



# MEDICAL MARIJUANA LEGISLATION IN FLORIDA: THE RECOMMENDATION VS. PRESCRIPTION DISTINCTION FOR HEALTHCARE PROVIDERS

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## I. INTRODUCTION

On November 4, 2014, Florida put the controversial medical marijuana legalization question directly to the people of Florida in the form of a ballot measure. While Amendment 2 to Article X of the Florida Constitution was ultimately defeated, the fact that more than fifty-seven percent of Florida citizens voted in favor of legalizing medical marijuana,<sup>1</sup> barely missing the required sixty percent vote needed to pass a ballot measure in Florida,<sup>2</sup> is indicative of the ever-growing movement to legalize medical marijuana across the United States. Medical marijuana is now legal in twenty-three states and the District of Columbia.<sup>3</sup>

As more and more states legalize medical marijuana, the contradiction of marijuana remaining an illegal substance under federal

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1. United for Care, *We're Not Stopping the Fight for Medical Marijuana*, UNITEDFORCARE.ORG (Nov. 25, 2014), [http://www.unitedforcare.org/we\\_re\\_not\\_stopping\\_the\\_fight\\_for\\_medical\\_marijuana](http://www.unitedforcare.org/we_re_not_stopping_the_fight_for_medical_marijuana) [hereinafter *United for Care*].

2. FLA. CONST. art. XI, § 5(e).

3. *23 Legal Medical Marijuana States and DC*, PROCON.ORG, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> (last updated Mar. 14, 2016, 10:23:46 AM PST). Recreational marijuana is currently legal in four states: Alaska, Colorado, Oregon, and Washington. GOVERNING, *State Marijuana Laws Map*, Governing, <http://www.governing.com/gov-data/state-marijuana-laws-map-medical-recreational.html> (last visited Apr. 14, 2016). Additionally, Washington D.C. legalized the possession of small amounts of marijuana, two ounces or less, in February of 2015. Metro. Police Dep't, *Know the Facts About Marijuana in DC*, DC.GOV, [http://mpdc.dc.gov/sites/default/files/dc/sites/mpdc/page\\_content/attachments/Marijuana%20Card\\_FEB2015.pdf](http://mpdc.dc.gov/sites/default/files/dc/sites/mpdc/page_content/attachments/Marijuana%20Card_FEB2015.pdf) (last visited Apr. 14, 2016).

law while being legal under state law is becoming more and more of an unworkable dilemma. Healthcare providers, in particular, are confronted with this federal versus state law contradiction. State medical marijuana laws require physicians to sign off on a patient's medical marijuana use in order for that patient to obtain medical marijuana.<sup>4</sup> However, because marijuana is illegal under federal law,<sup>5</sup> physicians are at risk of violating federal law by being an accomplice, in the form of aiding, abetting, or conspiring with a patient who is buying and using the federally banned substance. Therefore, a physician who believes medical marijuana has therapeutic effects is confronted with the predicament of whether to even discuss medical marijuana with a patient, if that discussion will put the physician at risk of violating federal law.

What is missing from many state medical marijuana laws, including Florida's past and current initiatives, is clarity regarding what kind of physician-to-patient communication is required, what is recommended, and what is crossing the line into the forbidden "aiding and abetting" territory. Further confusing the matter is the arbitrary line the United States Court of Appeals for the Ninth Circuit drew in *Conant v. Walters*,<sup>6</sup> which held that physicians are allowed to "recommend" medical marijuana, but are not allowed to "prescribe" medical marijuana.<sup>7</sup> The Ninth Circuit decision in *Conant*, which is persuasive authority for the Eleventh Circuit,<sup>8</sup> combined with the lack of clarity on the type of permissible physician-patient communication only serves to further exacerbate physicians' fears of federal repercussions.

Physicians should not have to be concerned with parsing their words ever-so-carefully because of a fear of sanctions, discipline, or worse,

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4. All state medical marijuana programs "[r]equire that qualifying patients be certified by a physician as having a medical condition that" may be treated or alleviated by the medical use of marijuana. LEGISLATIVE REFERENCE BUREAU, IS THE GRASS ALWAYS GREENER? AN UPDATED LOOK AT OTHER STATE MEDICAL MARIJUANA PROGRAMS, REP. NO. 1, H. R., 27th Leg. Executive Summary ix (Haw. 2014); e.g., ME. REV. STAT. tit. 22, § 2423-B (2014) (requiring written certification from a medical provider that the "qualifying patient is likely to receive therapeutic benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition"); NEV. REV. STAT. § 453A.210(2)(a)(2) (2013) (requiring written documentation from the patient's physician stating that "[t]he medical use of marijuana may mitigate the symptoms or effects of that condition"); WASH. REV. CODE § 69.51A.005 (2015) (finding that patients seeking medical marijuana should be advised by their health care professional that they may benefit from the medical use of marijuana).

5. 21 U.S.C. §§ 812 sched. I (c)(10), 841(a) (2012).

6. 309 F.3d 629 (9th Cir. 2002).

7. *Id.* at 635.

8. LINDA H. EDWARDS, LEGAL WRITING AND ANALYSIS 26 (2d ed. 2007). Although the Ninth Circuit is not binding on the Eleventh Circuit, the circuit to which Florida's federal district courts appeal, the Ninth Circuit is persuasive authority for all of the federal circuits.

imprisonment. A physician's focus should be on the best course of treatment for his or her patient, making sure to thoroughly inform every patient about his or her therapeutic options. Allowing a physician to "recommend"—but not "prescribe"—medical marijuana hinders physicians from completely informing their patients of the benefits, risks, and proper use of medical marijuana as a therapeutic treatment because the physician may fear that the recommendation looks or sounds like a prescription. Therefore, a physician recommending medical marijuana to patients should be allowed to freely discuss a recommended dosage, a reputable dispensary, and the physician's medical and perhaps even personal opinion of its therapeutic effects free from fear that saying too much will expose the physician to federal criminal liability.

While there is no quick fix to lessen the tension between the ban on marijuana at the federal level and the legalization of medical marijuana at the state level,<sup>9</sup> if Florida wants to move forward with medical marijuana legislation, lawmakers should ensure that there is language inserted in the legislation that addresses the current stalemate between federal and state law. One way to address the conundrum is for the legislation to focus on alleviating physicians' fears of federal ramifications by encouraging open communication between physicians and patients. If medical marijuana proponents want to ensure that Florida physicians are in fact considering medical marijuana as a possible treatment option for their patients, this kind of language is necessary to alleviate physicians' fear of imprisonment or sanctions for merely suggesting medical marijuana to a patient.

This Article argues that Florida should focus on taking steps to make healthcare providers feel more comfortable recommending medical marijuana as a viable therapeutic treatment for their patients before jumping to another ballot measure,<sup>10</sup> like failed Amendment 2,<sup>11</sup> to legalize marijuana. This Article proposes that, if Florida wants to legalize

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9. There is no quick fix to alleviating the tension, absent removing marijuana from the Schedule I classification under the Controlled Substances Act (CSA). 21 U.S.C. §§ 801–904 (2012). For a unique perspective on how to solve the medical marijuana legal battle between the federal government and state governments, see Claire A. Frezza, Note, *Medical Marijuana: A Drug Without a Medical Model*, 101 GEO. L.J. 1117, 1138 (2013) (suggesting that marijuana should be treated as an alternative medicine, similar to the opioid addiction treatment model).

10. For example, the American College of Physicians is worried that state ballot initiatives undermine the federal regulatory structure for assessing safety and efficacy of new drugs. Am. Coll. of Physicians, *Supporting Research Into the Therapeutic Role of Marijuana*, Position paper, at 18 (2008) (American College of Physicians Position Paper at 18) (*available at* [https://www.acponline.org/acp\\_policy/policies/supporting\\_medmarijuana\\_2008.pdf](https://www.acponline.org/acp_policy/policies/supporting_medmarijuana_2008.pdf)).

11. For the official petition form for Amendment 2, see *Constitutional Amendment Petition Form*, FLA. DEP'T OF ST., *available at* <http://dos.elections.myflorida.com/initiatives/fulltext/pdf/50438-2.pdf> (last approved July 10, 2013).

medical marijuana, the Eleventh Circuit should decline to follow *Conant*'s recommendation versus prescription distinction. First, Part II of this Article briefly describes the federal government's position on medical marijuana, emphasizing that marijuana is still illegal under federal law. Then, Part III discusses various healthcare provider positions on medical marijuana. Part IV reviews Florida's largely unsuccessful medical marijuana legislation, including Florida's Compassionate Medical Cannabis Act of 2014; the Amendment 2 ballot measure in November 2014; and the unenacted Florida Medical Marijuana Act. Part V analyzes the recommendation versus prescription distinction formulated in *Conant v. Walters* as well as the aiding, abetting, and conspiring analysis used by the Ninth Circuit in *Conant*. Part VI sets forth the argument that the recommendation versus prescription distinction hinders open communication between a physician and patient. Finally, Part VII addresses specific issues with failed Amendment 2 and the Florida Medical Marijuana Act, and suggests ways to make future legislation in Florida more conducive for physicians under the current federal law.

