The Arizona Medical Marijuana Act: A Pot Hole for Employers?

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I. Introduction

The medical, legal, and political debate over the therapeutic use of marijuana is not a new phenomenon. Not surprisingly, the decades-old debate cen-
ters on the question of whether the potential medical benefits from the use of marijuana outweigh the known risks of the drug.\footnote{See State v. Jones, No. 1 CA-CR 09-0944, 2011 WL 3300366, at *3 (Ariz. Ct. App. Aug. 2, 2011) ("We recognize that the fears of marijuana’s possible adverse effects on health and society are subject to serious question, and there is still an ongoing debate about the benefits and health risks of marijuana use and whether it should be decriminalized."); Seeley v. Washington, 940 P.2d 604, 616-18 (Wash. 1997) (highlighting opposing medical opinions regarding the medical benefits of marijuana, including the opinion of a Harvard Medical School specialist on psychoactive drugs that "marijuana is one of the safest drugs available" and the opinion of a medical oncology specialist that "there is no therapeutic use for marijuana" and that "the hazards associated with smoking marijuana . . . include lung disease, cardiac dysfunction, brain damage, genetic damage, immune disorders and psychomotor impairment."); Allison J. Bergstrom, Medical Use of Marijuana: A Look at Federal & State Responses to California[ ]Compassionate Use Act, 2 DePaul J. Health Care L. 155, 155 (1997) ("Conflict centers on whether marijuana does, in fact, provide a unique form of pain relief not found from other available drugs.").} Courts have been hesitant to weigh in on the substance of the debate,\footnote{See, e.g., Cole v. Laird, 468 F.2d 829, 833 n.5 (5th Cir. 1972) ("We do not as Judges undertake to enter the contemporary controversy as to the nature of marijuana or its medico-sociological classification."); United States v. 325 Skyline Circle, 534 F. Supp. 2d 1163, 1168 n.10 (S.D. Cal. 2008) ("This Court finds it inappropriate to debate the effects, positive or negative, of marijuana smoking here. Therefore, this Court does not consider the effects, harmful or not, of marijuana smoking . . . .").} instead leaving that task to voters and elected lawmakers.\footnote{Michael M. O’Hear, Federalism and Drug Control, 57 Vand. L. Rev. 783, 836 (2004); see Seeley, 940 P.2d at 623 ("The debate over the proper classification of marijuana belongs in the political arena."); see also Butler v. Douglas County, Civil No. 07-6241-HO, 2010 WL 3220199, at *4 n.4 (D. Or. Aug. 10, 2010) ("The debate over the necessity to legalize marijuana for medical use and whether the federal government should decline to prosecute in such cases, is a political issue that plays no role in this court’s decision.").} Despite persistent public resistance to the broad legalization of marijuana for personal recreational use,\footnote{See, e.g., People v. Urziceanu, 33 Cal. Rptr. 3d 859, 873 (Ct. App. 2005) ("[T]he people of this state . . . have declined to decriminalize marijuana on a wholesale basis."); State v. Dixson, 740 P.2d 1224, 1239 (Or. Ct. App. 1987) (Van Hoomissen, J., dissenting) (noting that a 1986 ballot measure in Oregon which “would have legalized private possession and growing of marijuana for personal use . . . was soundly defeated at the polls”), rev’d on other grounds, 766 P.2d 1015 (Or. 1988); O’Hear, supra note 4, at 836 ("[D]espite success in getting onto state ballots, liberalizing initiatives for nonmedical marijuana use have been repeatedly and decisively defeated."). But see Ekow N. Yankah, A Paradox in Overcriminalization, 14 New Crim. L. Rev. 1, 7 (2011) ("One might argue that the restricted use of marijuana for medical purposes does little to evidence a coherent trend toward decriminalization were it not for two obvious features. The first is that the link between personal marijuana consumption and medical need in many of these jurisdictions is becoming increasingly illusionary. . . . Secondly, the proliferation of permissive medical marijuana regimes has occurred in concert with an explicit decriminalization of marijuana use or recession of criminal penalties on the state and local levels.").} laws seemingly recognizing the potential medical benefits of marijuana were enacted by various states throughout the twentieth century. [The National Organization for Reform of Marijuana Laws] has sought to change the federal government’s control over marijuana since the early 1970s.\footnote{See, e.g., People v. Urziceanu, 33 Cal. Rptr. 3d 859, 873 (Ct. App. 2005) ("[T]he people of this state . . . have declined to decriminalize marijuana on a wholesale basis."); State v. Dixson, 740 P.2d 1224, 1239 (Or. Ct. App. 1987) (Van Hoomissen, J., dissenting) (noting that a 1986 ballot measure in Oregon which “would have legalized private possession and growing of marijuana for personal use . . . was soundly defeated at the polls”), rev’d on other grounds, 766 P.2d 1015 (Or. 1988); O’Hear, supra note 4, at 836 ("[D]espite success in getting onto state ballots, liberalizing initiatives for nonmedical marijuana use have been repeatedly and decisively defeated."). But see Ekow N. Yankah, A Paradox in Overcriminalization, 14 New Crim. L. Rev. 1, 7 (2011) ("One might argue that the restricted use of marijuana for medical purposes does little to evidence a coherent trend toward decriminalization were it not for two obvious features. The first is that the link between personal marijuana consumption and medical need in many of these jurisdictions is becoming increasingly illusionary. . . . Secondly, the proliferation of permissive medical marijuana regimes has occurred in concert with an explicit decriminalization of marijuana use or recession of criminal penalties on the state and local levels.").}
eth century. However, most of these laws were purely symbolic in nature, in many cases because they authorized the medical use of marijuana only if prescribed by a doctor, and prescribing marijuana is prohibited by federal law.

California rekindled the medical marijuana debate when it enacted the California Compassionate Use Act ("CUA") by voter referendum in 1996, making California the first state in the modern era to effectively decriminalize the medical use of marijuana. The marijuana legalization movement gained con-

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6 See, e.g., Murphy v. Commonwealth, 521 S.E.2d 301, 302 (Va. Ct. App. 1999) ("The first statute criminalizing the possession of marijuana in Virginia was enacted in 1936. Notwithstanding its enactment . . . the General Assembly permitted doctors to use the drug for medicinal purposes.") (citation omitted). See Ross v. RagingWire Telecomms., Inc., 174 P.3d 200, 211 n.1 (Cal. 2008) (Kennard, J., concurring in part and dissenting in part) ("State and federal laws permitting marijuana use for medical purposes have existed at various times and in various forms . . . for many decades.").

7 See Troy E. Grandel, One Toke over the Line: The Proliferation of State Medical Marijuana Laws, 9 U. N.H. L. REV. 135, 140-49 (2010) ("In 1993, California passed a bipartisan medical marijuana bill, but the bill was purely symbolic in that it failed to provide patients with protection from arrest.") (citation omitted) (internal quotation marks omitted) (brackets omitted); Sara L. Imhof & Brian Kaskie, Promoting a "Good Death": Determinants of Pain-Management Policies in the United States, 33 J. HEALTH POL. POL'Y & L. 907, 920 (2008) ("While several states have passed laws since 1978 that were favorable to medicinal marijuana use, early policies were largely symbolic.").

8 See, e.g., Pearson v. McCaffrey, 139 F. Supp. 2d 113, 116 n.1 (D.D.C. 2001) (noting that "Virginia, Connecticut, Vermont, and New Hampshire have authorized doctors to prescribe marijuana"); see also Daniel Abrahamson, Speeches, The Criminalization of Medicinal Marijuana, 11 HASTINGS WOMEN'S L.J. 75, 86 (2000) ("Between 1970 and the mid-1980's, thirty-five states in this country passed laws permitting physicians to prescribe marijuana to patients. Most of those laws lay dormant on the books."); Michelle Patton, The Legalization of Marijuana: A Dead-End or the High Road to Fiscal Solvency?, 15 BERKELEY J. CRIM. L. 163, 166 n.31 (2010) ("Prior to 1996, a number of states passed laws permitting doctors to prescribe marijuana . . . . These laws were ineffective because it was illegal under federal law for doctors to prescribe marijuana and the laws did not provide for a method in which the patients could fill the prescriptions.").

9 See, e.g., State v. Padua, 869 A.2d 192, 205 n.23 (Conn. 2005) ("[Connecticut] General Statutes § 21a-253 permits the possession of marijuana pursuant to a prescription by a licensed physician . . . . This statute was enacted, however, to permit the medical use of marijuana consistent with federal law. Because the federal government has not permitted such use, no prescriptions have ever been issued under this statute.") (citation omitted). See Pearson, 139 F. Supp. 2d at 121 (noting that "the prescription . . . of medicinal marijuana . . . is still a violation of federal law"); United States v. Friel, 699 F. Supp. 2d 328, 330 (D. Me. 2010) (noting that it is "illegal to prescribe marijuana under federal law").

10 CAL. HEALTH & SAFETY CODE § 11362.5 (West, Westlaw through 2011 legislation).

11 See Ross, 174 P.3d at 211 (Kennard, J., concurring in part and dissenting in part) (observing that "the Compassionate Use Act was the first law of its kind in the nation"); Ari Lieberman & Aaron Solomon, Notes, A Cruel Choice: Patients Forced to Decide Between Medical Marijuana and Employment, 26 HOFSTRA L. & EMP. L.J. 619, 620 (2009) ("California was the first state to recognize a medical marijuana law with the enactment of the [Compassionate Use Act] in 1996.").
siderable momentum as a result of this enactment, and several other states soon followed California’s lead in providing legal protection for medical marijuana users.

Arizona recently joined this trend. In the November 2010 General Election, Arizona voters passed by a narrow margin Proposition 203, now the Arizona Medical Marijuana Act (“AMMA”), making Arizona the 15th state, in addition to the District of Columbia, to decriminalize the medical use of marijuana. As has been the case in other states enacting such legislation, this development poses significant managerial and legal problems for employers.

12 See Raich v. Gonzales, 500 F.3d 850, 869 (9th Cir. 2007) (asserting that “changes in state law reveal a clear trend towards the protection of medical marijuana use”); County of San Diego v. San Diego NORM, 81 Cal. Rptr. 3d 461, 470 (Ct. App. 2008) (observing that “the use of marijuana for medical purposes has found growing acceptance among the states”); Deborah Garner, Note, Up in Smoke: The Medicinal Marijuana Debate, 75 N.D. L. REV. 555, 555 (1999) (“The current trend in the marijuana controversy, as seen in recent legislative enactments in both California and Arizona, is legalization of marijuana for medical uses.”).

13 See Conant v. Walters, 309 F.3d 629, 643 (9th Cir. 2002) (Kozinski, J., concurring) (identifying seven states that, by late 2002, had “followed California in enacting medical marijuana laws by voter initiative,” and another state that had “done so by legislative enactment”); Imhof & Kaskie, supra note 7, at 920-21 (“Starting with California’s policy adoption in 1996, some states began to adopt more substantial medical marijuana policies with strengthened patient and clinician safeguards.”).

14 The authors’ previous analysis of the employment implications of this development appears in the July/August 2011 issue of Arizona Attorney magazine. The authors are grateful to the editors of that publication for permission to explore the topic in more detail here. They also wish to thank Suzy Walker for her assistance in the preparation of both articles.


17 See State Bar of Ariz., Ethics Op. 11-01 (2011) (“Arizona [is] the 16th jurisdiction (15 states and the District of Columbia) to adopt a medical-marijuana law.”); Allison M. Bushy, Comment, Seeking a Second Opinion: How to Cure Maryland’s Medical Marijuana Law, 40 U. BALT. L. REV. 139, 148-49 (2010) (identifying Arizona as one of “fifteen states that currently protect individuals suffering from chronic or debilitating medical conditions against marijuana prosecution,” and noting that the “District of Columbia’s medical marijuana law [also] came into effect in 2010 . . . .”). In early 2011, Delaware became the 17th jurisdiction to legalize the medical use of marijuana. See 78 Del. Laws 23 (2011); cf. Delaware: Medical Marijuana Nears Legalization, N.Y. TIMES, May 11, 2011, at A18 (noting that on May 11, 2011, the Delaware Senate approved a bill (Senate Bill 17) “allow[ing] people 18 and older with certain serious or debilitating conditions that could be alleviated by marijuana to possess up to six ounces of the drug.”). Given the obvious trend, other states are likely to follow suit.

18 See Lieberman & Solomon, supra note 11.

19 See Jahna Berry, Arizona Medical Marijuana Law Likely to Test Workplace Regulations, Ariz. Republic, Dec. 1, 2010, at A9 (predicting “widespread uncertainty among employers” concerning the AMMA’s requirements, and noting that “[i]n many states with existing medical-marijuana laws are still struggling with many of the same issues”).
This article begins with a historical discussion of the nation’s movement to criminalize marijuana in the United States, which was led by the states, and reached a pinnacle with Congress’s enactment of the Controlled Substances Act of 1970. The article then discusses the criminalization of marijuana in Arizona. Next, the article discusses state medical marijuana laws generally, and the provisions of the AMMA specifically. The article then explores potential problems the AMMA poses for Arizona employers and attempts to offer guidance to employers seeking to comply with the AMMA’s requirements. The article ultimately concludes with a discussion of the federal government’s reaction to the AMMA and other states’ medical marijuana laws and the uncertainty that reaction has caused among employers, medical marijuana users, law makers, and law enforcement agencies.

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20 See infra Part II.
21 See infra Part II.B.
22 See infra Part II.C.
23 See infra Part III.
24 See infra Part IV.
25 See infra Part V.
26 See infra Part VI. Despite the widespread attention state medical marijuana laws have received from employer organizations and legal commentators, the courts of “[o]nly a few states that allow the medical use of marijuana have considered the question of how the laws will affect employment, specifically a private employer’s ability to terminate or refuse to hire employees for their use of medical marijuana.” Lieberman & Solomon, supra note 11, at 624.
27 See infra Part VII.
II. THE CRIMINALIZATION OF MARIJUANA IN THE UNITED STATES

A. Marijuana: A Cash Crop in the Nation’s Early Years

For much of the nation’s history, marijuana was not regulated. Thus, the possession, cultivation, sale, and use of marijuana were entirely lawful until the first part of the twentieth century. In fact, the federal Harrison Narcotic Act of 1914, which was the nation’s first primary drug control law and required those authorized to manufacture or handle certain drugs to register
with the Internal Revenue Service, pay a tax, and maintain records of their sales and purchases,\(^\text{34}\) did not encompass marijuana.\(^\text{35}\)

**B. The States’ Shift Toward Regulation of Marijuana**

States, rather than the federal government,\(^\text{36}\) generally led the way in the regulation of marijuana.\(^\text{37}\) California and Utah were the first states to move to criminalize the drug.\(^\text{38}\) In 1907, even before California outlawed marijuana, California’s legislature classified the drug as a poison.\(^\text{39}\) Among other things, the 1907 law made it unlawful for any person to sell marijuana without labeling

\(^{34}\) See Gonzales v. Raich, 545 U.S. 1, 10 (2005) ("[T]he primary drug control law, before being repealed by the passage of the [Controlled Substances Act], was the Harrison Narcotics Act of 1914, 38 Stat. 785 (repealed 1970). The Harrison Act sought to exert control over the possession and sale of narcotics, specifically cocaine and opiates, by requiring producers, distributors, and purchasers to register with the Federal Government, by assessing taxes against parties so registered, and by regulating the issuance of prescriptions.").

