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PUBLIC COMMENTS ON PROPOSED RULE 22-C100; MEDICAL MARIJUANA

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The office of Mayor Fenty, the Alcoholic Beverage Regulation Administration, the District Department of Health, and the Metropolitan Police Department are all to be congratulated for their work on this first round of draft regulations. The issues considered therein are comprehensive, and the level of detail in which each issue is addressed is commendable. While no first effort is perfect, these draft regulations represent a remarkable first step. Through a healthy consideration and discussion of competing ideas and comments, the District will soon have in place the medical marijuana program District voters have awaited for over a dozen years.

The Marijuana Policy Project – the nation's largest organization devoted to reform of medical and non-medical marijuana policy – submits these comments with the goal of establishing a sustainable public program that offers medical marijuana patients safe, reliable access to doctor-recommended medicine. These comments offer both positive and negative assessments of proposed regulations where appropriate, and make reference to practices that have succeeded and failed in other jurisdictions where needed.

For efficiency purposes, comments are offered in numerical order as they are presented in the draft regulations. But, in updating and/or finalizing draft regulations, particular emphasis should be on expanding the list of qualifying conditions so that it more closely reflects the language of the original initiative approved by nearly 70 percent of District voters. The original initiative promised legal protection to patients with the conditions already covered herein, and "any other conditions for which the recommending physician reasonably believes that marijuana has a demonstrated utility." Additionally, when considering applications for prospective dispensary or cultivation center operators, a scored and/or competitive review process should be utilized, rather than awarding licenses and registrations on a first-come, first-served basis. The ABRA's goal should be to grant operating licenses to the best, not necessarily the first, applicants.

If you have any questions about these comments or medical marijuana policy in general, please contact the author at the address listed above, by email at driffle@mpp.org, or by phone at (202) 905-2726 ext. 2026.

Qualifying Medical Conditions

In its current form, the proposed rules list only five conditions as "qualifying medical conditions." They are HIV, AIDS, glaucoma, cancer, and multiple sclerosis (and similar conditions characterized by severe/persistent muscle spasms). The legislation passed by the Council, B18-622, authorizes the list to be expanded, through rulemaking, to include any other condition that meets three requirements. In order to be added the condition must (1) be chronic or long lasting, (2) be debilitating or interfere with the basic functions of life and (3) be a serious medical condition for which the use of medical marijuana is beneficial. One additional qualification is that the condition must not be treatable by "ordinary medical or surgical measures," unless there is scientific evidence that marijuana would be less addictive than such "ordinary" measures. Several conditions meet these requirements and should be added to the list of qualifying conditions.

1.) Debilitating chronic pain – For perhaps no other condition does there exist a more thorough body of research showing the medical efficacy of marijuana as a treatment option than severe, chronic pain. The University of California's Center for Medical Cannabis Research (CMCR) recently completed the first clinical trials in the U.S. in more than two decades on the medical benefits of marijuana. In their report to the California legislature,[1] researchers had this to say:

> To date, four CMCR-funded studies have demonstrated that cannabis has analgesic effects in pain conditions secondary to injury (e.g. spinal cord injury) or disease (e.g. HIV disease, HIV drug therapy) of the nervous system. This result is particularly important because three of these CMCR studies utilized cannabis as an add-on treatment for patients who were not receiving adequate benefit from a wide range of standard pain-relieving medications. This suggests that cannabis may provide a treatment option for those individuals who do not respond or respond inadequately to currently available therapies.

Such findings comport with those of a 1999 report issued by United States Academy of Sciences' Institute of Medicine (IOM), which found "…the available data from animal studies indicate that cannabinoids could be useful analgesics. In general, cannabinoids seem to be mild to moderate analgesics. Opiates, such as morphine and codeine, are the most widely used drugs for the treatment of acute pain, *but they are not consistently effective in chronic pain*; they often induce nausea and sedation, and tolerance occurs in some patients."[2] Several other studies have made similar conclusions,[3] including one released just last week in which researchers concluded, "Our

[1] Available at http://www.cmcr.ucsd.edu/

[2] Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base*, 1999. Available at http://www.nap.edu/openbook.php?record_id=6376. Emphasis added.

