No. 03-1454

In The
Supreme Court of the United States

JOHN D. ASHCROFT, Attorney General, et al.,

Petitioners,

v.

ANGEL McCLARY RAICH, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF U.S. REPRESENTATIVE MARK E. SOUDER; U.S. REPRESENTATIVE CASS BALLENGER; U.S. REPRESENTATIVE DAN BURTON; U.S. REPRESENTATIVE KATHERINE HARRIS; U.S. REPRESENTATIVE ERNEST J. ISTOOK, JR.; U.S. REPRESENTATIVE JACK KINGSTON; AND U.S. REPRESENTATIVE DOUG OSE, AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the Controlled Substances Act, 21 U.S.C. 801 *et seq.*, exceeds Congress's power under the Commerce Clause as applied to the intrastate cultivation and possession of marijuana for purported personal "medicinal" use or to the distribution of marijuana without charge for such use.

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INTEREST OF AMICI AND SUMMARY OF ARGUMENT[1]

Amici are Members of the U.S. House of Representatives, each of whom has taken a strong interest in drug and narcotics policy. Representative Mark E. Souder is Co-Chair of the Speaker's Task Force For a Drug-Free America ("Speaker's Task Force"), and Chairman of the Subcommittee on Criminal Justice, Drug Policy and Human Resources (Government Reform Committee), which has oversight over all aspects of federal narcotics policy. Representative Cass Ballenger is a member of the Speaker's Task Force, and Chairman of the Subcommittee on the Western Hemisphere (International Relations Committee). Representative Dan Burton is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Human Rights and Wellness. Representative Katherine Harris is a member of the Speaker's Task Force, and Vice Chair of the Subcommittee on the Western Hemisphere (International Relations Committee). Representative Ernest J. Istook, Jr., is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Transportation and Treasury, and Independent Agencies (Committee on Appropriations), which has responsibility for the annual budget of the federal Office of National Drug Control Policy. Representative Jack Kingston is a member of the Speaker's Task Force, and Chairman of the Subcommittee on the Legislative Branch (Committee on

[1] The parties have consented to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, the Subcommittee on Criminal Justice, Drug Policy and Human Resources (Government Reform Committee), or their counsel, made a monetary contribution to the preparation and submission of this brief.

Appropriations). Representative Doug Ose is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Energy Policy, Natural Resources and Regulatory Affairs (Government Reform Committee).

Drug abuse remains the nation's most important public health problem. Each year, over 20,000 people die as a direct consequence of drug abuse, while many thousands more end up in emergency rooms due to drug-related causes. *See* Centers for Disease Control, *Deaths: Preliminary Data for 2002*, National Vital Statistics Reports, at 18 (Feb. 11, 2004); Substance Abuse & Mental Health Servs. Admin., *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1995-2002* (July 2003). The annual economic costs of drug abuse to the nation as a whole have been estimated at $143.2 billion, including $12.9 billion in health care costs (such as emergency medical care, and drug abuse treatment) and $98.5 billion in lost productivity. Executive Office of the President, Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States, 1992-1998*, at 2, 4-6 (2001).

Drug abuse is facilitated by an illegal but nationwide and flourishing market for illicit drugs. Congress and the Executive Branch have responded by attacking this commercial trade in illicit drugs, through regulation of the market backed by vigorous law enforcement. *See, e.g.*, Executive Office of the President, Office of National Drug Control Policy, *National Drug Control Strategy 2004*, at 31 (2004).

This case raises a fundamental issue: Will the Congress continue to be able to take *effective* action against the national problem of drug trafficking and abuse? In the decision here on appeal, the Ninth Circuit Court of Appeals held that

the federal government may not regulate what the court believed to be essentially "local" and "medical" illegal drug production and distribution. *Raich v. Ashcroft*, 352 F.3d 1222, 1228-34 (9th Cir. 2003). This ruling is inconsistent with this Court's Commerce Clause jurisprudence, which holds that even intrastate activities may be regulated by the federal government where, among other things, those activities have "a substantial relation to interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558-60 (1995).

Marijuana is a commercial product, and its cultivation and distribution are "economic" activities, even when taking place within one state. No one state is able to take complete and effective action against this illegal market; rather, Congressional action is required. That action takes the form of a sophisticated and scientifically-based federal regulatory framework for drugs (whether medical or non-medical), including the statute at issue here – the Controlled Substances Act (CSA), 21 U.S.C. 801 *et seq*. (2004). If local marijuana production, possession and distribution are excised from that regulatory framework, the nation's ability to address the narcotics epidemic will be seriously undermined.

ARGUMENT

I. MARIJUANA, WHETHER USED FOR "MEDICAL" PURPOSES OR NOT, IS PART OF THE LARGER, COMMERCIAL MARKET FOR DRUGS, AND AS SUCH MAY BE REGULATED BY CONGRESS UNDER THE COMMERCE CLAUSE.

The Ninth Circuit's ruling is inconsistent with this Court's Commerce Clause jurisprudence. Under Article I, Section 8 of the U.S. Constitution, Congress is empowered to "regulate Commerce with foreign Nations, and among

the several States." Although the Commerce Clause speaks only to interstate commerce, Article I, Section 8 also provides that Congress shall "make all Laws which are necessary and proper for carrying into Execution the foregoing Powers." Pursuant to the "Necessary and Proper" clause, this Court has held that even intrastate activities may be regulated by the federal government where, among other things, those activities have "a substantial relation to interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558-60 (1995) ("Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained.").

