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**MEDICAL MARIJUANA:**

**THE CONFLICT BETWEEN CALIFORNIA AND  
FEDERAL LAW AND ITS EFFECT ON LOCAL  
LAW ENFORCEMENT AND ORDINANCES**

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## I. INTRODUCTION

This article presents an overview of the California and federal law on medical marijuana, and the conflict between the two. With this conflict in mind, this article then discusses how local governments can advise their police officers on law enforcement issues and enact policies regarding medical marijuana in ways that do not run afoul of the continuing federal prohibition on all marijuana.

## II. CALIFORNIA LAW

### A. Health & Safety Code § 11362.5 As Supplemented By Health & Safety Code §§ 11362.7 to 11362.83

In 1996, Proposition 215 (entitled “the Compassionate Use Act”) was approved by California’s voters and codified as California Health & Safety Code section 11362.5.<sup>1</sup> Section 11362.5(b)(1)(A) provides that the purpose of the initiative is:

To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use...has been recommended by a physician....

The operative text of Proposition 215 is concise.<sup>2</sup> Section 11362.5(d) provides that:

(Health & Safety Code) Section 11357 (possession of marijuana) and Section 11358 (cultivation of marijuana) shall not apply to a patient, or to a patient’s primary care giver, who possesses or cultivates marijuana for the **personal medical purposes** of the patient, upon the **written or oral recommendation or approval of a physician**.

(Emphasis added.) Thus, the basic elements of Section 11362.5(d) are: (1) a physician’s oral or written recommendation or approval, and (2) possession or cultivation for personal medical purposes.<sup>3</sup>

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<sup>1</sup> All further statutory references are to the Health & Safety Code, unless otherwise noted.

<sup>2</sup> Attachment A sets forth the entire text of Proposition 215.

<sup>3</sup> While the stated intent of Proposition 215 is to help “seriously ill” Californians, Section 11362.5(d) is neither limited to Californians nor to seriously ill persons. Thus, there is no requirement that a patient be a California resident to possess medical marijuana in California under state law. In addition, if a physician has approved medical marijuana for a medical purpose, even without further proof of a “serious” illness, the possession is lawful under state law. *People v. Tilehkooh* (2003) 113 Cal.App.4<sup>th</sup> 1433, 1441.

## 1. A “Physician” Is An M.D. or a D.O.

Preliminarily, Section 11362.5(d) requires that a “physician” provide a recommendation or approval of medical marijuana. In California, a “physician” is either a medical doctor (M.D.) licensed to practice medicine by the Medical Board of California or a doctor of osteopathy (D.O.) licensed to practice osteopathy by the Osteopathic Medical Board of California. Bus. & Prof. Code § 2453(a). Accordingly, under Section 11362.5(d) an M.D. or an D.O. can provide the recommendation or approval.

## 2. An Oral Recommendation With No Written Record Is Sufficient

Section 11362.5(d) unambiguously provides that the physician’s recommendation or approval may be “written or oral.” Thus, a formal written prescription is not required. The allowance for an “oral recommendation” in Section 11362.5(d) also implies that no written record whatsoever by a physician is needed to qualify for medical marijuana use under state law.<sup>4</sup>

Effective January 1, 2004, the California Legislature enacted Sections 11362.7 to 11362.83 as supplemental medical marijuana legislation entitled “Article 2.5 Medical Marijuana Program” (hereafter referred to as “the 2004 legislation”).<sup>5</sup> The 2004 legislation created a state-approved medical marijuana ID card program, set the quantity of marijuana that a qualified patient or primary caregiver can possess, and created additional immunities from state marijuana laws, among other things.

In the 2004 legislation, Sections 11362.7 - 11362.7(a) define “attending physician” for “the purposes of this article” as a physician who makes a “recording in the patient’s medical record” regarding the appropriate use of medical marijuana. Thus, under the 2004 legislation, the definition of “attending physician” requires more than simply an M.D. or a D.O. making an oral recommendation as provided in the original initiative text in Section 11362.5(d). Rather, for the purposes of the 2004 legislation (Sections 11362.7 to 11362.83), the “attending physician” must have made a written record in the patient’s chart that the use of medical marijuana is appropriate.

The definition of an “attending physician” in the 2004 legislation in Section 11362.7(a) raises the question of whether a “physician,” as that term was used in the original initiative text in Section 11362.5(d), must *write* in the patient’s chart that the use of medical marijuana is appropriate, even if the recommendation to the patient is “oral.” The rules of statutory construction require that the terms “physician” as used in the original text of Section 11362.5(d)

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<sup>4</sup> In fact, a federal district court ruled that although doctors have a First Amendment right to recommend medical marijuana, doctors should *not* make a note in the patient’s medical chart to avoid a criminal charge of “aiding and abetting” a violation of federal law. *Conant v. Walters*, 2000 U.S. Dist. Lexis 13024 at p. 46 (unpublished); affirmed in *Conant v. Walters*, 309 F.3d 629 (9<sup>th</sup> Cir. 2002).

