Dying to Get High

Marijuana as Medicine

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Introduction

Wendy Chapkis

People always want to know whether I've actually done the things I write about. It was a popular question when I was writing about prostitution[1] and is undiminished now that I'm doing research on drugs. I've considered taking the path laid out by Dr. Charles Grob, a physician and longtime researcher on the medical applications of psychoactive drugs, and defer an answer; Grob observes, "I'm damned if I have [tried drugs] and I'm damned if I haven't. If I have, then my perspective would be discounted due to my own personal bias, and if I haven't, it would be discounted because I would not truly understand the full range of experience the drug can induce."[2]

But the idea that direct experience—or the lack of it—is the most salient divide between good research and bad seems misguided to me. The fact that I wasn't a prostitute when I decided to write about prostitution didn't really undermine my ability to think critically about the practice and its meanings. Neither can it be said that my familiarity with marijuana, as a recreational and as a medicinal drug, certifies my understanding of cannabis prohibition and consumption. In both my research on prostitution and my research on the medical uses of marijuana, direct experience isn't what separates my work from that of other social scientists. Instead, if there is a distinguishing quality, I would say that it lies in a clear sense that my work is explicitly value laden rather than value neutral.

I didn't approach this study as a dispassionate observer. I came to the subject of the medical use of marijuana already suspicious of the War on Drugs. I entered the research field also believing that doctors should have the right to recommend nonaddictive and nontoxic herbs to their patients in an effort to relieve suffering; I also believe that patients should have the right to obtain and use those substances. These values underlie my work and color my account.

My understanding of medical marijuana as a social issue relies heavily on the research strategy of participant observation, an approach that inevitably, and often usefully, troubles the line dividing researcher and researched. But even before I began my formal research, my web of connection to this issue was unquestionably sticky. While my formal research on cannabis and, specifically, on the California-based organization the Wo/Men's Alliance for Medical Marijuana (WAMM), didn't begin until the late 1990s, my relationship to some of the key players well predates that. From the mid-1980s, I shared a social and political community in Santa Cruz, California, with several people who would become members of WAMM, including the two cofounders of the organization, Valerie Leveroni Corral (a medical marijuana patient) and Michael Corral (a master gardener). In the years prior to the founding of WAMM, I participated in an informal support network for the Corrals as they twice faced arrest for growing a small quantity of marijuana that Valerie (and her physician) believed useful in controlling her epileptic seizures. A few years later, I supported their efforts to rewrite local and state laws to enable patients in California to legally use marijuana as medicine, efforts that culminated in 1996 in the passage of Proposition 215, the California "Compassionate Use Act." And I watched them take that victory and use it not simply to increase their personal protection against future arrest, but instead as a platform for organizing a unique nonprofit patient/caregiver medical marijuana cooperative to assist seriously and terminally ill people in collectively growing their own medicine. In 2001 I gained additional access to the organization when my partner, Gabriel, became employed for a year as WAMM's human resource coordinator.

Despite—or perhaps because of—the exceptional access I had to the organization, the two cofounders, and the 250 medical marijuana patients in WAMM, I resisted formally studying and writing about medical marijuana for many years. My scholarship has been primarily in the area of gender and sexuality, but increasingly I found myself clipping news items on the War on Drugs and reading with interest the political, legal, and scientific arguments surrounding the medicinal use of marijuana. I began to see numerous connections between state responses to prostitution (my most recent area of study) and antidrug discourse. In the criminalization of both drugs and sex, the state claims for itself the right to police consensual adult behaviors and punish willing participants. This is justified by emphasizing possible harms to the "general public" and to the participants themselves. I was also struck by the fact that the United States

has become increasingly isolated among advanced industrial democratic nations in its insistence that prostitution and drug use are "vice crimes" that must be prohibited, rather than public health matters that might be regulated.

The question of federal drug prohibition became even more compelling as I became more familiar with the lives of WAMM members. Especially in the immediate aftermath of the 9/11 attacks in 2001, it was tremendously reassuring to be in the company of people looking death in the face with great courage and dignity. In a context of terror and enforced obedience, the medical marijuana patients within WAMM became unexpected mentors for me. The great majority of WAMM members live with serious and life-threatening illnesses; anxiety and uncertainty are their constant companions. Yet, despite these already-significant challenges, and in full knowledge of ever-increasing federal politics of surveillance, harassment, and detention, WAMM members chose to openly defy one of the most powerful governments on Earth.

Almost exactly one year after the September 11 attacks, WAMM members were confronted with the consequences of being designated enemy combatants in the War on Drugs: on September 5, 2002, Drug Enforcement Administration (DEA) agents staged an early morning raid on the organization, arresting the cofounders and seizing the collective's entire crop of marijuana. The membership was effectively terrorized, but the organization survived. In fact, WAMM went on the offensive, successfully suing the federal government. Studying this group and working alongside these individuals has helped me to better survive the first few years of twenty-first-century America.

After I made the decision to formally study medical marijuana, I discovered several additional points of connection to the subject. One of the most startling was an unanticipated family tie to the debates over federal prohibition on the medicinal use of marijuana. In 2003 I attended a fiftieth wedding anniversary party for my parents where I encountered relatives I hadn't seen in years. During an exchange of small talk, my Aunt Bern and Uncle Harry asked me what I had been up to over the past few years. At the mention of medical marijuana, my uncle turned and walked away. My extended family has never failed to greet with curiosity and apparent enthusiasm the eccentricities of my research and my life, so his response surprised me. It was only several months later that I discovered that his reaction was due to a need for professional, not personal, distance. While I always think of Uncle Harry as simply a slightly distant and unusually

fierce family member, he is also a federal judge. A few months after our awkward exchange at my parents' party, Harry Pregerson of the Ninth Circuit Court of Appeals, authored the opinion in the historic medical marijuana case of "Raich v. Ashcroft."[3]

My contributions to this book, then, clearly reflect—in Adrienne Rich's words—a particular "politics of location": personal, geographic, political, and analytical.[4] My intimacy with the subject carries certain risks; but in studies of marginalized communities, engaged participation can be indispensable both in gaining access and achieving understanding. In the context of strict federal prohibition on marijuana use, WAMM members have every reason to be concerned about their own safety and about the motives of outsiders asking questions about their organization. Despite this, more than three dozen patients made themselves available to me for in-depth interviews—often lasting more than an hour—in which they were asked detailed questions about their participation in a targeted organization and about their use of a federally prohibited substance.[5] This gift of time and energy is all the more remarkable coming from a population of seriously ill people with little of either to spare.[6]

In my focus on medical marijuana, just as in my research on prostitution, I have been acutely aware of the social and legal vulnerability of the group under study. I take seriously Native American writer and activist Winona LaDuke's charge that all academics must address the question of "how will your research benefit the people you study."[7] It is my hope that a sympathetic but not uncritical account of the medical use of marijuana—and federal opposition to it—will help clarify what is at stake in the medical marijuana debates for policy makers, the American public, and, most especially, for the patients who have entrusted me with their stories.

Because of the hostile federal climate toward medical marijuana, I encouraged interview subjects to remain anonymous but offered them the option of requesting (in writing) to be identified by name. For individuals who requested anonymity, names and identifying information have been changed. In the pages that follow, anonymous subjects are introduced by a first-name-only pseudonym, while intentionally self-identifying subjects are referenced by both first and last name. My assumption going into this research was that those who would wish to be identified by name would be public officials and high-profile activists. Significantly, however, many "ordinary" patients demanded to be "known subjects." WAMM member

Pamela Cutler, for example, explained, "This is *my* story, my legacy. Use my name." The question of "legacy" has a particular resonance for the very seriously ill members of WAMM; many of the individuals whose accounts shape this book, including Pamela Cutler, have since died.

Well into this research project, I discovered that a fellow academic, Dr. Richard J. Webb, was also engaged in participant-observation research of a very intimate nature with WAMM—he had served as a caregiver for a dying patient and had even joined the organization's board of directors. In the cooperative spirit that defines the very essence of WAMM, we decided to come together and coauthor an account of this remarkable organization and its relationship to medical marijuana prohibition. Creating a woven whole out of two such distinctive voices has been a significant challenge; the result is by no means a seamless account. The analytical material that follows was crafted in collaboration between the two of us, though much of the most richly descriptive material is Rick's, while the interview data is mine.

Richard J. Webb

I first became acquainted with the Wo/Men's Alliance for Medical Marijuana in 1997. I had spent the summer looking for a business organization that would allow me to collect data for my doctoral thesis on justice and fairness in the workplace. Unfortunately, as my academic advisors had warned, no managers at the numerous companies I approached were willing to give me adequate access for my purposes, and as the last few weeks of the summer approached, I became more uncertain about how I was going to proceed.

One Sunday in August, my friend Noel, a bass player, showed up at my home in Santa Cruz, California, with an aging hippy guitarist named Gene. I set up my drums and we tried to imitate famous sixties power trios for an hour or so, and when we finally took a break, Gene pulled from his pocket a small baggie with a sticker on it, from the Santa Cruz Cannabis Buyers' Club. I had heard of medical marijuana, of course. My friend Dianne had used it during her cancer chemotherapy, and she had even purchased it from the same buyers' club, but I hadn't thought much about it at the time. It suddenly occurred to me that an organization distributing medical marijuana might be an interesting research project.

Gene told me that if I really wanted to learn more about medical marijuana, I needed to meet his wife, Silver, one of the locally notorious Holy Hemp Sisters, a sort of high priestess of pot. Silver, he explained, not only worked at the buyers' club, she belonged to a small and very unusual alternative health care collective known as WAMM, the Wo/Men's Alliance for Medical Marijuana. Gene finished retuning his guitar, and we stumbled through Rolling Stones cover tunes for a little while longer, then I drove him home so that I could meet his wife.

Perhaps it is worth noting that, like Gene and Noel, I was something of an aging hippy too. Although all of us have gone a bit gray as the years have passed, in my case aging has also taken the form of male-pattern baldness. Because few things look more woeful to me than bald men struggling to make their few remaining strands of hair resemble actual ponytails or braids, and because professional athletes suddenly seemed to have made baldness fashionable, I figured the time was right to do what my parents had begged me to do for years: cut my hair. Unfortunately, I did this a few days before I met Silver. For most of my adult life, I had experienced a middling degree of criticism and distrust from conservatives and authorities because of my long hair and beard, but I was thoroughly unprepared to be distrusted for looking too clean-cut! It wasn't until I handed Silver my driver's license, which showed the long-haired, full-bearded me, that she decided I wasn't a narc and warmed up to me. She arranged a meeting for me with Valerie Corral, cofounder and executive director of WAMM, and Valerie was intrigued by my research proposal. With the consent of the board of directors, I appealed to the general membership of WAMM, asking for their permission to attend meetings, observe activities, and interview them; with some enthusiasm they collectively agreed.

My primary interest was in the ways that patients and caregivers constructed and operated a renegade health care organization, with particular attention paid to the communicative strategies they employed to sustain themselves in the face of debilitating illnesses, social criticism, and the threat of legal prosecution. My initial objective was both to earn the trust necessary to elicit candid testimony and cooperation from the members, and to gain firsthand knowledge of what WAMM was like from insider's point of view. Especially at the very beginning of my research, when it became clear that I was neither a patient nor caregiver, I had few sources of information of the kind I was after. But I also had an interest in

experimenting with alternative relations of exchange between researcher and those being researched, relations that have traditionally been based on the authority and professional interests of the investigator, not the practical interests or welfare of those being studied. So, I started looking for ways I could contribute to the organization. I worked at fundraising events, taxied people to and from meetings and organizational activities, kept minutes of the board meetings, helped set up lighting systems for indoor gardens, moved furniture, fixed cars, and hauled trash to the dump. I tried to be friendly while I was doing these things, so inevitably I made friends, and as people got to know me better, they allowed me to get to know more about them.

After five months of this, I was invited for the first time to visit WAMM's communal marijuana garden and given the opportunity to gain firsthand knowledge of pot farming. This is often strenuous work in the hot sun, and there are rarely enough members in good-enough health to adequately share the burden, so my participation there was always welcome. In fact, it soon got to the point that I was actively participating in so many organizational activities that Valerie suggested I become caregiver for a WAMM member, which would entitle me to a membership card and the potentially vital protection against trouble with the local authorities that membership in WAMM could provide. Since then, I have served as caregiver for three WAMM members, all men with AIDS, two of whom are now deceased, one living out his final weeks on a hospital bed in my living room. The third, whom I have been assisting for just a few months, has been a WAMM member for many years.

My experiences with WAMM have been personally transformational, and I cannot pretend that my contributions to this book are emotionally or politically detached. Prior to my involvement with WAMM, I knew little—essentially nothing—about caring for people who suffered from life-threatening illnesses, never mind the trials and tribulations of living with disease, poverty, isolation, and uncertainty. As it turns out, neither do most of those who are responsible for making decisions and establishing policies for the regulation of medical marijuana. I remember talking with Valerie Corral, WAMM's founder and executive director, one evening when she returned from Sacramento. State representatives and law enforcement officials had spent the day arguing over how to regulate possession of medical marijuana, and they had clearly been more concerned about the possibility that liberal guidelines would be exploited by

fraudulent patients selling their surplus to recreational users than in making sure that truly suffering patients had enough medicine to meet their needs. When Valerie's appeals to their sense of compassion were met with intransigence, she asked if anyone in the room had ever actually had to care for a dying friend or relative: not one person in that room full of decision makers had ever done so.

This disconnection between practical knowledge and the power of public policy makers is one of the recurring themes in this book. An argument is being made by those who oppose the use of marijuana as medicine, an argument that deserves full consideration, but one that also deserves more comprehensive and critical analysis than has previously been possible. If our conclusions border on advocacy, it is because we have been persuaded that the burden of proof in that argument has not been met. Worse, it appears that the government has actively impeded open and honest research and discussion of the issue, and that unnecessary suffering has been, and continues to be, the result. As we came face-to-face with that suffering over the months and years, and as people we came to know died or grieved over the loss of loved ones, it became impossible not to care. Caring is good. I would argue that there is a place in much scholarly inquiry and most public policy making—particularly involving sick people and poor people—for much greater compassion and generosity. I remember another time, during the gay pride festival in San Francisco, one of WAMM's biggest annual fundraising events. I was working T-shirt sales, and when I turned my back for a moment, someone in the crowd stole a pile of shirts. Angry and embarrassed, I told Val about it, and all she said was, "Well, let's hope they get a good price for them, because they must need the money very badly." It was a powerful lesson in compassion, generosity, and letting go. Because of the years I have spent working with WAMM, I believe I am a better scholar, a better teacher, and a better person.

So, like Dr. Chapkis, I have to acknowledge my biases against federal marijuana policy and in support of the self-determination of patients and physicians in the management of illness. But I also believe, like Dr. Chapkis, that critical reflection on social practices need not be hampered, and may in some respects be enhanced, by emotional involvement with the community being studied. There is no question that the vitality and credibility of our account is largely a result of the trust and intimacy that the members of WAMM felt they could share with us as friends and allies in their confrontations with adversity.

Limitations of This Study

Much of the material in this book is based on a single organization, one that has achieved an unusual degree of prominence within the medical marijuana movement. Furthermore, it is located in a very specific cultural context in a community highly supportive of medical marijuana use. The story of this organization and the accounts by its members may not be broadly generalizable. It also bears saying that this study is not intended to establish whether marijuana does, in fact, have medical value. Scientific proof of the medical efficacy of cannabis should be established through carefully designed clinical trials; sadly, the U.S. federal government for many years blocked research in this area.[8] As federal restrictions begin to loosen, scientists in the United States are joining those in other countries in reporting compelling evidence of the therapeutic potential of cannabis and cannabinoids. Nonetheless, the accounts that follow are anecdotal patient reports, not clinical trials.

Furthermore, the effects discussed by patients are not uniform. Not all individuals respond to marijuana—or to any other drug—in exactly the same way, nor do they all find it equally effective. It is reasonable to assume that patients who tried marijuana but found it to be ineffective or to have negative effects might discontinue use. Such individuals would be unlikely to remain active participants in a demanding medical marijuana collective like WAMM. The accounts by WAMM patients in this book, then, capture only the experiences of those who find marijuana effective. Despite these limitations, this book offers the often missing and always important perspective of patients in an ongoing discussion of the medical use of marijuana.

Summary of Chapter Contents

In this book, we intend to do two things: to discuss the uses (and prohibitions on the use) of cannabis as medicine and to give life to these issues by describing a contemporary, and in many ways exemplary, medical marijuana organization. For this reason, the material is organized in alternating chapters, shifting between those offering an institutional analysis of marijuana and medicine and those providing detailed ethnographic material on the Wo/Men's Alliance for Medical Marijuana (WAMM). Throughout the book, the terms "cannabis" (the botanical designation)

and "marijuana" (the more familiar and politically charged term) are used interchangeably.

The opening chapter, "Shamans and Snake Oil Salesmen," discusses the transformation in the nineteenth and twentieth centuries of cannabis, a commonly used medicinal plant, into marijuana, a strictly prohibited substance. The chapter examines the process of the exclusion of marijuana from medicine in the context of the professionalization of the healing arts and the marginalization of botanical remedies. The chapter also examines how policy makers and the public have struggled over the meaning of such fundamental concepts as legitimate medicine, dangerous drugs, and public safety. This examination of the rhetorical underpinnings and material effects of the federal campaign against marijuana is the backdrop against which the emergence and remarkable history of the Wo/Men's Alliance for Medical Marijuana plays out.

Chapter 2, "Set and Setting," provides the more-local context for the creation of the Wo/Men's Alliance for Medical Marijuana. The chapter opens with Valerie Leveroni's (later Corral's) 1973 automobile accident in which she sustained serious head injuries. The injuries produced seizures that she discovered she could control with the use of marijuana. Arguing that her use of the prohibited substance was a medical necessity, Valerie and her husband, Michael Corral, created a cooperative in which patients could secure collectively cultivated marijuana free of charge. Their organization, the Wo/Men's Alliance for Medical Marijuana, took root in the specific setting of a small California coastal town, Santa Cruz, in soil already well enriched by work of previous health and social justice movements. The chapter argues that the inheritance left by the feminist women's health care movement of the 1970s and AIDS activism of the 1980s and 1990s was critical to the success of WAMM.

Chapter 3, "The Greening of Modern Medicine," examines both federal obstruction in the 1980s and 1990s of scientific research into the medical efficacy of cannabis and the campaigns that effectively broke that blockade. The chapter also considers renewed attempts by federal regulators to discredit medical use of marijuana through the creation of a problematic distinction between cannabis (a crude botanical) and cannabinoid medicines (pure pharmaceuticals). This is set against the growing interest among the American public in alternative and complementary therapies, including medicinal herbs.

Chapter 4, "Potheads Scamming the System," describes how the medical use of marijuana by patients in WAMM complicates the distinction

between "legitimate medical marijuana users" and illegitimate "potheads." This chapter suggests that the more-important difference isn't one of identity but rather of context. WAMM members are neither simply recreational users nor are they simply conventional patients consuming the herbal equivalent of a pharmaceutical medicine. The chapter also explores the structure and the effects of WAMM's unique not-for-profit collective model of medical marijuana provision.

Chapter 5, "Cannabis and Consciousness," discusses the well-known "consciousness-altering" effects of marijuana. The "high" associated with cannabis figures prominently in the federal government's justification for prohibition of the substance even for medicinal purposes. This chapter challenges the notion that the "high" is no more than a dangerous and unwelcome side effect, and presents patient accounts of the possible therapeutic value of "getting high."

Chapter 6, "Mother's Milk and the Muffin Man," considers the question of the possible health risks of using marijuana as a medicine. In particular, this chapter discusses how the dangers associated with one common delivery system—smoking—often substitute for the less-established risks of the plant medicine itself. Included in this chapter is a detailed description of alternative delivery systems developed at the grassroots level by WAMM members, including tinctures, beverages, baked goods, liniments, and capsules.

Chapter 7, "Love Grows Here," discusses the operation of the collectively cultivated WAMM garden under the skilled leadership of Michael Corral. For WAMM members, the garden has been both the source of high-quality organically grown medicinal cannabis and also a strikingly beautiful environment in which horticultural therapy can be practiced by very ill patients. The chapter concludes with an account by Valerie and Michael Corral of the 2002 DEA raid intended to stop the collective's cultivation of marijuana and close the organization.

Chapter 8, "Lessons in Endurance and Impermanence," describes the future of both medicinal cannabis and the Wo/Men's Alliance for Medical Marijuana. In the aftermath of the 2002 raid, the organization not only continued to operate, but went on the offensive, suing the federal government. In 2004 WAMM won a protective injunction in federal court against further action by the DEA and, for a brief period—until the 2005 U.S. Supreme Court ruling in Gonzales v. Raich—operated the only legal, private marijuana garden in the United States. The chapter concludes with a discussion of ongoing battles between grassroots providers of medical

marijuana, like WAMM, and corporate attempts to control access through the pharmaceuticalization of cannabinoid medications.

Interspersed between these chapters, and interwoven within them, are interviews and photos of those on the front lines: patients, physicians, legislators, and law enforcement. This book is dedicated to the many WAMM members who died during the decade in which this account was crafted as well as to all those still active, still defiant, still demanding alternatives to war.

1

Shamans and Snake Oil Salesmen

Why Marijuana Isn't a Medicine

For many modern critics, the concept of "medical marijuana" is a contradiction in terms. Medicine is standardized, synthetic, and pure; marijuana involves the unrefined and promiscuous coupling of more than four hundred components rooted in the dirt. Medicine—in its most powerful and privileged forms—rests in the hands of men,[1] while the most potent form of marijuana is found in the female flowering plant. Medicine engages in heroic battles against death. Marijuana claims only to enhance the quality of life. Medicine presents itself as an objective science safeguarded by the ritual of the double-blind, randomized clinical trial.[2] The therapeutic value of marijuana relies largely on the "soft science" of subjective experience and anecdotal evidence. From the perspective of its critics, then, cannabis is an effeminate interloper in the masculine world of real medicine, a dangerous drug pushed on a credulous public by illegitimate quacks.

But this story is too simple. The line separating regular doctors from snake oil salesmen, good drugs from bad, is as much the product of politics as it is of science.

The dominance of politics in determining the value of marijuana as a medicine was first demonstrated in the 1930s when the federal government began to restrict the medical use of marijuana, against the recommendations of the American Medical Association (AMA).[3]

The struggle between politics and science over the use of cannabis as a medicine continues. In the final decade of the twentieth century, the federal government threatened physicians with the loss of their license for recommending marijuana to patients, made criminals of patients who followed their doctor's advice, and actively blocked scientific research into the therapeutic value of cannabis, while insisting that it was an established scientific fact that marijuana is not a medicine.

During the opening of a 2004 congressional hearing on medical marijuana, this ongoing battle over cannabis was described by committee chair

Rep. Mark Souder (R-IN) as a critical front in the War on Drugs and consistent with the modernization of medicine:

> This hearing will address a controversial topic, the use of marijuana for so-called medicinal purposes. In recent years, a large and well-funded pro-drug movement has succeeded in convincing many Americans that marijuana is a true medicine to be used in treating a wide variety of illnesses. . . . Marijuana was once used as a folk remedy in many primitive cultures, and even in the 19th century was frequently used by some American doctors, much as alcohol, cocaine, and heroin were once used by doctors. By the 20th century, however, its use by legitimate medical practitioners has dwindled, while its illegitimate use as a recreational drug has risen.[4]

Souder thus sets the stage for a morality tale populated by primitive practitioners and legitimate doctors, dangerous drug fiends and decent drug warriors.

Fox News personality Bill O'Reilly invoked a similar cast of characters in his 2004 discussion of medical marijuana with U.S. Deputy "Drug Czar" Dr. Andrea Barthwell.[5] That year, voters in Oregon were to be presented with a ballot measure to amend their state's already-existing medical marijuana law. The proposed amendment (which ultimately failed) was intended both to increase the amount of marijuana a patient could have over the course of a year and to redefine which health professionals could legally recommend marijuana for medical use.

O'Reilly scoffed at the idea that licensed health practitioners other than physicians might be authorized to recommend the use of cannabis to their patients: "Even a shaman could grant permission for you to toke in Oregon. I mean, this is, you know, any health practitioner. So you're a shaman from the Amazon and you set up shop. Come on, I mean, everybody knows this is a ruse. Am I wrong?"[6] Andrea Barthwell confirmed for viewers that O'Reilly's concerns were quite legitimate: "No, you're absolutely right, Bill. This is what we've been trying to make clear to people when they have these proposals presented to them. This is not about getting medicine to people who are sick and dying. This is about making marijuana legal."

While both host and guest shared the belief that the Oregon proposal was no more than a thinly disguised attempt to legalize marijuana, O'Reilly asked whether cannabis itself might not be a legitimate medicine

Kathy using a water pipe. Photo courtesy of Jean Hanamoto.

if prescribed by a legitimate physician to a patient with a legitimate need: "But there is a legitimate issue here, Doctor. We had Montel Williams [another popular TV talk show host] on a few weeks back. He has MS [multiple sclerosis]. And I believe Montel Williams when he says, 'Look, medical marijuana helps me, helps me cope with this disease, cope with my suffering. There's no reason why I should be denied it.' And I agree with Montel Williams that if this is the case, if a doctor—*a doctor*—says that he needs it for his MS, he should have it. You don't disagree with that, do you?" Barthwell's response was uncompromising: "Well, I do, actually.

There is nothing that tells us from the science now that smoked, crude botanical should be a medication. We have a process that has been in place for 100 years in this country that protects the sick and dying from snake oil salesmen. And just because something makes you feel better doesn't make it medicine."

In this short exchange, the terms of the debate for dismissing cannabis therapeutics are neatly laid out: medical marijuana is a ruse; cannabis is the modern day equivalent of "snake oil"; "crude botanicals" are not real medicine; licensed alternative health practitioners are not legitimate healers; marijuana is reduced to and synonymous with smoking as a delivery system; and "feeling better" isn't always therapeutic. Taken together, these claims create a neat division between marijuana and "real medicine," with medicine narrowly defined as that which is practiced by physicians prescribing pharmaceuticals to patients who will not necessarily feel better as a result.

The Rise of "Regular" Medicine and the Battle against Botanicals

According to Dr. Raphael Mechoulam, an Israeli research chemist who performed much of the original work in the early 1960s isolating the active ingredients in marijuana:

> From ancient times to the early 20th Century, cannabis was used for a wide variety of medical purposes including the treatment of pain and swelling, depression, arthritis, impotence, kidney stones, hemorrhaging in childbirth, irregular bowel movements, cold sores, distending stomach, dropsy, headaches, diseases of the respiratory organs, hysteria, neuralgia, sciatica, tetanus, dysentery, fatigue, disorders of the female reproductive system, convulsions, cholera, delirium tremens, vomiting, spasmodic asthma, and a host of other ailments. Most of these therapeutic claims were either based on folklore or were anecdotal, but the use of cannabis as a therapeutic agent in the past provides an insight for future drug development. More recently, some of the historical therapeutic properties of cannabis have been verified with pure natural or synthetic cannabinoids; however, in several fields no modern scientific work exists.[7]

In order to understand why marijuana, a promising medicinal botanical, should now be excluded not only from the modern pharmacopeia but

also from much formal scientific study, it is necessary to ask why some drugs, but not all, get labeled "medicine"; why some healers, and not others, are "regular doctors"; why some effects, but only some, are understood as "therapeutic"; and why some risks are acceptable while others are prohibited under penalty of law. The answers cannot be found in a simple appeal to scientific standards. Instead, in order to understand what counts as "legitimate" medicine, it is useful to ask who, beyond the patient, might benefit from such distinctions.

In our exploration of the role of organized medicine, state regulatory agencies, the courts, and the pharmaceutical industry in the demonization of marijuana, the intent is not to perform the reverse process, demonizing modern medicine. Over the past century, during which organized medicine consolidated its authority and cannabis was first marginalized and then removed from the pharmacopeia, astonishing medical advances have been made. Unquestionably, the public would be ill served by a return to a time of unregulated medicine practiced by poorly trained doctors with recourse to few effective drugs.

Nonetheless, it is also the case that the healing arts remain an impure science.[8] The most striking difference between marijuana and "real medicine" is not the physical but the social effects the plant has on users and healers alike. Association with marijuana marks those it touches as illegitimate—a distinction with deep historical roots. Prior to the professionalization of medicine, lay healers—often women—made extensive use of medicinal plants. But as modern medicine moved into the ranks of the professions, and into hands of men, botanicals were discredited along with the women who had used them. In their pathbreaking study of the rise of the male medical expert, *For Her Own Good*, Barbara Ehrenreich and Deirdre English note that, in the fifteenth and sixteenth centuries, anxiety over women's knowledge of medicinal botanicals contributed to the European witch hunts: charges against the accused often included the provision of herbs.[9]

In Colonial America and the early republic, health and healing practices also rested largely in the hands of lay women practicing herbal medicine.[10] Historian Carol Smith-Rosenberg observes that "women as midwives and as family nurses, women wise in the ancient herbal pharmacopoeia, had always cared for their own and neighboring families. A survey of cookbooks and women's diaries for the eighteenth and early nineteenth centuries shows that women collected and exchanged recipes for medicines as routinely as they did for pies and cookies."[11]

By the nineteenth century, however, as medicine entered the marketplace, male physicians with little formal training claimed for themselves the designation "Regular doctor" while moving all others to the margins of the healing arts. In North America, midwives, bonesetters, and "root and herb" doctors were thus gradually displaced by the self-proclaimed "Regulars," not through the violence of witch burnings, as happened in Europe, but rather through professionalization. This challenge was, according to Ehrenreich and English, "at bottom, economic. Medicine in the 19th century . . . [became] a thing to be bought and sold."[12]

Professionalization required that the Regulars distinguish themselves from midwives and herbalists; they did so through "heroic medicine," a practice involving dramatic (though not necessarily beneficial) techniques such as bloodletting, blistering, purging, and the use of toxic mercury-based medicines. These interventions were intended to produce "the strongest possible effect on the patient."[13] Though such therapies were not only dangerous and often ineffective, Ehrenreich and English observe that they gave "regular doctors something activist, masculine, and imminently more salable than the herbal teas and sympathy served up by rural female healers."[14] In fact, despite the very serious risks of heroic medicine, Smith-Rosenberg notes that the Regulars insisted that it was they who were protecting "the lives of innocent citizens from ill-trained, irresponsible 'irregulars,' and hysterical midwives."[15]

The Regulars prospered during the first two decades of the nineteenth century and succeeded in securing licensing laws in many states restricting the practice of medicine to those in their ranks and limiting membership to men. But growing dissatisfaction with the results of "heroic medicine," and populist misgivings about monopolies and elites, led to the temporary repeal of such laws during the 1830s.[16] The "Popular Health Movement" of the period challenged the position of Regulars by emphasizing "self-help" (through better hygiene and healthy living) and by embracing the therapeutic approaches of alternative medical sects, including those advocating botanical treatments.[17]

As sociologist Carol Weisman notes, under the banner of science, Sectarians or Irregulars "were attacked by mainstream physicians as 'quacks,' although the therapeutics of the regular physicians were not generally more effective than those of the irregulars."[18] The Regulars reinforced their claim that they, and they alone, were legitimate physicians by founding a national professional organization in 1847—the American Medical Association—explicitly excluding both women and sectarian practitioners.[19]

In the second half of the nineteenth century, economic competition intensified as both Regulars and their rivals—now known as the "Eclectics"—opened medical schools to train practitioners. The Eclectics, who advocated the use of botanical therapies, also represented a more populist and egalitarian politics—for example, they admitted women to their medical schools.[20] During this same period, in 1854, cannabis joined other herbal remedies in the national pharmacopeias and was freely prescribed for a large number of medical conditions ranging from insomnia to neuropathic pain.[21] In the late nineteenth and early twentieth centuries, dozens of research papers were published on the various medicinal uses of marijuana.[22]

This corresponds to a period in which Regulars began to consolidate the power of the newly organized medical profession, in part by absorbing Eclectics into their ranks. As Paul Starr observes in his landmark study, *The Social Transformation of American Medicine*, Eclectics "succumbed to quiet cooptation; they were only too glad to be welcomed into the fold."[23] By co-opting much of the opposition, physicians were able to secure new licensing laws restricting the practice of medicine. But Eclectics paid a significant price; with the consolidation of control by conventional medicine, botanical therapies were increasingly marginalized by mainstream medicine.

The allopathic approach[24] of the Regulars was not only dominant but also institutionalized in the early twentieth century when organized medicine completed its process of professionalization by gaining control over medical education, access to hospitals, and the right to prescribe drugs.[25] The dominance of this paradigm was reflected in the growing strength of the American Medical Association. In 1900 the AMA had no more than eight thousand members, but by 1910 membership reached seventy thousand, and by 1920 the majority of physicians in the United States had become members.[26] In fact, by 1931 only about 5 percent of all cases of illness were handled by non-MD practitioners.[27]

This exponential increase in the power and professional authority of regular doctors surprisingly did not rest primarily on the provision of more effective medicines; these were slow to be developed.[28] Instead, doctors were forced to find other ways to assert their newly established social and cultural legitimacy. One strategy was to position themselves as experts in not only the physical but also the moral health of the nation. In the nineteenth century, condemnation of birth control and abortion, for instance, provided physicians with a clear moral platform that allowed

them to denounce practices still largely in the hands of "irregulars." According to Carol Smith-Rosenberg, these efforts to limit women's reproductive choices became a key arena "in the war between the allopaths and the 'irregulars' for patients and for power. . . . The 'irregular' physician and the 'irregular' wife, the 'regulars' insisted, conspired together against public order and national well-being."[29] As Carol Weisman observes, this claim of medical and moral expertise "provided regular physicians with an element of social respectability and moral authority, which was enhanced by publicly criticizing the abortion practices of other practitioners and the crass commercialism of purveyors of contraceptives and abortifacients."[30]

At the end of the nineteenth century, flush with its legislative success against abortion, the AMA turned its attention to another arena that neatly linked morality and public health: the provision of drugs. Physicians enhanced their professional authority by speaking out against the dangers of addictive drugs frequently found in "patent medicines" and available directly to the public.[31] Because the formulae of proprietary medicines were secret, it was impossible for patients to judge the safety of those drugs.[32] The practitioners of organized medicine thus joined forces with muckraking journalists to bring to the public's attention the possible risks of patent medicines.[33] This important public service had a significant payoff for the profession as well, reinforcing a growing distinction in the public mind between good drugs (dispensed by doctors) and bad drugs (available directly to the public by unlicensed practitioners).[34]

Demon Drugs

Public discussion of drugs as a social problem thus began, primarily, as a conversation about their medicinal—not recreational—use. While the danger of addiction was a key concern, addicts were understood by both the medical profession and the public to be innocent victims. By the early twentieth century, "accidental addicts" dependent on morphine found in patent medicines composed between 3 percent and 5 percent of the American population.[35] Their innocence was further established by their social position; as Peter Conrad and Joseph Schneider point out, "the typical 19th century addict was middle-aged, female, rural, middle-class, and white."[36] The problem of accidental addiction helped to secure the passage of the first federal drug regulation in the United States, the 1906 Pure Food and Drug Act. The 1906 act required accurate labeling to help

identify the presence of opiates or cocaine in drugs directly available to the public.[37]

But not all drug users were considered equally innocent and not all concerns about drugs rested purely on health risks. Thanks to the efforts of temperance activists, intoxication itself, especially when willfully pursued, was positioned as a moral not a medical problem. Just as it is impossible to discuss the rise of modern medicine without attention to gender, it is equally impossible to explain the advent of drug regulation (and prohibition) without a careful accounting of the influence of race and the perceived threat posed by immigration. As drug use became associated in the popular imagination with "dangerous minorities" rather than self-medicating white women, concern about the effects of drugs shifted from medical to social risks. As Desmond Manderson observes, "There are elements of an objective concern about sickness in social attitudes to drug use, but its metaphoric resonances have been inadequately acknowledged. The experience of drug use is of the dissolution of boundaries. The use of drugs threatens a loss of physical control . . . just as the immigration of a different culture invites a loss of social control and breaks down the self-other distinction hallowed by Western nationalism."[38] Even the most ubiquitous intoxicant of all, alcohol, was marked by temperance activists as especially dangerous in the hands of immigrants.[39] As one social reformer of the early twentieth century proclaimed, "The influx of foreigners into our urban centers, many of whom have liquor habits, is a menace to good government."[40]

Thus, while addiction of the nineteenth century might have been largely a white and female problem, concern about the use of addictive substances quickly became focused on the danger of their use by racial minorities and immigrants.[41] The result was a shift in approach to drug regulation. If early regulation of drugs focused on the possibility of a literate public making informed choices about potentially dangerous drugs (for example, through accurate labeling of patent medicines), new laws sought restrictions on access to drugs on the assumption that, when in the hands of certain populations, drugs posed an unacceptable risk to the public and to the social order. The 1906 Pure Food and Drug Act was followed in 1909 by a law effectively banning opium not intended for medical use and restricting legal access to the drug to licensed physicians and dentists.[42] David Musto argues that the 1909 law "developed from the fear and loathing of the Chinese, who were associated intimately with this particular manner [smoking] of ingesting opium."[43] According to

Manderson, opium smoking functioned "as a metaphor for those fears of difference and change" occasioned by Chinese immigration to the West: "The hostility to opium smoking which ushered in an era of drug prohibition was therefore another example of our society's tendency to express fear through metaphors and then, regrettably, to treat them literally."[44]

Cocaine, which had been freely available in tonics of the late 19th century, including as a "nerve stimulant" in the soft drink Coca-Cola,[45] became a dangerous drug when linked to African Americans. According to David Musto, the fear was that access to cocaine might make Blacks "oblivious of their prescribed bounds and attack white society."[46] In 1903 the *New York Times* described Blacks as "running amuck in a cocaine frenzy" in an article titled, "Negro Cocaine Fiends Are a New Southern Menace."[47] Linking "willful" drug use to immigrants and racial minorities provided a convenient explanation for the unequal economic and social status of those groups, as well as a justification for their continued unequal treatment. As Musto points out with reference to cocaine, "The identification of cocaine use with African Americans soon elaborated a link between cocaine and supposed African American criminality, [illustrating] the tendency to find in drug use a simple explanation for complex social problems."[48]

Early federal drug regulations were justified, then, on the grounds that they served to protect the public from drug-crazed minorities and accidental addicts. These regulations also had the effect of establishing a new authority for the state to regulate medical, and to prohibit recreational, access to drugs, while simultaneously enhancing control by doctors over areas previously in the hands of commercial competitors or patients themselves. As Paul Starr points out, the regulatory system served to "withhold information from consumers and re-channel drug purchasing through physicians."[49] The pact between physicians and the state, however, was not without cost to organized medicine: by embracing state regulation, physicians also surrendered some measure of control. The Harrison Narcotics Act of 1914, for example, placed control of medicines containing opiates and cocaine in the hands of the federal government. The law established a tax on their use collected from physicians and pharmacists who dispensed them. While this made access to such drugs dependent on a relationship with a physician, it also began to limit doctors' independence in determining a course of treatment free of governmental interference.

This point was swiftly and dramatically demonstrated when federal courts interpreted the Harrison Narcotics Act to prohibit the medical

treatment of addiction through drug maintenance, declaring in the 1919 Supreme Court case of "Webb et al. v. United States," that "indefinite maintenance for 'mere addiction' was outside legitimate medical practice."[50] This led to the arrest and intimidation of thousands of physicians for violations of the Harrison Narcotics Act in their treatment of addicts with opiates.[51] The drug regulations thus worked to criminalize not only the addicts who previously had been considered patients in need of ongoing care, but also their physicians who were judged by lawmakers and the courts to be making inappropriate treatment choices. Addiction was thus transformed from a medical problem into a criminal one and treatment from a purely medical issue to a political one. Again, this change in approach reflected the shift in the image of the addict. As Merrill Singer reports, "Gone were the self-medicating middle-class female addicts who purchased heroin legally as a drinkable tincture or smokable cheroot at their local pharmacy; they were replaced by the young male heroin snorters, often inhabitants of immigrant slums."[52] As Roger Smith argues, these "willfully indulgent criminals" were seen by the public to be "unwilling to respond to humane medical treatment, and fully deserving of society's moral and penal action."[53]

The Invention of "Marijuana"

The federal government's successful campaign to control access to opiates and cocaine encouraged other drug regulation efforts, including those related to cannabis. Doctors, however, were now wary of such attempts and began to oppose the inclusion of other medicinal drugs in federal regulations. In 1930, when the head of the Federal Bureau of Narcotics (FBN), Harry Anslinger, approached the American Medical Association about adding marijuana to the Harrison Act, he met with resistance. Dr. William Woodward, the director of legal medicine and legislation for the AMA, responded with thirteen pages of extracts from letters he had received from pharmaceutical manufacturers addressing the medicinal uses of cannabis and any possible risks of dependency; twenty-nine of the thirty respondents strongly opposed including cannabis in the Narcotics Drugs Act.[54] As a result, cannabis at least temporarily remained outside of federal regulation. But it, too, was soon to follow the familiar trajectory from widely used medicine to increasingly regulated substance to dangerous—and prohibited—drug.

Unlike opiates and cocaine, marijuana was a drug unknown to most Americans despite its common use as tincture of cannabis in many medicines in the late nineteenth century. Its transformation into a "dangerous drug" was facilitated by antidrug officials who began replacing the botanical name, cannabis, with the term "marijuana." In much the same way that cocaine became a feared drug by linking it to African Americans, the term marijuana was used to more effectively associate the recreational use of cannabis with the one million Mexican immigrants who had entered the southwest in the first three decades of the twentieth century.[55] As Musto observes, "The practice of smoking cannabis leaves arrived in the United States with Mexican immigrants, who had come north during the 1920s to work in agriculture, and extended to white and black jazz musicians. As the Great Depression settled over America, the immigrants became an unwelcome minority linked with violence, and growing and smoking marijuana."[56] In 1935 an antimarijuana spokesperson from California explicitly drew this connection, telling the *New York Times* that "marijuana, perhaps now the most insidious of our narcotics, is a direct by-product of unrestricted Mexican immigration."[57]

By the mid-1930s, the menace of marijuana began to occupy a central role in Anslinger's antidrug campaigns waged through the Federal Bureau of Narcotics. His efforts to bring marijuana under governmental control drew on Prohibition-era morality, established public fears of opiate addicts, and racist propaganda focused primarily on Mexicans and urban Blacks. The FBN fabricated lurid and sensational stories of assault, rape, murder, and mayhem allegedly perpetrated by marijuana smokers, accounts often understood as factual by readers of newspapers and magazines.[58] In 1938, for example, the *Christian Century* magazine reported that in some areas "inhabited by Latino Americans, Filipinos, Spaniards, and Negroes, half the crimes are attributed to the marijuana craze."[59]

On the basis of these sensational accounts, Anslinger pushed for the passage of a new law, the Marijuana Tax Act of 1937. During hearings on the proposed legislation, Dr. William Woodward of the AMA once again spoke out against the regulation of marijuana through such measures. Woodward pointed out that "the burden of this bill is placed heavily on the doctors and pharmacists of the country."[60] He noted that the medicinal use of marijuana had already substantially declined, but he argued that "to say, however, as has been proposed here, that the use of the drug should be prevented by a prohibitive tax, loses sight of the fact that future investigations may show that there are substantial medical uses for cannabis."[61]

The legislation passed despite Woodward's objections that the tax and accounting requirements would effectively discourage virtually any medical practitioner from continuing to make use of marijuana. The Marijuana Tax Act of 1937 thus became the first federal legislation regulating cannabis on a national level. The act set a fee of one dollar an ounce for specified medical or industrial use and one hundred dollars an ounce for unspecified uses.[62] At least initially, the one-dollar tax was "not sufficiently high to end the medical use of marijuana which continued to be prescribed."[63] But the ongoing efforts of the Federal Bureau of Narcotics to discredit marijuana were so effective that, within four years, in 1941, cannabis in all of its forms was removed from the U.S. Pharmacopeia and National Formulary. This was the first edition printed after the Marijuana Tax Act took effect.[64]

The Marijuana Tax Act did not, however, close the conversation about the possible therapeutic uses of cannabis. While organized medicine had abandoned the plant, individual physicians and medical researchers continued to express interest in its effects. In 1938, when a blue-ribbon panel was assembled by New York City Mayor Fiorello LaGuardia to examine the effects of marijuana on individual users and on public order, it was composed of "thirty-one eminent physicians, psychiatrists, clinical psychologists, pharmacologists, chemists and sociologists [who] undertook a scientific study, utilizing both sociological fieldwork methods and controlled clinical experiments."[65]

Two years before the final report was published in 1944, two members of the panel—Dr. Samuel Allentuck and Dr. Karl Bowman—gave a preview of the findings in an article published in the *American Journal of Psychiatry*. Allentuck and Bowman concluded that "prolonged use of the drug does not lead to physical, mental, or moral degeneration, nor have we observed any permanent deleterious effects from its continued use. Quite the contrary, marihuana and its derivatives and allied synthetics have potentially valuable therapeutic applications which merit further investigation."[66] The LaGuardia report itself echoed these findings, adding that marijuana use did not lead to addiction, was not common among children, and no causal relationship existed between marijuana use and urban crime.[67]

Despite the presence of seventeen physicians among the experts on the panel, Anslinger turned to the American Medical Association in his effort to discredit the findings of the report. The AMA's relationship to the federal government had warmed in recent years thanks to Anslinger's efforts

to curtail the arrest of physicians for narcotics violations under the Harrison Act.[68] In a dramatic change from its previous positions on marijuana, in April 1945 the *Journal of the American Medical Association* (*JAMA*) published an editorial denouncing the findings of the LaGuardia report. The journal asserted that "for many years, medical scientists have considered cannabis a dangerous drug" and that "public officials will do well to disregard this unscientific, uncritical study, and continue to regard marijuana as a menace wherever it is purveyed."[69] The AMA's charge against the LaGuardia study, then, was that it was "unscientific" in reaching its conclusions that marijuana was relatively benign as a recreational drug and showed promise as a medicinal one. The *JAMA* editorial argued that the very opposite had already been established by real medical scientists: marijuana was a dangerous drug and under no circumstances should be used.

Resolving which of these conflicting accounts of the effects of marijuana was more accurate should have been a relatively straightforward matter, making use of the scientific process itself. Additional studies would have confirmed, or at least usefully complicated, one of these competing conclusions on the benefits and risks associated with cannabis. Instead—through the use of a strategy still popular with the U.S. federal government—Harry Anslinger made certain that the question of the medical efficacy and safety of marijuana could not be resolved by science: he actively impeded such research. While clinical research was still technically possible if permission was obtained in advance, no such permission was granted and no nonmilitary research took place during Anslinger's tenure[70] of over thirty years at the Federal Bureau of Narcotics.[71] The agency systematically blocked scientific research on marijuana: "By thwarting researchers, whom he denied the proper permission to obtain and possess the drug for experiment's sake, [Anslinger] was able to resist any movement for change in the marijuana laws, since so little was known about the subject."[72]

Marijuana and Modern Moral Panic

The transformation of a common medicinal herb into a dangerous and disreputable drug was thus accomplished not through the presentation of carefully collected scientific evidence, but rather through a process of proclamation. Marijuana was proclaimed to be a dangerous drug, its

medicinal value denied, and the U.S. federal government systematically blocked all research that might confirm or disprove these claims. The demonization of marijuana was accomplished by linking its recreational use to racial minorities and political radicals, thereby generating a moral panic around marijuana use and users.[73] As Musto and Korsmeyer observe, the marginalization of marijuana persisted into the late 1950s and early 1960s when drug use in the United States "was thought to be largely confined to the urban poor, criminal elements, and 'beatnik' artists and intellectuals."[74]

In 1961, an international "Single Convention on Narcotic Drugs" included cannabis among its tightly regulated drugs. The convention did not prohibit the medical use of cannabis outright, but set specific conditions for such use. In fact, the convention stressed that "controlled substances must be made available for—and their use limited to—medical and scientific uses."[75] One provision of the treaty, however, was used to significantly limit the ability of scientists in the United States to do research: under the Single Convention, the state has the "exclusive rights to manufacture and trade marijuana for medical purposes."[76] Although the state is specifically allowed to extend those rights to a nongovernmental agency empowered to grow marijuana for licensed medical uses or research, the United States has never permitted this. The complete monopoly enjoyed by the National Institute on Drug Abuse (NIDA) over access to marijuana has meant that even Food and Drug Administration (FDA)–approved research can be—and has been—blocked.[77] According to Harvard Medical School researcher Dr. Norman Zinberg, between 1934 and the late 1960s "there was very little research on the medical usefulness of marijuana."[78]

In fact, research on marijuana was much more difficult to undertake than studies of other more powerful psychoactive drugs. The psychedelic drug LSD, for instance, first synthesized in 1938 by a Swiss chemist, Dr. Albert Hoffman, was provided free to research scientists by the Sandoz Laboratory until 1966. Already by the mid-1950s, research using LSD in a therapeutic context had taken place in many countries, including France, Germany, Italy, Switzerland, and the United States.[79] Between 1950 and the mid-1960s more than one thousand clinical papers were published on psychedelic therapy for the treatment of such problems as pain and psychological distress in cancer patients, posttraumatic stress in concentration camp survivors, and childhood autism.[80]

In the early 1960s, however, concerns about the growing use of psychedelics, facilitated by experiments at Harvard University by Dr. Timothy

Leary and Dr. Richard Alpert (later known as Ram Dass), led to new federal regulations. In 1965 the U.S. Drug Abuse Control Amendments were passed, restricting the nonmedical use of stimulants, depressants, and psychedelics. As Dr. Rick Doblin, president of the Multidisciplinary Association for Psychedelic Studies (MAPS),[81] observes, "As with laws against the non-medical use of opiates and the non-medical use of marijuana, the laws against the non-medical use of psychedelics began to impact medical research."[82] The FDA immediately began demanding "that almost all LSD researchers stop their studies and return their supplies of LSD,"[83] and within seven years of the passage of the 1965 amendments, medical research on psychedelics had "dwindled to almost nothing."

This new round of federal drug restrictions once again fed a growing moral panic around rising drug use. But this time, concern about drug use—especially use of cannabis and LSD—was associated with white middle-class youth and linked to broader cultural and political concerns. The invention of the birth control pill in 1960, the passage of the Civil Rights Act of 1964, the escalation of an unpopular and increasingly deadly war in Southeast Asia, and the celebration of drug use in popular music and film all combined to produce a cultural divide in the country. On one side were supporters of law and order, tradition and discipline. On the other were those advocating social transformation through defiance of the state, the established social order, and the law.[84]

Historian David Courtwright has also identified a critical precondition for the proliferation of recreational drug use in general, and marijuana smoking in particular: the development of the most revolutionary psychoactive drug delivery system since the hypodermic needle, the cigarette. According to Courtwright, "The ongoing cigarette revolution, which taught Americans to absorb drugs through their lungs, facilitated the spread of marijuana smoking, as did the abundant domestic supply."[85] Indeed, Courtwright argues that "tobacco was a gateway to cannabis experimentation. The marijuana complex could not have arisen as quickly or spread as far as it did without the antecedent cigarette explosion."[86]

As the decade progressed, marijuana use in the United States continued to increase, particularly among middle- and upper-class high school students and undergraduates, who found that it operated as a "convenient multivalent symbol of rebellion."[87] By the end of the 1960s, it was clear that marijuana use in the United States was no longer restricted to what had been seen as the safely contained margins of society. In 1968 then-President Lyndon Johnson warned Americans against the use of "these

powders and pills which threaten our nation's health, vitality, and self-respect."[88] In Johnson's statement, concerns about public health are linked to concerns about public morality; illicit drug use, much like illicit sex, is presented as a threat not only to the nation's physical well being, but also to its sense of honor. A nation of potheads and pill poppers wouldn't respect itself in the morning.

A federal commission established specifically to spotlight the dangers of widespread marijuana use unexpectedly undermined this marriage of the moral and the medical. In 1970 the Republican administration of Richard Nixon appointed Pennsylvania Governor Raymond Shafer to chair a National Commission on Marihuana and Drug Abuse. After two years of study, the Shafer Commission reached conclusions very similar to those of the LaGuardia Commission some three decades earlier. It concluded that the risks of cannabis use were minimal; that it did not result in seriously impaired health; that it did not inevitably lead to experimentation with harder drugs; and that it did not cause users to engage in criminal, antisocial, or immoral activities. In fact, the commission concluded that enforcement of the laws prohibiting marijuana possession was more costly to society than the use of the drug itself and recommended decriminalizing possession of small amounts for personal use.[89] Because these findings directly contradicted the nation's newest and most extensive drug control legislation, the Comprehensive Drug Abuse Prevention and Control Act of 1970, President Nixon summarily rejected the recommendations and formally declared a "War on Drugs."

The medicinal value of cannabis was effectively abolished by statute with the passage of the 1970 act, more commonly referred to as the Controlled Substances Act (CSA). This law superseded all prior federal drug statutes and classified most drugs within one of five different schedules based on their safety, medicinal value, and risks of abuse. Under the Controlled Substance Act, marijuana—like heroin and LSD—is classified as a Schedule 1 controlled substance, meaning that it has no currently accepted medical use, a high potential for abuse, and is unsafe even if used under a doctor's supervision.[90]

Despite the fact that the 1970 legislation was focused on controlling recreational drug use, it also had an effect on scientific research. By the early 1970s, anecdotal accounts were surfacing of the effect of marijuana on nausea associated with cancer chemotherapy. Harvard Medical School researchers were poised to study THC (tetrahydrocannabinol) in cancer patients but ended up using a synthetic rather than botanical form of the

substance because, in the words of one of the researchers, "it would have been impossible to get a marijuana protocol approved."[91]

This initial classification of marijuana as a controlled substance did not go unchallenged. In May 1972 the National Organization for the Reform of Marijuana Laws (NORML) filed a petition to reschedule marijuana in order "to make the drug available for medical applications."[92] The Federal Bureau of Narcotics and Dangerous Drugs (BNDD) summarily rejected the petition and, over the next several years, repeatedly defied U.S. Court of Appeals orders to schedule public hearings. It would be fourteen years before the Drug Enforcement Administration (DEA)—successor to the BNDD—would finally hold public hearings on the classification of marijuana.

Federal intransigence on the prohibition of marijuana, however, was not matched on the state level. From 1973 to 1977, ten states passed marijuana decriminalization laws and, from 1978 to 1982, thirty-three states passed bills supporting medical research on, or the medicinal use of, marijuana.[93]

Medical Necessity and Compassionate Access

Among a small but persistent community of patients demanding the right to use marijuana as medicine was Robert Randall. In 1976 Randall became the first person to successfully argue that marijuana use was a "medical necessity" and win an individual exception to the federal prohibition on the drug.[94] Randall, a glaucoma patient from Washington, DC, employed the little-used common-law doctrine of "compelling need." More commonly referred to as the "necessity defense," the doctrine is based on four general principles: that there is no adequate or legal alternative to the commission of an act; that the harm to be prevented is greater than the harm caused by the illegal activity; that the harm to be prevented is immanent; and that it is reasonable to believe that the illegal action will be effective in abating the harm.[95] On these grounds, Randall was acquitted of cultivating and possessing marijuana after demonstrating to the satisfaction of a federal judge that cannabis was the only medicine that effectively controlled the ocular pressure causing deterioration of his vision.[96]

One dramatic effect of this legal victory was the unlikely decision by the federal government, under President Jimmy Carter, to begin directly

supplying Robert Randall with medical marijuana. Under the auspices of the FDA, the government provided Randall with cannabis through the Compassionate Investigational New Drug program (IND). In effect, Randall and his physician were authorized to conduct an ongoing treatment study—with Randall serving as the only research subject—into the medicinal effects of marijuana. Randall received monthly supplies of pre-rolled marijuana cigarettes, using marijuana grown at the University of Mississippi under the supervision of the National Institute on Drug Abuse. Although the application process for participation in the IND program was challenging, and approvals were only grudgingly provided, seven other patients eventually received federally grown marijuana for a variety of medicinal purposes.

The contradiction between the federal government directly supplying patients with marijuana for medical use while simultaneously insisting that the substance had no medical value was inescapable and led Randall (along with a dozen other patients living with such illnesses and disabilities as cancer, multiple sclerosis, asthma, glaucoma, para- and quadriplegia, and chronic pain) to petition the Drug Enforcement Administration for the reclassification of marijuana in recognition of its therapeutic effects.[97] These patients, organized as the Alliance for Cannabis Therapeutics (ACT), joined NORML in 1977 to demand public hearings on the classification of marijuana under the Controlled Substances Act. After almost a decade of repeatedly defying U.S. Court of Appeals orders to schedule public hearings, the DEA finally announced, in May 1986, that public hearings would commence.

Randall, along with a number of doctors, nurses, patients, and researchers, submitted affidavits to DEA Administrative Law Judge Francis L. Young concerning the medicinal use of marijuana. The DEA submitted counterarguments in support of the current classification of marijuana. Based on the evidence presented to him, in September 1988 Judge Young concluded that the use of marijuana in the treatment of nausea and vomiting (caused by cancer chemotherapy) and muscle spasticity (resulting from multiple sclerosis and other causes) was accepted by "a respectable minority" of physicians in the United States; he further determined that marijuana was safe when used in accordance with a doctor's recommendations for the treatment of those ailments. Indeed, to conclude otherwise, Judge Young declared, "would be unreasonable, arbitrary, and capricious."[98] But Young's decision was not binding and the DEA refused to act

on his recommendations. Marijuana remained (and remains) a Schedule 1 controlled substance.

The DEA's decision not to reclassify marijuana to make it available as a medicine under the Controlled Substances Act led to a dramatic increase in applications for the FDA's Compassionate Investigational New Drug program, the only legal source of medical marijuana in the United States. The great majority of new applications were submitted by HIV patients who struggled not only with the symptoms of the disease, but also with the debilitating side effects of the pharmaceuticals prescribed for their treatment.

The government responded to this surge in demand by suspending the program. In March 1992 Louis W. Sullivan, secretary of the Department of Health and Human Services under President George H. W. Bush, announced that NIDA would not provide marijuana for investigational studies except to those patients who were already receiving it at that time.[99] Twenty-seven recently approved single-patient IND applications were canceled, and no more would ever be accepted.

