California Physicians & Medical Marijuana

A Statement by the Medical Board of California (Revised November 5, 2004)

On August 10, 2004, board staff met with State Sen. John Vasconcellos and representatives from the CMA to discuss their concerns about the board's statement on medicinal marijuana. Consequently, the board agreed to make a minor revision to its prior statement removing the words "or prescription drug treatment" in two places within the document.

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health & Safety Code, and is also known as the Compassionate Use Act of 1996. The purposes of the Act include, in part:

"(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; and

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

Furthermore, Health & Safety Code section 11362.5(c) **provides strong protection for physicians who choose to participate in the implementation of the Act.** "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

The Medical Board of California developed this statement since medical marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend medical marijuana to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the MBC if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending medical marijuana will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, and include the following:

1. History and good faith examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of medical marijuana.

In other words, if physicians use the same care in recommending medical marijuana to patients as they would recommending or approving any other medication, they have nothing to fear from the Medical Board.

Here are some important points to consider when recommending medical marijuana:

1. Although it could trigger federal action, making a recommendation in writing to the patient will not trigger action by the Medical Board of California.
2. A patient need not have failed on all standard medications, in order for a physician to recommend or approve the use of medical marijuana.
3. The physician should determine that medical marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.
4. The Act names certain medical conditions for which medical marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of medical marijuana is as

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DEA Controlled Substance Registration Certification Makeover

Effective October 1, 2004, the DEA Controlled Substance Registration Certificate has been revised. The revised Certificate of Registration will consist of two parts: one that can be displayed on the wall and a smaller, wallet-size version. The certificate will have an imbedded watermark logo, which will provide authentication of the certificate and deter counterfeiting.

Registrants that are currently allowed to renew their DEA registration via the Diversion Control Program's Web site (i.e., retail pharmacies, hospitals, practitioners, mid-level practitioners and teaching institutions) may print their Certificate of Registration upon completion of the registration renewal process as long as no changes have been made to their registration since their last renewal. The Diversion Control Program's Web site may be accessed at www.DEAdiversion.usdoj.gov. The DEA will continue to send Certificates of Registration via the U.S. Postal Service to all new registrants and all other DEA registrants renewing their DEA registration.

Triplicate Prescriptions No Longer Valid

Effective January 1, 2005, when a physician provides a **written** prescription to a patient for a controlled drug (Schedule II-V) a tamper-resistant prescription must be used. There is no alternative when prescribing Schedule II controlled drugs. However, there is another option for physicians to consider when prescribing Schedule III-V controlled drugs. In this latter situation, the physician can **fax** or **provide an oral prescription** directly to the pharmacist, who will fill out the necessary forms as required by law. But if a physician wishes to provide a written prescription to the patient, then the physician must use the new tamper-resistant form.

Note: Physicians may continue to use regular prescription pads to prescribe a controlled substance if the patient is terminally ill, per Health and Safety Code section 11159.2, which became effective in January 1999.

For a list of approved security printers, please see the Board of Pharmacy's Web site at www.pharmacy.ca.gov or phone (916) 445-5014.

Medical Marijuana *(continued from page 10)*

good, or better, than other medications that could be used for that individual patient.

5. A physician who is not the primary treating physician may still recommend medical marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
6. The initial examination for the condition for which medical marijuana is being recommended must be in-person.
7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.
8. If a physician recommends or approves the use of medical marijuana for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to CMA's ON-CALL Document #1315 titled "The Compassionate Use Act of 1996," updated annually for additional information and guidance. The document is available online at http://www.cmanet.org/publicdoc.cfm/4.

Although the Compassionate Use Act allows the use of medical marijuana by a patient upon the recommendation or approval of a physician, California physicians should bear in mind that marijuana is listed in Schedule I of the federal Controlled Substances Act, which means that it has no accepted medical use under federal law. However, in Conant v. Walters (9th Cir. 2002) 309 F.3d 629 the United States Court of Appeals recognized that physicians have a constitutionally-protected right to discuss medical marijuana as a treatment option with their patients and make oral or written recommendation for medical marijuana. However, the court cautioned that physicians could exceed the scope of this constitutional protection if they conspire with, or aid and abet, their patients in obtaining medical marijuana.

