry the Fourth*, act 1, sc 1), and "Come hither, sir. / Though it be honest, it is never good / To bring bad news," (*Antony and Cleopatra*, act 2, sc 5), and a more modern equivalent: Please don't shoot the messenger.

VII. CONCLUSION

To quote from Sir Walter Scott's 1808 poem, *Marmion*, canto 6, st. 17, "O, what a tangled web we weave, / When first we practise to deceive!" Of central importance to this appeal is the question, Is the MMMA a subterfuge for legalizing marijuana in this state, or is it a legitimate medical reform intended to help only those individuals who have a terminal illness or a serious or debilitating medical condition?

The answer is simple. For those who instituted the process of placing the proposal on the ballot, the MMMA was both an avenue for allowing society to explore the medical uses of marijuana and a first step in legalizing marijuana in Michigan. For some citizens who voted for the initiative petition out of empathy for the terminally ill or those suffering from debilitating conditions, it was a vote for a medical process that would help those in need. Unfortunately for all concerned with the implementation of the medical mission, including compassionate-care groups, marijuana growers, marijuana users, marijuana dispensers, the police, prosecutors, municipalities, townships, etc., the act has resulted in much confusion. And it has suggested itself to many purely recreational marijuana consumers as a vehicle to aid in their continuing illicit indulgence in that vice.

In any event, the MMMA is currently the law in Michigan. To the extent possible, it must be administered in a manner that protects the rights of all our citizens. When prosecutors and defense attorneys agree that the law is hazy and unclear and poses hazards to all concerned because it does not with sufficient clarity identify what conduct is subject to prosecution, it is time for action from our legislative and executive officials. While the MMMA may be controversial and polarizing, politics should be set aside in the interest of the rule of law in our state.[38]

With the MMMA, two roads have diverged in the forest:[39] one leads to refining and distilling the administrative rules and other law associated with the act, and the other leads to the regulators and regulated alike being totally confused concerning how to give effect to the act. The former leads to the orderly implementation of the MMMA, while the latter leads to disrespect for the law and possibly contempt for the rule of the law itself.[40] Our legislative and administrative officials must make a choice: they can either clarify the law with legislative

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[38] I note that Senators Roger Kahn, Wayne Kuipers, and Gerald Van Woerkom have introduced bills that might resolve some of the issues raised in this opinion. See SB 616, SB 617, and SB 618.

[39] This line is adapted from the beginning of Robert Frost's poem, *The Road Not Taken* ("Two roads diverged in a yellow wood . . . .").

[40] An example of confusion at best, or disrespect for the law at worst, is that there is a marijuana shop in Lansing that is less than 100 feet from a school. Clearly, this shop is in violation of the federal Safe and Drug-Free Schools and Communities Act, 20 USC 7101 *et seq.*

refinements and a comprehensive set of administrative rules, or they can do nothing. In this situation, not deciding is, in fact, a decision to do nothing.[41]

/s/ Peter D. O'Connell

[41] I recall an old cartoon that depicted a king in his palace, with his subjects outside rioting, pillaging, and otherwise destroying the kingdom. The king asks, "Why are they rioting, I didn't do anything?" His wisest advisor responds, "Maybe that is the problem."