

Truth vs. Fact: Federalism, Medical Marijuana, and the Rights of States

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Introduction

During roughly the last fifteen years, many changes in drug policy have occurred between the states and the federal government. Many states and cities have been trying new techniques to solve the nation's drug problems, mainly because the federal government's policy of prohibition with no treatment has failed. One area that has become increasingly controversial throughout the years is the issue of marijuana and whether or not it holds any type of medical value. Under our federal government's current drug policy, marijuana is seen as an illicit drug that has no type of medical value whatsoever. This is contradicted by many states, counties, and cities, which have enacted medical marijuana laws, or have at least recognized the medical value of marijuana through certain pieces of legislation. Despite some of these actions to try and liberalize medical marijuana laws, the federal government has been adamant in its stance to reject the states' ability to regulate medical marijuana laws as they see fit.

According to a 2003 Zogby poll, two out of every five Americans say that marijuana should be regulated in the same way that alcohol currently is (Nadelmann, National Review). When asked about medical marijuana, the country is even more supportive, with 70 percent of respondents in a Center for Substance Abuse Research poll agreeing that medical marijuana should be allowed in America. Other national and state polls done by a number of different research centers have also come to similar conclusions, with between 70-80 percent of all Americans approving of marijuana's usage for medical purposes. While the federal government has been fairly consistent in its stance, polls are showing that more and more people are becoming accepting of marijuana when used as a medicine. Because metropolitan areas are greatly affected by federal drug policy as well as those who are sick and in need of helpful medicine, cities have an obligation to provide medicine to those who need it. Despite the pleas of the sick, the elderly, and many in the medical community, the federal government has continued to ignore, as well as arrest those who have a desire and need to use medical marijuana.

As this paper will examine, medical marijuana has a broader issue at stake, and that is the issue of federalism and the state's right to regulate health policy, with specific concern to marijuana. Because it is a fairly taboo issue, the federal government continues to violate patient's rights under state law, and continue to insist that marijuana is a drug that will not help them. This is unfortunate because many people, who have to live with a variety of different diseases, are consistent in their pleas that marijuana does indeed help them. It is also interesting to point out that the people who are using medical marijuana come in all shapes and forms, and include many people like the elderly, who are not commonly seen as medical marijuana users. This is important because there is an argument used by opponents of medical marijuana that those who choose to use marijuana are really just trying to legalize the drug for recreational use. While this viewpoint may hold true for certain, select individuals, the oppositional argument does not seem to hold true across the board for the majority of patients utilizing medical marijuana.

In this paper, federalism and the problems that the federal government creates for city governments, specifically in the handling of drug policy will be examined. Since 1996, eleven states have enacted medical marijuana laws, causing the federal government to take a proactive stance in its position to not allow a medical marijuana exception. The federal government's stance is rooted in the 1970 Controlled Substance Act, which makes the prescription of

marijuana illegal. My hypothesis is that increases in federal government regulatory power over marijuana lead to a decrease in local government autonomy to develop and implement locally-based programs dealing with the medical usage of marijuana. For this analysis, city problems include seriously ill patients who are helped by marijuana, and large populations of people with a variety of different diseases whom desire medical marijuana but are unable to use it out of fear of the federal government. Because most of the medical marijuana bills have been passed through ballot initiatives with fairly large majorities, under current federal law the state and the city is unable to fully meet the wishes of the voters. As a result of federal law going against what many cities are trying to enact, the process of setting up safe medical marijuana programs proves to be more problematic than certain cities would like. While this study does not go into great detail about the specific programs that are administered by the cities, the lack of city autonomy when dealing with this issue certainly seems to undermine the cities' ability to be successful in the implementation of desired programs. Because individuals in different parts of the country, even within states, feel very differently about the issue at-hand, I will argue that drug policy is best handled by cities, at least when dealing with the narrow issues of legalizing marijuana for medicinal purposes.

