UNITED STATES COURT OF APPEAL

FOR THE NINTH CIRCUIT

NO. 98-16950

OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES,

Appellants/Defendants,

v.

UNITED STATES OF AMERICA

Appellee/Plaintiff.

Appeal from Order Denying Motion to Modify Preliminary Injunction
Appeal From Order Modifying Injunction by the United States District Court
for the Northern District of California
Case No. C 98-0088 CRB
entered on October 13, 1998, by Judge Charles R. Breyer.

EXCERPTS OF RECORD
VOLUME III

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See signature pages for complete list of parties joining in this pleading, Civil L.R. 3-4(a)(1).

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATORS' CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS.	Nos. C 98-00085 CRB C 98-00086 CRB C 98-00087 CRB C 98-00088 CRB C 98-00089 CRB C 98-00245 CRB DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION, PERMANENT INJUNCTION AND FOR SUMMARY JUDGEMENT No Hearing Scheduled

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TO THE HONORABLE CHARLES R. BREYER, UNITED STATES DISTRICT JUDGE, AND TO ALL PARTIES TO THE ABOVE-CAPTIONED ACTION:

Defendants herein, by and through their respective counsel, specially appearing, submit the following Supplemental Joint Memorandum of Points and Authorities in Opposition to Plaintiff United States' Motion for Preliminary Injunction, Permanent Injunction and for Summary Judgment:

I. PROCEDURAL HISTORY

On January 9, 1998, the government filed the instant suit against six medical cannabis providers and individuals associated with them under to 21 U.S.C. Sec. 882. This Honorable Court granted Defendants' Motion for Continuance and directed Defendants to file Memoranda addressing the effect of federal law on Defendants' activities protected by Proposition 215, codified as California Health and Safety Code Sec. 11362.5, (hereinafter "H&S Sec. 11362.5"). On February 27, 1998, Defendants filed Memoranda of Points and Authorities in opposition to the government's motions. On March 24, 1998, this Honorable Court held a hearing in this matter. At the hearing, the Court instructed the parties to file supplemental briefs regarding issues raised at the hearing. Defendants herewith submit their Supplemental Joint Memorandum of Points and Authorities.

II. ARGUMENT

A. THE COURT'S EQUITABLE DISCRETION AND THE PROPER STANDARDS FOR INJUNCTIVE RELIEF.

A key question before the Court in this proceeding is whether the Court's equitable discretion is limited when the government seeks an injunction pursuant to a statutory enforcement scheme. The government contends that if it proves probability of success on the merits it need not prove irreparable injury because irreparable injury is

presumed. Moreover, the government contends that this presumption is irrebuttable. According to this argument, if the government establishes a likelihood of success on the merits (*i.e.* proving a statutory violation) the Court's equitable analysis ends there. The Court would be required to accept, *a priori*, the existence of irreparable injury and obligated to issue an injunction as a matter of course. No balancing of hardships or consideration of the public interest would be required or, for that matter, allowed. This analysis simply does not comport with the facts or the law.

First and foremost, as argued in Defendant's initial briefing, in oral argument on March 24, 1998, and elsewhere in this brief, the government has not established probability of success on the merits. As such, "the government is not entitled to a presumption, rebuttable or otherwise, of irreparable injury." *United States v. Nutri-Cology, Inc.*, 982 F.2d 394, 398 (9th Cir.1992). Second, the language in the *en banc* decision of *Miller v. California Pacific Medical Center*, 19 F.3d 449 (9th Cir. 1994) (*en banc*), suggests that such a presumption is limited to cases in which the statutory violation is conceded. "There [referring to *United States v. Odessa Union Warehouse Co-op*, 833 F.2d 172 (9th Cir. 1987)], the traditional requirement of irreparable injury was inapplicable because the parties *conceded* that the federal statute involved was violated." 19 F.3d at 459, (emphasis added). Clearly, here the Defendants concede no statutory violation. Third, even if the government were to show a likelihood of success on the merits, any presumption of irreparable injury would have to be rebuttable. To hold otherwise would run afoul of clearly established Supreme Court precedent. *Weinberger v. Romero-Barcelo*, 456 U.S. 305, (1982); *TVA v. Hill*, 437 U.S. 174 (1978).

There is no Ninth Circuit case that squarely addresses whether a presumption of irreparable injury is rebuttable or irrebuttable. The closest is *United States v. Nutri-Cology, Inc., supra.* In *Nutri-Cology* the Food and Drug Administration sought to enjoin the distribution of dietary supplements as unapproved "new drugs". The Ninth Circuit held that because the defendant disputed the statutory violation, the government was not entitled to a presumption of irreparable injury. The Court referred to such a presumption as

"rebuttable or otherwise". 982 F.2d at 398. Because the Court found the government entitled to no presumption, it never reached the issue of whether such a presumption would be rebuttable. The Court's choice of language, however, suggests that it viewed such a presumption as rebuttable.

In *Weinberger v. Romero-Barcelo*, the Supreme Court addressed the appropriate equitable standards when an injunction is sought pursuant to a statutory scheme. Most relevant to the issue at hand, the Court stated, "[t]he grant of jurisdiction to ensure compliance with a statute hardly suggests an absolute duty to do so under any and all circumstances, and a federal judge sitting as chancellor is not mechanically obligated to grant an injunction for every violation of law." *Romero-Barcelo*, at 313. If a presumption of irreparable injury were irrebuttable, then a judge sitting as chancellor in equity would be "mechanically obligated to grant an injunction for every violation of law."

In *Romero-Barcelo*, as in *TVA v. Hill, supra* before it, and *Amoco Prod. Co. v Village of Gambell*, 480 U.S. 531 (1987) after it, the Supreme Court has clearly stated that an injunction is an extraordinary remedy, and "unless a statute in so many words, or by a necessary and inescapable inference, restricts the Court's jurisdiction in equity, the full scope of that jurisdiction is to be recognized and applied." *Romero-Barcelo*, at 313. The Court further explained, "that a major departure from the long tradition of equity practice should not be lightly implied . . . we construe the statute at issue in favor of that interpretation which affords a full opportunity for equity courts to treat enforcement proceedings . . . in accordance with their traditional practices, as conditioned by the necessities of the public interest which Congress has sought to protect."

Section 882 of the Controlled Substances Act, (hereinafter "CSA"), does not in any way, 'in so many words, or by a necessary and inescapable inference,' limit a court's jurisdiction in equity. As such, in an enforcement proceeding under Sec. 882, the traditional equitable criteria of irreparable injury, a balancing of hardships, and the public interest *can and must* be weighed by the Court before any injunction can issue. The government has made no showing, beyond its claimed presumption of irreparable injury, that it will suffer

any irreparable injury. Neither has it shown in any way that the balance of hardships or the public interest require the extraordinary remedy of an injunction. On the contrary, Defendants and the *Amici* have shown that the only injury and hardship that would be suffered by individuals and the public at large would come as a result of an injunction being issued against the cooperatives. This Court is not obligated to issue an injunction. Principles of equity dictate that it must not issue an injunction.