<sup>5</sup> Attachment B sets forth the entire text of Sections 11362.7 to 11362.83.

and “attending physician” as used in the 2004 legislation, be harmonized, if possible. Code of Civ. Proc. § 1859.

Section 11362.7 of the 2004 legislation provides that the definition of “attending physician” is “for the purposes of this article.” The limiting phrase “for the purposes of this article” in Section 11362.7 refers to Article 2.5, entitled Medical Marijuana Program. Proposition 215, on the other hand, codified as Section 11362.5, falls within Article 2, entitled Marijuana. Therefore, the defined term “attending physician” (which requires a writing) is limited to Article 2.5 (Sections 11362.7 to 11362.83) and does not apply to the original text of Proposition 215 (Section 11362.5), which was placed in Article 2.

This conclusion is supported by the narrow and specific use of the term “attending physician” in the 2004 legislation only in connection with the issuance of a state-approved medical marijuana ID card. See Sections 11362.7(i), 11362.715(a)(2), 11362.72(a)(2), and 11362.72(a)(3).<sup>6</sup> However, an ID card is not required for either a qualified patient or a primary caregiver, rather it is optional and voluntary. Section 11362.71(f). Other than for the specific purpose of obtaining an optional official state-approved ID card, no other aspect of the 2004 legislation uses the phrase “attending physician” or otherwise suggests that the Legislature intended to modify or clarify the apparent acceptability of a purely oral recommendation under the original initiative text in Section 11362.5(d).

For instance, Section 11362.77 of the 2004 legislation sets forth the permissible quantities of marijuana a qualified patient can possess. Yet, this section avoids choosing between “physician” and “attending physician,” and simply uses the word “doctor” instead, a word which neither the original Section 11362.5 nor the 2004 legislation defines. Similarly, with respect to professional licensing board disciplinary actions, Section 11362.8 of the 2004 legislation protects “primary caregivers” with respect to medical marijuana, but does not protect “acts performed by a physician relating to the discussion or recommendation of the medical use of marijuana to a patient.” Here, the use of the word “physician” instead of “attending physician,” and the phrase “discussion of medical marijuana use,” again strongly suggests that no written record is required to become a qualified patient under Section 11362.5.

In summary, despite expressly referring to physicians or doctors three times, the 2004 legislation only uses the phrase “attending physician” in connection with obtaining optional state-approved medical marijuana ID cards. Thus, the term “attending physician” in Section 11362.7(a) and “physician” in the original Section 11362.5(d) are harmonized by concluding that an oral recommendation with no written record remains sufficient to become a qualified patient for medical marijuana under Section 11362.5(d). The use of an “attending physician,” who by definition must make a writing that marijuana use is appropriate, is a separate and more stringent requirement reserved for obtaining an official state-approved ID card.

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<sup>6</sup> To obtain an optional and voluntary California medical marijuana ID card under Section 11362.715(a)(2), the patient must submit a copy of a portion of his or her medical chart created by the “attending physician” stating that the person has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate.

### **3. Marijuana For “Personal Medical Purposes” Means Up To Eight Ounces, Plus Six Mature Plants or 12 Immature Plants, Unless (a) A Doctor Recommends More, Or (b) The Local Ordinance Allows More**

Before the 2004 legislation was enacted, one of the central problems with implementing Section 11362.5(d) was that it did not provide any guidelines as to the amount of medical marijuana that is considered appropriate for “personal medical purposes.” The 2004 legislation resolved this problem. Now, Section 11362.77(a) provides that under state law, a qualified patient or primary caregiver may possess up to 8 ounces of dried marijuana per qualified patient, plus up to 6 mature marijuana plants or 12 immature marijuana plants. A qualified patient or primary caregiver can possess greater quantities of dried marijuana and/or plants than is allowed by state law, if a “doctor” recommends more. Section 11362.77(b). In addition, cities and counties are free to enact medical marijuana guidelines that allow qualified patients and primary caregivers to possess greater quantities than is allowed by state law, but are prohibited from imposing smaller limits. Section 11362.77(c).

#### **B. Primary Caregiver Defined**

With respect to possession and cultivation of marijuana, Section 11362.5 provides that not only the patient, but also the patient’s primary caregiver, may possess or cultivate marijuana for the patient’s personal medical use. Section 11362.5(e) defines a “primary care giver” as:

A person who has consistently assumed responsibility for the housing, health, or safety of the patient.