Concepts of Federalism under the Rehnquist Court

While most of the federalism cases decided under the Rehnquist court deal with the relationship between federal and state governments, the end result does seem to be one that affects cities as well. The reason behind this is if the state is given more power to rule in a certain area as a result of a particular decision, the state then can delegate power to the cities, as California has been trying to do with the issue of medical marijuana. Because certain federalism cases can have an indirect impact on cities, it is important to see where the Rehnquist court stands on issues that deal with the power of the federal government to control the states. With the landmark decisions of two cases during the spring of 1995, the Supreme Court under Chief Justice Rehnquist laid down rulings that exemplify the confusion and indecisiveness that can occur when deciding legal issues of federalism. In the important case of *United States v. Lopez* (1995), a narrow five to four majority declared that a congressional act that limited the use of handguns in and around schools was unconstitutional because it violated the commerce clause of the US Constitution. In the majority opinion written by Chief Justice Rehnquist, the court pronounced that a federal law banning guns from schools was inappropriate because it “neither regulates a commercial activity nor contains a requirement that the possession be connected in any way to interstate commerce”(642).

A month after *Lopez*, the Supreme Court in the case of *United States Term Limits v. Thornton* (1995) ruled that state ballot restrictions to limit the terms of US Congressmen were unconstitutional because they violated the supremacy powers of the federal government. Taking *McCulloch v. Maryland* (1819) into consideration, the majority opinion written by Justice John Paul Stevens “equates Arkansas’s claim to restrict the terms of congressional candidates with Maryland’s claim to tax a national bank” (Colluci, 128). Looking mainly at the Marshall Court, the liberal and conservative members tend to disagree on how much power the federal government should be able to hold over the states. When dealing with issues of drug policy, especially when examining the legalization of medical marijuana, the issue does not get any simpler.

In the majority opinion of *Lopez*, Rehnquist declares that the federal government's powers are derived from individuals in the states, who hold all original powers not specifically ceded during the ratification of the Constitution (Colucci, 131). Furthermore, Justice Thomas in the dissenting opinion of *US Term Limits* exclaims that when the Constitution is silent on a specific issue, congress cannot limit the rights of the States or the people (926). With the conservative voting bloc of Chief Justice Rehnquist, Clarence Thomas, Antonin Scalia, Sandra Day O'Connor and occasionally Anthony Kennedy, the court has been known to be an advocate of "new federalism," a principle that is based on "conservative activism, that seeks to limit federal authority and return power back to the states" (Gostlin, 26). While many cases have been decided on the merits of this concept, we will see that this idea of new federalism is hardly applied equally to all cases, and not always supported by the conservative block.

Besides upholding or striking down congressional laws that interfere with the rights of states through the commerce clause, the Tenth Amendment has also proven to be effective at upholding states rights. In the case of *New York v. United States* (1992), the court held in the majority opinion by Justice O'Connor that Congress cannot "legislate in a manner that commandeered state legislative processes" (Tolley and Wallin, 19). Basing this decision on the commerce clause in conjunction with the Tenth Amendment, the Court in *New York* recognized that there are limits on the federal government's ability to regulate and influence the states. In *Printz v. United States* (1997), the court also used the Tenth Amendment to overturn provisions of the Brady Bill, which mandated state and local law enforcement officers to provide background checks for all potential handgun owners (Gostin, 26). This concept of "coercive federalism," or the idea that congress can "commandeer" the states to do what the federal government wants has been limited by the decisions in *Lopez*, *Printz*, and *New York*.

While it should be noted that no cases were overturned in *Lopez*, certainly the decision in that case marked a shift in focus for the court in considering what is the appropriate use of power for the federal government. Along with *Lopez* and a slew of other cases, the Rehnquist court has garnered attention by using the commerce clause, the tenth, and the eleventh amendments to strike down many acts of congress (Dinan, 1). Since the New Deal this has been a rare occasion, with past courts frequently upholding Congresses power to regulate the states through the commerce clause. Scholars alike have suggested that the original meaning of the commerce clause was to "empower Congress to regulate trade between and among the States" (Bork and Troy, 851). So while the term 'regulate' can mean the prohibition of certain actions, it is ultimately up to the courts to decide on what it is that can actually be regulated (Bork and Troy, 861).