B. THE DEFENDANTS ACTIVITIES BEAR NO RELATION TO INTERSTATE COMMERCE AND ARE NOT AMENABLE TO REGULATION UNDER THE CSA

At the hearing of March 24th, this Court posed several questions to both sides relating to the Commerce Clause issue raised by the Defendants. Initially the Court queried the government as to whether there was "any evidence that Congress, when it enacted the Controlled Substance Act of 1970, considered the medical use of marijuana?" Reporter's Transcript of March 24, 1998, Hearing, 9:19, (hereinafter "Transcript"). The government never responded to this question, but if it had, the government would have had to acknowledge that the legislative history of the CSA establishes that Congress did not consider such medical use.

The Court next asked "can the government articulate how interstate commerce ... is affected by these particular intrastate activities which are proscribed by the controlled substance act?" Transcript, 9:23. Again the government failed to respond to the Court's query, other than to repeat the allegation made in its brief that the Defendants were distributing mexican-grown marijuana, (an allegation that Defendants deny). Upon questioning from the Court, however, the government stated that even if the Court tailored an injunction to bar interstate activities, the government would still view Defendants' activities as violative of federal law. Transcript, 30:25-31:12. At no time during the hearing did the government offer any theory explaining how the Defendants' activities affected interstate commerce.

A review of congressional findings contained in the CSA reveals that Congress found intrastate trafficking in illicit drugs does have an effect on interstate commerce. See 21 USC § 801. However, as noted in Defendants' initial brief, none of these findings are applicable to Defendants' activities. See Defendants' Joint Memorandum Of Points And Authorities In Opposition To Plaintiff's Motions For Preliminary Injunction, at 17.

The Court next asked the government whether "the intrastate activities have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that which can be regulated?" Transcript, 10:2. Again the government never responded. Defendants submit herein that the government cannot identify *any* relation to interstate commerce, let alone one that is "close and substantial", because such a relationship does not exist.

In questioning the Defendants, the Court asked two questions regarding the Commerce Clause issue. First, the Court asked the Defendants how their activity was distinguishable from that of other defendants who have unsuccessfully sought to challenge the application of the CSA to intrastate activity following the *Lopez* decision. Transcript, 39:12. Secondly, the Court inquired as to whether Defendants' activities constituted "commerce". Transcript, 39:19.

Responding to these questions, Defendants admit that their activities would probably fall within the meaning of "commerce" as courts have traditionally liberally construed the term. However, other than the general definition as "commerce", Defendants' activities bear no resemblance to those of the defendants in any other Ninth Circuit post-*Lopez* Commerce Clause challenge.

As each appellate panel that has considered such a challenge has found, Congress in most cases may lawfully regulate a class of activities that affects interstate commerce, even those specific members of the class which are intrastate in nature only. The government, in presenting its case to the Court, has proceeded on the assumption that the Defendants' activities are part and parcel of the "class of activities" Congress

sought to ban in promulgating Sections 841, 846, and 856 of the CSA, the sections the government seeks to enforce against the Defendants by this action. Defendants have argued in their earlier brief and at the hearing of March 24th that their activities are not in this "class of activities" Congress sought to regulate. In its response brief, and again at the March 24th hearing, the government failed to respond to this argument.

The Ninth Circuit has considered four post-*Lopez* Commerce Clause challenges to prosecutions brought under the CSA. *U.S. v. Staples*, 85 F.3d 461 (9th Cir. 1996), (use of firearm while distributing cocaine, in violation of 18 U.S.C. § 924(c)(1), the underlying offense being a violation of § 841); *U.S. v. Kim*, 94 F.3d 1247, 1248 (9th Cir. 1996), (possession of methamphetamine with the intent to distribute, in violation of 21 USC § 841); *U.S. v. Tisor*, 96 F.3d 370 (9th Cir. 1996), (conspiracy to distribute and distribution of methamphetamine, in violation of §§ 841 and 846); and *U.S. v. Henson* 123 F.3d 1226 (9th Cir. 1997), (distribution of PCP in violation of §§ 841 and 846). In each and every one of these cases there was no argument that the Defendants were involved in anything other than the trafficking of illicit drugs.

In contrast, the Defendants herein are involved in supplying a needed medicine to the member of their cooperatives on a non-profit basis. The Defendants are performing this service in compliance with state and local regulations and oversight in a medically responsible manner. See, for example, Oakland Cannabis Buyers' Cooperative Protocols, attached hereto as Exhibit "1".

As the Ninth Circuit recognized in these cases, as illustrated in *Lopez*, Congress may properly regulate intrastate activity that "*substantially* affected interstate commerce." *Staples*, at 463 [Emphasis added]; see also *Tisor*, at 375; *Henson*, at 1233. The Ninth Circuit noted that it could properly rely on the Congressional findings in §801 of the CSA to find that the intrastate trafficking of illicit drugs has such a substantial effect on interstate commerce. *Kim*, at 1250; *Tisor*, at 375. This reliance on Congressional findings to establish the necessary "substantial effect" is essentially a presumption upon which the government may rely in criminal prosecutions, and upon

which the government seeks to rely in this action. However, as the Ninth Circuit has made abundantly clear, this presumption is a *rebuttable* presumption. *U.S. v. Rodriquez-Camacho*, 468 F.2d 1220, 1222 (9th Cir. 1972); *U.S. v. Visman*, 919 F.2d 1390, 1392 (9th Cir. 1990).

The Defendants herein, if given the opportunity, are prepared to establish that the relation of their activities to, and the effect upon, interstate commerce is clearly non-existent. The government has made no proffer to the contrary and, in fact, failed to identify any such connection, even when directly questioned by the Court. If no such connection exists, the sections of the CSA upon which the government relies are inapplicable to the Defendants' conduct.

C. SUBSTANTIVE DUE PROCESS

1. The Fundamental Right Asserted By The Defendants Cannot Accurately Be Described As a Claim to a "Particular Treatment".

Defendants contend the government is attempting to infringe on their Substantive Due Process rights to be free from unnecessary pain, to receive palliative treatment for a painful medical condition, to care for oneself, and to preserve one's own life. *Washington v. Glucksberg*, ____ U.S. ____, 117 S.Ct. 2258 (1997); *Deshaney v. Winnebago Cty. So. Servs. Dept.*, 498 U.S. 189, 200 (1989). In response to Defendants' argument, the Government points to the Laetrile cases where terminally ill patients were denied access to Laetrile, a supposed cancer cure whose safety and effectiveness were unknown and untested.

These cases, and the drug Laetrile, are not analogous to using marijuana for medical purposes. The Court's objective in barring patients from obtaining Laetrile was the protection of those very patients against sham treatments of great expense. No such claim could me made here. As the late Justice Marshall warned,

> "[R]esourceful entrepreneurs have advertised a wide variety of purported...cures for cancer including liniments...; peat moss; arrangements of colored flood lamps; pastes made

> from glycerin and limburger cheese; mineral tables; and 'Fountain of Youth' mixtures". He continued his observation that,"Congress could reasonably have determined to protect the terminally ill...from the vast range of self-styled panaceas that inventive minds can devise".