\(^{35}\) See DuVivier, supra note 28, at 276 n.315 ("The first federal regulation of drugs, the Harrison Act of 1914, addressed the importation of opium for medicinal purposes and the interstate trade of cocaine, morphine, and heroin; it did not mention marijuana."). The Harrison Act eventually was repealed by the Controlled Substances Act of 1970. See United States v. Green, 511 F.2d 1062, 1068 (7th Cir. 1975); Thomas v. United States, 650 A.2d 183, 187 (D.C. 1994).

\(^{36}\) See Gonzales, 545 U.S. at 11 ("Marijuana itself was not significantly regulated by the Federal Government until 1937 when accounts of marijuana’s addictive qualities and physiological effects, paired with dissatisfaction with enforcement efforts at state and local levels, prompted Congress to pass the Marihuana Tax Act, 50 Stat. 551 (repealed 1970.").); Richard J. Bonnie & Charles L. Whitebread II, *The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition*, 56 Va. L. Rev. 971, 1010 (1970) ("Until the inclusion of marijuana in the Uniform Narcotic Drug Act in 1932 and the passage of the Marihuana Tax Act in 1937, there was no ‘national’ public policy regarding the drug.").

\(^{37}\) See O’Hear, supra note 4, at 796 ("[T]he federal government did not develop an interest in marijuana regulation until after earlier efforts at the state and local level.") (emphasis added).

Some localities prohibited the use or possession of marijuana even before the criminalization of the drug at the state level. For example, in “1914 the New York City Sanitary Laws included cannabis in a prohibited drug list.” Bonnie & Whitebread, supra note 36, at 1010; see also El Paso, Tex., Penal Code § 53 (1917) in *Charter and Penal Code of the City of El Paso*, 1917 (Julian Richardson, codifier).

\(^{38}\) See Daniel J. Pfeifer, *Smoking Gun: The Moral and Legal Struggle for Medical Marijuana*, 27 Touro L. Rev. 339, 362 (2011) ("Since marijuana was considered a valuable medication, marijuana was not subject to federal or state regulation until California and Utah first prohibited its possession or sale in 1915."); cf. DuVivier, supra note 28, at 276 ("California and Utah passed state laws outlawing marijuana in 1915, and Colorado followed suit in 1917.").

the package in which marijuana was contained "poison." Nevertheless, possession of the drug remained lawful in California until 1915, when the state's legislature passed a law making it illegal to possess marijuana without a prescription. Utah also passed a law in 1915 broadly prohibiting the sale and possession of marijuana, but, like its California counterpart, allowing for the medical use of the drug with a prescription. Other states soon followed suit. According to two authoritative authors on the subject of marijuana regulation, there were three primary reasons for the states' initial regulation of marijuana: racial prejudice; an assumption that marijuana would be used as a substitute for narcotics and alcohol; and publicity surrounding the 1925 Geneva Convention's attention to marijuana.


41 Poison Regulation Act, 1915 Cal. Stat. 1066; see also Vitiello, supra note 39, at 758 n.317 ("Possession of marijuana remained legal [in California] until 1915, at which point state law mandated that the drug could be possessed legally only with the prescription of a physician."); Michael A. Town, Comment, The California Marijuana Possession Statute: An Infringement on the Right of Privacy or Other Peripheral Constitutional Rights?, 19 Hastings L.J. 758, 759 (1968) ("Possession of marijuana was lawful until 1915 when possession unless prescribed by a physician was prohibited.").

42 See Poison Regulation Act, 1915 Utah Laws 74; Bonnie & Whitebread, supra note 36, at 1012 n.14 (observing that the 1915 Utah statute "forbade sale and possession of the named drugs, and provided for medical use under a system of prescriptions and order blanks").

43 See DuVivier, supra note 28, at 276 n.317 (observing that from about 1914 to 1931, many states, "including seventeen west of the Mississippi, passed laws that prohibited the use of marijuana for nonmedicinal purposes").

44 See Bonnie & Whitebread, supra note 36, at 1010-11 (observing that by 1931, twenty-one states had restricted the sale of marijuana, "one state had prohibited its use for any purpose, and four states had outlawed its cultivation").

45 Id. at 1012 ("It was thought [after the turn of the century] . . . that use of marijuana west of the Mississippi was limited primarily to the Mexican segment of the population. . . . Whether motivated by outright prejudice or simple discriminatory disinterest, the result was the same in each legislature—little if any public attention, no debate, pointed references to the drug's Mexican origins, and sometimes vociferous allusion to the criminal conduct inevitably generated when Mexicans ate 'the killer weed.'"); cf. United States v. Bannister, 786 F. Supp. 2d 617, 646 (E.D.N.Y. 2011) ("[A] series of drug prohibitions in American history [were] prompted in part by fears of and distaste for distinct ethnic or racial minority groups. . . . 'Chicanos in the Southwest were believed to be incited to violence by smoking marijuana . . . .'") (quoting DAVID MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 244-45 (1973)).

46 See Bonnie & Whitebread, supra note 36, at 1019 (observing that the argument for New York's criminalization of marijuana in 1927 was that the drug "must be prohibited to keep addicts from switching to it as a substitute for the drugs which had become much more difficult to obtain after the enactment of the Harrison Act, and for alcohol after Prohibition").

47 See id. In particular, the Geneva Convention called upon participating countries "to enact laws ensuring the effective control of the production, distribution, and export of opium, cocaine,
In 1932, the National Conference of Commissioners on Uniform State Laws adopted the Uniform Narcotic Drug Act. The purpose of the uniform act was to curtail illegal drug traffic and to regulate the sale and distribution of narcotic drugs. The uniform act did not include marijuana as a controlled substance. However, a footnote to the act suggested certain statutory language in the event a state decided to regulate marijuana. Specifically, states that wished to regulate the sale and possession of marijuana were instructed to add "cannabis" to the definition of "narcotic drugs." Eventually, most states adopted the uniform law in some form.

C. The Federal Government Joins the Marijuana Criminalization Movement

The federal government's first regulation of marijuana occurred in 1937 when Congress passed the Marihuana Tax Act. The regulation was in the form of a tax due to "constitutional limits still enforced against federal lawmak-
Although the Marihuana Tax Act did not expressly outlaw the drug, it was essentially intended to prohibit the use and possession of marijuana. The act was described as having been “so burdensome both financially and procedurally that it virtually eliminated any legal medicinal, industrial, or recreational use of marijuana.” The act ultimately was held to be unconstitutional in 1969 by the Supreme Court because it violated the Fifth Amendment’s guarantee against self-incrimination.

In response to the Supreme Court’s invalidation of the Marihuana Tax Act, Congress passed the Controlled Substances Act of 1970, “placing marijuana in Schedule I and directly criminalizing any use of it.” In classifying marijuana as a Schedule I drug, Congress found that marijuana has “a high potential

55 Seeley v. State, 940 P.2d 604, 614 n.10 (Wash. 1997) (Sanders, J., dissenting); see also Waters v. Farr, 291 S.W.3d 873, 883 (Tenn. 2009) (observing that “most domestic drug regulations prior to 1970 generally came in the guise of revenue laws” and that the “leading statute in this area was the Harrison Narcotics Act of 1914,” followed by the Marihuana Tax Act of 1937, “which [like the Harrison Act . . . did not outlaw the possession or sale of marijuana outright’ but imposed similar registration and reporting requirements for individuals who produced, imported, distributed, sold, or dealt marijuana and ‘required the payment of annual taxes in addition to transfer taxes whenever the drug changed hands’”) (quoting Gonzales v. Raich, 545 U.S. 1, 10-11 (2005)).

56 See Leary v. United States, 395 U.S. 6, 21 (1969) (observing that the Marijuana Tax Act was intended to impose a very high tax on certain transfers of marijuana, but not to entirely prohibit those transfers); Kasey C. Phillips, Drug War Madness: A Call for Consistency Amidst the Conflict, 13 CHAP. L. REV. 645, 654 (2010) (“While the Marihuana Tax Act did not actually prohibit marijuana, it imposed a tax on distributors.”).

57 See Leary, 395 U.S. at 21 (observing that the tax’s purpose was “not only to raise revenue from the marihuana traffic, but also to discourage the . . . widespread undesirable use of marihuana by smokers and drug addicts”) (quoting Hearings on H.R. 6385 Before the H. Comm. on Ways and Means, 75th Cong. 9 (1937)); United States v. Truelove, 527 F.2d 980, 983 (4th Cir. 1975) (“[T]he Marihuana Tax Act of 1937, as amended, controlled all domestic transactions of marihuana. This law, ostensibly a revenue measure, was enacted ‘to discourage the widespread use of the drug’ and ‘through [a] transfer tax to prevent the drug from coming into the hands of those who will put it to illicit uses.’”) (quoting Leary, 395 U.S. at 23); State v. Worthing, 160 P.2d 352, 354-55 (Ariz. 1945) (concluding that although the Marihuana Tax Act of 1937 was a “revenue tax act[,]” it complimented Arizona state law “in the control and abolition of the traffic in narcotics”); DuVivier, supra note 28, at 277 (observing that the Marijuana Tax Act “did not criminalize marijuana, but attempted to curb its use through a prohibitive tax”).

58 Seeley, 940 P.2d at 614 n.10 (Sanders, J., dissenting).

59 See Leary, 395 U.S. at 37.


61 Seeley, 940 P.2d at 614 n.10 (Sanders, J., dissenting); cf. State v. Hardesty, 214 P.3d 1004, 1008 (Ariz. 2009) (noting that “the federal Controlled Substances Act broadly prohibits possession of schedule one substances”).
for abuse" and "no currently accepted medical use in treatment in the United States," and that "[t]here is a lack of accepted safety for use of the drug . . . under medical supervision." Marijuana currently remains a Schedule I drug. Accordingly, under federal law, marijuana cannot be used for any purpose.

III. THE CRIMINALIZATION OF MARIJUANA IN ARIZONA

Following the national pattern, the private use and possession of marijuana were not crimes in Arizona during the territorial era or the early years of statehood. In fact, marijuana use was lawful as a matter of Arizona state law until 1931, when the Arizona Legislature enacted the Arizona Narcotic Control Act. This act for the first time made the possession or sale of marijuana.

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64 21 U.S.C. § 812(b)(1)(C); see Pearson v. McCaffrey, 139 F. Supp. 2d 113, 119 (D.D.C. 2001) ("Schedule I drugs have . . . no currently accepted medical value in the United States, and a lack of accepted safety for use under medical supervision. . . . Marijuana is a Schedule I controlled substance.") (citations omitted); see also United States v. Rush, 738 F.2d 497, 512 (1st Cir. 1984) ("Every federal court that has considered the matter, so far as we are aware, has accepted the congressional determination that marijuana in fact poses a real threat to individual health and social welfare . . .").

65 21 U.S.C. § 812(c). As recently as July 8, 2011, the Drug Enforcement Administration ("DEA") rejected a petition filed in 2002 by medical marijuana supporters that sought to have marijuana removed from the Schedule I category of the Controlled Substances Act and reclassified as a Schedule III, IV, or V drug. In reaching its decision, the DEA noted the Department of Health and Human Services' recent conclusion that marijuana continues to meet all of the criteria for a Schedule I drug and should remain in Schedule I. Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 76 Fed. Reg. 40,552 (July 8, 2011).

66 See Raich v. Gonzalez, 500 F.3d 850, 865 (9th Cir. 2007) ("Congress placed marijuana on Schedule I of the Controlled Substances Act, taking it outside of the realm of all uses, including medical, under federal law."); cf. Conant v. Walters, 309 F.3d 629, 634 (9th Cir. 2002) (noting that "a doctor who actually prescribes or dispenses marijuana violates federal law."). But see People v. Tilekkooh, 7 Cal. Rptr. 3d 226, 235 n.11 (Ct. App. 2003) ("Marijuana is a controlled substance under the federal law. However, the mere use of marijuana is not a federal offense.").

67 See supra notes 28-29 and accompanying text.

68 See Stoudamire v. Simon, 141 P.3d 776, 778 (Ariz. Ct. App. 2006) (observing that "[n]either possession of marijuana nor possession of drug paraphernalia was a crime at the time of statehood").

69 See id. (citing 1931 Ariz. Sess. Laws ch. 36 § 3). By 1931, other states had already begun to criminalize private marijuana use. See supra notes 43-44 and accompanying text. Indeed, by the end of 1931, more than half the states had "passed laws that prohibited the use of marijuana for nonmedicinal purposes, and by 1933, nearly every western state had passed anti-marijuana legislation." DuVivier, supra note 28, at 276 n.317.
illegal in Arizona by necessary implication, also criminalized any private use of the drug.

The Arizona Legislature revised its anti-drug statutes four years later when it adopted the Arizona Uniform Narcotics Act of 1935, which prohibited the private possession or sale of any narcotic drug including marijuana. The 1935 Arizona act was premised on the Uniform Narcotic Drug Act of 1932. Arizona statutory law on the subject then remained relatively static for the next several decades until the Arizona Legislature, following the lead of several other states, adopted the Uniform Narcotics Act of 1935. The classification of marijuana as a narcotic drug has been retained in more recent Arizona anti-drug legislation. See generally supra note 72 and accompanying text.

Arizona’s prohibition of marijuana and other drugs mirrored the law in most other states during this period. See Leary v. United States, 395 U.S. 6, 16 n.15 (1969) ("Forty-eight] states and the District of Columbia had on their books in some form essentially the provisions of the Uniform Narcotic Drug Act. Section 2 of that Act states: ‘It shall be unlawful for any person to . . . possess . . . any narcotic drug, except as authorized in this Act.’ Section 1 (14) defines ‘narcotic drugs’ to include marihuana (‘cannabis’)."