According to Bork and Troy, it is also of issue to determine the correct definition of commerce, an issue that is brought up by advocates of medical marijuana. Looking at the words of the Federalist Papers, it is noted that the word commerce is never used beyond the definition of trading or exchanging goods (Bork and Troy, 857). Bork and Troy also look at a letter written in 1828 by Madison in their search to find a definitive meaning of the commerce clause, and it is noted that Madison consistently replaced the word commerce with trade, as in Congress is given the power to regulate trade (857). Looking at framers' intent is important, because it is a commonly used method by the Supreme Court, as Rehnquist demonstrates in *Lopez*, where he

refers to one of James Madison's writings in which he writes, "[t]he powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the state governments are numerous and indefinite" (115 S. Ct. 1624, 1626).

The rulings of the Rehnquist court coincide with Agranoff and McGuire's study on how the federal system has been changing in recent years (671). Because of the reemergence of state powers through Rehnquist court decisions, new models of management have had to be enacted to deal with these changes. Charles R. Wise concurs that "judicial federalism has signaled a shift in the legal basis of intergovernmental relations, and thus a shift in the environment of public administration as well" (Wise, 343). Wise also confirms that the Rehnquist court has taken on a role as protector of the states, against unnecessary federal encroachment (Wise, 95). Because the federal government took on such a powerful role between the 1930's and the 1980's, the imbalance of federalism did not represent the constitutional foundations on which federalism is based on (Walker, 271). The Rehnquist court has made attempts to make federalism healthy again by ending ambiguities between what is a federal power and what is a state power, and this in the long run allows each of the levels of government to run in a more effective manner (Walker, 271). Whether or not the court will apply this train of thought to the issue of medical marijuana is one that is yet to be seen.

Medical Marijuana

Several cases have been decided in recent years that help clarify the issue of state and local rights in concern to being able to legalize marijuana for medicinal purposes. Before discussing the specific issue of medical marijuana, it is important to look at the federal statute that is question by the states. The Controlled Substance Act of 1970 ("CSA"), was enacted through the commerce clause, and makes it illegal to "manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance (Herman 121,122, Muldrew, 371, Schneider, 11). In addition, the CSA established five different "Schedules" that were used to classify drugs, with a "Schedule I" meaning that the drug may lead to addiction, and in addition has no medical value (Herman, 122). Along with drugs such as heroin, cocaine, and LSD, marijuana was given a Schedule I classification by Congress. Because Schedule I drugs are highly regulated by Congress, physicians are not allowed to prescribe Schedule I substances, although they are allowed to prescribe and distribute substances with Schedule levels of II through V (Herman, 122).

Since many of the court cases have stemmed from California, it is appropriate to talk about the role California has played in the fight for states to legalize medical marijuana. In 1996 with passage of Proposition 215, also known as the "Compassionate Use Act," seriously ill Californians were given the right to possess marijuana without prosecution, if they had a recommendation from their physician (Herman, 122). Under the CSA, a physician must obtain registration from the Drug Enforcement Agency in order to prescribe controlled substances (Christenson, 174). If the DEA finds out that the physician is violating this act, the CSA gives the DEA the right to revoke the physician's medical license. Because Proposition 215 goes directly against the CSA, there has been a lengthy and blurry battle on whether or not the states have the right to legalize medical marijuana. Since California passed Proposition 215, ten other states have also passed medical marijuana statutes (Alaska, Arizona, Colorado, Hawaii, Maine,

Montana, Nevada, Oregon, Vermont, and Washington) with 35 other states passing legislation to recognize marijuana's medicinal values (Mears, 1).

