THE LEGAL STRUGGLE FOR

MEDICINAL CANNABIS IN CALIFORNIA.

By Gerald F. Uelmen*

On November 5, 1996, California voters approved an initiative measure known as the Compassionate Use Act of 1996.[1] Calif. Health & Safety Code § 11362.5. It declared three primary purposes:

1. To ensure that seriously ill Californians have the right to obtain and use cannabis for medical purposes where medical use has been approved by a physician;
2. To ensure that patients and their primary caregivers who obtain and use cannabis for medical purposes with the approval of a physician are not subject to criminal prosecution or sanction;
3. To encourage the federal and state governments to implement a plan to provide for safe and affordable distribution of cannabis to all patients in medical need.

The purpose of this article is to assess our progress in achieving these laudable goals. During the past eight years, I have been directly involved in five major

[1] At least eight other states have since passed similar laws. *See* Alaska Stat. Ann. §§ 11.71.090, 17.37.010 to 17.37.080; Arizona Rev. Stat. § 13-3412.01; Colorado Const. art. XVIII, § 14; Hawaii Rev. Stat. §§ 329-121 to 329-128; Maine Rev. Stat. Ann. Tit.22, § 2383-B5; Nevada Const. art. 4, § 38; Oregon Rev. Stat. §§ 475.300 to 475.346; Washington Rev. Code §§ 69.51A.005 to 69.51A.902.

cases in both state and federal court,[2] representing patients, caregivers and collectives seeking to implement the Compassionate Use Act, and have served on a statewide Task Force assembled by Attorney General Bill Lockyer to craft implementing legislation which was enacted in 2003. Calif. Health & Safety Code §§ 11362.7 to 11362.9. Like many of my fellow Californians, I have also witnessed first-hand the remarkable therapeutic benefits of medical use of cannabis for a close relative struggling through a very painful death. I have no doubts whatever that all of the goals of the Compassionate Use Act will ultimately be achieved. The only question is how long it will take to overcome the intransigence of elected representatives and government officials who are burdened with the baggage of our "War on Drugs." Nearly every drug which a doctor can lawfully prescribe has been diverted and abused by addicts and recreational drug users, yet widespread abuse of such drugs has never led us to foreclose their availability to those who are sick, and whose physicians approve their use. A doctor can prescribe cocaine to anesthetize, and morphine to relieve pain, even though the consequences of abuse of these drugs may be fatal. No one has ever died from an overdose of cannabis, and the potential adverse effects of its use will frequently be far outweighed by its benefits for patients already facing life-threatening illness.

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[2] *United States v. Oakland Cannabis Buyers Cooperative,* 532 U.S. 483 (2001); *People v. Baez,* 79 Cal.App.4th 1177 (2000); *People v. Mower,* 28 Cal.4th 457 (2002); *County of Santa Cruz v. Ashcroft,* 279 F.Supp.2d 1192 (N.D. Calif. 2003), *Motion for Reconsideration Granted,* 314 F.Supp.2d 1000 (2004); *Wo/Men's Alliance for Medical Marijuana v. United States,* --- F.3d ---, 2004 DJDAR 7349 (9th Cir. 2004).

1. The right to obtain and use cannabis for medical purposes.

The chief obstacle to full implementation of the right to obtain and use cannabis for medical purposes has been the federal Controlled Substances Act [CSA], which Congress enacted in 1970. 21 U.S.C. § 801 *et seq.* In enacting the CSA, Congress placed marijuana on Schedule I, reserved for drugs for which there is no "currently accepted medical use." 21 U.S.C. § 811. In *United States v. Oakland Cannabis Buyers Cooperative,* 532 U.S. 483 (2001), the U.S. Supreme Court rejected the argument that a common law defense of necessity could be asserted by those seeking to make cannabis available to patients who have no other alternative means of relieving serious pain, suffering and death. The case did not directly present the rights of patients themselves to possess and use medical cannabis, but only the rights of those seeking to provide the cannabis to the patients. Nonetheless, over the protests of three concurring Justices,[3] the Court broadly rejected any exceptions to the complete prohibition of possession or cultivation if cannabis for *any* purpose except a government-approved research project.[4] The Court expressly left open the underlying challenge to the constitutionality of the CSA, however. *Id.* at 494.

