IN THE SUPREME COURT OF IOWA

STATE OF IOWA,	)	
	)	
Plaintiff-Appellee,	)	
	)	
v.	)	SUPREME COURT NO.03-0309
	)	
LLOYD DEAN BONJOUR,	)	
	)	
Defendant-Appellant.	)	

APPEAL FROM THE IOWA DISTRICT COURT

IN AND FOR FLOYD COUNTY

HONORABLE BRYAN H. MCKINLEY
AND
HONORABLE STEPHEN P. CARROLL, JUDGES

APPELLANT'S BRIEF AND ARGUMENT

AND

REQUEST FOR ORAL ARGUMENT

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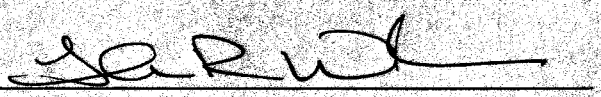
CERTIFICATE OF SERVICE AND FILING

On the 9th day of August, 2004, the undersigned party did serve the within Appellant's Brief and Argument and Request for Oral Argument on all other parties to this appeal by hand delivering two copies thereof to the following respective counsel for said parties: Thomas J. Miller, Attorney General of Iowa, Criminal Appeals Division, Hoover State Office Building, Des Moines, Iowa 50319, and on Defendant-Appellant by placing one copy thereof in the United States mail, proper postage attached, addressed to Lloyd Bonjour, 778 Highway 65, Hampton, IA 50441.

I certify that on August 9, 2004, I will file this document by mailing 18 copies of it to the Clerk of the Supreme Court, Iowa Judicial Building, 1111 East Court Avenue, Des Moines, Iowa 50319 through Iowa State Capital Complex Local Mail.

STATE APPELLATE DEFENDER'S OFFICE



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Wayne R. LaFave, Substantive Criminal Law § 10.1(a), 10.1(d)(3), (5)-(6) (2d ed. 2003)

State v. Ward, 170 Iowa 185, 152 N.W.2d N.W.501 (1915)

State v. Walton, 311 N.W.2d 113, 114-15 (Iowa 1981)

W. LaFave & A. Scott, Handbook on Criminal Law § 50, at 385-88 (1972)

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Emily Farr, United States v. Oakland Cannabis Buyers' Cooperative: The Medical Necessity Defense as an Exception to the Controlled Substance Act, 53 S.C. L. Rev. 439, 452 (2002)

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Michael Aldrich, History of Therapeutic Cannabis, in Cannabis in Medical Practice 35 (Mary Lynn Mathre, ed. 1997)

Deborah Garner, Up in Smoke: The Medicinal Marijuana Debate, 75 N. Dak. L. Rev. 555, 557 (1999)

Lester Grinspoon & James B. Bakalar, Marijuana, The Forbidden Medicine 8 (1997)

Iowa Code § 204.204(6) (1981)

National Institutes of Health, Marijuana and Medicine: Assessing the Science Base (1999), (last visited February 4, 2004) <http://www.books.nap.edu/html/marimed>

Walter Krampf, AIDS and the Wasting Syndrome, in Cannabis in Medical Practice, 84 (Mary Lynn Mathre, ed. 1997)

Donald Abrams, et. al., Short Term Effects of Cannabinoids in Patients with HIV-1 Infection, 139 Annals of Internal Medicine, 258, 258 (Aug. 2003)

Cheryl Jay, et. al., The Effect of Smoked Marijuana on Chronic Neuropathic and Experimentally-Induced Pain in HIV Neuropathy: Results of an Open-Label Pilot

Study, (unpublished poster presentation available from Dr. Donald Abrams, University of California Center for Medicinal Cannabis Research)

Clinical Trials. gov., HIV Related Peripheral Neuropathy (last visited March 1, 2004), <http://www.clinicaltrials.gov/ct/chow/NCT0046722>

James B. Abrams, Note, A Missed Opportunity: Medical Use of Marijuana is Legally Defensible, 31 Cap. U.L. Rev. 883 (2003)

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STATEMENT OF THE CASE

Nature of the Case: This is an appeal by Defendant-Appellant Lloyd Bonjour from his deferred judgment following a bench trial on the minutes of testimony in Floyd County District Court on the charge of Manufacturing a Controlled Substance (Marijuana), a class D felony in violation of Iowa Code sections 124.401(1)(d) and 124.402(4)(m) (1999). The Honorable Stephen P. Carroll and the Honorable Bryan H. McKinley presided over all relevant proceedings.

Course of Proceedings: On July 15, 2002, the State filed a trial information in Floyd County District Court charging Defendant-Appellant Lloyd Bonjour with: Failure to Affix a Drug Tax Stamp, a class D felony in violation of Iowa Code sections 453B.1, 453B.3 and 453B.12 (1999) (Count I); Possession of a Schedule I Controlled Substance (Marijuana) with Intent to Deliver, a class D felony in violation of Iowa Code sections 124.401(1)(d) and 124.204(4)(m) (1999) (Count II); and Manufacturing a Schedule I Controlled Substance, a class D felony in violation of Iowa Code sections 124.401(1)(d) and 124.204(4)(m) (1999) (Count III). (Information) (App. pp. 1-2). Bonjour waived his right to a speedy trial on September 24, 2002. (Waiver of Right to Speedy Trial) (App. pp. 50-51).

On August 7, 2002, Bonjour filed a notice of intent to rely on the defense of medical necessity. (Notice of Defense) (App. p. 48). On August 12, 2002, the State filed a motion in limine seeking to exclude evidence regarding the medical necessity defense. (Motion in Limine) (App. p. 49). The District Court held a hearing on the motion on September 30, 2002. (Limine Tr. p. 1) (App. p. 52). On October 25,

2002, the court issued an order granting the State's motion in limine, but allowing Bonjour to present evidence of his use of marijuana as it related to his intent to deliver the substance. (10/25/02 Order) (App. pp. 83-94).

On November 18, 2002, Bonjour appeared in open court and submitted to a bench trial on the minutes of testimony and the motion in limine transcript. (Trial Tr. pp. 2-6; Waiver of Jury Trial) (App. pp. 96-100, 108). Pursuant to an agreement, the State dismissed Counts I and II of the information. (Trial Tr. p. 3) (App. p. 97). The District Court found Bonjour guilty under Count III, manufacturing marijuana. (Trial Tr. pp. 12-13; Judgment Entry) (App. pp. 106-107, 109-110).

On December 5, 2002, Bonjour filed a motion for new trial and a motion in arrest of judgment. (Motion for New Trial; Motion in Arrest) (App. pp. 112-115). Following appointment of substitute counsel, Bonjour withdrew his post-trial motions. (1/27/03 Tr. pp. 8-9) (App. pp. 124-125).

The District Court held a sentencing hearing on February 3, 2003. (Sent. Tr. p. 1) (App. p. 127). The court granted Bonjour a deferred judgment and placed him on probation for two years. (Sent. Tr. p. 13; Order for Deferred Judgment) (App. pp. 139, 143-144).

Bonjour filed a notice of appeal and application for discretionary review on February 20, 2003. (Notice) (App. pp. 145-148). The Iowa Supreme Court granted the application for discretionary review on September 25, 2003. (9/25/03 Order) (App. p. 150).

Facts: On October 6, 2000, Floyd County Sheriff's Deputies served warrants at the residence of Defendant-Appellant Lloyd Bonjour. While the officers were in

Bonjour's home, they observed marijuana plants and baggies containing marijuana. (Cannon Arrest Narrative p. 1) (App. p. 6). The deputies seized the marijuana and arrested Bonjour. (Cannon Arrest Narrative p. 1) (App. p. 6).