Within two months of the passing of Proposition 215, the White House Office of National Drug Control Policy issued a statement, which said that physicians prescribing marijuana was not in the general public's interest, and would lead to the revocation of physicians medical registrations if continued (Christenson, 175, Herman, 124). In addition, the Clinton Administration (and since the Bush Administration) was adamant in their opinion that California's legalization of medical marijuana did not change federal drug laws (Shneider, 11). On February 27, 1997, the government also sent a letter to all "national, state, and local practitioner associations, clarifying its position" that it is illegal for any physician to even discuss the benefits that marijuana can provide with their patients (Christenson, 175).

The failure of the government to recognize marijuana's medicinal value blatantly ignores "public opinion and scientific fact," which is why it is so surprising to many physicians (Capital Hill Testimony, Claudia Jensen, M.D.) Even government funded scientific reports published in the Institute of Medical Report and the National Institutes of Health Report claim "that it is highly likely that smoked marijuana has some analgesic activity in some kinds of clinical pain" (NIH Report, Congressional Hearing). Because of this statement, Dr. Claudia Jensen in her testimony to congress on April 1, 2004, makes a valid point that marijuana does in fact have medical value, and therefore is wrongly classified as a "Schedule I" substance. This is quite significant considering that many physicians, including Dr. Jensen, have been threatened, investigated, and in some cases had their medical licenses revoked because of their willingness to prescribe marijuana.

The federal government's opposition to physicians prescribing marijuana hurts everyone, including poor local areas that are dependent on physicians. Dr. Jensen provides a good example for this, because she works at a clinic that mainly services a poor population, which would be devastated if her license was to be revoked. Another example stems from Dr. Neil M. Flynn, a professor at the University of California- Davis, and owner of a clinic, which specializes in HIV/AIDS treatment. With the dangers of having his "Schedule II" license taken away, he would be unable to care for his patients with AIDS, which is 80 percent of his patients. Dr. Flynn is one of the petitioners in the case of *Conant et al. v. Walters et al.* (2002), and his testimony was used to give a different perspective on the government's decision to take away medical licenses.

The facts in *Conant v Walters* are quite interesting and demonstrate California's willingness to express state sovereignty. After the passing of Proposition 215 and the actions taken by the government to revoke medical licenses, two organizations filed suit together to stop the government's actions. The first group is a patient's organization called Being Alive: People With HIV/AIDS Action Coalition, Inc., and the second is a physician's organization called the Bay Area Physicians for Human Rights. In the decision for the 9th Circuit Court of Appeals, the majority held that the federal government could not revoke the licenses of physicians who recommend marijuana for their patients (Christenson, 174). While the federal government wanted the decision to be upheld in their favor based on the First Amendment, the court instead rested their decision on the principles of federalism. Using Steven's concurrence in *Oakland*

Cannabis Cooperative v. U.S., the court acknowledged that the federal government must respect the sovereignty of the states, especially in an instance where the citizens decide themselves “to serve as a laboratory in the trial of novel and economic experiments without risk to the rest of the country” (532 U.S. 501). On June 7, 2003 the government attempted to appeal the case of *Conant* to the Supreme Court by filing a writ of certiorari. On October 14, 2003 the Supreme Court denied writ without comment, protecting in the mean time doctors in the Ninth Circuit who recommend and prescribe marijuana to their patients (Christenson, 178).

Methodology

Studying the impact and effects that medical marijuana has had on cities is not without problems, because a majority of the states with laws legalizing medical marijuana have not been able to freely delegate power to cities to regulate medical marijuana usage. The opposition of the federal government has instilled fear upon the states, which in turn limits the city’s ability to establish safe facilities without fear of legal repercussions. So while some cities have chosen to enact their own laws pertaining to medical marijuana, many cities who want to establish medical marijuana programs are not going to have this opportunity, primarily because of state law. Considering these facts and the lack of research available on most cities, this paper is going to mainly deal with California cities, which have been given an extraordinary amount of power in dealing with medical marijuana by California law. While other cities will be referred to as necessary cross examination points, cities in California provide a unique perspective on the cities right to legalize marijuana for medicinal purposes.