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70 See Stoudamire, 141 P.3d at 778. The act made the possession or sale of marijuana punishable “by a fine of not less than fifty nor more than one thousand dollars, or by imprisonment for not less than sixty days nor more than five years, or both.” 1931 Ariz. Sess. Laws ch. 36 § 3.

71 See Borsari v. Fed. Aviation Admin., 699 F.2d 106, 111 (2d Cir. 1983) (observing that those who use illicit substances “must, in the nature of the act, . . . have possessed illicit substances”); United States v. Stacy, No. 09cr3695 BTM, 2010 WL 4117276, at *6 (S.D. Cal. Oct. 18, 2010) (“Clearly, the lawfulness of use is tied to the lawfulness of possession. One cannot use a drug without possessing it in some form. Thus, common sense dictates that if it is illegal to possess a certain drug . . . it is also unlawful . . . to be a user of that drug.”); Washburn v. Columbia Forest Prods., Inc., 134 P.3d 161, 167 (Or. 2006) (Kistler, J., concurring) (noting that a person “cannot use marijuana without possessing it”).


76 Arizona’s prohibition of marijuana and other drugs mirrored the law in most other states during this period. See Leary v. United States, 395 U.S. 6, 16 n.15 (1969) (“Forty-eight] states and the District of Columbia had on their books in some form essentially the provisions of the Uniform Narcotic Drug Act. Section 2 of that Act states: ‘It shall be unlawful for any person to . . . possess . . . any narcotic drug, except as authorized in this Act.’ Section 1 (14) defines ‘narcotic drugs’ to include marihuana (‘cannabis’).”) (citation omitted).
other states, replaced the Uniform Narcotics Act with the Arizona Uniform Controlled Substances Act in 1979.

The Arizona Uniform Controlled Substances Act is a variation of a model state law originally drafted by the Bureau of Narcotics and Dangerous Drugs (now the Drug Enforcement Administration), the agency charged with primary responsibility for waging the federal government’s widely-publicized war on drugs, and an entity notoriously hostile to any efforts to legalize the private use of marijuana. The model state act in turn was patterned after


See United States v. Falcone, 416 U.S. 430, 448-49 (1974) (noting that the Bureau of Narcotics and Dangerous Drugs was “the federal agency set up to enforce the [federal drug] laws”); Babineaux v. State, 803 S.W.2d 301, 301 (Tex. Crim. App. 1990) (Teague, J., dissenting) (“The present day ‘War on Drugs,’ as it relates to the controlled substance marihuana, actually commenced in the 1930’s, through the efforts of H.J. Anslinger of the then Federal Bureau of Narcotics, now the Drug Enforcement Administration.”).

See supra note 65 and accompanying text; Susan David Dwyer, Note, The Hemp Controversy: Can Industrial Hemp Save Kentucky?, 86 Ky. L.J. 1143, 1157 n.109 (1998) (noting that the early twentieth century public campaign against the private use of marijuana “was supported by the Federal Bureau of Narcotics,” which may have “turned to marijuana eradication to justify its own existence once opiate use began to decline”). Indeed, one commentator has observed that
the federal Controlled Substances Act\textsuperscript{84} and ultimately was adopted by most states\textsuperscript{85} including Arizona.\textsuperscript{86}

Like its federal counterpart,\textsuperscript{87} the Uniform Controlled Substances Act classified marijuana as a Schedule I controlled substance.\textsuperscript{88} As a result of this classification, marijuana is considered to be a dangerous drug with no safe or acceptable medical use,\textsuperscript{89} and lawful possession of the drug was limited to a select group of individuals licensed to manufacture, dispense, or use it strictly for scientific research purposes.\textsuperscript{90}
The Arizona Legislature briefly recognized an exception to the broad statutory prohibition of private marijuana use beginning in 1980 known as the Arizona Controlled Substances Therapeutic Research Act. This act permitted cancer and glaucoma patients who were not responding to conventional treatment to use marijuana under the direct supervision and control of a licensed medical practitioner. However, this limited medical use exception expired through legislative inaction in 1985, prompting the Arizona Court of Appeals to observe that private marijuana use “previously allowed for therapeutic purposes, was . . . outlawed without exception” in Arizona. This situation mirrored similar contemporaneous developments in other states.

93 See 1980 Ariz. Sess. Laws ch. 122 § 3. Similar laws were enacted by several other states. See, e.g., McIntosh v. State, 443 So. 2d 1275, 1282 (Ala. Crim. App. 1983) (Alabama), rev’d on other grounds, 443 So. 2d 1283 (Ala. 1983); State v. Hanson, 468 N.W.2d 77, 78 (Minn. Ct. App. 1991) (Minnesota); State v. Diana, 604 P.2d 1312, 1316-17 (Wash. Ct. App. 1979) (Washington). On the federal level, “demand for medical marijuana by patients and physicians throughout the United States persuaded the Food and Drug Administration (‘FDA’) in 1976 to approve the medicinal use of marijuana on a restricted basis.” Miklos Pongratz, Note, Constitutional Law—Medical Marijuana and the Medical Necessity Defense in the Aftermath of United States v. Oakland Cannabis Buyers’ Cooperative, 25 W. New Eng. L. Rev. 147, 155 (2003). The FDA implemented the “Individual Treatment Investigational New Drug Program (or Compassionate Use IND Program) [‘IND Program’], under which physicians could obtain special authority to administer marijuana to patients.” Id. At its peak, the IND program enrolled as many as seventy-eight patients nationwide, but “was closed to all new applicants in 1992, in an effort to prevent it from being overrun with AIDS patients requesting access to medical marijuana supplies.” Id. at 155-56; see also Kuromiya v. United States, 78 F. Supp. 2d 367, 368-70 (E.D. Pa. 1999) (“The . . . FDA . . . does provide a mechanism known as the treatment IND by which drugs that are under clinical investigation may be distributed to patients for whom no alternative drug or therapy is available. However, the compassionate use program did not comply with the requirements of a treatment IND. Rather, the marijuana program may more appropriately be described as a ‘single patient IND,’ in which the drug was simply distributed to certain individuals. . . . At the time the program stopped accepting new applicants in March 1992, there were thirteen participants . . .”).


IV. STATE EFFORTS TO DECRIMINALIZE MARIJUANA FOR MEDICAL USE

The marijuana regulation landscape began to change dramatically in 1996 with the voter-initiated enactment of medical marijuana reform legislation in Arizona and California. Voters in both states passed these initiatives following several unsuccessful legislative and voter-initiated efforts to legalize or decriminalize the use of marijuana in other states, including Hawaii, Oregon, Washington, and California.

The Arizona initiative, known as Proposition 200 (and, subsequent to its enactment, as the Drug Medicalization, Prevention and Control Act of 1996), was in some respects the more ambitious of the two state medical marijuana initiatives passed in 1996. In particular, Proposition 200 passed the Controlled Substances Therapeutic Research Act (Research Act) in 1979. The Legislature stopped funding the program in 1980.

See Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002) (discussing the “1996 ... initiatives passed in both Arizona and California decriminalizing the use of marijuana for limited medical purposes”); Pearson v. McCaffrey, 139 F. Supp. 2d 113, 116 n.1 (D.D.C. 2001) (“Arizona and California voters approved medical marijuana laws in 1996.”); Grandel, supra note 7, at 139 (“Marijuana policy began to change ... in the 1990s. ... The 1990s, however, brought about a direct democracy movement, with the people becoming involved at a grassroots level.”).

See, e.g., Commonwealth v. Hutchins, 575 N.E.2d 741, 743 (Mass. 1991) (“The Massachusetts Legislature has considered a bill providing for the use of marihuana in therapeutic research on more than one occasion, but no such statute has been enacted in the Commonwealth.”); cf. Hart v. Sec'y of State, 715 A.2d 165, 166 (Me. 1998) (discussing a rejected 1997 Maine “direct initiative petition entitled ‘An Act to Permit the Medical Use of Marijuana’”). For a discussion of other failed attempts to legalize the medical use of marijuana, see Albert DiChiara & John F. Galliher, Dissonance and Contradictions in the Origins of Marihuana Decriminalization, 28 LAW & SOC. REV. 41, 62-65 (1994).

See State v. Bachman, 595 P.2d 287, 288 n.1 (Haw. 1979) (“We note that the legislature, in its 1979 session, has again rejected proposals to decriminalize possession of marijuana.”).

See Ownbey, 996 P.2d at 512 n.3 (“The Oregon legislature ... considered legalizing marijuana for medical use in 1993 and 1997, but did not do so.”).

See State v. Smith, 610 P.2d 869, 878 (Wash. 1980) (“Historically, Washington’s citizens who supported liberal marijuana laws have consistently failed to gain broad-based citizen support for marijuana legalization or decriminalization initiatives.”).

See, e.g., Laura M. Rojas, Comment, California’s Compassionate Use Act and the Federal Government’s Medical Marijuana Policy: Can California Physicians Recommend Marijuana to Their Patients Without Subjecting Themselves to Sanctions?, 30 McGeorge L. Rev. 1373, 1381 (1999) (“In 1972, Proposition 19, a California initiative designed to decriminalize marijuana was defeated by a statewide margin of two to one.”).


See J. Ryan Conboy, Smoke Screen: America’s Drug Policy and Medical Marijuana, 55 FOOD & DRUG L.J. 601, 608 n.67 (2000) (noting that Arizona’s Proposition 200 was “broader than the California law”); Dogwill, supra note 94, at 274 (noting that Proposition 200 “distinct-
ported to authorize Arizona physicians, under certain specified conditions, to prescribe not only marijuana, but over 100 other Schedule I drugs including heroin and LSD, to seriously or terminally ill patients.

However well-intentioned it may have been, the Arizona Drug Medicalization, Prevention, and Control Act had virtually no practical impact on the medicinal use of marijuana in Arizona. The purely symbolic nature of the act stems primarily from the fact that it purports to authorize physicians to prescribe marijuana to a seriously ill patient "if documented scientific research concluded that the drug would provide medical benefits for treatment of the patient's disease or condition and if a second physician concurred in writing." Finding even one physician willing to prescribe marijuana is

108 See 1997 Ariz. Legis. Sess. 2895, 2897 ("The people of the State of Arizona declare their purposes to be . . . to permit doctors to prescribe Schedule I controlled substances to treat a disease, or to relieve the pain and suffering of seriously ill and terminally ill patients."); Dogwill, supra note 94, at 269 ("The purpose of the Act was to give physicians the tools necessary to relieve patients' pain and suffering.").
110 Ariz. Legis. Council, 965 P.2d at 772; see also O'Hear, supra note 4, at 830 ("In order to provide a prescription, a doctor was required to document a scientific basis for the drug's therapeutic value and to obtain a written second opinion from another doctor."); Cathryn L. Blaine, Note, Supreme Court "Just Says No" to Medical Marijuana: A Look at United States v. Oakland Cannabis Buyers' Cooperative, 39 Hous. L. Rev. 1195, 1214 (2002) ("Arizona law allows physicians to prescribe marijuana to patients only after they receive a second physician's written concurring opinion.").
extremely difficult, and persuading a pharmacy to dispense marijuana presumably would be impossible even if the drug was prescribed.

In addition, the documented scientific evidence concerning the medical benefits of marijuana is at best inconclusive, due largely to the fact that the use of marijuana and other Schedule I drugs was unlawful for any purpose during most of the quarter century immediately preceding Proposition 200's

111 See, e.g., Conant v. Walters, 309 F.3d 629, 634 (9th Cir. 2002) (noting that "a doctor who actually prescribes or dispenses marijuana violates federal law"); State v. Cole, 874 P.2d 878, 881 (Wash. Ct. App. 1994) ("[The defendant] sought a prescription for marijuana from his doctors . . . . The doctors refused because marijuana is a Schedule I drug which cannot be prescribed."); impliedly overruled on other grounds by Seeley v. State, 940 P.2d 604 (Wash. 1997); see also Boyd, supra note 109, at 1260 n.53 ("Arizona doctors have refused to write prescriptions for marijuana, fearing prosecution under federal law."); Blaine, supra note 110, at 1214 ("[F]ew Arizona physicians are willing to prescribe marijuana to their patients because the Arizona law is in direct conflict with the federal [Controlled Substances Act], which would likely subject the physicians to criminal liability.") (footnotes omitted). See generally Christina E. Coleman, Note, The Future of the Federalism Revolution: Gonzales v. Raich and the Legacy of the Rehnquist Court, 37 Loy. U. Chi. L.J. 803, 828 n.151 (2006) ("[B]ecause the text of Arizona's law allows prescription of marijuana, it is arguably not effective until such time as a physician can legally prescribe marijuana, i.e., until the federal government reclassifies the drug.").

112 See United States v. Kerr, 778 F.2d 690, 698 n.7 (11th Cir. 1985) (Hoffman, J., dissenting) ("Schedule I drugs . . . cannot be sold in a pharmacy."); Warren v. State, 288 So. 2d 817, 825 (Ala. Crim. App. 1973) ("Marijuana is not . . . normally prescribed by physicians and sold over-the-counter by pharmacists."); rev'd on other grounds, 288 So. 2d 826 (Ala. 1973); Seeley, 940 P.2d at 607 ("Marijuana cannot be legally prescribed, nor can a prescription for marijuana be filled by a pharmacist . . . unless a federal registration is granted."); Sterling, supra note 109, at 638 ("[N]one of the Schedule I substances are available at a pharmacy, thus there is no lawful way that a prescription can be filled. Proposition 200 does not, on its face, permit a physician to 'dispense' a Schedule I controlled substance.").

113 See Conant, 309 F.3d at 643 (Kozinski, J., concurring) ("The evidence supporting the medical use of marijuana does not prove that it is, in fact, beneficial. . . . [T]here is a genuine difference of expert opinion on the subject, with significant scientific and anecdotal evidence supporting both points of view."); Alliance for Cannabis Therapeutics v. Drug Enforcement Admin., 15 F.3d 1131, 1137 (D.C. Cir. 1994) (noting "the testimony of numerous experts that marijuana’s medicinal value has never been proven in sound scientific studies"); Crites-Leoni, supra note 107, at 279 ("One problem with the argument for marijuana’s viability as medicine is that scientific studies are limited and contradictory. . . . [S]tudies concerning the effects of marijuana on terminally and seriously ill patients are not conclusive.").
enactment\textsuperscript{114} (and continues to be unlawful as a matter of federal law today).\textsuperscript{115} As one court has noted, “a litany of legal, administrative, and practical obstacles . . . hinder researchers seeking to conduct experiments with Schedule I drugs,” including “difficulty in obtaining volunteers for clinical studies and, for academic researchers, difficulty in securing approval from institutional review boards.”\textsuperscript{116}

The fact that the Arizona initiative authorized physicians to prescribe drugs generally deemed to be more addictive and thus more dangerous than marijuana, such as LSD and heroin,\textsuperscript{117} also may have contributed to the act’s inef-

\textsuperscript{114} See Raich v. Gonzales, 500 F.3d 850, 865 (9th Cir. 2007) (“[N]o state permitted medical marijuana usage until . . . 1996. Thus, from 1970 to 1996, the possession or use of marijuana—medically or otherwise—was proscribed under state and federal law.”); In re Jones, 110 Cal. Rptr. 765, 767-68 (Ct. App. 1974) (“Various studies and reports have attempted to analyze the [effects of marijuana] but with little success. One of the difficulties encountered was the fact that as the use of marijuana was illegal there was no standardization of pharmacological potency and the amount of [the] drug . . . actually consumed by a user was not known.”); cf. Peter J. Cohen, Symposium, Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology, 2009 UTAH L. REV. 35, 56 (2009) (noting that “marijuana has not been used in a medical context for a sufficiently long period to allow the collection of scientific observations and data”).