Bonjour is a man in his 60s living with AIDS. (Limine Tr. pp. 9, 13) (App. pp. 59, 63). The virus Bonjour carries has become resistant to various medications. (Limine Tr. p. 9) (App. p. 59). In order to contain his disease, Bonjour must take a very toxic cocktail of medications. (Limine Tr. pp. 9-10) (App. pp. 59-60). The cocktail causes nausea, poor appetite, diarrhea and painful damage to the nerves, a condition called neuropathy. (Limine Tr. p. 10) (App. p. 60). Bonjour has been on the cocktail since 1999, and must take the medications to live. (Limine Tr. p. 10) (App. p. 60).

Dr. Jeffery Meier is Bonjour's treating physician. (Limine Tr. p. 9) (App. p. 59). Meier prescribed Marinol for Bonjour in order to alleviate some of the toxic effects caused by the cocktail. (Limine Tr. p. 11) (App. p. 61). Marinol is a synthetic form of marijuana, and for some people the THC in Marinol can alleviate the nausea and loss of appetite caused by the cocktail. (Limine Tr. p. 11) (App. p. 61).

In November of 1999, Bonjour told Meier that he had been using marijuana in his cooking to help alleviate the side effects of the cocktail. (Limine Tr. pp. 12, 14, 18) (App. pp. 62, 64, 68). Meier testified that Bonjour's symptoms started to improve, and that Bonjour has achieved continuing improvement. (Limine Tr. p. 12) (App. p. 62).

Meier testified that Marinol did not appear to be serving its purpose and that Bonjour's tolerance of his AIDS medications was due to his use of marijuana.

(Limine Tr. pp. 14-15) (App. pp. 64-65). Meier never observed Bonjour under the influence of marijuana, but Bonjour indicated the Marinol caused mind-altering effects. (Limine Tr. p. 15) (App. p. 65). Meier admitted that he was relying on Bonjour's self-reporting as to the use of Marinol, but said that it would not be the first time someone reported that Marinol did not achieve the necessary effect. (Limine Tr. pp. 16-18) (App. pp. 66-68). Marijuana plants contain a more complex combination of chemicals than Marinol does, which may play a role in the plant's effectiveness. (Limine Tr. p. 23) (App. p. 73).

The medications Bonjour takes are effective only if there is total adherence to the regimen. (Limine Tr. p. 20) (App. p. 70). The nausea and vomiting the cocktail causes can lead to a patient regurgitating the medications. (Limine Tr. p. 21) (App. p. 71). In addition, the nausea and diarrhea can lead to dehydration, particularly for someone Bonjour's age. (Limine Tr. p. 21) (App. p. 71). Meier described these as life-threatening side effects. (Limine Tr. p. 22) (App. p. 72).

ROUTING STATEMENT

Iowa Rule of Appellate Procedure 6.401 outlines the criteria for determining whether a case will be retained by the Iowa Supreme Court or transferred to the Iowa Court of Appeals. Iowa R. App. P. 6.401 (2003). Defendant-Appellant Lloyd Bonjour asks that his case be retained by the Iowa Supreme Court because it "(3) ... involv[es] substantial issues of first impression; [and] (4) ... involv[es] fundamental and urgent issues of broad public importance requiring prompt or ultimate determination by the Supreme Court." Iowa R. App. P. 6.401(b) (2003). It also

involves "substantial questions of enunciating or changing legal principles." Iowa R. App. P. 6.401(c) (2003).

ARGUMENT

THE DISTRICT COURT ERRED IN EXCLUDING DEFENDANT'S MEDICAL NECESSITY DEFENSE.

Preservation of Error/Scope of Review: Error was preserved by the District Court's grant of the State's motion in limine, which the court re-affirmed in its judgment entry. (Motion in Limine, 10/25/02 Order; Judgment Entry p. 2) (App. pp. 49, 83-94, 110). If for any reason this Court believes error was not preserved by these final rulings, Bonjour claims his original and substitute trial counsel ineffective for failing to preserve error. Appellate review is not precluded if failure to preserve error results from a denial of effective assistance of counsel. State v. Clark, 351 N.W.2d 532, 535 (Iowa 1985).

Review is for correction of errors at law. Iowa R. App. P. 6.4 (2003). When a defendant asserts a constitutional violation, such as ineffective assistance of counsel, the reviewing court makes an independent evaluation of the totality of the circumstances, which is the equivalent of a de novo review. Taylor v. State, 352 N.W.2d 683, 684 (Iowa 1984).

Merits: On August 7, 2002, Defendant-Appellant Lloyd Bonjour filed a notice of intent to rely on the defense of medical necessity. (Notice of Defense) (App. p. 48). The State moved to exclude the defense, holding that Iowa's drug statutes do not provide for a medical necessity defense. (Motion in Limine) (App. p. 49).

On October 25, 2002, the District Court issued an order granting the State's motion in limine and excluding Bonjour's defense of medical necessity. (10/25/04 Order) (App. pp. 83-94). The District Court determined that the legislative scheme regulating marijuana did not provide for a medical necessity defense. (10/25/04 Order pp. 8-11) (App. pp. 90-93). The District Court did permit Bonjour to provide evidence of his medical use of marijuana to contradict the element of an intent to deliver. (10/25/04 Order pp. 11-12) (App. pp. 93-94).

Bonjour challenges the holding of the District Court and asserts that the medical necessity defense should be allowed in those limited cases in which a defendant can show a medical necessity for ingesting marijuana.

1. The necessity defense generally

English and American courts have long recognized the common law defense of necessity, and approximately half of the States have actually codified the necessity defense. Miklos Pongratz, Medical Marijuana and the Medical Necessity Defense in the Aftermath of United States v. Oakland Cannabis Buyers' Cooperative, 25 W. N. Eng. L. Rev. 147, 165 (2003). The necessity defense derives from public policy. Wayne R. LaFave, Substantive Criminal Law § 10.1(a) (2d ed. 2003) [hereinafter LaFave]. It recognizes that "the law ought to promote the achievement of higher values at the expense of lesser values, and sometimes the greater good for society will be accomplished by violating the literal language of the criminal law." Id.

> The matter is often expressed in terms of choice of evils: When the pressure of circumstances presents one with a choice of evils, the law prefers that he avoid the greater evil by bringing about the lesser evil.

> Thus the evil involved in violating the terms of the criminal law (taking another's property; even taking another's life) may be less than that which would result from literal compliance with the law (starving to death; two lives lost).

Id. The defense is generally available where the legislature has not already made a clear preference for one of the chosen evils. Id.

The common law defense of necessity requires a balancing of the harm done with the harm avoided. Id. § 10.1(d). A defendant must "have acted with the intention of avoiding the greater harm." Id. § 10.1(d)(3). A court must weigh the relative harmfulness of the two options and, for a defendant to use the defense, make a determination that the harm avoided was greater than the harm done. Id. § 10.1(d)(4). The necessity defense is not available if there is a third, less harmful option available to a defendant. Id. § 10.1(d)(5). In addition:

> It is sometimes said that the defense of necessity does not apply except in an emergency – when the threatened harm is immediate, the threatened disaster imminent. Perhaps this is but a way of saying that, until the time comes when the threatened harm is immediate, there are generally options open to the defendant, to avoid the harm, other than the option of disobeying the literal terms of the law...

Id. A defendant's culpability in bringing about the choice-of-evils dilemma may either render the defense unavailable entirely or render it unavailable to crimes of negligence or recklessness. Id. § 10.1(d)(6).

Iowa has long recognized the common law defense of necessity. See generally State v. Ward, 170 Iowa 185, 152 N.W.2d N.W. 501 (1915) (recognizing defense of necessity where landowner killed deer that had destroyed property). The Iowa Supreme Court has held the defense to apply equally with respect to physical

forces and human forces that may act upon a defendant. State v. Walton, 311 N.W.2d 113, 114-15 (Iowa 1981).