2005 WL 1502081 (Cal.A.G.)

Office of the Attorney General
State of California

*1 Opinion No. 04-709
June 23, 2005

THE HONORABLE CHRISTINE KEHOE
MEMBER OF THE STATE SENATE

THE HONORABLE CHRISTINE KEHOE, MEMBER OF THE STATE SENATE, has requested an opinion on the following questions:

1. Does the statewide registry and identification card program for medical marijuana users preempt the operation of a city's own registry and identification program?
2. May a city continue to operate its own registry and identification card program for medical marijuana users until the statewide registry and identification card program is implemented in the county in which the city is located?
3. May a county designate a city to perform the functions of the county health department under the statewide registry and identification card program for medical marijuana users?

CONCLUSIONS

1. The statewide registry and identification card program for medical marijuana users preempts the operation of a city's own registry and identification card program, but a city may adopt and enforce other ordinances consistent with the statewide program.
2. A city may continue to operate its own registry and identification card program for medical marijuana users until the statewide registry and identification card program is implemented in the county in which the city is located, except to the extent that the operation of the city's program would be inconsistent with state law.
3. A county may not designate a city to perform the functions of the county health department under the statewide registry and identification card program for medical marijuana users.

ANALYSIS

On November 5, 1996, the voters of California adopted Proposition 215, an initiative statute authorizing the medical use of marijuana. (See People v. Mower (2002) 28 Cal.4th 457, 463; People v. Bianco (2001) 93 Cal.App.4th 748, 751; People v. Rigo (1999) 69 Cal.App.4th 409, 412.) The measure added section 11362.5 to the Health and Safety Code [FN1] and entitled the statute the "Compassionate Use Act of 1996." (§§ 11362.5, subd. (a).) Section 11362.5 "creates an exception to California laws prohibiting the possession and cultivation of marijuana." (United States v. Oakland Cannabis Buyers' Cooperative (2001) 532 U.S. 483, 486.) "These prohibitions no longer apply to a patient or his primary caregiver who possesses or cultivates marijuana for the patient's medical

purposes upon the recommendation or approval of a physician." (Ibid.; see People v. Mower, supra, 28 Cal.4th at pp. 471-474; People v. Galambos (2002) 104 Cal.App.4th 1147, 1160 - 1162; People v. Young (2001) 92 Cal.App. 4th 229, 235.) [FN2]
The chief purposes of Proposition 215 are: (1) to give Californians the right to obtain and use marijuana in the medical treatment of illnesses for which it provides appropriate relief, as recommended by a physician, (2) to protect patients and primary caregivers, as defined, from criminal prosecution or other sanctions based on their possession, use, or distribution of marijuana for medical purposes, and (3) to encourage implementation of a cooperative governmental plan to make marijuana available and affordable to all patients in medical need thereof. (§ 11362.5, subd. (b)(1); see also § 11362.5, subd. (c) [barring punishment of physicians for recommending marijuana to patients]; 86 Ops.Cal.Atty.Gen. 180, 181 (2003).)
*2 The three questions presented for analysis concern a recently established state program to facilitate implementation of Proposition 215. In 2003, the Legislature enacted sections 11362.7 through 11362.83 to provide a uniform system of "identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution...." (Stats. 2003, ch. 875, § 1.) Under this legislation, the state Department of Health Services ("Department") is directed to "establish and maintain a voluntary program for the issuance of identification cards" to qualified patients and primary caregivers, and to provide a process through which state and local law enforcement officers may immediately verify a card's validity. (§ 11362.71, subd. (a); see also § 11362.71, subd. (d)(3).) Each county health department, or other "health-related governmental or nongovernmental entity or organization" designated by the county (§ 11362.71, subd. (c)), is to provide applications, receive and process completed applications, and issue identification cards. (§§ 11362.71, subd. (b); 11362.72-11362.74.) [FN3] Section 11362.77, subdivision (a), sets forth the maximum amount of marijuana and number of marijuana plants that a qualified patient or caregiver may possess without prosecution; however, local governments are expressly authorized to allow greater amounts. Subdivision (c) of section 11362.77 provides: "Counties and cities may retain or enact medical marijuana guidelines allowing qualified patients or primary caregivers to exceed the state limits set forth in subdivision (a)." [FN4] Section 11362.83 additionally provides: "Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article."