The main cities that will be explored in this analysis are the cities in California which have been the most active or vocal in their pursuit to legalize medical marijuana. California is also an interesting case because no other state has had as much resistance or attention paid to it by the federal government (Anderson, 2). Case studies will be conducted on a variety of California cities that include: Oakland, Berkeley, San Francisco, Santa Cruz, and San Diego, all of which have been very supportive in the quest to legally establish marijuana as a medicine. Due to space constraints, a bulk of the attention for this paper will deal with the Bay Area cities, which have garnered the most attention of the country, and therefore have the most research available.

Because of the lack of scholarly research done on this subject in regards to cities, the case studies will be supported by using a variety of different sources including: newspaper articles, city websites, local ordinances, NORML newsletters, court rulings, and government agency studies. This data allows thorough analysis on what cities are trying to do in conjunction with state and federal law, and demonstrates the difficulties that cities may or may not face when dealing with medical marijuana. While some cities have done more than others in their pursuit to establish marijuana as a viable, legal drug, it is important to note than other cities in California such as Rancho Cordova and Rocklin have not been as supportive. Because of the lack of support for medical marijuana, these cities have chosen to establish ordinances that outlaw cannabis clubs, which distributes the marijuana to the sick (Longley, US Government Info). According to the California chapter of the National Organization for the Reform of Marijuana Law’s newsletter, other cities have also made attempts to limit or eliminate cannabis clubs through the use of zoning restrictions or strict regulations.

While the focus of this study is limited to one state, it is not without merit when one considers that California tends to be a leader of trends in many different areas of public policy around the country. Whether the issue is smoking cigarettes in public buildings, pledge of allegiance issues in public schools, or stricter EPA standards for automobiles, California has proven to be a leader when it comes to establishing unprecedented pieces of legislation. The issue of medical marijuana is no exception, with California becoming the first state to enact a medical exception for marijuana usage, and other states soon following thereafter. As of November 2, 2004, Montana became the newest state to enact medical marijuana laws through a ballot initiative, with Oregon also passing a new amendment to further liberalize their existing medical marijuana policy. By focusing on California cities, one might be able to more adequately forecast a prediction on what is to come of other cities, in states that have legalized medical marijuana.

Cannabis Cooperatives and the case of Oakland

Considering that the Supreme Court failed to decide on the case in *Conant*, there is still a blurry line on the extent to which cities and states can legalize marijuana for medical reasons. Perhaps if the court would have decided on the issue, they could have clarified the federal government's correct role in their decision to intervene with states rights. While Stevens concurrence was used in *Oakland Cannabis Cooperative*, the case itself is quite unsettling because it was not ruled on the principles of federalism, a surprising phenomena based on the reputation of the Rehnquist Court. Instead of even considering the federalism issue, Justice Thomas, one of the staunchest advocates of states rights, declared that there was "no medical exception to the CSA," because of the clear language written in the act (Herman, 121). By not even considering the issue of whether or not Congress exceeded its boundaries by passing the CSA, the court is not seen as being consistent in their rulings, which results in a lot of confusion and bitterness today.

Looking at the city of Oakland, one can see that the city has truly led the way for the medical marijuana movement amongst cities, by being the first city in the nation in 1998 to name Oakland Cannabis Buyers' Cooperative employees "as officers of the city" (Alcoholism and Drug Abuse Weekly, 7). By making them officers, the cooperative employees were given a status much like that of an undercover cop, who cannot be arrested for selling illegal drugs while on official duty. In addition, Oakland continued to run cooperatives throughout the late 90's, when many were folding around the country due to government pressures (Alcoholism, 7). Besides allowing cannabis cooperatives to run freely, Oakland allowed its residents who were prescribed medical marijuana to possess up to 675 grams of marijuana for "personal use," an amount that can carry a significant amount of jail time in other states and cities (Alcohol, 7). As previously mentioned, Oakland cannabis cooperatives were respondents in a 2001 Supreme Court case in which an eight member majority decided that there was no medical marijuana exception to the CSA, in effect making cannabis cooperatives illegal under federal law (Herman, 121).