In State v. Walton, the Iowa Supreme Court favorably discussed the factors outlined in LaFave in applying the necessity defense. The Court referred to the relevant factors as "(1) the harm avoided, (2) the harm done, (3) the defendant's intention to avoid the greater harm, (4) the relative value of the harm avoided and the harm done, and (5) optional courses of action and the imminence of disaster." Id. at 115 (citing W. LaFave & A. Scott, Handbook on Criminal Law, § 50, at 385-88 (1972). The Court held the necessity defense did not apply except in emergency situations where the threatened harm is imminent and immediate, so that a defendant is stripped of options for avoiding both evils. Id.

A defendant has the burden of generating a fact question on the necessity defense. Id. If the defendant fails to meet all of the requirements for the defense, then the defense is not available to him. Id. If the defendant does generate a fact question on the defense, then the State has the burden of disproving the defense beyond a reasonable doubt. Id. See also State v. Reese, 272 N.W.2d 863, 867 (Iowa 1978) (equating the burden standards with those for self-defense, alibi, insanity, entrapment, and intoxication).

2. The medical necessity defense

The medical necessity defense is merely a more specific application of the general necessity defense. Emily Farr, United States v. Oakland Cannabis Buyers' Cooperative: The Medical Necessity Defense as an Exception to the Controlled Substances Act, 53 S.C. L. Rev. 439, 452 (2002). The medical necessity defense

permits unlawful conduct that is necessary to alleviate a medical condition. Id. at 452-53.

The first case to recognize a medical necessity defense in a marijuana prosecution was United States v. Randall. See Medical Necessity as a Defense to Criminal Liability: United States v. Randall, 46 Geo. Wash. L. Rev. 273 (1978).[1] Randall was charged with unlawful possession of marijuana in the District of Columbia. Id. at 273. In his defense, Randall asserted that he was using marijuana to treat his glaucoma because conventional medication had become ineffective and surgery presented a high risk of immediate blindness. Id.

The Superior Court of the District of Columbia extended the necessity defense to cover the facts of Randall, holding an individual threatened with disease and eventual loss of health could escape criminal liability for an unlawful act designed to alleviate the threat to his well-being. Id. at 284. The Court reasoned that a necessity defense existed at common law, relieving a defendant of the culpability of his acts where no acceptable alternative to breaking the law was available. Id. The Court defined three limitations upon the necessity defense: "that the actor must not have brought about the necessitous circumstances, that there must be no less offensive act available to accomplish the defendant's objective, and

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[1] United States v. Randall was an unpublished opinion, and has been reported in 104 Daily Wash. L. Rep. 2249 (D.C. Super. Ct. Nov. 24, 1976). The validity of Randall's holding has been questioned after Congress blocked a voter-approved initiative that would have permitted the medical use of marijuana. See Emry v. United States, 829 A.2d 970, 974 (D.C. 2003) (recognizing medical necessity defense may exist, but questioning it in light of the Barr Amendment).

that the evil sought to be averted must be less heinous than that entailed in the defendant's act." Id. at 284-85.

The Superior Court determined Randall was not at fault in creating his glaucoma, and that there was no reasonable alternative for him. Id. at 285. It found Randall's interest in protecting his sight to be obvious, and the dangers of marijuana smoking to be uncertain. Id. Touching upon a constitutional analysis, the court found that government limitations on an individual's right to protect his own body must be reasonably related to health. Id. It determined that Randall's right to sight outweighed any "slight, speculative and undemonstrable" social harm that his use of marijuana might cause. Id. The court determined that a defendant must prove necessity by a preponderance of the evidence, but if he does so then his actions are not voluntary and not illegal. Id. at 285-86.

In 1979, the state of Washington recognized a medical necessity defense. In State v. Diana, the Washington Court of Appeals held that medical necessity would exist in Diana's case when "(1) the defendant reasonably believed his use of marijuana was necessary to minimize the effects of multiple sclerosis; (2) the benefits derived from its use are greater than the harm sought to be prevented by the controlled substances law; and (3) no drug is as effective in minimizing the effects of the disease." State v. Diana, 604 P.2d 1312, 1317 (Wash Ct. App. 1979).[2] Diana was required to present corroborating medical testimony to support his

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[2]. Diana has been effectively overruled, as the Washington appellate courts have since decided that the legislature's finding that marijuana has no accepted medical use negates the availability of a medical necessity defense. State v. Williams, 968 P.2d 26, 30 (Wash. Ct. App. 1998).

defense and had the burden to prove the defense by a preponderance of the evidence. Id. The court was required to balance Diana's interest in preserving his health against the State' interest in regulating the drug involved. Id. The case was remanded for additional proceedings. Id.

In 1991, a Florida appellate court reversed the convictions of two AIDS patients who were charged with manufacturing and possessing marijuana so that they could present a medical necessity defense. Jenks v. State, 582 So.2d 676 (Fla. Ct. App. 1991). Kenneth Jenks was a hemophiliac who contracted AIDS from a blood transfusion and then unknowingly infected his wife. Id. at 677. Barbra Jenks' weight dropped 38 pounds in three weeks from constant vomiting and she was hospitalized on six occasions. Id. Previous treatments for her nausea either failed or left her in a stupor and unable to function. Id. Kenneth Jenks also lost weight because of nausea caused by his antiviral treatment. Id. The Jenks found that marijuana helped to alleviate their symptoms, retain their AIDS medications, and gain weight. Id. Because they could not obtain marijuana through their physician, the Jenks grew two marijuana plants in their home. Id.

The Florida court held that the necessity defense was recognized at common law and had not been specifically rejected by the legislature, and that a medical necessity defense was merely a more specific application of the necessity defense. Id. at 678-79. The court determined that Florida's drug laws did not abrogate the defense, as the drug laws still envisioned potential medical uses for marijuana. Id. at 679. The court agreed with Randall that the factors in a medical necessity case are "1. That the defendant did not intentionally bring about the circumstance which

precipitated the unlawful act; 2. That the defendant could not accomplish the same objective using a less offensive alternative available to the defendant; and 3. That the evil sought to be avoided was more heinous than the unlawful act perpetrated to avoid it." Id. The court found the Jenks met all three factors and vacated their convictions. Id. at 680. In a more recent case, a Florida appellate court reaffirmed Jenks in light of changes to the applicable drug statute. See generally Sowell v. State, 738 So.2d 333 (Fla. Ct. App. 1998).

Idaho also permits a defendant to use the necessity defense against a charge of possession of a controlled substance when there is a medical justification for the possession. State v. Hastings, 801 P.2d 563 (Idaho 1990). Although the Idaho courts have not specifically adopted a medical necessity defense, in State v. Hastings the Idaho Supreme Court vacated Hastings' conviction for felony possession of marijuana and remanded for further proceedings where Hastings claimed the marijuana was used to treat her arthritis. Id. at 563-64. The Idaho Supreme Court defined the elements of necessity as "(1) A specific threat of immediate harm; (2) The circumstances which necessitate the illegal act must not have been brought about by the defendant; (3) The same objective could not have been accomplished by a less offensive alternative available to the actor; (4) the harm caused was not disproportionate to the harm avoided." Id. at 564. The defense is not available when the crime charged includes an intent to deliver. State v. Tadlock, 34 P.3d 1096, 1098 (Idaho Ct. App. 2001).

In State v. Bachman, the Hawaii Supreme Court acknowledged that a medical necessity defense may apply to a charge of possession of marijuana as per

United States v. Randall, but rejected such a defense where the defendant failed to present medical testimony. State v. Bachman, 595 P.2d 287, 288 (Haw. 1979). In addition, Hawaii law in effect at the time permitted a patient to obtain marijuana from a physician. Id. In People v. Trippet, a California appellate court equated the elements of a medical necessity defense with the elements of a general necessity defense, but determined that Trippet had not presented sufficient evidence to indicate she lacked adequate legal alternatives to marijuana for her migraine headaches. People v. Trippet, 56 Cal. App. 4th 1532, 1540 (Cal. Ct. App. 1997).