The decision to limit the Compassionate IND program, and thus to deny legal access to a physician-recommended medication, may have been facilitated by the fact most of the new applications were from those living with AIDS. In the early years of the U.S. epidemic, the majority of people with AIDS were gay men and intravenous (IV) drug users—so-called guilty victims. They were depicted both by the media and by conservative politicians as responsible for their own suffering—much like Mexicans and African Americans of an earlier drug-related moral panic. Compassionate access, especially to a drug like cannabis associated with pleasure, may have been seen as a "reward" that discreditable individuals did not deserve.

In any case, this attempt to restrict access to medical marijuana only served to further fuel an explosion of popular interest and political activism. Within four years, in 1996, citizens of California voted to legalize medical marijuana in that state. In response, the federal government threatened to revoke the license of any physician who recommended the use of cannabis to a patient. The departments of Justice and of Health and Human Services notified national, state, and local practitioner associations that physicians who "intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law . . . risk revocation of their DEA prescription authority."[100]

Just Say Know

Government officials intended the threat against physicians to communicate to the public intransigent opposition to the use of marijuana. But an even more important, though clearly unintended, effect was the mobilization and politicization of organized medicine around this issue. California physicians, led by Dr. Marcus Conant, immediately contested the federal policy, suing "Drug Czar" Barry McCaffrey and other federal officials for violation of their First Amendment right to free speech. In April 1997 a U.S. District Court judge issued a preliminary injunction against federal interference with physicians who recommended marijuana to their patients. The injunction was made permanent in 1999 and upheld by the Ninth Circuit Court of Appeals in 2002. The court held that "by chilling doctors' ability to recommend marijuana to a patient . . . the prohibition compromises a patient's meaningful participation in public discourse."[101] The court found that "the harm to patients from being denied the right to receive candid medical advice" and the "harm to doctors from being unable to deliver such advice" were both insupportable.[102]

While this attempt to silence physicians failed, it was consistent with a broader political proscription on open conversation about drug use beyond discussion of any associated risks.[103] The federal War on Drugs —with its proliferation of law enforcement agencies, multibillion-dollar budgets, and a vast, albeit one-sided, public information campaign—is an ongoing attempt to frame and control public discussion of illicit drug use. With few exceptions, that discussion has begun with the presumption that marijuana use can only be seen as a form of drug abuse, at best something comparable to—although probably worse than—alcohol abuse.

Within this framework, serious consideration of the medical use of marijuana has been dismissed not only because of concerns about its safety or efficacy, but also, and more important, because of the "message" it might send. In 1996 then–"Drug Czar" Barry McCaffrey warned, "Labeling marijuana as 'medicine' sends the wrong message to our youth."[104]

But evidence emerging from states that have since passed medical marijuana laws suggests that the public is, in fact, capable of more complexity than McCaffrey assumes. Researchers Shereen Khatapoush and Denise Hallfors report that in California, for example, the state's medical marijuana policy "has had little impact on youth and young adult marijuana-related attitudes and use."[105] Khatapoush and Hallfors note that respondents "distinguish between recreational and medical use; they can believe

marijuana is not greatly harmful and approve of legalization for medical use, but still disapprove of personal use."[106]

In short, since the early twentieth century, the U.S. federal government —sometimes working in consort with organized medicine and sometimes challenging its authority—effectively stigmatized most cannabis use. But by the late twentieth century, public perception of marijuana once again began to shift as the federal government began threatening doctors and punishing patients for medical use of the drug. By linking prohibition of marijuana to the perpetuation of unnecessary suffering, medical marijuana patients and their advocates effectively reopened the public debate about the consequences of federal drug policy on marijuana.

A Prescription for Marijuana

Interview with Dr. Arnold Leff, MD, HIV and Palliative Care Specialist, Clinical Professor at Stanford University School of Medicine

I've had a long history of being involved in drug issues; one of my interests has always been addictionology, if you will. During the Vietnam era, after I came out of the service, I became the medical director of the Cincinnati Free Clinic. At the same time, I was also the drug czar for the city of Cincinnati. So there I was, free clinic doc and the city drug czar. It was a nice combination, actually.

They didn't pay me to do the free clinic, but the health department did pay me to start talking about drug abuse in the community, which I did. I did a lot of talks at all the PTAs and the Rotary Clubs, but I always talked about drug culture, not about drugs. We make artificial distinctions between drugs that are probably not appropriate. Advertising by big corporate pharma giants has helped to create a culture that encourages drug use. You know, "If you can't sleep, take Ambien; if you have a pain, take a pain pill."

In the early 1970s, Hoffman-La Roche, the big pharmaceutical company, had a mega drug called Valium. The problem with Valium was that it also caused dependence. The Congress started getting involved, holding hearings on Valium and how bad it was. It was very interesting how Hoffman-La Roche dealt with it. They hired a guy who was basically an old hippie—he wasn't that old, actually; he was probably in his thirties—and they sent him around to all the free clinics with the message that they were concerned about Valium addiction: "How can we help? Is this a big problem? What are you seeing?" So there was a little epidemiology, a little data gathering, and a little support. They produced a drug abuse pamphlet that probably all of us ex-hippies, or current hippies at the time, participated in. I mean, they really did an interesting job.

This was also around the same time as the Controlled Substances Act and the formation of the White House Special Action Office of Drug Abuse Prevention. But they had this problem; they were having trouble hiring anybody that knew anything because a lot of the treatment folks in the drug abuse arena didn't want anything to do with Nixon. Well, one day, the Hoffman-La Roche guy—who I knew quite well by this time—calls me up and says, "The Nixon White House is looking for folks; are you interested?" I was in my Birkenstocks and Levis but I thought, "A trip to the White House? Let's talk." In August 1972, I became the deputy associate director of the first White House Drug Abuse Office. I might add that it was also the Watergate year and McGovern was the candidate the Democrats put up in October. I mean, it was an incredible year.

Nobody knew quite what to do with me. They sort of looked at me and went, "This guy? No way." But they put me on a team, sent me to Oklahoma. I did my thing and they liked it. They were putting a lot of money behind this; drug abuse was public enemy number one, so we were giving bucks away. But while we were doing that, we were also trying to formulate some good policy. For example, we had this program called Treatment Alternatives to Street Crime, which, already in 1972, was a way to defer folks into treatment. We put millions into that program.

It made a huge difference that Jerry Jaffe was the White House Drug Abuse director [under Nixon] and he was a doctor. That's critically important; he and his immediate successor were the only doc drug czars ever. But already, during the Nixon administration, things started to change. I walked into the office one day and they introduced me to the head of what was going to be the DEA and I thought, "We're in trouble here." And, in fact, that's exactly what happened; the conservative position won out. The people behind the law enforcement approach to substance abuse eventually won out. Even though I'd only been there a year, it was enough. I saw the handwriting on the wall. Dr. Jaffe was leaving and I continued only as a consultant.

I went back to public health and for fifteen years I worked as a public health doctor. In California, I was the health services director for Contra Costa County and then the county public health director in Santa Cruz on an interim basis. I was the interim public health director when the first AIDS death occurred in Santa Cruz. So AIDS became one of my issues. And, when I became a practicing physician, I became an AIDS doc. In fact, I was really the only AIDS doc in Santa Cruz for about seven or eight years. The only other AIDS doc, theoretically, was an infectious disease

specialist who had an unusual perspective in the sense that he tried to convert a lot of people to be "born-again" and that didn't quite fit.

So I became the de facto AIDS doctor, which was pretty difficult because there was no good backup and really nobody knew what to do, especially me. But there was a group in San Francisco of primary care HIV docs who put together a community AIDS consortium and invited me to sit in with them. I used to go up there every month and try, by osmosis, to figure out what to do.

Our patients were wasting away. They couldn't eat; nausea and vomiting was a major side effect of everything we did. And everybody knew marijuana gave people the munchies; everybody knew marijuana did away with nausea and vomiting. I mean, everybody knew it. It was not even an issue. So obviously I was going to support patients who wanted to use marijuana. I was actually writing marijuana prescriptions. In Santa Cruz, in the late 80s and early 90s, if you had a marijuana prescription from Arnie Leff, you didn't get busted.

I felt pretty secure in Santa Cruz. I had legitimate backup because I documented well.

Besides, I really don't think cops care about drugs anyway; they really don't. What they care about are the people who do drugs. And then really only about some of the people who do drugs—only the "underclass" who does drugs. The police use drugs as a surrogate; it allows them to arrest and control the underclass. I really think that's the reason [FBI Director] Hoover got involved in the marijuana thing: to bust people he didn't like. If the only people who were smoking marijuana were upper-middle-class bluebloods, my guess is we would not be having this discussion.

Because I was prescribing marijuana to AIDS patients, I became one of the original plaintiffs in "Conant v. McCaffrey" [the class action suit in 2000 challenging the federal government's threat to punish physicians who recommended marijuana to their patients]. Ultimately they had to kick me off the lawsuit because I had documented evidence in my medical records of prescriptions for marijuana and the Conant lawsuit became strictly a freedom-of-speech issue. They decided to separate the issues of recommending and prescribing. The result is that, if you look at the opinion, the courts ruled that physicians could recommend based on their freedom of speech but they couldn't prescribe based on DEA laws. I thought they should have pushed it further. Authorities are always trying to tell doctors what they think doctors should do; but only the wimpy doctors listen.

No one, the DEA or HMOs or any insurer, gets to tell me what to do.

When they say, "We won't approve this," I say, "Let me talk to your boss." The boss says, "We won't approve it." I say, "Let me talk to *your* boss." I actually teach this: when you get to the third level, it always gets approved. There is no such thing as disapproval. It's a myth. It's just a bureaucracy to convince docs not to do something, or to make it so difficult for them that they're not going to make the effort to do it. Ultimately I've never had anybody say no. It just depends on how far you want to—or have the time to—push the envelope; that's the issue.

Physicians have the capability of pushing the envelope; whether they do it or not is another issue. Physicians have a huge amount of power, but the reality is, most of them are wimps. Of course, if you fight, there's a cost to you—it's one of the reasons I never made any money in medicine. And you do develop a reputation of being a pain in the ass. But I also have the reputation of taking care of my patients. I've always tried to be the "best doc" in town, whatever that is, or at least as good as they come. And I'm a mainstream doc, despite the fact that I have some views that are not mainstream. I've never been a "marijuana doc." I've kept my credibility because I've never prescribed it [marijuana] to anybody but my current patients.

But there's really no question about the usefulness of marijuana. It's such a tragedy that people are so uptight about it. I've quit the California Medical Association (CMA) two or three times, including right after Proposition 215 [the California medical marijuana law] passed. Rather than the California Medical Association coming out and saying, "Marijuana is a potentially useful medication and finally we have something that will protect our doctors who recommend its use," the CMA instead did their usual, very conservative thing of, "Be very careful, this may not be good."

2

Set and Setting

Accidental Activists

On March 24, 1973, Valerie Leveroni and Barbara Raymond, students at the University of Nevada, were returning to Reno after spending the day at a hot spring near Pyramid Lake. As they drove south along Highway 395, Barbara, who was at the wheel of Valerie's Volkswagen, suddenly noticed a small plane heading toward the car, fairly high up but clearly descending toward the highway. Thinking that the pilot might be in trouble, Valerie suggested that they pull off the road in case he was intending to make an emergency landing on the highway. The plane continued to descend as the car came to a stop, but instead of landing it passed just a small distance above and to the left of the car, so close that Barbara was able to see clearly that the pilot had a moustache. The plane roared past, and the two young women realized with amazement that there was no emergency at all, that the pilot was just recklessly playing around with them.

> *Valerie*: We get back on the road, and we're thinking, my God, that's just so dangerous and crazy that anyone would do that. Hard to believe. We're driving for a few more minutes and I hear my friend suddenly gasp and, simultaneously, I hear the plane. I look up and there's the belly of the plane right over us, coming up from behind. So what he'd done is make a loop around Pyramid Lake and come back and fly right over the top of our car. And that's what my friend saw in the rearview mirror. That's why she gasped. Our car suddenly lifts off the ground from the turbulence of the plane going by, and my friend loses control of the car. We skidded off the road and the car rolled over three times. Both of us were ejected on the third roll.

Fortunately, an off-duty sheriff, who had been out hunting arrowheads with his son, witnessed the first pass made by the plane. The risky stunt captured his attention, and he was watching through binoculars when it

returned and forced the little automobile off the road. He was able to record the plane's identification numbers; he then radioed for emergency medical assistance. Both women were found unconscious at the scene. Barbara had broken several bones, including her left shoulder, femur, and wrist, and Valerie suffered severe closed-head trauma.

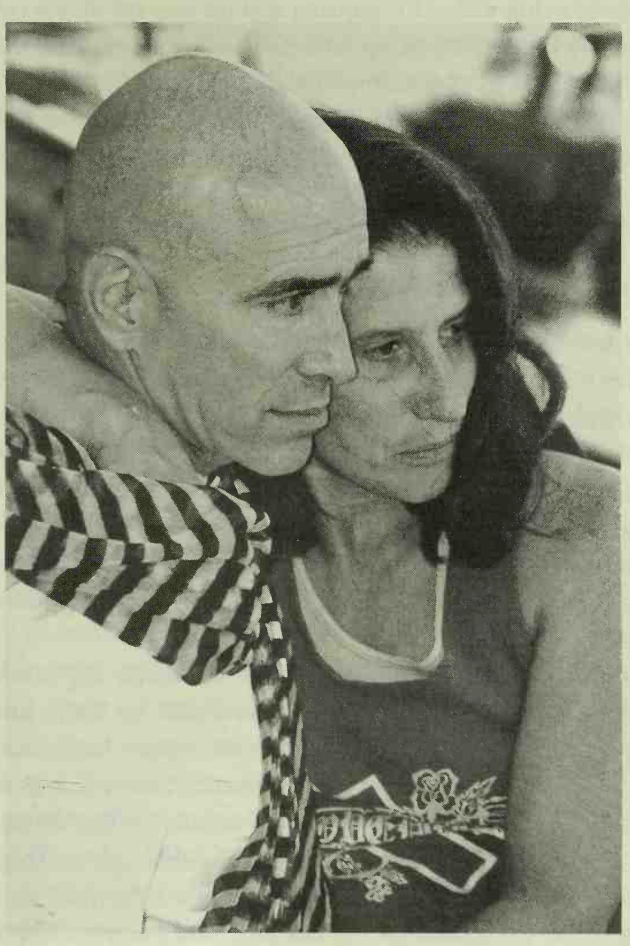
> *Valerie*: As a result of the head injury, I began having massive, uncontrollable seizures, sometimes as many as five a day. I was constantly being hospitalized. The doctors tried to control the seizures with drugs—Mysoline [primadone], phenobarbital and Dilantin [phenytoin]—and Percodan and Valium [diazepam] for pain. They tried many others, and nothing really worked. So the whole thing, the injury and the medications, left me feeling deeply depressed, and very impaired. I couldn't read, I couldn't focus my eyes, I couldn't comprehend, and I couldn't retain information if I did comprehend it. I couldn't take a bath by myself or even spend an afternoon alone, because of the seizures. And the drugs made me feel so weighted down, like I was living underwater, under a veil or in a fog. Anticonvulsants are powerfully strong drugs. The side effects can damage your liver, kidneys, and connective tissue. They also affect your gums and teeth; there are a lot of serious and injurious side effects. But the stoned part of it was the worst; they made me feel absolutely numb and stupid. I had to drop out of school, of course. At first, I tried to go back, but I had a seizure and fell right down the stairs.

In June 1973 Valerie met Michael Corral, the man who would eventually become her husband and primary caregiver. Mike was dismayed by the severity of Valerie's convulsions and, after finding her bleeding and unconscious on the floor at home, became afraid to leave her alone for any length of time. In 1974 he located an article in a medical journal in which researchers reported that marijuana was used successfully to control seizures in laboratory animals.[1] He shared the information with Valerie, who was skeptical but increasingly desperate.

> *Valerie*: I was seeing the best neurologists and, I mean, what's the purpose of seeing the neurologists and not using the medications they recommended? But the seizures were uncontrollable even though I was on the medication. They didn't stop them, or really even diminish them. Then Mike read about the marijuana experiment, and we looked at each other and I kind of went, "No, it can't be. It's ridiculous. How could that work?"

In any case, it appeared that it did work, so I tried it. I would keep a joint rolled and keep one in different rooms, keep it in my pocket. If I felt an aura coming on, I would smoke, because I had a couple of minutes before the seizure would hit. The moment I felt it, I would smoke pot right away. And as soon as I started using the marijuana, we immediately noted a difference in the spasms. Within weeks, we noticed a lessening of the seizure activity itself.

After experimenting over a period of several months, Valerie stopped taking the pharmaceuticals and, to her immense relief, found that a small



Valerie and Michael Corral. Photo courtesy of Jean Hanamoto.

amount of marijuana taken every day seemed to control her convulsions. Although cannabis is an intoxicant, she rapidly developed a tolerance to its comparatively mild psychoactive effects, and her mental clarity quickly returned. To ensure that Valerie would have reliable access to organically grown cannabis, the Corrals began cultivating a few marijuana plants at home despite the risk of arrest for violation of state and federal laws.

> *Valerie*: I don't think either Mike or myself have ever been very preoccupied with the notion of risk. Not that we didn't understand there is some risk. Of course there is some risk, but we never lived in fear of it, with the shadow of that fear. I think it was primarily because I had already had the experience of living without marijuana and the way my illness completely controlled my life. Maybe being an outlaw felt more realistic than being without the means to control the illness. Living outside the law was the obvious thing to do; it wasn't as though it was something that was wrong. So that is why I never think of myself as a criminal.

From Patient to Outlaw

During the late 1970s and throughout the 1980s, Valerie Leveroni Corral and Michael Corral lived a quiet, rural life, focusing their energies on Valerie's recovery from the injuries she sustained in the 1973 automobile accident. The Corrals not only grew their own food, they also discretely grew a small number of marijuana plants for Valerie's use in managing her epileptic seizures. In August 1992 this quiet life was disrupted, and then completely transformed, when a helicopter flyover, funded by a state marijuana eradication grant,[2] identified five marijuana plants in their garden.

This was not the first time the Corrals had been approached by law enforcement officers who had spotted marijuana on their property. But in the past, Valerie's explanation of her medical need had always sufficed. This time, however, the Corrals were arrested. Given the small number of plants and a local culture accepting of cannabis, the district attorney offered Valerie and Michael reduced charges through a drug diversion program. According to Michael, "We spent the next four or five weeks agonizing: should we challenge the law or should we just cop a plea and get a minimum fine with probation and walk?"

For the Corrals, accepting diversion would have meant attending drug

abuse classes and successfully observing a period of probation in which no marijuana could be used. Michael Corral was able to accept the offer, but Valerie was in a more difficult position. Cannabis controlled her seizures. How could she promise not to use it? She decided she could not accept diversion.

During her subsequent trial, Valerie argued that her marijuana use was a medical necessity; it would be both unethical and dangerous for her to promise not to use a substance both she and her physician believed allowed her to live a seizure-free life. Her trial took place just weeks before Santa Cruz County residents were to vote on a groundbreaking medical marijuana initiative, Measure A.[3]

> *Michael Corral*: I have to admit that, before our arrest, we had never really thought about marijuana as being political. We were pretty much totally unaware that there was any kind of medical marijuana movement around at all. We lived back in the woods and just minded our own business, doing our own thing. The arrest changed all that; the people involved in the Measure A campaign found out about us and Valerie became the poster child for the initiative.

In October 1992, Municipal Court Judge Richard Atack ruled against Valerie, despite finding that she had indeed satisfied most of the legal points of medical necessity.[4] While the ruling was a disappointment to the Corrals (who quickly appealed the decision to Superior Court), it may have helped ensure the passage of the local medical marijuana initiative the following month by an astonishing 77 percent of Santa Cruz voters. The Corrals thus effectively transformed what had been their personal medical challenge into an important public issue.

Measure A instructed the sheriff's office and the district attorney to "exercise discretionary powers . . . to minimize the impacts of current drug laws in cases of medical use."[5] The district attorney, Art Danner, acknowledged the connection in the public mind between the need for Measure A and the arrest of patients like Valerie Corral, but he argued that, even prior to the passage of the local initiative, his office used discretion in medical cases: "The woman has already been offered a drug diversion program and reduced charges but has turned down the offer."[6]

But Danner was clearly impressed by the overwhelming support Measure A had received in the county, and, on the Friday before the Corral case was scheduled to go to trial in Superior Court, the DA's office

made the surprise announcement that they were dropping the charges. Danner explained: "She [Valerie Corral] made a very strong showing [of medical necessity] and I think if it had gone to trial, she would have clearly been found not guilty."[7] The local sheriff's department, however, did not share this view. Not only did they announce that they were "unhappy to learn charges had been dropped,"[8] but, within six months, the sheriff's department responded to the public's demand that they exercise discretion in medical marijuana cases by once again arresting Valerie Corral for marijuana cultivation.[9] This time, however, the district attorney's office refused to even file criminal charges.

The two arrests made the Corrals public figures who were increasingly sought out by others in the community struggling with serious illness and attempting to secure marijuana for themselves or a loved one.

> *Michael Corral*: We kept making the front page of the *Santa Cruz Sentinel* and, within a couple of weeks, we started getting phone calls, mostly from terminal people with cancer. At first it was only four or five people, but we knew it would grow. We started meeting with the district attorney and city and county officials and, in November 1994, a new sheriff was elected in Santa Cruz County who was open to a dialogue with us. In many ways, we didn't realize what we were doing. We were just doing it. There was this momentum happening. WAMM grew out of that necessity, out of the sheer number of people contacting us, and having to deal with law enforcement and with politics.

At first informally, and then in an increasingly organized fashion, Valerie and Michael began providing free marijuana from their garden to a handful of local residents living with life-threatening illnesses such as cancer and AIDS. The Corrals also became involved in helping to draft a statewide medical marijuana initiative, California Proposition 215.[10] The "Compassionate Use Act of 1996" passed in every one of the state's fifty-eight counties, amending state law to permit patients to cultivate and possess medical marijuana with a physician's recommendation. Two days after the passage of the new law, on November 7, 1996, the Wo/Men's Alliance for Medical Marijuana (WAMM) was incorporated as a nonprofit organization dedicated to medical marijuana research and education and to providing organically grown cannabis to patients struggling with a variety of chronic and life-threatening illnesses.

The Wo/Men's Alliance for Medical Marijuana

From the outset, WAMM was designed as an exercise in compassion and generosity—WAMM would never sell marijuana but instead would provide it free of charge to those in need. During the next six years, WAMM's membership grew to 250 patients who collectively cultivated their own herbal medicine on the Corrals' land in strict accordance with state and local law. As the organization's mission statement explains, "WAMM is a collective of patients and caregivers creating community, building hope, dissolving barriers, providing support and medical marijuana at no cost."[11] WAMM members use marijuana for a variety of conditions, including nausea and appetite loss related to cancer and AIDS treatments; muscle spasticity and seizures accompanying multiple sclerosis, muscular dystrophy, and epilepsy; glaucoma; and chronic pain.

In order to become a member of WAMM, a patient participant must have discussed with their doctor the possible therapeutic value of marijuana and have procured a written recommendation that cannabis might prove useful in managing the specific symptoms associated with their illness, disability, or course of treatment. The number of members the program can accommodate is limited by the amount of marijuana the organization is able to grow. There is an extensive waiting list to join, and with more than 80 percent of members living with a life-threatening illness, the standing joke is that "people are literally dying to get into WAMM." This is dark humor indeed, as it is unusual for a month to pass without the loss of a member or two; almost 200 members have died since 1996—a particularly significant loss in an organization counting no more than 250 members at any given time.

These seriously ill patients and their primary caregivers not only collectively cultivate marijuana, they also produce a variety of medicinal products that members share among themselves according to need and without charge.[12] Rather than simply paying for their medicine, members are encouraged to contribute volunteer hours to the organization, as their health permits, by working in the garden; assisting with fund-raising; making cannabis tinctures, capsules, and baked goods; helping each other with informal hospice care; or volunteering in the office.

For the first few years, WAMM was literally run from a closet in the Corrals' home with Valerie as executive director and Michael as agricultural director. Both worked full-time for the organization without pay.

WAMM patient, Victor, works in the collective's garden. Photo courtesy of Jean Hanamoto.

Finally, as donations increased and WAMM began to secure some small external grants, the group was able to pay the Corrals each a small stipend and to begin looking for an affordable office space outside of the Corrals' home. Despite widespread sympathy for medical marijuana patients (as evidenced in broad voter support for both local and state medical marijuana laws), fear of violating federal law kept landlords from renting to the organization. This reluctance was understandable given the risk of property forfeiture under federal drug laws.

In 2001, after years of searching, WAMM finally secured office space in an old warehouse at the edge of town. Using only volunteer labor, an inhospitable industrial space was transformed into a welcoming home for the organization and its members. The members built walls, lowered ceilings, repaired floors, and painted and furnished the rooms. The new space meant that the organization could now hold workshops facilitated both by members and by community partners (for example, the local hospice project) and could offer support services such as a weekly meditation group for WAMM members.[13] But having an office also meant the burden of paying rent.

Because WAMM has always refused to charge for marijuana, it is entirely dependent on donations and grants to survive. WAMM's fragile financial health was compromised in 1998 when the federal Internal Revenue Service (IRS) refused to recognize WAMM's nonprofit status granted by the California tax authority, the Franchise Tax Board. A federal official representing the IRS expressed sympathy for the group but explained that the agency felt compelled to revoke the organization's nonprofit status because of federal prohibitions on the medical use of marijuana. This increased the organization's tax burden and made it more difficult to secure outside funding.[14]

WAMM suddenly found itself responsible not only for taxes on any future income, but also for two years of penalties, fines, and interest for the period during which they had been operating as an approved nonprofit. The financial blow was substantial for an organization that has never had an annual budget exceeding $145,000.[15]

Despite federal obstacles, and the almost-unimaginable challenge of running a comprehensive social service organization on such a shoestring budget, WAMM managed to survive and indeed thrive. Against all odds and for over a decade, WAMM has functioned as a successful social experiment in community health care, a defiant local response to federal marijuana prohibition, and a grassroots research project on the delivery and efficacy of multiple forms of medical marijuana.

That this should be true is as dependent on the setting of Santa Cruz, in which WAMM took root, as it is on the remarkable efforts of its members. Since its inception, WAMM has operated in full compliance with state law, with the explicit endorsement of local public officials, and —following a change of sheriffs—in close cooperation with local law enforcement.

Santa Cruz

The improbable success and survival of the Wo/Men's Alliance for Medical Marijuana, achieved in the midst of an intensifying federal War on Drugs, can only be understood by locating it within the specific social setting and the particular cultural/political mind-set of the people of Santa Cruz, California.[16] As Sandra Morgen observes about the women's health movement, "Local history always provides the soil from which particular organizations grow."[17] Santa Cruz is an outspokenly progressive community,

proud of its more-openly radical members and their ability to capture national attention. A local bumper sticker urges residents to "Keep Santa Cruz Weird."

The fertile land of Santa Cruz County has been long famous for its "green gold," though the reference was to lettuce, not cannabis. Prior to the 1960s, Santa Cruz was known as little more than a quiet fishing and agricultural area with an aging population and good surf. But the community did have a history of ignoring unpopular federal laws. During the years of federal alcohol prohibition, from 1920 to 1933, the coastal community was a center for smuggling. According to historian David Heron, "The general public didn't particularly disapprove of bringing booze ashore. What they got tired of in Santa Cruz was the corruption of public officials and the occasional violence."[18]

Still, Santa Cruz maintained a fairly conservative profile until the 1960s. In 1959 a local community college—Cabrillo—opened and began accepting students; six years later, the newest—and most experimental—campus of the University of California system opened: UC Santa Cruz (UCSC). Both Cabrillo College and UCSC brought an infusion of progressive politics into the local community. In addition, just eighty miles to the north, the San Francisco Bay Area had become the epicenter of 1960s social activism through the burgeoning antiwar and Free Speech movements, the antiracist militancy of the Black Panthers, and the counterculture of acid rock and sexual liberation. Life in Santa Cruz was profoundly affected by many of these social forces; as the local daily paper, the *Santa Cruz Sentinel*, explained: "Provoked by the Vietnam War, the draft, the civil rights movement and concern about nuclear weapons, protests grew larger and more militant as the decade [the 1960s] progressed. Then-Governor Ronald Reagan experienced the effect of Santa Cruz's political culture when he attended a UC Regents meeting [the university system's governance board] in October 1968. For three days, university students, joined by their peers from Cabrillo and other community members, blocked buses, heckled speakers and held rallies."[19]

Changing social attitudes weren't limited to the college campuses, as a 1967 comment by Santa Cruz Superior Court Judge Charles Franich in the Santa Cruz press suggests: "You'd be surprised at the prominent people in this county who think marijuana should be legalized."[20] The concern of longtime residents that their traditionally conservative town was transforming only intensified in 1971 when the voting age was lowered nationally from twenty-one to eighteen, enfranchising local college

students. And, indeed, by the late 1970s, Santa Cruz had a well-established reputation as "an important center for the burgeoning women's movement, the gay and lesbian movement, the farm worker and the anti-war movement."[21]

Even during the national turn to the Right in the 1980s, when Ronald Reagan was elected to the presidency, Santa Cruz continued to move to the Left. In fact, in 1981, for the first time in sixty years, progressives secured a majority on the Santa Cruz City Council—a majority they have continued to maintain. One important marker of the irrevocable shift in the local culture and politics occurred in 1985 when the Miss California Beauty Pageant, created in Santa Cruz some sixty years earlier, was forced to relocate to Southern California in response to unrelenting, well-organized, and enormously creative feminist protests.[22] Despite a devastating earthquake in 1989, which destroyed much of the downtown area, and an equally destructive rise in property values, which nearly eliminated affordable housing in the private sector for most lower- and middle-income residents,[23] in the last decade of the twentieth century the community continued to function as a radical enclave within the progressive San Francisco Bay area in one of the most politically progressive states in the United States.

The "counterculture" and its drug of choice, cannabis, have survived despite the fact that the community's fortunes have become more closely tied to the cycles of the dot-com industry (located just over the hill in Silicon Valley) than they are to the boom and bust of marijuana planting and prohibition. Nonetheless, in 1993 then-Sheriff of Santa Cruz Al Noren submitted a state grant application to fund "cannabis suppression and prosecution," arguing that such efforts were more necessary than ever:

> Not only is marijuana grown in abundance here, it is used in abundance. . . . The quality of Santa Cruz *sinsemilla* [seedless marijuana bud] is legendary. . . . Prices for marijuana are very high. Unemployment rates are twice the state average in our south county area. Rainfall this year has been abundant. The county's fiscal short comings and their reciprocal effects to law enforcement are well publicized. The rumors that CAMP [Campaign Against Marijuana Planting] is dead are rampant. The psychological impact of Measure A [the local medical marijuana initiative] permeates the community. This year has all the signs of being a bumper crop year for marijuana producers and the criminal organizations they serve.[24]

Social Movement Spillover

In this fertile ground, Santa Cruz's most famous "criminal" cannabis organization, the Wo/Men's Alliance for Medical Marijuana, took root. WAMM benefited not only from the overall progressive political culture of Santa Cruz—including its widespread anti-prohibitionist perspective on marijuana use—but also from earlier social activism specifically in the area of health. In fact, many of the features of WAMM that seem most distinctive—such as the free provision of medicine, the cooperative structure of the organization, and the central role of the empowered patient—actually mirror the vision of earlier health and social justice movements. Initiatives organized over the past thirty years, such as feminist women's health care organizing and AIDS activism—both at the local and national level—inform WAMM's structure, mission, and practices.[25] Activists in these organizations created "social movement spillover,"[26] leaving in their wake organizational and ideological resources available to WAMM. It is no exaggeration to say that the medical marijuana movement is unthinkable without those earlier interventions.

In Santa Cruz, decades of health activism have made commonplace the notions that health care should be accessible regardless of ability to pay, that physicians should work in close collaboration with their patients, and that conventional "Western" medicine is only one healing modality among many. This transformation began in the 1970s with the founding of two important feminist women's health care organizations: the Santa Cruz Women's Health Collective[27] and the Santa Cruz Birth Center.[28] Both organizations reflected the ideals of the feminist health movement that services should be provided "free, low-cost, or sliding scale," based on a client's ability to pay.[29] Moreover, they should be presented in an egalitarian setting emphasizing peer support and experiential training. The birth center was staffed by lay midwives assisting women with home births, operating strictly on a donation basis and providing services without charge. The Santa Cruz Women's Health Collective (now "Center") offered (and continues to offer) care provided by formally trained physicians, but "doctors and staff always explain everything and are open to patient suggestions."[30] More recently, in 1992, Santa Cruz feminist health activists formed an additional organization, designed specifically to assist women living with cancer, WomenCARE (Women's Cancer Advocacy, Resources, and Education). In the tradition of its older sister organizations,

the group's mission is to empower patients by offering alternatives to "the cancer establishment's limited agenda."[31] Each of these manifestations of the local women's health care movement provides WAMM with a model both of health care as a right rather than a commercial commodity and of patients as active participants in (not passive recipients of) medical care.[32]

For WAMM, a more direct resource than even the feminist health care movement, though, was the local legacy of AIDS activism. Since the inception of WAMM, a deep connection has existed between the organization and local AIDS activists. As Valerie Corral reports, "A lot of our early participants were from the AIDS community—in part because it was a community, and in part because they had to have already come out. It created a kind of resilience and bravery."

Not only have people living with AIDS received marijuana from WAMM to help manage the symptoms of their disease (and the side effects of treatment), but local AIDS organizations and activists have provided critical material support to the medical marijuana organization. "Bill," a fifty-three-year-old WAMM member, explains how his AIDS activism made clear to him the need for an organization like WAMM:

> One of the first cases of AIDS in Santa Cruz in the early 80s was a good friend of mine. A really nice guy and suddenly he's sick like I'd never seen somebody sick before. He's got layers of problems. I got talking with a couple of other men about it and said, "We've got to do something and we've got to do it fast." Turns out they were already planning to set up an AIDS project or whatever we were calling it at the time. I started working with them. But I didn't want to have anything to do with the administrative kinds of things. So I started working with people who were sick.
>
> People were sharing all the information they had: the medicines they were using, the problems they already knew could come up, the opportunistic infections that would occur and how to treat them. A huge problem with the HIV virus was that people would quit eating. When you're nauseous, you don't want to eat. You're just afraid you're going to throw it back up. The medicines cause it and the sickness itself sometimes causes it. And then there were things in the 80s like the wasting syndrome; I can see it now. People looked like they came from Auschwitz. We found that marijuana really helped people eat again. I talked to other people in SCAP [the Santa Cruz AIDS Project] and they all agreed that it was a necessary

thing but there was a lot of risk in it. And how to do it was questionable. I couldn't grow on my land; I'm surrounded by other houses and there's always kids taking shortcuts through my property. So the biggest problem was procuring and distributing. How were we going to do that?

It was around the same time that WAMM was starting up; they were starting a co-op and I pledged to become a part of it. I wanted WAMM to be a more successful vehicle for supplying marijuana than just under the table. I like being up front and honest and ethically correct in my life. And this provided such an opportunity for that.

Another WAMM member, Jeremy Griffey, also entered medical marijuana activism through involvement with AIDS:

I lived with Randy for twenty-one years and then he became ill. For a while, he was on AZT [azidothymidine, the first antiretroviral drug approved in the treatment of HIV] and so sick; they were frying them on AZT in those days; they just didn't know. We started giving him marijuana on a regular basis to control the nausea and to try to get him to eat; but the problem became getting it. Who do you know who isn't a criminal? Who do you know, period? When we'd used it recreationally in the past, we'd just wait until someone had a lid for sale. But now it was something he really needed. So many of my friends were getting sick and I watched each of them pass before my eyes. It made me feel crazy having to fight to get a simple thing like an herb to help them feel better. Anyway, one day a dear friend of mine, Gary MacMillan, God bless him, God rest him (he would appreciate that I mentioned his name), came over and said, "I have a woman you have to meet, Valerie Corral, and—catch this—she is going to *give away* marijuana. She's having a meeting tonight, so whatever you are doing, put it aside and let's go." That first real legitimate meeting was held at the SCAP office that night; I guess there were twelve or fourteen of us there. And Valerie laid out her dream. She knew exactly what she wanted and she knew she needed the help of others to create it. She even had a name for the organization: "I want it for the impact—WAMM: the Wo/Men's Alliance for Medical Marijuana—but we can change that if you want to." We loved it, of course. We elected officers and I became one of the founding members. Now there are just a couple of us left; Gary's gone, Joe's gone, Susan's gone . . . God, it's hard to believe they've all died. Anyway, SCAP let us meet there until they found out we were going to

distribute marijuana. And then they didn't want us anymore. As a matter of fact, nobody wanted us.

Early in the AIDS epidemic, radical health care activists in Santa Cruz became aware of another population heavily affected by HIV: intravenous drug users. In 1989 Santa Cruz became the home of one of the nation's first "clean needle" programs, designed to reduce the spread of HIV by exchanging used (or "dirty") needles for new ones. The relationship between WAMM and the needle-exchange program offers another explicit example of social movement spillover in which one organization provides resources to another. It also suggests that, at least in the case of medical marijuana, the more marginal the health-related organization (and the more stigmatized the population with which they work), the more solid the collaboration. While SCAP provided initial meeting space, only the needle exchange project was willing to allow actual marijuana distribution to take place in their one-room "drop-in center" in the downtown area. The connection between the organizations went beyond an ideological commitment to seeing illicit drug use as a health matter rather than a criminal justice one. Several WAMM members contracted diseases through the use of contaminated needles and used medical marijuana to treat the symptoms; Valerie Corral was outspoken in her support of harm-reduction strategies[33] like needle exchange.

Another socially marginalized group that proved to be an early and critical ally for WAMM was the local queer community. While AIDS was the link for many gay men, from the very beginning there were also many lesbians in positions of leadership within the organization, including on the WAMM board of directors. In part, this was a reflection of the fact that many of Valerie and Michael Corral's most significant relationships were with lesbians and bisexual women. These activists brought to WAMM decades of experience as political organizers both within health care activism and in broader social justice and civil rights work. In this way, WAMM was able to draw on the vast organizing experience of several of the community's most prominent local political activists, women responsible for such high-profile events as the annual Gay Pride parade, the Pink Saturday street dance, the Dyke March, and World AIDS Day commemorations.[34] The extremely close relationship between WAMM and the local queer community also helped to keep the organization financially afloat; for many years, WAMM's biggest annual social event—and

most successful fund-raiser—involved staffing a booth selling T-shirts at the Santa Cruz and San Francisco Gay Pride celebrations each June.

But WAMM's close connection to, and reliance on, the gay community and AIDS activists is far more organic than a strategic relationship of shared practical and ideological resources. In fact, referring to this connection in terms of "spillover" may be misleading. The image of social movement spillover suggests distinct streams running in close proximity, feeding one another as they overrun their banks. Perhaps a better metaphor is of a waterfall[35] formed through the ideological pull and pleasure of social change that has effectively compelled currents to join together, increasing their collective power. But the relationship of WAMM to queer liberation, economic justice work, and AIDS activism is much more intimate than even those images suggest. It may be less the result of spillover and more a reflection of what the Combahee River Collective called a simultaneity of oppression.[36]

WAMM members come together as patients attempting collectively to alleviate some measure of suffering and to challenge legal barriers to cannabis consumption. But the hardships they face as patients are often inseparable from the challenges of poverty and discrimination. Sometimes that poverty and discrimination are directly attributable to their illness; but often they are at least exacerbated by inequalities of sex, race, social status, or sexuality. This complex reality can create among members a more expansive sense of social activism, of what the relevant "social issue" really is, beyond a simple demand for access to medical marijuana. While AIDS activism is certainly distinct from the medical marijuana movement, drawing clear distinctions between the two may be less relevant to a person living with AIDS relying on cannabis to manage the side effects of treatment. Similarly, a homeless WAMM member undergoing cancer chemotherapy and faced with the choice between federally subsidized housing—which demands that residents be "drug free"—and the need to use cannabis to control nausea, will have difficulty separating the issues of poverty and the medicinal use of marijuana.

Patients Producing Knowledge

This experience by patients of intense and often multiple marginalization is offset somewhat in an organization like WAMM by the prominent

role these individuals play in public advocacy, education, and research. In much the same way that early AIDS activists were forced to challenge the assumption that the sick and dying are no more than victims who occupy the position of passive recipient of scientific and medical expertise, medical marijuana patients also often find themselves on the front lines, challenging conventional wisdom, educating their physicians and the public, and demanding access to effective treatment. As Steven Epstein observes, it has "become something of a cliche to say that the doctor-patient relationship will never be the same in the wake of AIDS."[37] Indeed, "embodied health movements,"[38] from feminist women's health care and AIDS activism to the medical marijuana movement, have collectively posed a significant challenge to the traditional monopoly on medical expertise previously claimed by physicians and scientists. These movements have effectively emphasized the collaborative role of patients in producing knowledge about disease and treatment and in shaping responses to it.[39]

Another useful legacy for medical marijuana advocates is the challenge AIDS posed to the idea that only the most rigorously designed, randomized, double-blind study could produce scientific data of any use.[40] As Steven Epstein describes, AIDS activists proposed a more pragmatic approach that would be "less preoccupied with the formal rules that prevent 'contamination' and more open to the varying of experimental design in recognition of practical barriers, ethical demands, and other 'real-world' exigencies."[41] As with AIDS activism, the reliance within the medical marijuana movement on the patient as knowledge producer is born of necessity—federal opposition to cannabis has stifled more methodologically rigorous, scientific research.[42] The medical marijuana movement is certainly not "anti-science" but is, instead, committed to expanding what counts as knowledge and who can be said to legitimately produce it. In the words of sociologists Susan Cozzens and Edward Woodhouse, such movements attempt to "re-value forms of knowledge that professional science has excluded, rather than to devalue scientific knowledge itself."[43]

In the tradition of AIDS activism, medical marijuana patients have attempted "not only to reform science by exerting pressure from the outside but also to perform science by locating themselves on the inside. . . . Most fundamentally, they claim to speak credibly as experts in their own right —as people who know things scientific and who can partake of this special and powerful discourse of truth."[44] This has meant an insistence on

the importance of "anecdotal evidence" coupled with a demand that barriers to more formal research be lifted. In the meantime, federal obstacles to scientific research have made organizations like WAMM especially significant as "real world" laboratories for those working in the field. Not only have several medical marijuana researchers made use of data collected by WAMM, but WAMM cofounder Valerie Corral has herself authored a peer-reviewed article published in a scholarly journal.[45]

Medical marijuana patients are key producers of knowledge about the therapeutic effects of cannabis; they are also responsible for much of the education of the public and the medical profession on this issue. During a 2004 congressional hearing on medical marijuana, the head of enforcement for the Medical Board of California, Joan Jerzak, observed that the flow of information on medical marijuana is largely from patient to physician: "As you know, the traditional medical model flows from the presentation of ideas that lead to new emerging medicines. . . . And physicians are traditionally introduced to these new methods through education settings and through ongoing review of medical journals. In contrast, alternative medical modalities, such as medical marijuana, are typically consumer-driven, whereby the consumers find out about a particular modality or treatment and may ask their practitioners about it."[46]

While Jerzak's comments acknowledge the role of the patient in alerting doctors to alternative treatment modalities, her remarks also serve to transform the patient into no more than a demanding consumer, effectively depoliticizing the interaction between patient and physician.[47] But medical marijuana patients, especially those organized in patient cooperatives, are much more than simple "consumers." This is especially true within the structure of WAMM, where patients produce their own medicine, thus directly contesting the market-driven model.

In addition, many physicians acknowledge that it is the medical marijuana user, not the health care provider, who is the expert in this area of medicine. Dr. Joseph McSherry, for example, opened his 2006 remarks on medical marijuana at the Godnick Center in Vermont noting: "I asked a very good friend, who happens to be a medical marijuana patient, what I should tell you today. He said to tell you not to ask a doctor. Doctors don't know [expletive] about medical marijuana."[48] McSherry, a neurophysiologist and PhD associated with Fletcher Allen Medical Center and the University of Vermont, concluded that his friend was largely correct, telling his audience, "You'll probably be more educated than your doctor by the time we get through."[49]

Stigma Spillover

While some well-established professional and patient-support groups have publicly endorsed the medical use of marijuana,[50] many organizations are uncomfortable, at best, with grassroots medicine practiced outside, or alongside, conventional pharmaceutical and regulatory channels. This is especially true when the drug in question has a long and stigmatized history of recreational use. Marijuana carries the inevitable burden of a medicine that, in the words of one law enforcement officer, "will always wear blue jeans."[51] Diane Dias, a fifty-one-year-old breast cancer survivor, offers one recent example of the effect of medical marijuana's tainted status:

> I've been doing the American Cancer Society twenty-four-hour Relay for Life walk in Santa Cruz for the past three years, carrying the "survivor's banner." The first year I had hair; the second year I was bald. The third year, which was last year, I was able to present them with a check from WAMM for $150 as a donation.
>
> I called the American Cancer Society after a couple of weeks to ask for a receipt so we could do our paperwork on the donation. Within twenty-four hours, I had the regional director on the phone with me. She says, "I'm sitting here holding your check and I can't accept it." She says it's because she works for an organization that "doesn't believe in medical marijuana." I said, "Not believe? Marijuana is what got me through my chemo and my radiation. Not one more pill; not Marinol. It was the pot that got me through it." I was livid and really hurt at the same time. Like our money wasn't good enough for them when maybe that $150 would have helped to find the cure. It breaks my heart.

The reservations about medical marijuana by more-mainstream health organizations have helped to reinforce WAMM's reliance on both the perspective of, and resources available through, more radical health-related organizations, such as the local AIDS project and needle exchange activism. While WAMM clearly has benefited from both ideological and material resources provided by those social movements, this association may have intensified the already marginalized status of the movement, the effect of something like "stigma spillover." WAMM's close association with people living with AIDS, IV drug users, and homosexuals has produced some tensions within the organization as well. As one member who is gay observes, "One of the miracles of WAMM is that we are all

WAMM members burning sage to bless the garden before the harvest. Photo courtesy of Jean Hanamoto.

in the room together despite the fact that we have nothing in common except that we are ill and need our medicine. That's remarkable. You have gay people in there who don't interact well with straight people, and straight people who are afraid of gay people. There are women who are involved with their own home and their own health who don't have much in common with some of the men. There is such a diversity there. It's amazing."

Community within WAMM does not result automatically from that diversity, as "Codi," a forty-nine-year-old woman with blindness and chronic pain due to glaucoma, points out:

> This is a very difficult program to run. For one, you have people who are very ill, with HIV, full-blown AIDS, hepatitis. I don't fit into any of those categories. I'm not as acutely ill as they are. I look at people with HIV and AIDS and hepatitis and think, "You caused that, I didn't." So I take a different perspective than a lot of these other people do. These people are not my friends. I'm different from them. I come to the meetings, I'm

friendly. But they aren't my friends. I wish I could say otherwise, but they're not.

This ranking of the membership based on relative social stigma (with gay men and IV drug users held responsible by some members for their health problems, for example) clearly threatens organizational cohesion. WAMM aspires to be a community, but it only imperfectly achieves its objective, as "Hal," one of the most active members, admits: "It's not that WAMM fully functions as a collective, but it's a magnificent goal. The idea of a collective, a community, is not easy for people. Still, I have to say that, in WAMM, we have more people willing to try to achieve that than any place I've ever been."

Because of the inevitable challenges of creating community across difference and in the face of a hostile and threatening federal police apparatus, the support of the broader community has been especially important to the survival of this fragile social experiment. Both informally and formally, the city, county, and citizenry of Santa Cruz have embraced WAMM. As one local resident living with AIDS reports: "When I moved to Santa Cruz in the 1990s, the AIDS Care Team at the local county health clinic told me about this amazing medical marijuana organization, the Wo/Men's Alliance for Medical Marijuana. I was amazed. Here were county health workers telling me how to get medical marijuana. It was wonderful. I have to say that Santa Cruz county has been just incredible and so has WAMM."

Nobody Enforces Every Single Law

Interview with Mardi Wormhoudt, County Supervisor and Former Mayor of the City of Santa Cruz

It is of great interest to me that even in the conservative parts of this county, where you generally do not find liberalism on social issues, even there, the Santa Cruz medical marijuana initiative passed [in 1992]. A lot of the people who worked on the local measure went on to do the state initiative [Proposition 215]. In general, things have gone fairly smoothly here around this issue. We actually have a county sheriff who has been quite willing to work with medical marijuana advocates, who wants to find a way to honor the spirit of the ordinance. He walks a fine line because, as county sheriff, he is bound to enforce the law and respect federal law and so on. But I know that he has no interest in arresting patients who use medical marijuana or the people who provide medical marijuana.

Mark [Tracy, the sheriff] and I have an excellent relationship even though we disagree on a number of things. He and I have been very oppositional on the issue of state grants for marijuana eradication, for example. It's a ridiculous state program, totally ridiculous. The nature of how people grow drugs has changed incredibly and flying helicopters around the county while dressed in camouflage, it's just boys playing war. It's silly. Most of the large-scale commercial marijuana production has gone indoors, not outdoors. It's not done that way anymore. If you look at the reports year to year about how much marijuana they have confiscated and where they get it and so on, most of it is not from those raids anymore. I don't like helicopter law enforcement period. It's a ridiculous program and a stupid way to spend $250,000. We can do better than that, at least at the local level.

I don't, however, feel very hopeful about influencing federal law in terms of medical marijuana. I just don't. I mean I could tell you that we should work to change the federal law; well, sure we should. But do I feel it's going to happen in my lifetime? Not really. But in terms of policy, certainly policy, can be changed. For instance, I do think that the federal government could be respectful of state law and local law on this issue. Furthermore, we all know that all law enforcement agencies have priorities. Nobody enforces every single law. You don't have a cop at every stop sign.

It's just crazy for the DEA to be paying attention to marijuana issues. God knows there are far more harmful drugs around. I continue to hear that in Santa Cruz there is a major problem with heroin, there is a major problem with amphetamines, crank, crack. My understanding is that the city of Santa Cruz has asked the DEA for help with dealing with those problems and didn't get whatever they needed. I'm not particularly advocating having the DEA come into Santa Cruz County. But if they are going to become involved, I'd like to see them working with local law enforcement to deal with major drug providers dealing hard drugs like heroin and amphetamines. And that's a question of policy, not legislation.

We need to have the courage to articulate and define an alternative to the War on Drugs. We lost that war a long time ago. Give it up. I can tell you that 80 percent of the people booked in the county jail are there for drugs. It may not be a drug arrest; it may be for prostitution or bad checks or any number of things. But if you look at what is going on there, it's a drug arrest really. It's about people getting money in some fashion to get drugs. It's ridiculous. It fills our jails and costs us a fortune. I mean, it is amazing what the War on Drugs costs us. And without absolutely any positive effect at all. I think it is a disaster; it only really benefits the prison industry.

It costs the county a great deal of money to keep people in jail. When we try to put money aside for things like beds in treatment facilities, everyone is like, "Well, I don't know whether we should do that. Is that a good use of our resources?" But nobody asks, "Well, gee, do you want to spend that much on jail beds?" You don't hear that.

I don't think the drug war has worked, but other things do work. I think we've shown that. And I don't just mean things like treatment programs and early intervention. If you want to talk about root causes, you've got to talk about poverty, you've got to talk about people who see no future out there for themselves, for good reason. That is a population that is growing and whose conditions are getting worse.

We also have to acknowledge that we have a confused attitude toward drugs—they are seen as a problem but increasingly also as a solution to problems. A friend of mine who lives out of town, for instance, is going through a disastrous breakup. She keeps calling me. She lives in a place where she has no friends, everything is a mess. She calls me, totally out of control, and I said to her, "You've got to find a doctor. You've got to go see someone because you have to get a handle on this." She called me back; she had gone to the doctor and he had prescribed Ativan. She was doing much better. Didn't mean that it solved all her problems, but she was at least calm enough where it looked like she could start to look at some of this stuff.

You can say we all reach for drugs in this society. In this case, I wasn't even critical of it; I was extremely relieved, despite the fact that the drug she was prescribed, Ativan, is extremely addictive. But for her, in that moment, it was the right thing to do. There are probably other drugs [you have access to] if you are in another economic position. There is a lot of self-medicating that goes on in this society. If you're really stressed out, having a horrible time, you take what is available to you. Alcohol and drugs are a big part of this society, at all levels. What's funny is that we are so judgmental about some and not about others.

It may be that the issue of medical marijuana is a way to begin to talk about all of this. There is an incredible amount of support for medical marijuana among people who would have a harder time talking about drug-policy reform in relation to other drugs. I think Valerie and Mike [Corral, the cofounders of the Wo/Men's Alliance for Medical Marijuana] have been exactly the right people, in the right place, at the right time, to represent this issue. First of all, there is the protocol they use; what they do is so clean. There just aren't any questions about what they're doing. And that has not been true for every medical marijuana distribution center. There are examples in a lot of other communities where stuff goes out the back door. But they have been so exemplary in their protocol that there are no questions like that. And they're both very charismatic. That's also a good thing for leaders on an issue like this. Not to get into a cult of personality thing, because I know that there are tons of other people doing hard work and all. But as the spokespeople for this, they have been phenomenal. They've helped to bring attention to the issue on a local and a national level.

I suppose some people think it's typical that Santa Cruz would be a center for this kind of activism. But I don't really care whether people

outside of our community think Santa Cruz is weird or wonderful. That never struck me as anything that is very important. What I do think is important is that people have as much power as possible over the issues that affect their daily lives. The people who live in this community have a right to that.

3

The Greening of Modern Medicine

Obstructing Science

Throughout the late 1990s and the early years of the twenty-first century, the U.S. Supreme Court consistently ruled in support of federal authority over the cultivation and possession of marijuana even for medical use. The justices often appeared sympathetic to the plight of patients, but the majority refused to challenge federal power in this area. The prevailing view appeared to be, as Justice Stephen Breyer suggested, that patients would be better served by working *with* the federal government rather than *against* it. Going through the Federal Drug Administration to get marijuana formally approved as a medicine, Breyer argued, would be "the obvious way [for patients] to get what they want. . . . And while the FDA can make mistakes, I guess medicine by regulation is better than medicine by referendum."[1]

Breyer's comments ignore the already more than thirty years of effort by patients and researchers seeking to obtain federal reclassification of marijuana to allow for medical use. As Dr. Rick Doblin, a prominent drug policy critic, has observed, those who have attempted to conduct the necessary research for FDA approval have discovered that the normal approval process has been "politically hobbled" by the "systematic hindrance of scientific research by governmental agencies over the last several decades."[2] These governmental agencies most prominently include the Drug Enforcement Administration and the National Institute on Drug Abuse (NIDA). As the American Civil Liberties Union (ACLU) points out, "NIDA discriminates against scientists who seek to study marijuana's efficacy and safety. Such research clashes with NIDA's mission to study only the harmful effects of drugs."[3]

It's not surprising that agencies devoted to the dangers of drug abuse might be uneasy about scientific research focused on the therapeutic value

of the nation's most popular illegal drug. What is surprising, however, is that the DEA and NIDA have been in a position to block even carefully designed, FDA-approved research on the medical value of marijuana. This veto power is the product of a legal monopoly enjoyed by the National Institute on Drug Abuse on the supply of all marijuana to be used in FDA-approved clinical trials. Such an arrangement is unique to marijuana; for every other controlled substance—including other Schedule 1 drugs such as heroin and LSD—researchers can apply to a number of licensed suppliers. But in the case of marijuana, scientists are only allowed to request cannabis cultivated at a single NIDA-licensed facility at the University of Mississippi. The DEA and NIDA have the right, frequently exercised, to refuse researchers access to that marijuana. As Betty Gillespie Pollack, the executive director of the San Francisco Medical Association, observes, "Researchers have attempted to start such studies, only to be blocked by law enforcement agencies that won't give approval."[4]

Yet without apparent irony, in 1997, after more than a decade in which all clinical research into the safety and efficacy of marijuana as a medicine had been blocked by the DEA, federal "Drug Czar" Barry McCaffrey announced, "Drug policy must be based on science, not ideology."[5] On its Web site, the DEA has made similar claims, boldly announcing that, when it comes to "'Medical' Marijuana, the DEA recognizes the importance of listening to science."[6] While it is possible that the DEA and NIDA have indeed been listening, science must not have been saying what the agencies wanted to hear.

In the 1980s, before NIDA fully sealed off access to marijuana for clinical trials, more than thirty states enacted legislation to make cannabis available to cancer patients through state research programs.[7] The federal government immediately began impeding such studies; only six states were successful in securing NIDA marijuana for their research programs. Nonetheless, in each of those state studies, researchers reported that cannabis did indeed have "therapeutic efficacy for patients undergoing cancer chemotherapy."[8]

From 1986—when the last of the state studies was completed—until 1998, not a single new patient in the United States received cannabis in an FDA-approved study despite ongoing interest within the medical research community.[9] Rather than allowing unfettered research into the medicinal uses of the cannabis plant, the federal government instead diverted scientific research into the development of a pharmaceutical substitute. Seventy-five percent of the funding for research into synthetic THC (one

of the therapeutically active components in marijuana) came from the federal government. The resulting prescription medication, Marinol, was approved for use in treating precisely the conditions (nausea and vomiting associated with cancer chemotherapy) that the six state studies had suggested marijuana could effectively treat.[10] As attorney and policy analyst Alice Mead remarks, "Once Marinol was available by prescription, the federal government contended that the use of smoked cannabis was unnecessary."[11] The development of Marinol provided federal drug prohibitionists with an important—if contradictory—argument against the rescheduling of marijuana for medical use: not only does cannabis have no medicinal value, but also all its important medicinal effects are better delivered in the form of a pill than a plant.