1. Preemption of Local Programs

The first question to be resolved is whether the statewide registry and identification card program preempts the operation of a city's own registry and identification card program. We conclude that the statewide program preempts the operation of any local programs, but that cities may adopt and enforce other related ordinances if they are consistent with state law.
Under the California Constitution, each city and county is authorized to "make and enforce within its limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws." (Cal. Const., art. XI, § 7.) In Candid Enterprises, Inc. v. Grossmont Union High School Dist. (1985) 39 Cal.3d 878, 885, the Supreme Court examined the scope of this constitutional grant of authority:

"Under the police power granted by the Constitution, counties and cities have plenary authority to govern, subject only to the limitation that they exercise their power within their territorial limits and subordinate to state law. (Cal. Const., art. XI, §§ 7.) Apart from this limitation, the 'police power [of a county or city] under this provision... is as broad as the police power exercisable by the Legislature itself.' [Citation.]"

*3 In addition, charter cities may adopt and enforce ordinances that conflict with general state laws, if the subject matter is a "municipal affair" and not a "statewide concern." (Cal. Const., art. XI, § 5; see American Financial Services Assn. v. City of Oakland (2005) 34 Cal.4th 1239, 1251; Johnson v. Bradley (1992) 4 Cal.4th 389, 399.) Here, as we shall demonstrate, the statewide registry and identification card program is a subject of statewide concern; accordingly, if the operation of the city's program conflicts with state law, the local program is preempted and void. (See American Financial Services Assn. v. City of Oakland, supra, 34 Cal.4th at p. 1251; Morehart v. County of Santa Barbara (1994) 7 Cal.4th 725, 747; Cohen v. Board of Supervisors (1985) 40 Cal.3d 277, 290; Candid Enterprises v. Inc. v. Grossmont Union High School Dist., supra, 39 Cal.3d at p. 885; City of Lodi v. Randtron (2004) 118 Cal.App.4th 337, 351.)

A conflict between a state law and a local ordinance exits where "the ordinance duplicates or is coextensive therewith, is contradictory or inimical thereto, or enters an area either expressly or impliedly fully occupied by general law." (American Financial Services Assn. v. City of Oakland, supra, 34 Cal.4th at p. 1251; see Sherwin-Williams Co. v. City of Los Angeles (1993) 4 Cal.4th 893, 897-898.)

Initially, we note that the Legislature expressly did not intend to "fully occupy" all areas of law concerning the use of medical marijuana when it enacted the statewide registry and identification card program. To the contrary, the 2003 legislation affirmatively authorizes local governments to retain or establish guidelines permitting possession of greater amounts of marijuana (§ 11362.77, subd. (c)) and to adopt and enforce other "laws consistent with this article" (§ 11362.83). Hence, the state statutes at issue here do not expressly or impliedly preempt this entire field of regulation. (See Malish v. City of San Diego (2000) 84 Cal.App.4th 725,728-729 [state law expressly permits local regulation of pawnbrokers and other secondhand dealers].)

On the other hand, the Legislature has demonstrated its intention to fully occupy a narrower, more specific field of regulation with respect to the use of medical marijuana: the establishment of a registry and identification card program designed to "facilitate the prompt identification of qualified patients and their designated primary caregivers...." (Stats. 2003, ch. 875, § 1, subd. (b)(1).) This statewide program includes a mechanism by which law enforcement officers throughout the state "have immediate access to information necessary to verify the validity of an identification card." (§ 11362.71, subd. (b).) The statutory provisions are elaborate, detailed, and comprehensive. (See, e.g., §§ 11362.7 [definitions]; 11362.77 [implementation duties of Department and each county health department]; 11362.715 [information required for applications]; 11362.72 [required steps for processing and issuing applications]; 11362.735 [required contents of identification cards]; 11362.74 [limited reasons for denial of application; appeal; waiting period to reapply]; 11362.745 [annual renewal of card]; 11362.755 [application and renewal fees].) While patients' and caregivers' participation in the program is voluntary (§ 11362.71, subds. (a)(1), (f)), the statutes mandate that all necessary steps be taken by the Department and each county to make the program available to all applicants statewide (§