A. Marijuana Is a Commercial Product Subject to Congressional Regulation, Even When Used For So-Called "Medical" Purposes

In the post-New Deal era, this Court has struck down acts of Congress as exceeding the scope of the Commerce Clause only where the regulated activity lacks an "economic" character. Conversely, where federal regulations are targeted at economic activity, they have been sustained. *See Lopez*, 514 U.S. at 559; *United States v. Morrison*, 529 U.S. 598, 611 (2000). The Court of Appeals erred in holding that the cultivation, possession, and distribution of marijuana for "medical" purposes are not economic activities within the scope of the Commerce Clause. *Raich v. Ashcroft*, 352 F.3d 1222, 1228 (9th Cir. 2003). First, marijuana is an economic commodity, with a large and well-defined national market. Second, as a fungible, highly portable product, marijuana grown in one state can easily find its way to other states, necessitating a national system of regulation.

1. Marijuana Is an Inherently Commercial Product, With a Substantial National Market

Like all drugs, marijuana is an essentially commercial product. The fact that it may be used for alleged medical purposes certainly does not remove it from "commerce"; on the contrary, there are few commercial markets larger than that for "medical" products. In 2002, Americans spent over $1.3 trillion on personal healthcare and healthcare products; of that amount, $162.4 billion were spent on (legitimate) prescription drugs. Paulette C. Morgan, Congressional Research Service, *Health Care Spending: Past Trends and Projections*, Order Code RL31094, at CRS-1, -2 (2004).

As an illegal drug, marijuana is part of an equally commercial – albeit illegitimate – market. It is estimated that in 1998, Americans spent approximately $66 billion on illegal drugs, including $11 billion on marijuana alone. Executive Office of the President, Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988-1998*, at 1 (2000).[2] Marijuana is, in fact, the most widely used illegal drug in the United States; of the nearly 20 million current drug users in this country, approximately 14.6 million (75 percent) are using marijuana. Substance Abuse & Mental Health Servs. Admin., *2002 National Survey on Drug Use and Health* (2003).

[2] The billions of dollars in drug proceeds produced here in the U.S. (including those from marijuana trafficking) have also spawned a massive money laundering industry, which uses our transportation and financial services networks to smuggle funds out of the country. *See* National Drug Intelligence Center, U.S. Dept. of Justice, *National Drug Threat Assessment 2004*, at 97-99.

The fact that some medical marijuana is ostensibly distributed free of charge or on a "non-profit" basis does not make this commodity any less "economic." The drug retains its value and its potential for sale, even when it is distributed for free and kept for ostensibly "medical" use. A bottle of the powerful opiate OxyContin, for example, does not lose its commercial potential while it sits in a patient's medicine cabinet.

Moreover, even "free" distribution can be economically motivated. Many companies provide certain goods or services free of charge to customers, often to build their reputations and market share; drug dealers have also been known to build their client base by providing "free samples" to prospective users. *See, e.g.*, Executive Office of the President, Office of National Drug Control Policy, *Pulse Check: Trends in Drug Abuse*, at 66 (2004) ("Some dealers distribute free drugs to 'testers' early in the morning, and then count on word-of-mouth to bring them more buyers throughout the day based on the quality or purity of the drug."). As the California court of appeals noted in 1998, permitting "non-profit" sales would allow businesses to use marijuana as an enticement to customers for other services. *People ex rel. Lungren v. Peron*, 59 Cal. App. 4th 1383, 1392-3, 70 Cal. Rptr. 2d 20, 27 (Cal. Ct. App. 1997).

2. Marijuana Is a Fungible, Portable Commodity That Can Easily Move From State to State

Marijuana is a highly fungible and portable product. As Judge Beam noted in his dissent in the opinion below, marijuana is a fungible, transferable, and therefore fundamentally economic product – even if a particular amount of marijuana has not actually been exchanged for

cash. *Raich*, 352 F.3d at 1242 ("While it is clear that plaintiffs did not propose to sell or share their marijuana with others similarly situated (or even not similarly situated), they *could*.") (emphasis in original).

Not only is marijuana a fungible product, it is extremely difficult to trace back to its source; there is currently no operational "marijuana signature" (source identification) program, as there is for cocaine and heroin. *See* National Drug Intelligence Center, U.S. Dept. of Justice, *National Drug Threat Assessment 2004*, at 48. This makes proof that the drug actually moved through interstate commerce extremely difficult, and overly burdensome to effective regulation – which is why Congress dispensed with this requirement when it enacted the CSA. *See United States v. Lopez*, 459 F.2d 949, 953 (5th Cir. 1972).

3. Effective Regulation of Marijuana Requires Federal Control of all Aspects of the Market, Including Initial Production and Distribution

As a valuable, fungible, portable, and untraceable product, marijuana presents significant challenges that can only be completely met by federal regulation. The individual states cannot adequately control marijuana trafficking. We live in a national, not a state or regional, market; if one state permits marijuana production to flourish within its borders, that production will quickly spill over into neighboring states. Stopping the flow would require each state to set up its own customs controls at its border, a solution that would be highly burdensome to the national economy, and likely to be ineffective. *See, e.g.*, Executive Office of the President, Office of National Drug

Control Policy, *2002 Final Report on the 1998 National Drug Control Strategy: Performance Measures of Effectiveness*, at 24-25 (2002) (reporting that, despite efforts of federal border and interdiction authorities, 94 percent of heroin, and 69 percent of cocaine targeted for the U.S. market entered the country).

The solution is provided by federal enforcement of the CSA. Unlike individual state regulators, the federal government can reach activity in every state. This Court has previously upheld, as valid enactments under the Commerce Clause, federal regulations of intrastate activities that affect more than one state. *See, e.g., Hodel v. Virginia Surface Mining and Reclamation Ass'n*, 452 U.S. 264, 282 (1981) (upholding environmental regulations). The CSA should be upheld on these grounds as well. *See Lopez*, 514 U.S. at 574 (Kennedy, J., concurring) ("Congress can regulate in the commercial sphere on the assumption that we have a single market and a unified purpose to build a stable national economy.").