The preference for a pill over a plant necessarily relied on ideology, not science, especially because the federal government stifled research that might have compared the efficacy of the botanical to the synthetic forms of the drug. The twelve-year federal blockade on clinical research into the therapeutic efficacy of the botanical drug was only breached in the late 1990s through the force of what Justice Breyer disparagingly referred to as "medicine by referendum." In 1996 voters in California authorized the cultivation and use of marijuana by eligible patients and, simultaneously, established a Center for Medicinal Cannabis Research to be located at the University of California at San Diego.[12] Two years after the California referendum, Dr. Donald Abrams of the University of California at San Francisco received the first NIDA marijuana for use in a clinical study in more than a decade.

Abrams's study had already received FDA approval three years earlier, but, until the passage of the California law, NIDA had blocked the research. According to Rick Doblin, once the California law was in place, "NIDA indicated to Dr. Abrams that it might be willing to work out some arrangement whereby his long dormant FDA-approved study could go forward."[13] But in a telling example of NIDA's enduring reluctance to allow research into the therapeutic value of cannabis, in order to receive marijuana needed for his study, Abrams had to redesign the research protocol. While the FDA-approved protocol had focused on testing the safety and efficacy of using marijuana to treat AIDS-wasting syndrome, NIDA demanded that the study be transformed into an assessment of the *risks* of cannabis use by AIDS patients.[14] According to the *San Francisco Chronicle*, "At the insistence of government funders, the Abrams study did

not set out [as originally intended] to prove or disprove the contention of medical marijuana advocates that smoking pot can improve appetite, body weight, and well-being of patients with AIDS, cancer, and other wasting diseases. Abrams' stated goal in this [revised] study was to determine whether the chemical components of marijuana in any way interfered with the body's ability to break down the components of protease inhibitors [the antiviral drugs used to control HIV]."[15]

Abrams's study produced intriguing results; not only did he find no risk to AIDS patients consuming cannabis, but, in fact, his study suggested that patients appeared to benefit from use of the drug. Despite no longer being the central research question, Abrams managed to take "a little peek to see if there was any change in appetite, caloric intake, and body composition"[16] among those patients suffering from AIDS-related wasting syndrome and nausea. Patients who smoked marijuana gained 7.7 pounds compared to an average of only 2.9 pounds gained by those taking a placebo.[17] The need to "sneak a peak" at potential benefits of cannabis use while reorienting research to focus on risks demonstrates the power of federal drug abuse administrators in limiting what scientists have been formally allowed to study.

In a direct challenge to that power, Dr. Lyle Craker, the director of the University of Massachusetts at Amherst's Medicinal Plant Program, attempted to break NIDA's long-standing monopoly on access to marijuana for scientific research. In June 2001 Craker applied for a license to establish a small medicinal cannabis production facility as an alternative source of marijuana for FDA- and DEA-approved research. The treatment his application received would seem comical if the consequences of a continued NIDA monopoly on marijuana were not so serious. For six months after submitting his application, Craker heard nothing from the DEA until, in December 2001, he was informed that his application had been lost.[18] A photocopy of the original would not be accepted. In July 2002, as Craker worked to reassemble his documents, the original application suddenly reappeared, returned unprocessed to Dr. Craker, without a cover note or comment except for a DEA date stamp indicating its receipt a year earlier.[19] Craker quickly resubmitted the original application but it was not until March 2003—more than twenty months after the application had first been submitted—that the DEA responded, and then only to inform Dr. Craker that he would need to submit "'credible evidence' that researchers were not adequately served by NIDA cannabis."[20] After Craker

supplied this evidence, the DEA once again held his application for another full year without taking any action to approve or deny it as required by law.

Finally, in July 2004, a full three years after submitting his application, Dr. Craker—joined by Dr. Rick Doblin, patient-activist Valerie Corral of WAMM, and the ACLU—sued the DEA for unreasonable delay.[21] Alan Hopper of the ACLU explained his organization's decision to join the lawsuit noting, "We believe scientists and researchers should be able to pursue the truth about all drugs. . . . They [members of the federal government] always say we need more research, but at the same time, they block it. The government is placing ideology above the health and safety of patients."[22] Dr. Lyle Craker observed, "Only through unobstructed medical research can doctors and scientists determine the value of marijuana in treating human afflictions. My job is to make plant material available for research, and the refusal of the DEA to allow me to grow marijuana for medical research prevents a full investigation of the potential health benefits of the plant material."[23] The increased pressure on the DEA generated by lawsuits and state legislation produced some modest results; by 2004 the number of FDA-approved research studies receiving federal marijuana had increased to eighteen.[24]

Anxiety about what new research might reveal about the medicinal value of marijuana may have contributed to the timing of a federal request to the national Institute of Medicine (IOM) for a comprehensive review of the existing scientific literature on medical marijuana and its constituent compounds. The federal request was made in 1997—the year *before* NIDA ended a twelve-year blockade on any new clinical research in the area.[25]

Pure Pharmaceuticals and Crude Botanicals

Despite more than a decade of obstructionism, the IOM declared itself committed to "Assessing the Science Base" of the medical use of marijuana. Its report would emphasize "evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science)."[26] The report's tone was judicious, careful not to overstate the findings of available research nor understate any risks associated with marijuana. The IOM suggested, for

example, that, for many patients, existing pharmaceutical drugs might offer better symptom relief than cannabis, but they acknowledged that "people vary in their responses to medications, and there will likely always be a sub-population of patients who do not respond well to other medications."[27] The IOM concluded that, for those patients, "cannabinoids would be moderately well suited," in particular for such conditions as "chemotherapy-induced nausea and vomiting and AIDS wasting."[28]

This clear, if qualified, support for the therapeutic value of cannabis was not the only bad news in the report for antidrug warriors. Other unwelcome findings included the determination that, as a medication, marijuana could not be considered unusually dangerous: "Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications."[29] The report even specifically rejected the notion that marijuana is a highly addictive substance and questioned the belief that it serves as a "gateway," leading to the use of more dangerous drugs. Scientific evidence, the IOM reported, suggests that "few marijuana users develop dependence" and, for those who do, withdrawal is "mild and short lived."[30] Furthermore, "There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs."[31]

Most of these findings were simply ignored by federal policy makers. But the IOM did throw one critical lifeline to antidrug officials: the report concluded that while cannabis did appear to have therapeutic potential, a distinction should be made between the plant itself and any medicinal products to be developed from it: "If there is any future for marijuana as a medicine," the IOM proclaimed, "it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures."[32] The IOM report acknowledged that botanical cannabis had a long-standing history of medicinal use, but the authors insisted that "modern medicine adheres to different standards from those used in the past. The question is not whether marijuana can be used as an herbal remedy but rather how well this remedy meets today's standards of efficacy and safety."[33]

But, in fact, the urgent policy question precisely is whether marijuana can be used as an herbal remedy. Because of political opposition, it is unclear whether the herb—even if proved safe and effective—will be available for medical use or whether access instead will be fully controlled by

the pharmaceutical industry manufacturing cannabinoid-based medications. Rather than attempting to directly address the question of the safety and efficacy of botanical medicine, the IOM report simply asserts that a pharmaceutical would be preferable to a plant: "Defined substances, such as purified cannabinoid compounds, are preferable to plant products, which are of variable and uncertain composition."[34]

This preference has been trumpeted by policy makers seeking justification for the continued prohibition on botanical marijuana even for medical use. For example, Representative Mark Souder (R-IN) paraphrased the IOM's position when he argued at a 2004 congressional hearing on marijuana that "the real debate is not over whether marijuana could be used as medicine. The debate is over the most *scientifically safe and effective* [*way*] *that components of marijuana* may be used as medicine."[35] Without evidence supporting such a distinction between components and the crude botanical itself in terms of safety and efficacy, the debate remains fully within an ideological frame. In the aftermath of the IOM review, anti–medical marijuana warriors are left with little more than an appeal to the superiority of the man-made over the natural and of the pharmaceutical over the botanical.

The assumed disadvantage of the diversity of chemicals found in botanical marijuana was repeatedly raised by Rep. Souder during the congressional hearings. Nora Volkow, director of the National Institute on Drug Abuse, for example, was asked to testify about problems with a complex botanical like cannabis; as Volkow explained, cannabis "is not just a single drug . . . it contains more than 400 chemicals."[36] A second witness, Dr. Robert Meyer, director of the FDA's Office of Drug Evaluation, confirmed that this is what distinguishes marijuana from approved prescription medications like Marinol (dronabinol) and Cesamet (nabilone), all of which are composed of synthetic forms of the "active ingredients related to those present in botanical marijuana."[37]

Souder seized on this testimony as evidence of a crucial difference between real medicine and marijuana: "Let me see if I understood your positions correctly. . . . You do not believe that marijuana is medical. But there are some components and chemicals in marijuana that you are actively researching . . . and there are products that have been developed from those chemicals that are helping to treat the parts of different illnesses that some people have used the arguments for marijuana to treat. . . . And, in the minds of both your agencies, marijuana itself is not medical, but it does have components that you will continue to research. . . . Is

that a fair statement?"[38] The representative of the FDA, Meyer, responded cautiously to this overtly political conclusion: "I would say that we do not have the evidence to say that it has a legitimate, safe and effective use. . . . We feel that there would be much more research needed to both explore the efficacy and to document the safety [of botanical marijuana]."[39] Meyer's response was unsettling to Souder, leaving open the possibility that future research might provide evidence of a legitimate medicinal use for the plant. Turning quickly to Volkow, Souder insisted: "[And] four hundred chemicals probably wouldn't be in it because you'd be isolating what you're treating. Is that correct, Dr. Volkow?"[40] The head of NIDA proved more amenable to this conclusion than the scientist from the FDA: "Yes. Ideally, of course, you want to get as pure a medication as you can to minimize side effects."[41]

This exchange between Souder and Volkow is an excellent example of "belief based," not "science based," medicine. The claim that an isolated compound is always to be preferred to the naturally occurring complexity of a plant is not a scientific fact, but rather part of an ideological apparatus used to create an imaginary line separating safe and effective pharmaceuticals from crude and dangerous botanicals.

If It Feels Bad, It Must Be Good for You

> Just because something makes you feel better doesn't make it medicine.
>
> —Andrea Barthwell, U.S. deputy "drug czar"[42]

> You want to get as pure a medication as you can to minimize side effects.
>
> —Nora Volkow, director of the National Institute on Drug Abuse[43]

If we consider these two statements together, they reveal a great deal about the pharmacological assumptions underlying the practice of modern medicine. First is Barthwell's idea that "feeling better," in and of itself, is not the goal of therapeutic drug use. Despite the fact that this is precisely the purpose of many approved pharmaceuticals, a lingering, puritan distrust of pleasure, a kind of "pharmacological Calvinism,"[44] remains firmly entrenched in the American psyche, even within a commercial culture preoccupied with pursuit of pleasure. In the case of prescription pharmaceuticals that do produce pleasurable (i.e., intoxicating) side effects, tight regulations and strong warnings against illicit or excessive use

are in place. In fact, "preventing drug abuse" is tantamount to preventing the use of drugs for pleasure or recreation. Pain killers, antidepressants, and cannabis—drugs that make patients "feel better"—constitute a special problem not only for medical practitioners, but also for law enforcement officials. It is precisely because marijuana is used recreationally for pleasure that many, including Andrea Barthwell, oppose its medicinal applications; there is something amiss if patients actually enjoy taking their medicine.

Punishment for misbehavior among children has often been referred to as "taking one's medicine"—something that authority figures have long contended is good for us, but certainly not something to be understood as pleasurable. As Susan Sontag observes, the idea that real medicine should not be pleasant is related to the persistent, if irrational, belief that "illness reveals, and is punishment for, moral laxity or turpitude."[45] Like sickness itself, medical treatments are widely perceived as punitive: diagnostic procedures are often painful, humiliating, and costly; pharmaceuticals may produce distressing physical and mental side effects; surgical operations are only bearable by virtue of often-risky anesthetics. Corrective treatments of all sorts are expected to be objectionable and perhaps only effective to the degree that they are unpleasant; the most "heroic" interventions are also the most horrific.

Certainly nobody "abuses" protease inhibitors or cytostatic chemotherapy agents. Indeed, as any cancer or AIDS patient will tell you, the drugs used in the treatment of their disease frequently do not make them feel better in the short run, even if they permit a respectable percentage of patients to survive in the long run. Cancer and AIDS patients routinely become nauseated and distraught at the very thought of their treatments, even before the drugs themselves are administered. Susan Sontag, who battled cancer, reported "a common cancer hospital witticism, heard as often from doctors as from patients: 'The treatment is worse than the disease.'"[46] John Paul Taylor, a WAMM member living with HIV, complained that the simple act of opening his pillbox in the morning would produce the dry heaves. Writer Dan Shapiro, like numerous other cancer patients, became physically sick in the car on his way to his chemotherapy treatments.[47] Dr. Barthwell would perhaps be more accurate if she were to state that just because something is called "medicine" doesn't mean it will make you feel better.

Second, Nora Volkow's idea that pharmaceutical purity necessarily minimizes side effects is a phenomenally misleading statement, as anyone

who has ever taken prescription drugs of virtually any kind can easily understand. Rare, indeed, is the prescription medication unaccompanied by a lengthy warning about risks of use and predictable side effects. From the hair loss and debilitating nausea associated with chemotherapy administered to cancer patients to possible kidney and liver damage resulting from the use of antiviral medications by HIV patients, serious side effects are all but a foregone conclusion in the use of many prescription and over-the-counter drugs. Antiinflammatories are notoriously hard on the stomach; erectile-dysfunction drugs—rushed to the market in anticipation of their immense profitability—were subsequently linked to risks of heart failure and blindness; even popular arthritis medications have been recently withdrawn from the market due to harmful side effects. In fact, each year, more than two million Americans experience adverse reactions to prescription drugs and more than a one hundred thousand die of them.[48]

It is not obvious, then, that the transformation of marijuana into a pharmaceutical drug through the extraction or manufacture of single components would necessarily increase the drug's safety. Indeed, instead of ensuring safety and reducing the risk of side effects, pharmaceutical purity might actually increase the risk of harm to users. As Lester Grinspoon, a physician and researcher at Harvard University, observes, "As drugs are purified, they become potentially more dangerous. As we create single compound drugs from cannabis, we are likely to find that we have created more dangerous drugs."[49]

Contrary to what Ms. Volkow suggests, the essential reason for regulatory insistence on the "purity" of pharmaceuticals is to facilitate measurement and control over dosage, not to eliminate side effects. There are, of course, considerable marketing advantages to the packaging of drugs in precisely measured doses. It might be difficult to know how many doses an ounce of marijuana will provide; no such sloppiness is permitted in the pharmaceutical industry, where Marinol, a synthetic cannabinoid, can cost thirty dollars per pill. In terms of safety and effectiveness, standardized dosage is more a matter of balancing the intended primary therapeutic effects of synthetic chemicals with their harmful but predictable side effects than it is a question of preventing the harmful side effects in the first place. Yet federal regulators continue to insist that, in order to be safe, drugs must be simple chemicals or very simple combinations of chemicals, mainly synthesized in laboratories, and provided in reliably measured doses.

From Isolation and Standardization to Complexity and Synergy

Measures of purity and standardized dosage serve as sentries protecting the status of pharmaceuticals as "real medicine" and keeping botanical remedies outside the gates. A clear statement of this position was made during the 1986 DEA hearings first examining the possibility of rescheduling cannabis for medical use. In his testimony, Dr. Norman Farnsworth argued that "the problem of using natural substances as drugs is that it is difficult to regulate the doses of the active constituents and the presence of other potentially active constituents in the natural substances. . . . As a result, most natural drugs and their crude extracts cannot meet present quality control standards in the United States."[50]

Indeed, plants are not uniform; the quality of seed, the location and climate in which the plant is grown, and the time of harvest all affect the strength of medicinal herbs.[51] But the necessity for precise measurement presumes that the substance is dangerous at different strengths. While consistency is desirable in herbal remedies, minor variability would appear to pose no substantial risk with a plant as nontoxic as marijuana. As DEA Administrative Law Judge Francis Young concluded, "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man."[52]

While the desire for a precise and standardized dosage may be useful to regulators attempting to distinguish botanical from pharmaceutical drugs, it appears to be relatively unimportant to medical marijuana patients seeking effective relief. Although a patient might never receive two measurably identical doses of the drug, most report that, because marijuana smoke produces its effects very rapidly, it is relatively easy to regulate dosage through titration: taking one or two hits from a joint or from a vaporizer and then pausing to gauge the effect. WAMM member John Paul Taylor would awaken in the morning unable to swallow his medications, never mind eat breakfast. "A puff or two" on a joint was usually all he required to ease his morning nausea. On other occasions, when symptoms were more severe, John would smoke more, sometimes a whole joint to secure full relief. The only "dangerous side effect" from higher "doses" was the altered state of consciousness so appealing to recreational users.

It is possible that the drive to isolate and synthesize active components in marijuana may be less about the need to establish a fully standardized dosage than it is to select out certain "desirable" effects from "undesirable" ones (most notably the psychoactive properties of the plant).[53] This

possibility is suggested in the IOM's explanation for their preference for cannabinoid pharmaceutical products over whole plant medicine: "Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone. Medications that can maximize the desired effects of cannabinoids and minimize the undesired effects can very likely be identified."[54]

As the IOM suggests, extracting cannabinoids to create standardized pharmaceutical products may prove to be important in developing concentrated medications for the treatment of specific conditions in certain patients. For other patients, however, the herbal form of the medicine may be entirely adequate and even preferable, both in terms of cost and effect. It is, in any case, at best disingenuous to suggest that the variability of botanicals necessarily makes them inferior as a medicine to the standardized dosage of an isolated chemical available in the form of a pill.

But the notion that synthetic drugs are inherently superior to plant medicines is reinforced in the language used to distinguish "pure pharmaceuticals" from "crude botanicals." In the IOM report, for example, they observe that "*marijuana* refers to unpurified plant substances including leaves or flower tops."[55] The implication is that botanical medicines are somehow impure even when they are composed of nothing but clean, organically grown plant matter. Here "purity" is a quality that can only be produced by isolating and extracting (or synthesizing) specific active compounds.

But, in fact, this sort of synthetic purity is not always superior to the natural complexity of plants. Certainly, isolating specific components allows for greater human control over exactly what is ingested and in what quantity; but it also effectively eliminates "synergy" in which naturally co-occurring components interact. That interaction can offer unique benefits that enhance therapeutic effects or diminish undesirable side effects. Dr. Andrew Weil, whose research with whole plant medicines, including cannabis, has spanned decades, observes, "We have no reason to believe that a synthetically manufactured product will be as safe or as effective as the natural product. Indeed, my studies indicate that the synthesis of natural plant products into pharmaceutical preparations invariably increases the potential for adverse effects, but may not enhance therapeutic action."[56] Research by Dr. Norman Zinberg, who conducted some of the first studies on the medicinal use of marijuana in the 1960s, appears to bear this out; in the case of botanical marijuana, he discovered an increased effectiveness of the whole plant medicine compared to synthetic THC and

ascribed this to marijuana's natural chemical complexity.[57] Similarly, in 2004, neurologist Dr. Ethan Russo, a longtime researcher on the medicinal effects of marijuana, argued, "There is increasing evidence that the biological effects of cannabis are not produced by THC alone, but rather, that the herbal synergy of the whole cannabis extract yields pharmacological results greater than the sum of its parts."[58] This synergistic interaction Russo calls the "entourage effect."[59]

Even Nora Volkow, director of NIDA, was compelled to acknowledge during congressional hearings on medical marijuana that, in some instances, "combinations appear to be better than just a single [component]."[60] Representative Souder quickly "clarified" her point by interjecting, "So you could take a component of marijuana and maybe find another one somewhere else that wasn't even in marijuana to combine with something that you find inside marijuana to make a more effective pill."[61] Volkow's response reflected an awkward attempt to both support Souder's position while simultaneously acknowledging evidence of the value of naturally occurring synergy: "Correct. And there are naturally occurring compounds that, for example, in the case of amphetamines, which we used to treat children with ADHD (Attention Deficit Hyperactivity Disorder), there are actually really two components to it, and it has been shown that both of them exert slightly different effects."[62]

As Volkow notes, naturally occurring combinations can have beneficial effects; these may be difficult to mimic using synthetic pharmaceuticals. In 2006 researchers studying breast cancer among women taking estrogen following hysterectomies were puzzled when they found that estrogen-replacement therapy, known to fuel the growth of many breast cancers, did not produce increased risk among the subjects in their study.[63] One hypothesis for the lower-than-expected rates of cancer was that the form of estrogen used by the women in the study, Premarin, contains natural hormones. As the lead researcher noted, Premarin "consists of a complex mixture of hormones, some of which mimic human estrogen" making it possible that it "contains hormones that protected against cancer as well as ones that spurred its growth, effectively leading to a neutral effect."[64]

This recognition of the therapeutic value of natural complexity is fundamental to some non-Western medical approaches, including traditional Chinese medicine. American researchers studying a plant extract, Tripterygium wilfordii Hook F, used in Chinese medicine to treat rheumatoid arthritis, discovered that "although the main active ingredient of this extract, triptolide, has been identified, it was shown to be toxic unless

given as part of the root extract, suggesting that other unidentified extract components increase its safety and, possibly, efficacy."[65] Researchers concluded that it is the "enormous propensity of plants to synthesize mixtures of structurally diverse bio-active compounds with multiple and mutually potentiating therapeutic effects" that may create an advantage for some botanicals over single-compound synthetic medicines.[66]

In Western Europe, where botanical medicine has been much more fully integrated into conventional care than in the United States, the complexity of botanicals is increasingly accepted as an advantage rather than a problem to be overcome. In a 1999 paper drafted for the European Union, the European Herbal Practitioners Association observed that "plant medicines invariably comprise a multiplicity of chemical components whose overall effect cannot simply be assumed by reference to perceived active components. In practice, apparently unimportant fractions of a plant may act in vivo to buffer or amplify the principal pharmacological characteristics of a plant."[67] Similarly, naturopathic practitioners argue that "despite our many medical technological advances, medicine is far from achieving the ability to mimic natural medicines in their native states . . . rarely does one nutrient achieve what many working in combination will."[68]

This process may explain why taking vitamins appears to produce fewer health benefits than consuming the fruits and vegetables in which they are found. In the 1990s vitamin E, for example, appeared to play a role in reducing heart disease and cancer; but subsequent scientific studies suggested that, in isolated form, the vitamin might not provide any overall protective benefit. As the *New York Times* reported, "Many scientists and health advisory groups who still have high hopes for the vitamin as it occurs naturally in vegetable oils, nuts, and leafy greens have begun to pan the pills."[69] Indeed, according Dr. Ilya Raskin, professor of plant science at Rutgers University, researchers are increasingly interested in the additive or synergistic effects of components found within plants and plant extracts.[70]

While proponents of pharmaceutical medicine base their preference for synthetic drugs on a belief that such substances are not only more effective but safer than "natural remedies," the public has increasingly embraced botanical therapies, in part because of a belief "that natural is healthy and that plant products are safe."[71] Medical marketing researcher Patricia Tam observes that there has been "a popular backlash to the increasing syntheticization of modern life. Not only is 'choosing natural' an aesthetic and lifestyle choice, many consumers consider this a protective

measure against the hazards of scientific progress, such as genetic modification, antibiotic abuse and drug side effects."[72] The notion that so-called crude botanicals might be as safe and effective as some pharmaceuticals, and may even have some advantages over manufactured single-compound pharmaceuticals, runs contrary to many core beliefs of contemporary Western medicine. But it is an idea that resonates with a growing segment of the public that appears to be increasingly interested in "natural remedies" and other alternative therapies.

Golden Bullets

The strong and growing support for the use of botanical marijuana as a medicinal drug has been dismissed by federal prohibitionists such as Representative Mark Souder (R-IN) as no more than evidence that a "large and well-funded pro-drug movement" has duped the American public.[73] If so, it is not clear that the "pro-drug" people have received their money's worth. According to the nonpartisan public research organization Public Agenda, 64 percent of Americans in 2005 still believed that the nonmedical use of marijuana should remain illegal.[74] This suggests the possibility that widespread popular support for medical marijuana at the turn of the twenty-first century is less a reflection of changing views on drug prohibition than it is of changing attitudes toward medicine.

For much of the twentieth century, Americans expressed deep confidence in the power of modern medicine. As late as 1994, for example, 34 percent of all Americans believed that modern medicine could "cure almost any illness for people who have access to the most advanced technology and treatment."[75] In contrast, only 11 percent of Germans held the same belief.[76] Americans persist in this unrealistic belief despite research findings that, while more than thirty thousand diseases have been clinically described, "less than one-third of these can be treated symptomatically, and only a few can be cured."[77]

In the mid-twentieth century, licensed physicians, armed with newly effective and carefully regulated drugs, appeared to work miracles. But, by the end of the century, conventional medicine was beginning to lose some of its magic. In 1971 President Richard Nixon confidently declared a "War on Cancer." But, within fifteen years, with cancer rates rising, the *New England Journal of Medicine* acknowledged, "We are losing the war."[78] While astonishing breakthroughs are being made in many areas of medicine (for

example, in the treatment of AIDS), Harvard Medical School professor John Abramson observes that "the overall death rate from cancer was exactly the same in the year 2000 as it had been in 1971, when the 'war' was declared."[79]

That may slowly be improving. For the first time since 1930, cancer deaths declined, by about 2 percent in 2003 and in 2004.[80] John Bailar III, who studies cancer trends at the National Academy of Sciences, argues, however, that "this is largely the pay off from increased attention in recent years to cancer prevention and early detection. Treatment results remain disappointing."[81] As the *New York Times* reports, "Cancer has the greatest chasm between hope and reality . . . life extensions usually are measured in weeks or months, not years. True cancer cures are still exceptionally rare."[82] Public perceptions of the power of modern medicine are not fully matched by reality, as Dr. Steven Hirchfield, an FDA medical officer, observes: "There are all these myths having to do with cancer drugs. That they're very targeted, when in fact all these drugs have multiple targets. That they're nontoxic, when in fact the latest ones have their own set of side effects. And that they're cures, when they are not."[83] It appears that a final victory over cancer and other life-threatening illnesses may be as elusive as victory in Nixon's other domestic battle, the War on Drugs.[84]

Not only are cancer cures rare and treatment often grueling, but therapies are typically incredibly expensive; the *New York Times* reports that these high-tech drugs cost patients, on average, $250,000 a year.[85] Americans' disenchantment with modern medicine also may be fueled by a dawning awareness that health care is much more expensive and less available in the United States than elsewhere. According to a 2005 study, Americans pay more for health care per person than citizens anywhere else in the world, 53 percent more than any other industrialized country.[86] Furthermore, this extremely expensive health care system delivers less to the public at large: the United States ranks only forty-sixth among nations in life expectancy.[87]

Health care remains an unaffordable luxury for many; approximately forty-five million Americans had no health insurance in 2005, and, according to the Institute of Medicine, as many as eighteen thousand deaths each year are the direct result of that lack of coverage.[88] Even those Americans with insurance are feeling the pinch of the profit-driven system as health care premiums continue to rise. Moreover, modern medicine is increasingly dependent on expensive pharmaceutical drugs. A 2004 Kaiser Family Foundation study revealed that prescription drug purchases have

increased by 74 percent since 1992.[89] Forty-four percent of all Americans now take at least one prescription drug.[90] And that usage spans across all age groups. While some might blame the steep increase on aging baby boomers, a recent federal study found that, though prescription drug use does increase with age, almost a quarter of Americans under the age of eighteen are taking at least one prescription medication.[91]

These already-expensive prescriptions are becoming increasingly unaffordable. Prescription drug costs have risen at least 15 percent every year since 1998.[92] According to the former editor of the *New England Journal of Medicine*, Dr. Marcia Angell, the pharmaceutical industry "has consistently ranked as the most profitable in the United States—by a long shot."[93] In 2002, for example, the combined profit of the ten drug companies in the Fortune 500 was higher than the profits of the other 490 combined.[94]

The growing dependence on an ever-more-expensive prescription drug habit has begun to color Americans' perception of the drug industry and the practice of modern medicine. By the late 1990s, according to health industry journalist Fran Hawthorne, "News stories showed grandmas forced to choose between food and medicine, or elderly couples taking turns filling their prescriptions each month because they couldn't afford two sets of pills. Then, in the same newspapers and magazines, the business pages reported that the pharmaceutical industry was raking in profits of 17 or 18%, making it the most profitable industry in the United States."[95]

These growing profits have been matched by growing public dissatisfaction with the pharmaceutical industry ("Big Pharma"). In 1997, the first year the Harris Poll began polling on this subject, 79 percent of all adults thought the pharmaceutical industry was doing a "good job"; by 2004 that figure had dropped to 44 percent.[96] The only industries that ranked lower were health insurance, managed care companies, and the tobacco industry.[97]

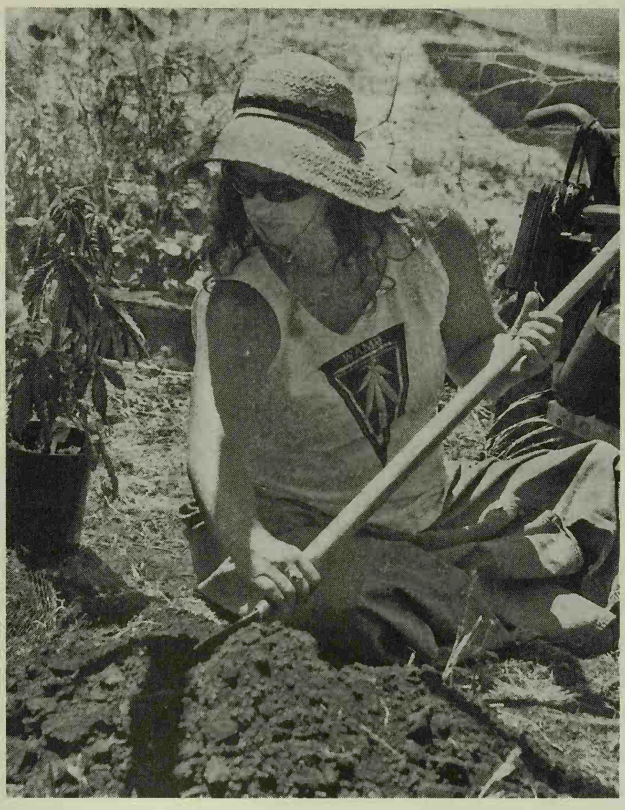
Natural "Cures"

Dissatisfaction with corporate-controlled medical care has contributed to a growing interest in alternative approaches to healing, especially those that allow patients to sidestep the pharmaceutical industry and to take a more direct and active role in their treatment. It is telling, for instance, that the second-best-selling book in the United States in the summer of

2005—just behind *Harry Potter and the Half-Blood Prince*—was *Natural Cures "They" Don't Want You to Know About*. According to the author, Kevin Trudeau, "These are the natural cures the drug companies, the FDA, the FTC, the American Medical Association, and government agencies DO NOT want you to know about because it would cut into the profits of the multinational pharmaceutical corporations."[98] The popularity of Trudeau's book suggests not only that the public has equally unreasonable expectations for natural "cures" as it does for pharmaceutical ones, but also that a widespread belief exists that organized medicine is aligned with the pharmaceutical industry and federal regulatory agencies to protect the for-profit nature of the enterprise. In this context, federal opposition to the medical use of a botanical such as cannabis actually may be contributing to its popularity.

Growing interest in alternative therapies like medical marijuana may also reflect the fact that the rate of discovery of pharmaceutical "wonder drugs" has fallen off in recent years. Observers of Big Pharma report that by the late 1990s, "The industry as a whole seemed to be having a harder and harder time coming up with breakthrough drugs—drugs that were significantly different from what was already on the market, that worked better, that had fewer side effects, that targeted ailments that had had no cure before this."[99] This current situation contrasts starkly with the "first great era of drug discovery" from 1935 to the mid-1960s, as well with as the second wave of drug innovation (the so-called biotechnology revolution) in the late 1970s and 1980s.[100] According to David Kessler, the former head of the FDA during the Clinton administration, of the many new drugs approved from 1989 to 1993, most were so-called me-too drugs, drugs comparable to and no better than those already available on the market.[101] Marcia Angell concludes that "of the many events that contributed to their [Big Pharma's] sudden great and good fortune [of record profits], none had to do with the quality of the drugs the companies were selling."[102]

It is not surprising then, that, according to a 2004 federal report, interest in botanical remedies and other "natural cures" increased substantially during the 1990s.[103] In fact, at the turn of the twenty-first century, more than one-third of American adults reported using some form of "complementary and alternative medicine" (CAM)—that is, therapies used either in conjunction with or as an alternative to conventional care. The federal study on complementary and alternative medicine found that herbal and botanical medicine was the most commonly used form of CAM. The



Suzanne Pfeil next to her wheelchair, gardening. Photo courtesy of Jean Hanamoto.

authors argued that this was the result not only of more sophisticated marketing and increased availability of information on the Internet, but also to "the desire of patients to be actively involved in medical decision making, and dissatisfaction with conventional (Western) medicine."[104]

Dissatisfaction was particularly profound among the seriously ill; the authors observed that this may be "related to the inability of conventional medicine to adequately treat many chronic diseases and their symptoms such as debilitating pain. Rates of CAM use are also exceptionally high among individuals with life-threatening illnesses such as cancer or HIV."[105] Similar findings were reported in an American Cancer Society survey administered in 2000, which reported that over 80 percent of cancer patients had used at least one form of alternative therapy in conjunc-

tion with their conventional therapies; of those using alternative therapies, 63 percent had used dietary or herbal supplements.[106] The 2004 federal report on CAM suggests that the use of these alternative therapies is especially understandable for individuals suffering from chronic or recurring pain: "The high prevalence of CAM use for these conditions is not surprising when one considers that one-quarter to one-third of the adult population might be suffering from one of these disorders in any given year, yet many forms of chronic pain are resistant to conventional medical treatment."[107]

It is precisely in the area of palliative care, of comforting and healing rather than "curing," that the shortcomings of conventional medicine have been most starkly revealed; a renewed interest in herbal medicines may be related to that fact. Remarkably, according to British anesthesiologist and medical researcher William Notcutt, only one new pain medicine has been developed in the past thirty years.[108] Given this sobering reality, it is not difficult to understand growing popular resistance to federal prohibitions on the medicinal use of a nontoxic herb such as cannabis, one that is inexpensive to produce, therapeutically promising, and primarily used to relieve pain, enhance the quality of life, and ease passage into death. WAMM member Suzanne Pfeil, living with severe post-polio syndrome, insists:

> I should have the right to relieve my suffering in the way that I choose. It's inhumane to force me to take pharmaceutical drugs, to make that my only option. I'm just trying to maintain my health with the best possible life I can live under the circumstances I have to deal with. And marijuana really helps me to do that—to stay positive, to be functional, to stay out of pain as much as I can with the least amount of side effects and the least amount of harm to my body. The reality is that I'm in this for the long haul and I can't destroy my body with muscle relaxers and other pharmaceuticals. I use them when I need to but not day in and day out. They produce liver damage, kidney damage. So instead I use homeopathics. I use vitamins. I use herbs. I grow chamomile, peppermint, aloe vera and other medicinal plants. And, when I can, I grow marijuana in my garden. It's just wonderful to cultivate medicine in your garden, to nurture it and watch it grow; to pick it when you think it's perfect. To me, that medicine is systemic and endemic to me and my environment. I just don't understand how you can wage war against a plant.

These People Aren't Potheads

Interview with "Betty," WAMM Caregiver

My mother got cancer really bad. She battled it for probably ten years, through the chemo and the operations, and it kept coming back. The last time it came back, she was so tired she just didn't want to deal with it anymore. And she couldn't even eat.

I had been working as a nurses' aide and there was a woman in the rest home who had cancer. The nurses' aides would sneak her pot because it made her feel so much better and she was able to eat. When my mother heard that marijuana makes you hungry, she asked would I bring her some. She had never used marijuana before in her life. But she had some really good experiences with it. The first time she said that she sat in a corner and watched a spider web for three hours. She said, "It was a really neat experience and when I was done with it I was really hungry!" For almost a year she used the pot and it really worked. Her doctor backed her up on it and this was fifteen years ago.

Now I caretake for a friend of the family, "Jay." He has stomach cancer, hepatitis B, and liver problems too. He can't be more than fifty but he is getting progressively worse. When he got the prescription for the marijuana he came to me and said, "I got into this organization, it's called WAMM." I had heard of WAMM, but had never been involved with it or anything. Anyway he says, "Everybody wants to be my caregiver. But they all smoke and they are going to steal my pot. I know you don't do marijuana, so would you do this for me?" At first I said, "No, I don't think so." A couple of weeks later he came back and asked me again. So I said, "I'll tell you what—I'll go and check this out, but I'm not going to be sitting around with a bunch of potheads. I'm really not into that, I might as well be honest. But I'll go with you and check it out."

So I went and I was really surprised at what I found. These people aren't potheads. These people aren't drug addicts. They're not derelicts. It's nothing like I had envisioned in my mind. I was very surprised. It was

like, "Wow, this is really something. These people are really sick. And it's not like they all sit around and get stoned." I was amazed.

So I became his caregiver, the person responsible for volunteering for him or for attending meetings and picking up his medicine when he wasn't able. After going for a couple of months, the issue came up about volunteering for certain things. Well, I cook for a living, so when they brought up the baking thing, I thought well you know what, that might be kind of fun. So I started to volunteer to make the muffins.

For the first few months that I did it, I really had no clue what I was doing. I was kind of faking it. Now I've got it down. Now I bake roughly one hundred muffins a week. One of the things that really convinced me to keep doing it was when I was first baking the muffins, this guy came up to me at a WAMM meeting and said, "I want to thank you because I'm having a really hard time, and I don't smoke pot, but the vanilla muffins are perfect." He proceeded to tell me about getting ill and being on up to sixty pills a day I think it was. And the pills were getting so bad he couldn't eat, got really weak, couldn't go to work, lost his job, the whole thing. But now he says, with the muffins, he can do his pills and he's feeling much stronger. It's stories like that that keep me going back. I wish people could see exactly what goes on there because I'm sure a lot of people have the same misconceptions that I did: that it's a bunch of potheads sitting around.

I enjoy going there. I enjoy the meetings and the other activities. I know that Jay hasn't dressed up for Halloween since he was a kid, for instance. But this Halloween we got him a costume, we got him dressed up, and he went to the WAMM party. He's the most antisocial person I know, but he loves to go to WAMM. It's not just the marijuana part of this that is good. It's the whole concept of what they do—everybody helps everybody. Everybody in there is sick. Everybody knows it.

It's really important for those of us who are caregivers to have that community too. Like there is this guy R. and his wife, and his wife has cancer. She's up to the morphine too, just like Jay. And every week we have a talk. You meet a lot of people going through the same thing, which is something you're not going to find just walking around town.

So I just can't see the government coming down on these people; there is no way you can look at some of those people in there and tell them they can't have marijuana. That's absolutely absurd. As a taxpayer and a voter, I can't see it. The funny thing is, I am antidrug, I really am antidrug. But in this case, I don't feel that these people are doing drugs. I see it as medicine that is helping them.

4

"Potheads Scamming the System"

Deserving Patients and Undeserving Potheads

Dorothy Gibbs is the sort of patient medical marijuana advocates hope voters will think of when therapeutic access to cannabis is on the ballot. At age ninety-four and confined to a bed in a Santa Cruz nursing home, this WAMM member is hardly the stereotypical "pothead" many critics believe to be hiding behind the medical marijuana movement. Cannabis, for Dorothy Gibbs, has never been anything but a medicine, a particularly effective analgesic that relieves severe pain associated with her post-polio syndrome: "I never smoked marijuana before; I had no reason to. But the relief I got was wonderful and long lasting and pretty immediate too. I didn't really have any misgivings about using marijuana; I figured it had to be better than what I'd got. They had me on lots of other medications but I couldn't stand them; they made me so sick."

Most Americans (80 percent according to a 2002 CNN/*Time* poll[1]) support the right of seriously ill patients like Dorothy Gibbs to access and to use medical marijuana. This broad support is coupled, however, with lingering concerns that medical marijuana may be largely "a kind of ruse," as *Time* magazine suggests in a cover story on "The New Politics of Pot."[2] From this perspective, medical marijuana campaigns are really a cover for drug-legalization efforts and most "medicinal use" is nothing more than a recreational habit dressed up in a doctor's recommendation.

Tensions between medical and social uses of marijuana are unavoidable in a political context in which nonmedicinal use is at once widespread, formally prohibited, and often severely punished. Because of the social and legal penalties associated with recreational use, it is reasonable that some consumers would attempt to acquire a measure of legitimacy and protection by identifying a medical need for marijuana. Medical marijuana users, then, become divided in the public mind between patients like Dorothy Gibbs, who have never used marijuana except as a medicine, and pretenders who have a social relationship to the drug. As with other

discreditable identities (like the prostitute, the poor person, or the single mother), a line can then be drawn between a small class of deserving "victims" and a much larger group of the willfully bad who are unworthy of protection or support.[3]

In fact, such divisions are both illusory and dangerous. In the case of marijuana use, the identities of medical and social user are not neatly dichotomous. Even within the membership of WAMM—which clearly presents the legitimate face of medical marijuana, the sick and dying widely seen as deserving of the drug—neat divisions between medical and social users are unworkable. Most WAMM patients acknowledge that, earlier in their lives, they did have experience with marijuana as a means of enhancing pleasure, before they had occasion to become familiar with its potential in relieving pain. "Alicia," a breast cancer survivor, for example, admits, "I am a product of the seventies so of course I had smoked pot before just recreationally. Then there was a period of my life when I was busy being a mother, working, grad school, and it just wasn't part of my circle at that point in time. Then I got very sick at the beginning of the nineties, and that was the first time in many many years that I had it. And I actually found it did help."

Much like Alicia, "Maria," a fifty-two-year-old single mother living with metastatic ovarian cancer, associated marijuana with her youth; at the time of her diagnosis she had no current relationship to the drug. Her past experiences with recreational use made it difficult for her initially to accept that cannabis might have any therapeutic value: "I don't even know if I would have believed [that marijuana was medicine] if I hadn't tried it for medical purposes myself. I hadn't smoked for many years since I had my daughter. But a good friend said that they had heard it was really good for the nausea [related to chemotherapy] and turned me on to WAMM. . . . What an incredible difference; the pharmaceuticals don't hold a candle [to marijuana] in terms of immediate relief . . . I don't think I would have believed it because it had always been recreational to me."

Some WAMM members only discovered the reasons for the plant's popularity as a recreational drug after being introduced to it for a more narrowly therapeutic purpose. "Jon," for example, had resisted using any illicit drugs, including marijuana, before beginning HIV treatment:

> I grew up in the Bronx around people being arrested for having dope and getting murdered for selling drugs. So I had this little thing in my head that kept me away from drugs. I never judged people for smoking

> but for me it just didn't seem right. But when I started taking my AIDS drugs, the side effects were really acute for me and it was suggested that I start using medical marijuana. I wasn't into it at first but, after being on the meds for a year and a half, I decided that something had to change. I just couldn't do it any longer. So I did start the medical marijuana and it did help a lot. Initially, I was still under my own neuroses about, "Oh I don't want to be a pothead" and all these negative stereotypes about what marijuana does and how it affects people. But, in fact, it was the [AIDS] cocktail [of antiviral drugs] that had me all whacked out. I discovered that when I was on the medical marijuana, I could function much better. I learned to trust that I could be stoned and be interactive and not dopey; I love it.

In addition to those patients who had never used marijuana prior to their illness and those who had consumed the drug for recreational purposes in the past but who had long since stopped, there is a third group who actively resist drawing a clear distinction between medical and social use, describing instead a seamless transition between the two. "Regina," for example, a WAMM member in her mid-forties living with AIDS, acknowledges,

> I'm just going to be totally honest—it wasn't AIDS that introduced me to pot. I had smoked marijuana as a kid and I liked it even then. When I tested positive in 1991, I felt that it was kind of a benefit that I got to use the term "medical marijuana" but I didn't quite own it as medicine because it had just been my lifestyle. But then, a few years ago, I traveled out of state [without access to marijuana]. I spent a week traveling and then went to Florida with my mom. By the time we got there, I was in so much pain from the neuropathy I couldn't get up. We went to Urgent Care and they gave me morphine. The pain just wouldn't go away. I took the morphine for a week until I got back to California. When I got home, I started smoking pot again as normal and it took about three or four days and I stopped taking the morphine. I realized I had probably kept myself from having this really severe nerve pain for a long time by smoking every day. It was like this big validation that I really was using good medicine.

Creating Community

Because of confusions about the legitimacy of marijuana as medicine and of users as patients, provider organizations such as WAMM are often misunderstood as well. Even within communities largely tolerant of marijuana use, such as Santa Cruz, suspicions remain about the role of a provider organization. "Hal," a seventy-year-old with severe neurological pain from failed back surgery, remembers that when a friend suggested he consider marijuana to manage his pain, he thought it was a scam: "Right, 'medical' marijuana, sure. But [after trying it] I couldn't deny I felt better. I didn't know anything about WAMM; I'd never even heard of a cannabis-buying club. I just wasn't in that world. I immediately jumped to the wrong conclusion. I thought, 'You're a bunch of potheads who are scamming the system.' Right? So I'll be a pothead and scam the system. I don't care because I need it. I need it."

Hal's suspicion that WAMM was largely a cover for drug dealing to recreational users was only shattered when he attended his first weekly membership meeting: "The first time I went to WAMM, with all these misconceptions in my mind, I looked around the room and thought, 'My god, these people are really not well.' I went home and said to my wife, 'I'm going to have to rethink this whole thing. I'm going to have to stop jumping to conclusions here because this was an incredible experience.'"

Attending a WAMM meeting is indeed consciousness altering, but not in the ways that new members typically expect. Patients often enter expecting a room thick with marijuana smoke; instead they find a room filled with human suffering and a collectively organized attempt to alleviate it. In fact, no marijuana is smoked at WAMM membership meetings. Rather the hour-and-a-half gathering is spent community building: sharing news about the needs of the organization and the needs of the membership. News is often bad—beloved members die, important pieces of legislation are defeated, donations are down. Announcements are made not only about volunteer opportunities to work in the garden or the office, but also about members needing hospital visits, meals, or informal hospice support. Get-well cards are circulated, memorials are planned for those who have recently died, holiday parties are organized for those with a desire to socialize and to celebrate. Information is exchanged about the practical dimensions of living with chronic or terminal illness and about coping with the often-cascading challenges of pain, poverty, and social isolation.

Much of the weekly meeting is taken up by a monologue delivered by Valerie, though members have ample opportunity to interject and make announcements if they wish. Valerie interrupts herself frequently to personally acknowledge and welcome a member who has drifted in late. In this atmosphere of controlled chaos, Valerie provides updates on medical marijuana legislation, offers social criticism and spiritual guidance, and makes regular requests for donations of time or money. Occasionally members complain that Valerie goes on too long and that meetings seem too much like sermons or guilt-trips. And sometimes her message is lost in the rising undercurrent of conversation among the many in attendance who may only see each other this one time during the week. The background rumble ebbs and flows, and sometimes has to be brought under control. "Whoa, whoa," Val calls out in an attempt to regain attention. Some members seem to find the meetings almost unbearably frustrating, while others experience them as essential and life affirming; for many, they represent both an obligation and a critical lifeline. The meetings conclude with members picking up their weekly supply of medical marijuana. For some that is the only reason to attend. For many others, however, the marijuana seems almost secondary. In fact, some members who have completed their treatments and no longer need marijuana continue to attend the meetings for the community they provide.[4]

Until 2000 these weekly membership and distribution meetings took place in the heart of downtown Santa Cruz at the local Needle Exchange Drop-in Center. Occasionally on nights when the center was given over to WAMM, someone would approach the door hoping to be able to procure a clean syringe. Dennis, WAMM's doorman, would politely turn them away with an apology and a request to check back the next day. Dennis has always been serious about his responsibilities at the door, and his imposing size gives him instant credibility. Although he knows most members by sight, he sometimes has had to check identification at the door. Once membership is confirmed, he becomes very welcoming, introducing himself with a soft voice and a friendly smile.[5]

During the years that the Needle Exchange sheltered WAMM, members often congregated as much as a half hour early, forming friendly conversational groups on the sidewalk as downtown traffic crawled by. By the summer of 2000, WAMM's expanding membership meant that a new Tuesday meeting place had to be found; the crowd outside the Drop-in Center was no longer unobtrusive, and the numbers of people milling around in front of the building began to capture the attention of

downtown visitors. Even inside the building, space had become inadequate—the room quickly filled past capacity with members in wheelchairs trying to negotiate around the furniture and groups of patients unable to find seats. WAMM began to be a liability for the otherwise low-profile Needle Exchange Center. The Santa Cruz fire marshal was sympathetic but firm: the Drop-in Center was too small for so large a group.

A scramble to find a new meeting place once again made clear that, while medical marijuana was supported in principle in Santa Cruz, most organizations were apprehensive about allowing marijuana distribution to take place in their facilities. But finally a group—a local ethnic heritage organization—offered WAMM use of its space for a small weekly fee. The substantially larger facility, located in a less-visible part of town but still easily accessible by car and public transportation, better met the needs of the membership than the Drop-in Center; this space has served as a weekly meeting hall and distribution center for WAMM since 2001.[6]

At the new location, as at the old, a half hour or so before the meeting begins, Valerie arrives with the keys to the building and big plastic boxes. Helpful hands carry the boxes inside while members surround Val, wanting a moment with her. Valerie gives and receives many hugs and kisses; such displays are the norm in this organization.[7]

> *Valerie*: I do have to set boundaries; sometimes, when people come up and ask me for things, like I might try to suggest who else they could talk to, to make that happen. That helps both of us to define our roles as members of a collective. I used to think people wanted a piece of me, but now I know it's not that. What they want is to be loved. We all want that. Sure, sometimes people drive me a little crazy, pushing their way in front of somebody else . . . but even that, the childishness that we all have in us, the second grader that demands, "What about me, me, me?" can usually just be dealt with if I just say, "Hey, you know what? Somebody is in front of you. It's OK, there's time. I have to stick around til 9:00. Stick around and ask me later." And people will do that, they'll go, "Yeah, yeah of course. Duh. It just felt urgent."

Each Tuesday evening, members of WAMM quickly transform the ethnic heritage hall into a medical marijuana community center. A small group of volunteers sets up folding tables at the front of the room to hold the containers of "Mother's Milk" (a cannabis-infused soy beverage); the

WAMM members picking up their medication at a weekly membership meeting. Photo © Chuck Nacke—Woodfin Camp.

small brown, one-ounce bottles of tincture; and the bags of marijuana muffins. Each of these products has been produced entirely through the volunteer efforts of other members. The plastic boxes turn out to be filled with manila envelopes, each one containing a baggie holding a few grams of weighed and packaged cannabis. Every patient who picks up medical marijuana has an envelope in one of the boxes, with their doctor's name and contact information printed on it. On any given Tuesday evening, dozens of WAMM members numbering as few as 50 and as many as 150 attend for all or some part of the ninety-minute meeting. The gathering quickly develops into a community conversation while some members cheerfully greet friends and others walk slowly to their seats, concentrating on some hidden pain.

Servant Leaders

Within the collective, Valerie's loving and charismatic persona positions her somewhere between selfless organizer and celebrated diva. During the 1999 Gay Pride celebrations in Santa Cruz, Valerie and Michael received a proclamation from the city in appreciation of their efforts on behalf of the community. Val, dressed in a black leather vest, black boots, and a pair of tight, partially unbuttoned jeans with a sheath knife sticking provocatively out of her back pocket, bowed theatrically and said, "Thank you. I am, as ever, your servant."

She serves in many ways.[8] As executive director, it is her job to manage the organization's always-impossibly tight budget; she is often preoccupied with fluctuations in monetary contributions. To keep the organization afloat, she applies for grants, organizes fund-raisers, and solicits financial contributions using all manner of persuasive appeals. But Valerie remains firm in her insistence that members' access to the marijuana grown by the collective be based entirely on medical need, not on ability to pay. Valerie also manages to spend a great deal of time at the bedsides of seriously ill members in their homes and at the hospital; she has been present at the passing of many members, developing an unusual familiarity—intellectually, spiritually, and pragmatically—with death.

Though it is her vision that is expressed in the mission of the organization and its weekly operation, she remains committed to encouraging a sense of shared responsibility among the members. This has been a more challenging process than she first had imagined.

> *Valerie*: I have been so struck by the commitment we had in setting up WAMM where members would take what they need and give what they can, thinking that most people given the opportunity would rise to meet that. What I've come to understand is that it takes a little cooking; it's not socially or culturally natural or conventional for humanity—or the piece of it that I'm working with—to rise to the occasion in that manner. But what I've found is that when we share our stories and experience each other's suffering, things do start to change, people do volunteer: "Here take some of mine. You're short, let me help you. You need to have some food made? I can cook you some food, I can spend a day or an afternoon at your house." The Marxist premise of taking what you need and giving what you can, is brilliant because it's empowering and it serves the greater community, outside of myself. It's about how it creates the future.

She wants WAMM to work, not because of incentives or constraints, but because others believe in it too. Once, after missing a weekly meeting due to illness, she reminded the group that they had survived her absence: "See, you don't really need me." But most members believe they do. Her authority extends well beyond the group; Corral has emerged as one of the most respected advocates and foremost authorities in the country on the subject of medical marijuana.

Within WAMM, Valerie's charismatic leadership is apparent, as patient-participant "Rev. Sonny" acknowledges:

> Val is an integral part of what WAMM is, without a doubt. She is the motivating force. Val has a vibrancy about her; she just touches everybody she comes in contact with. She has an extraordinary gift, you know. She's blessed with a power about her. That's what great evangelists have. But so do entertainers like Cher and Madonna and professional athletes. They all have that power. It's just a question of where they choose to direct it. Val directs hers into service. But while she's important to WAMM, there's no reason in the world why this kind of organization couldn't be created in every city in California. The only problem I can see with replicating this model is that you need the support of the sheriffs to keep those federal carpetbaggers off our land.

The Santa Cruz sheriff himself, however, is less convinced. According to Sheriff Mark Tracy, "I don't know about WAMM being a model. You're not going to find someone like Valerie everywhere, so how are you going to recreate what she's trying to do? Where are you going to find people to put their whole life in it? For me, knowing her for a few years, this is her whole life. I just think that it would be hard to find people who would do that everywhere."

The question of the role of charismatic leadership within a self-help collective is also raised by the crucial contributions made by Michael Corral. While less intimately involved in the day-to-day operation of the organization, WAMM would not have thrived without the commitment and particular skills Michael provides as agricultural director. Much like Valerie, Michael's energy and talents draw people to him. He is not only extraordinarily handsome and personable, he is also one of the best marijuana cultivators in the country.

But unlike Valerie, Michael has clearly defined boundaries within the

organization. He manages the collective's garden but does little, if any, hands-on caretaking of its sick and dying members. Still, his devotion to the WAMM garden and his expertise in the cultivation of cannabis have been critical to the group's ability to produce an annual crop of extremely high quality, organically grown marijuana adequate to meet the needs of over two hundred seriously ill patients using only a small plot of land. That the garden is located on the Corrals' property further cements their close identification with the organization. By allowing the collective to grow its marijuana on their land, the Corrals face the very real risk of losing both their property (under federal forfeiture laws) and their freedom.

Valerie and Michael's willingness to occupy such a central place in WAMM has helped the organization to survive despite federal threats and inadequate budgets. But it risks undermining the group's identity as a collective of equals. As Dr. Mike Alcalay, the medical director of the Oakland Cannabis Buyers' Cooperative (OCBC), notes: "People like Jeff Jones [the founder of the OCBC] and Valerie take it all very personally. For Jeff, it was *his* club. For Val, it's *her* organization. But, in fact, it's *our* movement. Pronouns are really important. I don't let people get away with that."

This tension between the rhetoric of collective endeavor and the reality of unequally distributed risks and responsibilities is a constant challenge within WAMM. "Cher," a patient and former board member, observes,

> In the beginning of WAMM I felt this incredible sense of ingratitude from most of the patients. And because it was directed toward Valerie, it really enraged me. I thought they were all just a bunch of whiners. At one point we had so many complaints that we had a special meeting outside WAMM for people who wanted to complain. Suzanne [another board member] agreed to set it up and run it. Well, she did the first one and she was just sobbing. So I said, "OK, Suzanne, you created this but you are too sensitive. I really think these people are assholes so they won't affect me. I'll go." I went and I was appalled. But I was not devastated by it. I just told them they were full of shit; and when we had the [complaints] meeting the next week, nobody came. I was not patient with it. For one thing, I was absolutely stunned. I thought that Valerie had taken on something that, to my great shock, was going to be completely unrewarding. When she told me she was founding the organization, I was worried —not because I thought the patients would be ungrateful, but because I

thought the cops would get her. I was actually astonished that anybody was anything but grateful. I had not anticipated it at all, but it was true.

Collective Contributions

"What do you think 'collective' means?" Valerie asks the membership one Tuesday evening in 1998. "That you come in and collect? WAMM doesn't work that way. Donations are way down, but we're giving away more pot than ever, more than a pound a week. Giving pot away free is what we do; but we need your assistance and support in order to be sure we're here next year, and not have this fizzle out, because it's too much work for a handful of people. You don't have to give money, but give energy."

Participation by members in WAMM has always been uneven, creating a source of concern for a largely volunteer-run organization. At every membership meeting, Valerie pleads for even the smallest contributions of time, money, or necessary materials: baking supplies, soy milk, plastic baggies. But donations go up and down. And, as the organization has grown, the effort and expenses necessary for survival have grown with it. Even in the early years, it took dozens of volunteers to tend, harvest, and clean the collective's annual crop of cannabis; to package the dried material; to transform it into medicinal baked goods and tinctures; to help staff the membership distribution meetings; and to provide minimal office support.

In 2001–02 the organization hired a part-time human resources coordinator, Gabriel Demaine, to undertake a systematic survey of the needs and assets of the membership and to link each member to appropriate programs within the collective. The predictable finding was that needs—both of the membership and of the organization—far exceeded available assets.