## II. MARIJUANA REMAINS AN ILLEGAL SUBSTANCE UNDER FEDERAL LAW

Despite increasing popular opinion among United States citizens that marijuana is generally harmless, "Congress has determined that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime."<sup>12</sup> As a result, under federal law, marijuana is classified as a Schedule I drug,<sup>13</sup> which is the category for substances with "no currently accepted medical use" and a "high potential for

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12. Office of Nat'l Drug Control Policy, *Answers to Frequently Asked Questions About Marijuana*, WHITE HOUSE, <http://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana#legalization> (last visited Apr. 14, 2016) [hereinafter *ONDCP*].

13. 21 U.S.C. § 812 sched. I (c)(10) (2012). Compare to Schedule V drugs, which are drugs deemed to have a low potential for abuse, a currently accepted medical use in treatment, and abuse of the drug leads to limited physical or psychological dependence. *Id.* § 812(b)(5)(A)–(C). For factors to consider in order to place, change, or remove a drug, see *id.* § 811(c)(1)–(8). Factor (2) is "[s]cientific evidence of its pharmacological effect, if known." *Id.* § 811(c)(2). Medical marijuana's pharmacological effects require further research, which is one of the hindrances to medical marijuana's reclassification under the CSA.

abuse.”<sup>14</sup> Moreover, physicians “may not prescribe Schedule I drugs.”<sup>15</sup> The Office of National Drug Control Policy (ONDCP)<sup>16</sup> supports the view that marijuana is a dangerous substance, stating, “[m]arijuana places a significant strain on our health care system, and poses considerable danger to the health and safety of the users themselves, their families, and our communities.”<sup>17</sup>

The federal government’s position is that marijuana should be subject to the Food and Drug Administration (FDA) clinical trials and scientific scrutiny that all other new medications are subject to before it is determined that marijuana is a type of medicine.<sup>18</sup> The federal government maintains that the marijuana plant “has not met the safety and efficacy standards” of the rigorous FDA approval process.<sup>19</sup> Among the medical community, this is not an uncommon view. Although the American Medical Association (AMA) “has urged the federal government to reconsider its classification of marijuana as a dangerous drug with no accepted medical use,” the AMA also has made clear that its encouragement for more research on medical marijuana is neither an endorsement of state medical marijuana programs, nor an assertion that research on the substance meets standards for prescription drug products.<sup>20</sup>

Although there are many people who staunchly support state marijuana initiatives, it is imperative to recognize that state laws

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14. *Id.* § 812(b)(1). The ONDCP, a component of the Executive Office of the President, reports that “long-term, chronic use or use starting at a young age[] can lead to dependence and addiction,” with approximately nine percent of marijuana users becoming dependent. ONDCP, *supra* note 12. The ONDCP also reports that “marijuana is the most commonly abused illicit drug in the United States.” *Id.*

15. BARRY R. FURROW ET AL., *HEALTH LAW CASES, MATERIALS AND PROBLEMS* 96 (7th ed. 2013).

16. The Office of Nat’l Drug Control Policy was created by the Anti-Drug Abuse Act of 1988 and, as one of its functions, advises the President on drug-control issues. Office of Nat’l Drug Control Policy, *About ONDCP*, WHITE HOUSE, <http://www.whitehouse.gov/ondcp/about>.

17. *ONDCP, supra* note 12. The ONDCP goes on to state that “[m]arijuana presents a major challenge for health care providers.” *Id.*

18. *Id.* Even the argument that medical marijuana should be an exception under the medical necessity doctrine has been rejected by the Supreme Court. *United States v. Oakland Cannabis Buyers’ Co-op*, 532 U.S. 483, 494 (2001).

19. *ONDCP, supra* note 12. The ONDCP control further notes that a popular vote should not be the determinative factor in deciding what is and what is not medicine—thereby implying that state marijuana initiatives are not the correct way to go about making marijuana a type of prescription drug. *Id.*

20. Jerome R. Stockfisch, *Florida Doctors’ Group Against Medical Pot Amendment*, TAMPA TRIBUNE (Aug. 5, 2014), <http://tbo.com/news/politics/as-in-other-states-doctors-group-opposes-medical-marijuana-20140805/>. Additionally, the American College of Physicians stated that “[a]dditional research is needed to clarify marijuana’s therapeutic properties and determine standard and optimal doses and routes of delivery.” Am. Coll. of Physicians, *supra* note 10, at 1.

decriminalizing medical marijuana do not decriminalize marijuana at the federal level.<sup>21</sup> All forms of marijuana remain illegal under federal law.<sup>22</sup> Further, the Controlled Substances Act preempts any medical marijuana state law because federal law preempts any state law on the same topic.<sup>23</sup> Therefore, regardless of where a person stands in the medical marijuana debate, the fact that anybody in the United States distributing or possessing marijuana is violating federal law must be acknowledged and taken into consideration when weighing the decision of whether to enact state medical marijuana legislation.

#### A. The Ogden Memo

Deputy Attorney General David Ogden's 2009 memorandum (Ogden Memo) to U.S. Attorneys is often used to support the notion that the federal government is not going to prosecute medical marijuana cases. However, it is critical to note that this memo did not affect medical marijuana's legality.<sup>24</sup> The Ogden Memo emphasizes that the "prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and

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21. See, e.g., *United States v. Stacy*, 734 F. Supp. 2d 1074, 1083–84 (S.D. Cal. 2010) (holding that the defendant was not immune from federal prosecution for marijuana possession despite California's Compassionate Use Act); see also A. Claire Frezza, Note, *Counseling Clients on Medical Marijuana: Ethics Caught in Smoke*, 25 GEO. J. LEGAL ETHICS 537, 549 (2012) (noting that caselaw shows compliance with state medical marijuana laws does not provide immunity at a federal level); Sam Kamin & Eli Wald, *Marijuana Lawyers: Outlaws or Crusaders?*, 91 OR. L. REV. 869, 871 (2013) (commenting on how a state's decriminalization of marijuana does not have the power to undo the federal criminal prohibition of the drug).

22. 21 U.S.C. § 812(c)(10) (2012).

23. See U.S. CONST. art. VI, § 2 (stating that "the Laws of the United States . . . shall be the supreme Law of the Land"); *Gonzales v. Raich*, 545 U.S. 1, 22 (2005) (confirming the federal government's authority to enforce the CSA). The topic of preemption in regards to the CSA and state marijuana initiatives is written about extensively. See, e.g., Robert A. Mikos, *Preemption Under the Controlled Substances Act*, 16 J. HEALTH CARE L. & POL'Y 5, 11 (2013) (arguing that state authorities should adopt a narrower direct conflict rule to avoid the dangers of broad preemption doctrines); Karen O'Keefe, *State Medical Marijuana Implementation and Federal Policy*, 16 J. HEALTH CARE L. & POL'Y 39, 49 (2013) (exploring how federal policy generally hinders research and advancement in the field of medical marijuana).

24. The memo clearly states "[t]he Department of Justice is committed to the enforcement of the Controlled Substances Act in all States" and merely provides *guidance* to focus federal investigations and prosecutions; it does not provide any kind of binding legal authority. Memorandum from David W. Ogden, Deputy Attorney Gen., to Selected U.S. Attorneys, *Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana* (Oct. 19, 2009), available at <http://www.justice.gov/opa/blog/memorandum-selected-united-state-attorneys-investigations-and-prosecutions-states>. The memo also specifically points out that "this memorandum does not alter in any way the Department's authority to enforce federal law" nor does it "'legalize' marijuana or provide a legal defense to a violation of federal law." *Id.*

trafficking networks continues to be a core priority.”<sup>25</sup> The Ogden Memo goes on to state that federal resources should not be focused on prosecuting seriously ill individuals whose actions are in compliance with state laws, “or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana.”<sup>26</sup> However, the Ogden Memo also states that “prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department.”<sup>27</sup> As such, the Ogden Memo only refocuses federal prosecutorial efforts away from patients, but not healthcare providers or medical marijuana distribution centers, which play an integral part in all medical marijuana legislation, including in Florida’s failed Amendment 2.<sup>28</sup> Therefore, proponents of medical marijuana must understand the federal government’s decision not to actively pursue medical marijuana users does not protect health care providers and dispensaries from federal prosecution.