B. Congress Has Created a Carefully Calibrated Regulatory Scheme for National Drug Markets (Including the Marijuana Market), Which Requires Effective Enforcement Even on the Local Scale

Congressional narcotics statutes are designed to deal with the local, national, and even international aspects of this enormous, complex drug market. As this Court has noted, a regulation of apparently local activity may be upheld as "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Lopez*, 514 U.S. at 561. Examples of such regulatory

frameworks upheld by this Court include price controls and quotas for wheat production, *Wickard v. Filburn*, 317 U.S. 111, 128-29 (1942); grain storage regulations, *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947); civil rights regulations of the public accommodations industry, *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 261 (1964); prohibitions on "loan sharking," *Perez v. United States*, 402 U.S. 146, 156 (1971); national wage and salary restrictions, *Fry v. United States*, 421 U.S. 542, 547-48 (1975); and environmental restrictions on coal mining, *Hodel,* 452 U.S. at 283.

Congressional regulation of narcotic drugs falls into this category as well. To regulate the frequently intersecting legal and illegal drug markets, Congress has established a finely calibrated regulatory system over the course of nearly a century. That system provides for regulations of how drugs are tested, approved, and marketed as medicines; and enforcement against those who refuse to comply with the regulations.

1. Congressional Regulation of the Drug Testing, Approval, and Marketing Process

Congress began establishing the modern-day system of medical drug regulation in 1906, with the passage of the original Pure Food and Drug Act. Prior to that Act, America "was mired in near medicinal anarchy." *See* Andrea Barthwell, M.D., *Don't Fall For Pot-Smoking Con*, Hartford Courant, Apr. 30, 2004, *available in* http://reform.house.gov/CJDPHR/Hearings/EventSingle.aspx?EventID=975. Traveling salesmen hawked "miracle medicines" that rarely actually cured anything; instead, they made patients feel better through the use of alcohol or opiates. *Id.*

This was the age of "patent medicines" which were heavily marketed and advertised with false claims as to their contents and efficacy. *See* Philip J. Hilts, *Protecting America's Health: The FDA, Business, and One Hundred Years of Regulation*, 25-30 (2003).

The 1906 Act created the agency that later came to be known as the U.S. Food and Drug Administration (FDA). *See* Hilts, *supra* at 74. The 1906 Act was superseded by the Food, Drug and Cosmetic Act (FDCA, 21 U.S.C. 301, *et seq.*) in 1938, which, for the first time, forced pharmaceutical companies to test their drugs for safety and efficacy, under the regulation of the FDA. *See* Hilts, *supra* at 95. The drug approval process under the FDCA requires rigorous scientific proof, careful review by the FDA's scientific staff, and the assurance that drugs will be marketed only for the specifically approved indications. *See Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong., 2d Sess. (Apr. 1, 2004) (statement of Robert J. Meyer, M.D., Director, Office of Drug Evaluation II, Center for Drug Evaluation & Research, U.S. Food & Drug Admin.), at 2-7.

These Congressional actions are largely responsible for creating the modern market in safe, effective medicines. One historian argues that after the passage of the FDCA, a "revolution in medicine took place . . . [T]he pharmaceutical industry went from a handful of chemical companies with no interest in research and no medical staffs to a huge machine that discovered, developed, and marketed drugs of real use in treating disease." *Id.* Indeed, "rather than being merely a bureaucratic imposition on scientific progress, the FDA was arguably the co-inventor

of the clinical trial process . . . This is the process on which modern medicine founds most of its claims." Todd Seavey, *Regulation for Dummies: Is the FDA Necessary?*, Reason, Apr. 2004, at printed page 4.

2. Enforcement of Congressional Drug Regulations

Within a decade after passing the Pure Food and Drug Act, Congress passed the first federal drug enforcement law, the Harrison Narcotics Act, in 1914.[3] In 1970, Congress undertook a thorough revision of the federal narcotics laws, replacing them with the Controlled Substances Act (CSA), 21 U.S.C. 801 *et seq*. Although drafted in the form of a criminal statute, the CSA "concerns an obviously economic activity," *United States v. Genao*, 79 F.3d 1333, 1337 (2d Cir. 1996), namely the black market in illegal (or illegally diverted) drugs. Many of the CSA's provisions govern the registration, labeling and packaging, production quotas, and record-keeping of those wishing to manufacture, distribute or dispense controlled substances. 21 U.S.C. 822-827 (2004). It is the "enforcement" side of the regulatory framework initially established by the FDCA.

Without effective law enforcement by DEA and similar agencies, it would be impossible for Congress to ensure that only safe and effective drugs are available to the public, and that those drugs are not diverted to the illegal black market. The FDA is not, by itself, capable of effectively carrying out

[3] The Harrison Act and other early federal narcotics enforcement statutes were based on Congress' revenue powers. *See* Charles Doyle, Congressional Research Service, *Drug Smuggling, Drug Dealing and Drug Abuse: Background and Overview of the Sanctions Under the Federal Controlled Substances Act and Related Statutes*, Order Code 97-141 A, at CRS-1 and -2 (2003).

this enforcement role; instead, it relies on enforcement of the CSA by the DEA and other federal law enforcement agencies to defend the federal government's regulation of drugs. As a law enforcement agency, "DEA has the authority, expertise, and resources to interdict the illegal use of controlled substances." *See* Letter from Patrick Ronan, Assistant Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder (July 1, 2004), at 3. Moreover, the CSA, as a statute primarily directed at criminal enforcement, is the more appropriate statute for enforcement actions, providing "greater penalties and requir[ing] proof of far fewer elements to establish a violation." *Id.*