United States v. Rutherford, 442 U.S. 544, 557 (1979).

It is clear from this case and the others[1] relied upon by the government that the petitioners were never able to establish that a "fundamental interest" was at stake in obtaining Laetrile because, very simply, they could not establish that Laetrile was either safe or effective as a remedy for any malady let alone as one which could save their lives. The courts considering the issue consistently pointed to the unknown medicinal value of Laetrile in denying the terminally ill patients demands for treatment. The Supreme Court went so far as to assert that such treatment could lead to needless deaths by terminally ill patients: "If an individual suffering from a potentially fatal disease rejects conventional therapy in favor of a drug with no demonstrable curative properties, the consequences can be irreversible". *Rutherford*, at 556.

The *Rutherford* line of cases examined the asserted right to a drug of unknown and questionable effectiveness. Furthermore, the proponents of Laetrile were primarily of two classes: those who were positioned to benefit financially from Laetrile's distribution and those who were desperate to try Laetrile at any cost to preserve their lives. The government's interest in protecting the desperate dying against charlatan remedies was clearly demonstrated.

The factual situation now before the Court is very different. The Defendants herein do not assert the unsupported fundamental right to "be left alone" but rather, they assert the clearly demonstrated rights to be free from agonizing pain,

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[1] In both Vital Health Products (E.D. Wis. 1992) 786 F.Supp. 761 and Kulsar v. Ambach, (W.D. N.Y. 1984) 598 F.Supp. 1124 the determinative factor was that the treatments sought were unproven or even shams. In Vital, a home remedy company was denied relief where it attempted to market unproven products without prior approval. Similarly in Kulsar, hypoglycemic patients were not entitled to obtain "nutritional-hormonal" therapy where there was only one physician in the country who utilized the treatment.

blindness and death. The stark contrast in the nature of the fundamental rights asserted make the Laetrile cases inapposite to the determination now before the Court. This is particularly true where the government does not even purport that it is denying marijuana to the defendants for safety concerns; nor can the Government, in light of its own studies, deny marijuana's effectiveness.

The Defendants do not assert the right to "whatever treatment" or a "particular" treatment, but rather they assert the right to a demonstrated and effective treatment as recommended bv their physician that can alleviate their agony, preserve their sight, and save their lives. *Rutherford* and its progeny have no bearing on this inquiry.

2. Cases Involving an Assertion of Equal Protection Rights Are Not Applicable to Substantive Due Process Analysis.

A number of the cases cited by the government in response do not address the issue of substantive due process, but rather that of Equal Protection. Thus, in *Mitchell v. Clayton*, 995 F.2d 772 (7th Cir. 1993), and *Sammon v. New Jersey Board of Medical Examiners*, 66 F.3d 639 (3rd Cir. 1995), the plaintiffs were not patients, but rather practitioners of the alternative medicines of acupuncture and midwifery. The plaintiffs complained that the states' requirements of a medical license to practice violated equal protection. Neither of the courts found that the practitioners were members of a suspect class, and thus the court applied the "rational basis" standard in evaluating the challenged laws and found that the requirement did bear a rational relation to a legitimate state interest. These cases bear no similarity to the Defendants' claims of violations of fundamental liberties.

3. The Government Cannot Demonstrate that the Marijuana Prohibition is Narrowly Tailored to Serve a Compelling State Interest; Nor Can It Demonstrate that it is Rationally Related to a Legitimate Governmental Interest.

If the Court finds that the Defendants have fundamental liberty interests

at stake, the Government must demonstrate that its arbitrary blanket marijuana prohibition, in the face of a state law, is narrowly tailored to serve a compelling governmental interest. Absent such a showing, the prohibition is nothing but an arbitrary exercise of Government power. The Government has never addressed this issue, nor enumerated its justification for such a broad proscription. The blanket prohibition, disregarding the medical needs of Defendants and restricting their physicians, cannot be said to be narrowly tailored to control the marijuana drug trade.

In *Andrews v. Ballard*, 498 F.Supp 1038 (1980), after concluding that there was a compelling state interest in protecting the health of patients by regulating acupuncture, the court went on to consider whether the regulations were sufficiently narrow. To do so, the court held that they "must be 'necessary,' *Shapiro v. Thompson*, 394 U.S. 618, 634, 89 S.Ct. 1322, 1331. 22 L.Ed2d 600 (1969), to the protection of the patient's health."[2]

D. FEDERAL LAW DOES NOT PREEMPT IMPLEMENTATION OF H&S Sec. 11362.5

The government argues that the supremacy of federal over state law "automatically" preempts implementation of H&S § 11362.5. Contrary to the government's argument, preemption under the Controlled Substance Act requires a *factual showing -- by the government* -- that the contested state law presents "a positive conflict" to the CSA. 21 U.S.C. § 903. Until and unless the government can prove that H&S § 11362.5 does, *in fact*, present such a "conflict," the government's request for

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[2] In Andrews v. Ballard (S.D. Tex. 1980) 498 F.Supp 1038, 1049, fn. 34, the court explains this holding as turning *not* on the "particular treatment" but rather because of a finding that the ban met constitutional muster in its purpose: "The outcome of the case [Rutherford], if correct, was proper not because the plaintiffs had no right to decide to obtain laetrile, but because the ban on laetrile was 'narrowly drawn' to achieve the 'compelling state interest' in protecting the health and safety of cancer patients." The Ballard court held that patients did have a constitutionally protected privacy interest in obtaining acupuncture treatment.

injunctive relief cannot issue.

There are three categories of federal preemption: "(1) *Explicit preemption* . . . ; (2) *Field Preemption* . . . ; and (3) *Conflict preemption* 'where compliance with both federal and state regulation is a physical impossibility,' . . . or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'." *Hunter Douglas, Inc. v. Harmonic Design, Inc.*, 962 F.Supp. 1249, 1251 (C.D. Cal. 1997), quoting *Cover v. Hydramatic Packing Co. Inc.*, 83 F.3d 1390 (Fed. Cir. 1996).

Congress has indicated that "conflict preemption" regulates the Controlled Substance Act. 21 U.S.C. § 903, set forth at n.1 herein, *supra*. As such, the burden is on the government, under Sec. 903, to prove that state law is in positive conflict with the CSA and that there is no way that the two can stand together. Accordingly, under 21 U.S.C. Sec. 903, the government's request for injunctive relief cannot issue until the government has shown through competent evidence that implementation of H&S Sec. 11362.5 actually and materially presents a "positive conflict" to the objectives set out in the CSA. To date, the government has made no such showing, and it would be difficult for the government ever to make such a showing. "It is unreasonable to believe that use of medical marijuana by this discrete population for this limited purpose will create a significant drug problem." *Conant v. McCaffrey*, 172 F.R.D. 681, 694 n5. (N.D. Cal. 1997).

The importance of this approach is to reject the assumption, until proved otherwise, that medical marijuana is illegal, and to give Sec. 903 the conflict preemption meaning Congress must have had when the words were chosen, rather than words showing mere express or field preemption.