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[3] *See* Concurring Opinion of Justice Stephens, joined by Justices Ginsberg and Souter, 532 U.S. at 499-503.

[4] The majority chose to ignore the fact that the federal government itself operated a compassionate use program to supply medical marijuana to 82 patients between 1977 and 1992, and that Congress was informed this was NOT a research program. When the Compassionate Investigative New Drug program was closed to new applicants, federal

The constitutionality of the CSA as applied to patients who possess and use cannabis for medical purposes in full compliance with California's Compassionate Use Act has since been presented to the U.S. Court of Appeals for the Ninth Circuit in three cases. In *Raich v. Ashcroft,* 352 F.3d 1222 (9th Cir. 2003), the court applied the four factor test for determining whether a regulated activity "substantially affects" interstate commerce,[5] and ruled that the CSA was unconstitutional as applied to the activity of two patients engaged in the cultivation and use of cannabis for medical purposes. One of those patients, Angel McClary Raich, was unable to cultivate her own cannabis, and relied upon two caregivers to grow it for her, and provide it to her free of charge. The *Raich* court concluded that the intrastate, noncommercial cultivation, possession and use of marijuana for personal medical purposes on the advice of a physician did not substantially affect interstate commerce, thus the inclusion of this class of activity under the CSA exceeded the constitutional authority of Congress to regulate interstate commerce. It is important to note that, although the delivery of medicinal marijuana to Angel McClary Raich by her caregivers would technically qualify as "distribution" under

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authorities agreed to continue supplying the patients who were enrolled. Four of them are still alive, and receive a monthly allotment of marijuana from the United States government. *See* Brief for the Respondents, *United States v. Oakland Cannabis Buyers' Cooperative,* U.S. Supreme Court No. 00-151, at pp. 28-31.

[5] *See United States v. Morrison,* 529 U.S. 598 (2000).

the CSA, [6] the *Raich* Court noted that federal authority under the commerce power would not treat all deliveries as "commerce":

> Although the Doe appellants are providing marijuana to Raich, there is no "exchange" sufficient to make such activity commercial in character. As Raich states in her declaration: "My caregivers grow my medicine specifically for me. They do not charge me, nor do we trade anything. They grow my marijuana and give it to me free of charge."

352 F.3d at 1230, n.3. The *Raich* Court also make it clear that the "aggregation principle" of *Wickard v. Filburn,* 317 U.S. 111 (1942), whereby the cumulative effect of economic activity is aggregated to assess the effect upon interstate commerce, has no application to cultivation and use of medical marijuana pursuant to a physician's recommendation, because such activity is neither commercial nor economic. Moreover, unlike the wheat in *Wickard v. Filburn,* the marijuana at issue was non-fungible, since its use was personal and there was no intention to exchange it or acquire marijuana from others in a market. The government's Petition for Certiorari to have the U.S. Supreme Court review *Raich* was granted on June 28, 2004, so the case will be heard during the coming term.

Whether the rationale of *Raich* can also be applied to patients who are collectively assisting each other in cultivating marijuana for their medical use was

[6] The CSA defines the term "distribute" to mean "to deliver (other than by administering or dispensing) a controlled substance . . ." 21 U.S.C. § 802 (11).

presented to the Ninth Circuit in two other cases. In *United States v. Oakland Cannabis Buyers' Cooperative,* on remand from the U.S. Supreme Court, District Court Judge Charles Breyer rejected the defendants' challenge to the breadth of an injunction that would prevent any cultivation or distribution of cannabis by the Cooperative, even under circumstances identical to the cultivation by Angel McClary Raich's caregivers. In *Wo/Men's Alliance for Medical Marijuana,* a Rule 41(e) Motion for Return of seized property, seeking return of medical cannabis seized by D.E.A. Agents from a Santa Cruz hospice cooperative, was denied by District Court Judge Jeremy Fogel. The appeals in both of these cases were consolidated for argument before the Ninth Circuit, but after submission another Ninth Circuit panel decided the *Raich* case. The Court requested supplemental briefing on the applicability of *Raich* to these two appeals, then remanded them both to the District Court, saying: "The issues in *Raich* may control the outcome in this case. Accordingly, this case is remanded for the district court to reconsider after the Supreme Court has completed its action in *Raich.*" 2004 DJDAR 7349, 7350 (2004).