Taken together, the FDCA and the CSA represent "a powerful 'social contract for drug use,' which established that potentially addictive (and abused) drugs would be available under a physician's prescription and only to treat illnesses other than addiction. . . . This approach to potentially abused medicines is now the standard throughout the world. It has served Americans admirably for most of the 20th century, separating medical from non-medical uses, labeling the contents of medicines, and subjecting medicines to scientific review for safety and efficacy." Robert L. DuPont, *Examining the Debate on the Use of Medical Marijuana*, 111 Proceedings of the Ass'n of American Physicians 166, 167 (Mar./Apr. 1999).[4]

[4] The fluid, global nature of the illicit drug market demands not simply a national strategy, but an international one. To that end, Congress has ratified a number of international narcotics treaties obligating signatory countries to take effective steps to control potentially dangerous drugs. *See, e.g.*, Multilateral Single Convention on Narcotic Drugs, Mar. 30, 1961, 18 U.S.T. 1407, T.I.A.S. 6298; Multilateral Amendment of the Single Convention on Narcotic Drugs, Mar. 25,

(Continued on following page)

3. Federal Drug Regulation and Marijuana

The history of marijuana in this country illustrates the efficacy of federal drug regulations – and the necessity of their full enforcement. Before the era of modern science, marijuana, like alcohol and tobacco, was used as a "folk remedy" for numerous ailments over the centuries. *See* DuPont, *supra* at 167. In the 19th century, marijuana was marketed as a medicine in the form of "tinctures, extracts, and elixirs," as a remedy for "asthma, bronchitis, migraine headaches, depression, gonorrhea, uterine hemorrhage, and dysmenorrhea." Andrea Barthwell, Deputy Director, Executive Office of the President, Office of National Drug Control Policy, *Marijuana as Medicine?*, Testimony before the New England Governors' Summit on Drug Use, Oct. 8, 2003. Quality controls were virtually non-existent. *Id.*

In the modern era, however, botanical marijuana has never been able to pass the strict scientific standards adopted by Congress; as a result, it has never been approved by the FDA as a safe and effective drug. *See* Response of Amit K. Sachdev, Associate Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder, Sept. 25, 2003, at 1. This is because marijuana is fundamentally bad for human health. *See, e.g.*, *Marijuana and Medicine: The Need for a Science-Based Approach,*

1972, 26 U.S.T. 1439, T.I.A.S. 8118; Multilateral Convention on Narcotic Drugs: Psychotropic Substances, Feb. 21, 1971, 32 U.S.T. 543, T.I.A.S. 9725. Among other things, the 1961 Treaty requires signatories (including the U.S.) to establish a single national agency to license and control all supplies of marijuana for medical or research purposes. *See* 1961 Treaty, art. 23, 28; *see also* International Narcotics Control Board, United Nations, *Report of the International Narcotics Control Board for 2003*, at 24 (reminding signatory countries that the 1961 Treaty requires the creation of a "national cannabis agency").

Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform, 108th Cong., 2d Sess. (Apr. 1, 2004) (statement of Nora Volkow, Director, National Institute on Drug Abuse) (detailing research into negative impacts of marijuana use on the human body, and noting that the drug is addictive); Eric A. Voth, *A Peek into Pandora's Box: The Medical Excuse Marijuana Controversy*, 22 Journal of Addictive Diseases 27, 36-38 (2003) (listing negative health effects of marijuana, including brain damage, lung damage, and heart disease).

While some research does suggest that certain components of marijuana, most notably THC, may be useful to treat certain conditions, the Director of NIDA also recently testified that "there is greater promise in purifying the active constituents of marijuana and developing alternate delivery systems, such as inhalers, rather than studying smoked marijuana." *See* Volkow Statement, at 6. In fact, the FDA has already approved pure THC in pill form (called dronabinol, or "Marinol") for some indications. *See* Eric A. Voth and Richard A. Schwartz, *Medicinal Applications of Delta-9-Tetrahydrocannabinol and Marijuana*, 126 Annals of Internal Medicine 791, 791-4 (1997). Contrary to the claims made by some pro-marijuana activists, the federal government permits and supports research into the therapeutic potential of marijuana and its components. *See* Volkow Statement, at 6-9. Pharmaceutical companies are also actively developing new treatments made from marijuana. *See, e.g., Researcher working on medical patch to deliver marijuana-like chemicals*, Aug. 20, 2003, Assoc. Press State & Local Wire, *available in* LEXIS/NEXIS (describing efforts to create a medical treatment delivering THC through the skin); Eric Bailey, *British Firm Holds Hope for Users of Medical Pot*, Los Angeles Times, Feb. 1,

2004, at B1 (describing experimental marijuana derivative known as Sativex). In short, federal regulation of marijuana is serving the interest of public health.

Through state medical marijuana laws and lawsuits such as this one, however, pro-marijuana activists are seeking to do an end-run around these important regulatory safeguards. According to the FDA, state laws purporting to legalize medical marijuana "are inconsistent with [FDA's] efforts to ensure that approved medications have undergone rigorous scientific scrutiny and FDA's approval process." *See* FDA Statement Re: Marijuana Legislation, provided to Rep. Mark E. Souder on July 7, 2004. In opposing recent legislation that would have prohibited the U.S. Department of Justice from fully enforcing marijuana laws in states purporting to legalize the drug's "medicinal" use, the FDA further stated that "DEA is the Federal agency with primary jurisdiction regarding enforcement actions relating to the sale or distribution of marijuana. FDA will continue to cooperate with DEA in these actions. . . . We reiterate that any legislation that would prevent the Department of Justice or the DEA from enforcing the CSA with respect to marijuana either generally or in specified States would not serve the interests of public health." *Id.*