11362.71, subds. (a)-(d)).
*4 The statewide program is intended to "[p]romote uniform and consistent application of the act among the counties within the state." (Stats. 2003, ch. 875, § 1, subd. (b)(2).) [FN5] It follows that a local identification card program will be preempted, and rendered void, once the state program is implemented in the locality. At that point, any local program will "exceed the scope of local regulation permitted by" sections 11362.7 through 11362.83. (Malish v. City of San Diego, supra, 84 Cal.App.4th at p. 729.) [FN6] We conclude that the statewide registry and identification card program for medical marijuana users preempts the operation of a city's own registry and identification card program, but a city may adopt and enforce other ordinances consistent with the statewide program.

2. Preemption Prior to Implementation of Statewide Program

The second question we are asked to address is whether a city may continue to operate its own program until the statewide program is implemented. We conclude that a local program may continue to be operated temporarily except for any element that is "contradictory to" state law.
A local ordinance, regulation, or program is contradictory to state law if it is "... inimical to state law; i.e., it penalizes conduct that state law expressly authorizes or permits conduct which state law forbids." (Suter v. City of Lafayette, supra, 57 Cal.App.4th at p. 1124; see Sherwin-Williams Co. v. City of Los Angeles, supra, 4 Cal.4th at p. 898; 77 Ops.Cal.Atty.Gen. 147, 148 (1994).) Here, we are asked to consider a city ordinance that (1) provides identification cards for patients and primary caregivers, (2) requires attending physicians to practice within the county where the city is located, (3) prohibits anyone under 18 years of age from receiving a card as a primary caregiver, (4) prohibits cardholders from being detained by city police officers longer than necessary to verify their status, (5) prohibits the seizure of medical marijuana by city police officers, (6) allows possession of marijuana in amounts different from the quantity specified in the statewide program, and (7) prohibits smoking marijuana in any public place. Do any of these elements of the local ordinance permit conduct that is prohibited by state law or forbid conduct that is permitted under state law?
We believe that a city may (1) continue to operate a local registry and identification program, (2) prohibit cardholders from being arrested by city police officers, (3) prohibit the seizure of medical marijuana by city police officers, and (4) allow possession of marijuana in amounts greater than specified in the 2003 legislation. These elements of a local program would be consistent with state law. (See §§ 11362.71, subd. (e); 11362.77, subds. (a), (b), (c), (f); Dublin v. City of Alameda (1993) 14 Cal.App.4th 264, 275- 277.) On the other hand, a city would be preempted from allowing possession of marijuana at levels less than what the state law permits and making identification cards a mandatory prerequisite for prohibiting detention and seizure, because such provisions would directly contradict state law. (See § 11362.77 [qualified patient or caregiver may have at least eight ounces of marijuana per patient; cities and counties may permit quantities that exceed state amounts]; § 11362.71, subd. (f) [identification card not required to claim Act's protections].) Similarly, a city program that defined "attending physician" and "primary caregiver" more narrowly than state law would be preempted to the extent that

it prohibited what state law expressly permitted. (Cf. §§ 11362.7, subd. (a) [defining "attending physician"], 11362.7, subd. (e) [permitting "primary caregiver" to be under 18 years of age under specified circumstances].)
*5 Finally, with respect to regulating where persons may use medical marijuana, the Legislature has provided in section 11362.79:
"Nothing in this article shall authorize a qualified patient or person with an identification card to engage in the smoking of medical marijuana under any of the following circumstances:
"(a) In any place where smoking is prohibited by law.
"....."
A city thus would not be preempted from continuing to prohibit marijuana use in any public place; such local limitation may in fact remain after the statewide program has been implemented. (See also § 11362.765, subd. (a); cf. City of San Jose v. Department of Health Services (1998) 66 Cal.App.4th 35, 42 [Legislature has left to local authorities the matter of regulating tobacco smoking in their respective jurisdictions absent a conflict with state law].)
We conclude in answer to the second question that a city may continue to operate its own registry and identification card program for medical marijuana users until the statewide program is implemented in the county in which the city is located, except to the extent that the operation of the city's program would be inconsistent with state law.