Gabriel: Fund-raising was an immediate priority. With WAMM's nonprofit status taken away,[9] the organization didn't have much success with grants. There was no tax advantage to funding us and, in any case, probably a lot of funding agencies were just too freaked out to be associated with marijuana. So I used my experience as an organizer to start producing community events to raise consciousness and money. I organized teams to work at the events and to do media outreach; to work in the office and the garden; to do what we called "kitchen help," making

medicinal products; and to participate in care teams [providing assistance to members who were sick or dying].

In addition to the appeals by the human resource coordinator for volunteer labor, Valerie also spends part of every weekly meeting reminding members of the critical need for practical and material support and trying to encourage a collective culture of cooperation and compassion. Fairness, for her, is defined more by altruism than equity; if everyone does their best, those who are most capable will contribute more than those who are less capable; and, for Val, that is how it should be. Their extra effort allows the group to support those who can do little or nothing.

But members know that their access to medical marijuana is not contingent on material contributions of any kind. In answer to the question "How little work can I do and still get my medicine?" or "How much money must I give in order to get my medicine?" the organization replies, "As much as you can afford." Because WAMM was founded with the explicit intention of catering to the needs of low-income and unemployed people who are managing life-threatening illness, nothing is demanded of the membership. Many are indeed limited in what they can offer; some only become members when their resources are exhausted and death is imminent.

On a number of occasions, the WAMM board of directors has discussed whether donations of time or money ought to be mandatory for members. But the majority has never supported the idea. Various schemes for encouraging participation have been considered, but in every case it was concluded that no one in an organization composed primarily of low-income people living with life-threatening or chronic diseases can say with authority whether someone else is doing all they can. Like other health-related organizations run by and for patients, poor health and the poverty that often results from it will always prevent some members from making material contributions.

Something like an honor system is at work in WAMM. No minimum standards or proofs are required to determine who is too sick or too poor to contribute. Members who choose not to participate are in no more danger of losing access to their medication than those who are genuinely incapable of participating. But somebody has to do the work, and in answer to the question "Why should I do more when so many here do less?" the collective answers, "Because you can . . . for now."

"Andy," a longtime member living with AIDS, survived several cycles

of strength and weakness as his illness progressed. During periods of relative health, he put in many long days in the marijuana garden, weeding and watering and leafing the plants. He worked at the distribution table on Tuesday evenings, and one autumn he put in more hours cleaning the harvested buds than any other member. His commitment to the organization was never in question, but, as his illness progressed, he became unable to continue as a volunteer. In his final illness, a number of WAMM members provided in-home hospice care, keeping him company and doing his shopping, cooking, and cleaning. Valerie was at his side when he died. Andy was very well liked and served as a reminder that the ability to contribute can change drastically, that those most active in the organization may not always be able to contribute, and that contributions to the collective can have a return well beyond what is received in marijuana. Many WAMM members will have to depend on the assistance of others at some point, as Andy did; this realization has encouraged many to contribute generously with time and energy while they can. WAMM defines itself by this culture of cooperation and compassion.

Free Riding

Still, the problem of the "free rider"[10] who doesn't contribute enough to the collective is a recurring subject of conversation among the membership. Reactions range from righteous indignation and shame to weariness and indifference. Inevitably, perhaps, a few highly committed and hard-working members of WAMM report feeling resentment toward others whom they perceive to be holding out on the group.

For many WAMM members, the organization becomes a focal point, providing a shared sense of camaraderie, acceptance, and empowerment in lives damaged by disease. Yet a few find it hard to shed long-held habits of individual self-interest in favor of the organization's communitarianism. Those members may come up short in the estimation of the deeply committed.

The fact of the matter is that some members don't want, or think that they don't need, a demanding community and its attendant responsibilities, efforts, and frustrations. These individuals would prefer to spend their time and energy living their own separate lives. They *do,* however, want to continue to receive their free or very affordable medical marijuana. The

result is tension and resentment between those who give abundantly and those perceived as doing less than they should.

"Alec," for example, became resentful watching some members picking up their medicine every Tuesday evening, members whom he believed were capable but unwilling to help in the work. He eventually chose to withdraw from the tiring labor performed by the garden crew. He continues to receive his medicine, but his identification with the collective has been compromised by the feeling that free riders took advantage of him. "Ricky," a member who has devoted considerable time and energy to the collective enterprise for many years, appeared before the board of directors one evening to remind them that the marijuana patients receive is not "free." It is produced through the hard work of a small group of volunteer laborers. He urged Mike Corral to calculate production costs so that members would know the monetary value of what they were being given. Mike calculated the cost at about two dollars per gram—fifty-six dollars an ounce. While that is less than one-sixth the cost of an ounce of much inferior marijuana on the street, the majority of members make donations that are only a fraction of that amount, if they donate at all.

During one Tuesday evening meeting in September 2000, Ricky took the floor and asked the members in attendance: "If you had to do this on your own, what would you do? You need to help the group more," he scolded them, "and think less of yourself. It's 'we' not 'me.'" Valerie, sensing the hostility in the room, quickly interjected: "Please don't anybody take this personally. Don't be hurt. But how can we resolve these questions if we can't even ask them?" While her comments elicited a few nods in the room, many looked skeptical. For many, the burden presented by a potentially deadly disease or pain that never goes away is explanation enough for why the demands of the collective take a backseat to their own immediate needs. "It's all some of us can do to stay alive," one man argued. An exasperated voice replied, "We're all sick, but we have to work anyway." Some became defensive; one member reported that she signed up to volunteer but never received a call back.

Many in the group of regular attendees at Tuesday night meetings *do* volunteer and *have made* contributions; they feel they shouldn't have to listen to such criticisms. On the other hand, there may be some sense of satisfaction watching those individuals believed to be "freeloading" squirm. Michael Cheslosky, one of WAMM's most active members until shortly before his death in 2005, observed,

> I feel a tremendous responsibility for WAMM, so it really bothers me sometimes when people just come in, pick up and leave. We go to the meetings faithfully every week and we are the ones who get yelled at. Those of us who know it is a collective—we don't need to be yelled at about the fact that others aren't showing up. And then we stand in line and watch somebody else just walk in at the very end. In fact, we joke about it a lot. I know these two guys that invariably come in at 7:35 every week and try to sort of melt into the line by coming up to you and saying, "Hi! How are you doing?" I'm always tempted to say, "I don't know you; who are you? What is your name?" I watched one guy come in way late who, of course, had a really high number [indicating his place in the distribution line], something like 72. So what he does is he rubs off the two and gets in line as if his number was a 7. It was so painfully obvious. Everybody knew, and of course we're all thinking, "How could you do that? Everybody here is just as sick as you are." But, you know, if you're going to go to that much trouble to do something like that, really all the rest of us can do is laugh. I mean it's really funny because I guess people think that other people don't know? But you better believe we're going to point you out to everybody else. "Oh, you're the one from last week who rubbed off their number!" Those guys deserve to be talked about. I guess they are getting whatever it is they need to get out of it but my sense is that they're not getting much. They're certainly not getting everything I do from WAMM. But that is their business. So pretty much with everybody, if they aren't too obnoxious about butting in line, or not helping put a chair back or something, then I try not to get too worked up about it.

Not everyone is as successful as Mike at letting the problem of unequal contributions roll off their back. George Hanamoto, a seventy-year-old WAMM member, struggles with members' obviously unequal investment in the organization:

> I get upset about people who take advantage of WAMM. I'm taking this mindfulness class [at WAMM] to try to make myself not let that bother me. But it does. I can't get it out of my mind that there could be this one person who doesn't donate no time, no money, nothing, but gets the most pot he can and takes up all of Val's time bitching at her for this and that. And there might be another person, a nice member, who works really hard for WAMM and only gets a portion of what that guy takes.

> I think someone should write down volunteer hours and whether they donate and what the status of their health is, so that we could say, "Hey, you haven't been to a meeting, you haven't volunteered, and you haven't donated no money. We're cutting you back to a minimum." We need to have an incentive; if they don't cooperate, we need to be able to give them a little push.

Another member, "Irv," a seventy-seven-year-old who prides himself on making a relatively large cash donation to the organization each week, resents those who give little or nothing, believing this to be a reflection of bad choices by those too cheap or too irresponsible to contribute:

> A lot of clubs, the buyers' clubs, are just using marijuana as a means of making money. People can't go there and give nothing, or five dollars or ten dollars, they pay really hard prices. People here ought to be thankful and want to make sure that this organization survives. I've kind of raised this question, you know, at meetings and it just fell on deaf ears. I mean, people go to a movie. You can't do anything these days without spending money; why should this be such a low priority? It's just ridiculous. You go out and buy a pack of cigarettes or something, it's three dollars a pack. Even a cup of coffee, you buy a latte or something and it's two and a half bucks or three bucks or four bucks. Don't buy one of those things. Just put the money aside. It really irritates me; it's like beating a dead horse. It's hard for me to believe that people have nothing.

But in fact, some members really do have little in the way of disposable income. Susan Durst, a sixty-two-year-old breast cancer survivor, for example, struggles with the challenges of living on a fixed and extremely limited income:

> I haven't gone to the last two WAMM meetings; I just can't make any donation at all. I know Valerie says we don't have to give anything but I still feel uncomfortable about it. The thing is, I don't have it. For the last year I've been getting $712 a month and putting out $581 for rent and storage. And then I have to pay PG&E [Pacific Gas and Electric] and the telephone. And poor selfish me, I have to have a morning paper and cable TV because I can't afford to go to the movies or go anywhere or do anything. Valerie is aware that I'm trying to live on $122 dollars a month. Sometimes I really find myself thinking, "If I don't open the

> curtains and go out the door today, I won't have to spend money." And I'll go four or five days in a row and not leave the house. And I just look to see how many more days til the first of the month. That's a really crappy way to live.

Dispensing with Intimacy

As these accounts suggest, the question of what constitutes a "free rider" is a complex one in an organization composed of poor and seriously ill individuals. Anxiety within the organization ostensibly over uneven membership contributions may in fact be less tied to that particular inequity and instead may be more a reflection of the general unfairness of a life limited by disease and suffering. Certainly, the level of physical, mental, and emotional distress experienced by many WAMM members is extreme. Under such circumstances, others may experience the modest contributions some members make to the collective's survival as an additional affront. As Cher observes,

> WAMM is not a group where we choose each other on the basis of liking each other. It is a group that people join when they fall ill. So it's people who are pretty much devastated in their own lives. Whoever said that suffering makes people noble has never suffered. They don't have a clue. I think the times in my life when I've been the least generous are the times when the chronic pain was the worst. You feel like a victim because you are one. In that sense, WAMM is a mixed bag. There is no common denominator except for illness. I think there are always people who are convinced that they aren't getting enough, that they are being overlooked, that they deserve more attention. But what I found most heartening and astonishing is the way people have changed. What happens for most—not all—of the people, is that they start connecting with each other and get to the garden and start feeling useful, and then they really change. At least people get a chance to. In terms of freeloading, there are some people that freeload. But maybe I'm a little more sympathetic because I really understand the radical poverty that many of the patients live with. Anyway, for me, who cares about the people who are freeloading? I mean all the people who are freeloading are in agony anyway. They are being punished enough. Unless they do something that is hurtful to Val, I can't feel much of anything but sympathy for them.

Patient participants may initially join WAMM for no other reason than to access doctor-recommended medication. But it is difficult for members to relate to the organization as nothing more than a dispensary. Attendance at the ninety-minute participants' meeting is generally required to pick up a member's weekly allotment. Minimally this requirement means that members—or, if they are too ill to attend, their caregivers—must become familiar with each other's faces, witness each other's suffering, and confront repeated requests for assistance by both the organization and by individual participants. In other words, just because the marijuana in WAMM is free doesn't make it without cost, at least in terms of emotional investment. For some, like Jon, the price feels very high indeed:

> I've had a strange relationship to WAMM because a dispensary is really what I would have rather had it be. I'm a matter of fact kind of person and if I have to have this condition, and I have to use a substance, I want to be able to get it and go and not be a part of anything. I don't want to know who my pharmacist is. That's exactly how I feel about WAMM. I go to the meetings because it is a requirement, but it's not necessarily what I would opt to do. I bet everybody who goes just wants to pick up their medicine and leave. Basically what we want is our medicine and to get on with our lives.

Indeed those "with a life" and, perhaps more important, an income, may well prefer a dispensary or buyers' club to a demandingly intimate self-help collective. As "Charles," another member living with AIDS, explains, the intimacy and exposure can be uncomfortable: "The meetings made me feel like I was coming out of the closet again and that was really hard for me. All of a sudden, people knew who I was in terms of what I had and that I had lost a partner. I felt like a sympathy case and I didn't really want that. So I didn't like the meetings much at first."

But for many who remain members, marijuana becomes only one of a number of threads tying them to the organization. "Joe," a forty-year-old with a severe seizure disorder, explains:

> The medicine is actually turning into a secondary or tertiary part of what WAMM is all about for me now. It's more about the group itself, the fellowship that goes on, the ways we help each other. Actually that's the biggest thing I want to rave about: that de-isolation that takes place.

> Isolation that accompanies illness gets to everybody eventually. Suddenly you are removed from any kind of social matrix, like being in school or at work so you don't have the day-to-day contacts with people that make all the difference in your life. WAMM takes you out of that isolation by putting you in contact with other people, like it or not. That's what I really like about the requirement that you come every week to get what you need. You have to be there. That's the only rule actually and that's what makes it work. People get there whether they'd rather stay at home and then they start finding things in themselves that relate to other people. It's a way for patients to get a hold of their own lives and feel whole, feel human.

Dying in the Embrace of Friends

One of the most distinctive features of belonging to the WAMM community is, in the words of one participant, the possibility of "dying in the embrace of friends." Because the majority of members are living with life-threatening illness, death is a close companion. For the most active members, this is both the source of great social cohesion and, simultaneously, an almost unbearably painful aspect of collective life. Charles explains:

> At first I came because I heard that this Mother Teresa was giving out the best medicinal marijuana in the fucking world. And I wanted to know what this was about. What I found was a collective. WAMM has become the most unique group I've belonged to in my whole life. Sometimes it's hard for me, though, because it's a place for the sick and dying. And I'm sick but I'm not dying. I've pulled away from WAMM these past years because every time I become close to someone, they've died. And I was like, "Fuck this. I'm not going to go through this every time." But what WAMM has done for me—and for everybody they've supplied—is what nobody could do. Whether it's the marijuana or the tincture, or Valerie just coming and sitting by your side. So many people have died but at least they had somebody sitting by their side.

For many members, participation in the organization serves both as an extended family and as a kind of long-term care policy, promising support and assistance as their health declines. Jeremy Griffey, for example,

Valerie sharing an embrace with WAMM members at a weekly membership meeting. Photo © Chuck Nacke—Woodfin Camp.

one of the founding members of WAMM, describes a relationship of tremendous intimacy within the group:

> Maybe you have to be there, at a WAMM meeting, to understand what WAMM is. I look around the room and I think, "This is my family." The hugging and touching that goes on there is as necessary as any of my medicines to my well-being. It gives me great comfort to be a member of WAMM and to know that as long as those people are alive, I'm going to be taken care of. I know that is true because I also know that as long as I am alive, I am going to be taking care of them as much as I can and as well as I can. It's a great feeling. I don't know if many people facing death have that.

With death a constant companion in WAMM, the terminal status of so many members is both a resource and a burden for the organization.

This common experience of mortality helps to unite an otherwise very disparate group of individuals. But such frequent death[11] also presents a significant organizational challenge, leading to a tremendous turnover in leadership within WAMM. Valerie Corral is one of only two members of the original board of directors still alive. And, on a personal level, the frequent loss of members produces great grief for the group to process. Cher, a longtime member of WAMM, captures both the transformative power of this constant confrontation with mortality and the toll it takes:

> There is this woman who works at the same place I do; I just hated her all these years. But now that she is faced with a situation where she has a kid the same age as my son and she is dying and has to take care of this child and she's terrified, everything I felt about her in the past is completely gone. The starkness of the situation makes all my past issues so petty. It just doesn't even matter anymore. Still, I have to admit that I'm not engaging with WAMM to the full degree I used to anymore and that's because I can't stand having that many people in my life dying. I can't stand making any more friends who are dying. I just can't. As it is, it's been brutal.

This intimacy with death is one of the most striking qualities separating WAMM members from those generally empowered to create policy on medical marijuana. In 1998 the California attorney general assembled a task force charged with formulating an implementation plan for the voter-approved medical marijuana law, Proposition 215. Valerie was invited to participate on the subcommittee charged with establishing specific guidelines on patient access to, and possession of, medical marijuana. Conflicts quickly emerged in the committee over how much marijuana a patient or caregiver should be allowed to grow or possess. From Valerie's perspective, such a narrow focus suggested misplaced priorities, with the needs of the patient taking a backseat to concerns about possible misuse of the medicine: "They think 'bad people will scam prescriptions,' not 'sick people will get what they need.'" During one meeting in June 1999, Valerie became so frustrated with the inability of the group to move beyond issues of quantity that she interrupted the discussion to ask whether anyone in the room had actually ever cared for a dying person. Not a single hand was raised.

This is not unusual. In a 1999 Gallup poll, 90 percent of those surveyed

expressed the desire to be cared for at home if terminally ill; but, in fact, 57 percent of all deaths took place in hospitals and another 37 percent in nursing homes.[12] Valerie's vision for WAMM has always included a commitment to assisting dying members in "choosing where they die and who they die with." She spends a good deal of time working with doctors, advocating for patient's needs and end-of-life desires:

> We're all in WAMM learning the same things, learning how to face the hardship of living with an illness and, ultimately, the practice of facing our deaths. In general, this culture does a bad job with that. It wasn't too many years ago that even doctors wouldn't really speak of death. Fortunately, there are some who do know how to have that conversation, to step into a partnership with their patients, but it's a rarity. When it happens, I think it's one of the most exquisite forms of healing. There are many doctors who are only practitioners, who practice medicine; but those few who can take a partnership role with the patient, those are the healers.

The hospice movement has arisen in part in response to the desire for a more-intimate and less-medicalized experience at the end of life. But, as Marilyn Webb observes in her book *The Good Death,* federal health care policies have made hospice care unavailable for patients likely to survive longer than six months.[13] Webb notes that "for patients, with chronic, eventually terminal illnesses, there are few good long-term care alternatives."[14] The patient/caregiver cooperative model as enacted by WAMM is one possible alternative.

Fortunately, WAMM members' collective experience with death is not only about loss. Those within the organization who are willing to serve as caregivers for the most seriously ill also find opportunities for deep connection. A special intimacy can develop in the communication of end-of-life needs and concerns, hopes and fears, regrets and amends. Certainly the patient/caregiver relationship can also be extremely trying; in some cases, insecurities and resentments overwhelm moments of trust and dignity. But within this final exchange are some of the most meaningful moments human beings can share. Valerie Corral argues that it is this experience that makes WAMM work: "We come together around the marijuana, but it's not just the marijuana; it's the community. If the government has its way and we have to go to the pharmacy to get our prescriptions filled,

then we do it alone. We would lack that coming together, and that is as important as anything else. Totally important. There's a magic in joining together with other beings in suffering. That's the 'joyful participation in the sorrows of the world' that the Buddhists talk about. It's how you recognize something is bigger than you and it's a paradigm breaker."

Not Willing to Simply Survive

Richard Webb (Caregiver) on John Paul Taylor (WAMM Patient)

John Paul Taylor hadn't known he was HIV positive until an opportunistic infection, a life-threatening illness that doesn't even register as a blip on the screens of people with intact immune systems, attacked his mouth and esophagus, rendering it too painful to eat or drink. He lost a third of his body weight before he finally went to the doctor and learned the truth. In order to combat the infections, John began what amounted to in-home chemotherapy. Over a period of several hours, he would sit in a chair in his living room while antifungal and antiviral medications slowly dripped into his bloodstream. After a few minutes, his body would begin reacting to the medications, and John would become nauseated and anxious. Then he'd start having convulsions, and a visiting nurse had to be present so that he wouldn't hurt himself or dislodge his IV needle. His muscles would become rigid, his eyes would roll back in their sockets, and his entire body would shake—"I was floppin' like a fish," he told me, with a rueful, toothless smile. Every other day, John endured this treatment, with just enough time in between to gather his strength for the next round. The thought of food made him feel nauseated, and when his weight dropped below one hundred pounds, he started considering his options and found himself thinking that anything would be preferable to a life like this—even death.

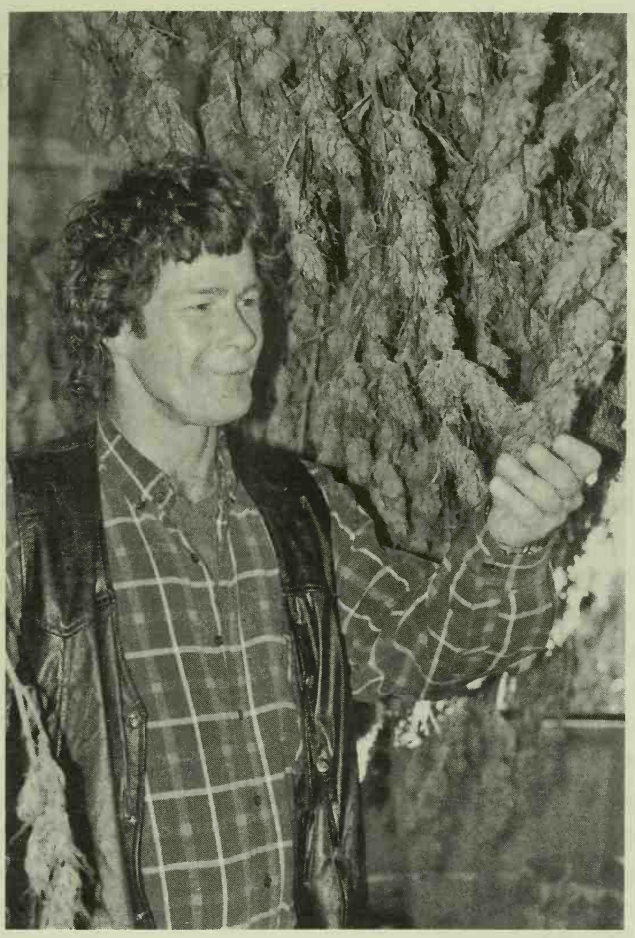
His visiting nurse had assisted several other clients with AIDS and was aware that some of them smoked marijuana to stimulate their appetites and relieve the nausea that accompanied their antiviral treatments, and she mentioned it to John. John had used marijuana recreationally on and off for many years, and he was receptive to the idea. His doctor told him that marijuana would not aggravate the fungal infection or interfere with the treatment, but that smoking might irritate his mouth and throat,

causing him some discomfort. John, a regular cigarette smoker, decided to risk it and asked a friend to bring him some marijuana. He self-medicated the next morning, before the nurse arrived to administer his treatment. He was pleasantly surprised at the result. Having a little pot to smoke, he said, actually made it possible for him to endure the treatments long enough to destroy the opportunistic infection that prevented him from eating. It subdued some of the symptoms and side effects—including anxiety—that were making both the illness and the treatment unbearable: "The fish stopped floppin' like that," he used to say, snapping his fingers. "I even forgot sometimes that I was hooked up to the IV. It made it worth it, staying alive." It's a story he enjoyed telling.

High-quality marijuana is easy to find in Santa Cruz, California, but it isn't cheap. An ounce, which would last John a month, costs three to four hundred dollars, but more often he was forced to buy it in eighth-ounce bags for fifty bucks, or to depend on the generosity of friends. Unable to work because of his illness, John's financial situation was bleak. With the help of social workers from the Santa Cruz AIDS Project, John found a rent-subsidized apartment, but his disability check didn't come close to covering marijuana purchases. Then his social workers told John about a group in town that was giving free medical marijuana to AIDS and cancer patients, the Wo/Men's Alliance for Medical Marijuana. John called the WAMM office and spoke to founder and director, Valerie Corral, who mailed him an application. Less than a month later, John received his first eighth of an ounce of free medical marijuana from WAMM.

I met John a few months later, when we both volunteered to move some donated office furniture from a storage unit to the WAMM office. Although he was still pretty thin, he was strong and energetic, and the two of us hit it off, beginning a friendship that lasted for several years. He had never graduated from high school, but he was one of those interesting people who read widely on their own and he had a wealth of life experience. We often sat in his tiny living room, drinking beer and discussing politics and religion, and despite that volatile combination we never once became angry with each other. In January 2001 I assumed the role of his caregiver, although at the time his requirements were relatively meager. I helped him in the production of marijuana muffins, delivered his medicine when he was too ill to attend the weekly WAMM meeting, and provided such companionship and social support as I could.

During the summer of 2002, his health took a serious turn for the worse. For the next few months, he was in and out of the hospital until,



John Paul Taylor inspecting the annual WAMM harvest. Photo courtesy of Jean Hanamoto.

in November, he was forced to begin kidney dialysis. John had stopped taking his antiviral medications about a year earlier, having learned that, among their unpleasant side effects, they placed considerable strain on the liver and kidneys. When he refused to resume his medications, the hospital's head physician became frustrated and, despite the fact that John was completely debilitated and unable to care for himself, the doctor insisted that he be discharged from intensive care and sent to a rehabilitation facility forty miles away.

John's decision to discontinue his medications brings to the foreground one of the central issues in the debate over medical marijuana:

who, ultimately, should have the authority to determine the way individuals are allowed to care for themselves? John, like all WAMM members, depends on qualified medical professionals—physicians, nurses, pharmacists, and a wide range of technical specialists. A recommendation from a physician is required with every WAMM application, and John was generally a cooperative and agreeable patient, consenting to prescribed treatments, albeit with resistance when they were particularly debilitating. He knew that by refusing to take his antiviral medications his viral load was likely to rise and his T-cell count was likely to drop, leaving his immune system seriously impaired—and that is precisely what happened—yet he preferred this risk to the immediate distress he was experiencing as a side effect of the medications. He was also frustrated by the chemical hostility of the drugs; the sight of his pillbox every morning was enough to produce dry heaves, and although marijuana helped calm his nausea, he was depressed by the knowledge that his course of treatment was so traumatic. He was not willing to simply survive; he expected a certain quality of life, and his choices reflected that requirement—much to the consternation of his doctor.

Valerie Corral called me the day before Thanksgiving and explained with dismay that John was being discharged. She was certain that he would not survive in the rehab facility, but he had no place else to go. "I guess they'd better bring him to my house," I heard myself reply, without considering what such an offer might entail. Valerie's gratitude and promise of assistance reassured me, and she began at once to make arrangements for a hospital bed, a commode, and the other supplies that would be needed for John's care.

The morning after Thanksgiving, I received an irate call from the physician in charge at the hospital, demanding to know what was delaying John's discharge. I explained that arrangements were still being made for his transfer to my home and that I would probably be ready to receive him on the Monday after the holiday weekend. Not good enough, I was told. John was no longer his concern, and if I couldn't take charge of him immediately, he would be sent to the rehab facility. In the angry confrontation that followed, I was forced to agree to have John delivered to my house that day, despite the fact that none of the necessary equipment and supplies would be delivered until the following week.

Early in the afternoon on November 29, John was transported to my house and carried into the spare bedroom by a couple of cheerful attendants. They arranged him on the bed as comfortably as possible, and he

almost immediately fell asleep. When he awoke, we talked for a while, but he was very disoriented and the conversation appeared to exhaust him. I went to bed that night in the room next to his and was awakened by his cries at about 1:00 in the morning. I hurried to his bedside and found him wild-eyed and incoherent. My presence seemed to calm him, but he was unable to tell me why he had called out or what he needed. I returned to bed, only to hear him cry out again several minutes later. For the rest of the night, every time I tried to return to sleep he would become upset and call for me—but each time I had no idea what he wanted me to do. By Sunday morning, when WAMM member Kathy Nicholson arrived to assist me, I was physically and emotionally exhausted. Kathy, who had experience in nursing, was able to show me how to change the soiled diaper John was wearing—a procedure I had been quite unprepared for—and I was able to get a few hours of relatively undisturbed rest while she and her husband, Tony, kept John company.

On Monday, the hospital equipment arrived, along with Valerie and an experienced caregiver, Laura Herring, whose services were originally provided for by the Santa Cruz AIDS Project. Valerie had organized a schedule of WAMM volunteers who agreed to take turns helping with John's care so that I could go to work during the day and get some rest at night. I cleared some space and we set up the hospital bed and commode in the living room, where there was more room for visitors and for providing John with the care he required. It would be some weeks before he could be assisted to the commode, and in the meantime the volunteers and I became more skillful at changing bedsheets and diapers. Funding was made available through In-Home Support Services to hire Laura as a full-time caregiver, and for several weeks she stayed at John's side, sleeping beside him on a futon in the living room. Dozens of WAMM members came by to visit him, and many of them cared for him so that Laura could have a little time off now and then.

With a quiet, safe place to rest and with the continuous attention of people devoted to his well-being, John slowly began to improve. I removed the doors to the shower, and Laura and I were able to wheel him into the bathroom and get him seated on a plastic chair for bathing, which made him feel much happier. He needed to be supported to get from the bed to the commode, but it was a great relief to all of us when he finally became strong enough to use it. Three times a week, at 6:00 a.m., a LiftLine wheelchair van would pick him up and bring him to the hospital for dialysis, returning him exhausted a few hours later. He didn't have much

appetite, however, and his arms and legs became little more than skin and bone. Tapioca pudding and scrambled eggs were the only things he seemed to want, until Valerie brought him a supply of "Mari-caps," gelatin capsules filled with a mixture of ground cannabis cooked in butter. We would separate the capsules and feed him the mixture with a spoon, and he washed that down with a little orange juice. The capsules relieved his discomfort and helped him sleep, and he began waking up hungry.

As so often happens when caring for people with AIDS, I was therefore unprepared when these early signs of improvement turned out to be misleading indicators of recovery. Nine weeks after arriving at my house, John's precarious health began to decline rapidly. He developed severe pulmonary difficulties and was readmitted to the hospital for a risky surgical procedure. He died during the operation on February 7, 2003.

5

Cannabis and Consciousness

A Dangerous Drug with No Medicinal Value

The consciousness-altering properties of cannabis are generally understood by policy makers as a critical impediment to the drug's designation as a medicine. For many, the claim that cannabis is of any therapeutic value is a "ruse" employed not for the benefit of the dying, but rather for those dying to get high.[1]

In response, many medical marijuana advocates have downplayed the drug's popular psychoactive effects, instead choosing to emphasize the role marijuana can play in managing pain, calming chemotherapy-related nausea, enhancing appetite in patients suffering from AIDS wasting, relieving muscle spasticity associated with MS, reducing intraocular pressure for glaucoma sufferers, or controlling seizure activity among epileptics. It is as if the "high" that makes the drug an attractive recreational substance either disappears with medical use or is nothing more than a trivial side effect unrelated to the plant's therapeutic value.

This reluctance to address the question of the therapeutic value of the high is easy to understand; it is hard to imagine that cannabis would have attracted any regulatory attention—much less placement in the most restrictive federal drug category—were it not for the herb's psychoactive effects. For decades, the federal government has rationalized placing cannabis alongside such dangerous drugs as heroin as a Schedule 1 substance[2] by arguing that marijuana not only has no accepted medical use but also carries extraordinary risks, including a high potential for abuse. In an effort to demonstrate these claims, the government has invested millions of dollars in research seeking to establish the dangers of the drug. In the 1980s alone, federal funding for research into risks associated with marijuana use increased nearly tenfold.[3]

But little evidence has emerged of clear harms associated with cannabis use beyond those related to the popular delivery system of smoking.[4] The National Institute of Medicine (IOM) and the World Health Organization

(WHO) both have concluded that the effects of marijuana are relatively benign and that there is "no convincing evidence of biological harm, psychological impairment, or social dysfunction" as a result of most cannabis consumption.[5]

This is not to say that cannabis is unequivocally safe. As with most medicines, some patients may experience rare but real harm from ingesting the drug. Recent research suggests, for example, that some middle-aged users might face an elevated risk of heart attack, especially those with unrecognized coronary disease.[6] Other research indicates that cannabis might be inappropriate as a medicine for a small subset of patients with a genetic predisposition to psychosis (including schizophrenia); for these patients, cannabis may serve as an environmental trigger for symptoms.[7]

But, for most patients, in the treatment of physiological and even some psychological symptoms,[8] cannabis appears to be—in the words of the DEA's own administrative law judge, Francis Young—"one of the safest therapeutically active drugs known."[9] And, unlike many approved prescription medications and over-the-counter drugs, it is impossible to ingest a fatal overdose of marijuana.[10]

In the face of growing evidence of the drug's therapeutic potential, and in the absence of clear evidence of significant harm, continued federal prohibition on even physician-supervised medical use of marijuana increasingly depends on the claim that, because of the plant's psychoactive properties, the drug carries a "high potential for abuse."[11] This claim, however, rests on unstable ground, undermined by the government's own contradictory policies on synthetic versus natural THC. THC (delta-9-tetrahydrocannabinol) is the most psychoactive component of cannabis. A synthetic version of the substance, dronabinol (Marinol), has been available on prescription in the United States for more than twenty years.

In 2004 synthetic THC was deemed so safe, with such a low risk of abuse, that dronabinol became the only drug ever moved from Schedule 2 to Schedule 3.[12] Recently, the World Health Organization's Expert Committee on Drug Dependence recommended a similar rescheduling of synthetic THC under international conventions to place it in the least stringently controlled category, Schedule 4.[13] The Expert Committee acknowledged that THC is "a well known psychotropic substance" and that the synthetic form produces the same "perception-altering effects possessed by cannabis."[14] But the group concluded that all evidence indicates an "extremely low" risk of abuse.[15] In other words, according to drug reg-

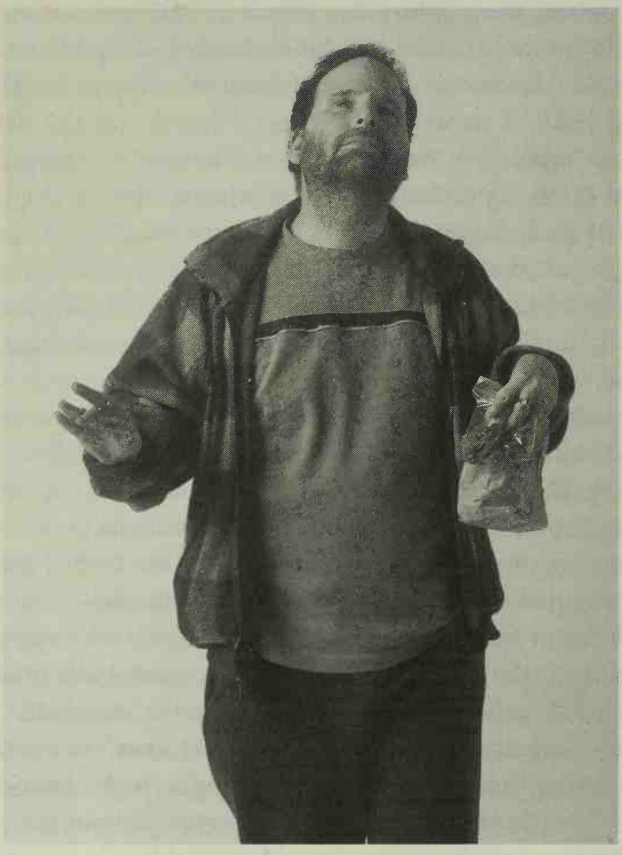
ulators themselves, the psychoactive effects of THC are not unacceptably dangerous nor do they inevitably produce a relationship of abuse.

Contradictory claims about the established safety of synthetic THC and asserted risks of natural THC depend largely on the definition of the former as "medicine" and the latter as "having no accepted medical use." If there is no legitimate use for marijuana, then a "high potential for abuse" can easily be established: all use can be defined as abuse. For federal drug regulators committed to continued prohibition of marijuana, the real problem with botanical cannabis is not that it is unusually unsafe, therapeutically ineffective, and highly addictive, but rather that it may be none of these.

For this reason, attempts to maintain federal control over cannabis are beginning to shift away from absolute prohibition to efforts at pharmaceuticalization. The first prescription drug composed entirely of botanical cannabis, Sativex, has already been approved in Canada and is now working its way through the FDA approval process in the United States.

The manufacturer of Sativex—GW Pharmaceuticals—insists that their product is different from marijuana because patients who use it don't get high. According to the company's Web site: "By careful self-titration (dose adjustment), most patients are able to separate the thresholds for symptom relief and intoxication, the 'therapeutic window,' so enabling them to obtain symptom relief without experiencing a 'high.' Patients emphasize that they seek to obtain the medical benefits without intoxication."[16] Here GW Pharmaceuticals makes the politically useful claim that, unlike recreational users of cannabis, legitimate patients reject the high as unnecessary, unwelcome, and entirely unrelated to the "medical benefits" of the drug.

But many medical marijuana users, physicians, and researchers—including at least one scientist affiliated with GW Pharmaceuticals itself—dispute such claims. Dr. William Notcutt, a medical researcher involved with the development of Sativex, acknowledges the psychoactive effects of the drug but answers critics by arguing that such effects are, in themselves, therapeutic: "There are many health professionals who perceive that a mild psychoactive effect from the drug is somehow wrong. This only seems to be of concern to those who do not treat patients in pain or distress. . . . Elevating the mood of a patient whose life is miserable because of chronic, untreatable pain would seem to be a worthwhile goal."[17]



Glaucoma patient Tony with his weekly allotment of cannabis. Photo © Chuck Nacke—Woodfin Camp.

The real problem, according to Notcutt, is that the effect has been stigmatized by the drug's countercultural origins: "The terms 'high' or 'stoned' belong to the hippy era and should be avoided in the context of medicinal cannabis. Euphoria, dysphoria, etc. are more appropriate descriptors of these effects."[18]

What Makes the High a Side Effect?

The fact that marijuana has psychoactive effects does not in itself distinguish it from other medications. There are numerous prescription drugs that alleviate medical symptoms, but which also appeal to certain recre-

ational drug users. Responses to pharmaceutical drugs vary widely among users, and drug-induced consciousness alteration is understood in a variety of different ways by those who experience it—desired and appreciated by some, tolerated or even dreaded by others. In general, the psychoactive properties of prescription pharmaceuticals are listed as "side effects," normally with warnings about drowsiness, disorientation, and inability to operate machinery or to complete complex tasks. Cannabis, too, has a range of established effects in addition to its well-known psychoactive ones, including analgesic, antiemetic, and antispasmodic properties.

Which should be considered the primary effect and which are the side effects? From the perspective of one prominent researcher, Dr. Raphael Mechoulam, whose research on cannabinoids spans several decades, "The valuable medicinal properties of cannabis, i.e. the analgesic, the anti-glaucoma, the anti-emetic, etc. effects are not necessarily linked to the psychotropic effect which I regard in a medical context as a side effect."[19] But the distinction between main and side effects of any drug is not to be found in an appeal to the science of pharmacology. According to sociologist Howard Becker, "Side effects are not a medically or pharmacologically distinct category of reactions to drugs. Rather, they are not the effects desired by either the user or the person administering the drugs."[20]

Nothing inherent in a drug demands placement in one category or another; both "main effects" and "side effects" as categories are socially constructed and subject to change. Consider the original intended purpose of aspirin—pain relief—as opposed to its recently discovered ancillary effect of reducing the formation of blood clots in arteries. This secondary effect of taking aspirin might be considered an alternate main effect, applicable to individuals with no need for pain relief, or a good side effect that accompanies pain relief for those who do. Indeed, according to some, pain relief should perhaps be considered the secondary or side effect if it is true that most adults should be taking an aspirin a day for its blood-thinning benefits.

What is really at stake in identifying the psychoactive properties of cannabis as a side effect is the suggestion that the high is a bad effect that should be eliminated before serious consideration of medicinal uses for marijuana can proceed. This is implicit in a discussion of research conducted at Stanford University on the effects of cannabinoids on perception, memory, and mood: "It may prove possible to tailor therapies by blocking or activating production of particular cannabinoids or cell

receptors, eliminating the 'high' while harnessing the most useful aspects of the chemical."[21]

But the complex relationship between the high and the more traditionally therapeutic effects of marijuana is far from settled. Patients' own reports suggest that, far from being an unwelcome side effect, the consciousness-altering properties of cannabis are deeply implicated in the drug's medicinal value. A growing body of research seems to confirm these anecdotal reports. Researcher Norman Zinberg, for example, observes that the antinausea effects associated with cannabis "accompany the existence of the 'high' state. It is when the high wears off that we have learned to expect the onset of nausea and vomiting."[22] Similarly, in 2006 researchers studying the therapeutic effectiveness of marijuana as an adjunct therapy in the treatment of the hepatitis C[23] reported that patients who used marijuana were significantly more likely to complete a difficult treatment protocol and to have a positive outcome from it; six months after treatment ended, 54 percent of the marijuana users were virus free, compared to only 18 percent of those who had not used cannabis.[24] The researchers concluded that cannabis might have some specific virological effect in fighting the virus but that it was much more likely that marijuana helped patients better tolerate the treatment by "reducing depression, improving appetite and offering psychological benefits."[25]

A Sense of Wellness

Whether this enhanced sense of wellness is called a "high," "euphoria," or simply "psychological benefits," the psychoactive effects of marijuana are a frequently commented-on aspect of the drug's medicinal value in interviews with patients. "Jon," a thirty-seven-year-old WAMM member living with HIV, for example, observes,

> Marijuana lifts me up past whatever symptoms I have at the moment and creates this sense of wellness and well-being that allows me to just function very much the way I could before I was HIV positive. I really feel like the worst symptom of HIV is how drained it makes you feel. The feeling of well-being that we all take for granted when we are healthy, that mental state disappears when we feel sick. So when I'm stoned, I'm able to just rise above it and press on. I love that. It's a good thing. People who are well might not understand this. When you are really sick it

> affects your desire to live. If you are constantly ill for a long period of time, you can feel like it's not worth climbing back up the ladder. Because every step back is a struggle. So if you can take some substance to make you feel well, even for a brief moment in time to remind you what that's like, it's invaluable.

The need to battle situational depression and to regain some sense of wellness is commonplace among those living with chronic pain or life-threatening illness. The effects of some prescription pain medications can intensify this struggle. WAMM member Suzanne Pfeil uses a range of pharmaceutical drugs to control severe neuropathic pain associated with post-polio syndrome. She observes,

> Some of the pharmaceuticals will take the pain down a notch but most of them are depressants—especially the muscle relaxers and pain pills—so they take your mood down. What I find is that I'm getting the edge taken off the pain but I'm also getting depressed. So, when I get a pain flair, I smoke [marijuana] and it helps to relieve the pain and relieve the spasms but it also means I don't get as depressed. . . . Marijuana never fails to lift my mood. I smoke and think, "OK, I'm just going to have to go with the pain today. It's beautiful outside and I'm going to go tool around the garden in my chair." It takes you to another level mentally of acceptance about being in this kind of pain. So when I'm in that "I can't handle this another minute stage," it produces a positive shift and I can go on to something else. The other drugs I'm prescribed have such major side effects, but if I smoke a joint, the biggest side effect is a mental lift. And that's a side effect I can live with.

It is significant that Suzanne doesn't claim that cannabis fully masks her pain but rather that it produces a shift in attitude toward pain. This was a frequent formulation by WAMM members discussing the effects of cannabis on pain management and depression. "Richard," a forty-nine-year-old epileptic, suggests that marijuana allows him to "sideline" pain and refocus on pleasures and possibilities:

> With my epilepsy, I've fallen on my nose, broken my jaw, I don't know what part of my body I haven't injured over the years. But with two or three touches of the marijuana, all that aching, that feeling like hell, kind of drops away. But largely I think it works by changing your mind. I

> mean, I still have the pain, I still have the nausea from the handful of Western meds I have to take every day. But using marijuana will let you somehow sideline that. You can take your mind off of it. I call it a kind of tai chi for my head, a spiritual tai chi. My spirit lifts, I can taste again, suddenly things around me are there to be noticed.

Another WAMM member, seventy-year-old "Hal," who uses cannabis to manage the pain of neuropathy, echoes the argument that cannabis creates distance from pain:

> When you are in constant pain, your focus is 100 percent on yourself: I can't move this way; I can't twist this way; I can't put my foot down that way. That kind of thing. It's terrible. I'd never been one who was self-absorbed to the extent that I would forget about other things. But I became that way. I don't know how my wife could stand it. I find, though, at this point [with the marijuana], I am in a sense witnessing my pain. What's happened as a result is that I am no longer so absorbed in my pain. I can rise above it and then I'm able to do whatever I have to do.

Productivity and Amotivational Syndrome

Hal's comments, like those of Suzanne Pfeil, Richard, and Jon, suggest that marijuana enhances their ability to function in the world. This runs counter to a common belief about the dangers of marijuana in undermining productivity. Some WAMM members spoke directly to the question of whether the consciousness-altering properties of the drug were an impediment to certain kinds of activity. "Judy," a WAMM member with MS, noted that, prior to her illness, any recreational use of marijuana would interfere with her ability to complete tasks: "I remember that I used to get very visually stimulated and distracted so I wouldn't use it if I had to really get things done." Her current medical use of marijuana, however, doesn't create the same problems, perhaps because of changed life circumstance: "It's different now. Of course, now, there is much less that I have to do." "Rev. Sonny," a former Baptist minister who began to use marijuana medicinally to manage side effects from cancer chemotherapy, observed a similar shift in what he perceived to be the effect of marijuana on his concentration and productivity:

> I never would have guessed that I would ever be using marijuana medicinally when I was well. I always said that it was written in heaven that I couldn't smoke marijuana because it had such an effect on me. I just got really stoned, you know? But something changed when I got sick. I never would have believed it, but now I can function perfectly well with marijuana. In fact, I notice that it not only takes away my pain but I can get really focused on things. I can get really into a project if the distractions leave me alone. The only side effect I really notice is forgetting things. But I don't have a lot that I really have to remember right now.

One complicating factor in attempting to identify the specific effects of the medical use of cannabis is that most patients suffering from serious illness—including most WAMM members—take a range of pharmaceutical drugs in addition to their marijuana. It can be difficult to identify which drug (or interaction among drugs) is causing a particular effect. Many prescription drugs, both those used to relieve symptoms and those used in treatment itself, have unanticipated effects. For example, between 40 percent and 80 percent of cancer patients undergoing cancer chemotherapy suffer from what some researchers are calling "chemobrain": mental fuzziness, memory loss, and cognitive impairment.[26] In addition, for breast cancer patients, chemotherapy produces hormonal changes that themselves can produce memory problems. Under such circumstances, it can be difficult to identify any specific cannabis-related effect among patients taking multiple medications and struggling with physiological changes caused by their illnesses.

It may also be difficult to directly compare reactions to a drug taken in the context of a serious health challenge and the same drug taken when well. Both Judy's and Rev. Sonny's accounts suggest that some of the potentially negative side effects of cannabis use seemed to be less prominent, or at least much less problematic, when the drug was used to manage disabling or life-threatening illness.[27] Both individuals remark that, as a result of their health challenges, they have a diminished need to be highly productive; under such circumstances, any effect on their ability to concentrate or complete a task might be less noticeable and more difficult to measure.

Not all medical marijuana patients, however, would agree that reduced productivity necessarily accompanies disease or disability, nor would they all accept that marijuana in any way impedes their performance. Many WAMM members are adamant about their desire to remain as productive

as possible in the face of their physical challenges. These patients tend to emphasize the ways in which marijuana can be used to enhance function. "Cher," for example, disabled by a serious seizure disorder and chronic pain, argues that marijuana has contributed to her ability to return to work: "Marijuana makes the pain easier to deal with. I won't say that it eliminates it—that would be overstating it. But it certainly makes it less of a nightmare so I can function. That's really important to me, to be able to function. From age twenty-five to thirty-five, I couldn't work because my seizures were so frequent and I was in so much pain. Now, when I hear people talking longingly about retirement, I realize how little they know about being useless. They are in for a big surprise. It is devastating to be useless." Suzanne Pfeil also emphasizes the importance of sidelining pain in order to enhance productivity: "When I'm in pain, it takes all that I have just to stay centered. It's hard work being in pain. Marijuana helps with that. After I smoke, I don't think in terms of 'I can't do this.' I think more in terms of what I can do. When I'm on pharmaceuticals, all I do is lay on the couch and watch TV or look out the window. Marijuana actually gets me moving."

This characterization runs directly counter to decades of federal antidrug education that has emphasized the risks of so-called amotivational syndrome. Marijuana users were described in a 1974 Senate hearing, for example, as existing in a state of "apathy approaching indolence."[28] In 1982 the American Council for Drug Education attributed to marijuana use "a loss of ambition and initiation, a withdrawal from customary activity, and a regression to a simpler kind of life."[29] Similarly, a 1998 pamphlet produced by the National Institute on Drug Abuse depicts those who use marijuana as "not caring about what happens in their lives, [demonstrating] no desire to work regularly, [experiencing] fatigue, and [exhibiting] a lack of concern about how they look."[30]

WAMM members are well aware of that stereotype. "Charles," for example, observes,

> My [AIDS-related antiviral] meds give me 24/7 flu-like symptoms. Under those conditions, it can be difficult to force myself to do more than to sit around and mope. Marijuana helps with that. I crack up when I see antidrug television commercials about marijuana causing a lack of motivation or something. That's you; that's not the marijuana. If you are procrastinating, that's just you. Blaming it on the marijuana is an excuse. It never gets in the way of me doing what I need to do. In fact, when I'm at

> home and I medicate, I'm very productive. I take care of things I need to do around here. That's when I get things accomplished. It breaks through my procrastination.

In a similar rebuttal to the image of the apathetic and unmotivated "pothead," television personality—and medical marijuana patient—Montel Williams told a New Jersey Senate Health Committee in 2006 that he had never missed a day of work in seven years of hosting a television talk show despite daily marijuana use to ease the pain associated with multiple sclerosis.[31] An emotional Williams announced, "It doesn't get me high at all. All it does is allow my feet to stop from hurting. What angers me so much now is people consider me a dope head and all I want to do is get up and go to work."[32]

Tolerance

Williams's statement that marijuana "doesn't get him high at all" clearly is intended to reinforce his argument that his drug use is medicinal, not recreational. But, beyond its rhetorical value, the claim may also reflect the fact that the intensive medicinal use of any substance may create some measure of tolerance and diminished effect. In fact, many WAMM members report that the euphoric effects of cannabis remembered from prior recreational use (or from the early days of their medicinal use) diminish or disappear over time. Hal, for example, explains that as he became more accustomed to the drug as a medicine, its effects seemed to change: "After a couple of months, I found that I wasn't getting high as much as I was getting calm. It took a couple of months though. At first, I'd smoke and get really high and have a wonderful afternoon or evening or whatever. But then it started to change and I just got calm."

Similarly, Cher argues that the loss of the high is a side effect of her regular medicinal use:

> I have to use marijuana every day to deal with pain. I feel like I'm so habituated that it really doesn't do that much to my mood anymore. Or at least it's hard to tell. . . . Anytime you use something everyday, your system almost naturalizes it. And frankly I do not really feel stoned anymore unless I smoke because I'm so habituated to eating it. When you are a medical user, especially if you eat it, it stays in your system for a long

> time. When I smoke, I remember how wonderful it was when marijuana actually got you high. It's like any drug; your body gets habituated.

Establishing a clear difference between consuming cannabis in a recreational and a medicinal setting is a priority for those WAMM members with a history of drug abuse and recovery. By drawing a line between "getting loaded" and "taking medicine," these individuals are able to maintain their sense of sobriety while using cannabis therapeutically. Inocencio Manjon-McFaline, a fifty-four-year-old cancer patient and former cocaine addict, describes his own initial reluctance to use marijuana medicinally:

> For me, the decision to start using marijuana was really hard. I had a long history of using drugs. You name it, I'd used it. I spent time in Vietnam where I got into injectable drugs and then I was in Central America for twenty-eight years working with the canine section at an international airport. What it amounted to was taking all the cocaine and putting it in my back pocket. I had at my disposal whatever I wanted. In 1988 I quit cold turkey. I stopped everything—cigarettes, alcohol, coffee, drugs—everything that I was addicted to. Completely clean. Given the amount of cocaine I'd been using, cleaning up was so painful I keep a good memory of it. So when my doctor suggested marijuana to me about four years ago, I said, "No. I don't want to start that." I was really against it. For me to start smoking was like, Did I fail? After all those years of being clean? For what? But it got to the point where it was only a choice between which pain relievers I would use—Oxycontin or marijuana. I decided to stop the Oxycontin and try the marijuana.

In his description of his current use of marijuana for pain relief, Manjon-McFaline emphasizes the profound difference in the effect of the drug when used medicinally and recreationally:

> What's strange now is that I don't feel the effects [from marijuana] that I remember from when I would smoke it before, smoking to get loaded. It's a different time for me. I'm not smoking it looking for a high. Maybe it's just psychologically different knowing I'm smoking it for medicinal use. But I haven't felt loaded. I smoke only for the pain. It gets me out of there, out of that frame of mind. I'll smoke and I'll tend to focus on what I want to focus on. Generally, that's my breathing and my heartbeat. And I'll get really into plants. I just really get into that and forget about pain. Every breath I take is a blessing.

But in attempting to establish a clear difference between recreational and medical use, Manjon-McFaline's comments raise the important question of what it means to get "high." Clearly, he is no longer looking to "get loaded" and argues that he no longer gets "high." Yet, his description of his medicinal use suggests that marijuana assists him in not only dealing with pain and nausea but also in focusing on his breath, on his heartbeat, on the blessings of being alive. This echoes reports by many recreational users of the psychoactive effects of the drug. The difference may be that this state seems more "altered" when there are more conventional demands making claims on the user's time.

A present-tense focus, attention to the breath, a renewed delight in living may not feel "altering" so much as "confirming" or "enhancing" in the context of terminal illness. In other words, at least some of the differences patients report in the effects of the drug when taken medicinally may be attributable to what Norman Zinberg refers to as the effects of "set" (the user's mindset) and "setting" (the context in which the drug is taken).[33] A substance taken in expectation of pleasurable intoxication by a healthy individual may produce a substantially different effect than that experienced by an individual living with a life threatening illness or in chronic pain. In short, partying and medicating are different. As Cher explains, the effect for her is highly dependent on the specific situation in which the drug has been consumed: "If truth be told, I would rather be a recreational user than a medical user. It was more fun being a big pothead than it is being a medical user, for me. You get higher when you are a recreational user . . . I mean, it's still fun when I do it in a good situation. But unfortunately being a medical user means that, a lot of the time, you do it in a bad situation."

Here, Cher suggests that the high is still achievable for her under the right conditions. This nuanced description of the range of effects that can be experienced from the same substance by the same user when consumed in contrasting settings, challenges the notion that a clear-cut distinction can be made between patients who don't get high and, in Montel Williams' words, "dope heads" who do.

In contrast, WAMM members describe a complex relationship to the drug depending on circumstance and intention. In one setting, a patient may be using marijuana specifically for physical symptom relief, while in another situation marijuana may be consumed with an expectation of deepened relaxation, introspection, or enhanced creativity. For example, despite scoffing at the idea of an "amotivational effect," Charles

acknowledges that he generally avoids using cannabis during working hours. He instead prefers to medicate with marijuana when at home, in a context in which the high will be most therapeutic: "I deal with teenagers and maybe parents in my work and I don't want to have to think 'responsibility' when I medicate. The whole idea of medicating is to let go of everything, to just surrender and let what mother earth has provided do what you need it to do. It should just be total surrender. I might light some candles and meditate and relax. It can help to just let go and find some peace of mind. Sometimes I can even feel my lover and my friends who have died."

Stoned Realizations

Charles is not alone among WAMM members who describe their therapeutic use of marijuana as targeted at more than physical symptom relief. Many emphasize the role the drug plays in allowing them to face difficult emotional issues with diminished anxiety. Rev. Sonny, for example, also found that it assisted him in confronting his own mortality and his relationship to God:

> I used to be a Baptist pastor and I think I had a pretty good touch with it. But even for me, God was often kind of on a back burner. But when you get real sick, when you think you are about to die, well that's when people get real spiritual lots of times. Or at least you want to be able to go there. But when you are so damn sick, it can be hard to focus on anything but the sickness. What I found was that smoking pot and getting stoned during that time allowed me to go to that spiritual place where I could commune with God.

Other patients reported that the introspective effects of cannabis allowed them to reflect on, and in some cases resolve, issues unrelated to their illness. "Sarah," a fifty-four-year-old living with MS, uses cannabis to control pain, but she acknowledges that increased introspection is a welcome side effect:

> I certainly wouldn't put the altered consciousness thing as a primary effect for me. Though I have to say that the last two or three years have

certainly been very surreal largely because my father was in the process of dying. It was interesting to see how marijuana maybe turned my head with regard to that, to his problems and insights into my own behavior. It was probably helpful in letting me just dwell longer in my mind on that particular topic and try to get to the bottom of things that had been brought up in one conversation or another. I think I was able to look at my life a little differently as a result.

Such "stoned realizations" were often discussed by WAMM members with a knowing nod to the drug's countercultural connotations. "Alicia," a thirty-four-year-old breast cancer survivor, for example, observes:

If I'm in a really high realm of pain, then I don't get any pleasure from pot at all. It just helps stop the torture. But there are also times when the pain is not nearly so bad; bad enough to treat but not in the upper stratosphere. Then marijuana is also a relaxing experience. It's not, you know, like something from the old psychedelic movies of the 70s, but there is a certain pleasure factor in there as well as the absence of pain. And it does lead to a certain degree of introspective enlightenment, a sort of free-form thinking. This is such a cliche that I feel like I need to have "Stairway to Heaven" playing. But it does inspire introspective thought. Like I say, it's so clichéd but it's definitely true. I remain very aware when it's occurring. I had something like that happen just last night. I was thinking about some family stuff—I have a very screwed up family. And I had a revelation that actually made sense to me about forgiveness. Now could I have had those kinds of thoughts if I weren't stoned? Definitely. Definitely I could have. Would I have, though? That's a different matter. Generally in a non-stoned state, I wouldn't even bother to think about those kinds of things. It's being in that altered state that you think, "Hmmm . . . this is interesting," as opposed to, "What else is on TV?"