C. Exempting So-Called "Medical" Marijuana From Federal Drug Regulations Would Seriously Undermine Their Effectiveness

In its opinion below, the Ninth Circuit refused to look at the problem of marijuana trafficking as a whole, or the impact that local production, possession, and distribution have on the drug trade. Instead, the court narrowed its focus to "a *separate and distinct class of activities:* the

intrastate, noncommercial cultivation and possession of cannabis for personal medical purposes." *Raich*, 352 F.3d at 1228 (emphasis in original). By examining this "class of activities" in isolation from the overall marijuana trade, the court failed to see the effects that it might have on drug trafficking and law enforcement. The Ninth Circuit's error illustrates why this Court has warned against too narrow a focus on individual cases when examining a general regulatory statute. *See Lopez*, 514 U.S. at 558 ("where a general regulatory statute bears a substantial relation to commerce, the de minimum character of individual instances arising under that statute is of no consequence") (quoting *Maryland v. Wirtz*, 392 U.S. 183, 197 n. 27 (1968)) (italics and internal quote marks omitted). Individual courts can often underestimate or even fail to recognize what motivated Congressional action – namely, the importance of seemingly local phenomena to a national problem.

As reflected in its detailed findings in the CSA, Congress understood that to be effective, enforcement of drug regulations needs to reach all levels of the drug trade – including the initial production of the drug, and its "local" possession and distribution.[5] This policy is based on

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[5] "The Congress makes the following findings and declarations:

. . .

(3) A major portion of the traffic in controlled substances flows through interstate and foreign commerce. Incidents of the traffic which are not an integral part of the interstate or foreign flow, such as manufacture, local distribution, and possession, nonetheless have a substantial and direct effect upon interstate commerce because –

(A) after manufacture, many controlled substances are transported in interstate commerce,

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the fact that often the most effective drug enforcement is that which goes to the initial source of the narcotics. As this Court has held, the Commerce Clause power "permits Congress to attack an evil directly at its source, provided the evil bears a substantial relationship to interstate commerce." *North American Co. v. Securities & Exchange Comm'n*, 327 U.S. 686, 705 (1946).

Permitting even the limited marijuana cultivation and distribution allegedly at issue in this case would undermine drug regulation by (1) giving drug traffickers a new strategy to evade arrest; (2) creating geographic "safe havens" for drug dealers to base their operations; (3) increasing the risk of diversion from "medical" use to purely recreational trafficking; (4) increasing the supply and lowering the price of marijuana; and (5) potentially

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(B) controlled substances distributed locally usually have been transported in interstate commerce immediately before their distribution, and

(C) controlled substances possessed commonly flow through interstate commerce immediately prior to such possession.

(4) Local distribution and possession of controlled substances contribute to swelling the interstate traffic in such substances.

(5) Controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate. Thus, it is not feasible to distinguish, in terms of controls, between controlled substances manufactured and distributed interstate and controlled substances manufactured and distributed intrastate.

(6) Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic."

21 U.S.C. Sec. 801 (2004).

increasing the demand for the drug through reduced public perception of marijuana's harms. These practical considerations must be taken into account when evaluating Congress' power to deal with the narcotics trade. *See id.* ("And in using this great power, Congress is not bound by technical legal conceptions. Commerce itself is an intensely practical power. . . . To deal with it effectively, Congress must be able to act in terms of economic and financial realities.").

1. Creating a "Medical" Loophole for Marijuana Cultivation, Possession, and Distribution Would Give Drug Traffickers a New Strategem to Evade Arrest and Punishment

State medical marijuana laws undermine effective law enforcement, as drug traffickers can simply assert that their products are "medicinal" – forcing law enforcement authorities to prove otherwise. There is mounting evidence that current state medical marijuana laws are already being used as a cover for large-scale drug production and trafficking. In Oregon, for example, police discovered underground marijuana greenhouses with more than 3,500 plants, with room for 5,000 to 7,000 plants; the owners held state "medical marijuana cards" entitling them to possess the drug. *See* Beth Quinn, *Southern Oregon Police Raids Find 3,500 Marijuana Plants*, Portland Oregonian, Dec. 13, 2003, at C01. In Denver, Colorado, federal agents seized 800 marijuana plants from 3 homeowners, 2 of whom had state authorization to grow "medical" marijuana. Kirk Mitchell, *Feds Seize 800 Pot Plants*, Denver Post, June 3, 2004, at B-01. And just last month, the California Highway Patrol discovered a massive clandestine marijuana growing operation – with almost 2,000 plants

worth millions of dollars; medical marijuana activists, however, claimed that the marijuana was for "medical" purposes and was legal under Oakland city laws. Paul T. Rosynsky, *Big dispute in city pot bust*, Alameda Times Star, July 1, 2004, *available in* LEXIS/NEXIS. According to the U.S. Department of Justice, outlaw motorcycle gangs have applied for medical marijuana "caregiver" status, in an effort to legitimize their marijuana grow operations. *See* Letter from Robert F. Diegelman, Acting Assistant Attorney General for Administration, U.S. Dept. of Justice, to Paul Jones, Director, Justice Issues, General Accounting Office, dated Sept. 27, 2002, *reprinted in* General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, Report No. GAO-03-189, at 57 (2002). In Nevada, a convicted drug dealer obtained a state "medical marijuana" registration card (purportedly to treat his "bipolar" mental condition), and began growing the drug and "sell[ing] or giv[ing]" it to "about 20 other medical marijuana patients through his enterprise, Primary Caregivers and Consultants." Ed Vogel, *Medical Marijuana: Working to smoke out abusers*, Las Vegas Review-Journal, Apr. 12, 2004, at 1B.