In *People v. Peron* (1997) 59 Cal.App.4<sup>th</sup> 1383, 1392-99, the court held that neither a marijuana club nor the marijuana club proprietor in question met the definition of primary caregiver because they did not consistently assume responsibility for the health or safety of the patient, but merely sold marijuana to qualified patients on demand. The court held that a patient simply designating a marijuana seller or club as a primary caregiver was “clearly a subterfuge designed to subvert the plainly expressed intent of section 11362.5 continuing the proscriptions of marijuana sale and possession for sale.” 59 Cal.App.4<sup>th</sup> at 1397. There is some ambiguity, however, in the *Peron* decision as to whether a person who consistently supplies marijuana to a qualified patient, to the exclusion of other suppliers, can be considered a primary caregiver by virtue of having consistently assumed this particular role in connection with the patient’s health. See 59 Cal.App.4<sup>th</sup> at 1400. A subsequent appellate court addressed this ambiguity in *Peron* and concluded that a person cannot be a primary caregiver simply by consistently growing and supplying medical marijuana to a qualified patient to serve the patient’s health needs. *People v. Frazier* (2005) 128 Cal.App.4<sup>th</sup> 807, 823.

The 2004 legislation shed no additional light on who qualifies as a primary caregiver because Section 11362.7(d) merely reiterates the original definition of primary caregiver under Section 11362.5(e), and adds non-exclusive examples of who can be a primary caregiver.<sup>7</sup>

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<sup>7</sup> Sections 11362.7(d) and (e) further define “primary caregiver” as the individual, designated by a “qualified patient” or “person with an identification card,” who has consistently assumed responsi-

Other than *Peron*, *Frazier*, and one additional case (*People v. Galambos* (2002) 104 Cal.App.4<sup>th</sup> 1147, 1165), all of which dealt with suppliers of medical marijuana that had no consistent relationship with a qualified patient, no other case address the meaning of “consistently assuming responsibility for the health or safety of the patient.” Thus, while the *Frazier* case states that there is no technical meaning of this phrase, the parameters of who qualifies as a primary caregiver has yet to be significantly developed by case law.

**C. A Primary Caregiver With Multiple Patients Can Legally Possess Large Quantities Of Marijuana Under State Law**

In the 2004 legislation, Section 11362.7(d)(2) expressly provides that there is *no limit* on the number of qualified patients one single primary caregiver can serve, as long as the patients reside in the same county as the primary caregiver.<sup>8</sup> This provision has a significant effect when coupled with Section 11362.77(a), which provides that the primary caregiver may possess 8 ounces, plus 6 mature or 12 immature plants “per qualified patient.” When read together, Sections 11362.7(d)(2) and 11362.77(a) provide that under state law, there is no limit to the amount of medical marijuana or medical marijuana plants a primary caregiver can possess, as long as the primary caregiver and the corresponding number of his or her qualified patients reside in the same county.<sup>9</sup> This express allowance for primary caregivers to grow or possess large amounts of medical marijuana for multiple patients under state law appears to leave local law as the sole means for non-federal officials to impose limits on the amount of marijuana or marijuana plants that can be kept at a single location.

**D. Reimbursement To Primary Caregivers – Wages And Costs Are Allowed, But “Profits” Are Not**

In *Peron*, the court stated that a primary caregiver who grows and supplies physician-approved medicinal marijuana to a qualified patient can be reimbursed for both supplies and services. 59 Cal.App.4<sup>th</sup> at 1399-1400. The new Section 11362.765(a) addressed the issue of reimbursement as follows: “... nothing in this section shall ... authorize any individual or

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bility for the housing, health, or safety of that patient or person. A primary caregiver may include any of the following, if they are designated as a primary caregiver by a qualified patient or a “person with an identification card:” A state-licensed health clinic, health care facility, residential care facility for persons with chronic life-threatening illnesses, hospice, or home health agency, and the owner or operator and up to three employees who are designated by the owner or operator. Section 11362.7(d)(1).

<sup>8</sup> However, if a primary caregiver serves an out-of-county patient, then he or she can only act as the primary caregiver to that one patient. Section 11362.7(d)(3).

<sup>9</sup> In addition, there is no general prohibition against a qualified patient designating more than one person as a primary caregiver, as long as the definition of a primary caregiver is met. This, of course, may lead to an abundance of persons deemed primary caregivers. One exception to this is found in Section 11362.7(d)(1), which limits the number of primary caregivers for one patient to no more than three employees of certain medical facilities that are providing services to the patient.



group to cultivate or distribute marijuana for a profit.”<sup>10</sup> This restriction on profit, however, may be illusory given that primary caregivers may receive reimbursement for services rendered in supplying the patient with medical marijuana. In other words, if a primary caregiver characterizes the money he or she receives from a patient as reimbursement for services (or wages), it is lawful, whereas if he or she characterizes it as profit, it is not. This difference is largely semantic and will likely be the subject of future litigation.