Some patients, like "Stephen," a forty-six-year-old whose physician recommended marijuana to him for pain relief, acknowledge that they would use the drug on occasion specifically in pursuit of the high rather than simply for physical pain relief:

My partner just died. I've been grieving a lot and I know I use marijuana to manage that too. Of course you could consider that just recreational

> use and not medical. But I actually think I'm using it medically on those days too. It helps me to step back, to just lovingly observe what I'm doing. That can soothe me and, from that position, allow me to reorient myself. When I am able to get stoned, sometimes things just come bubbling up that I didn't see—that's what you call "stoned realizations." Of course, everyone says that things like that aren't real because you're stoned: "You only think you're having an insight or feeling better when you're stoned, but you're really not." Great; just don't tell me the difference.

Escape from Reality

A common objection in antidrug literature to the "high" associated with psychoactive drugs is that the altered consciousness offers only a distortion of, or escape from, reality. The implication is that escape is both an unworthy pursuit and an undesirable outcome. In the context of chronic pain or terminal illness, however, one might question whether reality isn't greatly overrated. As writer Jane Wagner and comedian Lily Tomlin observe, "Reality is the leading cause of stress amongst those in touch with it."[34]

Susan Durst, a sixty-two-year-old WAMM member with cancer, for example, struggles not only with physical pain but also with poverty and social isolation related to her illness:

> I eat about an eighth or a sixteenth of a [marijuana] muffin in the morning, mostly to help with stopping all this anxiety and fear and this "poor me." It stops the fear, its stops the worrying. It isn't just the fear of the cancer, it's the poverty, it's the fear of being evicted, it's all of it. My world feels like it is closing in, closing down. My secret pleasure is watching baseball on television. To eat a little bit of muffin or drink a little bit of [cannabis-infused] milk and just lay back and watch the game is right now kind of bliss for me. Marijuana alters your thought processes, gives you a little sense of well-being, and takes away some of the minor bone pain. During the chemo, it helped to take the edge off and it made me believe I was getting better, and it made me able to sleep, to live in that awful mess and not fret about it too much.

For some patients—like Pamela Cutler who was facing terminal illness at an early age—marijuana use reportedly softened the focus on death:

> Marijuana kind of helps dull the reality of this situation. And anyone who says it's not a tough reality . . . I mean your mind will barely even take it in. It does dull it and I don't think there is anything wrong with that if I want to dull it. That's fine. I was diagnosed with breast cancer and had a radical mastectomy. The whole thing was a big shock. I mean, I was thirty-six. I was like, What? And ever since then it's been like a roller-coaster: OK, it's spread to your bones, and then it's spread to my lungs, and then my liver. . . . Marijuana makes it easier to take for me. It doesn't really take it away. It just dulls the sharpness of it—like, "Oh my god, I'm going to be dead." I just think that's just incredible.

Similarly, Charles argues that the need to occasionally escape is both valid and understandable in the context of living with AIDS:

> Since I tested positive in 1990, my life has been a real roller-coaster ride. On my worst days, it's hell, a living hell. I lie in bed, or on the couch, or on the floor. The meds make you so sick, you can't even cope with yourself, let alone the outside world. By "cope" I mean how many times do you have to run to the bathroom, for instance. The diarrhea is awful. And the first thing they want to do is give you another pill to stop it. I'm not taking another pill. I'd rather smoke marijuana. It can help put you in a different state of mind. I mean, I had never had a life-threatening disease and now I was watching everyone die in front of me. It wasn't just getting high anymore; it let me think about why I am still here after they are all gone. With marijuana, I can get high and let it all go. But at the same time, it also makes it possible for me to eat, to deal with the nausea, the insomnia, and all that. So it's not just an escape. Absolutely not. And even if it was, why would that be such a bad thing?

As Pamela Cutler and Charles suggest, the psychological dimensions of serious and life-threatening illness can be as important to treat as the physical symptoms. Under such circumstances, healing modalities associated with palliative care—for example, pain relief and anxiety reduction—may be more relevant than heroic measures intended to "cure." As Dr. Bal Mount, founder and director of the Palliative Care Unit at the Royal Victorian Hospital in Montreal, observes, "Healing doesn't necessarily have to do with just the physical body. If one has a broader idea of what healing and wellness are, all kinds of people die as well people."[35]

SilverKnight working in the WAMM garden. Photo courtesy of Jean Hanamoto.

Dependence and Self-Regulation

Discussions of appropriate treatment for life-threatening illness and chronic pain often include debates about the benefits of adequate pain relief measured against the risks of dependence on highly addictive prescription pain medications. WAMM members are aware of this problem

and many argue that marijuana allows them to reduce their dependence on more dangerous pharmaceutical drugs. SilverKnight, a fifty-four-year-old former nurse, notes, "I'm careful not to ever abuse my prescription drugs—in fact, that is part of the reason to use marijuana, to cut the need for those pain relievers that are very addictive. With the heavier strains of marijuana, I can take half [a prescription pill]. That's all I'll need."

But what about dependence on marijuana itself? Only one member, "Ali," a young woman with advanced MS, admitted to a serious problem with excessive cannabis use. Ali has no functional use of her arms or legs and relies on friends or caregivers to assist her with everything from dressing and eating to taking her medications. Marijuana, she reports, is effective in easing her spasticity and allowing her to sleep, but she is contemplating stopping its use:

> Marijuana helps but I'm not so sure whether or not I should keep doing it so much because I think I smoke too much. I smoke every day in the afternoon, a couple of hits. I don't usually smoke in the morning. But actually I don't stop at a couple of hits. I get really plastered. The people who come by to get me high want to keep smoking and I can't say no. I don't want to, I suppose. That's the addictive part of it I guess. I've actually been to MA [Marijuana Anonymous] meetings. People there talk about losing any interest in everything else except where to get the next joint. That doesn't really happen to me but the thing is, I want to walk again and I need to focus on that.
>
> I've been in this chair since 1994. When I first got into it, I could still get up to go to the bathroom. But now I can't get up at all. So my first priority is to get out of the wheelchair. I think that smoking might make me kind of lethargic like, "Who cares if I ever get out of this chair?" I just worry I might be too preoccupied with getting stoned to be a real go-getter when I'm getting high. But, on the other hand, if I am going to be stuck in this wheelchair forever, I might as well enjoy getting high. But I'm not going to be.

Other WAMM members echoed some of Ali's concerns about excessive use but described a process in which they learned to self-regulate—and assisted others in moderating—their use of marijuana. SilverKnight points out,

> You have to know what you're doing. Some of the strains are pretty strong and I know not to smoke too much and not to mix it with some of the prescription drugs that I have for pain. I look at marijuana as a friend, a medicinal helper, a spiritual helper, a wonderful thing. But I also know the parameters. Do you want to be knocked out stoned? Not me. I want to be able to alleviate the pain I'm having.
>
> It's like taking any other drug to help you: be responsible. I think you can abuse anything and, sure, some people do develop some type of dependence on marijuana that's not good. I mean, like Valerie says, "Once you are 'there,' why continue to smoke, smoke, smoke?" You are already there. So what is that? Why is that person picking up another joint? That's a concern. I've been in that place myself but I recognized it. I had to say to myself, "OK, now, you're there. You can always get there again. Just enjoy this; it's not going to be taken away from you." That's the old fear. But with WAMM, you don't have to go out on the street and try to find it. You are in a safe situation where there will be more.

Interestingly, SilverKnight's comments suggest that a guaranteed supply of free marijuana not only creates the possibility of excessive use but also provides a context in which patients can learn to regulate their consumption. For some members, the organizational structure of WAMM itself—a demanding patient cooperative involving considerable face time among the membership—provides an environment in which members can assist one another in developing a practice of responsible use. Richard, for example, explains,

> I think some people probably do use too much. When I think that's happening, I talk to them about it. I try to tell them that they're expecting too much from it and that they won't get the response they need once they've reached saturation. It's usually a result of that old way of thinking about it: "It's expensive; I'll grab as much as I can and I'll use it." But that doesn't need to go on in our group. You can get it later if you need it; use what you need now. That makes all the difference. I've had that conversation with people who tell me that they realize they're getting too carried away by it; they have this much to use so they feel they have to use it. But there's something that comes to a person when they reach that sense in themselves where they can provide their own sense of control, self-control. They learn how to use just enough right to where it's helpful. But it can take people a while to get to that point.

These reports suggest that, for some patients, the compelling psychoactive effects of cannabis lead to excessive use. Patients themselves recognize this risk and often self-regulate. The accounts also suggest that participation in a patient cooperative assists members in recognizing overuse and moderating their intake.

But it is also the case that not all patients even find the high attractive. For some, it is experienced as an unwelcome or even intolerable effect. Dr. Arnold Leff, an AIDS specialist and primary care physician for several WAMM members, reports that, while many of his patients find marijuana effective in relieving their symptoms, some do report that the high is counterproductive in managing the challenges of their illness:

> For a lot of my patients with AIDS, they smoke grass, get high, and that's great. But there's a group of patients who are very sick, who have significant nausea, significant appetite decrease, wasting, but who don't necessarily like getting high. Especially those who are suffering from neurological deficits—what used to be called AIDS dementia. They are already struggling to keep their heads together and don't want to lose it. Marijuana can confuse them, disrupting the baseline of where they are at and make it more difficult to cope. The point is, for some people, the high just doesn't work.

The fact that the psychoactive effects of cannabis are experienced as compelling and therapeutic by many patients but disturbing and unwelcome by others suggests that the medicinal use of marijuana will not be appropriate for all patients, even those who might find effective physical symptom relief through use of the drug. It further suggests that efforts to create some cannabinoid-based medications that remove the high would serve the needs of a subset of patients now reluctant to use the drug in its natural form or concerned about the challenges of moderating their consumption of a psychoactive substance. But patient reports also suggest that many are likely to find continued appeal in the herb itself, complete with its well-known "side effects" on mood and cognition.

Outside the Pain

Interview with Fred Brown, WAMM Patient

When I was a so-called hippie in the late sixties and seventies, I smoked a lot of marijuana. I went through a period where I was smoking it every day and practically off and on all day. Then it kind of got to a point where I wasn't enjoying it and so I discontinued using it. It wasn't like, "I'm not going to do this anymore"; it just kind of fell to the wayside because it wasn't pleasurable. One reason for that was that I had just become a Buddhist and started meditating a lot. The type of meditation I was doing was "calm abiding." I'd meditate and it would calm my mind and then, if I would go smoke a joint, I'd find that my mind became more active. So I thought it was kind of counterproductive, all this chatter going on in my head.

But about three years ago I started a heavy-duty regime of medications for HIV and I was experiencing a lot of nausea and stuff like that. A good friend who was dying of AIDS used marijuana and it was very effective for him, helping him with his appetite and to get rid of the side effects of the meds he was taking. I was still hesitant because of my past experience and because a number of different Buddhist teachers I'd had over the years implied we shouldn't. But finally I did try it again and I noticed immediate relief from the nausea and other side effects like the slight neuropathy. I had also been losing weight because of no appetite and it helped with that too. The positive effects of smoking marijuana were rather dramatic I thought.

I know from experience, and from talking to other people, that all drugs affect different people differently. The medicine I take for AIDS makes me nauseous—some people it doesn't. I think pot affects different people differently and different kinds of pot have different effects too. Some pot feels to me like more of a body trip, more like sedation. And I

think some people need that; it helps them sleep or calms their nervous system. Whereas, for me, there is another strain that I prefer that makes me more energized, where my mind is clearer. Just a couple of puffs and, within ten to twenty minutes, my nausea will usually go away and I feel more like doing things.

Sometimes even when there is still a little nausea there, or some neuropathy, or whatever's going on, it's kind of like you are removed from it. You are kind of outside of the pain, watching it go on but part of your "awareness mind" is not necessarily affected, instead it's an observer. What struck me was that, as a Buddhist, this was what I was practicing. "Awareness mind," or consciousness, is the witness that is always there. It is the clarity behind all the thoughts, like the silence behind all the sounds, and the emptiness that supports form.

I notice now that when I smoke pot, I don't experience that confusion and that chatter that I used to. It isn't distracting, in other words. I've thought a lot about that. I've wondered if it was due to the fact that I have done so many years of meditation practice and Buddhist study, intensively and extensively. The years of practice may have had some effect on how I experience it. Also, the type of meditation I do now has changed; with this type, thoughts are not the enemy.

Whereas before, with the calm-abiding type of meditation, I tried to get to the point of no thought. Thoughts come and go and you are supposed to just let them go, but I was more vigilant. And I felt disappointed whenever I would start thinking like crazy. So, of course, back then, when I smoked pot, I thought it was counterproductive.

But that's not the case now with the kind of practice that I do; we learn that thoughts come and go and are part of the practice. You are trained to notice with your awareness mind if your mind is calm or busy with thoughts. There is no difference; your awareness mind is there witnessing what is going on, whether you are chatting or you are quiet. With this practice, you incorporate everything on the path. When you are eating, when you are sleeping, everything, there are practices to do—reminding myself to be present. So my practice has changed. But also my experience with smoking pot has changed. I find that I become more present. That's the best way to put it. Other times, I might be just kind of busy with whatever is going on in my life; but I notice that when I smoke pot I become more aware, more self conscious, conscious of my self.

To tell you the truth, I find marijuana more supportive of my practice now than counter to it. Because in your practice, one of the results that

is supposed to happen is that you do things with more mindfulness. In my practice, I am encouraged to check the motivation behind what I say to somebody or how I interact with them. And I find that, when I smoke pot, I do that even more. I'm more aware of the result of my speech and my actions. It's no heavy thing, but it just kind of happens, happens more clearly. For some people that can be a problem and I think that's why they don't enjoy pot so much. They don't like to be self-conscious; but it's only the watcher, the witness, coming in. In my practice we are taught to be nonjudgmental, to just experience things as they happen in the moment, before you start labeling it as good or bad. When you first smoke, you can become concerned about how you appear, about why that person is looking at you that way. Instead you might try just accepting that you are becoming more aware of those things. It's just another shift in your awareness that's all

But our mind keeps wanting to judge whether what we are thinking or doing is good or bad. I think that's where my years of practice come in handy now. I enjoy it more—even that initial part where I do feel a little awkward or self-conscious. I'm aware of my witness saying, "There he goes getting carried away by what he is seeing or what he is thinking. Don't take things so seriously." Still, I'm a little hesitant to say anything to my fellow Buddhists about all this. When I told another woman who is student of the same teacher that I was going to do this interview, she was kind of shocked. I think like many Buddhists she's worried that people will generalize, "Oh Buddhists do this, or Buddhists do that. Buddhists smoke pot." She doesn't want it to reflect badly on her religion. But when I asked her, "Do you think your consciousness is affected adversely from smoking pot?" she said, "Oh absolutely not." Well there you go.

In any case, what's altered isn't your consciousness at all; instead it's these obstructions that keep you from being aware of your consciousness. That's altered; it's your mind that's affected. And by being affected, it allows your consciousness to come through, to be more present. When you smoke pot and become more aware of what's going on in your mind, that's your consciousness. The pot just allows you to be present with it.

6

Mother's Milk and the Muffin Man

Smoking Is Hazardous to Your Health

The most common and best-established risks of sustained marijuana use in botanical form are associated not with the plant, but with the effects of one of the most popular delivery systems: smoking. For this reason, drug prohibitionists tend to focus on the dangers of inhaling smoke as a way to avoid a discussion of the relative safety of cannabis itself. They can point to research on the effects of chronic marijuana smoking that concludes that lung function is impaired in much the same way as with heavy tobacco smoking; indeed, "Marijuana smoke and tobacco smoke are rather similar. Many of the toxic compounds, such as tar, carbon monoxide, and cyanide, are found in comparable levels in both types of smoke."[1]

The 1999 Institute of Medicine (IOM) report on marijuana also makes the point that "numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease."[2] But the report is clear that it is smoking—not the use of the plant itself—that is a safety concern: "Except for the harms associated with smoking, the adverse effects of marijuana use are within the range tolerated for other medicines."[3] Because of the dangers of smoking, the report strongly recommends research into alternative delivery systems: "The argument against the future of smoked marijuana for treating any condition is not that there is no reason to predict efficacy, but that there is risk. That risk could be overcome by the development of a non-smoked, rapid-onset delivery system for cannabinoid drugs."[4]

But because smoking is well established as hazardous, while marijuana itself is not, opponents of the legalization of even the medicinal uses of cannabis frequently focus on the dangers of the popular delivery system as a stand-in for missing or weak arguments about the dangers of the botanical drug itself. At an April 2004 congressional hearing on medical marijuana, the chair of the subcommittee—and an outspoken opponent of marijuana use—Representative Mark Souder (R-IN), used the IOM

report to dismiss the possibility that the botanical form of the drug might have any medicinal value. To establish this point, he noted that the IOM report "stressed that smoking marijuana is not safe, not a safe medical delivery device, and exposes patients to a significant number of harmful substances."[5]

Repeatedly during the hearings, risks of smoking are raised as the reason why whole plant, botanical cannabis should not be considered an appropriate medicinal substance. Dr. Robert Meyer, director of the FDA's Office of Drug Evaluation, in his testimony before the committee, for example, observed that while some components within cannabis appear to be therapeutically active, "Marijuana, botanical marijuana, is not an approved drug."[6] Souder immediately followed this observation with the suggestion that any cannabinoid medication would be distinct from the botanical plant: "And it wouldn't be marijuana? It would be some component inside the marijuana." Meyer's response is telling: "Well, again, I think there are inherent toxicities to smoking anything."[7] The substance in its botanical form becomes synonymous with the delivery system of smoking. At the end of his testimony, Meyer returned to the question of herbal or botanical medicine, arguing that the "FDA does not have an inherent bias against botanical products. If botanical products are developed correctly and shown to be safe and effective . . . we would approve of a botanical product."[8] Souder immediately interjected, "Do you have any smoked products you've approved?" Meyer replied, "I don't believe so. No."[9] Once again, the botanical form of the drug is reduced to a "smoked product."

This rhetorical strategy has been deployed in more-popular venues as well. During an interview on the television program the *O'Reilly Factor*, Dr. Andrea Barthwell, the U.S. deputy "drug czar," dismissed the possibility that marijuana might have medical value by saying, "There is nothing that tells us from the science now that smoked, crude botanical should be a medication."[10]

One notable exception to this approach among prominent public health officials has been articulated by former U.S. Surgeon General Joycelyn Elders. In a published editorial in 2004, Dr. Elders observed that "marijuana does not need to be smoked. Some patients prefer to eat it, while those who need the fast action and dose control provided by inhalation can avoid the hazards of smoke through simple devices called vaporizers."[11] Her acknowledgment of alternative delivery systems presents a clear challenge to those within the federal bureaucracy who oppose the medicinal

uses of the plant on the basis of the risks of smoking. But rather than seriously exploring the medicinal uses of botanical marijuana, most public officials continue to challenge cannabis as a "smoked botanical."

This narrow focus is justified by the claim that medical marijuana users and supporters are just "druggies" defending their access to joints. Dr. Robert Dupont (the first director of the National Institute on Drug Abuse), for example, argued in his testimony at the 2004 congressional hearing,

> Much of the [legitimate] talk about medical marijuana is dealing with individual chemicals in it and not with the smoked marijuana. . . . [But] the smoked marijuana is the only way it's interesting to the advocates in the field. They show no interest in the development of individual chemicals whatsoever. And that shows that their purpose is not medical. It's a way of influencing the country's policies toward marijuana. The legitimization of smoking marijuana, you can see that very clearly, with how little interest they have in individual chemicals or any delivery system, any delivery system other than smoking. They're only interested in smoking.[12]

The evidence, however, does not support Dupont's claims. Efforts by members of grassroots medical marijuana organizations like the Wo/Men's Alliance for Medical Marijuana to create nonsmoked forms of cannabis-based medicines suggest that many medical marijuana patients and their advocates are attempting to reduce (or, in some cases, to eliminate) their reliance on smoking in favor of consuming baked goods, tinctures, or beverages, or using a vaporizer.

Nor is the persistence of smoking as a popular delivery system among some patients an indication that their use of cannabis has no medical purpose. Some patients—especially those living in the final stages of terminal illness—find that the benefits of smoked marijuana outweigh any long-term risks. The IOM report itself acknowledges that this is a rational calculation: "It will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, will be available for patients. In the meantime, there are patients with debilitating symptoms for whom smoked marijuana might provide relief. . . . Because of the health risks associated with smoking, smoked marijuana should generally not be recommended for long-term medical use. Nonetheless, for certain patients, such as the terminally ill or those with debilitating symptoms, the long-term risks are not of great concern."[13]

"Jon," a WAMM member living with AIDS, agrees with the IOM's relative benefit-and-risk assessment:

> I for one don't have a major concern about smoking. I feel like I'm already dealing with everything knick-knack-paddy-whack that could kill you. This disease is probably going to kill me eventually. So if the worst is that I have some side effects because of smoking, oh well. Oh fucking well. And that's where I'm at with it. Because the side effects of my meds are going to eventually take my organs. So if the marijuana smoke takes my lungs, so be it. But not everyone in our collective feels that way. Not everyone can smoke. So they use the baked goods. And when I don't want to smoke, I do eat the muffins instead of having to fire up.

Indeed, for many WAMM members, especially those living with chronic conditions or in remission from life-threatening illnesses, smoking is a serious concern. "Mary," a woman in her forties who uses cannabis for relief from the effects of breast cancer treatment, observes:

> I use pot by smoking it simply because I have yet to find another route where I get the same sort of effect. But it is a major concern of mine. My sister died about a year ago of lung cancer. Of course, she smoked a phenomenal amount of tobacco; she smoked like three packs a day for thirty years. I don't fall in that category with my pot; my god. But even still, it's smoking. And ever since she's died, every single time I smoke, a little light in the back of my head goes off reminding me that that's not great. I mean, it's great now, and I weigh the benefit versus risk, and the benefit definitely outweighs the risks for me—especially considering how little I consume compared to a cigarette smoker. But still, if I can find another route that will give me the same degree of relief, I'd switch in a heartbeat. It's something I'm very conscious of. It's like right there in front of me.

Susan Durst, a WAMM member with both personal and family experience of cancer, has similar concerns about smoking: "I have two parents who died of primary lung cancer and my lungs are a big concern to me. I've had breast cancer and so many of my friends have had their cancers metastasize to their lungs. So of course I worry about lung cancer. Instead of smoking, I tend to just eat a little bit of a [cannabis-infused] muffin."

While most WAMM members acknowledge the risks of smoking, many also rely on reports of marijuana's possibly protective effects against

lung cancer to reduce their concern.[14] SilverKnight, a fifty-four-year-old WAMM member who uses marijuana to relieve pain, explains that the studies have been reassuring enough to her to justify the continued pleasure she finds in inhaling cannabis smoke:

> I've read a lot of things on it, and I know recently there was a study from UCLA or whatever a couple of years ago, that it doesn't damage the lungs. I am concerned and I keep aware of that but I just enjoy it so much; I love inhaling the smoke from the wonderful strains we grow at WAMM. I love to fill my body with it. You don't feel like you're putting poison in your lungs. I'm trying to rationalize that, maybe, but as I say, I've read up on it and I feel like it's not really that hurtful. The tobacco smoking I've done since I was fifteen certainly must be a lot more harmful.

Some members who do not feel comfortable smoking but need the rapid-onset properties of inhaled cannabis make use of a vaporizer that heats, but does not burn, the plant material. Jeremy Griffey, a WAMM member who uses marijuana to offset the side effects of AIDS medications, shifted from smoking to a vaporizer:

> I know there is probably some damage to the lungs from smoking marijuana. After all, smoking is not a normal thing for humans to do, you know, to intake smoke. So we use a vaporizer, a "huffer," where we don't take in smoke. It's just fumes basically. But it's so potent. I get into coughing fits if it's full of fresh bud. My partner [also a WAMM member living with AIDS] can smoke the green, but I have to wait until after the initial burning. He uses it first, and then I can smoke what we call the second burning. Otherwise I get a cough like no other cough I've had in my life. I mean lights go on, things get sparkly. I don't know what burns off in that first burning. I mean, it's not even really burning. There is no fire involved. But whatever it is, I can't handle it if it's full of fresh bud.

As Jeremy's account suggests, the vaporizer works well for some individuals, less well for others. In addition to the variable physical effects of inhaling fumes produced by the vaporizer, some individuals find the machine itself to be off-putting. "David," forty-three years old and living with AIDS, turned to a vaporizer as an alternative to smoking "spliffs" (tobacco mixed with marijuana) but notes: "I bought a vaporizer, but it's huge. It's like a chemistry set. I can't stand the thing so I just haven't put it to use."

Grassroots Alternatives to Smoking

For members who do not need the rapid onset of inhaled cannabis, a range of other alternatives is produced by the collective, including baked goods, a soy milk–based beverage, and tinctures. This is both a response to the needs of members who cannot or choose not to smoke, and a reflection of the fact that the collective's garden produces a significant quantity of leaf matter in addition to the buds used for smoking or vaporizing. Both the leaves (which are removed periodically throughout the growing season to increase sunlight to the buds) and the more-potent buds themselves contain the therapeutically active properties of the plant. Jeremy Griffey observes that after a Drug Enforcement Administration raid on the collective's garden in 2002, the organization had to reduce the amount of bud provided to the members in order to stretch the previous year's supply. This meant that members were encouraged to try the other products made of the more-abundant leaf matter: "I pulled way back on my smoking after the bust. We thought we had better hold on to what we had so I upped my eating because we had a lot of leaf. And I discovered that eating it has a different effect. It has an amazing effect on [pain from neuropathy in] my feet and legs."

Jeremy's observation that eating cannabis-based products has a different effect than smoking was widely reported by members. One woman with MS explained that the effectiveness of cannabis in relieving her symptoms depends entirely on the delivery system: "My doctor who is treating me for the MS asked me if I would be interested in trying marijuana to see if I would get relief. He didn't want me to smoke it, though, because of lung damage. I wasn't interested in smoking it either because I knew from past experience that it didn't work; I only hurt afterwards when I smoked it. But I had never tried eating it for that purpose. When I did try it for the pain and had the opportunity to eat the leaf, I was really pleased. It really worked."

"Cher," a fifty-two-year-old with a seizure disorder, helped to develop one of WAMM's alternative delivery methods, "Mother's Milk," because she found that smoking wasn't effective in treating her condition:

> My seizures were controlled with medications of all different sorts for a very long time but I kept complaining to my doctor about the side effects of the pharmaceuticals. Then he tried me on Marinol because he thought it would have fewer side effects. But after two months, my insurance

company said they would no longer cover it. And smoking [marijuana] wasn't enough to stop the seizures; it wasn't the same as Marinol. So that's how I figured out about the milk. I think I kind of invented it. I would boil the bud in milk and drink it. And I could use the same bud maybe four or five times. I started with regular milk, but that upset my stomach so I switched to soy. Even the soy milk upsets my stomach a little, but it works. On "Mother's Milk," I feel better than I had on drugs and better than I had on Marinol.

While nonsmoked forms of cannabis work well for many patients, one common concern is the challenge of establishing appropriate dosage. Patients report that unlike smoking, where they can easily control how much they ingest, eating cannabis-based products requires some experimentation to establish an effective—but not overpowering—dose. "Codi," who suffers from glaucoma-related blindness and pain, explains:

I like to smoke it the most because I have more control over what I'm doing, of the level. If I've done a pipeful, I know what I've done. If I've rolled a cigarette, I know what I'm getting. But when I'm away from the house, I feel like I have to be very, very careful that there's no odor or anything from smoking so I'll use the muffins or the brownies if I'm going somewhere. I'll use a half a brownie, a fourth of a brownie. I don't want to be too medicated; I just want to take away the pain. That's it because with loss of vision, you already have so many other things to deal with. I actually like the soy milk a lot because you can freeze a little in those ice-cube trays. Sometimes if I'm not feeling well, my daughter will make me a cup of tea and put a cube in. But I still feel that, with smoking, I have more control.

Both eating and smoking cannabis for therapeutic purposes requires a process of learning how to consume the plant-based medicine and how to recognize an effective dose.[15] Jon describes the process he went through learning how to both smoke and to eat medicinal marijuana:

— how strong brownies are.

I wasn't a smoker, so I knew that if I was going to smoke marijuana, I would have to get used to it. Instead I thought maybe if I would just ingest it, it would be easier for me. And it was easier but generally the effects either lasted way longer than I wanted or it took too long a time for me to get the effect. When I had my first muffin, I think I ate the whole

> thing. Within an hour or two I was so over the rainbow, I didn't know where I was. It was a really wonderful eye-opener. So then I started halving my muffins, if I took muffins. But often times, I needed something more immediate. The transition between doing muffins and smoking was a huge thing because, as I said, I just wasn't used to smoking. I had to learn how to do it. . . . It was all a little trial and tribulation at first, learning how to smoke and learning how to ingest.

The development by WAMM members of alternative methods of ingestion has also been a learning process. As a grassroots collective, members were necessarily involved in, and in control of, each step of the complex and labor-intensive process of developing new drug-delivery systems and learning how to use them. This process is a labor of love through which patients invent, and improve on, the organization's many nonsmoked medical marijuana products.

On Saturday mornings in January, as the coastal fog rises above the Santa Cruz Mountains, eight WAMM members arrive at the collective's marijuana garden site for some volunteer labor. The two hundred plants that grew there the summer before have been harvested and dried. The flowering tops, or "buds," have been trimmed and vacuum sealed in plastic bags. The buds are reserved for smoking, but every other part of the plant is utilized in nonsmokable alternatives. The members are here to process the leaves, stems, and trimmings into the active ingredients of a variety of alternative cannabis products.

During the harvest and cleaning processes, primary attention is, of course, devoted to the buds, which are the most potent part of the plant. The bud trimmings, however, are collected and stored in small kitchen garbage bags, and the leaves are dried and stored in black plastic trash bags. The stems are saved, too, and set aside for the production of liniment.

In an effort to provide consistency in dosage, the bags of leaf are mixed together in barrels, evening out most of the variations in potency that may occur among plants.[16] The leaf is then ground into powder using electric blenders. "You must remove the stems," cautions one volunteer, "or they will kill your blender." Grinding takes quite a while—only a handful or two can be ground at a time, and it can take half an hour or more before that much leaf is sufficiently pulverized. The blenders whine for hours, day after day, as the volunteers, most wearing earplugs, work their way through the mountain of marijuana leaves. Despite the conscientious removal of the stems, the blender attrition rate is shocking, and WAMM

members continually scour the flea markets and resale shops looking for replacements.

The ground leaf is then spread onto an extremely fine-mesh screen suspended in a wooden framework above a shallow, rectangular wooden box. A glass plate lines the bottom of the box, and when the leaf powder is rubbed vigorously over the surface of the screen, the finest cannabis flour, called kif, falls through the mesh and is collected on the surface of the glass. The flour-like kif is used in the production of baked goods, and the coarser powder that remains on top of the screen is used to make marijuana capsules, tinctures, and beverages.[17] Anything left over, material that would ordinarily be considered waste, is combined with the stems in producing cannabis liniment, used externally for the treatment of muscle and joint pain.

The Muffin Man

Until his death in 2003, John Paul Taylor was the Muffin Man. His baking routine began on Monday afternoon, with preparation of the dried cannabis leaf he would use to produce his marijuana muffins. John preferred to process the leaf he used at home by himself, grinding it first in a blender, then running it through a coffee grinder in order to produce a flour that would not be grainy once baked. The leaf powder was then stirred into an ancient electric Crock-Pot containing melted butter, vegetable oil, and water, where it would slowly cook on the lowest possible setting for the next twenty-four hours. John firmly believed that the longer the leaf powder was allowed to cook, the more potent the resulting muffins would be, and it was to this practice that he attributed his success whenever patients mentioned their uncommon effectiveness. By Tuesday afternoon, the mixture in the Crock-Pot was a dark green custard, of a consistency that John was very particular about. The cooked leaf mixture was then blended with commercial chocolate cake mix and a few eggs, poured into muffin tins, and shoved into the oven to bake. Once John had things rolling, there might be two dozen muffins in the oven, another three dozen cooling beside the window, and he would be dropping colorful paper cupcake liners into the next set of pans ready to be filled with batter. Wire racks covered with muffins sat on the countertop beside the sink, waiting until they were cool enough to be bagged. This, too, he was very particular about, and John often missed the beginning of a Tuesday

evening WAMM meeting because he had to wait a little longer for the muffins to cool.

John rarely used his muffins for medicinal purposes, being inclined by preference and the nature of his illness toward smoking marijuana instead of eating it, but he found pleasure and purpose in the weekly ritual of baking for others and in being able to provide marijuana in a form that members who could not or who chose not to smoke would still be able to access. He was also just a bit perversely proud of the fact that new members were warned by old timers to approach the muffins with caution. They were generally so strong that many regular users recommended eating only a half, or even a quarter, of a muffin at a time. A few members found them unpleasantly strong and resorted to other alternatives, and several claimed that a whole muffin would put them to sleep for hours, although whether this was reported as a desirable effect or an undesirable one varied between patients.

Mother's Milk

"Dianne" is fond of telling the story about her first experience with "Mother's Milk," a soy and cannabis beverage that was recommended to her for relief from chronic back pain. She consumed a bit more than might have been strictly necessary and found not only pain relief, but almost forgotten feelings of sensuality and, afterward, a long, deep, restful sleep. "It's a body high, not a head high—very relaxing," she reports. She professes to exercise greater moderation since that day, but she remains particularly committed to the production and use of Mother's Milk.

For several years, a team of volunteers produced gallons of Mother's Milk every week, but members were unreliable about returning the reusable glass bottles in which it was distributed, and it became too costly for the organization to continue to replace them. Only a few members, including Dianne, now go to the trouble of producing their own. She receives an ounce of ground leaf powder each week. She pours the leaf powder, along with two quarts of soy milk and two quarts of water, into a large Crock-Pot. She often adds a cinnamon stick for flavor and then cooks the mixture on the lowest possible heat for thirteen hours. Her husband then helps her strain the cooked milk though a fine-mesh tea strainer, then twice through a gold coffee filter. The pale green beverage that remains is bottled and refrigerated. Dianne consumes about six ounces of Mother's

Members making marijuana capsules in the WAMM office. Photo © Chuck Nacke—Woodfin Camp.

Milk with her dinner, an amount that "takes care of me for the evening." She complains that occasionally it upsets her stomach, but it always provides rapid relief from her pain, muscle spasms, and paresthesia.

Capsules

Organic, whole plant, medical marijuana comes in pill form as well. Cannabis capsules, known as "Mari-caps," are produced twice a month by a six-person team of "Happy Cappers," led by longtime WAMM member Jon.

The whole team works together separating by hand the 1,200 gelatin capsules that will be filled with a mixture of ground leaf and butter. This mixture is cooked in quantity beforehand, very slowly at low temperature, and then frozen. While the capsules are being separated, the mixture is thawed until it becomes sufficiently pliable, although Jon reports that "sometimes, when there is too much butter in the blend, it gets pretty sticky, and it slows you down. It works better when it's stiffer, more granular."

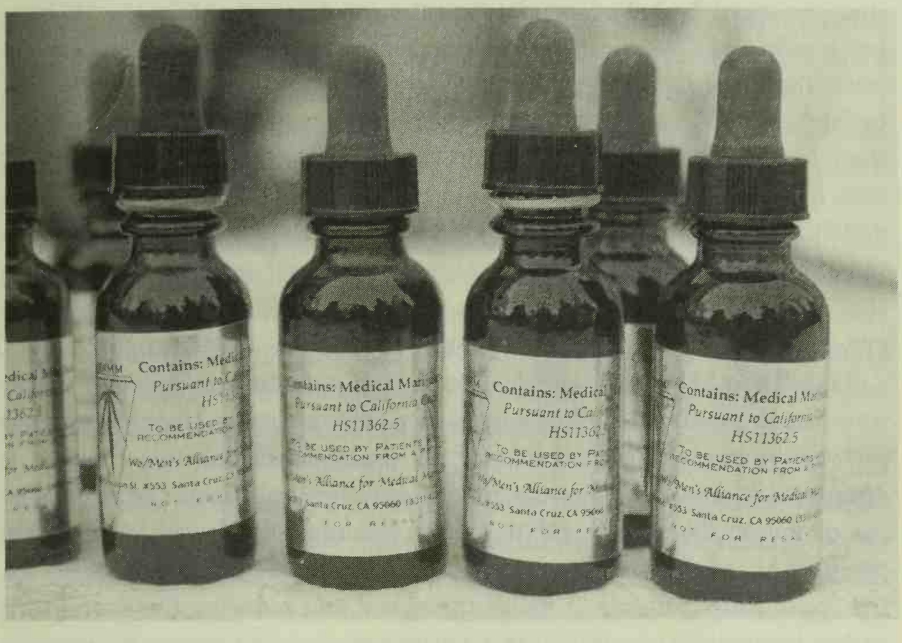
Once separated, the bottom half of each capsule is inserted into a plastic tray—like a tiny ice-cube tray—that holds fifty of them securely, their openings flush with its surface. A large, soft dollop of cannabis mixture is pressed into the capsules by scraping it across the surface of the tray, using spoons or plastic cards. The mixture is then tamped into each capsule with a special tool that allows all fifty capsules to be firmly packed at once. Before purchasing the tamper, the crew packed each capsule, one at a time, using the end of a chopstick. At least three pressings and tampings are required before the capsules are completely filled. The tops are then placed on the capsules and all of them are wiped clean of any residue before being packaged. The capsules are packaged seven to twenty-eight per bag, for patients who use from one to four of them per day.

The effect is reportedly much like what is experienced from eating part of one of John Paul Taylor's muffins, with a delay of thirty minutes to an hour and a half before the effects are noticeable. The effects last much longer than is customary with smoked marijuana, from four to eight, ten, or even twelve hours, according to some patients. Also like muffins, the capsules can be a bit unpredictable due to variations in potency, a problem that is being addressed by mixing the leaves of all the plants together before processing, in the hope that a consistent final product will result. The capsules are good, Jon says, because sometimes "downing a pill is easier than consuming a whole muffin, even though the pills can be a little tough on the stomach, sometimes, too." The capsules provide patients who are unable to smoke, either due to respiratory difficulties or social contexts in which smoking might be inappropriate, with an entirely unobtrusive alternative.

Tincture

"Charlene" holds up a canning jar filled with an opaque, greenish-black liquid: cannabis tincture, the mildest (i.e., least psychoactive) of the orally administered nonsmokables. She removes the lid and, holding it beneath a lamp, points to a surface that appears slightly reddish with iridescent flecks of a rusty golden hue. The THC extract floats to the top, she explains, and because of its tint is called "dragon's blood."

Producing the tincture is simple, Charlene explains, "Easier than making pickles." Fill a canning jar about three-quarters of the way with ground cannabis leaf. Pour 151-proof alcohol over the cannabis, filling the



Patient-produced WAMM cannabis tinctures. Photo © Chuck Nacke—Woodfin Camp.

jar almost to the top, but leaving just a little room so that it can be stirred and shaken. Cap the jar tightly and store it in a warm, dark place for at least two weeks, longer if possible. The jar should be shaken at least a couple of times a week—preferably once or twice a day—to keep the ground cannabis in suspension and prevent sedimentation.

Once the ground leaf has steeped in alcohol for a sufficient time, Charlene's caregiver helps her decant the mixture, pouring it through a metal tea strainer or a piece of cheesecloth into a Pyrex beaker. Then, using a small glass funnel, Charlene fills the small bottles that will be distributed to patients. She delivers twenty one-ounce bottles, four two-ounce bottles, and one four-ounce bottle of tincture a week.

Cleanup is perhaps the most labor-intensive part of the process. Charlene is comically emphatic about the superiority of one particular dish soap, claiming that it outperforms all the others when it comes to dissolving THC residue. After washing, the jars and bottles are sterilized by boiling the glass parts, soaking the droppers in a diluted chlorine-bleach bath, and then giving them a triple rinse.

The effect is different from that accompanying smoking, and also from

that produced by baked goods, capsules, or Mother's Milk: the tincture has a mild sedative effect, rather than a pronounced "high." Charlene reports that "one member used it for nausea at work, because she couldn't be high at work, and the tincture helped her without impairing her on the job. It's also ideal for nerve pain, and for muscle spasticity in patients with MS, Parkinson's disease, and post-polio [syndrome]. It works immediately. It stops my muscle spasms, and reduces the nerve pain and hypersensitivity." Her pain and hypersensitivity are worst at night, she explains, and a cup of tea with the recommended dose of three teaspoons (three eye-droppers full) of tincture is enough to settle her for the night.

Like the other nonsmokables, tincture is easy to use in public, when traveling or visiting, or when respiratory ailments make smoking uncomfortable or inadvisable. Because of its minimal psychoactive effect, it is often recommended to new members who have no history of marijuana use or who dislike the "high" that often accompanies the other medicinal products. It works rapidly and, like smoking, the patient can titrate—using just a little, pausing to gauge the effect, and tailoring the dose to his or her immediate requirements. Charlene also notes that any patient can make his or her own medicine, providing an empowering sense of self-control over one's symptoms.

Liniment

"Tasha" is petite and grandmotherly, with curly gray hair and bifocals. She smiles broadly and her eyes light up when talking about the cannabis liniment she produces, a balm known among WAMM members as "rub-a-dub."

At the end of the medicinal marijuana production line, after the kif has been given to the bakers and the ground leaf has been used to produce tincture, capsules, and Mother's Milk, pounds and pounds of stems and leaf fragments remain. These former waste products, residue from the harvest and cleaning processes, were once tossed onto the mulch pile, until Tasha, who suffers from debilitating rheumatoid arthritis, revived the ancient practice of using cannabis in an alcohol solution as a poultice for her swollen, painful joints. For two years now, Tasha has produced rub-a-dub for any WAMM member who desires it.

The process is the simplest of all. Tasha scoops "a couple of pounds" of stems and leaves into a five-gallon jar, fills the jar to the top with rubbing

alcohol, covers it, and stores it in a dark corner of her garage. After a month or more has gone by, she pours the dark green solution through a filter screen and back into the original rubbing alcohol bottles.

Tasha sometimes puts the rub-a-dub into a small spray bottle, or moistens a washcloth with it and applies it directly to her painful joints. She reports complete and rapid pain relief, lasting for about an hour.

Tasha recently discovered a five-gallon jar of rub-a-dub that had been hidden away in a corner of the garage and overlooked for a year. Its analgesic effects were considerably more powerful, she reports, her eyebrows arching in enthusiasm. Although demand for rub-a-dub normally forces her to turn each batch over after only a month or so, she admits that she has a couple of long-term batches secreted away.

As these anecdotes suggest, over the past decade, members of WAMM have developed a variety of innovative methods of administering cannabis orally and externally that challenge the rhetorical equivalence between smoking as a delivery method and botanical cannabis as a medicine. In so doing, they have addressed the most significant health risk associated with medical use of marijuana.

Their experiences with low-cost and low-tech production techniques have enabled even the poor and uninsured among them to access a physician-recommended herbal medicine in an effort to manage debilitating symptoms of their illnesses and the side effects of their often onerous courses of treatment. Members' direct involvement with the manufacture and distribution of their medicine also has contributed to an increased sense of patient empowerment. While such grassroots efforts should never be seen as a substitute for comprehensive and affordable health care, the WAMM model does provide a useful complement to an existing corporate monopoly on the production of medicine.

Suddenly We Were the Outlaws

Interview with "Cher," WAMM patient

There's no drug war. What there is, is a war over which drugs we are all going to take. In the 1950s, housewives were on Dextran because it helped you stay thin; so speed was healthy. Then, because stress wasn't healthy, Valium was used. Remember Dow Chemical? "Better living through chemistry." Now it's all about antidepressants. It's always been about which drugs people should use. Think about coffee—there was a time when coffee was considered dangerous. But once industrial society found that caffeine makes people work better, we all have "coffee breaks" built right into the workday.

I suspect that part of the problem with marijuana is that it might not be well suited to what they want out of the workforce in this country. At least for me, it makes alienated labor more difficult. I find the effects of marijuana to be profound; it makes me more aware of what is important. Even the munchies is a good example of that. Food is important. I am a person who finds it easy to forget about food. I need to push myself to eat. The munchies is a trivial example but it is such a well-known aspect of marijuana that I think it is worth mentioning. Marijuana grounds you in your body. It makes you more sensually aware. You take more pleasure in food. And, by enhancing the senses, it puts you more in the moment. For me, that's important because I have such a propensity to always be in the past or the future. You can lose so much that way because you are always somewhere else.

Marijuana is also really interesting because it is a psychedelic and I don't think psychedelics are like other drugs. They alter the way our minds filter the world, changing our perceptions of space and time. It seems to me that there is something so interesting there to explore. I understand that the effects of marijuana aren't appealing to everyone so I can see not wanting to do it yourself. But I am baffled—*baffled*—by the decision to ban scientific research. When you have this amazing experience and

realize that the universe is much weirder than our filter allows us to perceive, how can you not want to know more? I think it's the same impulse that makes me want to know if there is life on other planets. I don't have the illusion that I'll get to visit other planets and go shopping there. But I still want to know. I just want to know. It's all about curiosity.

Maybe it's just that these drugs are associated with a decade that conservatives still talk about as much as I do. I mean they're just as obsessed with the sixties as I am and they're still pissed off. The fact that they made marijuana illegal was very instrumental to what happened in the 1960s. Suddenly [middle-class white] kids like you and me, kids who had grown up thinking that the cops were our friends—there to protect us from the outlaws—suddenly we were the outlaws and the cops were a threat. I think that did a lot to reinforce our sense of alienation. When you're told you're an outlaw, the consequences of being further outside don't seem as great. And the law suddenly seems very arbitrary. I mean everybody was smoking dope back then but when someone would get busted, the penalty could be ten or twenty years. So it was impossible to see the system as reasonable. Now they're threatening to arrest even dying people because they're using marijuana instead of morphine. It's so ridiculous.

Sometimes I think the federal government is starting to recognize they're losing the battle over marijuana and that they're going to have to at least reschedule it as a medicine. But it's hard to know. Maybe they really are crazy enough to go after WAMM. What Valerie has going for her is that she is a political nightmare for them. With the buyer's clubs, it's about the money. But it's another matter to bust someone who is giving it away. She's like Mother Teresa. What are they going to say about her? But who knows? How do you predict the behavior of madmen? I've seen them do things that I never could have expected.

The government doesn't even have to use the DEA to go after a group like this; they can just rely on the IRS. The thing about the IRS is that it's not only draconian, it's so Kafkaesque. In a normal civil procedure, the prosecution is required to prove that you're guilty; with the IRS, you are required to prove that you're innocent—which, unless you devote your life to elaborate kinds of documentation, you may not be able to do.

It's a form of economic warfare and, with WAMM, it began with the decision to revoke their nonprofit status—presumably under pressure from the feds. The California Franchise Tax Board had granted WAMM nonprofit status and allowed them to operate as a nonprofit. And then suddenly they revoked it—at which time WAMM not only had to pay the

taxes as if they were a for-profit operation but they had to pay—and this is to me the truly surreal part—*late fees* because they had "mistakenly" operated as if they *were* a nonprofit, an illusion approved by the franchise tax board itself.

I think if WAMM goes down, it will be because of money. WAMM is so clearly not a profit-making enterprise. It doesn't even cover its costs. I've always thought that it would be more sensible if people in WAMM were forced to pay the cost of production for their marijuana. I know that would be a challenge; probably one of the reasons Val and Mike aren't in jail right now is that they have always given the marijuana away. And it's true that a lot of WAMM members are among the most economically disenfranchised people in Santa Cruz. They are poor, very very poor people. But I still think it's a mistake that there's no requirement in WAMM to give anything. It allows a lot of people to just transfer their attitudes about impersonal social welfare bureaucracies—agencies that don't give a damn about their welfare—right on to WAMM. No one gives back any more than they have to, to a bureaucracy.

But this isn't a paradigm that works for a collective. The members all talk about WAMM as a "family" but, when it comes down to it, all but an impressive minority still treat it as if it were just a resource they could just take from indefinitely. It's shocking to me how many WAMM members donate nothing, not a nickel, to the organization. Certainly there are notable exceptions, people who have done heroic service to WAMM. But a lot of members use WAMM like any other social welfare agency. The thing is, with Val and Mike, you're not taking from an agency; you're taking from two very vulnerable people. That WAMM has been able to survive for more than a decade is remarkable. It's a real testimony to Mike's botanical genius and Val's absolutely unrelenting will.

7

Love Grows Here

Secret Garden

A few miles north of the city of Santa Cruz, California, a winding farm road turns off scenic Highway 1 toward the rounded hilltops and wooded canyons of the coastal mountain range. Michael Corral bounces gently around the corners in a pickup truck loaded with gardening supplies, eventually turning on to a rough dirt road that winds through redwood trees high up onto a hill with a breathtaking view of the Pacific Ocean. Near the top, he unlocks a metal gate, drives the truck through, then locks the gate securely once again. A short distance beyond the gate, Corral parks beside an ancient Airstream trailer propped up on the hillside with railroad ties, kills the motor, and climbs out of the truck. He surveys the scene around him with evident satisfaction.

Above, beside, and below the truck are patches of ground that have been cleared of the weeds, briars, hemlock, and poison oak that otherwise cover the hillside. There is a scent of marijuana smoke in the air. Several cheerful, middle-aged men and women, including one confined to a wheelchair, sit under an awning forming circular baskets about sixteen inches deep out of chicken wire. A couple of men in faded jeans and work boots are digging holes in the rich, dark soil under the late morning sun, at spots specifically marked out ahead of time by Mike. Another volunteer inserts one of the chicken wire baskets into each hole as a defense against burrowing gophers. As they work, a chubby woman with a beaming smile crumbles a dried marijuana bud onto a tray and happily rolls a joint. A small, hand-painted wooden sign hanging over the entrance to the garden declares that "Love Grows Here."

The garden is remote, and although many in the surrounding community know of its existence, few have seen it or would be able to find it on their own. It is well outside the nearest town, and there is no sign or clue visible from the public road that indicates which turnout or dirt road is the right one. The bumpy little lane that leads to the garden is very steep

and narrow, winding through dark stands of redwood, pine, and fir trees. As it rises toward the ridgetop, the drop to the creek bed beside it becomes greater, until at last the creek veers away and the road arrives at a small, flat meadow and the first of the locked metal gates that protect access to the garden. Beyond the gate, the road becomes even steeper, rising rapidly into the woods. Rounding hairpin turns at one or two miles per hour, one is able to look back over the treetops and down the canyon toward the sea. Nearing the top, the road levels off and reaches another meadow, also secured by a locked gate, beyond which lies the garden.

There is only one way in or out, and it would be difficult to find without explicit directions. In addition, both a combination for one lock and a key for the other are needed to pass the gates and reach the garden with motor vehicles. Consequently, once within its boundaries, the garden evokes a profound sense of privacy and security, complicated only by a mild apprehension: the garden exists in violation of federal law, and there is a sense that to be here is to flirt with potential disaster. Such considerations are short-lived, however, and are not allowed to interfere with the spirit or purpose of the garden crew. In the surrounding silence, it is not difficult to hear approaching vehicles as they crawl up the roadway from below, so there is little risk of surprise. More important, Val and Mike are conscientious about trying to dispel fear of law enforcement and the anger that often accompanies that fear, in the belief that the psychic energy of the garden crew directly affects the growth of the plants and the therapeutic value of the garden as a healing space. They remind everyone to keep the garden hate-free, and Val often professes compassion for those who would destroy WAMM's work, rather than condemning them for their opposition.

Therapeutic Horticulture

The rustic beauty of the WAMM garden is emotionally uplifting; to arrive there on a sunny day is, for many, a healing experience in itself. The gated meadow lies just below a curving ridgetop, and is somewhat sheltered by it on two sides. Its lower half, where the slope is gentler, has been terraced with the beds for the marijuana plants. From the covered patio between the two largest terraces, one looks northwest across the road and down the canyon to a breathtaking view of the Pacific Ocean, framed by dark, forested hillsides. It is a spectacular location, with no sign of development

encroaching on the view, only the green woods of the coastal mountains rolling downward toward the beach.

During the summer and early autumn, when the cannabis plants are large and leafy, it is almost shocking to round the final corner beyond the gate and come upon the verdant emerald terraces nestled within the golden brown meadow. Except for the laughter and conversation of the garden workers and the whisper of the ocean breeze through the evergreens, it is very quiet. The air is warm and clean, tinged with the spicy green fragrance of the marijuana plants and the light perfume of roses, calla lilies, and nasturtiums growing nearby.

For Mike Corral and the members of WAMM, the garden is much more than a marijuana-growing operation:

> *Mike:* The garden isn't just a place where volunteers show up and grow the marijuana. Really what it is, is a healing space. People are ill; when they come to the garden, they are watering the plants, leafing the plants, touching the plants that are going to be their medicine. Taking care of the plants, they are taking care of themselves; that line dissolves because the plants become part of their bodies over the following year, after we've harvested.

A growing body of research on healing gardens and therapeutic horticulture indicates that gardening can help to restore physical and mental health to people suffering from a wide range of ailments.[1] For centuries, according to Steven Davis, physicians have recorded the beneficial effects of gardens and gardening on mentally disturbed patients; he attributes to this the widespread traditions of locating mental institutions in rural or parklike settings and giving flowers and plants to sick people.[2] Important contributions to physiological health and well-being were reported in the second half of the twentieth century when therapeutic horticulture became a recognized discipline—textbooks were written, degree programs at universities were developed, a professional association was founded—and theoretically informed treatment modalities were tested against a wide range of physiological disorders. Simply providing patients with exposure to natural settings—even views through a window—was discovered to result in "a reduction in the need for medical treatment. . . . Actual participation, either active or passive, in a nature experience (e.g., gardening) can enhance further the value of plants on an individual's mental and physical health."[3]

Research indicates that the passive enjoyment of healing gardens exerts a restorative influence on cognitive functioning and on emotional centers in the limbic system of the brain;[4] a more active involvement in gardening provides physical exercise, exposure to fresh air and sunlight, and inherently meaningful activity that improves self-esteem, reduces stress, and restores spiritual balance.[5] Landscape architects Ulrika Stigsdotter and Patrick Grahn contend that therapeutic gardening provides participants with a "flow experience," a harmonization between the demands and possibilities inherent in the environment and the capacities of the patient that result in "a feeling of well-being, total commitment, and forgetfulness of time and self."[6] They describe healing gardens as places "where you can forget yourself and melt into the surroundings so that you become a rather insignificant part of something bigger,"[7] and it is interesting to consider that many who use marijuana describe its psychoactive effects in surprisingly similar terminology. It is hard to dismiss the relief that must be provided by the opportunity to escape for a time from the otherwise constant awareness of one's illness and distress, whether that relief comes from cultivating marijuana or consuming it.

What makes the WAMM garden a healing garden? It is more than the obvious fact that a medicinal herb is grown there. According to Stigsdotter and Grahn, healing gardens "communicate with the visitor on many levels"[8]; people can quickly learn to "read" a garden's colors, scents, textures, and sounds. They refer to gardens as artistic compositions "designed to give the visitor fundamental feelings of security, hope, and life."[9] Its borders, they contend, should give the visitor "a feeling of being outside public life and of being safe,"[10] yet a healing garden "ought to be accessible irrespective of people's age or functional disorder."[11] And, indeed, WAMM's garden is easily described and understood in such terms. As "Charles" explains,

> The garden is what saved me. It wasn't so much the meetings or maybe even the medicine. I was raised in the country for sixteen years so once I got up to the garden, it was my Zen heaven. I was like, I'm not leaving. They made it my mountain too, my healing experience. It was what brought me back to life—to touch the earth, to sow the seed, to bring to life what's giving you and other people life. And it wasn't just me; it's important to see other people sow the seed with you and share their different levels of knowledge. It's the greatest gift that this land is being used for this. It's our secret garden.

The therapeutic value of the garden goes beyond its seclusion, its beauty, or its wheelchair accessibility. Literal relationships are formed between garden volunteers and the plants under their care. Weeding, watering, and leafing require frequent intimate contact with the plants, and their individual differences become well-known to the workers. Some are even named out of a sense of affection or pride; one unusually large plant in a recent crop became known as "Big Mary," and WAMM members enthusiastically tried to guess her eventual yield, forming a pool and placing small bets just for fun. The plants are regarded with a kind of loving gratitude that most gardeners experience at one time or another, regardless of what they grow—an almost maternal pride that grows stronger with the appearance of the fruits or flowers that provide physical or emotional nourishment. The plants depend on the garden workers, just as the workers depend on the plants. In taking care of the plants that will eventually provide medicine for the management of their illnesses, the garden workers are, indeed, taking care of themselves. These sentiments are widely shared among the membership but were perhaps most eloquently expressed by "Rev. Sonny":

> There is nothing like growing a marijuana plant. Just having a marijuana garden is almost spiritual. It was an especially good place when I was really sick. I was already growing plants when I joined WAMM. The first year I tried growing, I ended up with just a couple of crummy plants. But last year, I did real well; it's from learning how to really do it from George and Mike. When I was doing my chemo, I would go out into my garden and just sit among the plants. I was so sick that I couldn't stand up and work on them. But I would go out there and talk to them. I spent a great deal of time with them. I think they hear what I say. I'd tell them, "You are queens and you are going to be so good for me all year. I'm growing you for me and I want you to produce well." I'd touch them and pet them; I'd commune with them. I think they do a good job for me, because I did that for them.

The fact that the garden exists at all is a source of hope and inspiration to its beneficiaries. WAMM members realize they have created something unique; they have done this within a historical and legal environment that may be changing as a result of their efforts, but which is still fundamentally hostile. To succeed against such forces, even incrementally, is encouraging, perhaps especially for those who become discouraged in

their ongoing personal struggles against sickness and pain. The garden thus serves as more than a source of medicine; it operates as an organizing artifact, a source of inspiration and meaning that goes beyond each individual's health and well-being. It is a site of patient empowerment, an expression of individual self-efficacy and of collective responsibility. Like the cannabis plant itself, the garden's symbolic significance is out of proportion to its simple physical form.