Exemptions for "small" amounts of marijuana can also be a boon for drug traffickers. Three ounces of marijuana, for example, can make anywhere from 90 to over 250 marijuana cigarettes, or "joints" – enough to supply a so-called "medical marijuana user" for a month. *See* Dan Kulin, *Number of joints possible with 3 ounces of pot debated: Question 9 argument becomes food for commercial*, Las Vegas Sun, Oct. 15, 2002, 2002 WL 101210627. Where small amounts are presumed to be beyond the reach of the law, drug dealers will simply distribute drugs in those amounts so as to escape arrest. *See, e.g., Costa*

Rica: Review, Americas Review World of Information, Sept. 23, 2002, 2002 WL 100885937 (since Costa Ricans are allowed to possess small amounts of drugs, it makes it very difficult to stop dealing in drugs like crack cocaine).

2. Allowing Individual States To Immunize Marijuana Possession From Federal Regulation Would Create Geographic "Safe Havens" For Drug Traffickers

If certain states are permitted to simply "opt out" of federal drug regulation, they will quickly become a haven for drug traffickers. Drug trafficking organizations typically seek out venues where the drug laws, and/or the enforcement of those laws, are weaker; the drugs they manufacture or import in those areas can then be smuggled into areas where drug enforcement is more stringent. This has been especially obvious in the international arena. For example, when Congress passed stricter laws against the diversion of the precursor chemicals for methamphetamine production (such as pseudoephedrine), drug traffickers turned to Canada (where precursor chemical regulation was much weaker) as their source of supply. *See* Office of International Intelligence, U.S. Drug Enforcement Administration, and Criminal Intelligence Directorate, Royal Canadian Mounted Police, *Chemical Diversion and Synthetic Drug Manufacture*, at printed pages 1, 8. Similarly, lax Canadian laws and enforcement against marijuana growing have made the province of British Columbia a center of high-potency marijuana production. *See* Quentin Hardy, *Inside Dope*, Forbes, Nov. 10, 2003, at 146 (noting that in British Columbia only one-fifth of marijuana busts result in incarceration and the average sentence is only four months). This high-potency

marijuana is being smuggled into the U.S. *See* U.S. Department of State, *International Narcotics Control Strategy Report, 2003* (2004).

In Europe, lenient drug policies have made the Netherlands a haven for drug smuggling. *See, e.g.*, Justin Sparks, *Dutch Law Could Unleash Cocaine Flood In Britain*, London Times, Feb. 1, 2004, at 24; Ciarin McGuigan, *Mule be sorry; Dutch decision to 'let off' drug smugglers could lead to growth in trafficking here*, Belfast Telegraph Newspapers – Sunday Life, Mar. 14, 2004, *available in* LEXIS/NEXIS (Dutch policy of releasing drug smugglers at its airports carrying "normal" amounts of illegal drugs has sparked neighbors' fears that the Netherlands will become the preferred European Union gateway for narcotics). *See also* Anthony Browne, *Dutch drug café ban puts British noses out of joint*, London Times, Oct. 25, 2003, Overseas news section, at 5 (reporting on Dutch government's consideration of plan to forbid foreigners from accessing legal marijuana shops in the Netherlands, in part to stop cross-border trafficking by German drug dealers who purchase marijuana in the Netherlands and then drive it to Germany).

This problem is exacerbated by the fact that in states and localities that have attempted to legalize marijuana, state and local officials (facing local political pressures) are increasingly hostile to federal drug policies. For example, one California sheriff recently stated that he would, if necessary, actually remove seized marijuana from his department's evidence locker and give it to a friend in medical need. *See* Josh Richman, *Cops say feds' focus 'misplaced'*, Oakland Tribune, May 25, 2003, 2003 WL 8915341. According to the U.S. Department of Justice,

state officials are often refusing to prosecute obvious cases of drug dealing out of deference to state "medical marijuana" laws, and in one instance a local district attorney even ordered a county detective to arrest a DEA agent if the agent seized marijuana plants purportedly belonging to a "patient". *See* Diegelman Letter, *supra* at 56.

Furthermore, if drug production is permitted to take root in a community, that community can quickly become economically dependent on the drug – putting additional pressure on local governments to turn a blind eye to the problem. *See* Hardy, *supra* (reporting that marijuana has become Canada's most valuable agricultural crop, with even the legitimate British Columbian economy increasingly dependent on the profits from it). In fact, many so-called "medical" marijuana sellers now openly operate as businesses in California (which has the most permissive medical marijuana law). In Rosewood, California, a store sells strains of marijuana known as "Romulan," "White Rhino," "Acapulco Gold," and "Placer Gold" for $200-$320 per ounce, reportedly with the tacit approval of the local chief of police. *See* Art Campos and Jocelyn Wiener, *Store for medical pot opens in Roseville*, Sacramento Bee, Jan. 31, 2004, at A1. In Oakland, California, a dozen "cafes" selling purported medicinal marijuana (at least one owner claiming to serve 7,000 "patients") were in operation by the end of 2003, earning it the nickname "Oaksterdam"; in 2004, the city attempted to limit the number of stores by issuing marijuana "business permits" (in return for a $20,000 annual fee). *See* Jean Marbella, *Marijuana 'du jour' in Oakland*, Baltimore Sun, Nov. 28, 2003, at 1A; Laura Counts, *Medical marijuana merchant defies Oakland order to close*, Alameda Times-Star, June 2, 2004, *available in* LEXIS/NEXIS.