Other states may recognize a necessity defense, but rejected a medical necessity defense to charges of possession of controlled substances based upon their drug laws. In State v. Tate, a divided New Jersey Supreme Court held the medical necessity defense inapplicable to a charge of possession of marijuana against a defendant who used the substance to treat spasticity caused by quadripeligia. State v. Tate, 505 A.2d 941 (N.J. 1986). Among other things, the majority held that the state's drug law indicated the legislature believed marijuana had no accepted medical use. Id. at 944-46. The Minnesota Court of Appeals and the Alabama Court of Criminal Appeals have agreed. State v. Hanson, 468 N.W.2d 77, 78-79 (Minn. Ct. App. 1991); Kauffman v. State, 620 So.2d 90, 92-93 (Ala. Crim. App. 1992). In Commonwealth v. Hutchins, a divided Massachusetts Supreme Court determined a scleroderma patient's interest in taking marijuana to alleviate nausea, loss of appetite, spasticity and hypertension did not "outweigh the potential harm to the public were we to declare that the defendant's cultivation of marihuana

and its use for his medicinal purposes may not be punishable." Commonwealth v. Hutchins, 575 N.E.2d 741, 743, 745 (Mass. 1991).

The United States Supreme Court recently held that a marijuana supply club could not assert a medical necessity defense to a prosecution for manufacturing or distributing marijuana under the Federal Controlled Substances Act. United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 486, 121 S.Ct. 1711, 1715, 149 L.Ed.2d 722, 729 (2001). Writing for the majority, Justice Thomas questioned whether federal courts ever have authority to recognize a necessity defense not provided by statute. Id. at 490, 121 S.Ct. at 1717, 149 L.Ed.2d at 731. Justice Thomas did not further elaborate on the issue, instead holding that the Federal Controlled Substances Act reflected a legislative determination that marijuana had no medical value at all. Id. at 491, 121 S.Ct. at 1718, 149 L.Ed.2d at 732.

Justice Stevens wrote a separate concurrence and questioned the dicta in the majority's opinion. Justice Stevens noted the limited holding of the case, "that medical necessity is not a defense to *manufacturing* and *distributing* marijuana." Id. at 499, 121 S.Ct. at 1722, 149 L.Ed.2d at 737. Justice Stevens criticized the majority's dicta that the defense would not be available for those who actually use the marijuana to treat serious medical conditions, as opposed to those who supply the marijuana. Id. at 500-01, 121 S.Ct. at 1723, 149 L.Ed.2d at 738. "Most notably, whether the defense might be available to a seriously ill patient for whom there is no alternative means of avoiding starvation or extraordinary suffering is a difficult issue that is not presented here." Id. at 501, 121 S.Ct. at 1723, 149 L.Ed.2d at 738.

Further, Justice Stevens disputed the majority's characterization of the necessity defense, arguing that the Court's precedent "has expressed no doubt about the viability of the common-law defense." Id.

3. The medical uses of marijuana

Marijuana has been used as medicine for thousands of years. The world's oldest pharmacopoeia, the *Shen-nung pen-t'sao ching* whose oral heritage dates back to 2700 B.C., listed marijuana for its psychoactive properties. Michael Aldrich, History of Therapeutic Cannabis in Cannabis in Medical Practice 35 (Mary Lynn Mathre, ed. 1997) [hereinafter Aldrich]. Later editions of the Chinese pharmacopoeias listed more than 100 ailments that could be treated with marijuana, including waste diseases, and recognized marijuana's use as an antiemetic (to prevent nausea and vomiting). Id. at 36.

Ancient Indians used marijuana for various ailments, and recognized it as an appetite stimulant and digestive aid. Id. at 37. Assyrians used marijuana in salves for swellings and bruises. Id. at 38. The Greeks used marijuana to relieve pain and inflammation, and also recognized its use as an appetite stimulant. Id. at 39-40. Medieval Muslim society generally prohibited the use of hashish, a purified resin made from the marijuana plant. Id. at 40. Nonetheless, the prohibition did not apply to medical uses of hashish, which included uses as a digestive aid and as an analgesic. Id. at 40-41. Medical marijuana use in Africa has existed for at least six centuries, where the plant was recognized as a remedy for snake bites, asthma, malaria and dysentery, and also assisted in childbirth. Id. at 41.

Western medicine learned the therapeutic benefits of marijuana in the 1800s through the research and writings of Irish doctor William B. O'Shaughnessy. Id. at 44. Aside from using marijuana to relieve pain and spasms, O'Shaughnessy used marijuana to successfully treat the vomiting and diarrhea associated with cholera. Id. at 44-45. His success with medical marijuana sparked 100 articles on the therapeutic benefits of marijuana between 1840 and 1900 in Europe and North America. Id. at 45.

In the United States, the Civil War edition of the U.S. Dispensatory included four pages discussing the medical uses of marijuana. Id. at 46 (noting its use as "a decided aphrodisiac, to increase the appetite, and occasionally to induce the cataleptic state ... to cause sleep, to allay spasm, to compose nervous inquietude, and to relieve pain"). In 1924, Sajous' Analytic Cyclopedia of Practical Medicine listed three areas in which marijuana therapy was being used: as a sedative, as an analgesic, and to improve appetite and digestion. Id. at 48. By the 1930s, Eli-Lilly and Parke-Davis were marketing marijuana extracts and tinctures. Id. at 46.

Although marijuana was recognized for its medical uses in the United States during the early 1900s, the Eighteenth Amendment's prohibition against alcohol led to an increase in the recreational use of marijuana. Deborah Garner, Up In Smoke: The Medicinal Marijuana Debate, 75 N. Dak. L. Rev. 555, 557 (1999). The recreational use of marijuana led, in turn, to an increasing desire by the government to regulate marijuana use. Lester Grinspoon & James B. Bakalar, Marijuana, The Forbidden Medicine 8 (1997) [hereinafter Grinspoon].

The Marijuana Tax Act of 1937 was passed despite protest by the American Medical Association. Aldrich, supra, at 49. Under the Act, anyone wanting to use industrial or medical marijuana was required to register and to pay a tax at the rate of $1.00 per ounce, while all others had to pay a tax of $100 per ounce. Grinspoon, supra, at 8. Failure to abide by the law could result in large fines or imprisonment. Id. Although the Tax Act did not prohibit the medical use of marijuana, it created a bureaucratic framework that discouraged many physicians from prescribing marijuana. Id. See also Aldrich, supra, at 49 (noting that manufacturers removed cannabis from pharmaceutical formulations because of the inconvenience of federal restrictions). Eventually, in 1941, marijuana was removed from the United States Pharmacopoeia and National Formulary. Grinspoon, supra, at 8.

When the United States Supreme Court essentially gutted the Marijuana Tax Act in 1969, the federal government re-wrote the nation's drug laws and passed the Controlled Substances Act of 1970. Aldrich, supra, at 49-50. The Act assigned psychoactive drugs to one of five schedules, and marijuana was placed in Schedule I. Grinspoon, supra, at 13; 21 U.S.C. 812(c)(I)(a) (2003). According to definition, Schedule I drugs have no accepted medical use and have a high potential for abuse. 21 U.S.C. 812(b)(1) (2003).

Shortly after the government passed the Controlled Substances Act, new uses for medical marijuana emerged. Aldrich, supra, at 50. Marijuana was found to relieve intraocular pressure, which suggested it could be a treatment for glaucoma. Id. Marijuana was also discovered to have antiemetic effects for cancer

chemotherapy patients, whose chemotherapy treatments could result in severe, uncontrollable nausea and vomiting that were not amenable to other treatments. Id.