[3] Noyes, et al (1975). The analgesic properties of delta-9-tetrahydrocannabinol and codeine. Clinical Pharmacology and Therapeutics, 18, 84-89; Holdcroft, et al (1997). Pain relief with oral cannabinoids in familial Mediterranean fever. Anaesthesia, 5, 483-486; Growing, et al (1998). Therapeutic use of cannabis: clarifying the debate. Drug and Alcohol Review, 17, 445-452; Karst, et al (2003). Analgesic Effect of the Synthetic Cannabinoid CT-3 on Chronic Neuropathic

results support the claim that smoked cannabis reduces pain, improves mood, and helps sleep."[4] Further, all but one of the 14 states with effective medical marijuana laws allows for the use of marijuana in severe and/or chronic pain treatment.

These findings show that not only would many patients find relief from severe, chronic pain through medical marijuana, but that in many cases they could not do so through "ordinary medical or surgical means," and that such "ordinary" means – typically opiate based painkillers like codeine or morphine – are often more addictive than marijuana. The Institute of Medicine found, "compared to most other drugs … dependence among marijuana users is relatively rare." It also noted, "although few marijuana users develop dependence, some do. But they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence to other drugs."[5] The National Institute on Drug Abuse ranks prescription opioid painkillers – along with stimulants used to treat ADHD and depressants used for anxiety and sleep disorders – as among the most commonly abused prescription drugs in America.[6]

2.) Post-Traumatic Stress Disorder – A recent study by Dr. Irit Akirav published in the prestigious *Journal of Neurology*[7] finds that marijuana likely plays a significant role in blocking the deleterious effects of traumatic memories on stress receptors in the brain. "Together, our findings may support a wide therapeutic application for cannabinoids in the treatment of conditions associated with the inappropriate retention of aversive memories and stress-related disorders." Anecdotal evidence also suggests marijuana is an effective treatment for PTSD. Hebrew University of Jerusalem Professor Raphael Mechoulam, the first to discover and isolate marijuana's psychoactive component and a renowned expert on marijuana had this to say: "I expect that the endocannabinoid system is not in good shape in those post-traumatic patients, and chances are that [medical marijuana] will work in treating them… People that have PTSD claim that the only thing that helps them is smoking marijuana, so chances are that cannabinoid treatment may help them."[8]

For these reasons and others, New Mexico's Health Department added PTSD to the list of qualifying conditions in February 2009.[9] MPP recommends that PTSD be added to the list in DC. Paxil, Klonopin, and other anti-depressants frequently prescribed for depression have been found to be addictive and list "withdrawal syndrome" as a potential side effects.[10]

Pain, A Randomized Controlled Trial. JAMA, 290,1757-1762; Callahan R (1998). *How Does Marijuana Kill Pain?* Associated Press, October 4. http: //www.mapinc.org/drugnews/v98/n868/a07.html.

[4] Smoked cannabis for chronic neuropathic pain; a randomized controlled trial*:* Ware et. al., 2010. Available at http://www.cmaj.ca/cgi/rapidpdf/cmaj.091414v1?ijkey=44cf2a4e01bb03581946f0ab6b7217d7a6e78f0b.

[5] *Marijuana as Medicine.* p. 98.

[6] *Prescription Drugs: Abuse and Addiction*, National Institute on Drug Abuse, available at http://www.nida.nih.gov/researchreports/prescription/prescription2.html.