While the cooperatives still continue to operate with the support of most of the city, the decision preventing physicians from recommending marijuana was essentially overturned by the

Supreme Court's decision to not hear the case of *Conant*, although this only holds for the states under Ninth Circuit Court of Appeals (Christenson, 174). The willingness of Oakland to allow cannabis cooperatives has not been without troubles, which is why some cities in California have not chosen to support cannabis clubs. In order to prevent shady operations from thriving in Oakland where a number of clubs were acting unethically by taking advantage of people, the city council in May, 2004 limited the amount of cannabis dispensaries that are allowed to operate in Oakland to four (Bender, 1). In addition, residents in Oakland recently passed ballot measure Z on November 2, 2004, with 64.3 percent of the vote (S.F. Chronicle, B8). Under measure Z the city is required to lobby the state to legalize marijuana possession for adults, as well as directing the city to set up a system to regulate and tax cannabis, and also directing law enforcement officials to treat private cannabis use as the lowest of all possible offenses (Macdonald, Alameda Times- Star). While measure Z does not specifically deal with medical marijuana, the measure definitely indicates that the city does not intend to waver in its decision to liberalize marijuana laws for both the sick and the healthy.

San Francisco and Berkeley: Following in Oakland's Footsteps

San Francisco has certainly had similar problems with the federal government in their decision to legalize medical marijuana. In 1998, Mayor Willie Brown along with the mayor of Santa Cruz sent a letter to President Clinton urging him to reconsider the lawsuit brought against Oakland's Cannabis Cooperative by Attorney General Janet Reno (Aizenman, 18). With both mayors being staunch advocates of Proposition 215, it is no surprise that the San Francisco District Attorney Terrence Hallinan was also a firm supporter of medical marijuana, and is quoted as saying that "this is a local issue, a health issue, and the federal government is making a mistake trying to extend their jurisdiction" (Aizenman, 18). Besides aligning themselves with Oakland in their fight to keep medical marijuana legal, San Francisco has also been looking to possibly introduce a ballot measure to legalize the cultivation of marijuana on public property, although no measure has been officially voted on as of yet. In addition, the city has also considered establishing nonprofit cooperatives, which according to a report by the San Francisco Office of Legislative Analysis will help marijuana patients at a reduced cost, and risk (Alcoholism and Drug Abuse Weekly, 16:13:8).

Berkeley has also been an adamant supporter of the medical marijuana movement, and currently permits three cannabis clubs to operate with a permit from the city (Bender, 1). Despite their liberal position of medical marijuana, Berkeley has recently taken steps to put limits on cannabis cooperatives. In October 2004, the Berkeley city council voted 7-1 to limit the amount of cannabis cooperatives to the three that were already granted permission by the city (S.F. Chronicle, B5). This will probably not be much of a problem considering that there is no shortage of cannabis cooperatives in the neighboring Bay Area cities. In addition, Medical marijuana advocates in Berkeley were dealt another blow on November 2, 2004, when the voters of Berkeley narrowly decided to turn down ballot Measure R, which would have further liberalized the medical marijuana laws of the city (S.F. Chronicle, B8). Although the measure was defeated, the vote was very close with the nays winning by less than a thousand votes. Because Berkeley is such a liberal city that is surrounded by other cities that adamantly support medical marijuana, I do not anticipate that the recent limits imposed on medical marijuana will have a long lasting effect in Berkeley. Considering that Measure R was decided with a very

narrow margin, the citizens of Berkeley in the future are likely to support another ballot initiative to further liberalize medical marijuana laws.