3. Designated Health-Related Entity or Organization

The final question to be addressed concerns whether a city may be designated to perform the duties of the county health department under the statewide registry and identification card program for medical marijuana users. We conclude that a city would not be eligible for such designation.
Section 11362.71, subdivision (b), sets forth a number of duties to be performed by a county health department or by the county's "designee" in implementing the statewide registry and identification card program:
"Every county health department, or the county's designee, shall do all of the following:
"(1) Provide applications upon request to individuals seeking to join the identification card program.
"(2) Receive and process completed applications in accordance with Section 11362.72.
"(3) Maintain records of identification card programs.
"(4) Utilize protocols developed by the department pursuant to paragraph (1) of subdivision (d).
"(5) Issue identification cards developed by the department to approved applicants and designated primary caregivers." [FN7]
Section 11362.71, subdivision (c), specifies the entities from which a "county designee," as used in subdivision (b), may be selected:
"The county board of supervisors may designate another health-related governmental or nongovernmental entity or organization to perform the functions described in subdivision (b), except for an entity or organization that cultivates or distributes marijuana."
The term "health-related... entity or organization" is not defined in the 2003 legislation (cf. § 11362.7), nor was the term used in Proposition 215 itself. (See § 11362.5.) A

county health department would, of course, be such an entity, as reflected by the Legislature's use of the term "another" in section 11362.71, subdivision (c). Such department operates under the direction of the county health officer, who must be a graduate of a medical school. (§§ 101000, 101105; see Gov. Code, §§ 24000, subd. (s), 33201.) A county health department is responsible for preserving and protecting public health and sanitation, and for responding to public health emergencies. (§§ 101030-101085.) County mental health departments and welfare departments may also be considered health-related governmental entities. (See Gov. Code, § 33201.)

*6 In this case, we think the phrase "health-related... entity or organization" is ordinarily understood to mean an organization whose principal focus is on matters involving physical and mental health, including directly providing medical and health services or administering public health programs, disease detection and prevention programs, and therapeutic and educational programs. (See Webster's 3d New Internat. Dict. (2002) at pp. 1043 ["health," "health department"], 1916 ["related"].) [FN8]

We reject the suggestion that a city may be characterized as a "health-related governmental... entity" because it has the authority to enact ordinances and take other measures for the protection and preservation of public health. To be sure, section 101450 does give cities certain health related responsibilities:

"The governing body of a city shall take measures necessary to preserve and protect the public health, including the regulation of sanitary matters in the city, and including if indicated, the adoption of ordinances, regulations and orders not in conflict with general laws."

A city council may appoint a city health officer to discharge these responsibilities. (See §§ 101460-101470.)

However, unlike a county health department or another organization that specializes in matters of public health, a city is accountable for a broad spectrum of local activities, responsibilities, and programs that are not primarily "of, relating to, or engaged in welfare work directed to the cure and prevention of disease." (Webster's 3d New Internat. Dict., supra, at p. 1043.) Consequently, we do not believe that a city would meet the usual definition of the term "health-related... entity or organization."

Moreover, such a designation would result in a city's undertaking countywide responsibilities for implementing the statewide program. In 63 Ops.Cal.Atty.Gen. 8 (1980), we concluded that a city could perform health related responsibilities for a county outside the city's boundaries if authorized by the Legislature. (Id. at p. 10.) Here, we find that the 2003 legislation has not authorized a city to perform these services outside its boundaries. (Cf. People v. Pina (1977) 72 Cal.App.3d Supp. 35, 39-40 [county sheriff has statutory authority to empower city police officers to act as peace officers in any place within the county, including other cities].) [FN9] In the absence of such a legislative grant of extra-territorial authority, a city's power to act is confined to its own boundaries absent "the urgency of extreme expediency or necessity." (Harden v. Superior Court (1955) 44 Cal.2d 630, 638; see 63 Ops.Cal.Atty.Gen. 539, 547-548 (1980).)