Given the possibility for therapeutic uses of marijuana, states began to pass laws allowing patients to obtain marijuana for medical purposes under state research programs. Grinspoon, supra, at 17. In 1978, New Mexico enacted the first medical marijuana law. Id. By 1994, Missouri had become the 35th state to enact such a law.[3] Id.

These early state laws were often unsuccessful. Because marijuana was not classified as a medicine, states could only dispense it if they established formal research programs and received FDA approval for an Investigational New Drug (IND) application. Id. A number of states simply gave up when faced with the bureaucracy of federal regulations. Id. at 17-18. Between 1978 and 1984, 17 states were given permission to establish programs in which marijuana was used for the treatment of glaucoma and the nausea and vomiting associated with cancer chemotherapy treatments. Id. at 18. Only 10 states ended up establishing programs in which marijuana was used as medicine. Id. All of these programs have fallen into abeyance. Id.

At the same time as the state programs were beginning to take shape, the FDA created the Compassionate Use IND, which allowed doctors to obtain government-grown marijuana to give to their patients. Id. at 20. The program

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[3]. Iowa revised its laws prior to publication of the 1981 Code to except marijuana from Schedule I when it was used for medicinal purposes pursuant to the rules of the state board of pharmacy examiners. Iowa Code § 204.204(6) (1981). It is unclear whether Iowa ever established a state research program.

required the doctor to fill out special forms to apply for the program and special forms to order the marijuana, and pharmacies had to be willing to dispense the marijuana cigarettes. Id. at 20-21. The application process generally took between four to eight months. Id. at 21. Robert Randall became the first patient to receive medical marijuana under the Compassionate Use program. Id.

In 1989, though, the FDA started receiving numerous applications for medical marijuana from AIDS patients. Id. The applications increased following the publicity stemming from the arrest of Barbra and Kenneth Jenks, whose home was raided by law enforcement because they were using marijuana to treat their AIDS symptoms.[4] Id. After the Jenks were able to receive a Compassionate IND, other AIDS sufferers filed applications. Id. at 22. The number of existing Compassionate Use INDs rose from five to 34 in a year. Id. In 1991, the Bush administration suspended the Compassionate Use IND program as undercutting the war on drugs. Id. James Mason, the chief of the Public Health Service, stated there was "not a shred of evidence that smoking marijuana assists a person with AIDS." Id. The program was officially discontinued in 1992, although those patients who had already obtained approval were allowed to continue receiving medical marijuana. Id.

A 1999 report by the National Institutes of Health reviewed the medical uses and risks of marijuana based upon research available at the time. National Institutes of Health, Marijuana and Medicine: Assessing the Science Base (1999), (last visited February 4, 2004) <http://www.books.nap.edu/html/marimed>

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[4]. See discussion supra pp. 12-13.

[hereinafter NIH Report]. The report noted that data on the adverse effects of marijuana are more extensive than data on its effectiveness. Id. ch. 4. It specifically noted that clinical studies of marijuana were difficult to conduct because of limited research funds and "a daunting thicket of regulations" to be negotiated at the federal and state levels. Id.

The NIH determined that cannabinoids such as marijuana have potential uses as analgesics, although sedation was a noticeable side effect. Id. The NIH determined that the evidence suggesting cannabinoids can relieve spasticity or muscle spasms was not well developed, and suggested future clinical studies. Id. Although the NIH noted that glaucoma was one of the most frequently cited medical indications for marijuana, it questioned the efficacy of marijuana and other cannabinoids in treating the condition. Id. While it found that marijuana can reduce the intraocular pressure that contributes to glaucoma, it determined that the effects of marijuana are too short-lived and the side effects too numerous to recommend it as a life-long treatment. Id.

With respect to nausea and vomiting, the NIH report found that cannabinoids can have a modest antiemetic effect. Id. The report recognized that patients with severe nausea and vomiting were less likely to be able to retain oral THC, so that inhaled marijuana may be advantageous for treating these patients.[5] Id. According to the report, "Unitil the development of rapid-onset antiemetic drug delivery

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[5]. The report was addressing chemotherapy-induced nausea and vomiting, although the findings can be applicable to nausea and vomiting caused by AIDS medications. Id. (Present treatments for cancer cachexia are similar to that for cachexia in AIDS patients.)

systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana". Id.

4. Marijuana and AIDS

Marijuana does not cure AIDS. Marijuana may, however, be helpful in treating several conditions caused by AIDS or the treatments used to hold it in abeyance.

AIDS wasting syndrome is perhaps one of the worst symptoms of HIV infection. Walter Krampf, AIDS and the Wasting Syndrome, in Cannabis in Medical Practice, 84 (Mary Lynn Mathre, ed. 1997). Wasting syndrome is defined as more than 10 percent loss of body weight accompanied by diarrhea or fever in a person who is HIV antibody positive, and the presence of this symptom alone is sufficient to justify an AIDS diagnosis. Id. Wasting syndrome is common, with 17.8 percent of all AIDS patients being diagnosed based upon the presence of the syndrome. Id. at 85.

In addition to wasting syndrome, gastrointestinal infections in HIV patients can also contribute to loss of body weight. Id. So can loss of appetite. Id. Ironically, many of the medications used to treat HIV-infected patients – including AZT – can cause loss of appetite or nausea. Id. Weight loss "can quickly predispose the body to further infections, to significant weakness, and can render the patient unable to care for himself or herself." Id. The degree of weight loss in AIDS patients is a predictor for death. Id.

Although there are medications that have been studied for their effectiveness in treating AIDS wasting syndrome, many of the medications either lose effectiveness over time or are prohibitively expensive. Id. at 85-86. Dronabinol, marketed as Marinol, is a synthetic preparation of delta-9-tetrahydrocannabinol (the main psychoactive ingredient in marijuana) and has been approved by the FDA to promote appetite and weight gain in AIDS patients. Id. at 86-87. It is generally effective in treating wasting syndrome, although it can also be expensive for those patients who do not have insurance to cover the cost. Id. at 87; Grinspoon, supra, at 103-04.

According to the National Institutes of Health, AIDS/HIV patients are the largest group of people who use dronabinol. NIH Report, supra, ch. 4. Some patients "reject it because of the intensity of neuropsychological effects, an inability to titrate the oral dose easily, and the delayed onset and prolonged duration of its action." Id. The NIH recognized that some people report a preference for smoked marijuana because they can control the dose they receive and because of the faster action of inhaled marijuana. Id.

Nonetheless, the National Institutes of Health has been hesitant to recommend the use of marijuana. Its 1999 report noted that cannabinoids, especially THC, can modulate the function of immune cells. Id. ch. 2. In some instances, cannabinoids may enhance immune response and in other instances they can diminish immune response. Id. This may have particular implications for AIDS and HIV patients. At the time of the report's publication, the "complete effect of marijuana smoking on immune function remains unknown." Id.

At the same time, the NIH noted the lack of research on the effects of smoked marijuana versus oral dronabinol, and the effect of THC on viral infections. Id.; id. ch. 4 At the time the 1999 report was published, Dr. Donald Abrams of the University of California San Francisco was still in the process of conducting a clinical trial on the safety of smoked marijuana versus oral THC. Id. Despite the NIH's concern regarding smoked marijuana's possible cancer-causing and immunosuppressive effects, it recognized that for terminally ill patients who have not responded to traditional medications such as Marinol, "the medical benefits of smoked marijuana might outweigh the harm." Id.

Studies of smoked marijuana in healthy volunteers indicate that is effective for increasing appetite and weight gain. Grinspoon, supra, at 86. Until recently, though, research into the medical benefits of marijuana for AIDS patients was stymied by the federal government. Id. at 91. Dr. Abrams had received approval from the FDA to study the effects of inhaled marijuana versus Marinol on wasting and the immune system of AIDS patients, but was prevented from doing so by the refusal of federal agencies to provide him with marijuana for the study. Id. at 91-92. Five years after he first proposed the study, Dr. Abrams was finally able to conduct it.