Meanwhile, however, the Wo/men's Alliance for Medical Marijuana, joined by the City and County of Santa Cruz, filed a civil suit seeking to enjoin John Ashcroft and the D.E.A. from interfering with their intrastate, noncommercial cultivation and use of medical marijuana. The case was assigned to District Judge

Jeremy Fogel, and consistent with his ruling denying the previous Rule 41(e) Motion, he denied the plaintiff's motion for preliminary injunction and granted the government's motion to dismiss. *County of Santa Cruz v. Ashcroft,* 279 F.Supp.2d 1192 (N.D. Calif. 2003). But after the Ninth Circuit decision in *Raich* came down, the plaintiffs moved for reconsideration, and Judge Fogel granted the motion and issued a preliminary injunction to prevent federal interference with W.A.M.M.'s activities. He explained:

> [W]hile it is true that the plaintiffs in *Raich* were individuals, rather than a collective, the lead plaintiff in that case – Angel McClary Raich – was assisted by others in growing her plants. Thus, the fact that some WAMM members require assistance – because they may be physically unable to grow, cultivate or process the plants because of the advanced stage of their illness – is immaterial to the present legal analysis. The only difference between this case and *Raich* is the existence of a collective. In both cases, whether the use of medicinal marijuana is facilitated by a collective or by friends, such use remains limited to personal *noncommercial* medical purposes.

Order Granting Plaintiff's Motion for Reconsideration, 314 F.Supp.2d 1000.

Thus, the right to obtain and use cannabis for medical purposes in California has achieved more limited protection against federal interference than against state

interference. California state law broadly exempts patients and their caregivers from the prohibitions against cultivation and possession of marijuana with the recommendation or approval of a physician, and it does not preclude commercial support for this activity. *See People ex rel. Lungren v. Peron,* 59 Cal.App.4th 1383, 1400 (1997) ("A primary caregiver who consistently grows and supplies physician-approved or –prescribed medicinal marijuana for a section 11362.5 patient is serving a health need of the patient, and may seek reimbursement for such services."). California law also now gives specific approval to collective and cooperative cultivating activity, extending protection for such activity even to transportation and distribution or sale of marijuana. Calif. Health & Safety Code, § 11362.775. Under *Raich,* however, even as extended to collectives in *County of Santa Cruz v. Ashcroft,* protection against federal enforcement efforts under the CSA is limited to *noncommercial* activity.

2. Immunity From Criminal Prosecution or Sanction.

The earliest California cases construing the Compassionate Use Act interpreted the law to create an "affirmative defense" which could be asserted by a patient at trial. In *People v. Mower,* 28 Cal.4th 457 (2002), however, the California Supreme Court ruled that the Compassionate Use Act confers limited immunity from prosecution upon patients and their caregivers. The difference can be significant. The defendant bears the burden of proving an affirmative defense by a

preponderance of the evidence. When asserting immunity, however, the defendant need only raise a reasonable doubt. In addition, immunity can be asserted and litigated on a pretrial motion to dismiss the charges. The *Mower* Court concluded that a motion pursuant to California Penal Code § 995 was appropriate to raise the issue prior to trial: " To prevail, a defendant must show that, in light of the evidence presented to the grand jury or the magistrate, he or she was indicted or committed 'without reasonable or probable cause' to believe that he or she was guilty of possession or cultivation of marijuana in light of his or her status as a qualified patient or primary caregiver." *Id.* at 473. The Court noted that the defendant's status as a qualified patient or primary caregiver would be exculpatory evidence a prosecutor is required to present to a grand jury under Calif. Penal Code § 939.71, and that the defendant himself could offer exculpatory evidence of his status at a preliminary hearing. *Id.* at 473, n.5. More recently, in *People v. Konow,* 32 Cal.4th 995 (2004), the California Supreme Court ruled that a superior court ruling on a §995 motion can set aside an information charging marijuana distribution by a medicinal supplier on the ground the magistrate erroneously failed to consider whether to dismiss the complaint under Penal Code § 1385.