[7] Available at http://www.jneurosci.org/cgi/content/short/29/36/11078

[8] See http://www.smart-publications.com/articles/MOM-mechoulam.php

[9] "Health Secretary adds seven medical conditions to medical cannabis program." http://www.nmhealth.org/documents/medicalmarijuananewconditionsadded2-16-09.pdf

[10] See http://abcnews.go.com/Health/story?id=311956&page=1

3.) Conditions associated with nausea and/or vomiting – Conditions such as cyclical vomiting syndrome, which cause significant nausea in patients, cannot be treated through traditional pill-based medicines for the obvious reason that patients often regurgitate the pill before it's able to dissolve and take effect. For these patients, medical marijuana provides a much more effective alternative. Available data supports the inclusion of such conditions in the definition of "qualifying medical condition."

As stated in the IOM report, "[t]here are numerous cannabinoid receptors in the nucleus of the solitary tract, a brain center that is important in the control of emesis…. In studies that compared THC with a placebo, THC was usually found to possess antiemetic properties."[11] In fact, when the FDA approved Dronabinol, the pill-form of THC, it did so for its antiemetic properties.[12] Also of note, the American Public Health Association concluded in an amicus brief filed in a 2001 case involving the rights of doctors to discuss medical marijuana with their patients, "[m]arijuana can provide critical relief for persons suffering from acute or chronic nausea and vomiting who do not respond to conventional therapies."[13]

Of course, while the pill form of THC – Marinol – is available, as stated earlier, it's not necessarily an effective treatment, certainly when compared with whole-plant marijuana. In addition to the difficulty patients with nausea have in swallowing and retaining any pill, Marinol is nearly 100% synthetic THC which, when metabolized, forms a compound nearly three times as psychoactive as the THC in inhaled marijuana.[14] It is thus far more likely to induce a heavier psychological "high" than whole marijuana which is typically only 5-8% THC.[15] Further, patients who take marijuana in pill form have no way to titrate their dosage. Absorption through the digestive tract takes hours, meaning patients often consume more THC than is necessary, while patients who consume whole-plant marijuana via smoking or vaporization, where onset is nearly immediate, can easily determine the needed dosage and consume only the requisite amount and no more.[16] Finally, whole-plant marijuana, unlike Marinol, contains more than 80 active cannabinoids, which act in addition to or in concert with THC to provide palliative relief and even mitigate the psychoactive effects of THC.[17]

In sum, the IOM report, the numerous studies cited therein, and other anecdotal evidence all indicate that conditions resulting in nausea and/or vomiting satisfy the

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[11] IOM Report at 148-49.
[12] *Id*. at 149
[13] Brief of American Public Health Association, et al. as Amici Curiae Supporting Respondents, *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002)
[14] "Marinol (a synthetic form of THC) is classified as a schedule III controlled substance while marijuana is classified as schedule I – despite the fact that Marinol contains a THC metabolite that is three times more psychoactive than the THC delivered to the lungs by smoked cannabis." Brief of American Pain Foundation, et al., as Amici Curiae in Support of Petitioner, *Ross v. Ragingwire*, 123 P.3d 930 (Cal. 2006).
[15] Potency Montioring Project, National Institute on Drug Abuse, Report 104 (2009). Available at http://www.whitehousedrugpolicy.gov/publications/pdf/mpmp_report_104.pdf
[16] Haney, et al., "Dronabinol and Marijuana in HIV-Positive Marijuana Smokers: Caloric Intake, Mood, and Sleep," *Journal of Acquired Immune Deficiency Syndromes*, May 2007.
[17] Russo, et al., "Cannabis, Pain, and Sleep: Lessons from the therapeutic clinical trials of Sativex, a cannabis-based medicine," *Chemistry & Biodiversity*, August 2007.

standard for inclusion set forth in B18-622 in that they are chronic, debilitating, treatable with marijuana, and often not responsive to "ordinary medical or surgical measures."