Labor of Love

Each spring, on March 21, the vernal equinox, Mike plants hundreds of marijuana seeds in small flower pots; those seeds then spend a month or so sprouting on his back porch. Although Mike occasionally experiments with strains produced by other growers, for the most part he uses seeds from plants he has selectively bred himself:

> First of all, there are three different kinds of marijuana—cannabis sativa, cannabis indica, and cannabis ruderalis. Cannabis ruderalis is a type of marijuana that grows in Siberia and is virtually worthless for fiber and for drug use. It is just a species that happened to survive because marijuana is a weed that can grow pretty much anywhere. It's a survivor, but in terms of drug value or fiber value it doesn't have either one. Of the other two varieties, cannabis sativa is the one hemp comes from. It grows really tall and has a long distance between its branches and nodes and that gives it longer fibers that can be used for clothes or broken down for papermaking. It also has a certain drug quality to it. But what is called cannabis indica is the cannabis that was bred over centuries, millennia, to have a higher THC content and higher resin production. The varieties we grow include a pure-strain cannabis indica and a pure-strain cannabis sativa; our cannabis indica is an Afghanistan-based indica and the sativa is from Malawi in Africa. Then we also have hybrids of those two: a hybrid using the male of the indica and a female of the sativa, and one using a male of the sativa and a female of the indica. For a marijuana breeder like myself, I look for things in plants like the ability to carry a lot of flower weight. Because, as the plants flower, the flowers get heavier and heavier and if the plant doesn't have a sturdy enough branching structure the plant can literally break under the weight of the flowers.

Once the seedlings have reached a height of about eighteen inches, usually after four to six weeks, Mike carefully examines them and separates the male plants from the female plants. Only unpollinated females, known as sinsemilla, produce cannabinoids in sufficient quantity to be medically desirable. The females produce seeds if they become pollinated, but in the process they lose some of their medicinal quality. Consequently, most of the males are destroyed as soon as they are identified, in order to prevent any accidental pollination of the females. A few, however, are preserved and isolated so that Mike can collect their pollen, which he then carefully applies to small areas of a few selected females in order to propagate seeds for future generations of plants. Over the past three decades, Mike has developed his own distinctive varieties of medicinal cannabis, most with years of documentation concerning their effectiveness in treating a variety of ailments:

> In general, any kind of marijuana, other than hemp, works for pretty much any kind of illness that you would use marijuana for. But, in some cases, specific types work better for specific symptoms. For example, we've found that cannabis indica seems to work better to relieve pain. It also is better at inducing sleep. Cannabis sativa is better at preventing nausea and better at stimulating appetite. People with glaucoma have to keep a certain level in their blood all the time, but they can use a lower-quality marijuana so the THC content isn't that high. In fact, from the anecdotal evidence we've gotten, cannabis indica dries their eyes out, which is not what you want to have happen for glaucoma. So generally we suggest people with glaucoma smoke sativa. It has a little lower THC content so it doesn't tend to dry the eyes out as much and you can smoke it from morning til night and still be a functioning member of society.

Once the seedlings have been sexed, they are ready to be removed from their pots and planted in the garden. The female seedlings are carried reverently out to the garden by volunteers who then gently draw each one, with its entire root-ball, out of its flowerpot. The root-ball is either lightly scored with the edge of a trowel or crumpled gently around the bottom by hand in order to stimulate root growth, then oriented carefully as it is placed into the hole. Mike supervises the orientation of each plant, aligning them according to the path the sun will follow as the summer progresses, and spacing them in a way that will leave room for workers to move among them and tend them as they grow bigger. Dirt and organic

fertilizers are gently packed around the roots, and a four-foot-wide, three-inch-high ring of dirt is raised around each plant in a sort of dam to keep water concentrated in a little pool around them. A small white marker stuck in the ground near the base of each stalk identifies the plants as cannabis sativa ("African Queen," abbreviated as AF), cannabis indica ("Purple Indica" or PI), or one of the two blends, "AFPI" and "PIAF"; the first two letters of a blend designate the "mother" plant, the one that produced the seeds, and the second two letters designate the "father" plant, the one from which Mike collects pollen for cautious hand fertilization.

> *Mike*: Besides being on top of the genetics of growing marijuana, we also are committed to growing it organically. First of all, that's because it's just part of my and Val's philosophy. We grow our own food that way, so we just brought those ideals to growing marijuana as well. Also, it's known that a lot of chemicals, like fertilizers and pesticides, have an adverse effect on the immune system. For somebody who's already sick, that could be really serious. The Santa Cruz medical marijuana ordinance that we helped to draft specifies that marijuana has to be grown organically. This is important because there will be other people besides WAMM growing marijuana for medical use in Santa Cruz county. The estimates are that there are upwards of three thousand people in Santa Cruz County who either use or are eligible to use marijuana as medicine. So we wanted to have something crafted that would protect them. Anyway, it's just better for humans, better for the planet, to grow organically. That's the larger philosophy we got embodied in the ordinance.

Planting day concludes with a ritual prayer, in which the garden crew stands together in a circle in the middle of the garden. They join hands, and SilverKnight, a woman of African and Native American ancestry, smudges the garden with burning sage and leads the group in an appeal to the goddess for a bountiful harvest and protection against thieves, blights, and federal agents.

Two weeks after planting, the seedlings are well rooted and most have doubled or tripled in height. Mike then employs a procedure that appears strange at first. He gently grasps each plant a few inches below the top and pulls it sideways so that the slender, flexible stalk is forced to bend in a smooth, fairly tight arc just a few inches above the ground. The stalk is then staked down so that the entire plant now stretches horizontally, with its top pointing sideways, parallel to the ground instead of straight

up into the air. In a fashion reminiscent of fallen redwoods with young trees growing out of their sides, the cannabis plants' largest branches now develop as a series of vertical trunks, each capable of reaching a height of several feet. A rectangle of galvanized screen is secured beneath each horizontal stalk, which, like the wire baskets surrounding the root-balls, is intended to discourage gophers.

For the next four to five months, the plants are checked daily, tended twice a week, and, as they mature, guarded around-the-clock. On Wednesdays and Saturdays, the garden is weeded and the plants are watered. As they grow larger, they are regularly "leafed," a process in which excess foliage is pruned, then dried and stored for use in tinctures and baked goods. The plants are resinous and sticky, and working with them—especially leafing—results in very sticky fingers. Workers occasionally have to leave the garden and return to the patio, where they rub and roll the resin on their hands and arms into dark green balls of a soft, hashish-like substance that many then pack into their pipes. Occasionally, mold will appear on the stalks and branches of some plants and, if left unchecked, can —and in 1999 did—spread to the buds and destroy a substantial portion of the crop. Leafing allows sunlight to penetrate and fresh air to circulate throughout the garden, helping to keep the deepest recesses of the plants dry and mold-free.

The garden has expanded over the years. When Mike and Valerie began cultivating for others in earnest, in 1996, the plants were grown on roughly 1,500 square feet of ground. As membership in the organization gradually increased, the number of plants under cultivation has increased as well, until, in 1998, that original space contained 96 plants, all that there was room for. The next year, an additional 400 square feet was added just below the original garden, and the year after that another 1,000 square feet was cleared above the trailer. Since the summer of 2000, Mike has had nearly 3,000 square feet and 180 plants under cultivation, all with the help of only one paid assistant, George Hanamoto, and a volunteer crew of patients and caregivers.

Mike: The collective garden has gotten so big that, at this point, the WAMM volunteers really do most of the work. I'm more in the position of manager now. The biggest thing for me was to figure out how to plug the right people into the right jobs to get the most production done, but also to help people feel good about what they were contributing. There are varying degrees of physical abilities among the patients

and caregivers who come to the garden; the healthier people do more of the grunt work.

The people who aren't as healthy, they do other things that don't require as much muscle. Because of the [prescription] medications they're taking, some people can't be out in the sun for very long, so they may do other things that involve working indoors or being in a shaded area. Some people even have trouble walking and they feel guilty coming to the garden and not doing anything. So I try to make sure that there are jobs they can do sitting down. That way they feel useful and they feel like they have a purpose there because they want to come but they don't want to be in the way. I say, "No, come to the garden. There *is* something for you to do." We'll figure it out or I'll make something up, you know, because everyone is welcome.

We want WAMM to be a community and we want everybody in the community to feel like they are a valuable part of it whether they can lift one hundred pounds or they can lift a half a pound. We even set up part of the garden to be wheelchair accessible so that people in wheelchairs can do everything with the plants that everyone else does.

In addition to expanding the garden, the comfort and utility of the space around it have been improved over the past few years. At first, the only shelter from the sun was a beach umbrella and an awning erected on poles. Now, in addition to the Airstream trailer, a six-hundred-square-foot outbuilding provides needed storage and workspace; this space is used for drying and processing the marijuana plants. In front of the building, on the brick-floored "patio," members have erected a rustic kitchen and lounge, and a solar-heated shower, and they roofed the space with corrugate fiberglass for shade. This little patio is the social center of the garden site, where workers rest, socialize, and medicate with marijuana, while Valerie or George whip up big cold-cut sandwiches and salads for lunch.

Make a Wish

By late summer, the garden is a vivid green jungle, dotted here and there with plants whose leaves are a surprisingly deep, dark purple. The plants are enormous, and there is no longer much room to move among them. From above, the entire garden appears to be an unbroken expanse of pungent verdure, and the people tending the plants disappear from sight

beneath the leafy canopy. Some of the buds are over a foot long and up to six inches in circumference, an awe-inspiring sight for patients and potheads alike. John Paul Taylor, who might fairly be described as both, often talked about the garden as a dream come true: "It's like that deal where the little kids that are dying get to make a wish. You heard about that kid who was going to die from a brain tumor or something, and he wanted to ride in an Air Force jet, and they did it for him. They got this pilot to take him up in the jet. He died later on, but he got his dying wish. This is like that—Ronald McDonald House for adults. My dying wish is to get to work in the garden, growing marijuana."

There is some variation in the rate at which the plants come to maturity, depending largely on the specific variety of the plant and its location in the garden, which affects its exposure to sun, wind, and fog. Harvesting, then, occurs over a period of four or five weeks between early October and mid-November, allowing late bloomers to have enough time to fully mature. As the plants approach harvest, crew members remove as many of the large leaves as possible, drying and storing them for later use. The trunks are severed, and the stalks are hung indoors to dry. As soon as the cannabis plants are dried, the leaves and flowers need to be separated from the stalks and branches, and any mold that has managed to invade the tightly packed flowering tops must be removed by hand.

Not Your Father's Marijuana

Drug control officials like John Walters, director of the White House Office of Drug Control Policy, have contended that marijuana has much higher levels of tetrahydrocannabinol (THC) than it used to, making it a far more dangerous drug. In Walter's words, "It's not your father's marijuana."[12] Other authorities, however, challenge this claim. According to researchers Zimmer and Morgan, for example, "There is no reason to believe that today's marijuana is stronger or more dangerous than the marijuana smoked during the 1960s and 1970s. . . . No cultivation techniques have been shown to reliably increase marijuana's potency. Primarily, they increase yield, making it possible for growers to maximize the amount of marijuana grown in a small space."[13]

On the other hand, for those familiar with the dried, brown "dirt weed" smuggled into the United States from Mexico since the 1960s, it is easy to imagine that contemporary medicinal strains have improved significantly.

WAMM's organically grown cannabis buds are large and resinous, with a pungent, "skunky" fragrance that bears almost no resemblance to the dull, earthy odor of most imported Mexican marijuana. Of course, there are heirloom tomatoes and selectively bred rose bushes whose fruits and flowers arguably epitomize the possibilities inherent in the plants but which nonetheless remain tomatoes and roses. So, how different are the carefully bred cannabis plants that provide the most desirable medicinal attributes?

> *Mike*: The biggest change in marijuana cultivation over the past twenty years, in my mind, has been the advent of wide scale growing of what is called sinsemilla, plants without seeds. Any plant uses its energy for propagation of the self and continuation of the species, which entails seed production. If a plant is pollinated, its energy at maturity goes into producing seedpods. But with sinsemilla, the plant puts that energy into flower rather than seed growth.
>
> That's where the increase in potency comes in. It's not so much that the THC has increased in potency, it's the amount of THC in each ounce of pot that has increased. The federal government would have us believe that this makes marijuana dangerous. But, first of all, there has never been anybody in the world who has died from a marijuana overdose. It is impossible to ingest enough for that. So when I hear the word "dangerous," what I'm thinking they mean is that it has a higher intoxication level. And, yes, that is probably true.
>
> But the other side of it is that people can smoke far less now for the same effect. Thirty years ago, you would have to smoke a whole joint to reach a certain level; now you can reach that level in three or four puffs. So, if you were going to measure how much THC there is in a modern joint as opposed to a joint of thirty years ago, yeah, there is probably going to be more now. But I would be willing to bet that, on a blood level, there isn't any difference because the ingestion rate has dropped so much. And what that means is that people are going to be smoking less, which can only be a good thing.

The research seems to support Mike's analysis. Zimmer and Morgan report that "more potent marijuana is not necessarily more dangerous. . . . Because THC does not cause physiological damage to organs or tissues, high-potency marijuana poses no greater health hazard than marijuana of lower potency."[14] Indeed, Zimmer and Morgan reiterate Mike's claim that

because the primary risk of harm from smoking marijuana is respiratory damage, high-potency marijuana "might be slightly less harmful because it permits people to achieve the desired psychoactive effects while inhaling less burning plant material."[15] In any case, among the membership, the collectively grown marijuana from the WAMM garden has the reputation of being pure, potent, and very effective.

Trouble in Paradise

In 1999 a problem arose that was beyond the control of the garden crew, resulting in devastating damage to the season's harvest. Rain clouds appeared in late September, unusual for the time of year, just before the flowering tops of the marijuana plants reached their maximum size and potency. The plants were saturated, and the coastal fog combined with the unrelenting cloud cover prevented them from drying out in the normally bright California sun. Mold attacked the plants, weakening the stalks and branches, causing them to collapse under the weight of the large and now-damp buds. When the clouds finally broke up and the sun dried the garden, close inspection revealed that many of the buds themselves were also permeated with mold, rendering them useless as medicine. Entire plants were cut down and destroyed, and moldy buds on many others were eliminated in an attempt to keep the blight from spreading. More than a third of the crop was lost before harvest, and the remainder had to be meticulously inspected and cleaned by the trimming-and-packaging crew. It was heartbreaking work; many of the buds appeared perfect on the outside, but the mold followed a path up the center along the stem, consuming them from the inside. What had promised to be a record harvest prior to the arrival of the rain ended up as a major disappointment.

Even without such difficulties, pot farming turns out to be hard work. Clearing the underbrush and digging holes in the hot sun, bending and crawling beneath the plants to trim leaves and inspect for mold, dragging hoses up and down the hillside, and harvesting plants that often exceed ten feet in height and twice that in circumference—these are tiring tasks for the strong and able-bodied, to say nothing of the challenge they present to the many volunteers who must also deal with illness or limited strength and mobility. This can be discouraging, as Susan Durst, a breast cancer survivor, explains: "I've gone up to the garden to help four or five times and it's so beautiful up there. But it leaves me completely exhausted

and in pain. Valerie and Mike have said just come up and hang out; you don't have to do anything. But it just makes me feel worthless, like I do knowing I am unable to pay [for the weekly allotment of marijuana]. You go up there and everybody else is hauling lumber around and building things and trimming the plants and making lunch. And I can't."

Even tasks that are not physically demanding can be time consuming—trimming and processing the harvested marijuana takes weeks of daily effort. Willing spirits cannot always compensate for exhausted bodies, and occasionally the relatively few strong and healthy volunteers get burned out supplying the needs of those who are simply too sick to work. A few also become resentful of those who appear capable of contributing but don't, and so the roster of garden crew volunteers changes every few years.

There have also been a few instances of conflict over cultivation procedures. Although Mike has many years of experience, owns the property, and is officially WAMM's agricultural director, his authority has occasionally been challenged by volunteers who object to his methods or manner. As Mike observes, some have had years of cultivation experience themselves and don't like to be told how to do things:

> We are all equals when we are there, working together in the garden. But, of course, in another way, I'm in charge. I have the most knowledge about marijuana cultivation, so I'm the "agricultural director." But there is a difference between that and being the "boss." I try to just talk to people about how they are feeling that day, what they feel able to do, and then I explain what has to be done and try to find out who wants to do what.
>
> I'm very hands-on showing people how to do things like, if we are doing transplanting, I show them how to transplant a plant. If we are leafing, I show them how to leaf. I show them how to look at the soil to see if the plants need to be watered. When it's harvest time, I show them what the characteristics are when a plant is mature. We all work together in the garden while I try to figure out how to manage this human resource in a way that's not about talking down to them, that they feel like they are part of something and that we are all in this together.

He is not always successful. During the summer of 2000, two volunteers—critical of Mike's mold-management strategy and upset about the previous season's devastating loss—refused to comply with his directives and attempted to appropriate a few of the plants for themselves. Their

challenge to Mike's authority, and to the collective spirit of the organization, resulted in a hostile confrontation one afternoon. Mike was accused of verbally and physically assaulting one of these patients, and the matter was turned over to the organization's board of directors. Mike's insistence on specific cultivation procedures also resulted in a grievous conflict with his friend and paid assistant, George Hanamoto. George was a legendary force in the garden, a seventy-year-old man with the strength and stamina of someone half his age. Quiet and self-effacing, he not only performed the lion's share of the work in the communal garden, he also cultivated plants at home, meeting his own needs and donating his surplus to the group. He and his wife, Jean, a photographer and graphic artist, fell in love with the organization and devoted themselves to its mission and members. Mike, however, sometimes took exception to George's occasional use of unapproved cultivation techniques, and one day George took offense at his criticism. Buried resentments surfaced, the conflict escalated, and in 2004 the Hanamotos decided to withdraw from WAMM, to the great disappointment of their many close and grateful friends. But all these challenges—mold problems, understaffing by volunteers, and even painful personal conflicts among collective members—paled in comparison to the threat posed to the organization and its beloved garden by the U.S. federal government.

DEA on the Doorstep

On the evening of September 4, 2002, Suzanne Pfeil, a post-polio patient and member of WAMM's board of directors, had dinner with Valerie at the Corrals' secluded mountaintop cabin. They spent hours discussing long-term plans for developing a hospice facility for WAMM members, and by the time they finished, it was very late. Rather than driving down the winding mountain road in the dark, Suzanne decided to spend the night.

> *Valerie*: We'd been up late that night talking about trying to find a way to serve our members better. Trying to find a way to serve them during the last part of their lives, as they are facing death, because five of our members had died in a two-week period and it was overwhelming. We wanted to provide some assistance but we can't even be at all of their houses to take care of them. So we had been up late the night before.

A few hours later, as dawn broke, federal DEA agents began moving up the hillside. Once in position, several quickly stormed the residence, while others with chain saws and cargo vans surrounded the marijuana garden.

Michael: At ten minutes to seven in the morning, my dog started barking and I heard vehicles drive up to the house I was in [the house adjacent to the garden]. I sat up in bed and looked out the window and could see five or six agents in full SWAT gear, with a battering ram and everything. The full array. My big fear was that they would shoot my dog so I ran out the back door to grab him. By the time I got back inside, they were downstairs in the house. I yelled from upstairs, "This is medical marijuana. Just stay calm. Everything's OK. I'm nonviolent. I'm not going to resist you. Please don't hurt my dog." I got down the stairs and got hit in the face with these bright lights and voices screaming, "Get down on the floor, get down get down get down!" There were five agents with automatics pointed right at me. I went down on my knees and kept saying, "It's OK, stay calm, I'm nonviolent." Then a hand was put behind my head and they pushed me face down onto the floor. My hands were literally ripped behind me and I was handcuffed while they started screaming: "Where are they? Where is everybody else? Where is Valerie?" I realized that they didn't have a clue that there were two houses on the property. So I tried to explain that Valerie wasn't there, that she was at the other house. "What other house? Where is it?" The whole time they were screaming; they were so jacked up. "How do we get there? Where is it? Where is it?" I told them about the footpath between the two houses and a group of them left to get Val while another six agents stayed with me.

Valerie: The moment I heard them, that moment, was the most horrendous sound, the most incredible nightmare sound. If I hadn't lived in fear before, at that moment I sure was afraid. It was stomping, you know, rushing, rushing, running on the decks to the doors. I knew without a doubt exactly who it was. A robber would never come in stomping, they are much more stealthy. They had awakened sweet Suzanne who was in the other room. She hadn't really heard, just heard something rustling, because she had her respirator on, her breathing apparatus. And she probably had taken some medication also to keep the spasms and pain down. So when she awakened, she actually said she thought it was me making coffee, and thought, "Oh, Val's got to know that this is too early."

So anyway, I charged in on them. I swung the door open and I said, "What are you doing in my home, get out!" They turned around, I think they were surprised, and then they yelled, "Get down! Get down! Get down!" They were packing guns, and one had a helmet and a machine gun. The others didn't. One had a flack vest, like a vest over his shirt. They kept yelling and they had their guns turned on me. And I said, "I want to see a search warrant." They yelled again, and I really began to feel my knees weaken. In all honesty, I am glad there was a seat there, but what I said was, "OK, I'll sit but I want to see a search warrant."

With that, one of the agents came and pushed me down, pushed me to my knees. Then he pushed me to my face, grabbed an arm, put something on my back, then I felt something at the base of my skull. I didn't know what that was but I presume it was a gun. I didn't see it though. Mike actually did see a gun at his temple right by his eye, but I didn't see it. Clearly they presumed the worst, they presumed armed resistance, because it's happened to them before.

They dragged me from the deck and took me out to the room Suzanne was sleeping in. As I walked in, there was a cop with a gun. They are still saying for her to get up and of course Suzanne can't. I mean, Suzanne is a powerhouse, she is remarkable, beautiful, fabulously strong women. But she can't just stand up. And he's saying, "Get up, get up," and she is saying, "I can't, I can't." And I said, "She's crippled! What are you doing!" —just for the drama of it. There were somewhere between twenty and thirty cops at least. And they had eight SUVs and two huge moving vans [for the crop].

The agents must have been surprised when what they encountered was not the illicit nest of armed drug dealers they expected, but rather a comparatively small marijuana garden run by obviously sick and disabled people with no inclination toward violence.

Valerie: When they got here, I think many of them must have said, "Why am I here? This is not where I belong. I should not be doing this. We fucked up." I know that at least one did, because he said so. The DEA agents were surprised by what they found and, in general, they didn't act the way that I think they most normally act in a raid. But neither did we; I would guess that we met them in a way that they have never been met before. I think that is an important element in facing your enemy. It empowers you. "Empowers," what does that mean? It gives a kind of honesty

to the situation. I mean, we still went to jail. But it gives everybody the opportunity to touch something real.

It's very difficult to find words to describe, but, in that moment, I just seemed to arrive. I don't want to confuse it with being safe, but I felt as though it was OK. It was still, as though everything else was just happening around me. And in that stillness, it was so familiar and I was ready. I was armed in a way that they were not. It was a profound experience. When I was in my car accident, I felt something like that for a moment. It loses its physical, spatial reality. It becomes a different place, an arrival in a different way. I think everybody knows this, gets to that place in that kind of experience. So right then, at that moment, I got to be really present and not be hammered, beaten, terrified of them and what they can do. It's not like I was unaware of what they can do, but I was not afraid. It is like letting the air out of the bigness of their presence, the hugeness of their presence. It was an amazing experience.

So there you are, and there is nothing you can do to change the situation. And in realizing that, there was a kind of allowance, a surrender to the situation. That gives you a lot of space, you have an immense amount of space, within the limits of what you can do. So I started talking to this agent. I started to explain to him what WAMM was. But he tells me to be quiet: "I don't want to listen to you." I said, "I have the right to speak and I want to tell you what WAMM is about." Again he said he didn't want to hear it, and I said, "Well, I want to tell you. WAMM is these people, people facing death, and we are following Proposition 215. What we are doing here is our right. With recommendations from our physicians, we have a right to do this, and you don't have the right to say that we can't. We have created law; call the state attorney general, call Bill Lockyer. Call the sheriff, if you don't believe me. I have worked with them." "I am not gonna call anyone." "Call them. Call the attorney general; it is his job to protect us."

At one point he said, "I am not going to listen to you," and he turned his head away from me. And that's when I said, "Oh, yes you are. And tonight, today when you leave here, I am going to go home with you and when you climb in bed tonight I am going to be right there next to you, and when you go to sleep I am going to be inside of you. Until the day you face your own suffering and your own death and you understand what you don't understand now." It was amazing; he stopped and his eyes kind of . . . well, he wasn't crying, but his eyes glazed a little bit. And I thought, Oh wow, that did it. It got through.

Hostage Negotiations

Once the initial shock of the intrusion had passed, and the agents were busily ransacking the house, Suzanne began considering her options. She had helped to develop an emergency response plan for just such a contingency, a plan that included mobilizing a telephone network for informing members, attorneys, city officials, and news media. It seemed imperative that communication with these vital sources of support be established at once—but how?

> *Michael*: They brought Valerie over [to the house by the garden] but they left Suzanne, who's paraplegic, handcuffed in bed. We finally convinced them that it was dangerous to leave her alone—she might need medical help—so they brought her over too. By then, it was at least an hour and a half after they had first showed up and we finally got to see a search warrant. I noticed that Valerie and I were named specifically in the warrant but that was it, only her name and mine. So we said something about Suzanne not being named on the warrant.

> *Valerie*: I think Suzanne asked them, "Am I under arrest?" And they said no, and so she said, "Can I go?" And they said, "No, you can't go." And she started to have these chest pains. I looked at her and I said, "Are you OK?" And she said, "No, I am not." So I asked if we could get the blood pressure cuff so I could check her blood pressure. They said OK, so I got the cuff, took Suzanne's blood pressure, and it was pretty high. I said, "You know, this is dangerous, this is dangerously high." I don't even know if it was dangerously high at the moment. I don't know if I was reading it right or not, but I knew they couldn't read it. One of the cops said, "Do you need an ambulance?" And she said, "Yes, I need an ambulance." [The agent in charge] said, "We are not calling an ambulance." So I said, "Well, you need to do something. You need to let her go because something could happen; she could have a stroke." And Suzanne said, "I need to go. I need to have this checked." Finally, they allowed Suzanne out. By the time she hit the bottom of the road, Suzanne was on the cell phone, putting into action one of the three plans that we had. She called the media and the phone tree.

Suzanne's phone calls produced an immediate response. Even as the Corrals were being transported to jail and DEA agents were cutting down

Patients and local law enforcement face off against DEA. Photo © Chuck Nacke —Woodfin Camp.

the marijuana plants and loading them into their trucks, a battalion of outraged WAMM members was storming out of Santa Cruz in the hope that they might prevent the loss of their medicine. Local television crews toting cameras and microphones were right behind them. Contrary to the stereotype of pot smokers as ineffectual stoners, this defiant collection of medical patients—many in wheelchairs or supporting themselves with crutches and canes—barricaded the road, preventing the federal agents from departing with the marijuana.

Michael: The planning paid off beyond our wildest dreams. The media and dozens of patients got to the property while the DEA was still there. They had already taken Valerie and me to the federal jail in San Jose, but WAMM members got to the property pretty fast and blockaded the road, trapping the rest of the DEA.

Valerie: In San Jose, they took us to a couple of holding cells, maybe six-and-a-half feet wide by eight feet long. There was this little bench made

from metal strips, too short to lie down on, about four feet long. I didn't want to lie on the floor because I didn't want to touch anything. I really didn't want to touch anything in there and I still had my cowboy boots on and the silk pajamas my mother had given me for my birthday. And they have the worst lights in the world for an epileptic. Finally, they took us out to take our mug shots and we had some very interesting talks.

At one point they took Mike and I into this other small room and they said, "You know, we have a little problem on our hands. There appear to be a couple of hundred people at the gate and they've got the DEA locked on the other side." Mike and I looked at each other. It was one of the most glorious feelings to look into Mike's eyes at that moment. It was kind of hilarious to imagine the DEA stuck on one side of the fence with all of these patients on the other side.

Anyway, they said, "Uh listen, we want to ask you to get them to let the DEA go." Mike suggested that if they drove us back there, we'd try to talk to the patients. But instead they got me on the phone with Danny [a WAMM member] who was there at the fence. Danny was relaying the conversation to everybody. I could hear in the background people yelling, you know, amping up. I could hear the intensity. I was kind of worried about that. I was hoping there would be no problems and nobody else would get arrested.

They asked, "Would you ask the WAMM members to disperse?" and Mike joked, "Would you call this a hostage exchange?" and they all started laughing. The cop left the room for a while and, when he comes back, he says, "They don't want us to take you anywhere near there, but we'll take you to the edge of Santa Cruz and we will give you money for a cab to take you the rest of the way." So we said, "OK, Danny, tell everyone to stand aside and let the DEA go by. When the DEA leaves, they are going to bring us back."

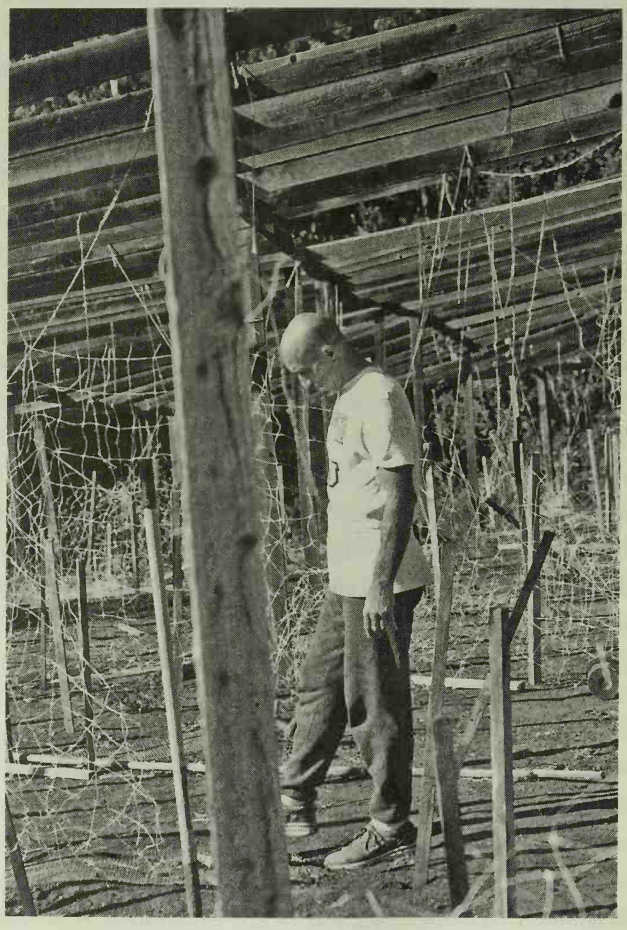
They took us to the 7-Eleven [a twenty-four-hour convenience store] at the edge of town and they gave us forty dollars for a cab, which we kept, of course, and called some friends. It was funny, because one of the guys said, "Do you think we ought to wait with you? You're sort of dressed strangely." And we said, "Are you kidding? This is Santa Cruz. Pajamas are fine. You stand out more than we do."

Coming home, we felt victorious, but walking in the garden, seeing it, it was difficult to realize the immensity of the loss. And the sacrilege; that garden is such a place of healing. Everything that comes from it has

been healing and to think they went in there with chain saws. To think of the disrespect, the destruction. Later, we used a lot of sage [to purify the place].

Turning Point

Although no charges were filed against the Corrals or against WAMM, the DEA agents chopped down the marijuana plants, destroying the collective's entire annual crop.



Michael Corral in the WAMM garden following the DEA raid. Photo courtesy of Jean Hanamoto.

Michael: Once the raid took place, we were propelled into political overdrive. Since then, we've just been consumed by the work it takes to keep doing the work that we need to do. They still haven't charged us with anything, but they could of course. There is a five-year statute of limitations on criminal charges. And we're still subject to asset forfeiture for another two years.

Valerie: There is no reason for them to come back, but that's not what they told us. When they left they said, "Any day of any week, any time for the next five years, we can come back here and get you." They might come up and arrest us; they might do that. But it is just feels so unlikely. It isn't unlikely, but it feels so unlikely. I don't mean to suggest that I have no fear of the federal government. And it isn't that I would put it past them. But I just don't think it would be very good politics. I don't think it would be very wise. In fact, it would be stupid to take Mike and me when 200 people will march into court and say, "It is mine," "It's mine," "It's mine," and some are wheeled in, some are paralyzed from the neck down, some are clearly dying.

They did it, and it turned out to be one of the dumbest things they had ever done. I really believe it was a turning point. Because WAMM is 250 people doing something to meet our own needs in a very reasonable and responsible way, and doing so by removing the very element that causes so much criticism: the money.

It is so much bigger than us. It is a groundswell, it is an earthquake. Because 79 percent of any group of people moving in the same direction is unstoppable. It really is. They are quite foolish to be putting up such resistance. You can imagine how many people would have to be put in prison for that to work. Of course, they are well on their way trying to meet that goal, but I don't think it is really possible.

They Just Took It

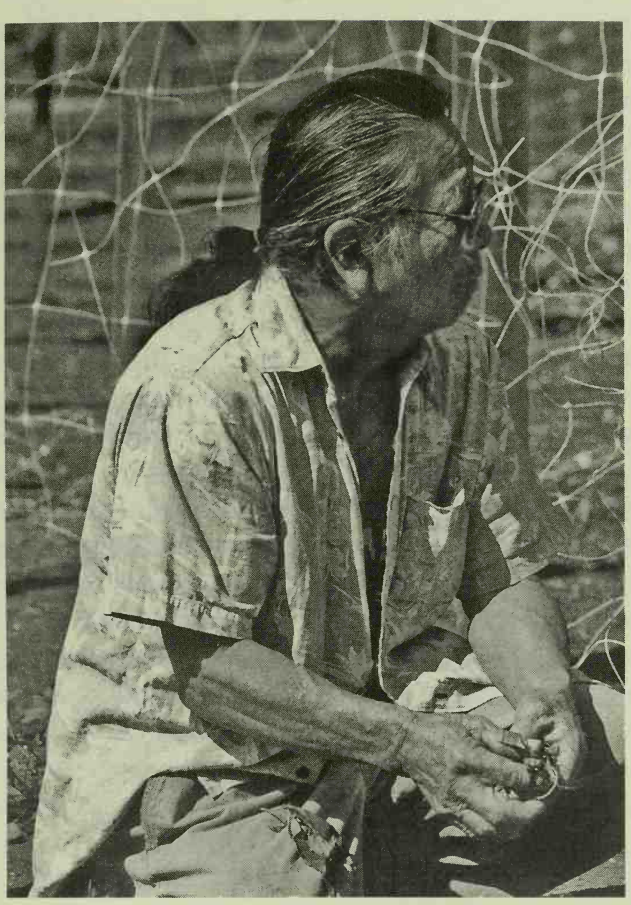
Interview with George Hanamoto, WAMM Patient

I joined WAMM a few years ago in my late sixties, after I was diagnosed with glaucoma. I met Val, put in my application and, after a couple of weeks, I got a phone call that said, "Come pick up your medicine." And that was the beginning of probably the most significant change in my life.

My whole outlook has completely changed in the last five years of being a WAMM member.

I went to my very first meeting; I looked around and I'm thinking, "What did I get myself into?" I did not know a gay person in my life. I wasn't a gay basher or nothing like that, but I was never raised by my parents to think about it; we never spoke. I never learned certain parts of life. Everything learned was through high school and friends, you know. So when I joined WAMM, it was just scary. I was scared of the disease; I was even scared of cancer. I wasn't aware of anything. So when I got home from that first meeting, my wife Jean downloaded about fifteen pages of information regarding how AIDS is transmitted and how to avoid it and the myths and so forth. In the meantime, Jean was talking to Val about talking to me about it.

I learned a lot and started getting more and more involved with WAMM. One of the things about WAMM is you get to know a lot of people and, over time, you see a lot of them die. That's the worst of it, the hard part. I have a lot more compassion for people now than I ever had before. WAMM has a table at [Gay] Pride every year in Santa Cruz and San Francisco and, believe it or not, I've attended every single one of them since I joined. Yeah, WAMM has definitely changed my life. But the garden is where I've been most involved. Already in the first year, I was lucky to work in the WAMM garden and I have been out there ever since. Three years ago, they asked me to be the garden coordinator.



George Hanamoto in the WAMM garden following the DEA raid. Photo courtesy of Jean Hanamoto.

I used to drive around in my truck with, like, thirty WAMM plants in the back but I was never afraid that I'd go to jail. That didn't occur to me; we're doing a good thing. When the [DEA] raid happened [in 2002], I was at home. We got the call and I guess we got over to the garden the fastest I ever got there in my life it seemed like. At first, it didn't hit me. I was doing all right. But when I got into the middle of the garden, and I see the leaves all over the ground and everything gone, then is when it just hit me. And the funny part is, the strange part of everything, was I started recalling these guys putting us in jail when I was eight years old, in the internment camp. I went in, in 1942 and came out in 1945 and I thought it didn't really bother me.

But in the garden, it all started coming back. I stood there and thought, "Can they just do anything they want to us?" And so I am thinking that, and I went to pieces out there. The garden hit me really hard. That was the whole crop for the membership. They just took it.

All the time I was growing up, we were in sharecropping and my mother would say, "You've got to behave well or you are going to give Japanese people a bad name." I was raised on that. In 1989 my wife and I opened a repair shop and a gallery. I put up a twenty-foot staff outside where we raised the American flag every single working day. Made sure it wasn't out in the rain; that if it was at night, that the light was shining on it. We went the whole way. Make sure me being Japanese, people knew that I wasn't any kind of spy or whatever. We displayed it real proud. I thought I was very patriotic.

I'm still proud and everything; I mean I know there is a lot to be grateful for in this country. But afterward [after the DEA raid], all of a sudden I started seeing something else. I even scraped the flag off my rear car window. I don't want to join no patriotic thing anymore. I see more rights being taken away and how people are treated. They think they can do anything they want to you. No, I don't put that flag out anymore.

8

Lessons in Endurance and Impermanence

A Sense of Violation and Fear

On the morning of September 5, 2002, Gabriel Demaine, WAMM's volunteer coordinator, wheeled her bike around the corner and into the WAMM parking lot. There she discovered three cars parked at hurried angles by the office door:

> *Gabriel*: I recognized the cars, but nothing about the way they were parked—or even the fact that they were there on a day when the office was closed—looked familiar. As I skidded to a stop and rushed through the open front door, I felt adrenaline shoot through me. I found a half dozen patients and caregivers systematically but frantically dismembering the office: unplugging computers, pulling files, and loading them into the cars out front. Every telephone was in use. There was an electrified atmosphere of Danger! Disaster! Emergency! Still I stupidly asked, "Hey, what's going on?" The answer, of course, was, "The DEA raided the garden this morning. Ange is calling the lawyers, Hal is calling the emergency response phone tree, Paul and Kimo are getting the files and computers out of here. Suzanne is talking to the press. We don't know how much time we've got." I started working a phone line, fielding and directing calls from the media and from the membership, telling everyone how to get up to the land to join the folks who had barricaded the road and trapped the DEA.

For WAMM members, the raid was a tremendous shock and yet not entirely unexpected. In the months preceding the raid, the organization had begun to actively prepare. One WAMM member, "Hal," had become so alarmed by the increasing federal threats that he helped to develop the emergency response activated after the raid: "I was incredibly concerned

about what the administration might do to us. I thought that if Val and Mike got arrested or if the office got busted or the garden got raided, we needed to have a phone tree. Someone would call me and then I would call the attorneys, the sheriff, the media, and fourteen other WAMM members. Those WAMM members would each in turn call twenty members. The idea was that, within two or three hours, everybody would know what was going on."

The plan was an effective one. As the news spread among the membership and then into the larger community, the response was immediate. County Supervisor Mardi Wormhoudt explained to the press that the Corrals operated in an "exemplary" fashion; she said that she was she "appalled" at the raid, which she called "an invasion."[1] It seemed almost inconceivable to many local residents that federal agents had entered the county and destroyed the work of terminally ill people growing their own medicine. That this occurred without the knowledge or consent of any public official or local law enforcement officer was widely reported in the media and further raised the hackles of the community.[2] The prevailing belief was that California voters had certified the right of WAMM members to do what they were doing; the DEA had no business there.

For WAMM members, the raid left in its wake a profound sense of violation and fear. As one member pointed out, "Now that the federal government has made clear that they don't care what we said [about medical marijuana] in the state election, I wonder what's the point of even voting then?" Disillusionment was coupled with tremendous anxiety; some patients suddenly found the price of membership in WAMM much too high. Others, like "Maria," a fifty-two-year-old woman with advanced ovarian cancer, weighed the risks but decided to stay active in the organization:

> We lost a lot of people right after the raid. Some died; anxiety probably hurried their process of dying. But we also lost people from ill feelings. We were expecting people to do more and get less. We needed more help but, at the same time, people were getting less medicine. That didn't go over well with some people. Some people decided to just go to the buyers' clubs instead. And we were all afraid to be in the meetings. We were afraid to work in the kitchens. I help make all the medicines and it makes me really nervous now. Are they going to come and take us away? Are they going to take my daughter away from me? I don't want to be around if the feds decide they're going to crack down again. But here I am.

Maria was far from alone; many shared both her fear and her sense of defiance. Diane Dias, a fifty-one-year-old WAMM member living with breast cancer, for example, admitted, "It was scary there at first. There were some people who didn't show up after the raid. And it was sad. But I could see where they were coming from; intimidation by the federal government, you know, some people will back down from that. Not me though. I had a therapist ask me one time, 'Diane, do you have a problem with authority?' And I said, 'No, Doc. It's not with authority. It's fucked-up authority that I have a problem with.'"

Another cancer patient, "Rev. Sonny," echoed Diane's sentiment: "Of course we are afraid. Who knows what the DEA is doing? Probably listening to us right now folks. But I don't care if they hear me. If you want to arrest me, come and arrest me. Put me in jail."

The decision to defy the federal government, even after the trauma of the raid, took a particular measure of courage on the part of WAMM members who were wholly or in part dependent on federal programs to survive. SilverKnight admitted, "I have always had a rational fear of them, of the federal government, and of certain law enforcement agencies. The fact that I am disabled and on Social Security and that a lot of us are in Section 8 [federally subsidized] housing, makes me vulnerable. But I feel in my heart and gut that I am not backing down."

In fact, for some members, economic and social marginalization enhanced not only their vulnerability but also their militancy. "Jon," for example, offered:

> My message to the federal government is: If you want to arrest someone with AIDS and throw me in the clink, go arrest me. I have nothing to lose. I'm the perfect kamikaze. I just don't care. There's nothing you can do to me; you're not going to ruin my social standing, you're not going to ruin my bank account. And I have a big mouth. Maybe before I got sick I had some sense of propriety, a sense that I had to do things in a certain way to make sure I was established and in the establishment. Now, seven years later, I'm on SSI, I'm on the low end of the totem pole. And I really don't have a lot to hide. I've told Val, if you need support, I'll be there with you darling. That I can give.

This sort of defiant response to the federal threat extended to WAMM's most senior member, ninety-four-year-old Dorothy Gibbs, and her care-

giver, Pat. Both remained outspoken in their support for WAMM following the DEA raid:

> *Pat*: When we found out about the bust and that there were people going to jail, I said to Dorothy, "what if they try to take you to jail?" And—
>
> *Dorothy*: And I said, "Let them take me; take my bed along." What could be worse than what I've been suffering with this pain? Without the medical marijuana, they might as well lock me up. I said, "Come on! What are you waiting for? Let's get going! What kind of life will I have without it? I'm lying in bed anyway; doesn't matter where that bed is."
>
> *Pat*: My main concern was not for my own personal safety, but for my church, damaging people in my church. If people didn't know anything about what I did, it would seem like it was secretive. And I thought, you know, I'm not doing anything wrong. So I stood up on a Wednesday night in my church and suggested that perhaps they might want to take me off the membership because there had been a bust at WAMM and they had all read about it. I explained that I intended to continue to deliver medical marijuana to Dorothy as long as I could get it, but that I loved them and that I didn't want to do anything that would hurt them. I must say, there was a few that verbalized their feelings about it. But a deacon of the church said, "I make a motion that we refuse her resignation" and someone seconded it. And then someone was saying, "Well, I think we ought to pray and think about it." And the preacher said, "It's already been seconded. There's nothing wrong with this. It's legal to have medical marijuana." I was shocked. Now if I had done that when we had another minister, it would have been really shaky. But even so, I didn't expect so much backing.

Taking It to the Streets

Pat's unexpected experience of support within her church was not unique. Other WAMM members, too, discovered a surprising breadth of support for medical marijuana among family and friends as they shared their stories of the effect of the DEA raid. The organization quickly recognized that the trauma of the raid could be transformed into an educational and political opportunity if they could swiftly move from fear and grief into effective activism. Organizers were aware, however, that there was only a brief window in which public attention could be captured. A period of intensive organizing followed:

Gabriel: One priority was the legal response, of course, and a meeting was immediately arranged with some lawyers, physicians, and politicians to develop a strategic plan in that area. But, we also wanted to do something in the streets. Our thinking was that if the story stayed big, there might be some protection for the organization and for Val and Mike. For me, it meant organizing a community-wide action that would allow the membership and the Santa Cruz community to voice anger and outrage. What we decided was to hold our weekly WAMM membership meeting on the steps of City Hall and to use that setting to publicly dispense medicinal marijuana to a handful of our patients. One reason we chose City Hall was because of its high visibility and significance as a public town hall space. But we also decided on it as a location to emphasize the support we had from our local government. Our plan was to keep the story alive, to control the spin, and to keep the pressure on the federal government by making clear that WAMM was not going down, we were not going away. We just knew that this was the type of political confrontation Santa Cruz was built for.

On September 17, 2002—U.S. Constitution Day—and less than two weeks after the DEA raid on WAMM, the organization defiantly distributed medical marijuana at Santa Cruz City Hall. The well-attended public action took place under the sometimes deafening and threatening whirr of what was assumed to be a DEA helicopter. Television crews and reporters from around the country and around the world stood several rows deep, keeping cameras and microphones trained on the patients, physicians, attorneys, politicians, and activists who spoke to the crowd. Supporters—including the current Santa Cruz mayor, several former mayors, and members of the City Council and County Board of Supervisors—filled the courtyard of City Hall.

The local newspaper observed that the large crowd attending the event was "decidedly pro-medical-marijuana," but there was a small handful of people protesting, including local resident Phil Baer. Baer, the paper reported, "was not sympathetic to the plight of the people using it [medical marijuana]. 'I think it would be noble of them if they felt the pain a little bit and did something for the higher good.'"[3]

In fact, relatively few Californians appeared to share Baer's view that the sick and dying should accept some measure of suffering in order to protect the federal War on Drugs. Already in 1996, the statewide medical marijuana law, Proposition 215, had passed with 56 percent of the vote.

WAMM Medical marijuana distribution on the steps of City Hall, 2002. Photo © Chuck Nacke—Woodfin Camp.

The intervening years of increasing federal activity against medical marijuana provider organizations did nothing to diminish that support. Indeed, it may have increased sympathy for medical marijuana patients. As Rev. Sonny suggests, "Honestly, I think the DEA raid was a huge gaff, a bad thing politically. Instead of causing people to hate marijuana, to hate people who smoke marijuana, it actually did the opposite. It caused people to see a bunch of sick people, people in wheelchairs, people who could hardly walk, people who are pasty white, to have to look them straight in the face all over the American news and say, 'You took their medicine?'"

A Field Poll conducted two years after the WAMM raid offers evidence that Sonny's analysis was correct.[4] Support for medical marijuana had increased substantially; 74 percent of Californians now favored legal protections for medical marijuana patients—up almost twenty points since the state law first passed.[5] Furthermore, the poll reported that support extended across all segments of society, from conservative to liberal and across all age groups.[6]

Taking It to the Courts: Santa Cruz v. Ashcroft

Widespread and outspoken public disapproval of the raid provided one source of support for the organization.[7] But, in order to continue to collectively cultivate marijuana, the organization needed legal coverage as well. Within days of the DEA raid, the organization's board of directors met with a group of attorneys, physicians, and local officials to discuss a legal response. Valerie and Michael Corral and Suzanne Pfeil, each of whom had been present during the raid, provided the group with a gripping account of the DEA action. The seizure of the group's entire annual crop haunted them. Local attorney Ben Rice and Santa Cruz physician Arnie Leff[8] suggested that one immediate concern should be an attempt to restrain the DEA from destroying the collective's medicine.

Another attorney at the meeting, Gerald Uehlman,[9] raised the question of a larger legal response. Uehlman, a professor at nearby Santa Clara University School of Law, suggested that WAMM's case could be legally significant. WAMM's was different than the other medical marijuana case recently taken to the U.S. Supreme Court, the Oakland Cannabis Buyers' Cooperative (OCBC) case in 2000.[10] WAMM, Uehlman argued, was not like the OCBC, which distributed marijuana for the benefit of others; rather, WAMM was a collective of patients cultivating their own marijuana for their own direct use out of personal necessity, a distinction that ought to be significant in court. With WAMM, he argued, the feds were taking medicine directly out of the hands of patients, not intervening in a commercial drug transaction. And he explained that WAMM's highly localized operation invited a showdown with the federal government over legal jurisdiction. Because no interstate commerce was involved, the state of California—not the federal government—ought to have constitutional authority to regulate the use of medical marijuana within its borders. Federal interference, the attorneys argued, presented an imminent harm to patients and a violation of their substantive due process rights.

Both Uehlman and Rice were eager for the Corrals to take their case to federal court seeking an injunction against the U.S. attorney general and the Drug Enforcement Administration.[11] Uehlman and Rice offered to provide their services pro bono (without charge), indicating their commitment to the case and their belief in its significance.

While Valerie was spoiling for a fight, Mike, who rarely shies away from a challenge, was nonetheless more cautious, hesitant about pursuing a response that might further provoke the federal government and increase

the chances that he and Valerie would lose their home. Their land is their only asset and, as both are in their mid-fifties, their only source of security as they approach retirement age. The risk of asset forfeiture under federal drug law seemed, at least to Mike, to demand caution. Clearly, no one else was risking what the Corrals were, and only Valerie attempted to persuade him. After some reflection, Michael agreed to go forward with the lawsuit:

> *Mike*: I have to be really honest; it's always been a life dream to challenge an unjust government. So here I am with a life's dream come true. And it's not easy. They say that each thing that happens to you in life prepares you for what's to come. Sometimes I think, If that's true, then, oh god, what's next? I feel—I don't know—not apprehensive exactly. Maybe more like prepared, on alert, like Homeland Security, on alert. But I think I'm ready; bring 'em on.

Also attending the legal-strategy meeting were two City Council members, Tim Fitzmaurice and Emily Reilly, and a county supervisor, Mardi Wormhoudt. Through their efforts, the Santa Cruz City Council and the County Board of Supervisors both agreed to join as plaintiffs in the case.[12] The defendants were U.S. Attorney General John Ashcroft, DEA Administrator Karen Tandy, federal "Drug Czar" John P. Walters, and "30 unknown Drug Enforcement Administration agents." After nearly a year of preliminary motions and formal hearings, on August 28, 2003, District Court Judge Jeremy Fogel ruled against WAMM, denying the organization a protective injunction. Some of the organization's documents and the Corrals' personal property seized during the raid were subsequently returned; but the collective's annual crop of medical marijuana was never recovered, presumably destroyed.

At the same time, another lawsuit involving medical marijuana was proceeding through the federal court system, just ahead of WAMM's case. In October 2002 Angel Raich and Diane Monson, two California patients using medical marijuana to manage serious illnesses, had filed suit against the DEA and the U.S. attorney general. Their motion for injunctive relief was also denied in district court.[13] The similarities between the two cases are important: as with WAMM members, Raich and Monson each had recommendations from their physicians and were engaged in cultivation of marijuana for personal use only, in full compliance with California

law. The most significant difference concerned the fact that WAMM was a collective involving over two hundred people. Diane Monson was an individual growing her own marijuana and Angel Raich received marijuana from caregivers who helped her without remuneration. WAMM's attorneys believed that the differences between the two cases were legally inconsequential and that decisions concerning Raich and Monson would directly affect WAMM's fate.

In October 2003, five weeks after Judge Fogel denied WAMM's injunction, Raich and Monson submitted their case to the Ninth Circuit Court of Appeals. Within two months, in December of that year, the circuit court judges ruled in a two-to-one decision that loss of access to marijuana would result in a medical emergency for the two patients and, contrary to the finding of the district court, that Raich and Monson had demonstrated a strong likelihood of success in the constitutional issues involved.[14]

In their ruling, the appellate court found that the women's noncommercial activities were fundamentally different from the kind of drug trafficking the Controlled Substances Act (CSA) was intended to control; for that reason, the court concluded, they were outside of federal jurisdiction. In the opinion of the federal appeals court, the fact that the plaintiffs were following the recommendation of a licensed physician mitigated public health and safety concerns. The fact that all their marijuana was grown and consumed within the state meant that federal authority to regulate interstate commerce did not apply. Indeed, the fact that the marijuana was cultivated exclusively for their personal medical use and that no commercial transaction was involved in its procurement or possession meant, in the view of the court, that no "commerce" was involved at all.[15] The Ninth Circuit Court of Appeals reversed the district court's ruling and instructed the judge to provide a preliminary injunction protecting Raich and Monson from federal interference.

Within weeks of this ruling, WAMM's attorneys filed a motion for reconsideration of their request for an injunction. In June 2004, citing the Ninth Circuit Court of Appeals' decision in "Raich v. Ashcroft," Judge Fogel barred the U.S. attorney general and the Drug Enforcement Administration from interfering with the Corrals, WAMM patients, or the collective's garden. The federal injunction provided at least a temporary respite in the ongoing battle with the federal government. WAMM suddenly became the only organization in the United States free to cultivate medical marijuana without fear of federal prosecution.

Commerce v. Compassion

While campaigning for the presidency in 1999, Texas Governor George W. Bush responded to a question about state medical marijuana laws by suggesting that the federal government should defer to states on this issue: "I believe each state can choose that decision as they so choose,"[16] Bush announced. But once installed in the White House, the Bush administration demonstrated a striking hostility to medical marijuana and an enthusiasm for the exercise of federal power. Not only did raids on medical marijuana provider organizations escalate, but the Ashcroft Justice Department also decided to appeal the Ninth Circuit Court decision offering protection to Raich, Monson, and the members of WAMM. In 2004 the U.S. Supreme Court agreed to hear the case that, with a change in U.S. attorneys general, would become "Gonzales v. Raich."

The case focused only on the question of federal authority, not on the issue of the therapeutic value of cannabis or the medical need of patients. The Supreme Court considered only whether, under the Commerce Clause of the U.S. Constitution, Congress could ban marijuana for medical use in states with laws protecting such use. In June 2005 the Court ruled in favor of the federal government, concluding that enforcement of the Controlled Substances Act was a legitimate exercise of federal power under the Commerce Clause. They argued that federal authority included "the power to regulate activities that substantially affect interstate commerce,"[17] even if those activities are purely intrastate and involve no buying or selling of goods or services. The Court cited a 1942 precedent established in the case of "Wickard v. Filburn" in which a farmer grew, for personal consumption, more wheat than was permitted under the Agricultural Adjustment Act. Following the Wickard decision, the Supreme Court ruled that cultivation of a crop grown strictly for personal use and not transported across state lines—at least if that crop is wheat or marijuana—may nonetheless be regulated under the Commerce Clause if Congress itself "concludes that failure to regulate that class of activity would undercut the regulation of the interstate market in that commodity."[18]

The Court acknowledged that wheat and marijuana were not entirely comparable substances because the wheat farmer could have purchased the wheat he needed for personal consumption on the open market as an alternative to violating federal regulations. In the absence of a legal market for marijuana, patients unable to grow their own cannabis would be left with no lawful means of following a course of treatment recommended

by a physician. But the distinction was inconsequential to the Court's majority; Congress, they concluded, has the authority to regulate lawful and unlawful markets alike, and prohibition is a legitimate form of regulation. Although no evidence was presented to show that any of the patients' medicine had ever entered the stream of trade, the Court found the argument that some homegrown medical marijuana could find its way into the commercial market sufficiently rational as to legitimize federal authority over all of it.