\textsuperscript{115} See Pearson v. McCaffrey, 139 F. Supp. 2d 113, 121 (D.D.C. 2001) (“Even though state law may allow for the prescription or recommendation of medicinal marijuana within its borders, to do so is still a violation of federal law under the [Controlled Substances Act].”); Washburn v. Columbia Forest Prods., Inc., 134 P.3d 161, 167 (Or. 2006) (Kistler, J., concurring) (“The federal Controlled Substances Act prohibits possessing, manufacturing, dispensing, and distributing marijuana. That prohibition applies even when a person possesses, manufactures, dispenses, or distributes marijuana for a medical use.”) (citations omitted).

\textsuperscript{116} Grinspoon v. Drug Enforcement Admin., 828 F.2d 881, 896 (1st Cir. 1987); see also Eric Blumenson & Eva Nilsen, No Rational Basis: The Pragmatic Case for Marijuana Law Reform, 17 VA. J. SOC. POL’Y & L. 43, 72 n.117 (2009) (“[M]arijuana research has . . . been hindered by marijuana’s inclusion in Schedule I, as well as by a complicated federal approval process, and limited availability of research-grade marijuana.”); Alistair E. Newhorn, Comment, Good Cop, Bad Cop: Federal Prosecution of State-Legalized Medical Marijuana Use After United States v. Lopez, 88 CALIF. L. REV. 1575, 1585 (2000) (“Classification as a Schedule I drug . . . limits the availability of a drug for research to determine possible medical uses.”) (footnote omitted).

\textsuperscript{117} See Dogwill, supra note 94, at 273-74 (“Arizona’s legislation . . . validated any prescription of a Schedule I substance as long as the correct protocol was followed. . . . [N]ot only could marijuana be prescribed, much harsher narcotics such as LSD and heroin could be prescribed in Arizona as well.”); cf. United States v. Kuch, 288 F. Supp. 439, 448 (D.D.C. 1968) (“There is . . . a clear and compelling interest in the regulation of the transfer and possession of LSD. The drug is more harmful than marijuana . . . .”) (footnote omitted); State v. Wadsworth, 505 P.2d 230, 233 (Ariz. 1973) (acknowledging that “dangerous drugs such as ‘L.S.D.’ . . . are more harmful to the user than marijuana”).
fectiveness (although the Arizona act is not entirely unique in this regard). Indeed, some observers have suggested that because Proposition 200 was widely promoted as a medical marijuana reform law (and is still typically viewed in this fashion), many Arizonans who supported the proposition may not have realized that it also purported to legalize the prescription and use of other more controversial Schedule I controlled substances.

In contrast to Proposition 200, the contemporaneous California initiative, known as Proposition 215 proved to be extremely influential, in part because it was considerably narrower than its Arizona counterpart. Specifi-

118 See Ariz. Legis. Council v. Howe, 965 P.2d 770, 776 (Ariz. 1998) (observing that drugs such as heroin "unquestionably evoke serious concerns in the minds of most people, even if used for medicinal purposes . . ."); Crites-Leoni, supra note 107, at 294 ("Broadly legalizing prescription of [all Schedule I] drugs is potentially reckless, because it permits physicians to prescribe substances that traditionally have been recognized as having a high incidence of abuse.").


120 See Crites-Leoni, supra note 107, at 294 (noting that "the media claimed Proposition 200 was intended to legalize marijuana"); cf. Jeffrey Allan Kilmark, Note & Comment, Government Knows Best? An Analysis of the Governor's Power to Veto and the Legislature's Power to Repeal or Amend Voter-Enacted Initiative and Referendum Petitions in Arizona, 30 ARIZ. ST. J. L. 829, 829 (1998) (describing Proposition 200 as "the so-called medical-marijuana initiative").

121 See supra note 97 and accompanying text.

122 See Bassett, supra note 1, at 442 (discussing an attempt by the Arizona Legislature to amend Proposition 200 "[a]mid concern that . . . some voters were unaware that the measure extended beyond marijuana to all Schedule I drugs").

123 See People v. Mower, 49 P.3d 1067, 1070 (Cal. 2002) ("At the General Election held on November 5, 1996, the electors approved an initiative statute designated on the ballot as Proposition 215 and entitled Medical Use of Marijuana. In pertinent part, the measure added section 11362.5 [of the California Health and Safety Code], the Compassionate Use Act of 1996.").

124 See, e.g., Conant v. Walters, 309 F.3d 629, 641 (9th Cir. 2002) (Kozinski, J., concurring) ("Following passage of the California initiative, the White House Office of National Drug Control Policy commissioned the National Institute of Medicine of the National Academy of Sciences (IOM) to review the scientific evidence of the therapeutic application of cannabis."); cf. Yankah, supra note 5, at 6 ("Since the passage of California's Compassionate Use Act, at least sixteen other states have passed similar bills to allow the personal use of marijuana with a doctor's recommendation."). For a prior academic discussion of the California proposition's impact, see Bergstrom, supra note 2.

125 See Alex Kreit & Aaron Marcus, Raich, Health Care, and the Commerce Clause, 31 WM. MITCHELL L. REV. 957, 962-63 (2005) (noting that "modern state law medical marijuana reform efforts began with the passage of . . . California's Compassionate Use Act, and a similar ballot initiative in Arizona," but the California act has been the principal focus of "most of the medical marijuana-related publicity and legal activity, in part because of the structure of California's law").
cally, Proposition 215—now the CUA—\textsuperscript{126} created a limited exemption from California state laws prohibiting the use and cultivation of marijuana\textsuperscript{127} by permitting patients and their primary caregivers\textsuperscript{128} to cultivate and possess marijuana for medical use upon a physician's recommendation or approval.\textsuperscript{129}

While Arizona's Proposition 200 ostensibly allows physicians to prescribe more than 100 Schedule I drugs, including heroin and LSD,\textsuperscript{130} the CUA only decriminalizes the medical use of marijuana.\textsuperscript{131} In addition, while Arizona's Proposition 200 allows physicians to prescribe a Schedule I drug only if documented scientific research indicates the drug would provide medical benefits to the patient and if a second physician provides a written concurrence,\textsuperscript{132} the

\textsuperscript{126} See Gonzales v. Raich, 545 U.S. 1, 5 (2005) ("In 1996, California voters passed Proposition 215, now codified as the Compassionate Use Act of 1996."); People v. Hochanadel, 98 Cal. Rptr. 3d 347, 354 (Ct. App. 2009) ("The CUA was approved by California voters as Proposition 215 in 1996 . . . .").

\textsuperscript{127} See Mower, 49 P.3d at 1075 (observing that the CUA "renders possession and cultivation of marijuana noncriminal—that is to say, it renders possession and cultivation of the marijuana noncriminal for a qualified patient or primary caregiver"); cf. Cnty. of Los Angeles v. Hill, 121 Cal. Rptr. 3d 722, 728 (Ct. App. 2011) ("The possession, dispensing, cultivation, or transportation of marijuana is ordinarily a crime under California law.").

\textsuperscript{128} The CUA defines a primary caregiver as "the individual designated by [the patient] who has consistently assumed responsibility for the housing, health, or safety of [the patient]." \textsc{Cal. Health \& Safety Code} § 11362.5(e) (West, Westlaw through 2012 legislation).

\textsuperscript{129} See \textsc{Cal. Health \& Safety Code} § 11362.5(d) (West, Westlaw through 2012 legislation); Cnty. of Santa Cruz v. Ashcroft, 314 F. Supp. 2d 1000, 1003 (N.D. Cal. 2004). The stated purpose of the CUA is to "ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate" in the treatment of "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief," to "ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction," and to "encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana." \textsc{Cal. Health \& Safety Code} § 11362.5(b)(1); see also People v. Spark, 16 Cal. Rptr. 3d 840, 844-45 (Ct. App. 2004) (discussing the enumerated purposes of the CUA).

\textsuperscript{130} See supra note 117 and accompanying text.

\textsuperscript{131} See \textsc{Cal. Health \& Safety Code} § 11362.5(d); O'Hear, supra note 4, at 830 ("California's Proposition 215 applies only to marijuana, not to all Schedule I substances . . . ."); Marcia Tiersky, Comment, \textit{Medical Marijuana: Putting the Power Where It Belongs}, 93 \textit{Nw. U. L. Rev.} 547, 573 (1999) ("Opponents claim that the standards set out in Proposition 200 allow all Schedule I drugs for anyone who can obtain a doctor's recommendation, [sic] and that this standard is too low. . . . Proposition 215, by contrast, only allows for marijuana use.").

\textsuperscript{132} See supra note 110 and accompanying text.
CUA allows physicians to "recommend" rather than prescribe marijuana, and no second opinion or supporting scientific evidence is required. Indeed, the drafters of the CUA apparently authorized doctors to "recommend" a patient's use of marijuana rather than to prescribe the drug precisely because, as a Schedule I controlled substance, marijuana cannot lawfully be prescribed. As another commentator previously observed, "[b]y requiring a doctor's recommendation, but not a prescription, the [Compassionate Use Act] avoided the federal prohibition against writing prescriptions for marijuana which had rendered similar initiatives ineffective."

V. THE AMMA: ARIZONA'S SECOND BITE AT THE MEDICAL MARIJUANA APPLE

In an apparent attempt to correct some of the problems with Arizona's 1996 act, the drafters of the AMMA followed to some extent the pattern of

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133 See People v. Chakos, 69 Cal. Rptr. 3d 667, 674 (Ct. App. 2008) ("[The Compassionate Use Act ... allow[s] lawful possession under state law pursuant to a physician's 'recommendation,' as distinct from a formal 'prescription[ ] ... ']; Ross v. RagingWire Telecomms., Inc., 33 Cal. Rptr. 3d 803, 811 (Ct. App. 2005) ("Unlike prescription drugs that are dispensed under regulated circumstances, the Compassionate Use Act requires only a physician's oral recommendation ... "). aff'd, 174 P.3d 200 (Cal. 2008); Crites-Leoni, supra note 107, at 289 (noting that under the CUA, "a physician need only recommend use to a patient, making it easier for patients to obtain marijuana").

134 See Taylor W. French, Notes, Free Trade and Illegal Drugs: Will NAFTA Transform the United States into the Netherlands?, 38 Vand. J. Transnat'l L. 501, 508 (2005) (asserting that "the 'second opinion' feature indicates hesitation to open the door to the medicalization of drugs"). Arizona's Proposition 200 was relatively unique in this regard. As one commentator noted, most state medical marijuana laws are "quite permissive, and require minimal scientific data to demonstrate that marijuana might be effective in treating every condition for which it may be recommended by a willing physician." Peter J. Cohen, Medical Marijuana 2010: It's Time to Fix the Regulatory Vacuum, 38 J.L. Med. & Ethics 654, 658 (2010) (emphasis omitted).

135 See Chakos, 69 Cal. Rptr. 3d at 673 n.7; People v. Wilson, 148 Cal. Rptr. 47, 52 (Ct. App. 1978) ("[T]here are no situations in which marijuana, like certain other controlled substances, can be prescribed by physicians."); State v. Adler, 118 P.3d 652, 658 (Haw. 2005).

136 Patton, supra note 8, at 166 n.32. A federal court in California has observed that even as a matter of federal law, "there are lawful and legitimate responses to a medical marijuana recommendation. The patient, armed with the doctor's recommendation, may urge the federal government to change the law." Denney v. Drug Enforcement Admin., 508 F. Supp. 2d 815, 828 (E.D. Cal. 2007). "Alternately, the patient may lawfully procure marijuana with the recommendation by enrolling in a federally-approved experimental marijuana therapy program or traveling to a country where marijuana is legal." Id. at 828 n.1.

137 See Howard Fischer, Poll: 52% of Likely Voters Support Medical Marijuana, Ariz. Daily Sun, Oct. 14, 2010, at A2 ("Arizonans approved a similar measure in 1996 but found it thwarted by legislative action. They re-approved it in 1998 . . . . But the law never was used because both versions required a prescription by a doctor. . . . Proposition 203 gets around that by instead requiring only a 'recommendation,' a tactic now used in laws in more than a dozen other states."); Jon Johnson, Medical Marijuana Proposition Passes, E. Ariz. Courier, Nov. 17, 2010, at A1
California’s CUA. Like the CUA and the medical marijuana laws in other states, the AMMA only authorizes the medical use of marijuana and not other Schedule I controlled substances. Also similar to the CUA, the AMMA does not require a physician’s prescription. The AMMA instead provides that a qualifying patient with a “written certification issued by a physician” may obtain a medical marijuana registry identification card. Patients with valid medical marijuana registry cards may receive up to 2.5 ounces of marijuana every two weeks from dispensaries, or, under some circumstances, to cultivate up to twelve marijuana plants for their own personal medical use.  

("Arizona also passed a proposition in 1996 (by a vote of 65 percent to 35 percent) to allow patients to use medical marijuana, but it . . . stated doctors could prescribe the drug. The United States Drug Administration threatened to punish doctors who wrote prescriptions for marijuana. The 2010 proposition only requires a doctor’s recommendation for a patient to obtain a medical marijuana registry card.").

138 See Niki D’Andrea, Smoke and Furors, PHOENIX NEW TIMES, Oct. 21, 2010, at 12 (“Arizona voters passed one of the first medical marijuana measures in the country, way back in 1996. It was called Proposition 200, and it . . . permitted doctors to ‘prescribe’ marijuana. . . . [T]his year’s Proposition 203 is the most detailed medical marijuana measure Arizona [has] ever seen, and it’s more evolved than similar laws passed in other states. . . . [It] bear[s] some resemblance to California’s Proposition 215 (passed by voters in 1996) . . .”).