## B. The Cole Memo

Further supporting this interpretation of the Ogden Memo is the 2011 memorandum issued by Deputy Attorney General James M. Cole (Cole Memo).<sup>29</sup> The Cole Memo explained that dispensaries are not shielded from federal enforcement action and that commercial cultivation of marijuana is more at risk of prosecution than individual patients.<sup>30</sup> If dispensaries and commercial cultivation are not shielded from federal prosecution, how can healthcare providers feel comfortable recommending medical marijuana knowing it will come from these “illegal and targeted” dispensaries?

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25. *Id.*

26. *Id.*

27. *Id.*

28. See *Constitutional Amendment Petition Form*, *supra* note 11, at Art. X, § 29(a)(1), (b)(5), (d)(1)(c) (stating that Medical Marijuana Treatment Centers will cultivate, process, sell, and distribute marijuana in Florida, to qualified patients).

29. Memorandum from James M. Cole, Deputy Attorney Gen., to U.S. Attorneys, *Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use* (June 29, 2011), available at <http://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf>.

30. *Id.* at 2 (advising that “[p]ersons who are in the business of cultivating, selling or distributing marijuana, and those who knowingly facilitate such activities, are in violation of the Controlled Substances Act, regardless of state law”).



### III. HEALTHCARE PROVIDER POSITIONS

Despite the legality of recommending medical marijuana in twenty-three states, the health benefits medical marijuana provides are not consistently accepted among the medical community. There are many organizations that would like to see more research on the therapeutic role of marijuana before giving it their therapeutic stamp of approval.<sup>31</sup>

One of the few widely cited research reports is the Institute of Medicine Report (IOM Report) from 1999.<sup>32</sup> In fact, the IOM Report is often cited by parties on both sides of the medical marijuana debate. Proponents of medical marijuana refer to the IOM Report's acknowledgment of the "existence of therapeutic value in marijuana as treatment for disease symptoms,"<sup>33</sup> and the IOM Report's specific recommendation that "plant-derived and synthetic cannabinoids, as well as marijuana, be studied for physiologic and therapeutic effects."<sup>34</sup> However, the opponents of medical marijuana often refer to the IOM Report's statement that "smoking marijuana is an unsafe delivery system" producing harmful effects,<sup>35</sup> as well as the notion that marijuana's therapeutic value may simply be its ability to produce a high.<sup>36</sup> In other words, opponents posit that this "high effect" creates a problem for researchers because patients may mistake the euphoric high feeling for actual pharmacological effects.<sup>37</sup>

What appears to be the common thread in both sides of the argument is that more research needs to be conducted in order to ascertain marijuana's true medicinal value. However, the current federal process for obtaining research-grade marijuana poses challenges for researchers.<sup>38</sup> Researchers who wish to study marijuana must submit

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31. See, e.g., Am. Coll. of Physicians, *supra* note 10, at 9. The position paper points out how the federal government's negative opinion of medical marijuana hinders further research, noting that a "clear discord exists between the scientific community and federal legal and regulatory agencies over the medicinal value of marijuana, which impedes the expansion of research." *Id.* at 8. The AMA also advocates more research on marijuana's therapeutic effects before it will support medical marijuana legislation in states. Stockfisch, *supra* note 20.

32. INST. MEDICINE, DIV. NEUROSCIENCE & BEHAVIORAL HEALTH, MARIJUANA AND MEDICINE ASSESSING THE SCIENCE BASE (1999), available at [http://medicalmarijuana.procon.org/sourcefiles/IOM\\_Report.pdf](http://medicalmarijuana.procon.org/sourcefiles/IOM_Report.pdf).

33. Moira Gibbons, *The Cannabis Conundrum: Medication v. Regulation*, 24 HEALTH LAW. (A.B.A. Health Law Section), Dec. 2011, at 1, 3 (emphasis omitted).

34. *Id.* at 4 (citing INST. MEDICINE, DIV. NEUROSCIENCE & BEHAVIORAL HEALTH, *supra* note 32, at 3).

35. ONDCP, *supra* note 12.

36. Gibbons, *supra* note 33, at 4.

37. *Id.*

38. Am. Coll. of Physicians, *supra* note 10, at 16.

their protocol to the National Institute on Drug Abuse (NIDA) in addition to the standard drug review practice of applying for a Drug Enforcement Agency (DEA) license and FDA approval.<sup>39</sup> The step of submitting protocols to NIDA is a review process required for no other drug.<sup>40</sup> The consequence of requiring such a laborious process is that there is a lack of research on medical marijuana. There is very little incentive for a research organization to further the exploration of marijuana when a research organization has to jump through so many bureaucratic hoops to even be considered for a research grant. Therefore, imposing extra steps on researchers wishing to study marijuana further impedes the ability of physicians to accurately assess medical marijuana's therapeutic benefits, and inhibits a physician's ability to communicate to patients all of the benefits and risks of using medical marijuana.

In the seven states that approved medical marijuana in the past two years, the medical associations in five of those states opposed the medical marijuana legislation, while the medical organizations in the other two states took no position on the legislation.<sup>41</sup> However, even in the states where the medical associations opposed medical marijuana laws, the medical associations typically participated in the creation of the training and educational requirements that went along with the legislation.<sup>42</sup> Medical associations, even those that are opposed to medical marijuana legislation, should, at the very least, get involved with the creation of training and education requirements in order to ensure that physicians who will be recommending medical marijuana to patients are making educated treatment decisions. Although the medical community may be divided on the beneficial effects of medical marijuana, physicians practicing in states where medical marijuana is legal must be properly educated on medical marijuana's risks and benefits in order to adequately inform inquiring patients.

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39. *Id.*

40. *Id.*

41. Stockfish, *supra* note 20. The five states where the medical societies opposed the legislation were Connecticut, Massachusetts, Minnesota, New Hampshire, and New York. *Id.* The two states where the medical societies remained neutral were Maryland and Illinois. *Id.*

42. *Id.*

#### IV. FLORIDA'S MEDICAL MARIJUANA LAWS

##### A. Compassionate Medical Cannabis Act of 2014

In June of 2014, the Florida legislature passed the Compassionate Medical Cannabis Act of 2014 (CMCA),<sup>43</sup> legalizing the use of low-THC cannabis<sup>44</sup> for medicinal purposes to a small group of qualified patients.<sup>45</sup> This strain of non-euphoric, low-THC cannabis is commonly referred to as “Charlotte’s Web,” and is considered a form of low-strength cannabis that does not produce the psychoactive or high effect of full-strength marijuana.<sup>46</sup> In March of 2016, the Florida legislature amended the CMCA to include full-strength marijuana, termed “medical cannabis” in the statute, intended for use by terminally ill patients only.<sup>47</sup>

43. See S. 1030, 2014 Leg., 116th Reg. Sess. (Fla. 2014) (creating FLA. STAT. §§ 381.986, 385.211, 385.212, and 1004.441, and amending FLA. STAT. § 893.02 (2014)); see also S. 1700, 116th Reg. Sess. (Fla. 2014) (creating FLA. STAT. § 381.987 and “exempting from public records requirements [of] personal identifying information of patients and physicians held by the Department of Health in the compassionate use registry”). Governor Rick Scott signed Senate Bill 1030 into law on June 16, 2014. Bill Cotterell, *Rick Scott Signs Law Allowing Limited Medical Marijuana Use in Florida*, HUFFINGTON POST (June 16, 2014, 2:41 PM EDT), [http://www.huffingtonpost.com/2014/06/16/florida-medical-marijuana\\_n\\_5500496.html](http://www.huffingtonpost.com/2014/06/16/florida-medical-marijuana_n_5500496.html). During the 2016 Florida legislative session, the CMCA was amended by House Bill 307: Medical Use of Cannabis. State of Fla., *House Bill 0307*, FLSENATE.GOV (Mar. 25, 2016), <https://www.flsenate.gov/Session/Bill/2016/307>. These amendments took effect upon the bill becoming law on March 25, 2016. *Id.* Shortly before this Article went to press, the legislation amending Florida Statutes 381.986 and 499.0295 was signed into law, but was not yet published in Florida’s Session Law publication or codified. It is available electronically as Chapter Law Number 2016-123 at [http://laws.flrules.org/files/Ch\\_2016-123.pdf](http://laws.flrules.org/files/Ch_2016-123.pdf).

44. FLA. STAT. § 381.986(1)(b) (2015). The statute defines “low-THC cannabis” as

a plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed only from a dispensing organization.

*Id.* (This definition is expected to appear in Section 381.986(1)(e) of the amended 2016 Florida Statutes. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. § 381.986(1)(e) (2016))).

45. *Id.*

46. Cotterell, *supra* note 43. “Charlotte’s Web” is named after a Colorado girl who benefitted from using this form of medical marijuana for her epileptic seizures. *Id.*

47. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. § 381.986(1)(f) (2016)). Medical cannabis is defined as

all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture, or preparation of the plant or its seeds or resin that is dispensed only from a dispensing organization for medical use by an eligible patient as defined in [Section] 499.0295.