In their dissent, three justices—O'Connor, Thomas, and Rehnquist—objected to the broad definition of commerce used by the majority in reaching their decision. Justice Thomas observed that "if the majority is to be taken seriously, the Federal Government may now regulate quilting bees, clothes drives, and potluck suppers throughout the 50 states."[19] O'Connor agreed, noting that "most commercial goods have some sort of privately producible analogue. Home care substitutes for daycare. Charades games substitute for movie tickets. Backyard or windowsill gardening substitutes for going to the supermarket. To draw the line wherever private activity affects the demand for market goods is to draw no line at all, and to declare everything economic. We have already rejected the result that would follow—a federal police power."[20] O'Connor also expressed concern that this unwarranted expansion of federal power would harm the legitimate role of states as laboratories for "novel social and economic experiments without risk to the rest of the country."[21]

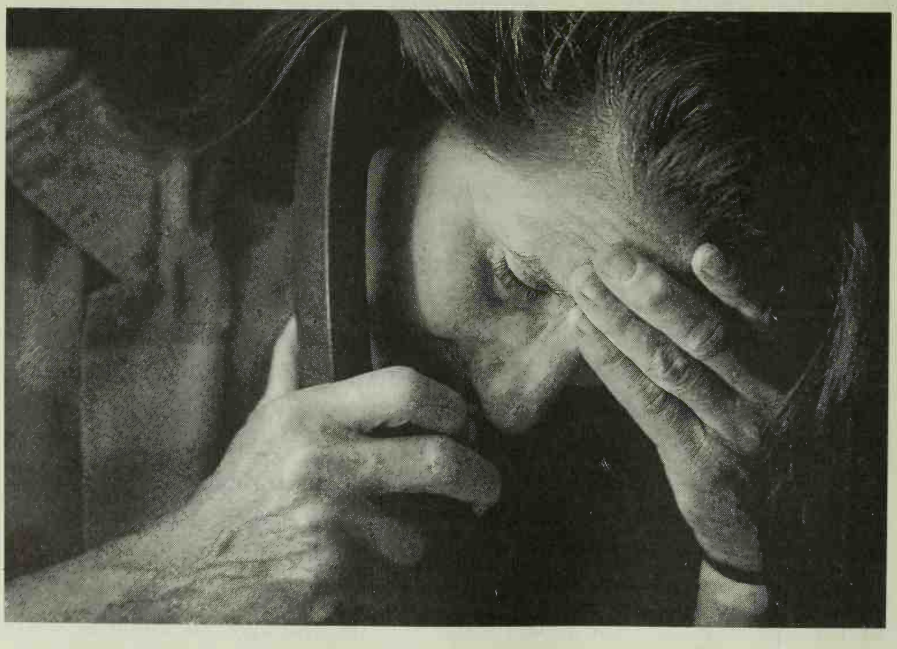
While not the focus of the Court's deliberations, the question of medical necessity hovered around the proceedings. Justice Stevens, who delivered the majority opinion, recognized that "Raich's physician believes that forgoing cannabis treatments would certainly cause Raich excruciating pain and could very well prove fatal."[22] Further, he acknowledged that the case "is made difficult by respondents strong arguments that they will suffer irreparable harm because, despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes."[23] In response to these concerns, the Court noted that Congress might wish to make a distinction between interstate drug trafficking and intrastate, noncommercial cultivation and possession for medical use; such a distinction, the Court suggested, "might be sufficient to justify a policy decision exempting the narrower class from the coverage of the CSA."[24]

The message from the Court was clear: the question of medical marijuana should be handled by the legislature, not the courts. Congress should consider new evidence in support of cannabis therapeutics and

take into account the interests and wishes of the majority of American voters. Nothing short of congressional action, the court suggested, could fully protect patients who use medicinal marijuana. States may pass laws that permit the use of medical marijuana and may even refuse to cooperate with federal eradication programs; but state law cannot limit or prevent federal drug enforcement activities within their borders. Indeed, the Supreme Court decision affirmed that federal power to regulate commerce is "'superior to that of the states to provide for the welfare or necessities of their inhabitants,' however legitimate or dire those necessities may be."[25]

Taking It to Heart

The Supreme Court decision in the Raich case represented a body blow for WAMM and its members who would no longer be protected from federal prosecution. Anxiety increased dramatically. Some members responded to the increased sense of risk by withdrawing from the organization and



Valerie Corral receives news of the 2005 Supreme Court ruling against medical marijuana patients. Photo courtesy of Shmuel Thaler.

turning to the streets in search of lower-profile suppliers or to for-profit cannabis buyers' clubs where club operators rather than patients assume legal risks.

Those who had been on the Corrals' property during the 2002 DEA raid felt the impact of the Raich decision particularly acutely. The morning following the Supreme Court ruling, one member who had been traumatized by being on the land during the DEA raid even attempted to commit suicide. All of them felt acutely vulnerable. Suzanne Pfeil, who also had been at the scene, admitted,

> I don't feel safe in my own country anymore. The federal government keeps saying, "Oh, we're not going after patients. Patients shouldn't worry." Well, hello, I'm a patient and I'm very worried. Once you have been under the gun, it is not very hard to imagine that they would do it again. No one should ever have to go through what I went through on September 5 [the 2002 DEA raid]. No one should wake up with a gun to their head just because the government doesn't like their medicine.
>
> The message now seems to be, "We're not interested in arresting sick and dying people but we have the power we need to do so. We probably won't go after you. But we might. And we can. So be very afraid."
>
> You know, I used to think they wouldn't go after us because we are really sympathetic. We are all patients and caregivers and we aren't making a dime on this. But I was wrong. They did go after us. They did it to make an example out of us, to say, "If these people can't get away with it, nobody can."

Remarkably enough, even in the face of the renewed federal threat, most WAMM members—including Suzanne Pfeil—once again dug in their heels, vowing to continue to cultivate, to collectively distribute, and to use cannabis in defiance of the federal government. On the evening of the Supreme Court ruling, June 7, 2005, more than 100 WAMM members and supporters gathered at the downtown clock tower, a popular site for political rallies and protest meetings in the heart of Santa Cruz. Dressed entirely in black, the protesters quietly and peacefully filled a small park near the clock, carrying placards commemorating the more than 150 WAMM members who had died since 1996. The placards, each shaped like a tombstone with "RIP" emblazoned above the names and pictures of the deceased, presented a compelling reminder to all who viewed them that the needs of those engaged in the struggle were dire indeed.

WAMM members protesting the 2005 Raich decision. Photo © Chuck Nacke —Woodfin Camp.

A few weeks later, WAMM members, accompanied by hundreds of supporters, including health care workers and elected officials, paraded through the streets of Santa Cruz in a "March for Medicine." Patients in wheelchairs and on foot carried not only the RIP signs but also marijuana plants from the collective's garden. Because of the renewed threat of asset forfeiture, the organization's collective cultivation would have to be suspended or at least greatly reduced. With the loss of their injunction, WAMM could no longer openly cultivate their medicine on the Corrals' property; plants would have to be distributed to individual members in hopes that the organization could continue to, at least minimally, meet patient needs.[26]

Determined patients and caregivers began growing marijuana at home, with varying degrees of success, in indoor and outdoor micro-gardens.[27] But, despite the plant's popular designation as "weed," growing medical-grade marijuana requires skill.[28] Inevitable inefficiencies considerably reduced the quality and quantity of medicinal marijuana available to the membership. As Rev. Sonny observes, the continuing federal threat presented a tremendous challenge to both the organization and its individual

members: "Take a bunch of sick people and then threaten to put them in prison. What is that going to do to them? How can you measure what these threats do to people here? People who are growing have got to be afraid. A bunch of storm troopers invaded with automatic weapons . . . of course, you're going to fear that one night they'll kick in your door. There's also a huge effect on the quality of the marijuana and the amount, now that it has to be grown by people who don't really know what they're doing."

Not only do many WAMM members lack the skill to cultivate at home, some are simply too ill to manage a garden, as Suzanne Pfeil points out: "How is the person who is in their bed, dying of AIDS, going to garden? How is an elder who is very frail and lives in an apartment going to garden? How is a quadriplegic who can't even feed himself going to garden? I mean, how are the most vulnerable going to manage? That's why there is a place for the buyers' clubs and for the collectives and for the cooperatives because some people just can't grow for themselves."

Even those WAMM members who are strong enough and skilled enough to tend their plants to maturity, cannot be assured their medicine will make it to harvest. Under conditions of prohibition, a mature marijuana plant is valuable and presents a significant temptation to thieves. For Suzanne Pfeil, for example, the media attention focused on her since the 2002 raid increased her visibility and her vulnerability: "I don't actually have plants in the ground right now because of the extra stress that would have caused. My partner doesn't want me to grow here again. He doesn't want to risk losing our home, which is our only asset. I can understand that. In any case, it's very difficult to grow for yourself if you live in town and, especially if you are high profile like me. I've been the target of robberies."

Ironically, then, one result of federal raids against legitimate patient/caregiver organizations like WAMM is the diversion of marijuana from medical to recreational use through petty theft. Diversion is precisely the problem federal officials claim their raids are intended to prevent.

Not only has federally enforced prohibition failed to keep marijuana out of the recreational market, it has not reduced the demand for medical marijuana. Federal policy, however, has been effective at punishing patients too poor to purchase their medicine and invigorating the profit-driven sectors of the street market and the buyers' clubs and cooperatives. After the 2002 DEA raid on WAMM, two buyers' clubs opened in the city

of Santa Cruz with dozens more located in the nearby cities of San Francisco and Oakland.

But the loss of WAMM's collective garden did more than reduce access to affordable medicine. It also represented an assault on the symbolic heart of the organization. Since the mid-1990s, the WAMM garden had served as an important sanctuary for its seriously ill membership. It provided a place of beauty where patients, often all too aware of their economic, social, and physical limitations, could contribute to the community. Some members attempted to recreate some of the effects of the garden by cultivating flowers and vegetables in the place of cannabis. But for those accustomed to the sight of tall, leafy marijuana plants lovingly tended by patients for their own eventual use, the appearance of rose bushes and squash vines were a painful reminder of the precariousness of their own survival and that of the organization.

The ongoing federal threats have taken a particularly heavy toll on the Corrals. Mike, tired and frustrated by political setbacks, anxious about the continuing threat to his property and personal freedom, and grieved by the recent death of his father, found himself increasingly unsatisfied with his life. In 2005 he moved off the land and out of the marriage he and Valerie had shared for more than thirty years. But despite the loss of that critically important partnership, and in the face of very real federal opposition, at the time of this writing in 2007, WAMM continues to operate under the leadership of Valerie Corral, with the assistance of Michael Corral, and with the support of the local community. The membership, which still numbers well over one hundred, meets weekly, sharing resources and providing medicine—if in reduced quantities—to seriously and terminally ill patients.

Valerie's vision for WAMM has always gone well beyond providing marijuana. One of the most important contributions WAMM has made in the lives of its members has been informal hospice care provided *by* patients *to* patients. Since the 2002 raid, a parallel organization—Raha Kudo—focusing on end-of-life care for WAMM members has secured its own nonprofit status.[29] Early discussions included the possibility of creating a modest hospice facility to house a small number of patients, particularly those who find themselves homeless or destitute in their final weeks of life. The cost of complying with public health and safety regulations, however, may prove prohibitive. For the time being at least, WAMM's hospice project will focus on training caregivers to provide the comfort and end-of-life care so many in the organization need.

Transplanting the WAMM Model

For more than a decade, WAMM has done much more than just survive; it has served as an important model of ethical medical marijuana provision for the state of California and beyond. California State Senator John Vasconcellos has called WAMM's noncommercial collective model "the most effective one operating under state law."[30] Federal Judge Jeremy Fogel has referred to the organization as "the gold standard of the medical marijuana movement."[31] Even public officials who have expressed serious reservations about medical marijuana suggest that, in states with medical marijuana laws, noncommercial provision should be the preferred approach. San Diego Assistant District Attorney Damon Mosler, for example, opposes buyers' clubs but argues that, under California state law, "You can have collectives or co-ops where small groups of patients or caregivers get together. If there are legitimate patients who can't grow it, cities can coordinate the collectives."[32] Understandably, Valerie and Michael Corral have become much sought-after consultants as officials attempt to address the question of medical marijuana provision in the context of federal prohibition.[33]

But whether WAMM's grassroots, patient-based, noncommercial organizational model can be replicated by other groups in other communities and other states depends largely on the possibility of change in federal drug laws or, at least, enforcement priorities. If the Controlled Substances Act is revised to reclassify marijuana for medical use, and if patients are allowed to cultivate their own cannabis, then the future for patient/caregiver cooperatives appears promising. If, however, federal opposition to medical marijuana continues, the obstacles to successful transplantation of the WAMM model are considerably increased. Until the U.S. Congress can be persuaded to rethink the blanket prohibition on the use of marijuana, no local or state-supported medical marijuana organization, including WAMM, can be safely insulated from the federal government's ongoing War on Drugs.

Some movement within Congress on this issue has begun. Every year since 2003, U.S. representatives Maurice Hinchey (D-NY) and Dana Rohrabacher (R-CA) have introduced an amendment to the appropriations bill for the Department of Justice that would prevent the department—which includes the DEA—from spending taxpayer money to raid, arrest, or prosecute medical marijuana patients in the states where marijuana is legal. Support for the amendment is increasing slowly. The first

year it was introduced, the House voted 273 to 152 against the amendment. Three years later, in 2006, an additional 11 members voted in favor. While this still left the amendment well short of passage, 18 Republicans joined 145 Democrats in supporting the measure.[34]

The 2006 general election, which gave Democrats a majority in Congress, also created new opportunities for committee hearings on medical marijuana.[35] In July 2007 the House Judiciary Subcommittee on Crime, Terrorism, and Homeland Security held hearings on the DEA's role in the regulation of medicine. Three witnesses were called to testify before the committee on medical marijuana issues: DEA Assistant Administrator Joseph Rannizzisi, ONDCP[36] chief scientist Dr. David Murray, and Valerie Corral of WAMM. Corral was asked about her organization's experiences with the DEA and about federal obstruction of research into the medical uses of marijuana. In an historic breakthrough, the committee chair, Robert Scott (D-VA), asked Corral to provide the subcommittee with international research reports demonstrating the efficacy of marijuana as a medicine[37] (specifically studies submitted to the International Cannabinoid Research Society and the International Association for Cannabis as Medicine), as well as peer-reviewed research conducted within the United States. This was a significant reversal in the federal government's previous refusal to consider evidence in support of cannabis therapeutics and represents a necessary first step toward possible rescheduling of marijuana under the Controlled Substances Act.

Opposition, however, remains fierce: even as Corral was testifying before the House of Representatives, the Senate was poised to consider a bill containing a provision by Sen. Tom Coburn (R-OK) that could undermine the twelve state laws protecting medical marijuana patients from arrest. The bill would place the state programs under the authority of the FDA, without providing an approval process for marijuana comparable to that for other prescription medications. According to Rob Kampia of the Marijuana Policy Project, "If enacted into law, the Coburn Amendment could cause medical marijuana patients and caregivers to face even greater risk under federal law than they already do. Even more disturbing, medical marijuana opponents could try to use the provision to shut down state medical marijuana programs across the country."[38]

In California the DEA has continued its aggressive enforcement program. During the summer of 2007, the DEA opened a new front in its ongoing war against cannabis when it sent letters to approximately 150 property owners in Los Angeles whose buildings were being leased by

medical marijuana dispensaries. The letters informed the landlords that they could lose their property, or face up to twenty years in prison, even if they had no direct involvement in the ownership or daily operation of the dispensaries. Sarah Pullen, a DEA representative, explained that "by renting their property to individuals violating federal drug laws, they are in and of themselves violating federal law. . . . These [letters] are definitely meant to serve as a notice. What might happen as to the continuing investigations, we'll just have to see."[39] Property owners have every reason to take the threat seriously. In 2001 the DEA raided the Los Angeles Cannabis Resource Center and seized assets in excess of $300,000 that the city of West Hollywood had loaned to the center to purchase its building.[40] Dale Geiringer argues that, based on this history, the 2007 DEA letter will likely lead to numerous evictions, shutdowns, and select property forfeiture prosecutions "to scare remaining landlords."[41]

Nonetheless, DEA actions have proved remarkably ineffective in stopping the progression of medical marijuana use and provision in California; there are currently some two hundred thousand authorized users in the state.[42] In Santa Cruz itself, the 2002 DEA raid against WAMM did little if anything to dissuade new—and profitable—medical marijuana businesses from establishing themselves in the community.[43] But the continuing federal threats against Valerie and Michael Corral have weakened the only nonprofit medical marijuana group in town. In the first five years following the raid, WAMM struggled with reduced supplies of marijuana and experienced a precipitous drop in monetary donations; these difficult circumstances led to a reduction in the number of patients able to be served and even threatened the survival of the organization. In the spring of 2007, Michael Corral reported that circumstances were so dire that the organization might close within "a matter of months not a year or years."[44] Valerie Corral appealed to the public: "If each of us contributes as little as $5 a month, we can move political history."[45] Media reporting on the plight of the organization led to a significant flow of small donations from around the country to the WAMM Web site.[46] An August 2007 benefit concert by renowned musician and cannabis supporter Willie Nelson further ensured the financial survival of the organization for at least an additional year.[47]

No one, however, is under the illusion that WAMM—or any other medical marijuana organization—can feel safe given the federal government's commitment to the War on Drugs. Federal intransigence on the issue of medical marijuana, however, is increasingly at odds with the will of

the citizenry. Opinion polls suggest that the great majority of Americans support the right of seriously ill patients to access this common botanical remedy without threat of prosecution.[48] Few Americans will go through life untouched by serious and life-threatening illness. Whether as a result of personal experience or through caring for a loved one, many Americans are familiar with the often-challenging effects of medical treatment and the urgency of the desire for relief from nausea, anxiety, and pain. Under these circumstances, many patients and their families are willing to consider the use of cannabis.

Others, however, remain reluctant to do so because of an entirely reasonable fear of their own government. Thus far, federal drug enforcement officials largely have targeted buyers' clubs and collectives rather than individual patients. But, according to Graham Boyd, founder of the ACLU's Drug Law Reform Project:

> They [the federal government] could change their minds any day and go after patients. I think that is something people understandably worry about. Is any particular patient likely to be prosecuted? No. But no lawyer, I would hope, would advise their client that they are safe. Because they're not. I think one of the costs of the federal government's insistence on treating all marijuana use as criminal is that many patients are actually deterred from using it. Especially people who just aren't familiar with marijuana, who haven't used it, or who haven't used it in a really long time, and suddenly they have cancer and they're undergoing chemotherapy and they hear that marijuana could make it so that they're not retching with horrible nausea, but they're afraid to [use it] because, well, it's illegal. I actually think that kind of deterrence is real; that's happening for patients all over the place.

Farm or Pharm

In the face of growing evidence of the medical efficacy of cannabis and of widespread public support for this relatively benign botanical, federal resistance to the rescheduling of cannabis for medical use would seem inexplicable were it not for the special place marijuana occupies in federal drug prohibition. To recognize the legitimacy of marijuana as a medicine would threaten the status of one of the War on Drugs' most important targets. Almost half of all adults in the United States reportedly have used

marijuana,[49] making it by far the most commonly used illicit drug. With any rehabilitation of marijuana, massive expenditures on the War on Drugs would become much more difficult to justify.

The legitimation of marijuana as a medicine also would represent at least a symbolic challenge to the power of the pharmaceutical industry working to retain a monopoly on drug production and provision. While the U.S. federal government continues to insist that cannabis has no medicinal value, the pharmaceutical industry knows otherwise. In June 2006, hundreds of scientists affiliated with some of the top research universities from around the world met in Hungary to discuss current research on the influence of cannabinoids on the human body.[50] The conference had significant corporate sponsorship from the pharmaceutical firms of Bristol-Myers Squibb, GW Pharmaceuticals, Eli Lilly, Merck, and Pfizer. Among the 253 poster sessions and research presentations on the effect of cannabinoids on nervous-system functioning, neuronal development, memory and learning, food-intake, and pain and inflammation, were several discussing clinical evidence of the apparent therapeutic efficacy of both synthetic and plant-derived cannabinoids in treating neuropathy, nausea, and spasticity.[51] Researchers also presented laboratory studies suggesting that cannabinoids may have neuroprotective effects in multiple sclerosis and Parkinson's and, perhaps most startling, may have anticancer properties in fighting human brain and breast carcinoma.[52]

Drug manufacturers are already involved in the development of several cannabinoid medications. In addition to the currently available drugs, Marinol (dronabinol) and Cesamet (nabilone), nearly two dozen other new cannabis-derived or -inspired pharmaceutical compounds are undergoing safety trials and pending approval.[53] In addition to these synthetic drugs, the British pharmaceutical company GW Pharmaceuticals has developed a botanical extract, Sativex, to treat neuropathic pain. Sativex is already available in Canada on prescription.[54]

In order to obtain approval for Sativex in the United States, GW Pharmaceuticals is attempting to create a clear distinction between its product and the prohibited forms of medical marijuana. This is no small challenge as Sativex is nothing more than a plant extract made from marijuana bud and leaf "in a ten part bud to one part leaf ratio," according to the company's Web site.[55] In an effort to expedite that approval, GW Pharmaceuticals has enlisted the assistance of a powerful but surprising ally: former U.S. Deputy "Drug Czar" Andrea Barthwell. In 2005 GW hired Barthwell to help them make their case to U.S. regulators that their marijuana

medicine, unlike its homegrown counterpart, deserves federal support. During her years at the White House Office of National Drug Control Policy, Barthwell was an outspoken opponent of medical marijuana, arguing that, unlike synthetic derivatives, "a crude plant is definitely not a medicine."[56] But after becoming a paid consultant to GW Pharmaceuticals, Barthwell threw her support behind the pharmaceuticalization of botanical marijuana.[57] Confronted with the apparent contradiction, Barthwell declared, "Comparing crude marijuana to Sativex is like comparing a raging forest fire to the fire in your home furnace. While both provide heat, one is out of control."[58]

As Barthwell suggests, the distinction between a cannabis tincture produced and marketed by a pharmaceutical company and one made at home is primarily a question of control. Homegrown marijuana threatens to erode both federal and corporate control over drugs. Because the drug in question is nontoxic and nonaddictive, the real risk is to profits and prohibition, not to patients. Barthwell acknowledges that, from her perspective, the great advantage of Sativex is that it can be used as a tool to "slow down the dash to make the crude plant material available to patients."[59] A more-apt analogy than a raging forest fire, then, may be the difference between being allowed to burn your own wood and being required to rely on the oil industry for heat.

While Sativex is useful to policy makers looking for a way to preserve prohibition on homegrown marijuana, prohibition is also critical to the profitability of cannabinoid pharmaceuticals. In its 1999 report on medical marijuana, the national Institute of Medicine (IOM) observed that it is extremely expensive to bring any new drug to market, with estimated costs running between $200 and $300 million.[60] The resulting prescription medications are also extremely expensive. According to news reports, Sativex currently costs about $125 in Canada for a spray bottle providing enough extract for about ten days for the average user, or about $375 monthly.[61] This makes Sativex considerably more expensive than the other commonly prescribed cannabinoid medication, Marinol (the FDA-approved synthetic cannabinoid medication).

In 1999 the IOM reported that, according to patients, "an important advantage of using marijuana for medical purposes is that it is much less expensive than Marinol."[62] Marinol, the IOM report points out, can cost up to two hundred dollars a month for its most commonly used indication (to combat AIDS-related wasting). This means that marijuana used

in comparable doses (approximately one cigarette per day) is cheaper than both Marinol and Sativex, even at inflated street prices.

The IOM observes, however, that "this comparison is deceptive. While the direct costs of marijuana are relatively low, the indirect costs can be prohibitive. Individuals who violate federal or state marijuana laws risk a variety of costs associated with engaging in criminal activity, ranging from increased vulnerability to theft and legal fees to long prison terms."[63] In short, the criminalization of medical marijuana through policies of prohibition is necessary to ensure that cannabinoid pharmaceuticals can compete with the botanical. As Lester Grinspoon of the Harvard Medical School notes, "Even if pharmaceutical companies invest the many millions of dollars it will take to develop useful cannabinoid products, they will not displace natural marijuana for most purposes. And because the primary, and for many the only, advantage of these drugs will be legality, their manufacturers will have an interest in vigorously enforced prohibition that raises the price of the competitive product, street marijuana."[64]

In places where prohibition has been relaxed, and pharmaceuticalized forms of cannabis are in direct competition with homegrown and even black-market marijuana, sales of the pharmaceutical products tend to suffer. In Canada, for example, where Sativex is available at pharmacies, and marijuana itself is legally available to patients directly through the federal health department (Health Canada), many patients are finding the prescription forms of the drug prohibitively expensive. In 2006 the Canadian media reported that, for at least one patient, Tom McMullen, the monthly cost of the marijuana he was authorized to use would consume more than 80 percent of his Canadian pension if purchased directly from Health Canada.[65] One reason for the high cost was that the Canadian government "charges patients 15 times more for certified medical marijuana than it pays to buy the weed in bulk from its official supplier."[66]

Similarly, in the Netherlands, where botanical marijuana has been available on prescription since 2003, the Bureau of Medicinal Cannabis, which supplies the marijuana to pharmacies, has been losing money.[67] Only about a third of the anticipated number of patients actually choose to purchase their marijuana through the pharmacy system; as a Dutch Health Ministry official explains, "Dutch prescription marijuana costs twice as much as similar products available at coffee shops [quasi-legal establishments that sell marijuana for recreational use] around the country

and people who wish to obtain pot for medical reasons are simply buying it at coffee shops."[68]

In general, pharmaceutical drugs cannot compete in terms of price with legal herbs and inexpensive vitamins. Their competitive edge relies on assumptions of greater efficacy and safety. But, even there, they can't always compete. This point was illustrated in 2007 with reports heralding the rediscovery of the effectiveness of niacin—an ordinary B vitamin—as a heart medication. Niacin appears to be as effective but safer than several prescription alternatives; nonetheless, it has not been developed commercially for that purpose. The reason, according to Dr. B. Greg Brown, professor of medicine at the University of Washington, is, "If you're a drug company, I guess you can't make money on a vitamin."[69]

In the United States, patients like Suzanne Pfeil are convinced that the ongoing federal assault on individual and collective cultivation of medical marijuana is as much about protecting corporate profits as it is about concerns with any dangers cannabis itself might pose:

> Sativex is basically tincture; it is a whole plant extract which I can make in my own kitchen. If the FDA approves it, I can get a prescription and go buy Sativex. But am I still going to be able to make it for myself? I already don't take as many pharmaceuticals as I should because I can't afford all of them. For me, it comes down to this: I should have the choice to use safe, effective, herbal medicine to treat myself. I would challenge the Justices of the Supreme Court to spend one day in my body, spend one hour in my body during my worst pain flair, and then tell me I don't have the right to use this medicine. Right after the Raich decision came down, someone in the White House was quoted as saying, "this ends medical marijuana as a political issue." Hello, honey, this doesn't end it. The debate is not going to go away. We are going to continue. We don't have a choice.

Moving Forward

Interview with Mark Tracy, Santa Cruz Sheriff

I think polls show that, nationwide, there is sympathy around the medical marijuana issue. But that's different than legalization. As I understand it, there is not a clear majority to legalize marijuana. Like a lot of people will tell you, it's not your mother's marijuana anymore. The strength is much stronger; people my age perceive it as something they did in college. Not that big a thing. But it's a more powerful drug than it used to be. Do people go crazy, commit murders? No, probably not. But are there intoxicated people driving cars? Are there intoxicated people doing other potentially dangerous things? Yeah, that can happen.

I guess I make the comparison to alcohol. First there was prohibition and then the government relinquished that prohibition. But alcohol abuse is now one of the highest problems we have in terms of drunk driving. It's linked to assaults and to domestic violence. So I guess that when people say, "If we just legalize this or that, everything would be fine," I tend to go, "Yeah, you know, that's a little too simplistic." I don't think there is some sort of magic pill around all this. That's naive.

As regards to medical marijuana, we have a state law and, as local sheriffs, we are an extension of the state. We enforce state law. I think most sheriffs in California have looked at [California medical marijuana law] Proposition 215 and accepted that it's state law. We've tried to find a balance and it's been very difficult at times to do.

I'm part of a committee that meets at the state level trying to get cleanup legislation around medical marijuana because a lot of pieces of Proposition 215 were confusing or not clear. On the committee there are people from public safety, from the medical marijuana community, and from the California Medical Association. The California Medical Association were the ones who blew the whole deal. They had some fear of the

DEA but it also had something to do with whether they really believed in it or just didn't want to play. A local example of this is our own county health director who is a person who just doesn't believe in this [the medical use of marijuana] at all.

I will periodically meet with Valerie Corral and members from WAMM. We have the chief of police come to the meetings and representatives from the DA's office. But the health services department has always been like, "We might come, whatever." And right now, Valerie is frustrated because she is trying to get them to do some sort of registry so a patient can have a card that identifies them so that, if they are stopped by a public safety officer, it would be a quicker way of saying, "Yes, I am a patient; there is a doctor's recommendation on file." The health services people don't want to do that. They don't want to be involved. So, sadly enough, it's the law enforcement agencies getting kicked around. I've been before the County Board of Supervisors many times where I've had people calling my officers Nazis and whatnot. But the fact is, we do make a differentiation with medical marijuana.

The sheriffs in California and the California Sheriffs' Association are really upset about all this. We would like to see some clear idea from the medical community about how all this should work. If it's medical marijuana, then the medical community should step up and do the work. I realize that there are all sorts of problems; I realize that there are restrictions on research. I know all that stuff exists. But I suspect there's more going on than that. The medical community has restrictions in other areas where there are strong political beliefs, like stem cell research. But does the medical community back off there? No. Because there are potentially huge, huge profits and benefits perhaps. I don't know.

With medical marijuana, one issue is can a patient who is dying of cancer grow marijuana? Probably not. So where are they going to get it? I think the dilemma is always the money end of it. Most of the drug industry is based on profit, on money. But medical marijuana folks can't be perceived as profiteering.

What WAMM is doing is a good thing. But I wonder if it's really even about the marijuana. I mean, it's almost like a hospice for people who are in the last stages of life. Having support and being part of something and perhaps having a substance that gives them some sense of health—it's fulfilling a need. People want that kind of support and, to Valerie's credit, that probably happens within her organization. But I think the effect is as much psychological as anything; it's not the marijuana so much.

From a patient's side, you've got to ask: Is the marijuana sometimes elevated way beyond what it can accomplish? Is it really just a pain suppressor or does it have some health effect in terms of digestion and these other things that it is said to be able to do? These are reasonable questions; don't raise it to the level of a miracle. It's almost like it has a halo around it; give me a break. It's not a miracle. It's not. You have to bring it back to reality and that's hard sometimes.

The whole process has gone down the wrong path. Rather than a referendum about one plant, it would have been better if the federal government had stepped in early on and said, "OK, look. We're really going to work on this; we're going to do more [scientific] trials" and not have been afraid of the potential for more controlled, medical outcomes involving prescriptive use and whatnot. But instead, now we seem to have ourselves in this situation—and I hope you don't get mad at me for saying this—where Valerie and her husband Michael have been elevated almost to some sort of sainthood, where they walk alone with the flag of justice. Sometimes it's a little much. I think you need to take some of the "hurrah" out of it and come back and look at it from a practical sense. It should come back around to some sensible prescriptive medicine that physicians are well aware of, cognizant of uses, pro and con. That's my belief. It's going to be a long time before it gets there though.

In the meantime, it's a difficult situation for all of us. The best example is what happened with the WAMM outfit and the DEA coming in and doing a raid on their garden. The DEA, who we have a decent relationship with, didn't even let us know they were coming in. It's common knowledge by now that we had no warning. In fact, when we heard that they were there, for the first hour we weren't sure if the Corral's were getting ripped off or whether it really was law enforcement. I think they did it that way knowing our conflict with state and federal law.

After the raid, we actually went up and negotiated the DEA's release. The advocates [WAMM patients] had locked the gate on them. With the help of Valerie, we were able to free the DEA. But other than that, we weren't involved. Now the San Jose [a neighboring city] police department did have some officers on this multistate, federal and local law enforcement task force. So they had some officers at the raid. Afterward, Chief Lansdowne, who is chief of police of San Jose, pulled those officers from the task force. I suspect that he generally has a good relationship with the DEA but the point was that he was upset. The DEA, knowing the conflict between federal and state law on this issue, might have said, "You know,

we'll just take our federal officers on this raid. You guys don't go." Probably Lansdowne's feeling was, "Why are we having local officers involved when there's a state law in conflict?" Lansdowne called us and apologized for not having notification. He didn't even know that his guys were going in there. I also talked to the [California State] Attorney General Lockyer a little bit about this too. He was kind of on the warpath about the DEA. He demanded a meeting with them and they sent him a kind of curt letter back. It wasn't very polite.

But in defense of both of them, there are two very clear positions: the federal and the state. And both have legal backing. Afterward, I spoke with the special agent in charge at the DEA. I think you always want to keep conversations professional. We will continue to work with them in other areas. This is an area we both recognize we are not going to be working on together.

I'd like some cleanup on this issue. I would like to have more medical trials and more aggressive research, with the medical community taking the lead. And I think, until that's done, we'll see more press articles and more lawsuits and I'm going to have more interviews with people like you. I'd like to see it all move forward.

Notes

NOTES TO THE INTRODUCTION

1. Wendy Chapkis. 1997. *Live Sex Acts: Women Performing Erotic Labor.* New York: Routledge.

2. Interview with Charles Grob by Sheerly Avni. 2002. "Ecstasy Begets Empathy," *Salon*, September 12.

3. Available at http://www.ca9.uscourts.gov/coa/newopinions.nsf/F847B86BCD2AB49488256DFE007B89AE/$file/0315481.pdf?openelement.

4. Adrienne Rich. 1986. "Notes Toward a Politics of Location." In *Blood, Bread, and Poetry.* New York: Norton: 210–231.

5. During the course of this research, I conducted fifty-seven in-depth, open-ended interviews. Four were with public officials and policy makers (an elected official, two senior public health administrators, and the senior attorney for a national organization working on drug policy reform), two were with law enforcement officials (a sheriff and a state assistant attorney general), two were with physicians, and forty-nine were with WAMM members. Of the forty-nine WAMM members, seven were caregivers and forty-two were patients.

Of the forty-two WAMM patients interviewed, 79 percent were white and 21 percent of color; 59 percent were men and 41 percent women. Patient's medical conditions varied widely; the largest group, 60 percent of the total, reported living with life-threatening illnesses (seventeen individuals were living with AIDS, and eight individuals with cancer); the next largest categories were serious neurological disorders such as MS and epilepsy (14 percent) and "severe chronic pain" (13 percent). The remaining patients reported using cannabis for post-polio syndrome (5 percent), glaucoma (5 percent) and psychological disorders (2 percent). Ages of interview subjects ranged from 29 to 94. The majority (52 percent) of those interviewed were between ages forty-five and fifty-four. Of the rest, 7 percent were under age thirty-five; 10 percent were thirty-five to forty-four; 10 percent were fifty-five to sixty-four; 7 percent were sixty-five to seventy-four; and 7 percent were over the age of seventy-five; 7 percent declined to state.

Finding precise demographic information about the overall WAMM membership against which to compare these percentages was something of a challenge. According to one internal WAMM needs assessment conducted in 2001,

30 percent of WAMM members were of color and 70 percent white; 35 percent female and 65 percent male. Eighty-three percent of the membership was living with life-threatening illness (59 percent with HIV/AIDS and 24 percent with cancer). Members' ages (given only as a range) were from four to ninety-six (the four-year-old was the only child receiving cannabis medication, in edible form, under close physician and parental supervision). Based on a visual estimate of members attending weekly meetings in 2001, the average age of WAMM members appeared to be over forty.

Each tape-recorded interview lasted between forty-five and ninety minutes. Interviews with public officials, policy makers, and law enforcement officials were conducted in their offices. One interview with a physician took place at home, the other in an office. Among WAMM members, most interviews were conducted in their homes or mine; a few took place at the WAMM office or following the weekly WAMM membership meeting. One interview took place in a nursing home.

Interviews with public officials, policy makers, law enforcement officials, and physicians were largely unstructured and focused on their particular points of entry into the issue of medical marijuana. In interviews with patients, I used a list of specific questions as a jumping off point but followed the patient's lead into areas most relevant to their experience with the medicinal use of cannabis and with WAMM as an organization. These questions included the following:

1. Briefly describe yourself in terms of your age, ethnicity, gender, and medical condition.
2. Describe how you first came to use marijuana as a medicine.
3. Describe the effects you find cannabis to have on the condition or symptoms for which it was advised.
4. Describe any "side effects" you find to be associated with your use of marijuana (these may be physical or psychological).
5. Do you experience the "consciousness altering" properties often associated with recreational use of the drug (the so-called high) and, if so, do you find that it interferes with, enhances, or leaves unaffected your ability to manage your illness/condition or to function effectively in other areas of your life?
6. Describe how and when you came into contact with WAMM.
7. How would you describe your involvement in WAMM? What, if any, contributions do you make to the organization?
8. Would you describe your relationship to WAMM as primarily one of a medical marijuana provider organization or does WAMM play any other role in your life? If WAMM does play a broader role, could you describe it briefly?
9. How open and public are you as a medical marijuana patient (to family, friends, colleagues, or the broader community)?
10. How has the legal status of marijuana at the state level affected, if at all, your willingness to use marijuana medicinally?

11. Have recent renewed efforts by the federal government to close medical marijuana organizations in California had any affect on your willingness to use marijuana medicinally and/or your involvement in WAMM? If so, please describe.

6. Most interview subjects came forward as volunteers from the general WAMM membership; these initial interviews were supplemented with key-person interviews (including interviews with the cofounders of the organization, several members of the board of directors, and representatives of local law enforcement and elected officials). Targeted interviewing within WAMM was also employed to ensure that the interview sample reflected the diversity within the membership (including differences of race, class, gender, sexual orientation, and physical condition).

7. Quoted in Winona LaDuke. 2006. *Recovering the Sacred.* Boston: South End Press: 79, note 25.

8. Rick Doblin. 2004. Amicus Curiae brief in U.S. Supreme Court case of Ashcroft v. Raich: 8.

NOTES TO CHAPTER 1

1. While the majority of lower-status and lower-paid health care providers are women, only about one in five physicians is female (Carol Weisman. 1998. *Women's Health Care.* Baltimore: Johns Hopkins University Press: 36).

2. According to Duncan Reekie and Michael Weber, double-blind is useful but not infallible: "Control groups of patients are placed on existing drugs or placebos while a further group is given the new drug. 'Double-blind' implies that neither the doctor nor the patient knows which group is a control at any one time. This minimizes any subjective assessment of results or influencing of results by the clinician's or patient's attitudes. Unfortunately, because human beings vary from time to time and place to place, a laboratory situation with all variables totally isolated is impossible. This is one of the reasons why drugs acclaimed as a success after a clinical trial frequently fail to measure up to initial hopes when administered to a larger population over a longer period of time" (Duncan W. Reekie and Michael Weber. 1979. *Profits, Politics, and Drugs.* New York: Holmes and Meier: 12).

3. Larry Sloman. 1998. *Reefer Madness.* New York: St. Martin's Griffin: 39.

4. Mark Souder. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness Project: http://www.mapinc.org/drugnews/v04.n553.a05.html.

5. *The O'Reilly Factor.* 2004. Transcript of "Are We Getting Close to Legalizing Pot?" Fox News. July 7.

6. Ibid.

7. Raphael Mechoulam. 1988. "Direct Testimony of Raphael Mechoulam, Ph.D." In *Marijuana, Medicine, and the Law,* edited by Robert C. Randall, 319–330. Washington, DC: Galen Press: 324–325.

8. Steven Epstein. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge.* Berkeley: University of California Press.

9. Barbara Ehrenreich and Deirdre English. 1978. *For Her Own Good.* New York: Anchor Books: 38. Ehrenreich and English's influential book has inspired several decades of feminist scholarship. Scholars who have deepened and complicated the original analysis of the early physician/patient relationship include: Rima Apple (1990. *Women, Health and Medicine in America.* New Brunswick, NJ: Rutgers University Press), Judith Houck (2006. *Hot and Bothered.* Cambridge, MA: Harvard University Press), Judith Walzer Leavitt (1984. *Women and Health in America.* Madison: University of Wisconsin Press), Regina Markell Morantz-Sanchez (1985. *Sympathy and Science.* New York: Oxford University Press), Susan Reverby (1987. *Ordered to Care.* New York: Cambridge University Press), Carroll Smith-Rosenberg (1985. *Disorderly Conduct.* New York: Knopf), and Carol Weisman (1998. *Women's Health Care.* Baltimore: Johns Hopkins University Press). For a more recent analysis of the relationship between botanical healing and charges of witchcraft, see Diane Purkiss (1996. *The Witch in History.* New York: Routledge).

10. Ehrenreich and English 1978, 40.

11. Smith-Rosenberg 1985, 228.

12. Ehrenreich and English 1978, 41.

13. Ibid., 45.

14. Ibid., 47.

15. Smith-Rosenberg 1985, 231.

16. Paul Starr. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

17. Weisman 1998.

18. Ibid., 41–42.

19. Ibid., 46.

20. Starr 1982, 96.

21. Alice Mead. 2004. "International Control of Cannabis." In *The Medicinal Uses of Cannabis and Cannabinoids,* edited by Geoffrey Guy, Brian Whittle, and Philip Robson, 369–426. London: Pharmaceutical Press of the Royal Pharmaceutical Society of Great Britain: 369–370.

22. Rick Doblin, 2001. "Regulation of the Medical Use of Psychedelics and Marijuana." Unpublished Dissertation. Kennedy School of Government, Harvard University: 15.

23. Starr 1982, 107.

24. "Allopathic medicine" refers to the treatment of disease by licensed MDs.

It is distinguished from such alternative approaches such as osteopathy (the practitioners of which can also be licensed physicians but hold the title DO) and homeopathy.

25. Starr 1982, 110.

26. Ibid.

27. Ibid., 127.

28. Tuberculosis, for example, was the leading cause of death in 1900, but, while death rates from TB dropped dramatically over the next fifty years (by a full 87 percent), medical intervention had little to do with it, according to Harvard Medical School professor John Abramson (2004. *Overdosed America: The Broken Promise of American Medicine.* New York: Harper Perennial: 49). Abramson notes that the decline in death "was entirely due to improvements in social and physical environment, such as healthier living and working conditions, better nutrition, more education, and greater prosperity. The first effective *medical* therapies for tuberculosis, the antibiotics isoniazid and streptomycin, were not even introduced until 1950, well after death rates for tuberculosis had plummeted" (49).

29. Smith-Rosenberg 1985, 232.

30. Weisman 1998, 57. By 1900 licensed physicians had secured a monopoly over women's reproductive health with legislation in place throughout the United States restricting contraception and criminalizing abortion; because of the "therapeutic exemption" to save the life of a woman, abortion became a medically controlled procedure exclusively "under the jurisdiction of regular physicians" (Weisman, 57). The dangers of co-optation of activist movements by organized medicine is illustrated by the fact that, by the end of the 1930s, a physician-dominated organization, the Clinical Research Bureau, merged with the American Birth Control League (founded by activist Margaret Sanger) to form Planned Parenthood of America. This apparent collaboration represented the triumph of the medical profession over control of contraception; as Jean Sharpe observes, "The new board was, not surprisingly, controlled by male physicians" (Jean Sharpe. 1977. "The Birth Controllers." In *Seizing Our Bodies,* edited by Claudia Dreifus, 57–72. New York: Vintage: 65).

31. Starr 1982, 127. Paul Starr points out that the so-called patent medicines in general were not in fact patented, because a patent required disclosure of the ingredients and the formulas, which were most often secret. Instead these medicines were "proprietary" with trademarks protected under copyright law (128).

32. See, for example, James Harvey. 1961. *Toadstool Millionaires: A Social History of Patent Medicines in America Before Federal Regulation.* Princeton, NJ: Princeton University Press.

33. From 1905 to 1910, the AMA distributed more than 150,000 copies of a popular *Collier's Weekly* story exposing the dangers of patent medicines and medical quacks, "The Great American Fraud."

34. Merrill Singer, in his 2006 book on illicit drug use and community health,

Something Dangerous: Emergent and Changing Illicit Drug Use and Community Health (Long Grove, IL: Waveland Press), observes that the term "drug" first became problematic in the early twentieth century: "In the original edition of the Oxford English Dictionary (published in 1897), the noun 'drug' was defined as a 'simple medicinal substance' without any reference to narcotics" (41). Within two decades, however, druggists felt the need to launch a campaign to "convince newspapers not to use the term 'drugs' to refer to non-medicinal substances used without prescription" (40). The failure of that campaign led to the decision by those professionals to rename themselves "pharmacists."

35. Mead 2004, 372.

36. Peter Conrad and Joseph Schneider. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University Press: 116.

37. David F. Musto. 2002. "Introduction: Opiates, Cocaine, Cannabis, and Other Drugs." In *Drugs in America: A Documentary History*, edited by David F. Musto, 183–193. New York: New York University Press.

38. Desmond Manderson. 1999. "Symbolism and Racism in Drug History and Policy," *Drug and Alcohol Review*, June, vol. 18, no. 2: 182.

39. Concerns about alcohol focused on its recreational use, but it was also a commonly available medicinal product, present in many patent medicines. By 1915 whisky and brandy were officially removed from the U.S. Pharmacopeia, but, even during the years of Prohibition (1920 to 1933), a medical exemption was available and whisky was available by physician's prescription. Jane Lang McGrew. 1972. "The History of Alcohol Prohibition," National Commission on Marihuana and Drug Abuse (Commissioned by President Richard M. Nixon, March 1972), available from the Schaffer Library of Drug Policy at http://www.druglibrary.org/schaffer/library/studies/nc/ncmenu.htm.

40. Lang McGrew 1972.

41. Singer 2006, 56.

42. Doblin 2001, 13.

43. David Musto. 1987. "The History of Legislative Control over Opium, Cocaine, and Their Derivatives." In *Dealing with Drugs: Consequences of Government Control*, edited by R. Hamowy, 17–71. Lexington, MA: Lexington Books.

44. Manderson 1999, 182.

45. Singer 2006, 50.

46. David Musto. 1987. *The American Disease*. New York: Oxford University Press: 6.

47. Singer 2006, 51.

48. David F. Musto. 2002. "Cocaine Defined as a Social Menace." In *Drugs in America: A Documentary History*, 360. New York: New York University Press: 360.

49. Starr 1982, 133.

50. Musto 2002, "Introduction," 187. Later, in Linder v. United States (1925), the Supreme Court refined its position, appearing to leave the door open for

physicians to provide small amounts of drugs to patients for self-administration in order to relieve conditions incident to addiction; the medical profession, however, "remained intimidated and subsequently refrained from treating addicts with opiates" (Doblin 2001, 14).

51. Sloman 1998, 75.

52. Singer 2006, 58.

53. Roger C. Smith. 1970. "U.S. Marijuana Legislation and the Creation of a Social Problem." In *The New Social Drug: Cultural, Medicinal, and Legal Perspectives on Marijuana*, edited by David E. Smith, 105–117. Englewood Cliffs, NJ: Prentice Hall: 112.

54. Sloman 1998, 39.

55. David T. Courtwright. 2001. *Forces of Habit: Drugs and the Making of the Modern World*. Cambridge, MA: Harvard University Press: 43.

56. Musto 2002, "Introduction," 189. It is also interesting to note that on the international stage, the effort to link the dangers of cannabis with racial minorities was also well underway. In 1925 a U.S.-led effort to set treaty restrictions on cannabis cultivation and production was supported by the South African government; the treaty restrictions argued that the drug should be included in the list of narcotics covered by international drug conventions because of the threat that it "would turn its Black population into an unruly mob" (Alice Mead. 2004. "International Control of Cannabis: Changing Attitudes." In *The Medicinal Uses of Cannabis and Cannabinoids*, edited by Geoffrey Guy, Brian Whittle, and Philip Robson, 369–426. London: Pharmaceutical Press of the Royal Pharmaceutical Society of Great Britain: 404.)

57. Quoted in Annalee Newitz. 2005. "Good Drugs," *AlterNet*, November 23, available at http://www.alternet.org/story/28681/.

58. Harry J. Anslinger and Courtney R. Cooper. 2002. "Marijuana: Assassin of Youth." In *Drugs in America: A Documentary History*, edited by David F. Musto, 443–440. New York: New York University Press; see also Patrick Andersen. 1981. *High in America*. New York: Penguin Books.

59. This quote from the June 29, 1938, issue of *The Christian Century* can be found at DRCnet. 2006. "This Week in History," *Drug War Chronicle*, June 23, Issue 441, available at http://stopthedrugwar.org/chronicle/441/thisweek2.shtml.

60. Sloman 1998, 76.

61. Ibid., 76.

62. Doblin 2001, 16.

63. Ibid.

64. Ibid.

65. Sloman 1998, 161.

66. Ibid., 162.

67. Ibid., 163–164.

68. Ibid., 164.

69. Editorial. 1945. "Marijuana Problems," *Journal of the American Medical Association,* April 28, vol. 127, no. 17: 1129.

70. Anslinger served as head of the Federal Bureau of Narcotics from 1930 to 1962 (the agency became the federal Drug Enforcement Administration in 1973).

71. Doblin 2001, 19. Doblin notes, however, that government-funded *military* research into the possible uses of marijuana and psychedelics as interrogation agents was conducted in the 1940s (19). See also Martin A. Lee and Bruce Shlain. 1985. *Acid Dreams.* New York: Grove Press.

72. Sloman 1998, 159.

73. On the phenomena of moral panics in America, see David Wagner. 1997. *The New Temperance: The American Obsession with Sin and Vice.* Boulder, CO: Westview.

74. David Musto and Pamela Kornsmeyer. 2002. *The Quest for Drug Control.* New Haven, CT: Yale University Press: 2.

75. Mead 2004, 398.

76. Doblin 2001, 44.

77. Currently the National Institute on Drug Abuse is the only federally authorized source of marijuana for research purposes. Dr. Lyle Craker, director of the Medicinal Plant Program at the University of Massachusetts-Amherst, contends that "many researchers believe that NIDA's monopoly is an obstacle to getting needed studies done on a timely basis" (Associated Press. 2004. "Scientists Say Marijuana Research Blocked," available at http://www.cannabisnews.com/news/thread19210.shtml.

In other countries, the state has contracted with third parties to grow marijuana for approved research. In the United Kingdom, for example, a private company, GW Pharmaceuticals, received approval in 1997 to grow marijuana for medical research. Canada and the Netherlands have similar agreements with non-governmental agencies.

78. Quoted in Doblin 2001, 46.

79. Ibid., 26.

80. Ibid., 38; see also Lester Grinspoon and James Bakalar. 1993. *Marijuana: The Forbidden Medicine.* New Haven, CT: Yale University Press: 192.

81. MAPS, the Multidisciplinary Association for Psychedelic Studies, is a membership-based, nonprofit (501c3) research and educational organization. The mission of MAPS, according to their Web site, "is to sponsor scientific research designed to develop psychedelics and marijuana into FDA-approved prescription medicines, and to educate the public honestly about the risks and benefits of these drugs." See http://www.maps.org.

82. Doblin 2001, 41.

83. Ibid.

84. Rep. Barney Frank (D-MA) has argued that "alcohol does much more damage in many areas of society than drugs, particularly marijuana, but we treat

marijuana as much worse, and that's because it's associated with the counterculture" (Joel Stein. 2002. "The New Politics of Pot," *Time*, November 4: 61).

85. Courtwright 2001, 43

86. Ibid., 105.

87. Ibid., 44. According to Merrill Singer (2006, 80), "Gallup survey findings on college students who had ever tried marijuana showed a rapid rise during this era: 1967 (5 percent); 1969 (22 percent); 1970 (42 percent) and 1971 (51 percent)."

88. Quoted in Doblin 2001, 46.

89. National Commission on Marihuana and Drug Abuse. 1972. *Marihuana: A Signal of Misunderstanding.* Washington, DC: U.S. Government Printing Office: 128–149.

90. Over-the-counter (i.e., nonprescription) drugs are not technically "controlled" substances. Drugs in schedules 2 through 5 are generally available only by prescription. Schedule 1 drugs are not available, even by prescription, except as provided for under the Investigational New Drug Program.

91. Doblin 2001, 50.

92. Robert C. Randall. 1988. "Case History." In *Marijuana, Medicine, and the Law,* edited by Robert C. Randall, v–viii. Washington, DC: Galen Press: v.

93. Doblin 2001, 60–61.

94. U.S. v. Randall. 1976. District of Columbia Superior Court, 104 Wash. Daily L. Rep. 2249.

95. Paul Schultz. 2003. "The Necessity Defense Revisited: An Examination Through the Case of Regina v. Dudley and Stephens and President Bush's Order to Shoot Down Hijacked Aircraft in the Wake of September 11, 2001," *Rutgers Journal of Law and Religion*, vol. 3, available at http://org.law.rutgers.edu/publications/law-religion/vol3.shtml.

96. Traditionally, the doctrine of compelling need has been applied to questions concerning the propriety of taking or destroying the property of others in order to save human lives, or to the question of whether it would be legitimate to kill an innocent person in order to save the lives of a greater number of people (George Christie. 1999. "The Defense of Necessity Considered from the Legal and Moral Points of View," *Duke Law Journal*, vol. 48, no. 5: 975–1042). As specifically applied to the question of medical marijuana, the courts held that a necessity defense must satisfy the following conditions:

1. The patient suffers from a serious medical condition.
2. The patient needs cannabis for treatment of his/her condition, or to alleviate the condition or symptoms associated with it.
3. The patient will suffer imminent harm if s/he does not have access to cannabis.
4. The patient has no reasonable legal alternative to cannabis, having tried all other legal alternatives and found them to be ineffective or accompanied by side effects that s/he cannot reasonably tolerate (C. Thomas. 2001. Opinion

of the Court. U.S. v. Oakland Cannabis Buyers Cooperative, 532 U.S. Pg. 4, note 2).

97. Randall 1988, "Case History," vi.

98. Francis L. Young. 1989. "Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge." In *Marijuana, Medicine, and the Law, Volume II,* edited by Robert C. Randall, 403–446. Washington, DC: Galen Press: 444.

99. Ethan Russo. 2001. *Cannabis Therapeutics in HIV/AIDS.* Binghamton, NY: Haworth Press: 25–26.

100. Conant v. Walters. 2002. U.S. Court of Appeals, 9th Circuit Court, 309 F.3d 629: 8

101. Conant v. Walters 2002, 10.

102. Ibid., 26.

103. "Just Say No" is just the tip of this iceberg. To admit having an interest in marijuana, never mind to admit having used it, continues to produce negative social and professional consequences.

104. Shereen Khatapoush and Denise Hallfors. 2004. "Sending the Wrong Message: Did Medical Marijuana Legalization in California Change Attitudes About and Use of Marijuana?" *Journal of Drug Issues,* vol. 34, no. 4: 751–770.

105. Khatapoush and Hallfors 2004, 765.

106. Ibid., 763.

NOTES TO CHAPTER 2

1. Scientific interest in the effects of cannabis on epileptic seizure was also discussed in the Nixon administration's 1972 National Commission on Marihuana and Drug Abuse in their report, "Marihuana, A Signal of Misunderstanding." Available at http://www.druglibrary.org/Schaffer/Library/studies/nc/nc1a.htm. In their report, they note that research on this subject had been conducted as early at 1949: "In 1949, Davis and Ramsey reported a study of the effect of THC on epileptic children. 'The demonstration of anticonvulsant activity of the tetrahydrocannabinol (THC) congeners by laboratory tests prompted clinical trial in five institutionalized epileptic children.' Of these five children, all had severe symptomatic grand mal epilepsy with mental retardation; three also had cerebral palsy; and three had focal seizure activity. The EEG tracings were reported to be grossly abnormal in all five children. The results after treatment with homologues of THC, were reported as follows: Three children-responded at least as well as to previous therapy. Fourth child-almost completely seizure free. Fifth child-entirely seizure free. As a result of their study, David and Ramsey felt that 'the cannabinols herein reported deserve further trial in non-institutionalized epileptics.' Dr. Vansim of Edgewood Arsenal has written in a recently published book 'Psychotomimetic Drugs,' that the synthetic preparations of cannabis are of interest. . . . One con-

cerns the use of a cannabis analogue which Dr. Walter S. Loewe reported very effective in preventing grand mal seizures if given in small doses." *National Commission on Marihuana and Drug Abuse. 1972. Marihuana: A Signal of Misunderstanding* (*Appendix, Vol. I*). Washington, DC: U.S. Government Printing Office, 7–8.

2. CAMP—the Campaign Against Marijuana Planting.

3. The Santa Cruz ballot measure of 1992 was one of the first medical marijuana initiatives in California, following San Francisco, which passed a similar measure the previous year.

4. Steve Perez. 1993. "Woman Puts Marijuana Initiative to Test," *Santa Cruz Sentinel*, January 14: A1, A2. See chapter 1, page 30 of this book for discussion of medical necessity defenses.

5. Ibid.

6. Ibid.

7. Steve Perez. 1993. "Woman Says She Will Continue to Use Pot for Epileptic Seizures," *Santa Cruz Sentinel*, March 27: A1.

8. Ibid.

9. Steve Perez. 1993. "Epileptic Poses Legal Dilemma," *Santa Cruz Sentinel*: B1, B2. For an interview with Santa Cruz Sheriff Al Noren further explaining his views on the prosecution of vice crime, especially prostitution, see Wendy Chapkis. 1997. *Live Sex Acts: Women Performing Erotic Labor.* New York: Routledge: 147–150.

10. Proposition 215 is an amendment to the California Health and Safety Code (section 11362). The Corrals helped to include provisions in the law that cover cultivation by patients and caregivers.

11. From the WAMM Web site, available at http://www.wamm.org.

12. Voluntary cash donations are accepted but are in no way required of members.

13. Because the landlords would not allow marijuana provision to take place on the premises, the organization continued to hold weekly membership distribution meetings in another downtown location.

14. Loss of 501c3 (nonprofit) status meant that supporters could no longer deduct donations from their taxes.

15. One consequence of operating on such a limited budget was that, for many years, the organization made use of an affordable, brand name, nationwide tax preparation service rather than a private accountant. Their returns had them paying income taxes not only on their very limited real income (from T-shirt sales) but also on donations received by the organization. It was not until 2006 that WAMM learned from a more-qualified tax advisor that donations do not represent income; unfortunately they were then able to recover only two years of overpayment.

16. Mind-set and social setting are understood in drug policy scholarship to be critically important in understanding patterns of licit and illicit drug provision, as well as in shaping the experience of drug use; see, for example, Norman Zinberg. 1984. *Drug, Set, and Setting.* New Haven, CT: Yale University Press. In

the preface to that work, Zinberg discusses physicians' reluctance to prescribe opiates for pain relief and patients' response to those drugs, both of which are, he concludes, the product of a particular mind-set and social setting: "We found ample reason for the medical apprehension about opiates. A whole set of traditional cultural and social attitudes toward opiate use had apparently been internalized by our physicians and was governing their thoughts and actions, engendering fears that were undermining their capacity to relieve suffering. In addition, the doctors' attitudes were not only determining their willingness or unwillingness to prescribe opiates but were also influencing the effect these drugs had on their patients. This was my first exposure to the power of what in this book is called the 'social setting' to modify behavior and dictate responses in drug users" (vii–viii).

17. Sandra Morgen. 2002. *Into Our Own Hands.* New Brunswick, NJ: Rutgers University Press: 35.

18. *Santa Cruz Sentinel.* 2005. "Santa Cruz County: A Century," available at http://www.santa-cruz.com/extra/century/index.html. In 1932 the city's chief of police and its public safety commissioner were convicted of accepting bribes from smugglers.

19. Ibid.

20. Ibid.

21. Geoffrey Dunn. 2005. "Dazed but Not Confused." In *Good Times, Thirty Years Collector Edition,* edited by Greg Archer, 11–13. Santa Cruz, CA: Good Times: 13.