#### **E. Several Other State Marijuana Laws Are Not Applicable To Medical Marijuana**

As stated at the outset, Proposition 215 (Section 11362.5) established that both qualified patients and primary caregivers are not in violation of the state laws prohibiting possession (Section 11357) and cultivation (Section 11358) of marijuana when there is a physician’s recommendation, and the amount of marijuana possessed or cultivated is for the patient’s personal medical use. In 2004, the enactment of Section 11362.765(a) and (b) extended these two exemptions for qualified patients and primary caregivers who possess the allowable amounts of marijuana to the following six related state laws: possession of marijuana for sale (Section 11359), transportation, distribution, and importation (Section 11360), maintaining a place for unlawfully selling, giving away, or using a controlled substance (Section 11366), knowingly making available a place for unlawfully manufacturing, storing, or distributing a controlled substance for sale or distribution (Section 11366.5), and using a place for unlawfully selling, keeping, manufacturing, or giving away a controlled substance (Section 11570).

The exemptions for importation (Section 11360) and sales (Section 11359), for example, would appear to allow a primary caregiver with 10 patients to import five pounds of marijuana with no attempt to cultivate any of it, and then obtain “reimbursement” from his or her patients (including the value of his or her “services”), as long as no “profit” was made. While this type of conduct would be directly contrary to the voter’s intent in enacting Section 11362.5,<sup>11</sup> this broad exemption finds its basis in the 2004 legislation, not the original proposition.

#### **F. Persons Assisting With Cultivation Are Also Protected By The New State Law**

In 2004, the enactment of Section 11362.765(b)(3) extended all the exemptions from state criminal laws listed in the preceding section not only to qualified patients and primary

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<sup>10</sup> Profit usually means the monetary surplus left to a producer or employer after deducting expenditures.

<sup>11</sup> The *Peron* court stated “the intent of the initiative was to allow persons to cultivate and possess a sufficient amount of marijuana for their own approved medical purposes, and to allow ‘primary caregiver[s]’ the same authority to act on behalf of those patients too ill or bedridden to do so.” 59 Cal.App.4<sup>th</sup> at 1394. The Court concluded that “(w)e find no support in section 11362.5 for respondents’ argument that sales of marijuana on an allegedly nonprofit basis do not violate state laws against marijuana sales.” 59 Cal.App.4<sup>th</sup> at 1392.

caregivers, but also to any individual who provides assistance to a qualified patient or primary caregiver in:

- (1) administering medical marijuana to the qualified patient, or (2) acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient.

This exemption appears to be designed to protect a person who teaches qualified patients and primary caregivers how to cultivate and actually ingest (administer) marijuana, e.g. via smoked and non-smoked methods. However, a broad reading of Section 11362.765(b)(3) could exempt a non-patient/non-primary caregiver who *cultivates* medical marijuana as a means of teaching patients and caregivers how to cultivate it for themselves. This is the first time that protections under state law for medical marijuana have been extended to persons other than qualified patients and their primary caregivers, and thus, the scope of this exemption is unsettled.

### **G. Medical Marijuana Clubs Are Unlawful, But Collectives Are Lawful**

A central legal issue under state law is whether and when medical marijuana clubs or dispensaries are lawful. As stated above, in *Peron*, the court held that marijuana “clubs” are not legal under Proposition 215 (Section 11362.5) because a club cannot be a “primary caregiver” as defined therein. 59 Cal.App.4<sup>th</sup> 1383, 1396. The *Peron* court reasoned that a primary care giver must be a person “who has *consistently* assumed responsibility for the housing, health, or safety of” the patient. 59 Cal.App.4<sup>th</sup> at 1396. This means that a patient cannot simply designate before a marijuana purchase, a seller (such as a club manager or employee) as a primary caregiver. 59 Cal.App.4<sup>th</sup> at 1397. As stated above, the definition of primary caregiver in Section 11362.5(e) was reiterated in the 2004 legislation in Section 11362.7(d). Thus, the *Peron* decision prohibiting patients from designating marijuana sellers as “primary caregivers,” absent a *bona fide* primary caregiver relationship, remains good law.

In the 2004 legislation, Section 11362.775 attempts to avoid this problem in the club model by expressly allowing medical marijuana to be cultivated collectively by qualified patients and primary caregivers, and by necessary implication, distributed among the collective’s members. Thus, “collectives” that are comprised *exclusively* of qualified patients and primary caregivers can legally cultivate medical marijuana under Section 11362.775. Under the collective model, qualified patients who are unwilling or unable to cultivate marijuana on their own can still have access to marijuana by joining together with other qualified patients to form a collective. Even under Section 11362.775, however, collectives still cannot include third parties such as directors or employees who are neither qualified patients nor primary caregivers. Under *Peron*, such third parties remain prohibited from distributing or selling medical marijuana.<sup>12</sup>

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<sup>12</sup> Because of the new language in Section 11362.765(b)(3), that allows third parties to help patients and primary caregivers in “administering medical marijuana to the patient,” the legality of “collectives” that are run by persons who are neither qualified patients nor primary caregivers will probably be litigated further in the coming years. However, the apparent intent of this narrow new exception