While recognizing that the limited immunity from prosecution conferred by the Compassionate Use Act could be asserted by a defendant to prevent prosecution, the *Mower* Court noted the statute did *not* confer immunity from

arrest. Thus, a legitimate patient with a physician's authorization found in possession of marijuana might still be subjected to arrest, if the arresting officer has probable cause that the authorization is invalid or the amount possessed exceeds the patient's medical needs. Under these circumstances, the arresting officer could simply say, "Tell it to the judge." This anomaly was addressed by the California legislature in S.B. 420, enacted in 2003 to add Sections 11362.7 through 11362.9 to the California Health & Safety Code. The statute creates a voluntary statewide registry for patients and caregivers. Those who submit "written documentation by the attending physician in the person's medical records stating that the person has been diagnosed with a serious medical condition and that medical use of marijuana is appropriate" will be issued an identification card. Calif. Health & Safety Code § 11362.715(a)(2).[7] One who has a valid registration card is immune from arrest pursuant to Calif. Health & Safety Code § 11362.71(e), which provides:

> No person or designated primary caregiver in possession of a valid identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount established pursuant to this article, unless there is reasonable cause to believe that the

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[7] It should be noted that the protection afforded by the voluntary registry is thus not available to all patients who are protected by the Compassionate Use Act. The Compassionate Use Act also protects patients who have oral approval of a physician, and many physicians are reluctant to prepare the kind of record the registry law requires.

> information contained in the card is false or falsified, the card has been obtained by means of fraud, or the person is otherwise in violation of the provisions of this article.

In establishing the quantitative amounts a card-carrier could possess, however, a major drafting glitch introduced some confusion into the California Health & Safety Code. S.B. 420 enacted Section 11362.77(a), which now provides:

> A qualified patient or primary caregiver may possess no more than eight ounces of dried marijuana per qualified patient. In addition, a qualified patient or primary caregiver may also maintain no more than six mature or 12 immature plants per qualified member.

Since "qualified patient" is defined to mean a person who is entitled to the protections of Section 11362.5 (The Compassionate Use Act), but who does not have an identification card, Calif. Health & Safety Code § 11362.7(f), this provision could be construed to restrict *all* patients protected by the Compassionate Use Act to the quantitative limits stated. Such construction would render Section 11362.77(a) unconstitutional, since the legislature cannot amend an initiative measure. What was obviously intended was to apply these quantitative limits to registered card carriers seeking immunity from arrest. *Cf.* § 11362.71(e). The confusion would have been removed by Senate Bill 1494, which was vetoed by

Governor Arnold Schwarzenegger on July 19, 2004. It would have amended Section 11362.77(a) to read:

> A qualified patient, a person with an identification card, or any designated primary caregiver may possess any amount of marijuana consistent with the medical needs of that qualified patient or person with an identification card.
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> (b)(1) A person with an identification card or a primary caregiver with an identification card shall not be subject to arrest for possession eight ounces or less of dried marijuana per person with an identification card, and maintaining six or fewer mature or 12 or fewer immature marijuana plants per person with an identification card.
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> (b)(2) Nothing in this section is intended to affect any city or county guidelines to the extent that the amounts contained in those guidelines exceed the quantities set forth in paragraph (1).

The Governor's veto leaves California Health & Safety Code Section 11362.77(a) vulnerable to constitutional attack. It should be construed to apply only to card-holders asserting immunity from arrest, as it was intended. If it is construed to place an absolute limit upon the amount of marijuana any patient can possess under the Compassionate Use Act, it will be unconstitutional because it amends the Compassionate Use Act, which was enacted by popular initiative. The Compassionate Use Act contains no limit on the amount of marijuana a patient

may possess, and the courts have construed it to allow cultivation or possession of any amount reasonably necessary for the patient's medical needs. The California constitution prohibits the amendment of initiative measures except by another subsequently enacted initiative, unless the initiative being amended itself authorizes legislative amendment. Calif. Const., art. II, Section 10(c). The Compassionate Use Act contains no such authorization.