The CMCA requires the Department of Health to create a “compassionate use registry” where the ordering physician registers the qualified patient.<sup>48</sup> A qualified patient is defined as a permanent Florida resident with symptoms of cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.<sup>49</sup> Terminally ill patients, as defined in Florida’s Right to Try Act, are also considered qualified patients, who are eligible to use medical cannabis, as opposed to the low-THC cannabis.<sup>50</sup> In order for a physician to be able to order Charlotte’s Web or medical cannabis, the physician must have “treated the patient for at least [three] months immediately preceding the patient’s registration in the compassionate use registry”<sup>51</sup> and must successfully complete an eight-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association.<sup>52</sup> Additionally, the physician must determine that “the risks of treating the patient with low-THC cannabis or medical cannabis are reasonable in light of the potential benefit to the patient.”<sup>53</sup> Ordering Charlotte’s Web or medical cannabis without a reasonable belief that the patient is suffering from conditions outlined in the CMCA or Right to Try Act is a first-degree misdemeanor, punishable by imprisonment for up to one year or up to \$1,000 in fines.<sup>54</sup>

Florida ordering physicians are required to maintain a treatment plan that includes “the dose, route of administration, planned duration, and monitoring of the patient’s symptoms and other indicators of

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*Id.* The Right to Try Act, Section 499.0295, Florida Statutes, allows terminally ill patients to have access to experimental drugs that have not been approved for general use by the FDA. FLA. STAT. § 499.0295(2)(b) (2015). House Bill 307, enacted in March 2016, amended Section 499.0295 to allow terminally ill patients to have access to medical marijuana by expanding the law to include marijuana. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. § 499.0295(2)(c)(2) (2016)).

48. FLA. STAT. § 381.986(1)(d), (5)(a) (2015). (The discussion of “compassionate use registry” is expected to appear in Sections 381.986(1)(h), (5)(a) of the amended 2016 Florida Statutes. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123>, expected to be codified as FLA. STAT. § 381.986(1)(h), (5)(a) (2016)).

49. *Id.* § 381.986(2) (2015).

50. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. §§ 381.986(2), 499.0295(2)(c)(2) (2016)).

51. *Id.* at \_\_\_ (expected to be codified as FLA. STAT. § 381.986(2)(b) (2016)).

52. FLA. STAT. § 381.986(4)(a) (2015). Failure to comply with these requirements is grounds for disciplinary action under Section 456.072(1)(k), Florida Statutes. *Id.* § 381.986 (4)(d).

53. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. § 381.986(2)(d) (2016)).

54. *Id.* at \_\_\_ (expected to be codified as FLA. STAT. § 381.986(3)(a)–(b) (2016)). FLA. STAT. §§ 775.082(4)(a), 775.083(1)(d) (2015).

tolerance or reaction.”<sup>55</sup> Every quarter, the physician must submit the patient treatment plan to the University of Florida College of Pharmacy for research on the safety and efficacy of the low-THC cannabis or medical cannabis on patients.<sup>56</sup> Finally, the CMCA requires that ordering physicians obtain “voluntary written informed consent”<sup>57</sup> from the patient or the patient’s legal representative “after sufficiently explaining the current state of knowledge in the medical community of the effectiveness of treatment of the patient’s condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.”<sup>58</sup>

The CMCA requires the Florida Department of Health to approve up to five dispensing organizations in various geographic regions throughout Florida.<sup>59</sup> The CMCA further requires that an applicant for approval as a dispensing organization “possess a valid certificate of registration issued by the Department of Agriculture . . . that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman . . . and have been operated as a registered nursery in [Florida] for at least [thirty] continuous years.”<sup>60</sup>

The CMCA was supposed to go into effect on January 1, 2015. However, the CMCA did not go into effect until June 17, 2015,<sup>61</sup> due to a series of legal challenges. The initial legal challenge came from a group of nurseries and other businesses that opposed the health department’s first proposal for a regulatory structure.<sup>62</sup> An administrative judge struck down the initial regulatory proposal, which proposed a lottery system to select the five dispensaries.<sup>63</sup> Subsequently, the Office of Compassionate

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55. FLA. STAT. § 381.986(2)(d) (2015). (This language is expected to appear in Section 381.986(2)(f) of the amended 2016 Florida Statutes. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123>, expected to be codified as FLA. STAT. § 381.986(2)(f) (2016)).

56. 2016 Fla. Laws \_\_\_, \_\_\_, available at <http://laws.flrules.org/2016/123> (expected to be codified as FLA. STAT. § 381.986(2)(g) (2016)).

57. *Id.* at \_\_\_ (expected to be codified as FLA. STAT. § 381.986(2)(h) (2016)).

58. *Id.*

59. FLA. STAT. § 381.986(5)(b) (2015).

60. *Id.* § 381.986(5)(b)(1). About seventy-five nurseries meet these criteria in Florida. Dara Kam, *Judge Strikes down Pot Rule*, CBS MIAMI (Nov. 14, 2014, 7:56 PM), <http://miami.cbslocal.com/2014/11/14/judge-strikes-down-pot-rule/>.

61. Fla. Dep’t of Health, *Office of Compassionate Use*, FLA. HEALTH, <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/> (last visited Apr. 14, 2016).

62. *Costa Farms v. Dep’t of Health*, No. 14-4296RP, 2014 WL 6537375, at \*1–2 (Fla. Div. Admin. Hearings Nov. 14, 2014). For the proposed regulations and rules, see *Rule 64-4.001*, FLA. ADMIN. CODE & FLA. ADMIN. REGISTER, FLA. DEP’T OF ST., <https://www.flrules.org/gateway/ruleNo.asp?id=64-4.001> (last visited Apr. 14, 2016).

63. *Costa Farms*, 2014 WL 6537375, at \*1. Judge W. David Watkins wrote in his twenty-nine page ruling that the lottery process is invalid because it is “vague, fails to establish adequate standards for agency decisions, and vests unbridled discretion in the agency.” *Id.* at \*24.

Use, an agency of the Florida Department of Health, came up with a revised set of rules and compiled a three-member panel to select the five dispensaries from a list of twenty-eight nurseries.<sup>64</sup> The Florida Department of Health approved five dispensing organizations on November 23, 2015.<sup>65</sup> All five dispensaries were required to request cultivation authorization by February 7, 2016, and upon receiving authorization, must begin cultivation within 210 days.<sup>66</sup>

The implementation of the CMCA is proving to be an arduous process—two years have passed since it became law, yet patients still do not have access to medical marijuana.<sup>67</sup> The CMCA's problematic enactment is a prime example of how unprepared the Florida state system truly is to handle any kind of medical marijuana implementation. It begs the question: If the Department of Health is struggling to implement this much narrower and restrictive form of medical marijuana legislation, how would it be able to implement the kind of broad and all-encompassing program Amendment 2 proposed?

## B. Failed Amendment 2

Taking the legalization of medicinal marijuana one step further was Amendment 2 to Article X of the Florida Constitution on Florida's ballot in November of 2014, titled "Use of Marijuana for Certain Medical Conditions."<sup>68</sup> While Amendment 2 garnered a notable fifty-seven percent vote in favor of legalizing medical marijuana,<sup>69</sup> it also had many staunch opponents, including seven former Florida Supreme Court

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64. Jim Rosica, *Lawmakers Irked over Delays in Medical Pot Law*, POLITICS OF POT (Oct. 6, 2015), <http://politicsofpot.com/archives/3342>.

65. Fla. Dep't of Health, *supra* note 61. The Final Chapter Rule 64-4 is available at [http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/\\_documents/64-4-rule-text.pdf](http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/64-4-rule-text.pdf).

66. Fla. Dep't of Health, *Frequently Asked Questions*, FLA. HEALTH, <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/frequently-asked-questions/index.html/> (last visited Apr. 14, 2016).

67. At the time this Article went to press, April 2016, medical marijuana was still inaccessible to qualifying patients under the CMCA.

68. *Constitutional Amendment Petition Form*, *supra* note 11. Amendment 2 is often referred to as the "Florida Right to Medical Marijuana Initiative." Jessica M. Smith, *Medical Marijuana: What Florida Health Care Providers and Their Attorneys Need to Know*, FLA. B. HEALTH L. SEC. NEWSL. (Fla. Bar Health Law Section, Fla.), Winter 2014, at 3, available at <http://www.mfmlegal.com/wp-content/uploads/2014/12/Medical-Marijuana-Jessica-Smith.pdf>.