E. RIGHTS RETAINED AND POWERS RESERVED BY THE PEOPLE OF THE STATE OF CALIFORNIA DICTATE THAT THE FEDERAL GOVERNMENT NOT INTRUDE UPON THE DEFENDANTS' ACTIVITIES.

During the March 24, 1998, hearing in this matter the Ninth and Tenth

Amendments were mentioned on two occasions. The Defendants' Substantive Due Process and Commerce Clause arguments are bolstered by the Ninth and Tenth Amendments respectively. The Ninth Amendment confirms that the people retain rights in addition to those specifically enumerated in the Constitution.[3] The Tenth Amendment confirms that congressional action must be within one of the powers enumerated in Article I.[4] Rep. James Madison, in a speech to Congress, referred to the Tenth Amendment "as excluding every source of power not within the Constitution itself"[5] and to the Ninth Amendment as "guarding against a latitude of interpretation" of those powers. 1 Annals of Cong. 1901. Thus, according to Madison, under the Tenth Amendment, Congress must identify a source of power to regulate or prohibit the medical use of marijuana *"within the Constitution itself,"* and, under the Ninth Amendment, enumerated powers, such as the commerce power, should not be given "a *latitude of interpretation*." As we have shown above, the government has failed to meet this standard, and the Ninth and Tenth Amendments, if they do nothing else, provide additional authority for refusing to grant the relief sought by the government.

1. The Ninth Amendment

The Ninth Amendment, once forgotten,[6] has been much discussed in

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[3] "The enumeration in the constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." U.S. Const. Amend. IX.

[4] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. Amend. X.

[5] Because the amendments were still pending when this speech was given, and the first two amendments had not yet failed to be ratified, he referred to the Ninth Amendment as the "11th" and the Tenth Amendment as the "12th".

[6] *See* B. Patterson, *The Forgotten Ninth Amendment* (1955).

recent years by Constitutional scholars.[7] In the landmark case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the opinion of the Court, jointly authored by Justices Kennedy, Souter, and O'Conner, cited the Ninth Amendment as authority for protecting liberties not specifically enumerated in the Constitution. "Neither the Bill of Rights nor the specific practices of the States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects. See U.S. Const. Amend. 9." 505 U.S. at 848. The Justices then went on to quote with approval Justice Harlan's statement that the "substantive sphere of liberty . . . includes a freedom from all substantial arbitrary impositions and purposeless restraints, . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs to justify their abridgment." *Id.* The government's scheduling of marijuana to prohibit its medical use cannot survive this scrutiny. Moreover, since this case involves the exercise of a federal power over a right retained by the people, the Ninth Amendment operates directly against the federal government without the intermediary of the Fourteenth Amendment.

The Ninth Amendment has been said to establish an even broader protection of liberty.[8] It establishes a presumption in favor of any rightful exercise of liberty (or "liberty interest") such that the burden falls upon the federal government to show that any infringement of that liberty is both *necessary* and *proper* -- the standard supplied by the Constitution itself.[9] This burden the government cannot meet. In sum,

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[7] *See, e.g.*, R. Barnett, ed., *The Rights Retained by the People: The History and Meaning of the Ninth Amendment* (Vol. 1, 1989; Vol. 2, 1993) (collection of Ninth Amendment scholarship).

[8] *See, e.g., Implementing the Ninth Amendment* in 2 *Id.* at 23.

[9] *See* U.S. Const. Art. 1 § 8, cl. 18. *See also*, G. Lawson & P. Granger, *The "Proper" Scope of the Federal Power: A Jurisdictional Interpretation of the Sweeping Clause*, 43 Duke L.J. 267 (1993); R. Barnett, *Necessary and Proper*, 44 U.C.L.A. Law. Rev. 745 (1997).

though the government may *regulate* the exercise of liberties retained by the people, heightened scrutiny applies to ensure that any regulation is "necessary." It is "improper" for the *regulation* of a liberty, protected by the Ninth Amendment, to be used as pretext to *prohibit* its exercise, as would be the case under the government's contention that the Controlled Substances Act completely prohibits the Defendants' activities with regard to medical marijuana.

But the Court need not go this far in the present case, for even the most conservative rendering of the Ninth Amendment would see it as protecting rights that the people, acting through state processes, have explicitly chosen to retain.[10] For this reason, the fact that the people of the State of California have, through their initiative process, spoken on this issue should be decisive in determining this liberty to be fundamental. While courts should be skeptical of even popular *interference* with the rights or liberties of individuals and minorities, (*see e.g.* Romer v. Evans, 116 S.Ct. 1620 (1996) (invalidating an initiative that amended the Colorado constitution to limit the rights of gay persons)), courts should give great deference to a judgment by the people that a particular individual liberty interest is fundamental. It is inconceivable that a liberty a majority of the people have endorsed in a free and fair election not be deemed by a court to be "fundamental" enough to require the strictest scrutiny of any governmental denial or disparagement.

The challenge for protecting the unenumerated rights retained by the people (as well as for applying substantive due process) has always been to identify which liberties are fundamental—and therefore deserving of heightened scrutiny. The initiative process provides one answer to this challenge. We do not claim that all initiatives are immune from judicial scrutiny. We do claim, however, that the people of

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[10] *See, e.g.*, Robert Bork, *The Tempting of America* 184 (1990) ("[T]he people retained certain rights because they were guaranteed by the various state constitutions, statutes, and common law."). *See also* Calvin Massey, *Silent Rights* (1995) (arguing that rights retained by the people should be defined by state law).

the State of California have deemed the medical use of marijuana to be a fundamental liberty interest. Judicial conservatism requires deference to this decision, followed by the heightened scrutiny that protects all fundamental rights from legislative infringement.

2. The Tenth Amendment.

As the quote from Madison, *supra.*, indicates, the Tenth Amendment primarily limits federal powers to those enumerated in the Constitution. In recent years, the Supreme Court has shown an increasing willingness to use the Tenth Amendment to limit the exercise of federal power when it infringes upon the powers of the states or the people. *See e.g. New York v. United States*, 505 U.S. 144, 157 (1995) ("[T]he Tenth Amendment confirms that the power of the Federal Government is subject to limits that may, in a given instance, reserve power to the States); *Printz, et al. v. United States*, 117 S.Ct. 2365, 2376 (1997) ("Residual state sovereignty was also implicit, of course, in the Constitution's conferral upon Congress of not all governmental powers, but only discrete, enumerated ones, Art. I, § 8, which implication was rendered express by the Tenth Amendment . . . ."). As discussed above and in the initial briefing, the commerce power does not justify federal interference with the Defendants' activities involving medical marijuana. The Tenth Amendment affirms that where an activity is not reached by the commerce power, or any other enumerated power, Congress may not act to interfere with this activity.