Nor can state medical boards in such states be relied on to provide effective regulation. As one commentator has observed, medical marijuana initiatives "have created serious regulatory dilemmas for state regulatory boards." Voth, *A Peek into Pandora's Box* at 27. Despite their mission to oversee the practice of medicine in their respective states, many of these boards disavow any responsibility to determine whether drugs are safe or effective. *See Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong., 2d Sess. (Apr. 1, 2004) (statement of James D. Scott, Member and Past Chair, Oregon Board of Medical Examiners), at 2, ("No one representing the [Board] is prepared to give any testimony regarding the scientific or medicinal value of marijuana, or any sociopolitical issues regarding marijuana. These issues are beyond our jurisdiction."); Letter from Joan M. Jerzak, Chief of Enforcement, Medical Board of California, to Rep. Mark E. Souder, May 11, 2004, at 1, 2 ("The Board does not establish 'procedures' which physicians must follow, nor does it take a position with regard to specific medications. . . . [I]t is not for the Board to determine which medical conditions may be appropriately treated with marijuana.").

3. Legalizing "Medical" Marijuana Will Increase the Chances of Diversion to Purely Recreational Use

By increasing the amount of marijuana, and the number of "legitimate" uses for it, state medical marijuana laws increase the chance that the drug will be diverted to purely recreational uses. The more legally available any

drug is, the more indications it is approved for, and the greater the quantities of the drug in legitimate channels, the higher the rate of illegal diversion, trafficking and abuse will be. *See* Responses of Thomas W. Raffanello, Special Agent in Charge, Miami Division, Drug Enforcement Administration, to Questions from Rep. Mark E. Souder, May 24, 2004, at 2; Letter from Amit K. Sachdev, Associate Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder, Apr. 26, 2004, at 2. The diversion of legal (but controlled) medical drugs into illegal uses is widespread, rivaling the market for strictly illegal drugs. For example, nationwide in 1993, people spent an estimated $25 billion on prescription drugs in the illegal market, compared with $31 billion on cocaine, including crack. *See* National Drug Strategy Network, *Prescription Drug Abuse Rivals Illicit Drug Abuse, Some See Double Standard in Law Enforcement*, New Briefs – Drug Use Trends (Oct. 1996). Abuse of legal prescription drugs, such as the opiate OxyContin, is on the rise; by 2001, prescription pain killers were second only to marijuana as the most abused category of drug. *See* National Survey on Drug Use and Health, *Nonmedical Use of Prescription Pain Relievers*, at 2 (2004).

Once a drug can be legally obtained, drug dealers and addicts have an increased number of avenues to obtain it – including prescription fraud (forging prescriptions; visiting multiple doctors to obtain prescriptions, often called "doctor shopping"; and altering prescriptions to increase the quantity); and outright theft or robbery from pharmacies (often performed by pharmacy workers themselves). *See* Julie Wartell and Nancy G. La Vigne, Office of Community Oriented Policing Services, U.S. Dept. of Justice, *Prescription Fraud* (2004), at 2-3. Those obtaining these drugs via fraud can, and do, ship them for profit to other

states. *See, e.g.*, Drug Enforcement Administration, *OxyContin: Pharmaceutical Diversion*, at printed page 5 (2002) (reporting DEA investigation into individual who took advantage of a severe medical condition to obtain legitimate prescriptions for OxyContin and other oxycodones from physicians in Arizona and California; he then shipped the pills – approximately 8,000 to 9,000 over the course of a year – via FedEx to another individual in Maryland for distribution).

The risk of "medical" marijuana being diverted is heightened by the fact that certain doctors have been consistently expanding their list of marijuana-treatable "conditions." One doctor, Frank H. Lucido, reports writing medical marijuana recommendations for 348 patients over a six-month period in 2002, for a wide range of conditions, including headaches, chronic anxiety, depression, insomnia, post-traumatic stress disorder, asthma, bipolar disorder, attention deficit disorder, vertigo, tinnitus, restless leg syndrome, phantom limb pain, and obsessive compulsive disorder. Frank H. Lucido and Mariavittoria Mangini, *Implementation of the Compassionate Use Act in a Family Medical Practice: Seven Years' Clinical Practice*, O'Shaughnessy's Journal of the California Cannabis Research Medical Group, Spring 2004, at 3. Claudia Jensen, a California pediatrician, has stated that she has recommended marijuana to teenagers with attention deficit disorder, despite acknowledging that "the science is lacking to justify some of her unorthodox uses." Daniel Costello, *Unorthodox uses for medical marijuana*, Los Angeles Times, Feb. 23, 2004, at F3; *see also Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong., 2d Sess. (Apr. 1, 2004)

(statement of Claudia Jensen, M.D.), at 7-9. These cases are not isolated incidents. A 2003 study of AIDS patients using marijuana showed that less than one third smoked the drug even to relieve pain; 57 percent smoked to relieve anxiety or depression, while 33 percent admitted they smoked for "recreational" reasons. Sara Zaske, *Study: Many HIV patients use pot for mental health*, San Francisco Examiner, June 9, 2003, *available in* http://reform.house.gov/CJDPHR/Hearings/EventSingle.aspx?EventID=975. In Oregon, of the 10,196 patients registered with the state's medical marijuana program, only 335 were listed as suffering from cancer; only 221 with HIV/AIDS; only 198 with glaucoma; and only 438 with cachexia; by contrast, 8,711 patients listed "pain" as their reason for taking the drug. *See* Oregon Department of Human Services, *Oregon Medical Marijuana Program Statistics* (July 1, 2004).

Other pro-marijuana doctors are, moreover, also writing very large numbers of "recommendations" for marijuana. According to one estimate, as of spring 2004, 100,000 marijuana recommendations had been issued in California, almost half written by only 12 physicians in California – all associated with a group known as the California Cannabis Research Medical Group. Fred Gardner, *Encouraged by 9th Circuit's Conant Ruling, More California Doctors Approve Cannabis Use*, O'Shaughnessy's Journal of the California Cannabis Research Medical Group, Spring 2004, at 1. One doctor alone acknowledged writing approximately 8,000 such recommendations. *Id.* at 7. In Oregon, Dr. Phillip E. Leveque was recently suspended by the state medical board for writing 4,000 medical marijuana authorizations – approximately 40 percent of the total such authorizations in the state – often without conducting any physical examination or even personally meeting with his patients. *See* Kramer, Andrew, *Oregon doctor's license*

suspended for signing marijuana cards, Associated Press, Mar. 5, 2004, *available in* LEXIS/NEXIS.