## **H. Membership In Collectives – Qualified Patients And Primary Caregivers**

Section 11362.775 provides that all the members of a medical marijuana collective must be either qualified patients or primary caregivers. However, state law appears to allow a collective composed entirely of primary caregivers, with no qualified patients as members. Thus, it appears that a group of primary caregivers who each have several qualified patients are allowed to cultivate and distribute medical marijuana to their patients in the amount collectively allowed for all their patients, with no patient participation in the collective.<sup>13</sup>

## **I. Official State-Approved Medical Marijuana ID Cards Are Voluntary**

In the 2004 legislation, Sections 11362.71 to 11362.76 established a voluntary state-approved medical marijuana ID card system run by the State Department of Health Services, which ID cards are to be issued by county officials to qualified patients and primary caregivers.<sup>14</sup> Participation in state-approved ID card system is strictly voluntary. Section 11362.71(f). Therefore, persons who are qualified patients or primary caregivers are **not** required to possess ID cards to cultivate or possess medical marijuana. *Id.* The ID cards are intended to “avoid unnecessary arrests.” Legislative Findings for S.B. 420; see also Section 11362.71(e). The State Department of Health Services is also required to establish a 24-hour telephone number to verify the validity of official ID cards. Section 11362.71(a)(2). At this time, the statewide ID card system is operating as a pilot program in three counties and is expected to be fully operational by September 2005. The status of the 24-hour telephone verification system is not known at this time, but the State Department of Health Services’ website appears to be running a verification system through a link to its web page.

## **J. Restriction On Police Arresting Persons With State-Approved Medical Marijuana ID Cards**

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for third party assistance does not appear to apply to a “club” or “collective” director who purchases and resells medical marijuana. Thus, the “club” or “collective” model run by a non-patient, non-primary caregiver remains illegal under state law.

<sup>13</sup> The City of Berkeley’s local ordinance (BMC 12.26.040(B) – Attachment C) prohibited a primary caregiver from being a member of a collective, unless the qualified patient is also a member, as a means of reducing fraud. However, given the apparent approval in Section 11362.77 of collectives composed only of primary caregivers under Section 11362.775, this local requirement may no longer be valid.

<sup>14</sup> Prior to 2004, Marin County and San Francisco had government-run ID card programs, and Oakland deputized the Oakland Cannabis Buyers’ Cooperative to run an ID card program. However, while these ID cards were perhaps helpful in certain law enforcement encounters, they had no legal impact except perhaps within the locality in which they were issued.

In the 2004 legislation, Sections 11362.71(e) and 11362.78 expressly prohibit police officers from arresting a person with a state-approved county-issued ID card for possession, transportation, delivery, or cultivation of medical marijuana, except under certain circumstances. These circumstances are when there is probable cause to believe that the ID card is false, fraudulently obtained, or no longer valid, or the amounts of marijuana possessed are beyond the legal limits allowed by state law, or by local law, if local law sets a higher limit.

#### **K. Places State Law Does Not Authorize For Smoking Medical Marijuana**

In the 2004 legislation, Section 11362.79 does not authorize a qualified patient to smoke marijuana in places where smoking is prohibited, as well as on a school bus, in a motor vehicle that is being operated, while driving a boat, and within 1,000 feet of the grounds of a school, recreation center, or youth center, unless that use is inside a residence.

#### **L. Jails And Workplaces May Disallow Smoking Medical Marijuana**

In the 2004 legislation, Section 11362.785 states that law enforcement agencies are not required to allow medical marijuana use by qualified patients in custody in jails, but are allowed to do so, if it can be done safely. With respect to workplaces, Section 11362.785 provides that the new law (Article 2.5) does not require employers to allow medical marijuana use in the workplace or during hours of employment. However, this issue may be revisited under other laws governing use of medication in the workplace.

### **III. FEDERAL LAW PROHIBITS MEDICAL MARIJUANA AND PRECLUDES A MEDICAL NECESSITY DEFENSE**

In 1999, the Ninth Circuit directed the District Court to reconsider enjoining the federal government from enforcing 21 U.S.C. Section 841(a) of the Controlled Substances Act (CSA) against the Oakland Cannabis Buyer's Cooperative as to patients for whom marijuana is a true medical necessity. *United States v. Oakland Cannabis Buyers' Cooperative*, 190 F.3d 1109, 1115 (9<sup>th</sup> Cir. 1999). Medical necessity was not defined by the Ninth Circuit merely as a doctor's approval or recommendation applicable under state law. Rather, the Ninth Circuit essentially directed the District Court consider the following much stricter criteria as constituting a medical necessity to use marijuana:

... patients whose physicians certify that (1) the patient suffers from a serious medical condition; (2) if the patient does not have access to cannabis, the patient will suffer imminent harm; (3) cannabis is necessary for the treatment of the patient's medical condition or cannabis will alleviate the medical condition or symptoms associated with it; (4) there is no legal alternative to cannabis for the effective treatment of the patient's medical condition because the patient has tried other legal alternatives to cannabis and has found them ineffective in treating his or her condition or has found that such alternatives result in intolerable side effects.