69. United for Care, *supra* note 1. For Amendment 2, there were 3,370,761 people that voted yes. *Id.*

Justices,<sup>70</sup> law enforcement, and the Florida Medical Association.<sup>71</sup> Dr. Alan Pillersdorf, President of the Florida Medical Association, expressed the association's concern with Amendment 2, that "[t]he lack of clear definitions in the amendment would allow healthcare providers with absolutely no training in the ordering of controlled substances to order medical marijuana."<sup>72</sup> Ultimately, opponents won the closely fought battle. Amendment 2 was defeated on November 4, 2014.<sup>73</sup>

Amendment 2 proposed far fewer restrictions than the CMCA, and did not limit the form or THC level of the marijuana.<sup>74</sup> Amendment 2 allowed the use of medical marijuana for a wide range of debilitating diseases.<sup>75</sup> It would have allowed licensed physicians in Florida to recommend medical marijuana to patients with debilitating diseases, as long as the physician determined that the potential benefits of marijuana outweighed the potential harms.<sup>76</sup> Further, the definition of a "qualifying patient" in Amendment 2 was much broader than in the CMCA—Amendment 2 defined a qualifying patient as a person who has been "diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card."<sup>77</sup>

Additionally, Amendment 2 did not include a training requirement for prescribing physicians. Instead, Amendment 2 would have required physicians to conduct a physical examination of the patient, complete a

70. The former Justices included Parker Lee McDonald, Leander J. Shaw, Jr., Stephen H. Grimes, Major B. Harding, Charles T. Wells, Raoul G. Cantero III, and Kenneth B. Bell. To read their editorial on why they opposed Amendment 2, see Parker Lee McDonald et al., *Former Justices: Why Voters Should Reject Medical Marijuana Amendment*, TAMPA BAY TIMES (Sept. 9, 2014, 5:05 PM), <http://www.tampabay.com/opinion/columns/former-justices-why-voters-should-reject-medical-marijuana-amendment/2196870>.

71. The Florida Medical Association took a stand against Amendment 2, stating the medical marijuana initiative carried unintended consequences that constituted a public health risk. Stockfisch, *supra* note 20. The organization has approximately twenty thousand doctors. *Id.*

72. *Id.* (internal quotations omitted).

73. BallotPedia, *Florida Right to Medical Marijuana Initiative, Amendment 2 (2014)*, BALLOTPEDIA.ORG, [http://ballotpedia.org/Florida\\_Right\\_to\\_Medical\\_Marijuana\\_Initiative\\_Amendment\\_2\\_%282014%29](http://ballotpedia.org/Florida_Right_to_Medical_Marijuana_Initiative_Amendment_2_%282014%29) (last visited Apr. 18, 2016).

74. Smith, *supra* note 68, at 4.

75. *Constitutional Amendment Petition Form*, *supra* note 11, at Ballot Summary. The constitutional amendment defines "debilitating medical condition" as

cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

*Id.* art. X, § 29(b)(1).

76. *Id.*

77. *Id.* § 29(b)(10).

full assessment of the patient's medical history, and note how long they recommend the patient use medical marijuana.<sup>78</sup> A qualifying patient would then receive a "physician certification"<sup>79</sup> from the physician, which would allow the patient to submit that certification to the Department of Health in order to receive a patient identification card that would then allow a patient to obtain marijuana from a "Medical Marijuana Treatment Center."<sup>80</sup> Amendment 2 directed the Department of Health to "protect the confidentiality of all qualifying patients" and to keep the records and identities of all patients confidential, unless needed for "valid medical or law enforcement purposes."<sup>81</sup>

Amendment 2 did not state any specific limits for the Medical Marijuana Treatment Centers, nor did it specify the maximum amount of marijuana a patient or caregiver could possess. However, Amendment 2 did have a provision that required the Department of Health to implement a "regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence."<sup>82</sup>

Although Amendment 2 specifically removed sanctions and criminal and civil liability from a qualifying patient, personal caregiver, and Florida licensed physicians,<sup>83</sup> Amendment 2 also specifically stated it did not authorize the "violation of federal law or purport[]" to give immunity under federal law."<sup>84</sup> Therein lies the rub: persons who are in the business of cultivating, selling, or distributing marijuana, and those who facilitate such activities, are in violation of the CSA, regardless of Florida's law immunizing liability.<sup>85</sup>

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78. *Id.* § 29(b)(9).

79. *Id.*

80. *Id.* § 29(b)(5),(9)–(10). The proposed amendment defines a treatment center as

an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their personal caregivers and is registered by the Department.

*Id.* § 29(b)(5).

81. *Id.* § 29(d)(4).

82. *Id.* § 29(d)(1). It also added that "[t]his presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use." *Id.*

83. *Id.* § 29(a)(1)–(2).

84. *Id.* § 29(c)(5).

85. *See* Cole, *supra* note 29 (explaining that such persons are subject to federal enforcement action, which includes potential prosecution).



### C. The Florida Medical Marijuana Act

After Amendment 2 failed in November 2014, Republican Senator Jeff Brandes filed a bill in January 2015, entitled the Florida Medical Marijuana Act (FMMA).<sup>86</sup> Similar to Amendment 2, the FMMA was a significant expansion of the Compassionate Medical Cannabis Act. The FMMA aimed to accomplish the same goal as Amendment 2—allow patients with medical conditions to obtain marijuana with a physician’s recommendation.<sup>87</sup> However, like Amendment 2, the FMMA failed to become law.<sup>88</sup>

Although the FMMA proposed legislation was more instructive and restrictive than that of Amendment 2, it still had significant holes. For example, the FMMA only partially addressed one of the main criticisms of Amendment 2—the lack of specified diseases that can be treated by medical marijuana—by listing eight specific illnesses that qualify as medical conditions eligible for medical marijuana treatment.<sup>89</sup> But, the ninth condition listed stated, “[a]ny physical medical condition or treatment for a medical condition that chronically produces one or more qualifying symptoms.”<sup>90</sup> Section 381.966 opened the door even wider by allowing patients who do not suffer from the listed conditions to still be able to obtain medical marijuana as long the patient’s physician “certifies that in his or her good faith medical judgment the patient has exhausted all other reasonably available medical treatments for any of the patient’s qualifying symptoms.”<sup>91</sup> Critics of Amendment 2 had the same qualm with the “[a]ny physical medical condition” language that they did with the open-ended “debilitating disease[]” language from Amendment 2—that this kind of language opens the door to the general use of marijuana

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86. FLORIDA MEDICAL MARIJUANA ACT, S. 528, 2015 Leg., 117th Sess. (Fla. 2015).

87. *Id.*

88. *Id.*; see *SB 528: Medical Use of Marijuana*, THE FLA. SENATE, <http://www.flsenate.gov/Session/Bill/2015/0528> (last visited Apr. 14, 2016) (noting that the bill died in the Regulated Industries Committee).

89. Fla. S. 528, § 381.991(15). The illnesses listed are the following: cancer; positive status for human immunodeficiency virus (HIV); acquired immune deficient syndrome (AIDS); epilepsy; amyotrophic lateral sclerosis (ALS); multiple sclerosis; Crohn’s disease; and Parkinson’s disease. *Id.*

90. *Id.* § 381.991(15)(i) (emphasis added). The five symptoms listed are: cachexia or wasting syndrome; severe and persistent pain; severe and persistent nausea; persistent seizures; or severe and persistent muscle spasms. *Id.* § 381.991(16).

91. *Id.* § 381.996(1)(c).

by allowing physicians such broad discretion in the types of conditions deemed treatable by medical marijuana.<sup>92</sup>

Similar to the procedure proposed by Amendment 2, the FMMA required physicians to certify qualified patients in order for those patients to obtain medical marijuana from an approved dispensary.<sup>93</sup> But, the FMMA took the physician's involvement in the medical marijuana recommendation process one step further by requiring the physician to "electronically transfer an original order for medical-grade marijuana for that patient to the medical marijuana patient registry."<sup>94</sup> The FMMA also listed the specific penalty if a physician ordered medical marijuana for a patient "without a reasonable belief that the patient is suffering from a condition or symptom listed in [the bill]."<sup>95</sup> However, the FMMA did include a training requirement for certifying physicians, a requirement Amendment 2 did not address.<sup>96</sup>

Although the bill was a step in the right direction, and an improvement from Amendment 2 in terms of wording and procedures, the FMMA still did not emphasize the kind of open communication that should, at the very least, be encouraged of Florida physicians, if not explicitly required of them. Significantly, of the twenty-eight page bill, only about two pages were devoted to the physician's role in the medical marijuana program.<sup>97</sup> There was no language in the FMMA dealing with what physicians can specifically discuss without violating the federal law.

#### V. CONANT V. WALTERS: RECOMMENDING VS. PRESCRIBING

The dilemma healthcare providers, namely physicians, face regarding medical marijuana is that the more specific a physician is about how to obtain and use medical marijuana, the more a physician's comments start to sound like a prescription, as opposed to a recommendation—and prescriptions for medical marijuana have been

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92. *Id.* § 381.991(15). See McDonald et al., *supra* note 70 (criticizing Amendment 2 for allowing "the use of marijuana for virtually any medical condition at the discretion of any recommending physician").