Although the courts have sometimes had difficulty determining when the Tenth Amendment protects state sovereignty and when it does not (*see Garcia v. San Antonio Metropolitan Transit District*, 469 U.S. 528, (1985)), when considering a popular initiative that identifies for the people a *zone of liberty*, a Tenth Amendment analysis is easier. The Tenth Amendment reserves power to the states "*or to the people.*" U.S. Const. Amend. X. The people of California have reserved to themselves the power of popular initiative, a power nowhere surrendered in the Constitution to the general

government. We are not therefore speaking only of the choice of a patient to use marijuana for medical purposes, but of the choice *of the people* of the State of California to permit this decision. Whereas the individual's choice or *liberty* is protected by the Ninth Amendment, the *power* of the people to recognize and protect that choice is protected by the Tenth.

When the people exercise their reserved power to carve out a *zone of liberty*, the federal government cannot infringe upon this zone except when it can establish the most compelling claim of a delegated federal power. As we have shown, the government cannot meet this standard in the case of marijuana grown and distributed within California for medical uses. The U.S. Constitution nowhere gives the federal government the power to restrict the use of marijuana for medical purposes or a more general power in which this specific power would be subsumed. As explained above, the power to regulate commerce "among the states" clearly does not apply to the purely local activities of Defendants. Nor do their activities have any substantial effect or burden on commerce among the states.

The Tenth Amendment requires that, in the absence of an enumerated power, the federal government shall not interfere with a power "reserved to the states . . . or to the people." Here, the people have reserved their initiative power, and have exercised that power to define a zone of liberty, which is not properly reached by the power to regulate commerce among the states and within which the federal government may not intrude.

F. THE COURT SHOULD ABSTAIN, PENDING FURTHER IMPLEMENTATION AND CLARIFICATION OF CALIFORNIA LAW.

Further interpretation of H&S Sec. 11362.5 by California courts and localities may result in a confirmation that the medical use of cannabis is outside the class of activities Congress seeks to regulate by the Controlled Substances Act.

California courts and policy-makers have only begun to define the conduct regulated by H&S Sec. 11362.5. Without time for this new law to develop, defendants will lack a fair opportunity to prove the points critical to their argument, mainly, that the use of medical marijuana governed by H&S Sec. 11362.5 does not involve illicit drug use, is an entirely intrastate activity, and falls outside the reach of Congress' commerce power. (See Commerce Clause Argument, below). Implementation of H&S Sec. 11362.5 by individual localities and clarification of the law by California courts is therefore necessary to distinguish the illicit drug trade regulated by the Controlled Substances Act, (hereinafter "CSA"), from the legal access to marijuana for specific medical purposes that H&S Sec. 11362.5 controls. Thus, in order to provide defendants with an opportunity to present comprehensive arguments with respect to Commerce Clause and Substantive Due Process issues, defendants request that the Court abstain. See *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943); *Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800 (1976).

At this point in the new law's evolution, it is unclear exactly who may possess, distribute, or cultivate marijuana. For example, it is yet to be determined who a "primary caregiver" is that may possess and cultivate marijuana "for the personal medical purposes of the patient upon the oral or written recommendation of a physician." H&S Sec. 11362.5(d). How one may accomplish these activities is also unclear. Judicial interpretation will clarify some of these uncertainties. State court determinations will aid this Court by helping to distinguish the conduct the CSA seeks to regulate from that which California seeks to regulate through H&S Sec. 11362.5. Decisions by the California Supreme Court concerning this statute will also help to define the law's boundaries. To permit this and other judicial interpretations, abstention is required.

G. THE COOPERATIVES AND INDIVIDUAL DEFENDANTS WHO ARE NOT THEMSELVES IN MEDICAL NEED OF MARIJUANA CAN ASSERT A DEFENSE OF MEDICAL NECESSITY.

The common law defense of medical necessity is not limited to the patient who possesses or cultivates the marijuana. The defense is also available to one who engages in otherwise criminal conduct to avoid imminent harm to a third party. As explained by the Sixth Circuit Court of Appeals in *United States v. Newcomb,* 6 F.3d 1129, 1135 (6th Cir. 1993):

> In light of the fact that the philosophical underpinning of the justification defense is the avoidance of a greater evil, it is fundamental that the defense must apply equally to a choice-of-evils case when the evil is to a third party as to the case where the evil is to one's self. Conduct should be deemed justified when it is an emergency measure necessary to avoid an imminent injury -- an injury sufficiently grave that, according to objective standards, the desirability of avoiding that injury outweighs the desirability of avoiding the injury sought to be prevented by the violated statute.

United States v. Schoon, 939 F.2d 826, 828-29 (9th Cir. 1991).

It is especially important to note that the Sixth Circuit, in reaching this conclusion, relied explicitly upon Ninth Circuit case authority:

> Moreover, in canvassing other circuits' treatment of the defense, we find that most who have considered the question would permit application of the justification defense when avoidance of harm to third parties is the basis for the defendant's action. The Ninth Circuit, for example, frames its test as follows:
>
> > As a matter of law, a defendant must establish the existence of four elements to be entitled to a necessity defense: *(1) that he was faced with a choice of evils and chose the lesser evil; (2) that he acted to prevent imminent harm;* (3) that he reasonably anticipated a causal relation between his conduct and the harm to be avoided; and (4) that there were no other legal alternatives to violating the law.
>
> *United States v. Aguilar,* 883 F.2d 662, 693 (9th Cir. 1989) (emphasis added) (citing *United States v. Dorrell,* 758 F.2d 427, 430-31 (9th Cir. 1985), *cert. denied,* 498 U.S. 1046, 111 S.Ct. 751, 112 L.Ed.2d 771 (1991).

Newcomb, at 1136.

While each of the Ninth Circuit cases cited upheld the rejection of a necessity defense in the context of political protest activity, the court in all of these cases

gave implicit recognition to availability of the defense where evidence of each of its elements is proffered, and made it clear the defense is equally available to third parties acting to relieve the necessity of others.

H. CONGRESS HAS NOT CONSIDERED THE MEDICAL USES OF MARIJUANA.

At the March 24, 1998, hearing, the court's first question to the government was whether Congress considered medical marijuana when enacting the Controlled Substances Act. The answer to that question is a resonating, "No."

Although Congress did consider the medical utility of drugs generally, (see 21 U.S.C. § 801(1)), Defendants can find no indication that Congress gave any consideration to the medical utility of marijuana specifically. Indeed, Congress intended to place marijuana *only tentatively* in Schedule I, the category subject to the most stringent controls, awaiting forthcoming information and recommendations. Placement in Schedule I requires that a drug, inter alia, have "no currently accepted medical use in treatment," (21 U.S.C. § 812(b)(1)(B)), and effectively precludes marijuana's use as a prescribed medicine.

A review of the legislative history of the Controlled Substances Act reveals that Congress deferred to the request of the Nixon Administration's Department of Health, Education, and Welfare, that Congress place marijuana "within schedule I at least until the completion of certain studies now underway." 1970 U.S. Code Cong. & Admin. News 4579. It is unclear what those "certain studies now underway" were; however, Congress never revisited the issue of where properly to schedule marijuana in light of the results of those alleged studies. Moreover, Congress appropriated $1,000,000 to commission a thorough study to provide recommendations for appropriate marijuana legislation. According to the legislative history, "In addition, section 601 of the bill provides for establishment of a Presidential Commission on Marihuana and Drug Abuse. The recommendations of this Commission will be of aid in determining

the appropriate disposition of this question in the future." *Id.* Unfortunately, as discussed below, Congress promptly ignored the recommendations of that Commission.