Dr. Abrams' study was a short-term trial, lasting only 21 days, but is the first of its kind in comparing the effects of inhaled marijuana and Marinol. Donald Abrams, et. al., Short Term Effects of Cannabinoids in Patients with HIV-1 Infection, 139 Annals of Internal Medicine 258, 258 (Aug. 2003). Sixty-two HIV-infected patients on protease inhibitors received a marijuana cigarette, Marinol, or a placebo

three times daily in the randomized, double-blind study. Id. at 259. The conductors of the study watched the participants' HIV RNA levels to determine if the treatments interfered with suppression of the HIV virus, either by unfavorable interaction with the protease inhibitor or by suppressing the immune system. Id. The study determined that both marijuana and Marinol were effective in causing weight gain among patients. Id. at 263. Neither caused any statistically significant increase in viral loads among HIV patients receiving antiviral treatments. Id. at 264.

The study indicates the National Institutes of Health's concern regarding the effects of THC on the immune system may not be warranted. For those patients who cannot tolerate the effects of Marinol or are incapable of retaining Marinol because it is a pill, marijuana may provide a viable alternative to alleviating the nausea and vomiting associated with AIDS medications and for assisting AIDS patients in gaining weight.

Dr. Abrams also conducted a recent pilot study into the effectiveness of smoked marijuana in treating AIDS-related neuropathy, where damage to the nerve endings causes patients to have pain in their fingers and toes. Cheryl Jay, et. al., The Effect of Smoked Marijuana on Chronic Neuropathic and Experimentally-Induced Pain in HIV Neuropathy: Results of an Open-Label Pilot Study, (unpublished poster presentation available from Dr. Donald Abrams, University of California Center for Medicinal Cannabis Research). (Limine Tr. p. 10) (App. p. 60). The study found that smoked marijuana was associated with a greater than 30 percent reduction of average daily neuropathic pain in 10 or 16 experienced marijuana users. Id. Dr. Abrams is currently working on a randomized, double-blind

placebo controlled study to confirm the results of the pilot study. Clinical Trials. gov, HIV Related Peripheral Neuropathy (last visited March 1, 2004), <http://www.clinicaltrials.gov/ct/chow/NCT00046722>.

The treatment dilemmas facing AIDS patients have been recognized by the National Institutes of Health:

> Patients who are currently suffering from debilitating conditions unrelieved by legally available drugs and who might find relief with smoked marijuana, will find little comfort in a promise of a better drug 10 years from now. In terms of good medicine, marijuana should rarely be recommended unless all reasonable options have been eliminated. But then what? It is conceivable that the medical and scientific opinion might find itself in conflict with drug regulations. This presents a policy issue that must weigh – at least temporarily – the needs of individual patients against broader social issues....
>
> Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting.

NIH Report, supra, ch. 4.

5. Applying the medical necessity defense to the use of medical marijuana in the case at bar

Defendant-Appellant Lloyd Bonjour asks the Court to adopt the defense of medical necessity in this case. Contrary to the assertions of the State below, the defense is not unavailable under Iowa law.

In support of its motion in limine, the State argued that the defense was precluded under United States v. Oakland Cannabis Buyers' Cooperative and Iowa chapter 124. (Motion in Limine; Limine Tr. pp. 4-5) (App. pp. 49, 54-55). As noted in Section 2 above, the majority opinion in Oakland held that the medical necessity defense was not available to marijuana suppliers charged with manufacturing and

delivering marijuana for medical purposes because the Federal Controlled Substances Act reflected a legislative determination that marijuana had no medical value at all. United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 491, 121 S.Ct. 1711, 1718, 149 L.Ed.2d 722, 732.

The majority's decision in Oakland has come under considerable criticism for the breadth of its dicta.[6] Perhaps the most astute criticism came in the concurring opinion by Justice Stevens, who disputed the majority's characterization of the necessity defense by arguing that the Court's precedent "has expressed no doubt about the viability of the common-law defense, even in the context of federal criminal statutes that do not provide for it in so many words." Id. at 501, 121 S.Ct. at 1723, 149 L.Ed.2d at 738.

Justice Stevens also noted the limited holding of the case, "that medical necessity is not a defense to *manufacturing* and *distributing* marijuana." Id. at 499, 121 S.Ct. at 1722, 149 L.Ed.2d at 737. He criticized the majority's dicta that the defense would not be available for those who actually use the marijuana to treat serious medical conditions, as opposed to those who supply the marijuana for others. Id. at 500-01, 121 S.Ct. at 1723, 149 L.Ed.2d at 738. "Most notably, whether the defense might be available to a seriously ill patient for whom there is

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[6]. For an example of the criticism levied against the majority opinion, see generally Miklos Pongratz, Medical Marijuana and the Medical Necessity Defense in the Aftermath of United States v. Oakland Cannabis Buyers' Cooperative, 25 W. N. Eng. L. Rev. 147 (2003); James D. Abrams, Note, A Missed Opportunity: Medical Use of Marijuana is Legally Defensible, 31 Cap. U. L. Rev. 883 (2003); Emily Farr, United States v. Oakland Cannabis Buyers' Cooperative: The Medical Necessity Defense as an Exception to the Controlled Substances Act, 53 S.C. L. Rev. 439 (2002).

no alternative means of avoiding starvation or extraordinary suffering is a difficult issue that is not presented here." Id. at 501, 121 S.Ct. at 1723, 149 L.Ed.2d at 738.

Clearly, Oakland did not resolve the issue of whether a patient may assert a medical necessity defense when prosecuted for his cultivation and use of marijuana to treat his own medical condition. And while Oakland may currently be the controlling interpretation of the Federal Controlled Substances Act, that does not necessarily preclude a different interpretation of Iowa's drug statutes.

As implied by Justice Stevens in his concurrence, a statute does not have to specifically allow a necessity or medical necessity defense for the defense to be applicable. Id. The defense of necessity is derived from public policy and has long been recognized in common law, with only about half of the states actually codifying the defense. LaFave, supra, § 10.1(a); Miklos Pongratz, Medical Marijuana and the Medical Necessity Defense in the Aftermath of United States v. Oakland Cannabis Buyers' Cooperative, 25 W. N. Eng. L. Rev. 147, 165 (2003).

The defense of necessity is generally available unless the legislature has already made a clear preference for one of the evils within the choice of evils. LaFave, supra, § 10(a). The fact that a law prohibits an act is not enough to warrant a holding that the necessity defense is inapplicable to the act. By definition, the necessity defense recognizes that a defendant committed an illegal act, but excuses him from culpability because of the circumstances prompting his choice. See id. (explaining that the defense recognizes that the greater good is sometimes achieved "by violating the literal language of the criminal law"). To hold that there is no necessity defense to a prosecution for marijuana possession simply because the

State has outlawed marijuana possession is not a proper analysis. The proper analysis requires a more in-depth consideration of whether the legislature has clearly considered and rejected the necessity defense.

Bonjour asserts that Iowa's drug statutes do not prohibit a medical necessity defense for the possession and manufacture of marijuana. While the Federal Controlled Substances Act does not provide a medical exception for the use of marijuana, the Iowa Code does recognize the potential medical uses of marijuana.

The Federal Controlled Substances Act categorizes marijuana as a Schedule I substance. 21 U.S.C. § 812(c)(a) (2003). Schedule I substances have a "high potential for abuse", "no currently accepted medical use in treatment in the United States" and "lack ... accepted safety for use of the drug." Id. § 812(b)(1). As Justice Thomas correctly noted in his Oakland majority opinion, the Federal Controlled Substances Act does not contain any exception for medical marijuana, outside of government approved research projects. United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 491, 121 S.Ct. 1711, 1718, 149 L.Ed.2d 722, 732.