4. The Aggregate Effect of Even Individual Cultivation of "Medical" Marijuana Justifies Federal Regulation

Even when marijuana never actually enters the immediate stream of commerce, it may still be regulated to prevent it from impacting the broader market. This Court has repeatedly held that Congress may look to the total, aggregate effect of many apparently small, local transactions on interstate commerce and federal regulations thereof. *See, e.g., Wickard*, 317 U.S. at 128-29 (aggregate effect of home-grown and personally consumed wheat); *Katzenbach v. McClung*, 379 U.S. 294, 301 (1964) (aggregate effect of many individual acts of racial discrimination at restaurants); *Perez*, 402 U.S. at 154-55 (aggregate effect of acts of loan sharking); *Fry*, 421 U.S. at 547 (aggregate effect of wage increases for state employees).

As was the case in *Wickard*, marijuana grown and consumed, even locally by purported "medical" users, can exert a significant effect on the traffic in the drug, by adding to the nation's marijuana supply while reducing demand on the immediate market. The result will be lower overall prices on the black market. *See Proyect v. United States*, 101 F.3d 11, 14 n. 1 (2d Cir. 1996) ("[T]he cultivation of marijuana for personal consumption most likely does substantially affect interstate commerce. This is so because 'it supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market.' ") (citing *Wickard*, 317 U.S. at 128); *see also* Drug Enforcement Administration, *Illegal Drug Price and Purity Report* (Apr. 2003) ("A decrease in drug price

typically indicates an increase in availability, and, conversely, a price increase usually indicates a decrease in supply."). This would undermine a key component of the federal government's anti-marijuana strategy, namely to increase the price of illicit drugs, resulting in a reduction in the demand. *See* Office of National Drug Control Policy, *National Drug Control Strategy 2004*, at 31 ("The main reason supply reduction matters to drug policy is that it makes drugs more expensive, less potent, and less available. Price, potency, and availability are significant drivers of both addicted use and casual use.").

5. Legitimizing "Medical" Use of Marijuana Will Potentially Increase the Demand For the Drug, by Reducing Public Perception of Marijuana's Harms

Repeated claims of marijuana's "medicinal" value, coupled with the apparent ratification of those claims by state medical marijuana laws, have lowered the public perception of marijuana's scientifically demonstrated harmfulness – particularly among young people. *See* Andrea Barthwell, Deputy Director, Office of National Drug Control Policy, *Marijuana Is Not Medicine*, Chicago Tribune, Feb. 17, 2004, at C19 ("Children entering drug abuse treatment routinely report that they heard that 'pot is medicine' and, therefore, believed it to be good for them."). These public perceptions can have a significant impact on marijuana usage rates. *See, e.g.*, Wilson M. Compton, et al., *Prevalence of Marijuana Use Disorders in the United States, 1991-1992 and 2001-2002*, 291 JAMA 2114, 2119 (2004) (reporting study demonstrating that decreases in the perceived risk of harmfulness and in

disapproval of marijuana use can explain the recent rise in marijuana use by young people).

D. If Congress Is Prevented From Regulating Local Production, Possession, and Distribution of Marijuana, Its Ability To Regulate Other Drugs Will Be Placed in Jeopardy

A ruling that the federal government may not regulate local production, possession, and distribution of "medical" marijuana would have far-reaching implications for the regulation of all drugs, both legal and illegal. A vast number of controlled substances may be produced in the home, including methamphetamine, GHB, and MDMA ("ecstasy"). *See* Drug Enforcement Administration, *Drug Trafficking in the United States* (2001). And virtually all drugs have at least some putative "medical" uses; for example, cocaine and heroin were long used as anaesthetics, methamphetamine as a stimulant, and for many years LSD and ecstasy were used in psychotherapy.

This scenario is not as unlikely as it may seem. In fact, many of the same proponents of medicinal marijuana have actively sought to force the approval of some of these other drugs as "medicines." *See, e.g., Grinspoon v. Drug Enforcement Admin.*, 828 F.2d 881 (1st Cir. 1987) (petition by pro-medical marijuana advocate Dr. Lester Grinspoon to remove ecstasy from Schedule I of CSA). In several foreign countries, physicians may now prescribe heroin to addicts as part of a medical practice known as "maintenance," and the same may soon be done for cocaine. *See, e.g.*, Dan Gardner, *Free junk for junkies*, Ottawa Citizen, Jan. 18, 2004, at C3; *Doctors push for cocaine prescription*, Swissinfo, June 3, 2004, *available at* http://www.swissinfo.org/sen/Swissinfo.html?siteSect=105&sid=4958011. If a

state were to attempt to approve these or any other currently controlled drugs for "medical" use, it would set up the same federal-state conflict present here.

CONCLUSION

Describing the 19th century age of "quack medicines," one historian writes that, "The market in medicines, without any regulation, was essentially the same as the only market today with no regulation – the trade in heroin, cocaine, and other drugs. The supply was unreliable, the purity suspect, the price high and variable, and the corrupted substances sometimes fatal." Hilts, *supra* at 27. Proponents of "medical" marijuana would take us full circle, "back to a time before the passage of the Pure Food and Drug Act." Barthwell, *Marijuana as Medicine?* Through its power to regulate the interstate commerce in medical drugs, Congress has the responsibility to protect the American public from such a foolish step backwards. That power, and that responsibility, are fully consistent with the Constitution and should not be denied. The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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