139 See, e.g., State v. Hanson, 157 P.3d 438, 442 (Wash. Ct. App. 2007) (noting that the Washington State Medical Use of Marijuana Act merely authorizes the medical use of marijuana and “does not cover the entire scope of schedule I controlled substance designations”); see also supra note 131 and accompanying text.

140 ARIZ. REV. STAT. ANN. § 36-2811(B) (West, Westlaw through 2012 Legis. Sess.).

141 CAL. HEALTH & SAFETY CODE § 11362.5(c) (West, Westlaw through 2012 legislation).

142 ARIZ. REV. STAT. ANN. § 36-2804.02(A) (West, Westlaw through 2012 Legis. Sess.).

143 The act defines a qualifying patient as a person who “has been diagnosed by a physician as having a debilitating medical condition,” such as cancer, glaucoma, human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, crohn’s disease, and agitation of alzheimer’s disease. Id. § 36-2801(3)(a), (13).

144 Id. § 36-2804.02(A). Other state medical marijuana laws contain similar provisions. See, e.g., United States v. Barnard, 770 F. Supp. 2d 366, 369 (D. Me. 2011) (“[T]he Maine Medical Use of Marijuana Act requires that a registrant provide a written certification from a physician justifying the patient’s use . . .”); Rollins v. Ulmer, 15 P.3d 749, 753 (Alaska 2001) (“The Alaska statute does not . . . require that patients have a prescription. As long as a patient submits a letter from a physician certifying that the patient may benefit from marijuana, the decision to use marijuana as a medical treatment is left entirely to the individual.”); Burns v. State, 246 P.3d 283, 286 (Wyo. 2011) (“Colorado law simply allows for a physician to certify that a patient might benefit from the use of marijuana as a medical treatment. . . . Clearly, therefore, the physician is not prescribing . . . marijuana . . .”).

145 ARIZ. REV. STAT. ANN. §§ 36-2801(1)(a), 36-2811(B).
VI. THE AMMA’S MAZE FOR ARIZONA EMPLOYERS

A. Discrimination in Employment Prohibited

In most states that have legalized the medical use of marijuana, state criminal penalties for the use, possession, and cultivation of marijuana are removed for patients with a recommendation or referral from their physicians.\footnote{146} However, most state medical marijuana laws, including the CUA,\footnote{147} do not directly address the employment issues implicated by the use of marijuana for medical purposes.\footnote{148} Courts in several of these states have concluded that the protection afforded to medical marijuana users under these statutes is limited to the decriminalization of medical marijuana use, possession, or sale.\footnote{149} These courts generally uphold the right of employers to terminate or otherwise discipline employees whose use of marijuana for medical purposes violates drug-free workplace policies.\footnote{150}

\footnote{146} See Raich v. Gonzales, 500 F.3d 850, 865 (9th Cir. 2007) (noting that in the decade following enactment of California’s medical marijuana act, “ten states other than California... passed laws decriminalizing in varying degrees the use, possession, manufacture, and distribution of marijuana for the seriously ill.”); Qualified Patients Ass’n v. City of Anaheim, 115 Cal. Rptr. 3d 89, 101 n.2 (Ct. App. 2010) (“California is not alone, nor an outlier among the states in decriminalizing medical marijuana; at least 12 states have done so despite the continuing federal ban...”).

\footnote{147} See Ross v. RagingWire Telecomms., Inc., 174 P.3d 200, 203 (Cal. 2008) (“Nothing in the text or history of the Compassionate Use Act suggests the voters intended the measure to address the respective rights and duties of employers and employees.”).


\footnote{150} See Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus., 230 P.3d 518, 524 n.7 (Or. 2010) (en banc) (“Both the California and Washington courts have held that, in enacting their states’ medical marijuana laws, the voters did not intend to affect an employer’s ability to take adverse employment actions based on the use of medical marijuana... We reach the same
In contrast to the medical marijuana laws of these other states, the AMMA specifically prohibits employers from discriminating against individuals in hiring, promotion, or other terms and conditions of employment based on their status as registered medical marijuana cardholders. Arizona employers also may not terminate, otherwise discipline, or refuse to hire a registered medical marijuana cardholder for testing positive for the use of marijuana unless the individual testing positive used, possessed, or was impaired by the drug on the employer's premises or during working hours.

B. The Interplay Between the AMMA and the Federal Drug-Free Workplace Act

The AMMA's anti-discrimination provisions are subject to a statutory exception permitting employers to base employment decisions upon an employee's status as a medical marijuana cardholder, or upon a cardholder's positive test for marijuana, if the employer's "failure to do so would cause [it] to lose a monetary or licensing related benefit under federal law or regulations." Most observers have interpreted this exception to be an implicit reference to the federal Drug-Free Workplace Act of 1988, which "imposes a drug-free workplace requirement on federal contractors and federal grant recipients."

Conclusion, although our analysis differs because Oregon has chosen to write its laws differently, (citations omitted).

151 Apart from Arizona (and Delaware more recently), Rhode Island is "the only state that specifically protects the jobs of employees who use medical marijuana." Lieberman & Solomon, supra note 11, at 624. To date, "no other medical marijuana statute has been held to regulate private employment." Casias, 764 F. Supp. 2d at 925 n.8.


153 Id. § 36-2813(B)(2). This aspect of the Act represents a significant change in Arizona employment law. See Weller v. Ariz. Dep't Econ. Sec., 860 P.2d 487, 490 (Ariz. Ct. App. 1993) ("An employer who terminates an at-will employee for failing a drug test ordinarily incurs no civil liability."). The change also distinguishes Arizona law from the law of other states. See, e.g., Ross v. RagingWire Telecomms., Inc., 174 P.3d 200, 203 (Cal. 2008) ("Under California law, an employer may require preemployment drug tests and take illegal drug use into consideration in making employment decisions.").

154 ARIZ. REV. STAT. ANN. § 36-2813(B)(2).

155 Id. § 36-2813(B).

156 41 U.S.C. §§ 8101-06 (2000). Several states have enacted their own drug-free workplace statutes designed "to maximize productivity and reduce the costs associated with substance abuse by employees." Oleszko v. State Comp. Ins. Fund, 243 F.3d 1154, 1159 n.7 (9th Cir. 2001). These state statutes typically require employers providing "property or services to any state agency" to certify that they will maintain drug-free work environments. Ross, 174 P.3d at 213 (discussing California's Drug-Free Workplace Act).
and requires employers to make a good faith effort to comply with this requirement “in order to remain eligible for federal funds.”

However, this exception for recipients of federal benefits may not be particularly helpful to employers attempting to comply with the AMMA.

Although the Drug-Free Workplace Act requires employers to notify their employees of the federal act’s requirements, and also arguably requires employers to condition an individual’s employment on compliance with those requirements, the act’s objectives have repeatedly been interpreted to be primarily educational and rehabilitative in nature.

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158 Parker, 818 F. Supp. at 347; see also Univ. of Haw. Prof'l Assembly, 900 P.2d at 163 (“The [Drug-free Workplace Act] . . . provides that continued payments on contracts with the federal government, or continued funding to the grantee, is contingent upon compliance with the Act.”).

159 See Carolyn Ladd, Medical Marijuana and the Workplace, 29 ASS'N OF CORP. COUNS. 58, 62 (April 2011) (“It is not entirely clear when an [Arizona] employer is subject to lose a monetary or licensing-related benefit under federal law or regulations.”); cf. Washburn v. Columbia Forest Prods., Inc., 104 P.3d 609, 615 (Or. Ct. App. 2005) (“The Federal Drug-Free Workplace Act prohibits only certain actions and then prohibits them only if they are ‘unlawful.’ Under Oregon law, [the] medical use of marijuana is not unlawful.”), rev’d on other grounds, 134 P.3d 161 (Or. 2006).

160 See Washburn, 104 P.3d at 615 (“The Federal Drug-Free Workplace Act imposes certain requirements on federal contractors and grant recipients. Contractors or grant recipients must . . . notify their employees that they must comply with the requirements.”).

161 See Collings v. Longview Fibre Co., 63 F.3d 828, 830 n.1 (9th Cir. 1995) (noting that the federal act requires employers to notify their employees that the unlawful use or possession of controlled substances is prohibited in the workplace, and to warn employees that “they must abide by those terms ‘as a condition of employment’”) (quoting 41 U.S.C. § 8102(a)(1) (2000)); Gulf Coast Indus. Workers Union v. Exxon Co., 991 F.2d 244, 250 (5th Cir. 1993) (“The Drug-Free Workplace Act . . . requires private employers with federal contracts to (1) publish a statement notifying their workers that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the workplace, [and] (2) notify employees that their continued employment hinges on compliance with the policies outlined in this statement . . . . A company’s failure to comply with the Act subjects the company’s federal contract to possible termination.”) (citing 41 U.S.C. § 8102(a)(1)(A)-(D) (2000)).

For example, the act does not require that employers test their employees or applicants for illegal drug use.¹⁶³ Nor does the act dictate the action an employer must take if an individual tests positive for illegal drugs.¹⁶⁴ Even more fundamentally, the Drug-Free Workplace Act expressly prohibits the unlawful use or possession of drugs only in the workplace.¹⁶⁵ The same is true of most state drug statutes patterned after the federal act.¹⁶⁶ The fact that these "drug-free workplace laws are not concerned with employees' possession or use of drugs like marijuana away from the jobsite" strongly suggests that "nothing in those laws would prevent an employer that knowingly accepted an

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¹⁶⁴ See Atl. Pipe Corp. v. Laborers Int'l Union, No. CV074015994S, 2008 WL 1970965, at *9 (Conn. Super. Ct. 2008) ("The act simply does not provide for, mandate or condone automatic termination of an employee as a result of the possession of marijuana at work."); Univ. of Haw. Prof'l Assembly v. Tomasu, 900 P.2d 161, 169 (Haw. 1995) ("[W]hen an employee violates the employer's drug enforcement policy, the employee must be duly sanctioned or must participate in a drug abuse assistance or rehabilitation program. The [Act] does not describe the exact procedure for these actions, leaving these details to the individual employers to fashion and implement."); Deanne J. Mouser, Combating Employee Drug Use Under a Narrow Public Policy Exception, 12 INDUS. REL. L.J. 184, 190-91 (1990) ("[T]he Drug-Free Workplace Act does not require that employers fire employees who use drug—the Act requires only a good faith effort to maintain a drug-free workplace . . . . A good faith effort may consist of drug testing and a rehabilitation program.").

¹⁶⁵ See 41 U.S.C. §§ 8102(a)(1)(A), 8103(a)(1)(A) (2000); cf. Figueroa, 1 F. Supp. 2d at 123 ("It is evident from the statute . . . that its application is circumscribed to work-related problems caused by drug use.") (emphasis omitted). This aspect of the Drug-Free Workplace Act has been criticized. See, e.g., Olsen, supra note 163, at 227 ("[T]he [Act] does not expressly prohibit reporting to work 'under the influence'. . . . Thus, an employee may 'beat the system' under the Drug-free Workplace Act by 'getting high' prior to work or during lunch breaks.").

¹⁶⁶ See Ross v. RagingWire Telecomm. Inc., 174 P.3d 200, 213 (Cal. 2008) (Kennard, J., concurring in part and dissenting in part) ("Both the state and federal drug-free workplace laws are concerned only with conduct at the jobsite . . . .")
employee’s use of marijuana as a medical treatment at the employee’s home from obtaining drug-free workplace certification.”

This interpretation of the Drug-Free Workplace Act is illustrated by the analysis in *Washburn v. Columbia Forest Products, Inc.*, a case arising under the Oregon Medical Marijuana Act (“OMMA”). The plaintiff in *Washburn* was authorized to use marijuana for medical purposes. The plaintiff’s employer terminated his employment after he tested positive for marijuana in a series of tests administered in accordance with the employer’s workplace drug policy. The plaintiff brought suit against the employer, arguing that “the OMMA does not allow employers to discriminate against medical marijuana users who do not use marijuana at work and are not impaired by marijuana while at work.”

The trial court awarded summary judgment to the employer. On appeal, the employer argued that its actions were required by the Drug-Free Workplace Act. The Oregon Court of Appeals rejected the employer’s argument and held that the trial court erred in granting the employer’s motion for summary judgment. The appellate court reasoned that because the plaintiff “did not take any actions that the Act prohibits in the workplace” he could not “be said to have violated (or caused [the employer] to violate) the Federal Drug-Free Workplace Act.”

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167 Id.; cf. Ladd, *supra* note 159, at 62 (asking rhetorically whether “a federal contractor or grantee [can] comply with the Drug-free Workplace . . . Act even if it allows an employee who tests positive for medical marijuana to continue working”).


169 OR. REV. STAT. §§ 475.300-.346 (2009).

170 *Washburn*, 104 P.3d at 610-11.

171 Id. at 611.

172 Id. The parties agreed that the urinalysis tests administered by the employer “did not, and indeed could not, reveal whether plaintiff was under the influence of marijuana at the time of the test, but only that plaintiff had used marijuana sometime in the previous two to three weeks.” *Id.*

173 The trial court adopted the employer’s contention that employers are not required to accommodate the needs of medical marijuana users, including those who merely test positive for use of the drug with no compelling evidence that they were actually impaired. *See id.*

174 *See id.* at 614-15.

175 *See id.* at 615 ("[A]nalysis of the Federal Drug-Free Workplace Act does not lead to the result that defendant suggests.").

176 *See id.* at 614.

177 *Id.* at 615. Although the Supreme Court of Oregon subsequently reversed the Court of Appeals’ decision, it did so on other grounds, holding that summary judgment was appropriate because the “employer had no statutory duty to accommodate the plaintiff’s physical limitation in the manner sought by [the] plaintiff.” *Washburn v. Columbia Forest Prods., Inc.*, 134 P.3d 161, 166 (Or. 2006). The Oregon Court of Appeals’ analysis of the interplay between the OMMA and the federal Drug-Free Workplace Act was not addressed by the Supreme Court of Oregon, and thus presumably continues to be a correct statement of Oregon law on this subject. *See Washburn,*
The AMMA reflects a similar focus by permitting employers to discipline their employees, including registered medical marijuana cardholders, for ingesting marijuana in the workplace, or for working while under the influence of marijuana. Although the AMMA does not specifically authorize employers to discipline cardholders solely for possessing marijuana in the workplace, any uncertainty over this issue may have been resolved by the Arizona Legislature’s subsequent enactment of a statute insulating employers from liability for taking disciplinary action (including termination of employment) against an employee “based on the employer’s good faith belief that [the] employee used or possessed any drug while on the employer’s premises or during the hours of employment.” However, neither the Drug-Free Workplace Act nor the AMMA appears to authorize the disciplining of a medical marijuana user solely for possessing or ingesting marijuana outside the workplace during nonworking hours.