4.) Conditions associated with cachexia, wasting syndrome or loss of appetite – Perhaps the most common benefit of medical marijuana for cancer and HIV/AIDS patients is its effect on appetite. Chemotherapy, anti-retroviral medications and other aggressive treatments often rob patients of their appetite and ability to properly digest food. Patients who use marijuana report that marijuana provides essential relief from these debilitating symptoms.[18] As the IOM report concluded, "[cannabinoids] could . . . be beneficial for a variety of effects, such as increased appetite, while reducing the nausea and vomiting caused by protease inhibitors and the pain and anxiety associated with AIDS."[19]

Not only does marijuana provide relief for appetite loss and wasting syndromes it often does so where, for many patients, conventional therapies have failed. "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. Although some medications are more effective than marijuana for these problems, *they are not equally effective in all patients*."[20] An estimated 20% of cancer deaths are associated with cachexia. If other medicines worked sufficiently for all patients' appetite loss and wasting, that would not be the case.[21]

Comments relating to specific rules and regulations in numerical order:

§ 300.9 – Two ounce possession and dispensation limits

Limiting patients to possession of no more than two ounces of marijuana and prohibiting them from obtaining more than 2 ounces of marijuana per month from their designated dispensary may prove unduly restrictive. Patients with chronic conditions who require frequent administration of medical marijuana may use up to six to eight ounces of marijuana in a 30-day period. And, patients who prefer to bake marijuana into edible goods or process it into tinctures or solvents require more marijuana to achieve the equivalent effects of an inhaled dose. This is one reason why patients enrolled in the federal government's Compassionate Investigational New Drug Program receive between eight and 11 ounces of cured marijuana every month.[22] New Mexico's law, which B18-622 is largely modeled after, allows patients to purchase and possess up to six ounces every 30 days.[23]

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[18] *Id. See also* Select Committee on Science and Technology, House of Lords, Sess. 1997-98, 9th Report, *Cannabis: The Scientific and Medical Evidence: Report* (Nov. 4, 1998)

[19] IOM Report at 157.

[20] *Id*. at 159, and at 157: "Few therapies have proved successful in treatment of the AIDS wasting syndrome."

[21] Guzman, Manuel, "Cannabinoids: Potential Anticancer Agents." *Nature Reviews* (October 2003) "About one-third of cancer patients lose more than 5% of their original body weight, and cachexia is estimated to account for —20% of cancer deaths."

[22] http://en.wikipedia.org/wiki/Compassionate_Investigational_New_Drug_program.

[23] NM Admin. Code § 7.34.3.7.

The Act after which these rules are promulgated allows each of these limits – both possession and dispensation – to be increased from two ounces to four through rulemaking. This is a critical step that should be taken for the benefit of patients who would suffer a hardship if limited to only 2 ounces per month. In addition to allowing patients to obtain the amount of medicine they need, such an expansion would also be vital to the health of the Districts medical marijuana program, which could then generate far more revenue through additional sales.

§ 600.1(e) – Prior Convictions

This section should read "…unless the conviction occurred ***prior to*** the effective date of the act…" The idea is that no person should be barred from participating in the program if they have a conviction for conduct authorized by the act, i.e. providing or using medical marijuana. Using the word *after*, as it currently reads, would not accomplish this objective, since anyone who's been convicted of a crime for using or providing medical marijuana will have been convicted before the act's effective date. It's logically inconsistent to use the word *after* because if the conduct occurs *after* the effective date of the act and is conduct authorized by the act, then the individual should not be convicted since the conduct would be authorized.

§ 702.1 – 60-Day Renewal Requirement

Requiring patients and caregivers to renew their registry cards 60 days in advance of expiration would present a hardship. Drivers licenses are typically renewed a week or two before, and in some cases the day of, the expiration date. A similar renewal requirement should be used for registry identification cards since patients may not be aware of the fact that they have to renew their cards so soon. At the very least, patients should be made aware of the early renewal requirement through a warning statement printed on the card itself.