190 F.3d at 1113-14 (*cannabis* is Latin for marijuana). As such, the Ninth Circuit recognized the application of the medical necessity defense to the CSA.

This decision by the Ninth Circuit was overruled by the Supreme Court in *United States v. Oakland Cannabis Buyers' Cooperative* (2001) 532 U.S. 483, 121 S. Ct. 1711, 149 L. Ed. 2d 722. At the Supreme Court, the Oakland Cannabis Buyers' Cooperative again contended that medical necessity was an implied exception to 21 U.S.C. Section 841(a) of the Controlled Substances Act (CSA), which prohibits the distribution or manufacture of marijuana. 532 U.S. at 490. The Court rejected this contention because the “a medical necessity exception for marijuana is at odds with the terms of the Controlled Substances Act.” *Id.* at 491. The Court explained that under the CSA, marijuana is listed as a “Schedule I” drug, which means that there has already been a finding under federal law that marijuana has “no currently accepted medical use.” *Id.* As such, “Congress has made a determination that marijuana has no medical benefits worthy of an exception.” *Id.* at 493. For this reason, the Court held that “the Controlled Substances Act cannot bear a medical necessity defense to distribution of marijuana.” *Id.* at 494. “Because the statutory prohibitions cover even those who have what could be termed a medical necessity, the Act precludes consideration of this (medical necessity) evidence.” *Id.* at 499.

Despite this strong language rejecting the medical necessity defense with respect to a Schedule I drug in the CSA such as marijuana, the Court included a revealing footnote as to how it would have ruled if the CSA had not listed marijuana as a Schedule I drug. The Court states that,

Lest there be any confusion, we clarify that nothing in our analysis, or the statute, suggests that a distinction should be drawn between the prohibitions on manufacturing and distributing and the other prohibitions in the Controlled Substances Act. The very point of our holding is that there is no medical necessity exception to the prohibitions at issue, even when the patient is ‘seriously ill’ and lacks alternative avenues for relief. ... We reject the argument that these factors warrant a medical necessity exception. **If we did not, we would be affirming instead of reversing the Court of Appeals.**

532 U.S. at 494 n. 7 (emphasis added). Here, the Court is saying that although the CSA expressly precludes a medical necessity defense for Schedule I drugs such as marijuana, if the CSA had not done so, the Court would have *affirmed* the Ninth Circuit’s application of the medical necessity defense.

In June 2005, the United States Supreme Court held in *Gonzales v. Raich* (2005) 545 U.S. - , 125 S.Ct. 2195, 2209, 2212, 162 L.Ed. 2d 1, 22, 26 that Congress has the power under the Commerce Clause of the United States Constitution to prohibit (under the federal Controlled Substances Act at 21 U.S.C. §§ 812, Schedule I(c)(10) and 841(a)) the distribution and manufacture of marijuana. This time, the Court declined to rule on whether the “medical necessity” defense could be an exception to the general prohibition on possession (under 21 U.S.C. § 841(a)) or cultivation of marijuana for personal use under the Substantive Due Process Clause because this issue was not briefed or decided in the lower court. 125 S.Ct. at

2215, 162 L.Ed.2d at 29. While the Court in *Raich* stated that it was declining to rule on the medical necessity defense, the Court already conclusively addressed this defense in its earlier decision in *United States v. Oakland Cannabis Buyers' Cooperative*, although that case did not involve the general prohibition on possession for personal use.

There is nothing in the Supreme Court's 2005 decision in *Raich* that would appear to change the Court's 2001 analysis in *Oakland Cannabis Buyers' Cooperative* of the medical necessity defense. In *Raich*, the first sentence of the Court's opinion observes that nine western states authorize the use of marijuana for medicinal purposes. 125 S.Ct. 2195, 2198, 162 L.Ed.2d 1, 11. The Court then openly laments that its ruling that federal law prohibiting the use of marijuana for medical purposes "is made difficult by respondents (the patients) strong arguments that they will suffer irreparable harm because, despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes." 125 S.Ct. at 2201, 162 L.Ed.2d at 14.<sup>15</sup>

The Court explains, however, that its proper role is to rule on whether Congress acted within its "power," not whether Congress is "wise" to require the enforcement of the total ban on marijuana in the CSA in every medical circumstance. *Id.* With its hands tied, the Court takes the unusual step of essentially advising those advocating the use of marijuana as a medicine as to the following avenues that could lead to the removal of marijuana from Schedule I of the CSA: (1) the federal government has the power to re-classify marijuana as a non-schedule I drug, and (2) "perhaps even more important than these legal avenues is the democratic process, in which the voices of the voters allied with these respondents may one day be heard in the halls of Congress." 125 S.Ct. at 2215, 162 L.Ed.2d at 29. "Under the present state of the law, however" there can be no medical necessity defense. *Id.* Thus, under *Raich* and *Oakland Cannabis Buyers' Club*, as long as marijuana remains a Schedule I drug, which by definition means that under federal law marijuana has no medicinal use, federal courts cannot entertain a medical necessity defense to any marijuana-related offense.