We conclude in answer to the third question that a county may not designate a city to perform the functions of the county health department under the statewide registry and identification card program for medical marijuana users.

*7 Bill Lockyer

Attorney General

Daniel G. Stone
Deputy Attorney General

[FN1]. All references hereafter to the Health and Safety Code are by section number only.

[FN2]. Possession and distribution of marijuana remain unlawful under the federal Controlled Substances Act (21 U.S.C. § 801 et seq.). (People ex rel. Lungren v. Peron (1997) 59 Cal.App.4th 1383, 1387, fn. 2.) Federal law contains no "compassionate use" exemption for medical necessity. (Gonzales v. Raich (2005) ___ U.S. ___, ___; United States v. Oakland Cannabis Buyers' Cooperative, supra, 532 U.S. at p. 486; People v. Mower, supra, 28 Cal.4th at p. 465, fn. 2; People v. Bianco, supra, 93 Cal.App.4th at p. 753.)

[FN3]. The Department is responsible for designing the applications and identification cards, developing protocols to process the applications, confirming the accuracy of the information submitted, and protecting the confidentiality of program records. (§ 11362.71, subd. (d).)

[FN4]. Even in the absence of more lenient local rules, patients and caregivers are not limited to the quantities of marijuana set forth in section 11362.77, subdivision (a); rather, they are entitled to possess and to use medical marijuana in any amounts consistent with the patients' needs, as reflected in doctors' recommendations. (§ 11362.77, subd. (b).) The amounts set forth in section 11362.77, subdivision (a), thus represent "threshold" quantities of marijuana - that is, the amounts up to which the protections of sections 11362.5, 11362.71, subdivision (e), and 11362.765 will automatically apply for every qualified user and possessor throughout the state. Whether greater amounts may be possessed and used depends on local rules and physicians' assessments of particular patients' needs.

[FN5]. As previously mentioned, charter cities may supersede state statutes "with respect to municipal affairs" involving "areas which are of intramural concern only." (California Fed. Savings & Loan Assn. v. City of Los Angeles (1991) 54 Cal.3d 1, 17; accord, Johnson v. Bradley, supra, 4 Cal.4th at p. 399; see 85 Ops.Cal.Atty.Gen. 210, 213-214 (2002).) This constitutional grant of authority for charter cities has no application here, however, because the establishment and protection of a right to possess and use medical marijuana notwithstanding state criminal statutes is plainly a matter of statewide concern. Further, it is self evident that the procedures and protections afforded by the 2003 legislation are reasonably related to the resolution of this statewide concern. Hence, these state laws would prevail over any conflicting regulatory acts of a charter city. (See, e.g., Johnson v. Bradley, supra, 4 Cal.4th at p. 404; Committee of Seven Thousand v. Superior Court (1988) 45 Cal.3d, 491, 507; 83 Ops.Cal.Atty.Gen. 24, 26-29 (2000); 82 Ops.Cal.Atty.Gen. 165, 167-170 (1999).)

[FN6]. A local identification program would also be in conflict with the statewide program by being "duplicative." (See Sherwin-Williams Co. v. City of Los Angeles, supra, 4 Cal.4th at p. 897.)

[FN7]. Sections 11362.72 and 11362.74 describe steps to be followed by "a county health department or the county's designee" in processing applications and issuing cards.

[FN8]. In attempting to resolve uncertainty or ambiguity in a statute, we may look to the ordinary, commonly understood meanings of the words and phrases used by the Legislature. (See Hunt v. Superior Court (1999) 21 Cal.4th 984, 1000; DaFonte v. Up-Right, Inc. (1992) 2 Cal.4th 593, 601.)

[FN9]. Significantly, no mention of cities is made in section 11362.71. If the Legislature had intended for cities to have a role in performing these particular duties under the statewide program, it knew how to authorize expressly that outcome (see, e.g., §§ 11362.7, 11362.77, 11362.83); however, it chose not to do so.
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