Congress instructed the Commission to "conduct a comprehensive study and investigation of the causes of drug abuse and their relative significance. The Commission shall . . . submit to the President and the Congress a final report which shall contain . . . such recommendations for legislation and administrative actions as it deems appropriate." Public Law 91-513, § 601(e) (October 27, 1970). (Sec. 601 of Public Law 91-513 is apparently not codified in Title 21). Specifically with respect to marijuana, Congress mandated, "The Commission shall conduct a study of marihuana including, but not limited to, the following areas: . . . (B) an evaluation of the efficacy of existing marihuana laws; (C) a study of the pharmacology of marihuana and its immediate and long-term effects, both physiological and psychological . . . ." *Id.* at § 601(d)(1).

The Commission became known as the "Shafer Commission." Its members were not "soft" on drugs. One historian described its composition as follows:

> The new Presidential Commission on Marijuana was shaping up to be a reefer-madness folly. Its chairman, hand-picked by Nixon, was the retired Republican governor of Pennsylvania, Raymond Shafer, a known drug hawk. The commission was stacked with conservative doctors. Senator Harold Hughes of Iowa -- who never tired of frightening Congress with drug horror stories -- was one of four congressional members. Of the rest, only Jacob Javits could be said to be remotely reasonable, and even he was no legalizer. Worst of all, the commission's executive director -- the man who decided whom to call for testimony -- had been involved in some of the darkest recent episodes in drug policy. His name was Michael Sonnenreich.

D. Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure* 52 (1996).

Despite its composition, the Shafer Commission -- as has virtually every other entity before or since that has conducted an independent, honest review of the facts -- made recommendations contrary to current government policy regarding marijuana.

Sonnenreich was no ideologue. He'd been assigned to

> gather the facts about marijuana use, and these were the facts he was finding. He also hadn't yet heard any medical evidence convincing him the stuff was as dangerous as the "reefer-madness crowd" liked to say it was. The gateway theory, he thought, was "crap." One afternoon, while poring over some medical research in his office, Sonnenreich suddenly looked up at his assistant and said, "There's nothing the matter with this drug."
>
> Having come to that conclusion, and appalled by the waste of court time, corrections money, and young lives on the alter of marijuana prohibition, Sonnenreich and his staff set out . . . . It wasn't that he thought marijuana was "good"; he still believed smoking it was foolish. But it was clear to his lawyer's eye that criminalizing it was cheapening the criminal justice system and overwhelming the prisons.

Id. at 63.

In response to "the threshold question: why has the use of marihuana reached problem status in the public mind?" the Shafer Commission concluded that the answer was not with its health effects, the behavior it causes, or any pharmacological property of the drug. Rather, according to the Commission, "Marihuana becomes more than a drug; it becomes a symbol" of the "counterculture."

> A final cost of the possession laws is the disrespect which the laws and their enforcement engender in the young. Our young cannot understand why society chooses to criminalize a behavior with so little visible ill-effect or adverse social impact . . . . And the disrespect for the possession laws fosters a disrespect for all law and the system in general
>
> On top of all this is the distinct impression among the youth that some police may use the marihuana laws to arrest people they don't like for other reasons, whether it be their politics, their hair style, or their ethnic background.

Marihuana: A Signal of Misunderstanding; First Report of the National Commission on Marihuana and Drug Abuse, 145-6 (1972). Pages of the Report are attached hereto in Exhibit "2".

Ultimately, the Shafer Commission recommended decriminalization of marijuana:

- POSSESSION OF MARIHUANA FOR PERSONAL USE WOULD NO LONGER BE AN OFFENSE . . . .
- CASUAL DISTRIBUTION OF SMALL

AMOUNTS OF MARIHUANA FOR NO REMUNERATION, OR INSIGNIFICANT REMUNERATION NOT INVOLVING PROFIT WOULD NO LONGER BE AN OFFENSE.

Id. at 152.

- POSSESSION IN PUBLIC OF ONE OUNCE OR UNDER OF MARIHUANA WOULD NOT BE AN OFFENSE . . . .
- POSSESSION IN PUBLIC OF MORE THAN ONE OUNCE OF MARIHUANA WOULD BE A CRIMINAL OFFENSE PUNISHABLE BY A FINE OF $100.

Id. at 154.

Perhaps because marijuana was a "symbol" for members of a "counterculture" who were enemies of Richard Nixon, and the marijuana laws provided a convenient vehicle by which to punish those enemies, President Nixon ignored the recommendations of his own Commission's Report.

> "I read it and reading it did not change my mind," Nixon told reporters during an impromptu Oval Office press conference a couple of days after its release. He offered no reason for his decision. None of the big newsweeklies reported on the commission's findings. . . . [A] commission of Nixon's own choosing recommended legalization, and the press let Nixon bury the story.

Smoke and Mirrors, supra, at 72.

Congress, also, ignored the recommendations of the Commission, and has never reconsidered the classification of marijuana in light of the Shafer Commission's recommendations.

Because of the Commission's recommendation for full decriminalization of marijuana, there was no need for it to make separate recommendations permitting medical use. Thus Congress did not consider the medical use of marijuana when enacting the Controlled Substances Act in 1970, or in response to the Shafer Commission's Report. Since that time Congress did not visit the issue until recently when both the Senate and the House have considered "Sense of the Senate" and "Sense of the House" resolutions opposing not only the medical use, but even the allocation of

funds for research into the medicinal use of marijuana. (See Exhibit "3").

For decades the government has, for political reasons, refused to recognize marijuana's medical value, or the plight of patients who can benefit from it. Such a refusal, while clinging tenaciously to groundless "findings," irremediably soils the government's hands. It is duplicitous for the government now to ask this court of equity to enjoin the Defendants' activities, when the government's own independent analyses do not justify the government's position. It is unconscionable for the government to request that this Honorable Court invoke its equitable power in complicity with such duplicity.

I. THE DRUG ENFORCEMENT ADMINISTRATION'S OWN ADMINISTRATIVE LAW JUDGE RECOMMENDED RESCHEDULING MARIJUANA.

At the hearing on March 24, 1998, an issue arose concerning implications of the D.C. Circuit's decision permitting the Drug Enforcement Administration ("DEA") to maintain marijuana's classification in Schedule I.

That case's origins trace to 1972, when groups petitioned to reschedule marijuana. Eventually, the DEA's own Administrative Law Judge, Francis L. Young, conducted extensive evidentiary hearings on marijuana's medical efficacy and safety. On the basis of a thorough review of the record, Judge Young issued an Opinion & Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge ("Decision"). *Reprinted in* 2 R. Randall, *Marijuana, Medicine & the Law* 403-446 (1989), attached hereto in Exhibit "2".

In the Decision, Judge Young recommended that the DEA Administrator reschedule marijuana from Schedule I to Schedule II. *Id.* at 445-6.