C. Compliance with the AMMA in the Face of Federal Regulations

As the preceding discussion suggests, the employment provisions of the AMMA may present significant problems for employers. Considerable empirical evidence shows that the use of marijuana, whether for medical purposes or otherwise, may impair the user’s cognitive functions and ability to

134 P.3d at 164; Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus., 186 P.3d 300, 306 (Or. Ct. App. 2008) (noting that the Supreme Court in Washburn “did not address any of the . . . issues that [the Court of Appeals] had decided concerning the application of the OMMA or the federal Drug-Free Workplace Act”), rev’d on other grounds, 230 P.3d 518 (Or. 2010).

178 ARIZ. REV. STAT. ANN. § 36-2814(A)(3), (A)(B) (West, Westlaw through 2012 Legis. Sess.); cf. Roe v. TeleTech Customer Care Mgmt. (Colo.) LLC, 257 P.3d 586, 593 (Wash. 2011) (“[A]n employer only has a duty to accommodate an employee’s off-site medical marijuana use if the employee’s use would not affect job safety or performance.”).

179 See County of Butte v. Superior Court, 96 Cal. Rptr. 3d 421, 429 (Ct. App. 2009) (noting that a state medical marijuana law “has no effect on . . . searches and seizures under federal law”). Cf. Ross v. RagingWire Telecomms., Inc., 33 Cal. Rptr. 3d 803, 811 (Ct. App. 2005) (“[I]t could be asserted that . . . the employer cannot discriminate against medicinal marijuana users by refusing to allow them to bring their medication to work . . . . If so, this would mean the employer would be compelled to tolerate on its premises the presence of a drug that is illegal under federal law—which, under circumstances not entirely speculative, could result in the employer’s workplace being subject to a search conducted by federal authorities pursuant to an employee’s violation of federal criminal laws.”), aff’d, 174 P.3d 200 (Cal. 2008).

180 ARIZ. REV. STAT. ANN. § 23-493.06(A)(5).

181 See Weller v. Ariz. Dep’t Econ. Sec., 860 P.2d 487, 493 (Ariz. Ct. App. 1993) (“[A] positive test result revealing that marijuana of unknown quantity inhaled or ingested at an unknown prior time may reflect only off-duty activity and may be entirely unrelated to work.”).

182 See Roe, 257 P.3d at 599 (Chambers, J., dissenting) (“[T]he employer may well have an overriding reason not to permit an employee to medicate with marijuana.”).
perform complex tasks requiring attention and mental coordination,\textsuperscript{183} and that the impairment may persist well after the drug was ingested.\textsuperscript{184} Employers are understandably concerned about the loss of productivity that may attend an employee's use of marijuana,\textsuperscript{185} as well as the liability to which they may be subject if third parties are injured by the actions of an employee working while under the influence of the drug.\textsuperscript{186}

In addition, Arizona employers must comply with Occupational Safety and Health Act ("OSHA")\textsuperscript{187} and other federal standards governing workplace safety.\textsuperscript{188} In this regard, the U.S. Department of Transportation ("DOT") has

\textsuperscript{183} See State v. Lucero, 85 P.3d 1059, 1063 (Ariz. Ct. App. 2004) (citing evidence that tetrahydrocannabinol (THC), the principal psychoactive chemical component of marijuana, "affects judgment, the ability to think, and the ability to solve problems," and "can make the ability to perform multiple tasks, such as those performed while driving, difficult."); see also Ross v. RagingWire Telecomms., Inc., 174 P.3d 200, 214 (Cal. 2008) (Kennard, J., concurring in part and dissenting in part) ("Considered strictly in terms of its physical effects relevant to employee productivity and safety, and not its legal status, marijuana . . . may affect cognitive functioning and have a potential for abuse.").

\textsuperscript{184} See Lucero, 85 P.3d at 1063 ("Even when THC is no longer detectable in the blood, it remains for a time in the nervous system and continues to affect the user . . . . Adverse effects endure as long as twenty-four hours after consumption."); see also Fowler v. New York City Dep't of Sanitation, 704 F. Supp. 1264, 1275 (S.D.N.Y. 1989) ("[D]rugs affect individuals long after ingestion. Serious skill impairment has been measured 24 hours after smoking a single marijuana cigarette.") (citing Jerome A. Yesavage et al., Carry-Over Effects of Marijuana Intoxication on Aircraft Pilot Performance: A Preliminary Report, 142 AM. J. PSYCHIATRY 1325, 1325-29 (1985) ("[T]he use of marijuana continues to influence a patient for some time after ingestion."); Yesavage et al., supra note 184.

\textsuperscript{185} See Loder v. City of Glendale, 927 P.2d 1200, 1222-23 (Cal. 1997) (acknowledging "the well documented problems that are associated with the abuse of drugs and alcohol by employees—increased absenteeism, diminished productivity, greater health costs, increased safety problems and potential liability to third parties, and more frequent turnover"); Dolan v. Svitak, 527 N.W.2d 621, 626 (Neb. 1995) (suggesting that drug-free workplace policies further "the employer's interest in job safety, absenteeism, productivity, morale, and health costs.").

\textsuperscript{186} See Thomas H. Barnard & Martin S. List, Defense Perspectives on Individual Employment Rights, 67 NEB. L. REV. 193, 202 (1988) ("[E]mployers have become more acutely concerned with the direct and indirect costs of drug use in, or affecting, the workplace. Additional costs can occur through liability to third parties for injuries caused by employees under the influence of drugs, whether directly or on the theory of negligent hiring.") (footnotes omitted). See also Weller, 860 P.2d at 495 ("[E]mployers have a legitimate interest in prohibiting employees from working while they are physically or mentally impaired by drugs. Impaired workers are not only a menace to the vitality of our economy but also to the safety of the community and other workers.").


\textsuperscript{188} See Weller, 860 P.2d at 494 (noting that an employer "may insist that its employees obey all health and safety laws relating to the workplace"). See also Wendland v. AdobeAir, Inc., 221 P.3d 390, 393 (Ariz. Ct. App. 2009) ("OSHA was adopted to reduce the number of occupational safety and health hazards in the workplace and to protect employees from dangerous work conditions. It imposes certain duties on employers to provide a safe working environment for employees.") (citation omitted).
taken the position that state medical marijuana laws do not supersede federal drug testing requirements applicable in the trucking, railroad, airline, and transit system industries, an employee’s use of marijuana for medical purposes does not excuse an employer from addressing the employee’s positive test for use of that drug as specified in the DOT’s regulations.

The DOT’s position on this issue poses a potential dilemma for Arizona employers because under the AMMA an employee’s positive test for marijuana use, standing alone, is not sufficient to establish that the employee was operating, navigating, or in physical control of a motor vehicle, aircraft, or motorboat while under the influence of marijuana. Under the AMMA, a positive test for marijuana provides no basis for disciplining an employee who is a medical marijuana cardholder unless the employee also used or possessed marijuana in the workplace, or the marijuana was present in the employee’s system in a sufficient amount to cause impairment.


190 See Compliance Notice, supra note 189; cf. People v. Feezel, 783 N.W.2d 67, 90 (Mich. 2010) (Young, J., concurring in part and dissenting in part) (“[Legalization of the use of marijuana for a limited medical purpose cannot be equated with an intent to allow its lawful consumption in conjunction with driving.”).

191 See Ariz. Rev. Stat. Ann. § 36-2802(D) (West, Westlaw through 2012 Legis. Sess.) (“This [Act] . . . does not . . . prevent the imposition of . . . penalties for . . . operating, navigating or being in actual physical control of any motor vehicle, aircraft or motorboat while under the influence of marijuana, except that a registered [medical marijuana cardholder] shall not be considered to be under the influence of marijuana solely because of the presence of metabolites or components of marijuana that appear in insufficient concentration to cause impairment.”). But cf. State v. Phillips, 873 P.2d 706, 710 (Ariz. Ct. App. 1994) (“[T]here is no level of illicit drug use which can be acceptably combined with driving a vehicle; the established potential for lethal consequences is too great.”).


193 See id. § 36-2814(A), (B); cf. Weller, 860 P.2d at 493 (“Absent any physical effects, we fail to see a substantial connection between a positive drug test and work”). A recent amendment to Arizona’s statute regarding drug testing of employees provides some protection to employers who take action against an employee based on the employer’s good faith belief that the “employee used or possessed any drug while on the employer’s premises or during the hours of employment.” Ariz. Rev. Stat. Ann. § 23-493.06(A)(5). Whether this protection extends to an employer who takes action against an employee solely because the employee possessed medical marijuana at work is an unanswered question. See infra note 203 and accompanying text.
The DOT’s regulations do not actually compel a different result.\textsuperscript{194} Although the regulations do not prohibit an employer from terminating an employee who tests positive for marijuana,\textsuperscript{195} they also do not compel the employer to terminate or otherwise discipline such an employee.\textsuperscript{196} Instead, the regulations merely require an employer to prohibit an employee who tests positive for marijuana use from performing safety-sensitive functions until the employee passes a subsequent drug test and completes the education and treatment requirements of a comprehensive return-to-duty process prescribed by the DOT,\textsuperscript{197} which must include compliance with a “written follow-up testing plan.”\textsuperscript{198}

D. Recent Arizona Legislation Impacting the AMMA

A recently enacted Arizona statute purports to immunize employers from liability for taking action to prevent an individual from working in a “safety sensitive position”\textsuperscript{199} based on the employer’s good faith belief that the indi-

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\item \textsuperscript{194} See Bhd. of Maint. of Way Emps. v. Chicago & N.W. Transp. Co., 514 N.W.2d 90, 94 (Iowa 1994) (concluding that state law “employee rights legislation in conflict with federal employee drug testing policy” is preempted by federal law).
\item \textsuperscript{196} See United Food & Commercial Workers Int’l Union, Local 588 v. Foster Poultry Farms, 74 F.3d 169, 174 (9th Cir. 1996) (“The DOT regulations only prohibit employees who test positive for drug use from operating commercial motor vehicles; the DOT regulations do not require that such employees be automatically discharged.”); Hill v. Eagle Motor Lines, 645 S.E.2d 424, 428 n.2 (S.C. 2007) (“Although the federal government requires a person seeking to drive a commercial vehicle to pass a drug test and a road test before driving a commercial vehicle, there is no obligation on an employer to perform these tests before hiring a truck driver employee.”).
\item \textsuperscript{197} See E. Associated Coal Corp. v. United Mine Workers of Am., Dist. 17, 531 U.S. 57, 64 (2000) (“The DOT regulations specifically state that a driver who has tested positive for drugs cannot return to a safety-sensitive position until . . . the driver has followed any rehabilitation program prescribed . . . and . . . passed a return-to-duty drug test . . . .”) (citations omitted); BNSF Ry. Co. v. U.S. Dep’t Transp., 566 F.3d 200, 202 (D.C. Cir. 2009) (“Under Department of Transportation regulations, employees in the aviation, rail, motor carrier, mass transit, maritime and pipeline industries who either fail or refuse to take a drug test must successfully complete a drug treatment program and pass a series of urine tests as a condition of performing any safety-sensitive duties.”).
\item \textsuperscript{198} 49 C.F.R. § 40.307(a) (2012). However, the DOT’s regulations state that an employer is “not required to return an employee to safety-sensitive duties” simply because the employee has completed the return-to-duty process. Id. § 40.305(b) (2012). The applicable regulation characterizes this issue as “a personnel decision that [the employer has] the discretion to make, subject to collective bargaining agreements or other legal requirements.” Id.
\item \textsuperscript{199} The statute defines “safety-sensitive positions” broadly to include any job the employer in good faith believes could affect the safety or health of the employee or others, including the
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individual is engaged in the current use of any drug that could cause an impairment or lessen the individual’s ability to perform the duties of the job. However, the statute does not specifically refer to the employment rights of medical marijuana cardholders, but instead applies to employees generally. Therefore, whether Arizona employers may take action, including termination, against registered medical marijuana users working in safety-sensitive positions who test positive for marijuana solely on the basis of the positive drug test is currently an open question.

The problems these statutory and regulatory ambiguities pose for Arizona employers are compounded by the fact that the AMMA fails to define the term “impairment,” which is the standard that triggers an employer’s authority to discipline a medical marijuana cardholder who tests positive for marijuana but cannot be shown to have used or possessed the drug in the workplace or during working hours. Urinalysis, the type of drug test most commonly used by employers, is notoriously ineffective in determining whether a marijuana user is impaired. There is no generally accepted external standard for determining whether a marijuana user is impaired.

operation of equipment, machinery, or power tools, or the performance of duties in or on the commercial premises of a customer, supplier, or vendor. ARIZ. REV. STAT. ANN. § 23-493(9)(a), (c).

Id. § 23-493(6)(a), (7).

See Roe v. TeleTech Customer Care Mgmt. (Colo.) LLC, 257 P.3d 586, 593 (Wash. 2011) (“One would expect any statute creating employment protections for authorized medical marijuana users might include exceptions for certain occupations . . . .”).

The Arizona Legislature’s ability to modify the AMMA is limited. See ARIZ. CONST. art. 4, pt. 1, § 1(6)(C) (“The legislature shall not have the power to amend an initiative measure approved by a majority of the votes cast thereon, or to amend a referendum measure decided by a majority of the votes cast thereon, unless the amending legislation furthers the purposes of such measure . . . .”); cf. Pijanowski v. Yuma Cnty., 43 P.3d 208, 211 (Ariz. Ct. App. 2002) (“[M]odification-by-implication is disfavored by courts when construing statutes, and we will not find such an intent unless the interplay between the statutes under consideration compels us to find the legislature must have intended the later statute to impliedly repeal the earlier one. . . .”).


See ARIZ. REV. STAT. ANN. § 36-2814; cf. Roe, 257 P.3d at 593 (“One would expect any statute creating employment protections for authorized medical marijuana users might include . . . permissible levels of impairment on the job.”).

See State v. Hammonds, 968 P.2d 601, 603 (Ariz. Ct. App. 1998) (“It is only when [a] drug is in the bloodstream that it is capable of impairment . . . and this impairment lasts only so long as the drug is in the bloodstream. . . . A urine test, while indicative of what has been in the bloodstream in the past, says nothing conclusive about what is presently in the bloodstream.”); cf. Burka v. New York City Transit Auth., 739 F. Supp. 814, 821 (S.D.N.Y. 1990) (“[U]rinalysis is
ing whether a marijuana user is impaired, unlike in the case of alcohol use, where an employer could presumably rely by analogy on state statutes defining “impairment” for purposes of operating a motor vehicle, or perhaps on the DOT’s even more stringent definition of the term.