22. See the documentary *Miss . . . or Myth?* 1986. Directed by Geoffrey Dunn, Mark Schwartz, and Claire Rubach.

23. In the late 1990s, the Santa Cruz region was identified as among the most expensive housing markets in the nation; the median cost for a single family home topped $350,000 (*Santa Cruz Sentinel* 2005, "Santa Cruz County: A Century").

24. Sheriff A. Noren. 1993. Problem Statement in Cannabis Suppression and Prosecution Program grant application, Office of Criminal Justice Planning: 2.

25. A similar argument has been made about the importance of the political and cultural histories of other northern California communities in which the medical marijuana movement has flourished. In San Francisco and Oakland, California, for example, buyers' clubs have taken root as the key means of medical marijuana provision. In a discussion of the two cities, one writer argues, "It is probably safe to say that it takes a certain kind of community to make such a venture [a Buyers' Club] possible. The San Francisco Bay area, with its twin legacies of counter-cultural ferment and left-leaning dissent, is a natural cauldron for innovative activism. The East Bay, with intellectual Berkeley and tough-eyed Oakland, brings its own special essence to Bay area cannabis culture. . . . While the Oakland approach has been radical, it has been radical with a difference. 'In San Francisco, you had sort of a Wild West free-for-all approach with Dennis Peron, but in Oakland we ended up with Jeff Jones,' [one activist said], referring to the

suit-and-tie, by-the-book, work-with-authorities efforts of Jones and his pioneering Oakland Cannabis Buyers' Co-op. 'This whole idea that we have the support of local political leadership and they recognize us as an important part of their political base is in some ways an outgrowth of that approach, and it has created a situation where we can actually propose ideas and see them implemented at a level far beyond what we could hope for in most other parts of the country.'" Drug Reform Coordination Network. 2006. *Drug War Chronicle*, February 24, issue 424, available at http://www.stopthedrugwar.org/chronicle/424/eastbay.shtml.

26. "Spillover" refers to the ways in which social movements may influence one another both directly (through sharing resources) and indirectly (through transforming social conditions). In his discussion of the rise of AIDS activism in the 1980s, for example, Steven Epstein points out that AIDS activists benefited from the lesbian and gay liberation movements of the 1970s and 1980s and, thus, came "equipped with a whole set of resources crucial for engagement in the struggle over social goods and social meanings" (Steven Epstein. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press, 11). For further discussion of the concept of "social movement spillover" see David Meyer and Nancy Whittier. 1994. "Social Movement Spillover," *Social Problems*, vol. 41, May: 277–298; and Carol Weisman. 1998. *Women's Health Care*. Baltimore: Johns Hopkins University Press: 29.

27. The Santa Cruz Women's Health Collective survives to the present day, though, significantly, it has been renamed a health "center" rather than "collective." It still offers affordable, high-quality, patient-centered care.

28. The birth center received national attention when, in 1974, despite an extremely good record of safety, three lay midwives were charged with practicing medicine without a license (Morgen 2002, 130). The three were acquitted of the charges on the grounds that pregnancy is not a disease and, therefore, that assisting in childbirth could not be construed as practicing medicine without a license; the case was appealed to the California Supreme Court, which ruled that midwives were, in fact, covered by the state's Medical Practices Act (Morgen 2002, 130; and Sheryl B. Ruzek. 1978. *The Women's Health Movement*. New York: Praeger: 60).

29. Morgen 2002.

30. See http://www.scwomenshealth.org/who.html.

31. See http://www.womencaresantacruz.org/about.html.

32. According to Sandra Morgen, "Self-help is first and foremost a reference to women taking decisions about their bodies and health into their own hands, and often quite literally. The concept was first used to talk about cervical self-examination." (Morgen 2002, 53).

33. The "harm reduction" movement in the United States developed in the mid-1980s in response to a growing HIV epidemic among IV drug users. As Alan Greig and Sara Kershnar report, "Faced with official denial and hostility, and

recognizing the explosion of an HIV epidemic in poor urban communities related to shared injection equipment, activists took their clean syringes and sharps containers onto the streets, as direct-action public health and civil disobedience" (Alan Greig and Sara Kershnar. 2002. "Harm Reduction in the USA." In *Act Up to the WTO: Urban Protest and Community Building in the Era of Globalization,* edited by Benjamin Shepard and Ronald Hayduk, 361–369. New York: Verso: 362). Greig and Kershnar observe that the harm reduction movement "explicitly rejected the 'abstinence' orthodoxy of the time—that drug users could only be helped by getting off drugs. They described their work as 'harm reduction'—in other words, working to reduce the harms related to drug use (in this case HIV/AIDS) without necessarily reducing the consumption of drugs" (363).

34. In particular, two local queer activists, Gabriel Demaine and Merrie Schaller, were critically important to the production of WAMM's highest-profile public protests: a city-sanctioned medical marijuana distribution event from the steps of City Hall following the 2002 DEA raid on the organization, an event that received national and international media coverage (organized by Gabriel Demaine); and a 2005 march through the streets of Santa Cruz attended by hundreds of local residents carrying marijuana plants and photos of dead WAMM members to protest the lifting of the organization's protective injunction following the U.S. Supreme Court ruling in the Raich case (organized by Merrie Schaller).

35. Chris Williamson, whose lyrics, "filling up and spilling over like an endless waterfall," became something of an anthem within 1970s lesbian feminist culture.

36. Combahee River Collective. 1983. "A Black Feminist Statement." In *This Bridge Called My Back: Writings by Radical Women of Color,* edited by Cherríe Moraga and Gloria Anzaldúa, 210–218. New York: Kitchen Table/Women of Color Press. The document confronted and named "the manifold and simultaneous oppressions that all women of color face." See also Chela Sandoval's discussions of "intersectionality" in "U.S. Third World Feminism: The Theory and Practice of Oppositional Consciousness." 1991. *Genders,* vol. 10: 1–23.

In Nomy Lamm's "It's a Big Fat Revolution," she notes that our embodiment as complex subjects defies neat demarcations: "When I think about all the marks I have against me in this society, I am amazed that I haven't turned into some worthless lump of shit. Fatkikecripplecuntqueer. In a nutshell. But then I have to take into account the fact that I'm an articulate, white, middle-class college kid, and that provides me with a hell of a lot of privilege and opportunity for dealing with my oppression that may not be available to other oppressed people. And since my personality/being isn't divided up into a privileged part and an oppressed part, I have to deal with the ways that these things interact, counterbalance and sometimes even overshadow each other. For example, I was born with one leg. I guess it's a big deal, but it's never worked into my body image in the same way that being fat has. And what does it mean to be a white woman as opposed to a woman of color? A middle-class fat girl as opposed to a poor fat girl?

What does it mean to be fat, physically disabled and bisexual? (Or fat, disabled, and *sexual at all*?)" (Nomy Lamm. 1995. "It's a Big Fat Revolution," available at http://www.tehomet.net/nomy.html). Lamm's contribution to women's liberation, antiracist work, disability rights, and fat activism, for instance, is precisely her insistence that these are all interconnected.

37. Epstein 1996, 346.

38. Within health-related activism, campaigns most deeply rooted in the lived experience of patients have been described as "embodied health movements" (Phil Brown, Stephen Zavestoski, Sabrina McCormick, Brian Mayer, Rachel Morello-Frosch, and Rebecca Gasior Altman. 2004. "Embodied Health Movements: New Approaches to Social Movements in Health," *Sociology of Health and Illness*, vol. 26, no. 1: 50–80).

39. See Steven Epstein (1996) for an analysis of the role of AIDS patients as knowledge producers in the context of the early AIDS epidemic.

40. Epstein points out that by the mid-twentieth century, doctors were understood to be applied scientists, making disinterested use of objective data provided by studies employing the new gold standard of randomized clinical trials. But this belief served to "obscure political decisions about how to measure the risks and benefits of a drug, cloaking them in the aura and mystery of objective science . . . clinical trial results in practice can be subject to enormous amounts of interpretive flexibility" (1996, 33).

41. For example, when activists believed that the formal studies had been to quick to dismiss the potential of a compound derived from Chinese cucumber that killed HIV in a test tube, "Compound Q" (tricosanthin), they initiated a grassroots study of their own: "Believing that the official study of Compound Q was too small and that it was using inadequate dosages, Project Inform initiated its own study with the cooperation of a number of doctors and laboratories and forty-two participants in three cities" (Epstein 1996, 257). The study used no placebo controls and allowed participants to simultaneously take their other medications: "Rather than accept that such procedures contaminated his study, Delaney argued that the 'real-world conditions' of his study were precisely its virtues and the warrants of its validity" (257).

42. In fact, medical marijuana activists have been outspoken in demanding that the federal government lift barriers to formal, scientific research on medical marijuana. But, under federal law, the federal government has a monopoly on the supply of marijuana available for research, all of which must come from the National Institute on Drug Abuse farm in Mississippi. This is unique to marijuana among all Schedule 1 drugs; all other Schedule 1 drugs can be obtained from a number of DEA-licensed laboratories. NIDA has repeatedly refused to provide marijuana for FDA-approved research. See chapter 3, "The Greening of Modern Medicine," for a more-detailed discussion of federal obstruction of scientific research on cannabis.

43. Susan Cozzens and Edward Woodhouse. 1995. "Science, Government, and the Politics of Knowledge." In *Handbook of Science and Technology Studies*, edited by Sheila Jasanoff, Gerald E. Markle, James C. Peterson, and Trevor J. Pinch, 533–553. Thousand Oaks, CA: Sage Press: 547.

44. Epstein 1996, 13.

45. Valerie Leveroni Corral. 2001. "Differential Effects of Medical Marijuana Based on Strain and Route of Administration: A Three-year Observational Study," *Journal of Cannabis Therapeutics*, vol. 1, no. 3/4: 43–59.

46. Joan Jerzak. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness Project: http://www.mapinc.org/drugnews/v04.n553.a05.html.

47. Patients asking their doctors about a treatment they have heard about is not unique to "alternative modalities" like medical marijuana. Pharmaceutical companies invest heavily in direct-to-consumer advertising to instruct patients to "ask your doctor whether this drug is right for you."

48. Brendan McKenna. 2006. "Physician Advocates for Medical Marijuana," *Rutland Herald* (VT), February 26.

49. Ibid.

50. According to the medical marijuana advocacy group Patients Out of Time (see http://www.medicalcannabis.com/Grouplist.htm), the following organizations are among those which have gone on record supporting access to therapeutic cannabis: The American Academy of Family Physicians; the American Public Health Association; the state medical associations of California, Florida, New York, and New Mexico; the American Nurses Association and the state nurses associations of Alaska, California, Colorado, Connecticut, Hawaii, Illinois, Mississippi, New Jersey, New Mexico, New York, North Carolina, Texas, Virginia, and Wisconsin; the national AIDS Action Council; the Crescent Alliance Self Help for Sickle Cell; the Lymphoma Foundation of America; and the Multiple Sclerosis California Action Network.

51. Personal communication from Cumberland County, Maine, Sheriff Mark Dion.

NOTES TO CHAPTER 3

1. Stephen Breyer. 2004. Oral Arguments in U.S. Supreme Court case Ashcroft v. Raich. November 29: 50.

2. Rick Doblin. 2004. Amicus Curiae brief in U.S. Supreme Court case of Ashcroft v. Raich: 4. Doblin is the founder and director of the Multidisciplinary Association for Psychedelic Studies (MAPS), a nonprofit research and educational organization and pharmaceutical company working to develop cannabis and

other Schedule 1 drugs into FDA-approved prescription medicines. See http://www.maps.org.

3. Doblin 2004, 4.

4. Donna Alvarado. 1996. "Medicinal-pot Measure Stokes Fires of Opinion," *San Jose Mercury News*, October 1: 16A.

5. Geoffrey Cowley. 1997. "Can Marijuana Be Medicine," *Newsweek*, February 3: 27.

6. DEA. 2006. "'Medical' Marijuana—The Facts," available at http://www/dea.gov/ongoing/marinol.html.

7. Alice Mead. 2004. "International Control of Cannabis: Changing Attitudes." In *The Medicinal Uses of Cannabis and Cannabinoids*, edited by Geoffrey Guy, Brian Whittle, and Philip Robson, 369–426. London: Pharmaceutical Press: 382.

8. Ibid.

9. Doblin 2001, 8. The eight original IND patients who received marijuana from the federal government, including Robert Randall, continued to receive their individual supply.

10. Mead 2004, 382.

11. Ibid.

12. In quick succession, eleven other states and the District of Columbia passed medical marijuana laws: Alaska, Arizona, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, and Washington.

13. Doblin 2001, 9.

14. Ibid.

15. Sabin Russell. 2000. "Study Finds Pot Safe for AIDS Patients," *San Francisco Chronicle*, July 14: A1, A15.

16. Usha Lee McFarling and Howard Mintz. 1999. "U.S. Study Sees Limited Medicinal-marijuana Role," *San Jose Mercury News*, March 18: 15A.

17. McFarling and Mintz 1999, 15A. John Cloud, in a *Time* magazine article, "Is Pot Good for You?" also discusses the Abrams study. He reports slightly different numbers: 6.6 pounds gained by marijuana smokers and 2.4 pounds by the group taking the placebo. Cloud. 2002. "Is Pot Good for You?" *Time*, November 4: 64.

18. Doblin 2001, 10.

19. Ibid.

20. Ibid., 11.

21. Ibid., 12.

22. Ibid.

23. Ibid. Craker's application to cultivate cannabis was denied by the DEA in December 2004. Hearings before a DEA administrative law judge on the issue were held the following year. In February 2007 the administrative law judge, Mary Ellen Bittner ruled, in Craker's favor; her opinion noted that "there is currently an inadequate supply of marijuana available for research purposes . . .

[and] competition in the provision of marijuana for such purposes is inadequate" (DRCnet. 2007. "Medical Marijuana: DEA Judge Says Let Professor Grow Marijuana for Research Purposes," *Drug War Chronicle*, February 16, Issue 473). The ruling, however, is advisory only; the DEA may elect to ignore the judge's finding. This would be consistent with DEA past practice; in 1988 DEA Administrative Law Judge Francis Young found that marijuana should be rescheduled as a prescription medicine, but the agency ignored his decision.

24. Donald McNeil. 2004. "College Fails in Bid to Grow Marijuana," *New York Times*, December 14. Researchers with FDA-approved studies, however, were still being turned down. In 1999 Dr. Ethan Russo received FDA approval for a study on marijuana in the treatment of migraines; in December of that year, however, NIDA informed him that he would not be able to secure marijuana from NIDA for the study, thus effectively blocking his research (http://www.maps.org/mmj/mjrusso.html).

25. The Institute of Medicine is located within the National Academy of the Sciences and was chartered in 1863 to advise federal agencies on medical issues.

26. Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. Washington, DC: National Academy of Press: 2.

27. Ibid., 3.

28. Ibid., 4.

29. Ibid., 5.

30. Ibid., 6.

31. Ibid.

32. Ibid., 11.

33. Ibid., 19.

34. Ibid., 4.

35. Mark Souder. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness: http://www.mapinc.org/drugnews/v04.n553.a05.html.

36. Nora Volkow. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness: http://www.mapinc.org/drugnews/v04.n553.a05.html [emphasis mine].

37. Robert Meyer. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness: http://www.mapinc.org/drugnews/v04.n553.a05.html.

38. Souder 2004.

39. Meyer 2004.

40. Souder 2004.

41. Volkow 2004.

42. Interview on *The O'Reilly Factor*. 2004. "Are We Getting Close to Legalizing Pot?" Fox News, July 7.

43. Volkow 2004.

44. 1996. "Better than Well," *The Economist*, April 6: 87–88.

45. Susan Sontag. 1990. *Illness as Metaphor and AIDS and Its Metaphors*. New York: Doubleday: 145.

46. Sontag 1990, 64

47. Dan Shapiro. 2000. *Mom's Marijuana: Life, Love, and Beating the Odds*. New York: Vintage.

48. Josh Gulick, and David Golan, MD. 2005. "The Science of Drugs," *Newsweek*, special edition: The Future of Medicine, Summer, vol. 145, no. 26A: 44. The *Newsweek* estimates are likely on the low side. A 1998 study published in the *Journal of the American Medical Association* reached the same figures by calculating only adverse effects from drugs prescribed in hospital settings, not deaths or severe side effects from drugs prescribed outside of hospitals (see Jason Lazarou, Bruce Pomeranz, and Paul Corey. 1998. "Incidence of Adverse Drug Reactions in Hospitalized Patients: A Meta Analysis of Prospective Studies," *Journal of American Medical Association*, April 15, vol. 279, no. 15: 1200–1205). For a comparison, it is also interesting to note that the Drug Enforcement Administration estimates that deaths from all illicit drug use were only about sixteen thousand in 2000 (see "Speaking Out Against Drug Legalization," http://www.dea.gov/demand/speakout/speaking_out-may03.pdf).

49. Lester Grinspoon. 1988. "Affidavit of Lester Grinspoon, MD." In *Marijuana, Medicine, and the Law*, edited by R. C. Randall, 419–427. Washington, DC: Galen Press: 426.

50. Norman R. Farnsworth. 1988. "Direct Testimony of Norman R. Farnsworth, Ph.D." In *Marijuana, Medicine, and the Law*, edited by Robert C. Randall, 309–311. Washington, DC: Galen Press: 310.

51. Ilya Raskin, David M. Ribnicky, Slavko Komarnytsky, Nebosja Ilic, Alexander Poulev, Nikolai Borisjuk, Anita Brinker, Diego A. Moreno, Christophe Ripoll, Mir Yakoby, Joseph M. O'Neal, Teresa Cornwell, Ira Pastor, and Bertold Fridlender. 2002. "Plants and Human Health in the 21st Century," *Trends in Biotechnology*, December, vol. 20 no. 12: 522–531, 524.

52. Francis L. Young. 1989. "Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge." In *Marijuana, Medicine, and the Law, Vol. II*, edited by Robert C. Randall, 403–446. Washington, DC: Galen Press: 440.

53. See chapter 5, "Cannabis and Consciousness," for a discussion of whether the "high" is an undesirable side effect or a necessary component in the therapeutic value of the drug.

54. Institute of Medicine 1999, 4.

55. Ibid., 2.

56. Andrew T. Weil. 1988. "Affidavit of Andrew Thomas Weil, MD." In *Marijuana, Medicine, and the Law*, edited by R. C. Randall, 429–441. Washington, DC: Galen Press: 439.

57. Norman E. Zinberg. 1988. "Affidavit of Norman E. Zinberg, MD." In *Marijuana, Medicine, and the Law*, edited by R. C. Randall, 415–418. Washington, DC: Galen Press: 416.

58. Ethan Russo. 2004. "History of Cannabis as a Medicine." In *The Medicinal Uses of Cannabis and Cannabinoids*, edited by Geoffrey Guy, Brian Whittle, and Philip Robson, 1–14. London: Pharmaceutical Press of the Royal Pharmaceutical Society of Great Britain: 10.

59. Ibid.

60. Volkow 2004.

61. Ibid.

62. Ibid.

63. Gina Kolata. 2006. "Studies Challenge Traditional Breast Cancer Treatments," *New York Times*, April 12.

64. Ibid.

65. Raskin et al. 2002, 525.

66. Ibid., 529.

67. Patricia Tam. 2001. "Complementary and Alternative Medicines." In *Brand Medicine*, edited by Tom Blackett and Rebecca Robins, 274–295. New York: Palgrave: 283.

68. Chris Meletis and Jason Barker. 2004. "Synergy in Nutrients," *Alternative and Complementary Therapies*, December, vol. 10, no. 6: 329.

69. Deborah Franklin. 2005. "Vitamin E Fails to Deliver on Early Promise," *New York Times*, August 2.

70. Raskin et al. 2002, 524.

71. Ibid., 527.

72. Tam 2001, 283.

73. Souder 2004.

74. Public Agenda. 2005, available at http://www.publicagenda.org/issues/red_flags.cfm?issue_type=illegal_drugs. Public Agenda observes, however, that Americans are divided over whether possession of small quantities should be treated as a criminal offense.

75. Jan Hoffman. 2005. "Doctors' Delicate Balance in Keeping Hope Alive," *New York Times*, December 24.

76. Ibid.

77. Susanne Grabley, Ralf Thiericke, and Axel Zeeck. 1999. *Drug Discovery from Nature*. Berlin: Springer Verlag: 1.

78. John Abramson. 2004. *Overdosed America: The Broken Promise of American Medicine*. New York: HarperCollins: 50.

79. Abramson 2004, 50.

80. Associated Press. 2007. "Cancer Deaths Drop for Second Straight Year," *New York Times*, January 17. In this story, the Associated Press reports that cancer deaths declined from 556,902 to 553,888 from 2003 to 2004.

81. Rob Stein. 2007. "Cancer Deaths Continue Decline," *Washington Post*, in *Portland Press Herald*, January 18: A1.

82. Gardiner Harris,. 2005. "New Drug Points Up Problems in Developing Cancer Cures," *New York Times*, December 21.

83. Ibid.

84. By 2005 leading cancer researchers were beginning to predict that, rather than a cure for cancer, hopes now rest on the prospect of turning cancer into a chronic disease, the treatment for which would involve taking drugs throughout a patient's lifetime. As the *New York Times* quotes Dr. Todd Golub, director of the Cancer Program at the Broad Institute of Harvard and MIT: "Seeing cancer become more like what has happened with AIDS would not be shocking. Does that mean cure? Not necessarily" (Gina Kolata. 2005. "Slowly, Cancer Genes Tender Their Secrets," *New York Times*, December 27). Much like HIV/AIDS treatments, the drugs that would be required to manage the disease are likely to have serious side effects.

85. Ibid.

86. New Service Dispatches. 2005. "Per Person Health Care Costs Highest in the U.S. Study Says," *Portland Press Herald*, July 14: A4.

87. Geoffrey Cowley. 2005. "New Treatments," *Newsweek*, special edition: The Future of Medicine, Summer, vol. 145, no. 26A: 10.

88. Cowley 2005, 10.

89. Dan Frosch. 2004. "Drug Store Cowboys," *AlterNet*, November 16, available at http://www.alternet.org/story/20512.

90. Frosch 2004.

91. Ibid.

92. Randolph Schmid. 2004. "Forty Percent in U.S. Use Prescription Drugs," *Santa Cruz Sentinel*.

93. Marcia Angell. 2004. *The Truth About Drug Companies*. New York: Random House: 3.

94. Angell 2004, 11.

95. Fran Hawthorne. 2003. *The Merck Druggernaut*. Hoboken, NJ: Wiley: 5–6.

96. Harris Poll. 2004. "Reputation of Pharmaceutical and Health Insurance Companies Continue Their Downward Slide," *Health Care News*, June 22, vol. 4, no. 11, available at http://www.harrisinteractive.com/news/newsletters_healthcare.asp.

97. Ibid.

98. Available at http://www.naturalcures.com. The book remained a best-seller for months, despite well-publicized suggestions that the author was, at best, an unreliable resource. According to the New York State Consumer Protection

Board, in 2004 Trudeau agreed to pay $2 million and to stop marketing coral calcium as a cure for cancer in order to settle a lawsuit brought by the U.S. Federal Trade Commission (FTC). The FTC sued Trudeau largely on the grounds that he could not substantiate his advertising claim that coral calcium can cure and prevent cancer. This is only one of at least ten products that Trudeau sold or promoted before the government leveled fraud charges. In addition, Trudeau pleaded guilty in 1990 to larceny in a Cambridge, Massachusetts, state court after being charged with depositing $80,000 in worthless checks. The following year, he also pleaded guilty to credit card fraud in federal court in Boston, resulting in a prison term of nearly two years. The federal charge involved the use of credit card numbers from customers of a memory-improvement course Trudeau was promoting at that time (Details available at http://www.ftc.gov/opa/2003/06/trudeau.shtm and http://www.salon.com/story/books/feature/2005/07/29/trudeau/index.html; see also Melanie Warner. 2005. "After Jail and More, Salesman Scores Big with Cure-all Book," *New York Times*, August 28: 1).

99. Hawthorne 2003, 51–52.

100. Merrill Goozner. 2004. *The $800 Million Pill.* Berkeley: University of California Press: 214.

101. Goozner 2004, 216.

102. Angell 2004, 3–4.

103. Patricia M. Barnes, Eve Powell-Griner, Kim McFann, and Richard L. Nahin. 2004. "Complementary and Alternative Medicine Use Among Adults: United States, 2002." Advance Data from Vital and Health Statistics, no. 343, May 27. Hyattsville, MD: National Center for Health Statistics: 1, available at http://www.cdc.gov/nchs/pressroom/04news/adultsmedicine.htm.

104. Ibid., 1.

105. Barnes et al. 2004, 2.

106. Tam 2001, 277.

107. Barnes et al., 5.

108. Interview with William Notcutt on Mother Jones Radio. October 30, 2005. Aired on 870 AM, Air America. Portland, ME.

NOTES TO CHAPTER 4

This chapter is based on work that originally appeared in the following article: Wendy Chapkis. 2005. "Patients, 'Potheads,' and Dying to Get High" in *Production of Reality,* 4th ed, edited by Jodi O'Brien, ed., 484–491. Thousand Oaks, CA: Pine Forge/Sage Press.

1. Joel Stein. 2002. "The New Politics of Pot," *Time*, November 4.

2. Stein 2002.

3. For a discussion of this attempt to divide innocent from guilty victims in the area of migratory prostitution, see Wendy Chapkis. 2004. "Soft Glove, Punishing

Fist: The Trafficking Victims Protection Act of 2000." In *Regulating Sex: Sexual Freedom and the Politics of Intimacy*, edited by Elizabeth Bernstein and Laurie Schaffner, 51–66. New York: Routledge.

4. The appeal of self-help community among the chronically ill has been usefully explored by sociologist Kristin Barker. Barker observes, "The appeal is being able to face one's illness in the company of those who understand one's experience because they share that experience. In this way, illness becomes a bond of affiliation" (Kristin Barker. 2002. "Self-help Literature and the Making of an Illness Identity: The Case of Fibromyalgia Syndrome," *Social Problems*, vol. 49, no. 3: 294; see also Kathy Charmaz. 1991. *Good Days, Bad Days: The Self in Chronic Illness and Time.* New Brunswick, NJ: Rutgers University Press).

5. Dennis faithfully stood guard at the door of WAMM meetings for many years until, in 2006, his health made that impossible. He died in 2007.

6. Even after WAMM managed to secure office space in Santa Cruz, weekly membership meetings continued to take place at the ethnic heritage center, which was both larger and more willing to assume any risks associated with medical marijuana provision on its premises.

7. Some research on organizational leadership has compared metaphors of male and female leadership, suggesting that men tend to see leadership as reaching down from above to their followers below, while women more often see it as a matter of reaching out from the center of a web of connection. See, for example, Susan B. Shimanoff and Mercilee M. Jenkins. 2003. "Leadership and Gender: Challenging Assumptions and Recognizing Resources." In *Small Group Communication: Theory and Practice,* edited by Randy Hirokawa, Robert S. Cathcart, Larry A. Samovar, and Linda D. Henman, 184–198. Los Angeles: Roxbury Press.

8. The notion of the servant leader has been developed by Robert Greenleaf, who refers to the emergence of a "new moral principle" under which leaders are chosen "because they are proven and trusted as servants" (Robert Greenleaf. 1977. *Servant Leadership*. New York: Paulist Press: 10). His conceptualization of leadership is essentially transformational; people, he notes, are "capable of great dedication and heroism if wisely led" (21). The essential condition is trust, which, Greenleaf argues, is the product of empathy for and acceptance of followers by the leader, expressed in the form of service in their interests. Valerie Corral, of course, would never describe WAMM members as her "followers."

9. WAMM's 501c3 status was revoked by the federal government in 1998.

10. Free riding refers to the tendency for some individuals to withhold effort in collective enterprises in the belief that they can obtain the benefits of group membership while letting others do all or most of the work. See Roland Kidwell and Nathan Bennett. 1993. "Employee Propensity to Withhold Effort: A Conceptual Model to Intersect Three Avenues of Research," *Academy of Management Review*, vol. 18: 429–456; Robert Albanese and David van Fleer. 1985. "Rational Behavior in Groups: The Free-riding Tendency," *Academy of Management Review*,

vol. 10: 244–255; Mancur Olson. 1965. *The Logic of Collective Action: Public Goods and the Theory of Groups*. Cambridge, MA: Harvard University Press.

11. In a fairly typical period in 2002 and 2003, for example, twenty-five WAMM members died over a twenty-month period.

12. Christina Puchalski, MD. 1999. "What Fills the Final Hours of Life," *Portland Press Herald* (reprinted from the *Los Angeles Times*), August 27: 15A.

13. Marilyn Webb. 1999. *The Good Death*. New York: Bantam Books: 345.

14. Ibid.

NOTES TO CHAPTER 5

This chapter is based on work that original appeared in the following article: Wendy Chapkis. 2007. "Cannabis, Consciousness, and Healing," *Contemporary Justice Review*, December, vol. 10, no. 4: 443–460.

1. *The O'Reilly Factor*. 2004. Transcript of "Are We Getting Close to Legalizing Pot?" Fox News, July 7.

2. The 1970 Controlled Substances Act established five schedules of controlled substances. Schedule 1 is reserved for drugs with the greatest potential for abuse and which have no recognized medical use. Schedule 1 drugs are strictly prohibited (http://www.dea.gov/pubs/csa/812.htm).

3. Expenditures increased from about $3 million to approximately $26 million by decade's end. Lynn Zimmer and John Morgan. 1997. *Marijuana Myths, Marijuana Facts*. New York: Lindesmith Center: 13.

4. Ibid. Certainly smoking represents a serious health threat, especially when the substance ingested is tobacco. The surgeon general's office reports that tobacco use is responsible for more than 430,000 deaths each year. Public Health Service. 2000. "Treating Tobacco Use and Dependence," available at http://www.surgeongeneral.gov/tobacco/systems.htm. The evidence of the harms of marijuana smoking is less well established. While researchers have found an increased risk of some chronic pulmonary conditions (such as bronchitis) among heavy marijuana smokers, there does not appear to be an increased risk of lung cancer. See Marc Kaufman. 2006. "Researchers Surprised to Find No Link Between Marijuana, Lung Cancer," *Washington Post*, May 26. Furthermore, smoking is not the only available means to deliver cannabinoids into the body. Grassroots medical marijuana organizations like WAMM have developed a range of alternatives, including tinctures, baked goods, capsules, and liniments. See chapter 6, "Mother's Milk and the Muffin Man."

5. Zimmer and Morgan 1997, 12. Some recent studies, however, suggest that, for the small minority of the population—approximately 1 percent—prone to schizophrenia, high levels of cannabis may trigger mental health problems. See Drug Reform Coordination Network. 2007. *Drug War Chronicle,* Issue 478, March 23, available at http://stopthedrugwar.org/478/reefer_madness_strikes_british_newspaper.

6. Holcomb Noble. 2000. "Report Links Heart Attacks to Marijuana," *New York Times*, March 3.

7. See A. Caspi, T. Moffitt, M. Cannon, J. McClay, R. Murray, H. Harrington, A. Taylor, L. Arseneault, B. Williams, and A. Braithwaite. 2005. "Moderation of the Effect of Adolescent-Onset Cannabis Use on Adult Psychosis by a Functional Polymorphism in the Catechol-O-Methyltransferase Gene," *Biological Psychiatry,* vol. 57, no. 10: 1117–1127; see also Cécile Henquet, Robin Murray, Don Linszen, and Jim Van Os. 2005. "The Environment and Schizophrenia: The Role of Cannabis Use," *Schizophrenia Bulletin,* vol. 31, no. 3: 608–612.

8. Recent research suggests that there may be specific therapeutic uses for cannabis and cannabinoid medications in the treatment of some mental illnesses, including bipolar disorder, depression, and posttraumatic stress disorder. In 2004, for example, the Israeli army began an experiment in providing cannabis to soldiers suffering from posttraumatic stress disorder. See Phillip Dawdy. 2004. "Mental Marijuana," *AlterNet,* August 29, available at http://www.alternet.org/story/19687/; see also Alan Mozes. 2005. "Marijuana Compound Spurs Brain Cell Growth," *Forbes* October 13, in which the author discusses research on a synthetic cannabinoid compound that appears to reduce depression and anxiety.

9. Judge Francis Young. 1988. U.S. Department of Justice (Drug Enforcement Administration), Marijuana Rescheduling Petition: Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge, September 6, Section VIII, Part 16.

10. Dr. Mike Alcalay, a California physician, observes that both morphine and alcohol have a therapeutic index of ten—that is, ten times the standard dose would be lethal. Acetaminophen (Tylenol) and ibuprofen (Advil) are at around twenty-five or thirty; penicillin is about one hundred. But a lethal dose of marijuana would be approximately forty thousand times the amount used to get high. Joe Eskenazi. 2005. "Jews Lead the Charge for Medical Marijuana," *Jewish News Weekly,* November 12. For additional discussion of this issue, see Jacob Sullum. 2003. *Saying Yes.* New York: Tarcher/Putnam: 125.

11. See http://www.dea.gov/pubs/csa/812.htm on the definition of Schedule 1 drugs.

12. See Solvay Pharmaceuticals' Web site for a discussion of the rescheduling of Marinol (dronabinol), available at http://www.marinol.com/ppt/cancer.pdf.

13. WHO Expert Committee on Drug Dependence. 2003. 33rd Report. WHO Technical Report Series 915. Geneva, Switzerland: 10, available at http://whqlibdoc.who.int/trs/WHO_TRS_915.pdf.

14. Ibid.

15. Ibid.

16. GW Pharmaceuticals Web site: http://www.gwpharm.com/faqs.asp#faqs2_10.

17. William Notcutt. 2004. "Cannabis in the Treatment of Chronic Pain." In

The Medicinal Uses of Cannabis and Cannabinoids, edited by Geoffrey Guy, Brian Whittle, and Philip Robson, 271–300. London: Pharmaceutical Press of the Royal Pharmaceutical Society of Great Britain: 293.

18. Ibid.

19. Raphael Mechoulam. 1988. "Direct Testimony of Raphael Mechoulam, Ph.D." In *Marijuana, Medicine, and the Law,* edited by Robert C. Randall, 319–330. Washington, DC: Galen Press: 329.

20. Howard Becker. 1974. "Consciousness, Power, and Drug Effects," *Journal of Psychedelic Drugs,* vol. 6, no. 1: 69.

21. Lisa Krieger. 2004. "How the Brain Produces a 'High,'" *San Jose Mercury News,* September 16: 5B.

22. Norman E. Zinberg. 1979. "Cannabis and Health," *Journal of Psychedelic Drugs,* vol. 11: 137

23. Rick Weiss. 2006. "Marijuana Aids Therapy," *Washington Post,* September 13.

24. Ibid.

25. Ibid.

26. *Los Angeles Times* News Service. 2006. "Chemotherapy a Threat to Brain, Studies Finds," *Portland Press Herald,* December 2: A10.

27. In fact, in some circumstances "negative side effects" may in themselves be therapeutic. The lead researcher in an Israeli study of the use of THC in the treatment of posttraumatic stress disorder, for example, suggests that forgetfulness might be helpful in treating stress by "suppressing unwanted memories." See Salim Muwakkil. 2004. "Medical Marijuana: The Pain of Prohibition," *Common Dreams,* December 29, available at http://www.commondreams.org/views04/1229-12.htm.

28. Sullum 2003, 108.

29. Sidney Cohen. 1982. "Marijuana: National Impact on Education." Rockville, MD: American Council for Drug Education: 24

30. Sullum 2003, 110.

31. Bob Grooves. 2006. "Marijuana Hearing Pits Talk Show Host, Drug Officials," *New Jersey Hackensack Record,* June 9.

32. Ibid.

33. Norman Zinberg. 1984. *Drug, Set, and Setting.* New Haven, CT: Yale University Press

34. Jane Wagner. 1986. *The Search for Signs of Intelligent Life in the Universe.* New York: Harper and Row.

35. Quoted in Marilyn Webb. 1999. *The Good Death.* New York: Bantam: 317.

NOTES TO CHAPTER 6

This chapter is based on work that originally appeared in following article: Wendy Chapkis and Richard J. Webb. 2005. "Mother's Milk and the Muffin Man:

Grassroots Innovations in Medical Marijuana Delivery Systems," *Journal of Ethnicity and Substance Abuse*, December, vol. 4, no. 3/4: 183–204.

1. Cynthia Kuhn, Scott Swartzwelder, and Wilkie Wilson. 2003. *Buzzed.* New York: Norton: 144.

2. Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base.* Washington, DC: National Academy Press: 6.

3. Ibid., 5.

4. Ibid., 178. Here the IOM tacitly acknowledges that the currently available pharmaceutical drugs, such as Marinol, are less effective than the smoked botanical form, precisely because the capsules do not allow for rapid onset.

5. Mark Souder. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness Project: http://www.mapinc.org/drugnews/v04.n553.a05.html.

6. Robert Meyer. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness Project: http://www.mapinc.org/drugnews/v04.n553.a05.html.

7. Ibid.

8. Ibid.

9. Souder 2004.

10. *The O'Reilly Factor.* 2004. Transcript of "Are We Getting Close to Legalizing Pot?" Fox News, July 7.

11. Joycelyn Elders. 2004. "Myths About Medical Marijuana," *The Providence Journal* (RI), March 26.

12. Robert Dupont. 2004. "Hearings on Medical Marijuana." U.S. House of Representatives, House Committee on Governmental Reform, Sub-Committee on Criminal Justice, Drug Policy, and Human Resources. April 1. Transcript available at Media Awareness Project: http://www.mapinc.org/drugnews/v04.n553.a05.html.

13. Institute of Medicine 1999, 7.

14. In 2005 Dr. Robert Melamede, chair of biology at the University of Colorado in Boulder, published a review of studies on the effects of smoked marijuana in the October issue of *Harm Reduction Journal.* He concluded that "marijuana is less carcinogenic than tobacco smoke and may even have some anti-cancer properties." Steve Mitchell. 2005. "Marijuana Less Cancerous than Tobacco," *United Press International*, October 17. Similarly, in 2006, Dr. Donald Tashkin of UCLA's School of Medicine, reported on additional research that found no link between marijuana smoking and lung cancer. Tashkin acknowledged that "we know that there are as many or more carcinogens and co-carcinogens in marijuana smoke

as in cigarettes. But we did not find any evidence for an increase in cancer risk for even heavy marijuana smokers" (DRC. 2006. "Marijuana: Smoking It Doesn't Cause Lung Cancer, Study Finds," *Stop the Drug War Chronicle,* May 26, available at http://stopthedrugwar.org/chronicle/437/tashkinstudy.shtml.

15. The classic discussion of learning how to be a marijuana user is found in Howard S. Becker. 1953. "Becoming a Marihuana User," *American Journal of Sociology*, November, vol. 59: 235–42. For WAMM members, the need to learn how to use botanical marijuana in its various forms is simplified by the fact that members can rely on the collective knowledge of the group freely shared at weekly membership meetings.

16. This low-tech intervention, intended to address the lack of standardization and consistency in plant materials, is a good example of the ways that the supposed inherent and insurmountable limitations of botanical medicines can be managed at the grassroots level.

17. The same method is used to process the bud trimmings, or "shake." The resulting kif, however, is considerably more potent due the higher THC content found in the buds. It is used to produce higher strength medicinal products for patients suffering from the most severe pain and muscular spasms.

NOTES TO CHAPTER 7

1. Sharon P. Simson and Martha C. Straus, eds. 1998. *Horticulture as Therapy: Principles and Practice*. New York: Haworth.

2. Steven Davis. 1998. "Development of the Profession of Horticultural Therapy." In *Horticulture as Therapy: Principles and Practice*, edited by Sharon P. Simson and Martha C. Straus, 3–20. New York: Haworth.

3. Paula D. Relf. 1998. "People-plant Relationship." In *Horticulture as Therapy: Principles and Practice*, edited by Sharon P. Simson and Martha C. Straus, 21–42. New York: Haworth: 27.

4. See R. Kaplan and S. Kaplan. 1989. *The Experience of Nature*. Cambridge, MA: Cambridge University Press; T. Hartig, M. Mang, and G. Evans. 1991. "Restorative Effects of Natural Environmental Experiences," *Environment and Behavior,* vol. 28: 3–26; Roger S. Ulrich. 1984. "View Through a Window May Influence Recovery from Surgery," *Science*, vol. 224: 420–421; R. S. Ulrich and R. Parsons. 1992. "Influences of Passive Experiences with Plants on Individual Well-being and Health." In *The Role of Horticulture in Human Well-being and Social Development*, edited by Diane Relf, 93–105. Portland, OR: Timber Press; and Roger S. Ulrich, Robert F. Simons, Barbara D. Losito, Evelyn Fiorito, Mark A. Miles, and Michael Zelson. 1991. "Stress Recovery During Exposure to Natural and Urban Environments," *Journal of Environmental Psychology,* vol. 11: 201–230.

5. Relf 1998.

6. Ulrika A. Stigsdotter and Patrick Grahn. 2002. "What Makes a Garden a Healing Garden?" *Journal of Therapeutic Horticulture*, vol. 13: 63.

7. Stigsdotter and Grahn 2002, 67.

8. Ibid., 63. Communication researcher Carole Blair, whose recent work explores the rhetorical effects of public memorials, invites us to "consider sites not just as places where communication happens, but as themselves communicative, and most specifically as rhetorical" (Carole Blair. 2006. "Civil Rights/Civil Sites." Carrol C. Arnold Distinguished Lecture presented at the meeting of the National Communication Association. November 2006).

9. Stigsdotter and Grahn 2002, 61.

10. Ibid.

11. Ibid., 66.

12. Joel Stein. 2002. "The New Politics of Pot," *Time*, November 4: 60.

13. Lynn Zimmer and John P. Morgan. 1997. *Marijuana Myths, Marijuana Facts*. New York: Lindesmith Center: 140.

14. Ibid., 139.

15. Ibid.

NOTES TO CHAPTER 8

1. Brian Seals. 2002. "DEA Agents Raid Medical Marijuana Farm," *Santa Cruz Sentinel*, September 6.

2. Law enforcement officials expressed public dismay at the fact that the DEA raid took place in their jurisdiction but without their knowledge. The Santa Cruz County sheriff's office was given no advance warning, learning about the destruction of the collective's garden and the Corrals' arrest only when summoned by federal authorities in an effort to remove patients blocking their exit from the property. A small number of drug enforcement officers from the neighboring city of San Jose were involved in the federal drug enforcement team that raided the WAMM garden, but they too had no advance knowledge that the action would be directed against a medical marijuana collective. San Jose Police Chief William Lansdowne—into whose jurisdiction the Corrals were carried without his notice or consent—withdrew all departmental support for the DEA joint task force that conducted the raid, refusing to cooperate further in the prosecution of California's medical marijuana users. Ann Harrison. 2003. "Medical Marijuana Patients Sue the Feds," *Counterpunch*, April 28, available at http://www.counterpunch.org/harrison04282003.html.

3. Brian Seals. 2004. "Medicinal Giveaway at City Hall Sends a Message," *Santa Cruz Sentinel*, September 18: A1, A10.

4. Bob Egelko. 2004. "Medical Pot Law Gains Acceptance," *San Francisco Chronicle*, January 30: 1A.

5. Ibid.

6. Ibid.

7. Santa Cruz public officials were not alone in expressing anger and concern over the raid; they were joined by a number of high-profile California political figures, including Governor Gray Davis. State Attorney General William Lockyer, in a letter to John Ashcroft, attorney general for the Bush administration, objected strenuously to the DEA's practice of conducting raids "without apparent regard for the likelihood of successful prosecution . . . Conversations with DEA representatives in California have made it clear that the DEA's strategic policy is to conduct these raids as punitive expeditions whether or not a crime can be successfully prosecuted." Laurel Chesky and Bruce Willey. 2002. "Pot or Politics," *Good Times*, October 10–16: 17.

8. Dr. Arnold Leff, a former deputy director of drug policy in the Nixon administration, is primary care physician for many HIV-positive members of WAMM; he has also served as medical advisor to the board of directors since the organization was founded in 1996.

9. Uehlmann is a nationally prominent attorney who had recently received significant media attention as a member of the O. J. Simpson defense team.

10. Shortly after the passage of Proposition 215, "cannabis buyers' clubs" were organized in numerous cities and counties throughout California. These organizations differ from WAMM's nonprofit cooperative model in that they purchase marijuana from clandestine growers and resell it to patients at prices that meet or exceed street value. In January 1998 the U.S. Justice Department filed civil lawsuits seeking injunctions against six prominent cannabis buyers' clubs. One of the clubs involved, the Oakland Cannabis Buyers' Cooperative (OCBC), defended itself using the doctrine of compelling need, arguing that its members faced immanent harm without safe access to medical marijuana. But U.S. District Court Judge Charles Breyer ruled that the necessity defense "might be available in individual cases in which patients and their suppliers could prove they had no legal alternative, but that it could not be used by a group of patients with varying illnesses some of which might be effectively treated with legal drugs." May Wong. 1998. "U.S. Judge Orders Pot Clubs Closed," *Santa Cruz Sentinel*, May 15: A1, A10.

On appeal, however, in September 1999, Breyer's ruling was overturned in a 2–1 decision by the Ninth Circuit Court of Appeals in San Francisco, which "carved out an exception to federal drug laws by recognizing the notion of 'medical necessity' and allowing distribution of pot to patients facing 'imminent harm' with no effective legal alternative to marijuana." Mercury News Staff and Wire Reports. 2000. "Oakland Club Barred from Dispensing Pot," *San Jose Mercury News*, August 30: 1A, 18A. But the Justice Department appealed the decision to the U.S. Supreme Court, which, in a unanimous 8–0 decision (Justice Stephen G. Breyer, the brother of District Court Judge Charles Breyer, recused himself), concluded

"that medical necessity is not a defense to manufacturing and distributing marijuana." United States v. Oakland Cannabis Buyers' Coop 532 U.S. 10. 2001.

In a separate statement, Justice Stevens—joined by Justice Souter and Justice Ginsburg—concurred with the final decision but argued that "the Court reaches beyond its holding, and beyond the facts of the case, by suggesting that the defense of necessity is unavailable for anyone under the Controlled Substances Act." United States v. Oakland Cannabis Buyers' Coop 532 U.S. 2001; Stevens, J., Concurring in Judgment, 2–3. Stevens argued that the OCBC was an organization involved in distributing a controlled substance, not an individual compelled to violate the law in order to avoid immanent harm. For that reason, he concluded, the OCBC could not legitimately employ the necessity defense. He seemed to suggest, however, that some future individual defendant might well be able to satisfy the specific provisions of a necessity defense (4).

11. An injunction would protect them from further federal intervention and allow the organization to legally grow marijuana.

12. County of Santa Cruz v. Ashcroft, 279 F. Supp. 2d 1192, 1208 (N.D. Cal 2003). In addition to the county and the city, plaintiffs included Valerie Corral, Eladio V. Acosta, James Daniel Baehr, Michael Cheslosky, Jennifer Lee Hentz, Dorothy Gibbs, Harold F. Margolin, and the Wo/Men's Alliance for Medical Marijuana.

13. The district court that originally denied Raich and Monson's motion for a preliminary injunction "found that the federal enforcement interests 'waned' when compared to the harm that California residents would suffer if denied access to medically necessary marijuana," but it doubted the likelihood of success on the merits of their argument against the constitutionality of the Controlled Substances Act. Cited in Gonzales v. Raich 545 U.S. 4 (2005).

14. Raich v. Ashcroft, 17934. The determination of "likelihood of success" is crucial; without it, the courts have no cause to allow the plaintiffs to go forward.

15. The decision followed precedent set in two landmark Supreme Court cases, United States v. Lopez, 514 U.S. 549 (1995) and United States v. Morrison, 529 U.S. 598 (2000), which restricted congressional authority to regulate "non-economic" activity under the Commerce Clause to the U.S. Constitution.

16. Spenser S. Hsu. 1999. "Bush: Marijuana Laws Up to States," *Washington Post,* October 22: B7.

17. Gonzales v. Raich 545 U.S. 13 (2005).

18. Gonzales v Raich 545 U.S. 15 (2005).

19. Gonzales v. Raich 545 U.S. (2005): p. 13 of dissent by Thomas.

20. Gonzales v. Raich 545 U.S. (2005): p. 9 of dissent by O'Connor.

21. Gonzales v. Raich 545 U.S. 23 (2005): p. 2 of dissent by O'Connor.

22. Gonzales v. Raich 545 U.S. 3 (2005).

23. Gonzales v. Raich 545 U.S. 6 (2005).

24. Gonzales v. Raich 545 U.S. 23 (2005).

25. Gonzales v. Raich 545 U.S. 26 (2005).

26. For the past few years, the organization has relied largely on marijuana grown in these dispersed gardens. Sympathetic local growers have also donated some marijuana to the organization. The possibility of asset forfeiture for the Corrals, however, continues to loom large, an anxiety fed by the fact that the current head of the Drug Enforcement Administration, Karen Tandy, had previously served as the chief of litigation in the Justice Department's Office of Asset Forfeiture.

27. Santa Cruz County residents with a physician's recommendation may cultivate a ten-foot-by-ten-foot area of marijuana plants. See Terri Morgan. 2006. "Law Library Weighs in on Medical Marijuana," *Santa Cruz Sentinel*, August 18.

28. Michael Corral has produced a WAMM video, "Cannabis Cultivation Outdoors: A Twelve-step Guide for Growing Medical Marijuana," available via the organization's Web site (http://www.wamm.org) to assist patients.

29. Raha Kudo—the pathway to heaven—is a registered 501c3 non-profit. The WAMM-affiliated hospice project is intended to provide end-of-life services through support, education, and research. See http://www.rahakudo.org.

30. Larry O'Hanlon. 1988. "Final Effort on Medicinal Pot," *Santa Cruz Sentinel*, May 26: A1, A8.

31. Fogel quoted in Paul Krassner. 2007. "The War on Medical Marijuana," *Huffington Post*, June 25, available at http://www.huffingtonpost.com/paul-krassner/the-war-on-medical-mariju_b_52754.html.

32. Stopthedrugwar.org. 2006. "Medical Marijuana in Crisis in San Diego as Feds, Locals Move to Shut Down Remaining Dispensaries," *Drug War Chronicle*, Issue 446, July 28, available at http://stopthedrugwar.org/chronicle/446/san_diego_medical_marijuana_crisis.shtml.

33. From 1996 to 2007, twelve states—Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington—had legalized the medical use of marijuana.

34. The Hinchey-Rohrabacher Amendment text, floor debate, roll-call votes, and regional maps and tables of voting by congressional district are available at http://www.drugscience.org/Archive/bcr1/n1_hinchey_ref.html.

35. In one significant shift, for example, Mark Souder (R-IN) lost the chair position on the House committee overseeing the White House Office of Drug Control Policy, replaced by progressive Democrat Dennis Kucinich (D-OH).

36. ONDCP—the Office of National Drug Control Policy, a component of the Executive Office of the President, was established by the Anti-Drug Abuse Act of 1988. See http://www.whitehousedrugpolicy.gov.

37. Valerie Corral's testimony of July 12, 2007, before the House Judiciary Committee during an oversight hearing on DEA's regulation of medicine can be found at http://www.aclu.org/drugpolicy/medmarijuana/30495leg20070712.html.

38. Personal communication with Richard Webb, July 12, 2007.

39. Eric Bailey. 2007. "DEA Targets Landlords of Pot Outlets," *Los Angeles Times*, July 17: B3.

40. Ibid.

41. Ibid.

42. By 2007 thirty-three of fifty-eight counties in the state had initiated medical marijuana ID card programs allowing for an approximate count of authorized users. See Patrick McCartney and Martin Lee. 2007. "Government Shows No Compassion for Medical Pot Consumption," *AlterNet*, June 16, available at http://www.alternet.org/story/54183.

43. Shanna McCord. 2005. "Pot Shop Lights Up the Town: Medical Users Get Santa Cruz Outlet," *Santa Cruz Sentinel*, September 16; and Shanna McCord. 2007. "Some Santa Cruz Pot Users, Sellers Find Loopholes in State's Medical Marijuana Laws," *Santa Cruz Sentinel*, January 28. The public health department in Santa Cruz reports that approximately 1,500 local residents now carry medical marijuana ID cards issued by the county.

44. Shanna McCord. 2007. "Pot Club Struggles for Financial Survival," *Santa Cruz Sentinel*, May 20.

45. Ibid.

46. See http://www.WAMM.org. Tax-deductible contributions can be made to the WAMM-affiliated hospice project, Raha Kudo, at http://www.rahakudo.org.

47. For more information on Willie Nelson's benefit concert, see NORML's website at http://norml.org/index.cfm?Group_ID=7307.

48. In a *Time*/CNN poll conducted in 2002, 80 percent of Americans indicated that they believe cannabis should be legal to dispense for medical use. Joel Stein. 2002. "The New Politics of Pot," *Time*, October 27.

49. An October 2002 *Time*/CNN poll reports that nearly one out of every two American adults acknowledges they have used marijuana, up from fewer than one in three in 1983. Stop the Drug War. 2006. "This Week in History," *Drug War Chronicle*, Issue 458, October 20.

50. See report on 2006 ICRS meeting at http://www.cannabinoidsociety.org.

51. See conference abstracts at http://www.cannabinoidsociety.org.

52. Ibid. The 2006 ICRS conference did not shy away from controversy; at the end of both the third and the fourth days, special sessions were organized on "Hot and Controversial Issues." Significantly, however, those sessions were devoted not to whether cannabis and cannabinoids should be considered medicinal, but rather to the "Pharmacology of Cannabidiol" and to the question, "Are there CB2 receptors in CNS neurons?"

53. These include Sanofi-Aventis's Acomplia, which is intended to control appetite and improve insulin resistance by targeting the body's cannabinoid system, and Pharmos Corporation's Cannabinor, which is said to stimulate cannabinoid receptors in the immune system and to relieve acute postoperative pain without

the side effects of opiates. Jim Davis. 2005. "The Straight Dope on Cannabis-inspired Meds," *Popular Science*, August: 44.

54. Gary Greenberg. 2005. "Respectable Reefer," *Mother Jones*, November/December.

55. See http://www.gwpharm.com/faqs.asp.

56. Mary Massingale. 2005. "Medical Marijuana Issue Heats Up," *State Journal-Register* (IL), February 9.

57. Pete Guither. 2005. "Andrea Barthwell, Snake Oil Salesman," *Drug War Rant*, available at http://blogs.salon.com/0002762/stories/2005/04/20/andreaBarthwell SnakeOilSal.html.

58. Ibid.

59. Ibid.

60. Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. See chapter 5, "Development of Cannabinoid Drugs."

61. Wendy Koch. 2005. "Spray Alternative to Pot on the Market in Canada." *USA Today*, June 23.

62. Institute of Medicine 1999, chapter 5.

63. Ibid.

64. Lester Grinspooon. 2003. "The Shifting Medical View on Marijuana," *Boston Globe*. August 17.

65. John Gillis. 2006. "Health Canada Cuts Off Sick Man's Pot Supply," *The Chronicle Herald* (Halifax, Nova Scotia). August 27.

66. Dean Beeby. 2007. "Health Canada Markup on Medical Marijuana: 1,500%." *Canadian Press*, April 15.

67. DRC.net. 2005. "Europe: Dutch Medical Marijuana Program Ailing in Face of Widespread Availability for All," *Drug War Chronicle*, Issue 390, June 10, available at http://stopthedrugwar.org/chronicle/390/dutchmedmj.shtml.

68. Ibid.

69. "The Chatter," *New York Times*, January 28, 2007, section 3: 2.

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About the Authors

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For more information about the Wom/Men's Alliance for Medical Marijuana and donations to its work: www.wamm.org or 309 Cedar Street, #34, Santa Cruz, CA 95060.

"How can a substance that is no mystery to half of all adults in the United States prompt such confusion and misrepresentation in the realms of law, medicine, and policy? Chapkis and Webb combine a careful historical analysis of debates over "medical marijuana" with a perceptive and sympathetic portrait of the activists who have sought to alleviate the suffering of people with AIDS and other life-threatening or chronic health conditions. Offering nuance in place of slogans, *Dying to Get High* tells an inspiring story of the tactics and philosophies of a little-understood health movement."

— Steven Epstein, author of *Inclusion: The Politics of Difference in Medical Research*

"A beautifully written account from the front lines of the struggle between a federal drug war complex determined to keep demonizing marijuana and the growing movement of patients and doctors who have found marijuana to be a valuable medicine."

— Craig Reinarman, co-editor of *Crack in America: Demon Drugs and Social Justice*

"Chapkis and Webb's new book provides a human element to the history, pharmacology, psychology, and politics of medical marijuana in a way that no other work has. I loved reading it."

— Mitch Earleywine, author of *Understanding Marijuana: A New Look at the Scientific Evidence*

Marijuana as medicine has been a politically charged topic in this country for more than three decades. Despite overwhelming public support and growing scientific evidence of its therapeutic effects—relief of the nausea caused by chemotherapy for cancer and AIDS, control over seizures or spasticity caused by epilepsy or MS, and relief from chronic and acute pain, to name a few—the drug remains illegal under federal law.

In *Dying to Get High*, noted sociologist Wendy Chapkis and Richard J. Webb investigate one community of seriously-ill patients fighting the federal government for the right to use physician-recommended marijuana. Through compelling interviews with patients, public officials, law enforcement officers, and physicians, Chapkis and Webb ask what distinguishes a legitimate patient from an illegitimate "pothead," "good" drugs from "bad," medicinal effects from "just getting high." *Dying to Get High* combines abstract argument and the messier terrain of how people actually live, suffer, and die, and offers a moving account of what is at stake in ongoing debates over the legalization of medical marijuana.

WENDY CHAPKIS is Professor of Sociology and Women and Gender Studies at the University of Southern Maine in Portland, ME. She is the author of the award-winning book *Live Sex Acts: Women Performing Erotic Labor* and *Beauty Secrets: Women and the Politics of Appearance.*

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About the cover: Tincture bottles. Patient-produced WAMM cannabis tinctures, photo © Chuck Nacke, Woodfin Camp; marijuana plants © iStockphoto.com/rodehi. Cover design: Mark Lerner

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