93. *Id.* § 381.996.

94. *Id.* § 381.996(2).

95. *Id.* § 381.998(1).

96. *Id.* § 381.996(4). Mirroring the training requirement of the Compassionate Medical Cannabis Act, an eight-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association is required. *Id.*

97. *Id.* § 381.996(1)–(4).

found to be illegal by the Ninth Circuit in *Conant v. Walters*.<sup>98</sup> Florida physicians will face this dilemma if medical marijuana legislation is passed. Therefore, they should be aware of how one part of the country has handled this predicament.

In the months following the passage of the Compassionate Use Act in California (the first state to legalize medical marijuana), federal officials made at least fifteen separate statements verifying the federal government's intent to prosecute physicians, to revoke the prescription licenses of physicians, and to deny physicians participation in Medicare and Medicaid if they recommended marijuana to their patients.<sup>99</sup> In response, patients suffering from serious illnesses, physicians licensed in California who treated patients with serious illnesses, a physicians' organization, and a patients' organization filed suit in early 1997, seeking to enjoin the part of the federal policy that threatened to punish physicians for discussing medical marijuana with their patients.<sup>100</sup> The district court issued a permanent injunction, which enjoined the federal government from "(i) revoking any physician class member's DEA registration merely because the doctor makes a recommendation for the use of medical marijuana based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground."<sup>101</sup> The district court added that the injunction applied "whether or not the physician anticipates that the recommendation will, in turn, be used by the patient to obtain marijuana in violation of federal law."<sup>102</sup> Subsequently, the federal government appealed the decision to the Ninth Circuit.<sup>103</sup>

On appeal, the Ninth Circuit analyzed whether a physician's recommendation of medical marijuana was analogous to a prescription of a controlled substance, because the federal government argued that a recommendation was essentially a prescription.<sup>104</sup> The Ninth Circuit held that if a physician who recommended medical marijuana to a patient intended for the patient to use the recommendation as a means to obtain

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98. 309 F.3d 629 (9th Cir. 2002).

99. *Conant v. McCaffrey*, No. C 97-00139 WHA, 2000 WL 1281174, at \*1 (N.D. Cal. Sept. 7, 2000) (*McCaffrey*) *aff'd sub nom.* *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (*Conant*). For a detailed analysis of *Conant* and its effect on physicians' First Amendment rights, see Kathy S. Pomerantz, Comment, "Silence Is a Fence Around Wisdom": How *Conant v. Walters* Broke Down the Fence by Securing Physicians' First Amendment Right to Recommend Medical Marijuana to Their Patients, 37 LOY. L.A. L. REV. 1771 (2004).

100. *Conant*, 309 F.3d at 633.

101. *McCaffrey*, 2000 WL 1281174, at \*16.

102. *Id.*

103. *Conant*, 309 F.3d at 634.

104. *Id.* at 635.

marijuana, “as a prescription is used as a means for a patient to obtain a controlled substance, then a physician would be guilty of aiding and abetting the violation of federal law.”<sup>105</sup> Thus brought about the ambiguous rule that a physician who *recommends* the medical use of marijuana to a patient does not translate into aiding, abetting, or conspiracy, but that *prescribing* and dispensing marijuana is a violation of federal law.<sup>106</sup>

### A. Aiding and Abetting

The federal criminal law punishes not only those who actively commit crimes but also those who aid and abet, or conspire with those who commit crimes.<sup>107</sup> Title 18 U.S.C. Section 2(a) imposes accomplice liability on anyone who aids in the commission of an offense against the United States, including violations of the CSA.<sup>108</sup> Hence, there is the concern that healthcare providers who recommend medical marijuana could be charged as an accomplice in violation of Title 21 U.S.C. Section 841(a), which makes it unlawful for any person to knowingly or intentionally “manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance,”<sup>109</sup> or Section 856, which bars anyone from knowingly using a space “for the purpose of manufacturing, distributing, or using any controlled substance.”<sup>110</sup>

In addressing the aiding and abetting issue in *Conant*, the Ninth Circuit adopted the four-part test from *United States v. Gaskins*,<sup>111</sup> which requires the government to prove:

- (1) that the accused had the specific intent to facilitate the commission of a crime by another, (2) that the accused had the requisite intent of the underlying substantive offense, (3) that the accused assisted or participated in the commission of the underlying substantive offense, and (4) that someone committed the underlying substantive offense.<sup>112</sup>

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105. *Id.*

106. *Id.* at 634–35.

107. 18 U.S.C. § 2(a) (2012).

108. *Id.*

109. 21 U.S.C. § 841(a)(1).

110. *Id.* § 856(a)(1).

111. 849 F.2d 454 (9th Cir. 1988).

112. *Conant*, 309 F.3d at 635 (quoting *Gaskins*, 849 F.2d at 459).

## B. Conspiring

The Ninth Circuit also adopted a test for conspiracy from a previous Ninth Circuit case, which required that a defendant make “an agreement to accomplish an illegal objective and [that he] knows of the illegal objective and intends to help accomplish it.”<sup>113</sup> Using these tests, the Ninth Circuit reasoned that aiding and abetting requires a physician to have the specific intent to provide a patient with a means to obtain marijuana, and that a physician’s anticipation that a patient may use the recommendation to obtain the federally banned substance does not translate into aiding and abetting, or conspiracy.<sup>114</sup> The Ninth Circuit further held that “a conspiracy would require that a doctor have knowledge that a patient intends to acquire marijuana, agree to help the patient acquire marijuana, and intend to help the patient acquire marijuana.”<sup>115</sup>

In short, the Ninth Circuit held that a physician’s recommendation of medical marijuana does not necessarily lead to a patient obtaining marijuana,<sup>116</sup> and that the mere anticipation that a patient may use a recommendation to obtain marijuana illegally is not considered aiding and abetting because aiding and abetting only becomes an issue when a physician has the specific intent to provide a patient with a way to acquire medical marijuana.<sup>117</sup> In terms of First Amendment protection (which this Article will not discuss in depth), the Ninth Circuit held that a physician’s recommendation of medical marijuana is protected up until the point that the physician intends for a patient to use the recommendation to engage in illegal activity.<sup>118</sup>

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113. *Id.* (internal quotations omitted) (quoting *Conant v. McCaffrey*, 172 F.R.D. 681, 700 (N.D. Cal. 1997) (citing 21 U.S.C. § 846 (2012); *United States v. Gil*, 58 F.3d 1414, 1423 & n.5 (9th Cir. 1995))).

114. *Id.* at 635–36.

115. *Id.* at 636.

116. *Id.* at 634. The court agreed with the district court’s conclusion that recommendations of marijuana can lead to legitimate responses, such as the patient petitioning the government to change the law on marijuana. *Id.*

117. *Id.* at 635–36.

118. *Id.* *But see* *Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 121 (D.D.C. 2001) (holding that there is no constitutional protection for a physician’s recommendation of medical marijuana because the speech itself is “an integral part of conduct in violation of a valid criminal statute”) (internal quotations omitted) (quoting *Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 498 (1949)).

VI. THE RECOMMENDATION VS. PRESCRIPTION  
DISTINCTION HINDERS PHYSICIAN–PATIENT COMMUNICATION

First and foremost, Florida’s Amendment 2 would have put patients who use medical marijuana in direct conflict with federal law because any possession of marijuana under federal law is illegal.<sup>119</sup> As for healthcare providers, at the very least, Amendment 2 would have put Florida physicians in a precarious position. Even though a physician would not have directly been breaking federal law—i.e., not knowingly or intentionally manufacturing, distributing, or dispensing marijuana<sup>120</sup>—the physician would have been helping a patient obtain the federally banned substance by enabling the patient to obtain marijuana with a physician certification, and following the *Conant* decision, this may be seen by some as aiding and abetting, or conspiring to obtain marijuana if the “recommendation” was deemed a prescription.<sup>121</sup>

The *Conant* Court made an arbitrary distinction when it held that a recommendation is not a prescription because a physician cannot anticipate what a patient will do with the recommendation. Although it is true that a physician has no way of knowing what a patient will do with the physician’s recommendation of medical marijuana, it is willfully ignorant to say that a physician who recommends medical marijuana to a patient does not intend that the patient will use that recommendation as a means to obtain medical marijuana—i.e., “as a means for a patient to obtain a controlled substance.”<sup>122</sup>

When a physician recommends that a patient take an antibiotic, the physician also does not know whether or not the patient will follow through with procuring and taking the antibiotic, but nobody questions whether the physician *intended* for the patient to take the antibiotic. The whole point of recommending antibiotics is so that the patient will take the antibiotic; that is the physician’s clear intention for uttering the recommendation or writing the prescription. Thus, physicians who (a) do not understand the nuanced distinction between recommendation and prescription or (b) do not think there is a true distinction between a recommendation and a prescription, and who are particularly concerned

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119. 21 U.S.C. § 844(a) (2012); Mikos, *supra* note 23, at 10.