A statute enacted by the Arizona Legislature in response to the AMMA attempted to clarify the matter by defining “impairment” as being under the influence of marijuana to the extent that the employee’s job performance abilities are “decreased or lessened.” The statute also describes various “symptoms” an employer can consider in attempting to determine whether an individual is impaired, including perceived changes in the individual’s speech, walking, standing, coordination, demeanor, physical appearance, and odor.

Not surprisingly, the symptoms the Arizona Legislature identified as being indicative of marijuana impairment are the same as those that may suggest

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207 See State v. Phillips, 873 P.2d 706, 710 (Ariz. Ct. App. 1994) (“Unlike the blood alcohol concentration test used to measure alcohol impairment, there is no useful indicator of impairment from . . . drugs because they are fundamentally different from alcohol.”); Shepler v. State, 758 N.E.2d 966, 970 (Ind. Ct. App. 2001) (“There is no accepted toxicological agreement as to the amount of marijuana . . . necessary to cause impairment.”).

208 See, e.g., ARIz. REV. STAT. ANN. § 28-1381(A)(2) (“It is unlawful for a person to drive or be in actual physical control of a vehicle in this state . . . if the person has an alcohol concentration of 0.08 or more within two hours of driving or being in actual physical control of the vehicle and the alcohol concentration results from alcohol consumed either before or while driving or being in actual physical control of the vehicle.”).

209 See 49 C.F.R. § 40.23(c) (2010) (“An employer who receives an alcohol test result of 0.04 or higher . . . must immediately remove the employee involved from performing safety-sensitive functions.”).

210 ARIz. REV. STAT. ANN. § 23-493(7) (West, Westlaw through 2012 Legis. Sess.); cf. Wiehe v. Kissick Constr. Co., 232 P.3d 866, 874-75 (Kan. Ct. App. 2010) (“Impairment is defined as ‘the fact or state of being damaged, weakened, or diminished.’ . . . Thus, when a person is impaired, it follows logically that the person’s mental and physical faculties are damaged or diminished.”) (quoting BLACK’S LAW DIcTIONARY 819 (9th ed. 2009)).

211 ARIz. REV. STAT. ANN. § 23-493(7); see Abbe M. Goncharsky & Alexandra G. Gormley, Guess Who’s Coming to Work?: Employers Prepare for the Arizona Medical Marijuana Program, ATT’y AT LAW MAGAZINE, June 2011, at 14 (“This new law defines ‘impairment’ by listing examples of symptoms ‘that may decrease or lessen the employee’s performance of the duties or tasks of the employee’s job position,’ including physical dexterity, appearance, odor, and negligence or carelessness in operating equipment.”); cf. State v. Anonymous (1976-3), 355 A.2d 729, 736 n.34 (Conn. Super. Ct. 1976) (noting that “a significantly stronger dose [of marijuana] impairs coordination and reaction time”); People v. Kaminski, 573 N.Y.S.2d 394, 395 (J. Ct. 1991) (noting that “the traditional signs of impairment” include “slow speech, blood shot eyes as well as the odor of marijuana”).
alcohol impairment. While there is some logic to this linkage (and to the legislature’s focus on observable symptoms of impairment), the statutory enumeration of those symptoms may be of limited benefit to employers attempting to comply with the AMMA, because “drug use is far harder for lay people to detect than... alcohol use.” Indeed, the guidance the legislature has attempted to provide is likely to be of virtually no use to employers in the hiring process because employers in that situation typically have “not had [an] opportunity to observe the applicant over a period of time.”

212 The statute defines impairment for purposes of both drug and alcohol use. Ariz. Rev. Stat. Ann. § 23-493(7) (“Impairment’ means symptoms that a prospective employee or employee while working may be under the influence of drugs or alcohol that may decrease or lessen the employee’s performance of the duties or tasks of the employee’s job position....”); see also Weller v. Ariz. Dep’t Econ. Sec., 860 P.2d 487, 495 (Ariz. Ct. App. 1993) (stating that “[h]and-eye coordination tests which focus on on-the-job [alcohol] impairment” are also “effective in detecting marijuana’s deleterious effects”) (citing A.G. GOODMAN & L.S. GILMAN, THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 550-51 (8th ed. 1990)).

213 See People v. Smith, 193 Cal. Rptr. 825, 827 (Ct. App. 1983) (observing that the “use of alcohol produces many effects similar to the effects produced by marijuana”); State v. Worster, 611 A.2d 979, 981 (Me. 1992) (noting “the similar effects and symptoms of both alcohol and marijuana”).

214 See Glide Lumber Prods. Co. v. Emp’t Div., 741 P.2d 907, 911 (Or. Ct. App. 1987) (“If an employee [sic] is actively intoxicated or residually impaired while at work, direct observation by supervisors and co-workers would appear to be a better means of ascertaining that fact than drug testing... In any event, observation cannot be a worse means, because [a] urine test can show nothing about on-the-job effects.”); cf. Burka v. New York City Transit Auth., 739 F. Supp. 814, 821 (S.D.N.Y. 1990) (“There may be means more effective than urinalysis [testing] with which to... prevent on-duty impairment...”); Harmon v. Thornburgh, 878 F.2d 484, 489 (D.C. Cir. 1989) (suggesting that employee drug impairment in traditional office environments “is, presumably, more easily detected by means other than urine testing”).

215 Fowler v. New York City Dep’t of Sanitation, 704 F. Supp. 1264, 1275 (S.D.N.Y. 1989); cf. Nat’l Air Traffic Controllers Ass’n v. Burnley, 700 F. Supp. 1043, 1046 (N.D. Cal. 1988) (“[I]t is very difficult for any employer, even with supervisors trained in identifying drug-related problems, to detect drug problems without a comprehensive drug testing program.”); New Jersey v. Bealor, 872 A.2d 1081, 1085 (N.J. Super. Ct. App. Div. 2005) (“Marijuana intoxication... is not a matter of common knowledge such that an inference of intoxication may be drawn solely from a lay witness’s testimony respecting [an individual’s] behavior.”), rev’d on other grounds, 902 A.2d 226 (N.J. 2006). See generally Bhd. of Maint. of Way Emps., Lodge 16 v. Burlington N. R.R. Co., 802 F.2d 1016, 1020 (8th Cir. 1986) (“[T]he use or abuse of marijuana and other illegal drugs frequently does not produce an externally obvious state of impairment... [T]oo often the user’s faculties are impaired... without any outward sign of his impairment that could lead a supervisor or other person to intervene.”).

216 See Burka, 739 F. Supp. at 821 (“[S]upervisors could in certain instances screen employees and thus be able to prevent an impaired worker from causing an injury...”)(emphasis added).

217 Loder v. City of Glendale, 927 P.2d 1200, 1223 (Cal. 1997); see also Willner v. Thornburgh, 928 F.2d 1185, 1193 (D.C. Cir. 1991) (“[A]t the pre-employment stage... the applicant is an outsider... [T]he applicant is a person the... prospective employer[ ] has had no opportunity to observe in the setting of the workplace.”).
VII. THE FEDERAL REACTION TO THE AMMA AND OTHER RECENT STATE MEDICAL MARIJUANA LAWS

As discussed earlier, even the use of marijuana for medical purposes remains unlawful under federal law (and, for that matter, under the law of most other states), despite repeated efforts by various interested parties to have the medical use of marijuana legalized on a national basis. However, in late 2009, the Obama Justice Department ("Justice Department") announced, in what has come to be known as the Ogden Memorandum, that as an exercise of prosecutorial discretion, the department's resources should not be focused on prosecuting medical marijuana users and caregivers who provide those individuals with marijuana in states where the medical use and sale of marijuana is lawful as a matter of state law. Notably, the Ogden Memorandum was par-

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218 See supra note 115 and accompanying text.

219 See United States v. Hicks, 722 F. Supp. 2d 829, 833 (E.D. Mich. 2010) ("[T]he possession of marijuana remains illegal under federal law, even if it is possessed for medicinal purposes in accordance with state law."); Ross v. RagingWire Telecomms., Inc., 174 P.3d 200, 204 (Cal. 2008) ("No state law could completely legalize marijuana for medical purposes because the drug remains illegal under federal law, even for medical users.") (citations omitted); D. Douglas Metcalf, Federal Supremacy and Arizona's Medical Marijuana Act, 47 Ariz. Att'y 22, 23 (2011) ("Arizona's new Medical Marijuana Act, which legalizes the distribution and use of marijuana for medical use in certain situations, has no bearing on whether such activities remain illegal under federal law.").


221 See United States v. Cannabis Cultivators Club, 5 F. Supp. 2d 1086, 1105 (N.D. Cal. 1998) ("[M]edical marijuana advocates have been unsuccessful in convincing the federal government decision makers that marijuana should be . . . made available to seriously ill patients upon a physician's recommendation."); People v. Bianco, 113 Cal. Rptr. 2d 392, 397 (Ct. App. 2001) ("Congress has not seen fit to change the law despite a growing movement in several states that supports the medical use of marijuana."); Vijay Sekhon, Comment, Highly Uncertain Times: An Analysis of the Executive Branch's Decision to Not Investigate or Prosecute Individuals in Compliance with State Medical Marijuana Laws, 37 Hastings Const. L.Q. 553, 557 (2010) (noting that "Congress has repeatedly considered but failed to pass legislation that would permit the possession, cultivation and use of marijuana by individuals in compliance with state medical marijuana laws").

particularly vague as to whether the Justice Department intends to allocate its resources to prosecuting distributors of medical marijuana in states with medical marijuana laws.\textsuperscript{223}

The Justice Department’s announcement did not abrogate its authority to enforce the provisions of the Controlled Substances Act prohibiting the use and sale of marijuana as a matter of federal law.\textsuperscript{224} Thus, despite the Justice Department’s apparent intent to accommodate state medical marijuana laws, the law on the subject remains in a troubling state of uncertainty; persons using or dispensing marijuana for medical purposes in accordance with state law nevertheless could be prosecuted—and certainly at least investigated—\textsuperscript{225} for violating federal prohibitions on the use or distribution of marijuana for any purpose.\textsuperscript{226}

\textsuperscript{222} See Ogden Memorandum, supra note 222, at 2 (“[P]rosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department.”).

\textsuperscript{224} See Hicks, 722 F. Supp. 2d at 833 (“The Department of Justice’s discretionary decision to direct its resources elsewhere does not mean that the federal government now lacks the power to prosecute those who possess marijuana.”); Cnty. of Butte v. Superior Court, 96 Cal. Rptr. 3d 421, 434 (Cal. Ct. App. 2009) (Morrisson, J., dissenting) (“[I]t is only in benign forbearance that medical marijuana users are protected.”), cert. denied, 130 S. Ct. 1522 (2010); cf. Metcalf, supra note 219, at 24 (“Gonzales v. Raich forecloses any serious argument that a person who is complying with Arizona’s Medical Marijuana Act cannot be prosecuted for violating the CSA.”).

\textsuperscript{225} See Mich. Dep’t of Cnty. Health, 2011 WL 2412602, at *14 (“[U]sers or providers of marijuana under [state medical marijuana laws] and their supporters should be concerned that . . . this Administration or the next may simply pull the plug and prosecute anyone using or distributing marijuana, which it unquestionably may do under existing federal law.”); Sekhon, supra note 221, at 561-62 (“The imprimatur of the Executive Branch . . . provides individuals with a false sense of security in relying upon compliance with state medical marijuana laws given the possibility of a change to [the] enforcement policy by the Executive Branch during or after the expiration of the term of President Obama.”).

\textsuperscript{226} See Mich. Dep’t of Cnty. Health, 2011 WL 2412602, at *14 (“Even if the Attorney General of the United States has adopted a policy of not prosecuting persons who are bona fide medical marijuana users and providers as far as [state law] is concerned, it certainly falls within the scope of the DEA’s responsibility, and authority, to determine, among other things, whether those claiming the benefits of [a] medical marijuana statute are doing so legitimately and should enjoy the Attorney General’s largess.”); Cnty. of Butte, 96 Cal. Rptr. 3d at 425 (“[M]edical marijuana laws do not prohibit police from investigating possible violations of the law.”).

\textsuperscript{227} See United States v. Pendleton, 636 F.3d 78, 85 (3d Cir. 2011) (“Medical marijuana users . . . could be using marijuana legally under state law, but still be vulnerable to federal prosecution.”); Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus., 230 P.3d 518, 529 (Or. 2010) (en banc) (“[S]tate law does not prevent the federal government from enforcing its marijuana laws against medical marijuana users . . . if the federal government chooses to do so.”); cf. Mich. Dep’t of Cnty. Health, 2011 WL 2412602, at *7 (“The use of marijuana continues to be a federal felony and reasonable persons would expect the DEA to continue to investigate those who use or traffic in marijuana.”); Metcalf, supra note 219, at 23 (“It seems counterintuitive that . . . a person
In this regard, a federal magistrate judge recently cautioned that “[o]nly the truly naive or the disingenuous would try to argue that [medical marijuana laws] will not be abused by others seeking a cover for illicitly using or distributing marijuana.”

Consistent with this concern, the then-United States Attorney for the District of Arizona, Dennis Burke, advised the Director of the Arizona Department of Health Services in May 2011 that federal prosecutors in Arizona would “vigorously prosecute individuals and organizations that participate in unlawful manufacturing, distribution and marketing activity involving marijuana, even if such activities are permitted under state law.”

In a subsequent memorandum directed to all United States Attorneys, Deputy Attorney General James M. Cole indicated that Mr. Burke’s letter, and similar and generally contemporaneous announcements made by several of Mr. Burke’s counterparts in other states, were “entirely consistent” with the enforcement policy previously articulated in the Ogden Memorandum. Mr. Cole went on to state that persons “cultivating, selling or distributing marijuana, and those who knowingly facilitate such activities, are in violation of the Controlled Substances Act, regardless of state law,” and that the Ogden Memo-

228 Mich. Dep’t of Comty. Health, 2011 WL 2412602, at *14; see, e.g., State v. Smith, 262 P.3d 72, 73 (Wash. Ct. App. 2011) (describing an individual “who had a medical marijuana license to grow marijuana for personal medicinal use, [but] had also engaged in the illegal sale of marijuana to friends and acquaintances”). See United States v. Stacy, 696 F. Supp. 2d 1141, 1149 (S.D. Cal. 2010) (“Federal prosecuting authorities are free to investigate or prosecute individuals if, in their judgment, there is reason to believe that state law is being invoked to mask the illegal production or distribution of marijuana.”).