San Diego, Santa Cruz, and the New Guidelines Under S.B. 420

On January 1, 2004 California Senate Bill 420, which amended Proposition 215 took effect, and gave more power to cities and municipalities to establish guidelines for medical marijuana. Besides increasing the total amount of marijuana that could be possessed and cultivated for personal, medical usage, S.B.420 allows local governments to increase the amounts of marijuana that could be possessed by patients who are prescribed marijuana. According to the California chapter of NORML, S.B. 420 also provides other protections, such as directing the California Department of State Health Services to create a medical marijuana patients registry as well issuing identification cards, and grants legal protections to state cannabis cooperatives (California NORML newsletter, August 1st, 2004). Because of these new guidelines, many Californian cities have taken it amongst themselves to establish new limits for medical marijuana.

For the last couple of years San Diego has established several measures that have distinguished the city in their right to control medical marijuana laws. According to the city of San Diego website, the city established a Medical Marijuana/ Cannabis Task Force on May 22, 2001, to assist the city council in establishing efficient policies that were in line with the guidelines set out in Proposition 215. Not long after establishing a task force, San Diego also established a system for medical marijuana ID cards, which safely and securely allows patients to receive their medicine without undue hardship. In another move that is similar to what Oakland has done, the city has also recently approved new amendments to their Municipal Code, which limits the way in which local law enforcement officers can handle patients who are caught with medical marijuana. Despite these moves to liberalize medical marijuana, the San Diego website clearly states that they have had trouble in implementing the decisions that they would like to employ, because of the federal government's efforts to prohibit medical marijuana (www.sandiego.gov/communityservices/medicalmarijuana).

Santa Cruz is another city that is not unfamiliar with the federal government's attempts to eliminate medical marijuana cooperatives. In September 2002, the Drug Enforcement Agency raided a cannabis cooperative in Santa Cruz, arresting the two owners as well as a wheelchair-bound patient who was disabled by polio (Kreit, 1787). Because the city had worked very closely with the cannabis cooperative for six years, the city organized an event to distribute marijuana to the sick on the steps of city hall (Kreit, 1787). In addition to shocking the city of Santa Cruz, other cities such as San Jose, Berkeley, San Francisco, and Sebastopol were also offended, and as a result passed "anti- DEA resolutions," which expressed the cities unwillingness to cooperate with the DEA (Bailey, B10). The Santa Cruz County Board of Supervisors have also passed a unanimous resolution in October 2004, which increased possession amounts for medical marijuana users, establishing a three pound limit (Gaura, B4). The board also approved a measure that allows medical marijuana patients the ability to cultivate marijuana in their homes, establishing a 100 square foot limit for garden plots (Gaura, B4).

Ann Arbor and Columbia: A New Wave

While California certainly has led the way in trying to legalize medical marijuana, it should be noted that other cities are starting to take the initiative in doing the same. Election Day November 2004 saw a couple of cities approve ballot initiatives to legalize medical marijuana. In Ann Arbor, Michigan, voters overwhelmingly voted in favor of Proposal C, which protects medical marijuana users from arrest and prosecution by local law enforcement officers (Davis, Ann Arbor News). Despite the measure being placed on the ballot by the City Council, and a very high voter approval rate (74 percent margin), City Attorney Stephen Postema has already declared that the new medical marijuana law is invalid, and in violation of federal and state law. In addition, the Chief of Police Dan Oates has also declared that the police are still under orders to enforce the laws that were place before the initiative was approved (Davis, Ann Arbor News). Detroit voters also approved a ballot initiative in August 2004 to change the existing city code to allow marijuana usage with a prescription, although people in the city who use medical marijuana are still prohibited to do so by state and federal law (Alcoholism and Drug Abuse Weekly, 16:7).

Columbia, Missouri voters have also approved a ballot initiative, Proposition 1, which legalizes medical marijuana. This was the third time the issue has been brought up on the Columbia ballot, with the issue just being defeated in 2003, by a 58-42 vote (Alcoholism and Drug Abuse, 15:8). In addition to Proposition 1, the voters also approved Proposition 2, a measure which decriminalizes marijuana, with only a fine being issued for those possessing up to 35 grams of marijuana (Moore, Columbia Daily Tribune). While there is no controversy as of yet in Columbia, it will be interesting to see how the medical marijuana laws will implemented, especially when one considers that Missouri, like Michigan, does not have a state medical marijuana exception. Considering that Ann Arbor, Detroit, and Columbia all had ballot initiatives pass with fairly large majorities, it is doubtful that issue will just go away if law enforcement officials decide to crack down on medical marijuana.