#### **IV. LOCAL LAW ENFORCEMENT AND ORDINANCE ISSUES ARISING OUT OF THE CONFLICT BETWEEN FEDERAL AND STATE LAW**

##### **A. State Law Preemption And The General Prohibition Against Aiding And Abetting A Federal Crime Both Act To Restrict Local Action**

Section 11362.83 provides that localities are free to adopt laws that are consistent with state law. State law sets forth allowable quantities for patients and primary caregivers that localities cannot reduce and also defines who is a primary caregiver. Thus, localities cannot contradict these provisions. State law does leave room, however, for other local laws that are not inconsistent with state law.

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<sup>15</sup> See also, *Conant v. Walters* (9<sup>th</sup> Cir. 2002) 309 F.3d 629, 639-45, for a heavily documented outline of reports regarding the effective medical use of marijuana by Judge Kozinski.

Federal law, on the other hand, currently prohibits medical marijuana in all instances. The elements of the crime of “aiding and abetting” a violation of federal marijuana laws are as follows:

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

*Conant v. Walters* (9<sup>th</sup> Cir. 2002) 309 F.3d 629, 635. Thus, the question arises as to how local governments should respond to law enforcement issues arising out of medical marijuana while not “aiding and abetting” the violation of federal law.

#### **B. Decision Makers Should Be Apprised Of The Risks Of Local Directives Requiring Non-Cooperation With The Federal Government**

Preliminarily, the federal government cannot require state or local authorities to help federal officials enforce federal marijuana laws. *Printz v. United States* (1997) 521 U.S. 898, 935. Local governments, on the other hand, probably cannot prohibit their local police officers from providing information regarding marijuana to federal officials because local police officers have authority under state law to respond to all crimes in their presence (Penal Code section 830.1) and possibly have a First Amendment right to report federal crimes to federal authorities. Therefore, a local policy prohibiting a local police officer from contacting a federal official regarding medical marijuana may be preempted by Penal Code section 830.1 and/or overbroad under the First Amendment.

Moreover, the federal government has the power to override state and local laws that expressly forbid local officials from cooperating with federal investigations. *New York v. United States* (2<sup>nd</sup> Cir. 1999) 179 F.3d 29 (upholding federal law forbidding local law or policy prohibiting local officials from reporting illegal aliens to the INS). The federal government can also withhold federal funds from local governments, but probably only if the condition for withholding the funds is related to the purpose of the funds. *South Dakota v. Dole* (1987) 483 U.S. 203, 206. For instance, the federal government could condition the grant of federal funds for police services on the absence of a local non-cooperation policy on marijuana. In summary, before local decision makers institute an express policy of non-cooperation with federal officials, they should be apprised that such a local policy is of uncertain legality, can be overridden by a responsive federal law, and may even draw a threatened loss of federal grant funding.

#### **C. The Return Of Seized Marijuana That Turns Out To Be Medicinal Under State Law Must Be Pursuant To Court Order**

Medical marijuana remains a controlled substance under state law, albeit one that can be legally possessed. Section 11473.5 provides that, “All seizures of controlled substances ... which are in possession of any city, county, or state official ... as the result of a case in

which no trial was had or which has been disposed of by way of dismissal or otherwise than by way of conviction, shall be destroyed by order of the court, unless the court finds that the controlled substances ... were lawfully possessed by the defendant.” Therefore, Section 11473.5 requires a court order with a finding that the marijuana was lawfully possessed under state law for the return of marijuana. See *People v. Chavez* (2004) 123 Cal.App.4<sup>th</sup> 104, 109 (authorizing destruction of medical marijuana because total quantity exceeded state law limits).

Even if a state court issues an order to return medical marijuana, the return might arguably violate federal law (21 U.S.C. § 841(a)), which prohibits distributing marijuana. Thus, local officials can be caught between a state court’s order to return medical marijuana and the federal law possibly prohibiting that action. The City of Berkeley has taken the position that once a court adjudicates marijuana to be medical marijuana and orders it to be returned, its officials are duty-bound to follow the court’s order even when doing so might be a technical violation of federal law. See Berkeley Police Department (BPD) Training Bulletin at p. 11, Attachment D.<sup>16</sup>

#### **D. Police Officer Training Regarding State Medical Marijuana Laws**

As stated above, police officers have no obligation to enforce federal marijuana laws. *Printz, supra*. On the other hand, the enforcement of state marijuana laws has become fairly complex with the advent of the 2004 legislation. The City of Berkeley has implemented a Police Training Bulletin that gives its officers specific questions to ask when trying to discern whether a claim of medical marijuana is genuine, and how to handle the issue of whether to confiscate the marijuana, and if so, how much of it. See BPD Training Bulletin at pp. 8-10, Attachment D.