Iowa's drug statute, by contrast, specifically recognizes the potential medical uses of marijuana. Initially, the Iowa General Assembly has categorized marijuana as a Schedule I substance, which is defined as having a "high potential for abuse" and either having "no accepted medical use in treatment" or lacking "accepted safety for use in treatment under medical supervision." Iowa Code §§ 124.203(1), 124.204(4)(m) (1999). Nonetheless, the General Assembly has left the door open to medicinal uses of marijuana, as it has excluded "marijuana,

tetrahydrocannabinols and chemical derivatives of tetrahydrocannabinols when utilized for medicinal purposes pursuant to rules of the state board of pharmacy examiners." Id. § 124.204(7).

Bonjour asserts that this difference between the Federal Controlled Substances Act and Iowa's drug statutes is significant. While the federal scheme does not recognize the potential medical uses of marijuana, the Iowa scheme does. Because the Iowa Code has left the door open to the potential medical uses of marijuana, it cannot be said that Iowa's statutory drug scheme has abrogated the common law defense of necessity or the more specific application of medical necessity.

Contrary to the ruling of the District Court, the fact that the State Board of Pharmacy Examiners has not promulgated rules permitting the medical use of marijuana does not negate the availability of the medical necessity defense. (10/25/02 Order pp. 8-10) (App. pp. 90-92). The Iowa General Assembly has recognized the potential medical use of marijuana via Iowa Code § 124.204(7). This permissive language defeats any argument that the Iowa General Assembly has specifically considered and rejected a necessity defense. Hence, the defense is available.

Bonjour argues that the Board of Pharmacy's failure to promulgate rules relating to the medical use of marijuana goes not go to the availability of the defense, but to whether he had any other legal options available aside from his personal possession and cultivation of marijuana. Had the Board created rules for permitting the medical use of marijuana by registered applicants, for example, then

Bonjour would not qualify for the medical necessity defense because he would have a legal option available to him. See, e.g., State v. Bachman, 595 P.2d 287, 288 (Haw. 1979) (rejected a necessity defense to possession of marijuana where, in part, Hawaii law permitted the defendant to obtain marijuana from a doctor). Such is not the case here.

Nor should the fact that Bonjour was charged with manufacturing marijuana, as opposed to possession, negate the availability of the medical necessity defense. Bonjour was not manufacturing marijuana to give to others, as in Oakland. Rather, he was cultivating his own supply, as in Jenks. (Judgment Entry p. 2) (App. p. 110). If one assumed Bonjour had a medical need for marijuana, obviously he would have to obtain marijuana from somewhere. Since neither the federal nor the state government has a program to provide him with marijuana for medical treatment, he cannot legally obtain the marijuana from anyone. By growing his own plants, he prevents any others from being exposed to criminal liability for his medical treatment. Thus, the medical necessity defense should be available against charges of both manufacturing and possession, so long as there is no intent to distribute.

If this Court finds the medical necessity defense is available in Iowa, Bonjour asks the Court to adopt the standard of medical necessity articulated in Jenks v. State, where a Florida appellate court allowed the defense for AIDS patients charged with manufacturing and possessing marijuana. According to Jenks, the three elements of the defense are: "1. That the defendant did not intentionally bring about the circumstance which precipitated the unlawful act; 2. That the defendant could not accomplish the same objective using a less offensive alternative available

to the defendant; and 3. That the evil sought to be avoided was more heinous than the unlawful act perpetrated to avoid it." Jenks v. State, 582 So.2d 676, 679 (Fla. Ct. App. 1991).

If the Iowa Supreme Court adopted this standard, Defendant-Appellant Bonjour would qualify. First, Bonjour did not choose to have AIDS.

Second, Bonjour uses marijuana because no other legal treatment has allowed him to retain the AIDS medications he must consume to keep his disease in abeyance. The cocktail Bonjour must take to keep his AIDS under control has toxic side effects, including nausea, poor appetite, diarrhea and neuropathy. (Limine Tr. pp. 10-11) (App. pp. 60-61). If he failed to maintain strict adherence to his medical regimen, Bonjour would die. (Limine Tr. pp. 10, 20) (App. pp. 60, 70). Although Bonjour was on Marinol and other medications to control these side effects, he was still having problems with nausea and neuropathy. (Limine Tr. pp. 11-12) (App. pp. 61-62). Bonjour started using marijuana in his cooking, and his symptoms improved. (Limine Tr. pp. 12, 14) (App. pp. 62-64). Bonjour's doctor, Jeffery Meier, admitted that the Marinol "was not doing the job" and actually caused Bonjour to suffer mind-altering effects that marijuana did not provide. (Limine Tr. p. 15) (App. p. 65). Meier acknowledged that marijuana contains other chemicals aside from the THC synthesized in Marinol that might contribute to its increased effect. (Limine Tr. pp. 22-23) (App. pp. 72-73). The marijuana Bonjour uses contains less than one percent THC. (1/27/03 Tr. p. 7) (App. p. 123).

Furthermore, there is no legal means by which Bonjour can obtain marijuana to treat the side effects of his AIDS medications. Although the Iowa General

Assembly has created an exception to Schedule I for the medical use of marijuana, the Board of Pharmacy Examiners has not promulgated rules to allow Bonjour to make use of this exception. See generally Iowa Administrative Code r. 657–10 (2002) (regarding controlled substances). Iowa has not established a therapeutic research program and the federal government has closed its Compassionate Use IND program.

Third, any harm caused by Bonjour's violation of Iowa's drug laws was clearly outweighed by the harm to him if he failed to ingest marijuana. Again, if Bonjour were not able to retain his AIDS cocktail because of its side effects, the cocktail would be ineffective and he would eventually die. (Limine Tr. pp. 10, 20) (App. pp. 60, 70). His use of marijuana allowed him to retain his cocktail. (Limine Tr. pp. 12, 14) (App. pp. 62, 64).

In support of its motion in limine, the State did not assert the harms caused by allowing Bonjour to possess marijuana. (Motion in Limine; Limine Tr. pp. 4-5) (App. pp. 49, 54-55). Rather, the State limited its argument to whether medical necessity existed as a defense at all under Iowa law and the recent holding of United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 121 S.Ct. 1711, 149 L.Ed.2d 722 (2001) (Motion in Limine; Limine Tr. pp. 4-5) (App. pp. 49, 54-55).

Even assuming the State has not waived this argument by failing to assert it below, there is no reasonable basis for finding Bonjour's possession of marijuana in his home for medical purposes causes serious harm. The 1999 report by the National Institutes of Health debunked common myths that marijuana use causes

persons to graduate to other illegal substances and that medical use or decriminalization of marijuana leads to substantial increases in marijuana use. NIH Report, supra, ch. 3. The report found that marijuana use can have psychological effects on patients and that these effects can be either beneficial or harmful, and accordingly treatment should be tailored to the patient. Id.

The NIH determined that the "epidemiological data indicate that in the general population marijuana use is not associated with increased mortality." Id. The NIH expressed some concern that the effects of marijuana on the immune system were unknown, and that this may have implications for those with suppressed immune systems. Id. Since the report, Dr. Abrams has published his short-term study indicating that both Marinol and marijuana had no significant effect on the immune system of AIDS patients. Donald Abrams, et. al., Short Term Effects of Cannabinoids in Patients with HIV-1 Infection, 139 Annals of Internal Medicine 258, 258 (Aug. 2003).

The NIH also expressed concerns that smoking marijuana may have the same negative effects as smoking tobacco, and may lead to respiratory problems. NIH Report, supra, ch. 3. It noted there "is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use." Id. Marijuana smoke could, however, be a risk factor for respiratory cancer. Id. In this case, Bonjour prefers to use marijuana in his cooking. (Limine Tr. pp. 14, 18) (App. pp. 64, 68). The Court should also consider that for terminally ill patients, including those with AIDS, the risk of being diagnosed with cancer decades down the road is

probably not as significant as the risk of succumbing to the terminal illness because of the inability to tolerate the medications needed to keep it in abeyance.