Conclusion

California and its cities are obviously determined to fight for their right to be able to legally distribute marijuana for medical purposes. Currently this view does not seem to be out of step with public opinion as a whole, which seems to be fairly supportive of the idea of allowing physicians the ability to prescribe marijuana for medicinal purposes. Gallup and a 2001 Pew Research Center poll both hold that 73 percent of respondents “would vote for making marijuana legally available for doctors to prescribe.” A 2002 Time Magazine/ CNN poll found a slightly higher percentage (80 percent), when they asked respondents if they supported adults using marijuana for medical use. This seems to be perfectly aligned with a California Field poll, in which 74 percent of Californians support the legalization of marijuana for medical use. This seems to be a common theme in a variety of polls looked at, and it does seem to be a common theme that the majority of Americans support some type of medical marijuana usage.

Considering the majority of support for medical marijuana, it is not surprising that the Supreme Court decided to hear the case of *Ashcroft et al., v. Raich et al.*, which should be decided by spring of 2005. The decision by the Ninth Circuit Court of Appeals states that the

federal government has exceeded its constitutional boundaries under the CSA, because personal possession and cultivation does not involve interstate commerce, making the CSA unconstitutional. This decision forces the Supreme Court to answer some interesting questions that they failed to address in *Oakland*. Considering the Rehnquist court's legacy of giving more power back to the states, it will be interesting to see how they answer the question of what the federal government's role should be in limiting the "states' authority to determine what medical practice is" (Coyle, NA). Because the case at hand involves marijuana that is grown intrastate and noncommercially, whether or not it constitutes commerce, and in effect applies to the CSA is yet to be seen. If this case did not involve the controversial subject of marijuana, it does seem likely that the Supreme Court would side with the state, especially by looking at past decisions by Thomas, Rehnquist, Scalia, and even Steven's concurrence in *Oakland*.

In closing, the issue of medical marijuana is certainly one that is growing more and more controversial, with many individuals accepting the fact that marijuana does have some type of medical value. While many doctors agree that smoking marijuana may prove to be harmful to the respiratory system, many sick patients prefer to take their medicine in a different form, such as making a particular type of food, tea, or compress. It certainly can be argued that marijuana that is grown in the state, and regulated by the state does not involve interstate commerce, in effect making the CSA incompatible with the notion of medical marijuana. While the federal government continues to raid cannabis cooperatives and arrest sick patients who are currently in violation of medical marijuana laws, it is only a matter of time before the public at large is vocal enough to promote change within the federal government.

The upcoming decision in *Raich* will have a tremendous effect on whether or not the federal government has the power to regulate the state's ability to establish medical marijuana laws. Because of the confusion surrounding the issue on what branch of government has the power to regulate medical marijuana, the decision in *Raich* will be a vital factor on whether or not cities are going to be effective in their efforts to regulate medicinal cannabis. As more and more states decide to enact laws favorable to legalizing medical marijuana, more research will be necessary on the effects and abilities of local governments to regulate laws as they see fit. Based on my research as a whole, it does seem to hold true that current federal law impedes the autonomy of cities, and diminishes their effectiveness in regulating medical marijuana laws. In addition, it also seems to hold true that current medical marijuana policy under the CSA is inaccurate, and in possible violation of the commerce clause. At the very least, congress should take a good look at federal and privately done research conducted on marijuana, to accurately determine if marijuana really deserves a Schedule I rating. Perhaps if congress made decisions based on the facts, and if the Rehnquist court was consistent in its decisions, states and cities would be able to freely allow the sick to have their medicine without harassment from the federal government.

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