> The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasoning, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefit of this substance in light of the evidence in this record.

Id. at 445.

Moreover, the Decision, in numerous other contexts, terms elements requiring marijuana's inclusion in Schedule I as "unreasonable, arbitrary and capricious." *Id.* at 427, 438, 444. With regard to marijuana's safety, the Decision stated, "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care." *Id.* at 440. Unfortunately, the Decision was advisory, not mandatory. Consequently, the DEA ignored its Administrative Law Judge, ordering that marijuana had "no currently accepted medical use" and thus had to remain in Schedule I.

In *Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 15 F.3d 1131 (D.C. Cir. 1994), the D.C. Circuit allowed the DEA administrator's order to stand, but only for the narrowest of reasons. The court did not reject the Administrative Law Judge's Decision in favor of the DEA Administrator's order. Rather, the D.C. Circuit noted that, 17 days after the close of the evidence in the rescheduling hearings, the DEA promulgated a new test for evaluating "currently accepted medical use." *Id.* at 1136. Because the petitioners had not sought to reopen the record before the Administrator issued his order utilizing the new test, the court declined to require reopening of the record to allow the petitioners an opportunity to submit additional evidence to satisfy that new test. *Id.*

The court also determined, amazingly, that the DEA did not display bias or a lack of objectivity by rejecting the recommendations of the Administrative Law Judge, and by ignoring a mountain of anecdotal evidence in favor of selected scientific evidence. *Id.* at 1137. The current pending rulemaking petition, referred by the DEA to the Department of Health and Human Services, (discussed below in the "Conclusion"), now presents just the sort of scientific evidence the D.C. Circuit said the DEA found lacking several years ago.

III. CONCLUSION

Stripped to the barest essentials, this case can be summarized in the following manner. The Defendants ask this Court to let the light of truth illuminate the courtroom, while the government maintains that the Court has no alternative but to block the doors and windows and keep the truth from shining on these proceedings. The Defendants seek the opportunity to establish that:

1. Marijuana is a useful and effective medicine beneficial in the treatment of numerous serious conditions;

2. Marijuana is a safe, completely non-toxic medicine with virtually no significant side effects;

3. Both scientific and anecdotal evidence overwhelmingly support the above claims;

4. The government is involved in a long-standing deliberate effort to suppress the truth about medicinal marijuana. This effort has nothing to do with science, logic, rationality, or concern for the safety, health, and welfare of its citizens; and

5. In maintaining the prohibition on the medicinal use of marijuana, the government is acting in an arbitrary and capricious manner.

The above allegations are borne out by the posturing of the parties in this litigation. The Defendants ask the Court to let them present evidence of the scientific truth about medical marijuana and the government's history of "reefer madness" propaganda. The Defendants invite the Court to review all of the potential evidence, to consider any and all facts that either party desires to place before the Court.

The government, true to form regarding this issue, is making every attempt to convince the Court to put on blinders, to avoid reviewing the evidence. In essence the government's position is that the truth is irrelevant because the government says so. The government contends that because Congress has voted that marijuana is a dangerous drug with a high potential for abuse and no accepted medical use, this Court

has no alternative but to accept such findings. Here the government essentially proffers that politicians may decide the truth by little more than a popularity contest, and that once they have done so this Court is precluded from reviewing the facts to independently ascertain the truth.

This is not the first time in our nation's history where popular positions voted on by politicians became "legislated truths", though such "truths" were unsupported by any logic, science, or reason. For more than 80 years "legislated truth" in this nation maintained that "negroes" were less than human beings. For nearly 150 years "legislated truth" declared women unfit to vote. During World War II "legislated truth" proclaimed that Americans of Japanese descent were traitors and had to be incarcerated.

Now, once again, the government insists that "legislated truth" must prevail over reason and science. The government insists on this state of affairs even though it means people will suffer; even though it means that people will go blind; even though it means that people will die; incredibly even though it means that crime will increase and the pockets of illicit drug dealers will be lined with more ill-gotten gains.

This Court, and indeed any tribunal in this country, should be extraordinarily suspicious of any party that seeks to bar the most relevant facts and information from being brought into the purview of the Court. From the very inception of this nation, as evidenced in the First Amendment, the union has been built on a foundation that all speech is welcome in the marketplace of ideas. The framework erected on that foundation requires that all persons and parties summoned before a Court have the opportunity to fully present their case, to place before the Court the evidence that supports their position, and to question the opposing party's evidence, all freely and openly in an effort to ascertain the truth.

At various times in our history there have been those in both the government and the private sector who have sought to subvert this process by hiding the facts. When they have prevailed our nation has experienced some of the darkest and most shameful periods in our history. The Defendants submit that we are experiencing

such a period at present where sick and dying people are subjected to arrest, forced to endure prosecution, and suffer a loss of their liberty, all for the "crime" of using a safe and effective medication in seeking relief.

If the government sincerely believes the Defendants are wrong, why should the government be ashamed to partake in an open, candid, and unimpeded search for truth? The very fact that the government urges this Honorable Court to avoid reviewing the evidence cries out to the necessity of this Court allowing such a review.

The government of course will disagree with this interpretation of its position. The government suggests that such a review should and can be effectively sought administratively through petitioning the government to reschedule marijuana. In fact the government argued, both in its last brief and at the hearing, that the Defendants' reliance on a necessity defense would be foreclosed by the availability of the petitioning process as an adequate legal remedy. In challenging the government's claim, the Defendants established that such a petition was brought in 1972, but was not finally resolved until 1994, some 22 years later.

At the conclusion of the hearing, the Court inquired of the government when they expected to respond to the petition to reschedule marijuana which was recently referred to the Department of Health & Human Services by the DEA, (a petition which has been pending since 1995, a copy of which is attached hereto as Exhibit "4"). When the government could not provide an answer, the Court requested that an answer be provided in the government's brief to be filed on April 16, 1998. (Transcript at 134:19-135:7).

Defendants herein submit that any decision to curtail their activities should be deferred at least for the amount of time that the government identifies it will take to rule on the pending petition. Should the petition be granted and marijuana be rescheduled and made available by prescription, this matter will be mooted. Should the government fail to respond timely to the petition, as Defendants suspect will happen, it will serve to further illustrate the fallacy of the government's "adequate legal remedy"

argument. Should the government fail to allow a fair and open-minded review of the

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evidence in evaluating the petition, it will establish additional proof that this Court represents the only available forum to which these Defendants may bring their pleas for relief and justice.

Dated: April 16, 1998

Respectfully submitted,

WILLIAM G. PANZER
Specially Appearing
for Defendants
MARIN ALLIANCE FOR MEDICAL MARIJUANA; LYNNETTE SHAW; OAKLAND CANNABIS BUYERS' COOPERATIVE; JEFFREY JONES

ROBERT A. RAICH
Specially Appearing
for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE; JEFFREY JONES

SIGNATURE PAGE

The undersigned counsel, Specially Appearing on behalf of SANTA CRUZ CANNABIS BUYERS CLUB, hereby submit the foregoing DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION on April 16, 1998.

