

The History of Medicinal Cannabis

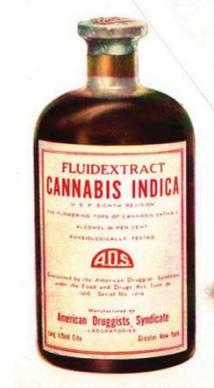
Background

As early as 2737 B.C., the mystical Emperor Shen Neng of China was prescribing marijuana tea for the treatment of gout, rheumatism, malaria and, oddly enough, poor memory. The drug's popularity as a medicine spread throughout Asia, the Middle East and down the eastern coast of Africa, and certain Hindu sects in India used marijuana for religious purposes and stress relief. Ancient physicians prescribed marijuana for everything from pain relief to earache to childbirth.

In terms of American history, it was reported that in 1492 Christopher Columbus brought cannabis as rope of hemp into the New World. In 1619, Jamestown colony law declared that all settlers were required to grow cannabis. George Washington grew cannabis for fiber production at Mount Vernon as his primary crop.

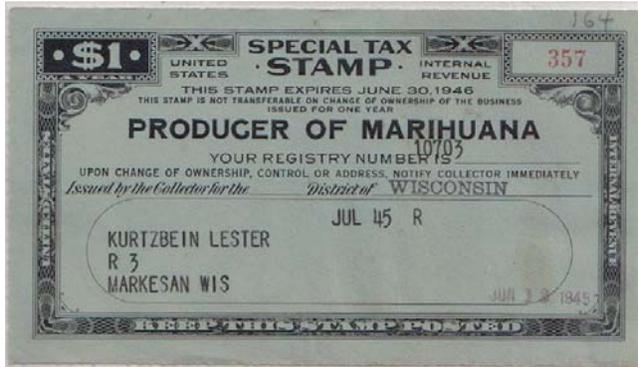
By the late 18th century, early editions of American medical journals showed recommendations of hemp seeds and roots for the treatment of inflamed skin, incontinence and venereal disease. Irish doctor William O'Shaughnessy first popularized marijuana's medical use in England and America. As a physician with the British East India Company, he found marijuana eased the pain of rheumatism and was helpful against discomfort and nausea in cases of rabies, cholera and tetanus.

The change in American attitudes toward marijuana came at the end of the 19th century, when between 2% and 5% of the U.S. population was unknowingly addicted to morphine, a popular secret ingredient in patent medicines. To prevent more of the country from morphine addiction, the government introduced the Pure Food and Drug Act in 1906, creating the Food and Drug Administration. While it didn't apply to marijuana and merely brought the distribution of opium and morphine under a doctors' control, the regulation of chemical substances was a major shift in American drug policy.



It wasn't until 1914 that drug use was defined as a crime, under the Harrison Act. To get around states' rights issues, the act used a tax to regulate opium- and coca-derived drugs; it levied a tax on nonmedical uses of the drugs that was much higher than the cost of the drugs themselves, and punished anyone using the drugs without paying the tax. The Marijuana Tax Act of 1937 made possession or transfer of cannabis illegal throughout the United States under federal law, excluding medical and industrial uses, in which an expensive excise tax was required. Annual fees for the tax were \$24 for importers, manufacturers, and cultivators of cannabis, \$1 annually for medical and research purposes, and \$3 annually for industrial uses. Detailed cannabis sale logs were required to keep record of cannabis sales. Cannabis could be sold to any person who has previously paid the tax at \$1 per ounce or fraction thereof; however, it was \$100

per ounce or fraction thereof if sold to any person who had not registered and paid the special tax.



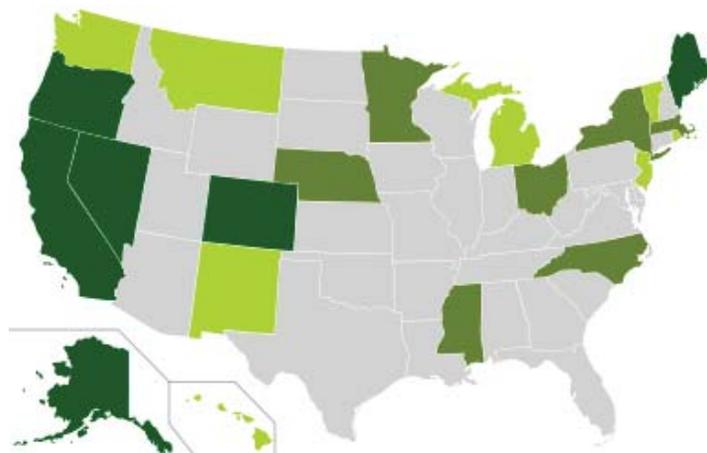
With an exception during World War II, when the government planted huge hemp crops to supply naval rope needs and make up for Asian hemp supplies controlled by the Japanese, marijuana was criminalized and harsher penalties were applied. In the 1950s Congress passed the Boggs Act and the Narcotics Control Act, which laid down mandatory sentences for drug offenders, including

marijuana possessors and distributors.