Thus, through judicial construction and amendment, the goal of the Compassionate Use Act to ensure patients and primary caregivers are not subject to criminal prosecution or sanction, has achieved limited success. Patients and caregivers are protected by limited immunity which can be asserted prior to trial as well as at a trial, but immunity from arrest is available only to those who register and obtain an identification card, and only for the quantitative limits contained in Calif. Health & Safety Code § 11362.77.

3.Federal and State implementation of a plan for safe and affordable distribution.

The third goal of the Compassionate Use Act may seem the most remote, in light of the brick walls federal authorities have erected, but it is not too early to start thinking about potential plans for safe and affordable distribution. One possible model is the one being implemented in Canada, which deserves our closest attention. For the official government explanation of the Canadian plan,

visit the website at http://www.hc-sc.gc.ca/english/protection/marijuana.html. Briefly, it permits patients who receive government authorization to possess a thirty day supply, and to grow their own if they receive a "Personal Use Production License." Such a license can also be granted to a designated person who will grow the marijuana for the patient. Government grown medical marijuana is available from Health Canada and through pharmacies, but the poor quality of the government grown product has led nearly one-third of the patients receiving it to send it back. The contractor the government hired to produce the product is in the fourth year of a $5.5 million contract, and has shipped 279 ounces, at a cost to Canadian taxpayers of $16,000 per ounce! *See* www.medicalmarijuana.ca. It would be interesting to compare these figures with the cost to the United States government of supplying the four patients left in the Compassionate I.N.D. program with their monthly supply. Ultimately, government production of medical marijuana may prove to be too costly, and is unlikely to supply a quality product.

If marijuana were rescheduled to Schedule II, private manufacturers could be licensed to produce it and supply it to pharmacies, where it would be available by prescription. There seems to be little interest in supplying this market on the part of major pharmaceutical companies, however. When they balance the cost of producing and marketing against the competition from backyard growers, they apparently don't see economic viability in this enterprise. Thus, the plan with the

best prospect of success would seem to be government licensing of enterprises like the cannabis clubs and cooperatives that have proliferated throughout California. Here again, California is leading the way with its explicit recognition of the legitimacy of collectives and cooperatives in Calif. Health & Safety Code § 11362.775.

It should also be noted that the immunity for local government officials contained in Section 885(d) of the federal CSA may still offer the possibility of lawful distribution of medical marijuana even without federal approval. While this possibility was rejected by Judge Breyer in *United States v. Rosenthal,* 266 F.Supp.2d 1068 (N.D. Calif. 2003) and by Judge Fogel in *County of Santa Cruz v. Ashcroft,* 279 F.Supp.2d 1192 (N.D. Calif. 2003), it has not yet been reviewed by the Ninth Circuit Court of Appeals or any other appellate court. The issue may be reached in the pending appeal of Ed Rosenthal's conviction. Both Oakland and Santa Cruz "deputized" the operators of collectives to take advantage of the immunity clause.

Conclusion.

The legal struggle for medicinal cannabis in California has proceeded in incremental stages, but after eight years of struggle, we appear closer than ever to full achievement of the goals of the Compassionate Use Act. The key element in this success is unquestionably the overwhelming level of public support for this

endeavor. In its 1999 Report, *Marijuana and Medicine: Assessing the Science Base,* the Institute of Medicine reported that public opinion polls generally demonstrate 60-70 % of respondents favored allowing medical use of marijuana. In California, that public support is manifested in overwhelming support by local government officials and law enforcement agencies for cooperatives like Wo'Men's Alliance for Medical Marijuana in Santa Cruz and the Oakland Cannabis Buyers' Cooperative in Oakland. The outcome of the *Raich* decision will be pivotal, but may not be the final word. If the U.S. Supreme Court affirms the Ninth Circuit, it may open the door to limited efforts to supply patients within a tightly closed non-commercial cooperative. If the high court rejects the *Raich* ruling, there will still be other constitutional challenges to be mounted, including the assertion of a substantive due process right of access when cannabis provides the only available relief from severe pain and disability.