§ 801.1(h) – Specified Amount of Marijuana

The regulations should not call on doctors to specify the amount of marijuana that should be provided to patients. I understand that this seems counterintuitive in that, with prescription pharmaceuticals, physicians include a quantity to be dispensed in the prescription. The problem, however, is federal law. Because marijuana is a Schedule I substance under the Controlled Substances Act,[24] doctors cannot write a prescription for marijuana and pharmacies cannot dispense marijuana. Requiring doctors to indicate an amount that should be dispensed to patients would be analogous to an "order to dispense" and could subject the regulations to a court challenge under federal preemption grounds. It could also lead to non-participation by doctors, which would make the law ineffective.

This issue was discussed in detail in by the Ninth Circuit Court of Appeals in the case of *Conant v. Walters*.[25] In the case, the court ruled that doctors have a

[24] 21 U.S.C. § 812(c).
[25] 309 F.3d 629 (9th Cir. 2002).

constitutionally protected First Amendment right to discuss the relative risks and benefits of marijuana, and to recommend marijuana. It also found that a doctor cannot act so as to aid and abet in the commission of a federal crime: the dispensation, possession, and use of marijuana. When determining where exactly that line is drawn, the court noted, "[a] doctor would aid and abet by acting with the specific intent to provide a patient with the means to acquire marijuana."[26] The legal counsel for the California Medical Association has provided advice to doctors based on the *Conant* decision. It says, "A physician should avoid the following: … b) Describing to a patient how the patient may obtain cannabis, for example, by giving the name and address of a cannabis distributor … d) Offering a specific patient *individualized* advice concerning appropriate dosage timing, amount, and route of administration. … Again, physicians cannot intentionally take an action for the purpose of enabling a patient to obtain cannabis or otherwise to violate the federal drug laws."[27]

My concern is that requiring doctors to go beyond the point of simply recommending marijuana – discussing it's relative risks and benefits for the patient and indicating that the patient may benefit, or certifying that the patient has a condition that can be treated with marijuana – by requiring the recommending physician to provide instructions to the DC Health Department or medical marijuana dispensaries as to how much marijuana to give to the patient would be to require a doctor to aid and abet the violation of federal law. In other words, such a requirement would transform the legal "recommendation" to an illegal "order to dispense." Not only that, but by requiring doctors to aid and abet the violation of federal law, these regulations would be susceptible to a lawsuit challenging their constitutionality on federal preemption grounds.

Until such time as the federal government changes its laws with respect to medical marijuana, these regulations must not require doctors to specify the amount that should be dispensed to qualifying patients.

§ 5102 – Fees

Generally speaking, the fees for cultivation centers and dispensaries seem somewhat high. When considering what would be an appropriate application and registration fee, it's important to have some idea of how long it will take for dispensary and cultivation center owners to recoup that investment. Given the restrictive nature of DC's law, there will likely be a limited number of patients enrolled in the program. Consequently, those businesses will not have a high sales volume that will enable them to generate enough revenue to justify the initial investment.

Estimating just how many patients will apply and be accepted into the District's medical marijuana program is difficult, but some comparisons can be made. Of course, when comparing population numbers from other states, it's important to keep in mind the

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[26] *Id* at 636.
[27] See < http://www.cmanet.org/bookstore/freeoncall2.cfm/CMAOnCall1315.pdf?call_number=1315&CFID=669529&CFTOKEN=18260579 >.

differences in the laws between those states and DC's law. For example, DC is the only medical marijuana jurisdiction other than New Jersey (where the law is not yet in effect) that will not include "severe, chronic pain," or some variation thereof, as a qualifying medical condition. Severe pain is the most common qualifying condition in most medical marijuana programs. For example, 89.8% of Oregon patients suffer from severe pain (though some also suffer from another qualifying condition or symptom).

Additionally, language requiring patients to have an ongoing relationship with their recommending physician[28] and prohibiting doctor consultations solely for the purpose of providing medical marijuana certifications[29] will severely limit the number of doctors who provide certifications and the number of patients to whom those doctors provide certifications. Severe pain is the most common qualifying condition in most medical marijuana programs. For example, 89.8% of Oregon patients suffer from severe pain (though some also suffer from another qualifying condition or symptom).