230 See, e.g., In re McGinnis, No. 11-60010-fra13, 2011 WL 2358672, at *2 n.3 (Bankr. D. Or. June 9, 2011) (“On June 3, 2011, the United States Attorney for Oregon and 33 of Oregon’s 36 District Attorneys released a ‘Notice to Owners, Operators and Landlords of Oregon Marijuana Dispensaries’ stating that ‘The sale of marijuana for any purpose—including as medicine—violates both Federal and Oregon law and will not be tolerated,’ and that property used by anyone to cultivate marijuana for sale may be subject to forfeiture.”); Mary K. Reinhart & Craig Anderson, Federal Pressure Stirs Legal Confusion, ARIZ. REPUBLIC, Apr. 21, 2011, at A1 (“Although the Justice Department said in 2009 that it would not prosecute sick people using medical marijuana, U.S. attorneys in California and Washington state have told officials there that they do intend to enforce federal laws that prohibit manufacture and distribution of the drug.”).

random "was never intended to shield such activities from federal enforcement action and prosecution, even where those activities purport to comply with state law."\textsuperscript{232}

These developments prompted Arizona's Attorney General, Tom Horne, to commence a federal declaratory judgment action on behalf of the State of Arizona seeking to clarify the implications of the conflict between state and federal law concerning the medical use of marijuana,\textsuperscript{233} and to determine the extent to which compliance with the AMMA "shields state employees, patients, dispensary owners and others from federal prosecution."\textsuperscript{234} The commencement of this litigation in turn prompted the Director of the Arizona Department of Health Services to suspend the licensing of medical marijuana dispensaries under the AMMA.\textsuperscript{235} One local observer subsequently cautioned that until this conflict is resolved,\textsuperscript{236} "if a person is using or dispensing medical marijuana in

\textsuperscript{232} Id.; cf. Metcalf, supra note 219, at 24 ("Does the Ogden Memorandum consider a person who dispenses medical marijuana in a state-licensed dispensary facility to be . . . within the exemption [from federal prosecution]? . . . The absence of any mention of dispensaries [in the Ogden Memorandum] suggests that the federal government did not intend to give dispensaries 'a pass.'").

\textsuperscript{233} Copies of letters issued by other U.S. Attorneys who have taken positions consistent with Mr. Burke's letter were discussed in, and attached as exhibits to, the State's Complaint for Declaratory Judgment. Complaint for Declaratory Judgment, State of Arizona v. United States, No. 2:11-cv-01072-SRB (D. Ariz. May 27, 2011).

\textsuperscript{234} Mary K. Reinhart, Medical-Pot Dispensary Applications to Be Denied, \textbf{ARIZ. REPUBLIC}, June 1, 2011, at B2; see also Metcalf, supra note 219, at 28 ("[T]he uncertainty of whether state employees who are tasked with implementing the Arizona Medical Marijuana Act are at risk of federal prosecution . . . caused the State of Arizona to file a declaratory judgment action against the U.S. Justice Department in federal court.").

\textsuperscript{235} See Mary K. Reinhart, Lawsuit Stalls Medical-Pot Dispensaries, \textbf{ARIZ. REPUBLIC}, May 28, 2011, at B1 ("Arizona's health director put medical-marijuana dispensaries on hold just days before he was to begin accepting applications, citing the lawsuit filed by the state in federal court . . . to determine whether the new law conflicts with federal drug statutes."). In early January 2012, the federal district court dismissed the State's declaratory judgment action without prejudice on the ground that the dispute alleged in the State's Complaint was not ripe for adjudication. See Order, at 8, 10, State of Arizona v. United States, No. CV 11-1072-PHX-SRB (D. Ariz. Jan. 4, 2012). The State subsequently elected not to amend its Complaint or appeal or otherwise challenge the court's ruling, and the Department of Health Services is now expected to begin accepting dispensary applications in approximately September 2012, and to start issuing dispensary licenses in November 2012. See Mary K. Reinhart, Governor OKs Licensing Tied to Medical Pot, \textbf{ARIZ. REPUBLIC}, January 14, 2012, at A1, A11.

\textsuperscript{236} Many observers believe the conflict can be resolved only by federal legislative or administrative action that effectively reclassifies marijuana as something other than a Schedule I controlled substance. See, e.g., Kathleen T. McCarthy, Commentary, \textit{Conversations About Medical Marijuana Between Physicians and Their Patients}, 25 \textbf{J. LEGAL MED.} 333, 348 (2004) ("[I]f state drug policies conflict with federal standards, this issue must be addressed. One of the ways this conflict could be avoided is to list marijuana on a different schedule under the Controlled Substances Act."); cf. United States v. Middleton, 690 F.2d 820, 823 (11th Cir. 1982) (noting that "a reclassification of marijuana is a matter for legislative or administrative, not judicial, judgment").
[a] way that undermines federal enforcement of the [Controlled Substances Act], that person could become a target of prosecution even if he or she is in clear and unambiguous compliance with Arizona law. 237

Despite these developments, the threat of federal prosecution faced by those dispensing medical marijuana seems unlikely to deter individual medical marijuana users (who may be authorized by the state to cultivate their own marijuana plants) 238 from exercising their rights under the AMMA. 239 Indeed, within nine months of the AMMA's enactment (and barely four months after the Arizona Department of Health Services began accepting applications), 240

Recent developments suggest that such reclassification is unlikely to occur anytime soon. See, e.g., supra note 65. See also Cnty. of Santa Cruz v. Ashcroft, 279 F. Supp. 2d 1192, 1203 (N.D. Cal. 2003) ("[T]here have been several attempts to reschedule marijuana; all were unsuccessful . . . ."), modified on reconsideration, 314 F. Supp. 2d 1000 (N.D. Cal. 2004); Erik R. Neusch, Comment, Medical Marijuana's Fate in the Aftermath of the Supreme Court's New Commerce Clause Jurisprudence, 72 U. COLO. L. REV. 201, 211 (2001) ("The most logical solution to the problem, rescheduling marijuana from a Schedule I category to a Schedule II category, is not politically viable. . . . Efforts to reclassify marijuana at both the administrative and legislative levels have repeatedly failed.").

237 Metcalf, supra note 219, at 24; see also Neusch, supra note 236, at 211 ("Because of marijuana's status as a Schedule I drug, physicians who recommend, and patients who use, marijuana in accordance with state law can be held criminally liable under federal law.").

238 See ARIZ. REV. STAT. ANN. §§ 36-2804.02(A)(3)(f), 36-2804.04(A)(7), 36-2812(A)(4) (West, Westlaw through 2012 Legis. Sess.) (ARIZ. REV. STAT. ANN. § 36-2812, repealed by 2010 Prop. 203 (an Initiative Measure), § 5 (effective Apr. 14, 2011)); Mary K. Reinhart, Arizona to Sue over Medical-Pot Law, ARIZ. REPUBLIC, May 27, 2011, at B1 ("Both patients and caregivers are authorized to grow 12 plants per patient if the patients live more than 25 miles from a dispensary. Since there are not yet any licensed dispensary licenses [sic], caregivers and patients are allowed to grow their own.").

239 See Robert A. Mikos, On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime, 62 VAND. L. REV. 1421, 1479 (2009) ("Given the federal government's limited enforcement resources and its comparatively weak influence over personal preferences, moral obligations, and social norms, many citizens are not dissuaded from using marijuana by the existence of the federal ban."). See also Cnty. of Butte v. Superior Court, 96 Cal. Rptr. 3d 421, 430 (Ct. App. 2009) (Morrison, J., dissenting) ("Because of the perceived minor nature of marijuana as compared to other drugs and other crimes generally, federal law enforcement agencies rarely investigate or seek prosecution for people who simply possess marijuana."); Metcalf, supra, note 219, at 28 ("Truly seriously ill individuals who use marijuana to ameliorate their medical symptoms would not be the focus [of] federal prosecution whether the Department of Justice issued its medical marijuana policy or not.").

240 The Department of Health Services did not begin accepting applications for medical marijuana certifications until April 14, 2011—some five months after the AMMA was approved by Arizona voters. See Michelle Ye Hee Lee & William Hermann, Final Medical-Pot Plan Unveiled, ARIZ. REPUBLIC, March 29, 2011, at B1 ("Arizona's medical marijuana program officially begins April 14, 2011 when the department will begin accepting patient applications."); Ginger Rough, Medical-Pot Clarification Sought, ARIZ. REPUBLIC, May 25, 2011 ("Proposition 203, which legalized medical-marijuana use for people with certain debilitating conditions, was approved by voters in November and took effect April 14.").
an estimated 10,000 Arizonans had been certified to use medical marijuana, and the overwhelming majority of those persons were authorized to grow their own marijuana plants. These numbers are even larger now, and because those who grow marijuana for their own personal medical use fall within the protection of the AMMA's anti-discrimination provisions, the compliance problems faced by Arizona employers do not appear to be ameliorated (or, conversely, significantly exacerbated) by the conflict between state and federal law that vexes others impacted by the AMMA.

VIII. CONCLUSION

Some observers expected the Arizona Department of Health Services to address the employment problems posed by the AMMA when it issued the implementing regulations it was directed to promulgate under the terms of the

241 See Mary K. Reinhart, Medical-Pot Probe Flags 8 Doctors, ARIZ. REPUBLIC, Aug. 20, 2011, at A1 (noting "the 10,000 Arizonans certified to use medical marijuana"); Editorial, ADHS Exposing Shady Doctors, ARIZ. REPUBLIC, Aug. 24, 2011, at B4 (discussing "the 10,000 certifications allowing people to legally use marijuana as medicine").

242 See Reinhart, supra note 241, at A7 ("About 80 percent of those issued state ID cards to use medical marijuana also are authorized to grow it.").

243 By the latter part of October 2011—approximately six months after the Department of Health Services began accepting applications—the number of Arizonans certified to use medical marijuana had grown to "more than 13,000," and "nearly 11,000" of those persons were authorized to grow their own plants. Mary K. Reinhart, Two Different Views on the Future of Medical Marijuana in Arizona, ARIZ. REPUBLIC, Oct. 23, 2011, at B3. By the end of 2011, these numbers had swelled to nearly 18,000 and 15,000, respectively. See Mary K. Reinhart, Arizona's Medical Marijuana Suit Tossed, ARIZ. REPUBLIC, Jan. 5, 2012, at A4.

244 Compare ARIZ. REV. STAT. ANN. § 36-2804.04(A)(7) (West, Westlaw through 2012 Legis. Sess.) ("Registry identification cards for qualifying patients and designated caregivers shall contain . . . a clear indication of whether the cardholder has been authorized to cultivate marijuana plants for the qualifying patient's medical use.") with id. § 36-2813(B)(1) ("An employer may not discriminate against a person in hiring, termination or imposing any term or condition of employment or otherwise penalize a person based upon . . . [t]he person's status as a cardholder."). But see Washburn v. Columbia Forest Prods., Inc., 134 P.3d 161, 166 (Or. 2006) (Kistler, J. concurring) ("Federal law preempts state . . . law to the extent it requires employers to accommodate medical marijuana users.").

245 See United States v. Lynch, No. CR 07-0689-GW, 2010 WL 1848209, at *23 (C.D. Cal. Apr. 29, 2010) ("[C]ertain states . . . allow the prescribing [sic] of marijuana for medical purposes and the Federal Government [has] the option of prosecuting persons who seek to act under the States' imprimatur. Individuals [dispensing medical marijuana] are caught in the middle of the shifting positions of governmental authorities."). Cf. Metcalf supra note 219, at 28 ("[L]andlords or lenders who facilitate the distribution of medical marijuana could find themselves at serious risk of federal prosecution and incarceration or seizure of their property even if they never touch or see the medical marijuana. . . . Unfortunately, there is simply no way . . . that anyone can become involved in dispensing medical marijuana without risking federal prosecution.").
Unfortunately, the regulations are silent as to any of the troubling employment aspects of the act. Until the Arizona courts or the state legislature provide further guidance as to the meaning and impact of the AMMA, employers will be operating in a troubling state of uncertainty concerning their legal rights and obligations and those of their employees who are medical marijuana card holders.

See, e.g., Berry, supra note 19, at A1 (suggesting that the DHS regulations might provide much needed guidance for employers “scrambling to review their drug-testing policies and scrutinize employee rules to comply with the new law”); John Alan Doran, Arizona Legislature Passes Law Protecting Employers from Medical Marijuana Claims; Governor Expected to Sign Bill into Law, Nat’l Law Rev. 1 (May 1, 2011), available at http://www.natlawreview.com/printpdf/4792 (“Prop. 203 provided virtually no guidance to Arizona employers with respect to compliance. It was with great anticipation, then, that Arizona employers awaited promulgation and publication of interpretive rules that would guide employers through the medical marijuana smokescreen.”). 

See Ariz. Admin. Code §§ R9-17-101 to R9-17-323 (2011); Doran, supra note 246, at 1 (“Unfortunately, when the Arizona Department of Health Services published its rules governing medical marijuana on March 28, 2011, it failed to so much as mention employer responsibilities in the new rules.”). The Department’s failure to address the employment implications of the AMMA may reflect the fact that it was given only 120 days to draft and issue its implementing regulations. See Ariz. Rev. Stat. Ann. § 36-2803(A) (West, Westlaw through 2012 Legis. Sess.); cf. People v. Redden, 799 N.W.2d 184, 223 (Mich. Ct. App. 2010) (O’Connell, P.J., concurring) (observing that “120 days to draft the administrative rules” guiding the application of the Michigan Medical Marijuana Act “was a totally unreasonable time limit for such a task.”), appeal withdrawn, 798 N.W.2d 513 (Mich. 2011).

See Berry, supra note 19, at A1 (“Zero tolerance of drug use is the workplace norm in Arizona, but the medical-marijuana law . . . will cloud what had been a clear-cut issue for workers and employers.”); Doran, supra note 246, at 1 (“Arizona employers remain[ ] very much in the dark with respect to Prop. 203’s employer mandates.”); Obele, supra note 148, at 13 (“[T]he law opens all sorts of questions for employers, whose zero-tolerance drug-use policies likely will be challenged.”); cf. Redden, 799 N.W.2d at 203-04 (O’Connell, P.J., concurring) (“[T]he confusing nature of the [Michigan Medical Marijuana Act], and its susceptibility to multiple interpretations, creates an untoward risk for Michiganders . . . . Until our Supreme Court and the Legislature clarify and define the scope of the [Act], it is important to proceed cautiously when seeking to take advantage of the protections in it.”).