In addition, Bonjour was not convicted of distributing marijuana to anyone else. Although Bonjour was initially charged with possession of marijuana with intent to distribute, this charge was dismissed by the State. (Trial Tr. p. 3) (App. p. 97). Dr. Meier testified Bonjour told him he never delivered or sold any of his marijuana, and that Bonjour never considered what he was using as a street drug. (Limine Tr. p. 18) (App. p. 68). There is no evidence in the record that Bonjour provided marijuana to anyone. In its judgment entry, the District Court found that Bonjour was manufacturing marijuana for his own medical use. (Judgment Entry p. 2) (App. p. 110).

Given all of the evidence, Bonjour should have been allowed to assert the defense of medical necessity and should not have been convicted had he been allowed to do so.

The articulation of the medical necessity defense supported by Bonjour and derived from Jenks v. State differs from Iowa's general necessity defense in one particular way. Iowa cases defining the general necessity defense have required that the harm to be avoided be imminent; the Jenks medical necessity standard does not require immediacy. Compare State v. Walton, 311 N.W.2d 113, 115 (Iowa 1981) (requiring immediacy of harm) with Jenks v. State, 582 So.2d 676, 679 (Fla. Ct. App. 1991) (not requiring immediacy of harm).

Bonjour argues that the requirement of immediacy simply is not warranted or applicable in cases of medical necessity. Diseases can often be killers months or

years down the road, while immediate treatment may reduce the risk of dying from disease. One author has articulated the argument this way:

> Unlike emergency situations in which life is in danger one minute and safe the next, disease if often an inexorable process of deterioration. Medical treatment may be designed for application at a certain stage in the progression of a disease; preventive and curative medication precede surgery, which itself precedes medications administered strictly as pain relievers in terminal cases. Thus, attempts to apply the immediate harm requirement to many medical conditions would be hopelessly complicated by the nature of the disease, its stage of development, and medical opinion concerning appropriate treatment. The better course would be to disregard the immediacy requirement for medical disease when a cure is possible rather than at an advanced stage when the only relief available is avoidance of pain.

Note, Medical Necessity as a Defense to Criminal Liability: United States v. Randall, 46 Geo. Wash. L. Rev. 273, 290 n.144 (1978).

Even if this Court chooses to require the immediacy of danger in a medical necessity context, Bonjour asserts that he would still qualify for a medical necessity defense. The need for treatment is immediate. Bonjour's failure to take his medications would lead to death perhaps months or years down the road, but his immediate ability to retain his medications will hold back impending death.

Furthermore, Bonjour suffers from the immediate symptoms of nausea, vomiting, diarrhea and neuropathy. (Limine Tr. pp. 10-11) (App. pp. 60-61). Recent research indicates marijuana can alleviate these debilitating conditions. Donald Abrams, et. al., Short Term Effects of Cannabinoids in Patients with HIV-1 Infection, 139 Annals of Internal Medicine 258, 258 (Aug. 2003); Cheryl Jay, et. al., The Effect of Smoked Marijuana on Chronic Neuropathic and Experimentally-Induced Pain in HIV Neuropathy: Results of an Open-Label Pilot Study, (unpublished poster

presentation available from Dr. Donald Abrams, University of California Center for Medicinal Cannabis Research).

Thus, even if this Court determines that an immediacy requirement applies to the defense of medical necessity just as it does to the defense of necessity generally, Bonjour asserts he was entitled to rely upon the defense and met all of the requirements by a preponderance of the evidence. Bonjour did not cause his disease, he sought to avoid death, wasting and pain from AIDS by using marijuana to assist him in retaining his AIDS medications, and there was no other available legal alternative that would accomplish the same objective.

6. If error was not preserved for any reason, Bonjour claims original and substitute counsel ineffective for failing to preserve error.

In the event this Court finds error was not preserved on this issue for any reason, Bonjour claims both original and substitute trial counsel ineffective for failing to preserve error. The benchmark for judging any claim of ineffective assistance of counsel must be whether counsel's conduct so undermined the proper functioning of the adversarial process that the trial cannot be relied on as having produced a just result. Strickland v. Washington, 466 U.S. 668, 686, 104 S.Ct. 2052, 2064, 80 L.Ed.2d 674 (1984).

A convicted defendant's claim that counsel's assistance was so defective as to require reversal of a conviction has two components:

> First, the defendant must show that counsel's performance was deficient. This requires showing that counsel made errors so serious that counsel was not functioning as the "counsel" guaranteed the defendant by the Sixth Amendment. Second, the defendant must show that the deficient performance prejudiced the defense. This

> requires showing that counsel's errors were so serious as to deprive the defendant of a fair trial, a trial whose result is reliable.

Id. at 687, 104 S.Ct. at 2065, 80 L.Ed.2d at 693. See also Taylor v. State, 352 N.W.2d 683, 685 (Iowa 1984). Defendant has the burden to prove both of these elements by a preponderance of the evidence. Strickland, 466 U.S. at 687, 104 S.Ct. at 2065, 80 L.Ed.2d at 693.

The ultimate test is whether under the entire record and totality of the circumstances counsel's performance was within the range of normal competency. Henderson v. Scurr, 313 N.W.2d 522, 524 (Iowa 1981). The defendant must show "a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different. A reasonable probability is a probability sufficient to undermine confidence in the outcome." Strickland, 446 U.S. at 694, 104 S.Ct. at 2068, 80 L.Ed.2d at 698.

Bonjour asserts the District Court's ruling on the State's motion in limine and its subsequent reaffirmance of that ruling were sufficient to preserve error. Nonetheless, he recognizes that substitute counsel withdrew his motion for new trial and motion in arrest of judgment that challenged the District Court's ruling on the motion in limine. (Motion for New Trial; Motion in Arrest of Judgment; Motion to Withdraw Prior Motions) (App. pp. 112-115, 118). If this motion served to waive error, Bonjour claims substitute counsel ineffective for waiving error. If such a waiver occurred, Bonjour was prejudiced because he was entitled to rely upon a medical necessity defense. If any other act of either original or substitute counsel

failed to preserve error, Bonjour claims them ineffective under both the United States and Iowa Constitutions. U.S. Const. amend. VI, XIV; Iowa Const. art. I § 10.

CONCLUSION

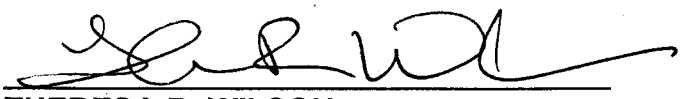
For all of the reasons listed above, Defendant-Appellant Lloyd Bonjour asks this Court to adopt a defense of medical necessity in his case and to hold that he has met the requirements. He respectfully requests this Court vacate his deferred judgment. In the alternative, if the Court chooses to adopt a medical necessity defense but finds the record insufficient to determine the validity of the defense in this case, Bonjour respectfully requests the Court vacate his deferred judgment and remand his case to the District Court for a full hearing and consideration of the medical necessity factors this Court adopts.

REQUEST FOR ORAL ARGUMENT

Counsel for Defendant-Appellant respectfully requests that she be heard in oral argument upon the submission of this case.

Respectfully submitted,

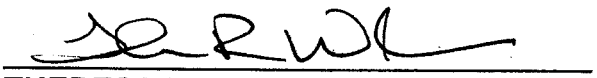
STATE APPELLATE DEFENDER'S OFFICE



THERESA R. WILSON
Assistant Appellate Defender

ATTORNEY'S COST CERTIFICATE

I, the undersigned, hereby certify that the true cost of producing the necessary copies of the foregoing Brief and Argument was $ 60.48, and that amount has been paid in full by the Office of the Appellate Defender.



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