Because DC's law is so restrictive, it's best to compare it to other jurisdictions with restrictive laws. New Jersey's is perhaps the most restrictive, but has not yet been implemented, so one cannot draw any analogies. The next most restrictive law is that of Vermont which also requires patients to have a "bona fide physician-patient relationship" that has lasted at least six months with their recommending physician and which allows severe pain to qualify, but only if "reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms.[30] Currently in Vermont, there are about 200 patients enrolled in the medical marijuana program. Vermont's population is similar to DC's (just over 600,000), so the District can expect a similar number of patients to be enrolled here, at least until more conditions and treatments are added to the list of qualifying conditions and treatments.

With no more than a few hundred potential "customers," it's not realistic to expect dispensaries and cultivation centers to be able to recoup an investment of over $15,000 just in application and registration fees, to say nothing of start-up costs such as retrofitting a growing facility, rent, legal fees, and employee wages. Again, this is particularly the case if the list of qualifying conditions is not expanded. Further, penalizing unsuccessful applicants by withholding a $5,000 application fee will likely discourage many potential applicants. While the fees should be such that they discourage applications from unqualified applicants, at their current totals many prospective applicants with excellent credentials could nonetheless shy away from such a substantial investment. A non-refundable application fee of $1,000-$2,000 with a registration fee of no more than $5,000 would be more appropriate.

§ 5104 – Medical Marijuana Certification Permit

MPP supports this requirement, which would be unique among medical marijuana regulations in the country, and applauds the board for including it. Having a mechanism

[28] D.C. Code § 7-1671.04.
[29] Proposed section 800.1(c).
[30] Vt. Stat. tit. 18, § 4472(1).

in place to provide training and education as to proper product handling and storage, possible drug interactions, new developments in medical marijuana research, and other important aspects of the industry is an invaluable element of this program. That said, since obtaining a certification is required in order to become a manager, steps should be taken to prevent certification providers from price gouging those who seek to become managers. The regulations should also address exactly what is required for successful completion of a certification course, such as a minimum number of classroom instruction hours.

§§ 5401 & 5402 – Dispensary And Cultivation Center Application Consideration

The goal for ABRA in determining who should be awarded registrations for cultivation centers and dispensaries should be to find the best applicants, not the first ones. By taking applications on a first-come, first-served basis and awarding registrations to the first five dispensary and 10 cultivation center applications that meet minimum requirements, ABRA runs the risks of penalizing credible applicants who take the time to ensure their applications meet all requirements or all their operating plans are in place. There's also the concern that more than five applications for dispensaries and 10 applications for cultivation centers will be submitted the day the administration begins accepting applications.

As has been done in other jurisdictions, most recently Maine, ABRA should instead open an application window of finite duration and accept an unlimited number of applications during the pendency of that window. Once the deadline for applications has passed, ABRA can review all applications to determine which applicants would be best suited to operate a dispensary or cultivation center. Additionally, to ensure transparency, the review process should utilize an objective, scored model using some of the considerations already outlined in the regulations, but also assigning maximum point values to each element and scoring individual applications based on their ability to satisfy each requirement.

MPP proposes the following application scoring model:

(1) Up to 100 points may be awarded based on the applicant's demonstrated knowledge of the legal requirements applying to medical marijuana in the District of Columbia.
(2) Up to 400 points may be awarded based on the applicant's applicable executive experience in business management and/or medical industry experience.
(3) Up to 300 points may be awarded based on the applicant's demonstrated available start-up capital.
(4) Up to 400 points may be awarded based on the suitability of the proposed geographic location and occupancy classification of the cultivation center or dispensary.
(5) Up to 250 points may be awarded based on the proposed business plan and services to be offered.
(6) Up to 100 points may be awarded based on the proposed staffing plan.
(7) Up to 500 points may be awarded based on the proposed security plan, including the dispensary's ability to prevent diversion of medical marijuana to anyone who is not a registered qualifying patient or designated caregiver.