120. 21 U.S.C. § 841(a)(1).

121. The healthcare industry is not the only profession concerned with the ethical implications of helping people obtain medical marijuana. Lawyers, as well, are becoming increasingly focused on the legal complexities of medical marijuana laws and on how advising clients on these laws may be seen as aiding or abetting a federal crime. Frezza, *supra* note 21, at 552.

122. *Conant*, 309 F.3d at 635.

with violating federal law, may be reluctant to give specific instructions to patients on how to use medical marijuana. This could lead to many patients being left unsupervised and misguided in their use of medical marijuana.<sup>123</sup> If a physician feels uncomfortable directing a patient to one of the five dispensaries in Florida, because the physician thinks that would be considered aiding and abetting a violation of Title 21 U.S.C. Sections 841(a) or 856, and the physician does not advise the patient where he can find medical marijuana, that patient may resort to obtaining marijuana from an unlicensed, civilian dealer, which *is* a direct violation of Florida<sup>124</sup> and federal law.<sup>125</sup>

Further, medical marijuana legislation should require physicians to tell their patients that it is still illegal to possess marijuana under federal law when the physician is recommending medical marijuana to their patients.<sup>126</sup> Although marijuana's illegality may be considered common knowledge to most, patients often think of physicians as *the* authority figure on medication and treatment. As such, patients place infinite trust and confidence in their physicians, and patients might mistake their physician's recommendation as a kind of "get out of jail free card" in relation to marijuana, not realizing that there are still ramifications for possessing marijuana under federal law.<sup>127</sup> However, following the *Conant* analysis, if a physician is explicitly required to tell a patient that possessing marijuana is a violation of the federal law, while also directing the patient where he or she can find medical marijuana and then certifying the patient to be eligible to obtain that medical marijuana, then the physician's speech starts to sound like conspiracy. The description of the physician statements above tend to show that the physician knew of the illegal objective—obtaining marijuana—and intended to accomplish it by informing the patient about medical marijuana as a treatment and where to find the marijuana, which meets the requirements

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123. See generally William Vertes & Sarah Barbantini, *Caught in the Crossfire: The Dilemma of Marijuana "Medicalization" for Healthcare Providers*, 58 WAYNE L. REV. 103, 121–22 (2012) (analyzing Michigan's medical marijuana statute, noting that physicians are not required to instruct a patient on how to use or obtain marijuana).

124. FLA. STAT. § 893.13 (2015).

125. 21 U.S.C. § 841(a)(1).

126. Additionally, physicians must disclose that medical marijuana has not been approved by the FDA. See *Gaston v. Hunter*, 588 P.2d 326, 340 (Ariz. Ct. App. 1978) (holding that when a drug is part of treatment, a patient is entitled to know whether that drug or substance has been tested or approved by federal authorities, such as the FDA).

127. See *Rust v. Sullivan*, 500 U.S. 173, 218 (1991) (acknowledging that all patients attach "profound importance and authority to the words of advice spoken by the physician"); *Trammel v. United States*, 445 U.S. 40, 51 (1980) (holding that the doctor–patient privilege is "rooted in the imperative need for confidence and trust").

of conspiracy. In turn, the physician may be reluctant to inform the patient of the federal consequences out of fear of federal repercussions to the physician.

The Ninth Circuit stressed in *Conant* that physicians should be able to speak openly and honestly with their patients.<sup>128</sup> Patients need open communication with physicians in order to ensure they are well informed of all of their options, including where to obtain, and how best to use medical marijuana. But, when physicians have to walk the line between making a recommendation for marijuana and prescribing marijuana, open communication gets lost in the minutia of carefully parsed words. Even though the Ninth Circuit in *Conant* broadened the protection of the First Amendment to physician speech, the arbitrary distinction the Ninth Circuit made between recommending and prescribing still serves to prohibit physician speech that is necessary to fully inform patients about medical marijuana as a therapeutic treatment.

#### VII. FLORIDA MEDICAL MARIJUANA LAW SPECIFIC PROBLEMS

As previously discussed,<sup>129</sup> Florida Amendment 2 required a qualifying patient to receive a physician certification from his or her physician in order to receive a patient identification card enabling the patient to obtain marijuana from a designated Medical Marijuana Treatment Center.<sup>130</sup> Although the wording of Amendment 2 and the FMMA, which had a similar physician certification requirement, were careful not to use the word “prescribe,”<sup>131</sup> the physician certification is, in essence, a prescription for medical marijuana.

As the Ninth Circuit stated in *Conant*, aiding and abetting only becomes an issue when a physician has the specific intent to provide a patient with a way to acquire medical marijuana.<sup>132</sup> When a physician issues a certification to a patient, it demonstrates that the physician has a specific intent to provide that patient with a way to acquire medical marijuana since the physician knows that the certification is required in

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128. *Conant v. Walters*, 309 F.3d 629, 636 (9th Cir. 2002).

129. *See supra* Part IV (discussing Florida’s 2014 failed ballot measure on the legalization of medical marijuana).

130. *Constitutional Amendment Petition Form*, *supra* note 11, at Art. X, § 29(b)(9).

131. The words “prescribe” or “prescription” did not appear at all in Amendment 2, and neither word appears in the FMMA. *Id.* at Art. X, § 29; Florida Medical Marijuana Act, S. 528, 2015 Leg., 117th Sess. (Fla. 2015).

132. *Conant*, 309 F.3d at 636.



order to obtain medical marijuana under Florida law.<sup>133</sup> Thus, the physician certification is the patient's direct ticket to acquiring medical marijuana.

Nevertheless, having a physician certification procedure acts as an important safeguard for medical marijuana distribution,<sup>134</sup> which is why physician approval should not be removed from the process just to mitigate physician liability. Florida can help to alleviate physician liability by choosing not to follow the recommendation versus prescription distinction made in *Conant*.<sup>135</sup> Instead, any Florida legislation or subsequent court decisions that legalize medical marijuana should focus on ensuring that physicians have the freedom to openly discuss medical marijuana with their patients, and not be arbitrarily constrained by the rule that physician speech is only protected to the point that the physician intends for a patient to use the recommendation to engage in illegal activity.<sup>136</sup>

Although a provision of Amendment 2 stated a physician would not be subject to sanctions under Florida law for issuing a physician certification,<sup>137</sup> there were no provisions in Amendment 2 or in the FMMA waiving disciplinary action by the Florida Board of Medicine, or any other professional licensing board, against physicians who properly recommended medical marijuana to their patients. Such a provision should be added to any future Florida legislation to allow physicians the freedom to openly discuss medical marijuana with their patients. For example, Nevada has specific language in its medical marijuana statute that states the Board of Medical Examiners cannot take disciplinary actions against physicians who advise a patient about the risks and benefits of medical marijuana use.<sup>138</sup> Maine, on the other hand, incorporates specific language that allows a professional licensing board

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133. The FMMA pushed physicians even closer to the line of prescribing (versus recommending), by requiring physicians to not only certify patients but also send an "order" for medical-grade marijuana to the actual patient registry, stating the allowed amount of marijuana and the concentration ranges for individual cannabinoids, if there are any. Florida Medical Marijuana Act, S. 528, 2015 Leg., 117th Sess., §7 (Fla. 2015).

134. The physician certification procedure acts as an important safeguard in terms of limiting medical marijuana to patients who will actually benefit from the use of it. By requiring that a physician sign-off on the patient's use of this drug, there is at least proof that a medically licensed professional, who theoretically has been trained and educated on the use of medical marijuana as a therapeutic drug, made a well-informed recommendation based on an educated evaluation of the patient's condition. *Id.*

135. *Conant*, 309 F.3d at 634.

136. *Id.* at 635–36.

137. *Constitutional Amendment Petition Form*, *supra* note 11, at Art. X. § 29(a)(2).

138. NEV. REV. STAT. § 453A.500 (2015).

to sanction physicians “for failing to properly evaluate or treat a patient’s medical condition or otherwise violating the applicable standard of care for evaluating or treating medical conditions.”<sup>139</sup>

There is an inherent standard of care issue for physicians recommending marijuana because there is not much guidance on acceptable practices with medical marijuana generally.<sup>140</sup> Therefore, what should be considered proper or acceptable medical practice in terms of recommending marijuana will be difficult for physicians to gauge because there is not a usual or customary medical marijuana prescription plan for physicians to follow at this time.<sup>141</sup> If physicians are legally allowed to recommend marijuana in the State of Florida, the legislation should contain a provision similar to that of Nevada, which protects physicians from disciplinary action on a professional level, as opposed to Maine’s statute, which incorporates a standard of care that does not currently exist in the medical marijuana field.