#### **E. Elements To Consider In A Local Medical Marijuana Ordinance**

##### **1. Quantities Allowed**

The 2004 legislation expressly allows cities to implement higher limits for possession and cultivation of medical marijuana than is allowed under state law (Section 11362.77(c)). Following this state law directive does not appear to be “aiding and abetting” a violation of federal law because the elements of (1) “specific intent” to violate federal law, and (2) “assistance” with the violation of federal law are not present.<sup>17</sup>

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<sup>16</sup> An unpublished District Court opinion from the Northern District of California supports this position on the grounds that federal courts lack jurisdiction to “trump” a state court order requiring the return of medical marijuana. *In Re The Matter Of: The Seizure of Approximately 28 Grams of Marijuana*, 2004 U.S. Dist. Lexis 25418, at p. 20.

<sup>17</sup> For instance, the California Attorney General’s opinion letter to the DHS of July 15, 2005 (Attachment E) concludes that state-approved medical marijuana ID cards do not constitute “aiding and abetting” a violation of the federal Controlled Substance Act, but merely implements state law by helping law enforcement officers distinguish between lawful and unlawful use of marijuana under state law.



## **2. Medical Marijuana ID Cards**

The issue of whether issuing medical marijuana ID cards is “aiding and abetting” a violation of federal law is no longer confronting local governments because the 2004 legislation mandated a state-wide program for such ID cards. Sections 11362.715 – 11362.76. It remains to be seen whether the federal government can or will attempt to enjoin the state’s ID card program on the grounds that it aides and abets the violation of federal law.

## **3. Capping The Number Of Medical Marijuana Dispensaries**

Localities may want to cap the total number of medical marijuana collectives (which are now calling themselves dispensaries) in a given area or within their jurisdiction generally. Section 11362.83 of the 2004 legislation provides that cities are not preempted with respect to regulations consistent with Article 2.5. Although Section 11362.775 allows for collectives, it does not appear to be inconsistent with that section to cap the number of collectives (or dispensaries) at a reasonable number. Therefore, a local cap does not appear to be preempted by Section 11362.83. The City of Berkeley’s cap on dispensaries within the City is three. See BMC § 12.26.110, Attachment C. In 2004, the City of Oakland instituted a cap of 4 or 5.

## **4. Regulating Medical Marijuana Dispensaries**

Because of the complete prohibition on marijuana under federal law, the issue of regulating dispensaries gives rise to very difficult issues. While most localities want to refrain from the appearance of aiding and abetting the violation of federal law by issuing use permits to dispensaries or collectives, leaving them unregulated has its disadvantages as well. The City of Berkeley does not have a specific use permit or zoning regulations pertaining to medical marijuana dispensaries, but has reserved the right to impose a use permit under the generally reserved powers in its zoning ordinance. In addition, the City reserves the right to deny any use permit application for a dispensary due to federal law restrictions. See BMC § 12.26.120. To date, there have been no completed use permit applications for a dispensary, but three dispensaries/collectives existed in Berkeley before the cap was implemented.

## **5. Capping The Amount Of Medical Marijuana At A Single Location**

Localities may want to cap the number of marijuana plants or dried marijuana that can be stored or grown *at a single location*. The City of Berkeley has done this by limiting the number of outdoor plants at a single location to 10, limiting the number of indoor plants at a single location to 50, and limiting the maximum amount of dried marijuana at a single location held by a collective to 12.5 pounds. BMC §§ 12.26.070 and 12.26.040(D), Attachment C. While such local caps may not be expressly allowed under the new state law, and therefore should probably not be characterized as criminal prohibitions, they appear to be appropriate land use regulations, which have traditionally been subject to local control, and not preempted by state law.

## **F. Localities Cannot Grow Or Distribute Medical Marijuana**

A locality cannot grow medical marijuana or distribute it to qualified patients because doing so would not only violate federal law, it would also violate state law because a locality cannot be considered a primary caregiver. *See* Section II B and II G, *infra*. A possible exception under state law would be health agency run by a locality. *See* Section 11362.7 for a list of such health agencies.

## **V. CONCLUSION**

The federal prohibition on marijuana has created a line in the sand over which localities may not step. Where that line lies, however, is not clear because it is uncertain whether a locality following state law could or would be charged with “aiding and abetting” a federal violation.

It would be appropriate for the federal government to simply challenge the state’s medical marijuana law under the Supremacy Clause of the United States Constitution and resolve the conflict one way or the other under the principles of federalism. Unfortunately, that day is not likely to arrive soon as we know of no pending case litigating that issue. What is more likely to happen first is the re-classification of marijuana by Congress as a non-Schedule I drug. If that occurs, we may see a legitimization of marijuana as a *bona fide* controlled substance that doctors may prescribe under both federal and state law like other prescribed drugs. Until federal law allows a doctor to write a prescription for medical marijuana, however, the conflict between state and federal law will continue for a long time to come.