(8) Up to 300 points may be awarded based on the applicant's plan for making medical marijuana available on an affordable basis to registered qualifying patients enrolled in Medicaid, a Ryan White CARE Act-funded program, and all other programs designed to offer assistance to those of limited income.
(9) Up to 200 points may be awarded based on a dispensary applicant's plan for maintaining an inventory of medical marijuana sufficient to ensure that it will be able to serve the needs of all registered qualifying patients who have made the applicant's facility their designated dispensary or a cultivation center applicant's cultivation plan.
(10) Up to 200 points may be awarded based on the applicant's plan for safe and accurate packaging and labeling of medical marijuana, including the applicant's plan for ensuring that all medical marijuana is free of contaminants.

§ 5607 – Labeling And Packaging Of Medical Marijuana

Subsection (f) of this proposed rule would require the name of the recommending physician to be printed on the label of any container in which marijuana is distributed. There is no compelling public policy rationale for such a requirement. Further, unlike other prescription medications, marijuana is illegal under federal law, even for medical purposes. As such, this requirement could discourage physicians from providing medical marijuana certifications to avoid having their names printed on container labels.

§ 5608.1 – Ingestible Items

Baked goods – as well as solvents, tinctures, and extracts – provide patients with an important alternative means of ingestion safer than smoking marijuana, and it's important to encourage practices that make such an alternative available. For this reason, the requirement that all edible items be prepared at cultivation centers should be removed. While cultivation centers should be allowed to prepare edible goods, so too should dispensaries once they've purchased marijuana from cultivation centers. Whatever public safety concerns that are addressed by this requirement can be properly served with safety regulations for dispensaries that produce edible medical marijuana items, rather than an outright ban.

§ 5620.1 – Manufacturing Standards

Subsection (d) of this rule prohibits the use of "synthetic growth regulators." Since marijuana will be grown indoors under this system, the definition should clearly indicate that this term does not prohibit the use of artificial lighting, a critical element required for indoor cultivation.

§ 5803.1 – Prohibition on Delivery of Medical Marijuana

This section prohibits dispensaries from delivering medical marijuana to patients. While there are legitimate public safety concerns that should be taken into account, there is no reason to think that appropriate regulations on deliveries cannot address any legitimate issues. In New Mexico, all medical marijuana is dispensed by delivery and we

have not heard a single report of any theft or other public safety issues caused by those deliveries. Many patients may be unable to travel to a dispensary to obtain medical marijuana. The inclusion of caregivers alleviates this concern to a large degree, but there may be some patients who are unable to find someone to serve as their caregiver to fulfill the role of traveling to a dispensary to obtain marijuana on their behalf. For example, the patient may be without any living relatives or loved ones in the area willing to serve as a caregiver or too embarrassed to ask someone to serve as their caregiver. Alternatively, because marijuana is illegal under federal law, some individuals may be unwilling to serve as caregivers and transport medical marijuana.

§ 5901.1 – Prohibited Statements

Presumably, this section was intended to apply to both cultivation centers and dispensaries; however, the text of this section mentions only cultivation centers.

§ 6001.1 – Cultivation Center Invoices

Subsection (d) of this section contains a typo. The word "he" should be "The."

Conclusion

Overall, these regulations represent a thoughtful, well-considered move in the implementation of medical marijuana in the District. Many provisions – such as the requirement of medical marijuana certification providers, signage restrictions, and the requirement that a manager be on staff at all times – represent novel, positive developments in the regulatory field. Still, some provisions do raise questions and concerns. Chief among them is the first-come, first-served consideration of dispensary and cultivation center registration applications.

MPP offers these comments with the hope that they will prove constructive. Once again, should you have any questions or require any additional information, please do not hesitate to contact the author at the address listed above.

Respectfully submitted,

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