An example of a medical marijuana law emphasizing communication between physicians and patients can be found in Colorado. In Colorado, the law specifically states physicians are exempt from state criminal laws if the physician advises a patient about the use of medical marijuana.<sup>142</sup> Using the term “advise” gives physicians much more leeway in terms of what they can say to their patients, leaving physicians less concerned with the recommendation versus prescription distinction defined in *Conant*. Florida’s Amendment 2 only stated that physicians “shall not be subject to criminal or civil liability or sanctions under Florida law for issuing a physician certification to a person diagnosed with a debilitating medical condition.”<sup>143</sup> In order for Florida physicians, who are acutely aware of the recommendation versus prescription distinction, to feel free to openly communicate with their patients, language similar to Colorado’s law—where advising patients about medical marijuana is clearly stated as an allowable action by physicians—should be included in any future Florida medical marijuana legislation.

In addition, Amendment 2 and the FMMA did not offer criminal or civil liability protection to nurse practitioners or physician assistants;

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139. ME. REV. STAT. tit. 22, § 2423-B(5) (2014).

140. Vertes & Barbantini, *supra* note 123, at 127–28.

141. See Gibbons, *supra* note 33, at 4 (reporting that researchers find it difficult to obtain marijuana through official government channels in order to conduct research on marijuana’s medicinal qualities).

142. COLO. CONST. art. XVIII, § 14(2)(c)(I).

143. *Constitutional Amendment Petition Form*, *supra* note 11, at § 29(a)(2).

Amendment 2 and the FMMA only explicitly mention licensed physicians in Florida. Thus, protections should be broadened to include nurse practitioners and physician assistants, who will likely be playing a significant role in the medical marijuana recommendation process. Additionally, the Florida Board of Medicine<sup>144</sup> or the Florida Department of Health should release guidelines for healthcare providers who would like to have the option of recommending medical marijuana to qualified patients.<sup>145</sup> These guidelines should include, among other recommendations and educational materials, follow-up procedures; possible side effects and explanation of which side effects should be considered particularly dangerous; potential drug interactions; techniques for the use of medical marijuana; different methods, forms, and routes of administration, signs and symptoms of substance abuse; alternative medical options;<sup>146</sup> and disclosure to patients that insurance companies are not required to cover medical marijuana treatments.<sup>147</sup>

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144. As of April 2016, the Florida Board of Medicine's website states: "Currently there are no laws or rules that allow for the use of medical marijuana in the State of Florida. It is possible that this may change in the future, but as of right now we cannot provide any guidance on the matter." Fla. Bd. Med., *Help Center / Can a Medical Doctor Prescribe or Dispense Marijuana?*, FLA. BD. MED., <http://flboardofmedicine.gov/help-center/can-a-medical-doctor-prescribe-or-dispense-marijuana-2/> (last modified Mar. 5, 2014, 12:11 PM).

145. See, e.g., Will Humble, *Arizona Medical Marijuana Program Keeping It Medical: The Role of the Physician*, AZ DEP'T HEALTH SERVICES (Aug. 16, 2012), available at [http://azdhs.gov/documents/licensing/medical-marijuana/physicians/MMJ\\_KeepingItMedical\\_TheRoleofthePhysician.pdf](http://azdhs.gov/documents/licensing/medical-marijuana/physicians/MMJ_KeepingItMedical_TheRoleofthePhysician.pdf) (providing guidelines for physicians in Arizona who participate in the Arizona Medical Marijuana Program).

146. *Id.*

147. Jennifer Mesko, *Health Insurance Companies Refuse to Cover Medical Marijuana*, DRUG WATCH (June 16, 2014), <http://www.drugwatch.com/2014/06/16/health-insurance-medical-marijuana/>. Another treacherous area physicians might find themselves in when recommending medical marijuana is self-referrals, which are prohibited by the "Stark Law" and the Florida Patient Self-Referral Act of 1992. 42 U.S.C. 1395 (2012); FLA. STAT. § 456.053(5) (2015). Any physician who has a financial interest in a Medical Marijuana Treatment Center would need to refrain from sending his or her patients there, in order to avoid violating these laws. Healthcare providers who recommend marijuana should also be conscious of the Florida Patient Brokering Act, the Anti-Kickback law, and the Fee-Splitting law. FLA. STAT. § 456.054(2) (making it unlawful for "any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients"); *id.* § 458.331(1)(i) (prohibiting "[p]laying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services"); *id.* § 817.505(1)(b) (prohibiting the solicitation or referrals of patients in return for any kind of "commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever").

### VIII. CONCLUSION

Although *Conant* broadened the protection of First Amendment physician-speech, it did not quite overcome the barrier that physicians and healthcare providers have to barrel through in order to recommend medical marijuana. The focus on whether a physician intends for a patient to use the recommendation to obtain medical marijuana as the deciding factor in whether the physician is aiding and abetting or conspiring to violate the federal ban on marijuana is misguided and amounts to a trivial distinction. Instead, the focus should be on ensuring that physicians feel comfortable disclosing as much information as possible to patients so the patient can make an informed medical decision on whether to use medical marijuana as a treatment.

Unfortunately, physician participation in the medical marijuana arena puts physicians in an uncomfortable and unwarranted position while medical marijuana remains illegal under federal law.<sup>148</sup> The legality of medical marijuana is a complicated and gray area that most physicians do not want to be tangled in, especially at the risk of losing his or her license to practice medicine.<sup>149</sup> Had Amendment 2 passed and the Eleventh Circuit chosen to follow suit with the Ninth Circuit's reasoning in *Conant*, Florida's recommending physicians would have been forced to be incredibly selective in their wording when discussing medical marijuana with patients in order to avoid criminal liability for aiding and abetting those patients in obtaining marijuana.<sup>150</sup> Therefore, Amendment 2 would not have fixed the physicians' fear of federal repercussion problem; it would have exacerbated it.

Although no Florida statute legalizing medical marijuana would remedy the federal versus state law conundrum,<sup>151</sup> Florida medical marijuana legislation could make Florida physicians feel more comfortable recommending medical marijuana by implementing legislation with a physician-patient communication focus, and disbanding the recommendation versus prescription distinction in *Conant*. There is an implicit public interest element at stake with medical

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148. See Vertes & Barbantini, *supra* note 123, at 137 (suggesting that physicians should not be required to be a part of the marijuana legalization medical process).

149. The DEA has the power to revoke a physician's permit or pursue criminal charges against physicians whose prescription of drugs covered by the CSA fall outside of the DEA's view of legitimate medical practice. FURROW ET AL., *supra* note 15, at 97.

150. Am. Coll. of Physicians, *supra* note 10, at 9.

151. The legal conundrum is that medical marijuana would be legal under Florida state law, but remain illegal under federal law.

marijuana recommendation restrictions, where the line between ensuring that patients make well-informed health decisions and ensuring that physicians are not blatantly violating federal law has become rather blurred. If medical marijuana is legalized in Florida,<sup>152</sup> it is imperative that physicians are able to freely discuss medical marijuana with their patients in order to provide them with proper care. However, it is worth repeating that no matter how well written a statute or act legalizing medical marijuana in Florida is, recommending marijuana, even for medicinal purposes, remains in direct opposition to federal law. It remains to be seen how the federal government will handle more states legalizing medical marijuana, as medical marijuana's prevalence is quickly becoming impossible to ignore.

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152. Florida voters will have another opportunity to legalize medical marijuana in November 2016; as of April, 2016, medical marijuana is back on the Florida ballot as a slightly revised Amendment 2. BallotPedia, *Florida Right to Medical Marijuana Initiative, Amendment 2 (2016)*, BALLOTPEDIA.ORG, [https://ballotpedia.org/Florida\\_Right\\_to\\_Medical\\_Marijuana\\_Initiative\\_Amendment\\_2\\_\(2016\)](https://ballotpedia.org/Florida_Right_to_Medical_Marijuana_Initiative_Amendment_2_(2016)) (last visited Apr. 14, 2016). The 2016 Amendment 2 is very similar to the 2014 Amendment 2, with a few differences: the 2016 version adds a parent or legal guardian written consent requirement in order for minors to receive a physician certification; slightly limits "other debilitating medical condition" by defining it as the "same kind or class as or comparable to" diseases including cancer, HIV, post-traumatic stress disorder, Parkinson's disease and epilepsy; and explicitly states that the amendment would not shield physicians from negligence or malpractice claims. *Constitutional Amendment Petition Form*, FLA. DEP'T OF ST. art. X, § 29(a)(9), (b)(1), (c)(8), available at <http://dos.elections.myflorida.com/initiatives/fulltext/pdf/50438-3.pdf> (last approved Jan. 9, 2015).