In 1969, the Supreme Court held the Marijuana Tax Act to be unconstitutional since it violated the Fifth Amendment privilege against self-incrimination. In response, Congress repealed the Marijuana Tax Act and passed the Controlled Substances Act as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Despite an easing of marijuana laws in the 1970s, the Reagan Administration's get-tough drug policies the following decade applied to marijuana as well. Still, the long-term trend has been toward relaxation. Since California became the first state to legalize medical marijuana in 1996, more than a dozen states have followed.

In October 2009, Attorney General Eric H. Holder Jr. directed federal prosecutors to back away from pursuing cases against medical marijuana patients, signaling a broad policy shift that drug reform advocates interpret as the first step toward legalization of the drug. The government's top lawyer said that in the 14 states with some provisions for medical marijuana use, federal prosecutors should focus only on cases involving higher-level drug traffickers, money launderers or people who use the state laws as a cover.



Medical Use of Marijuana

In 1978, Robert Randall sued the federal government for arresting him for using cannabis to treat his glaucoma. The judge ruled Randall needed cannabis for medical purposes and required the Food and Drug Administration set up a program to grow cannabis on a farm at the University of Mississippi and to distribute 300 cannabis cigarettes a month to Randall. In 1992, George H. W. Bush discontinued the program after Randall tried to make AIDS patients eligible for the program. At the time, thirteen people were already enrolled and were allowed to continue receiving cannabis cigarettes; today the government still ships cannabis cigarettes to seven people. Irvin Rosenfeld, who became eligible to receive cannabis from the program in 1982 to treat rare bone tumors, urged the George W. Bush administration to reopen the program; however, he was unsuccessful.

In 1972, 1995, and 2002, petitions for cannabis rescheduling in the United States were filed to remove cannabis from the "Schedule I" category of tightly-restricted drugs that have no medical use, as the Controlled Substance Act allows the executive branch to decriminalize medical and recreational use of cannabis without any action by Congress depending on the findings of the Secretary of the United States Department of Health and Human Services on certain scientific and medical issues specified by the Act.

DEA and NIDA opposition prevented any scientific studies of medical marijuana for more than a decade, but in the 1990s, activists and doctors were energized by seeing marijuana help dying AIDS patients. A study of smoked marijuana at the University of California, San Francisco, under Dr. Donald Abrams was approved after five years. Further research followed, particularly due to a ten million dollar research appropriation by the California legislature. The University of California coordinates this research. However, there are still significant barriers, unique among Schedule I substances, to conducting medical marijuana research in the US. Many years of work remain before sufficient research could be approved and conducted to meet the FDA's standards for approving marijuana as a new prescription medicine.

Montana Medical Marijuana Law

The State of Montana legalized the medical use of marijuana in 2004 by a 62% referendum vote. The Montana Medical Marijuana Program, administered by the Department of Health and Human Services licenses and permits a patient to grow six (6) plants and have in their possession one (1) usable ounce. The patient may also select a caregiver, a person who may also grow six (6) plants and possess one (1) usable ounce for that patient.

Montana's Medical Marijuana Industry as of July 31, 2010

A medical cannabis license is commonly known as a "green card." There are currently more than 20,000 patients licensed by the state of Montana. Enrollment in the program steadily increased in the first four years of the Initiative's passage, but has escalated sharply in the recent months. Since November 2009, there has been a more than 100% increase in total patient count.

The Montana Department of Health and Human Services projects that the number of medical marijuana licenses could be 50,000 by 2013. Other projections suggest that as much as 10% of the population, or 100,000 marijuana licenses, will be issued licenses in Montana by the year 2015.

How Medical Marijuana is Sold in Montana

Licensed patients may grow their own plants or they may designate another person as their registered caregiver to grow on their behalf. There are currently almost 4,000 licensed caregivers in the State. The majority of caregivers (approximately 85%) are small hobbyist growers, mom and pop operations, with four (4) or fewer patients. Just a handful of large professional caregiver/growers, only 5% of registered caregivers, have more than fifteen (15) patients. The current number of legal "plants in the ground" is estimated to be less than 40% of the current demand in Montana. This results in undesirable black market product being sold to patients.

Montanans have created a number of new business models to embrace this new industry. These include growing co-ops, contract growing, and storefront distribution sites. Due to Montana's extreme climate, most medical marijuana farm facilities in Montana are inside grow facilities. Some farm facilities produce a minimal number of strains while others may carry between 20-25 different strains. In Montana, outside growing results in one crop per year, while inside grows can anticipate 3 to 4 crops per year.

Many caregivers utilize home delivery to patients. While there are some state-wide home delivery caregiver services, most are local and regional due to the long traveling distances within the State. Some caregivers sell medicine to patients in storefront locations. These storefronts may ONLY serve medicine to patients who have selected a representative of that storefront as their caregiver.

Unlike some other states, the storefront is NOT an open dispensary that can serve any patients holding a license.

No marijuana product of any kind may cross ANY state line.