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The undersigned counsel, Specially Appearing on behalf of FLOWER THERAPY MEDICAL MARIJUANA CLUB, JOHN HUDSON, MARY PALMER, and BARBARA SWEENEY, hereby submit the foregoing DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION on April 16, 1998.

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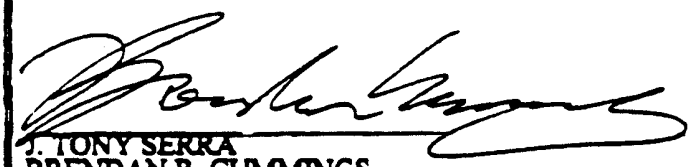
The undersigned counsel, Specially Appearing on behalf of CANNABIS CULTIVATOR'S CLUB and DENNIS PERON, hereby submit the foregoing DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION on April 16, 1998.



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The undersigned counsel, Specially Appearing on behalf of UKIAH CANNABIS BUYER'S CLUB, CHERRIE LOVETT, MARVIN LEHRMAN, and MILDRED LEHRMAN, hereby submit the foregoing DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION on April 16, 1998.

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The undersigned counsel, Specially Appearing on behalf of UKIAH CANNABIS BUYER'S CLUB, CHERRIE LOVETT, MARVIN LEHRMAN, and MILDRED LEHRMAN, hereby submit the foregoing DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION on April 16, 1998.

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PROOF OF SERVICE BY MAIL

The undersigned hereby declares:

I am employed in the City of Oakland, County of Alameda, am over the age of 18 years, and am not a party to the within action; my business address is 370 Grand Avenue, Suite 3, Oakland, California, 94610. On April 16, 1998, I served the attached:

DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FORPRELIMINARY INJUNCTION, PERMANENT INJUNCTION AND FOR SUMMARY JUDGEMENT

on the parties in said action by placing a true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Oakland, California, addressed as follows:

Mark T. Quinlivan
U.S. Dept. of Justice
901 E Street, N.W.
Washington D.C. 20530

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on April 16, 1998, at Oakland, California.

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Specially appearing for Defendants OAKLAND CANNABIS BUYERS' COOPERATIVE; JEFFREY JONES, MARIN ALLIANCE FOR MEDICAL MARIJUANA, and LYNNETTE SHAW

See signature pages for complete list of parties joining in this pleading, Civil L.R. 3-4(a)(1).

IN THE UNITED STATES DISTRICT COURT

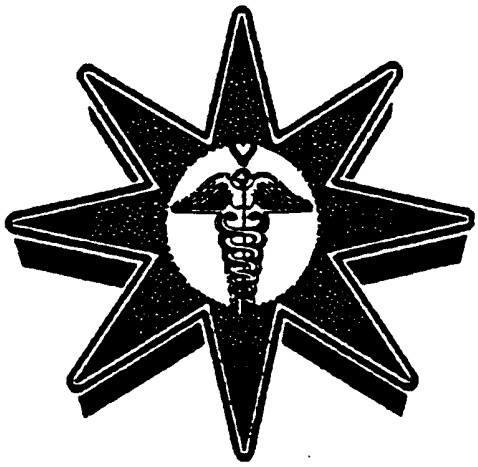
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATORS' CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS.	)	Nos. C 98-00085 CRB C 98-00086 CRB C 98-00087 CRB C 98-00088 CRB C 98-00089 CRB C 98-00245 CRB DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION, PERMANENT INJUNCTION AND FOR SUMMARY JUDGEMENT No Hearing Scheduled

EXHIBITS

Oakland Cannabis Buyers' Cooperative

Protocols



Compassion

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March, 30 1998

Oakland Cannabis Buyers' Cooperative

Protocols

The Oakland Cannabis Buyers' Cooperative operates pursuant to and in accordance with the statewide mandate of Proposition 215 (Exhibit A) and Resolutions passed unanimously by the Oakland City Council and an Administrative Memorandum promulgated by the Chief of Police (Exhibit B). Its operating procedures have been consolidated as these Protocols.

I. Admission and Membership Requirements

A person seeking membership of the Oakland Cannabis Buyers' Cooperative must at the threshold provide a note from a treating physician assenting to cannabis therapy for a medical condition listed on the Medicinal Cannabis User Initial Questionnaire (Exhibit C). Upon acceptance of the note by Intake staff, the prospective member will undergo an extensive screening and such questioning as shall establish that the candidate meets the Medical Admissions Criteria (Exhibit D) including, without being limited to, the Oakland Cannabis Buyers' Cooperative Information Form (Exhibit E). If, upon the screening by Cooperative staff the candidate does not appear to qualify for membership, he or she will be denied membership with a statement of reasons for his/her being screened out. If the candidate appears to qualify for membership, Intake staff will give the candidate the Authorization for Release of Patient Status form (Exhibit F) and the Physician Statement (Exhibit G), with a request that the candidate's treating physician sign it. When the form is returned, the Intake staff will verify the physician's approval by independent telephone verification. Medical cannabis cultivators and manufactures are issued cultivation and manufacturing Certificates (Exhibit H), which the City Council has approved to aid the Police in recognizing agents of the Cooperative.

No person under the age of eighteen shall be admitted to membership without the written consent of parents, in addition to meeting all other requirements.

II. Responsibilities of Membership

All members must sign a Membership Agreement (Exhibit I), whereupon they will receive a Membership Card (Exhibit J). Members agree to conduct themselves discreetly, in accordance with the Statement of Safe Use of Cannabis (Exhibit K) and the Principles of Responsible Cannabis Use (Exhibit L).

III. Other Provisions

A. Purpose. The purpose of the Oakland Cannabis Buyers' Cooperative is to help provide medicine for people who need it. Accordingly, it shall be operated as a not for profit organization.

B. Privacy of members. The staff of the Cooperative shall take steps to protect the privacy and identity of members. However, neither the Cooperative nor its staff shall be liable for any breach thereof

C. Changes. These Protocols, and all medical protocols, are subject to change without notice from time to time in the sole discretion of management.

D. Cooperative operation.

a. No smoking of anything on premises.
b. Members shall observe additional house rules as same maybe posted by management.
c. Management may eject any person at any time.

Exhibits

A. Proposition 215

B. Oakland City Council Resolutions and Police Memorandum

C. Medicinal Cannabis User Initial Questionnaire

D. Medical Admissions Criteria

E. Information Form

F. Authorization for Release of Patient Status

G. Physician Statement

H. Cultivation and Manufacturing Certificates

I. Membership Agreement

J. Membership Card

K. Statement of Safe Use of Cannabis

L. Principles of Responsible Cannabis Use

THE CALIFORNIA MEDICAL MARIJUANA INITIATIVE

This initiative to permit medical use of marijuana will appear on the ballot November 5, 1996. The Attorney General of California has prepared the following title and summary of the chief purpose and points of the initiative.

MEDICAL USE OF MARIJUANA. INITIATIVE STATUTE. Provides that patients or defined caregivers, who possess or cultivate marijuana for medical treatment recommended by a physician, are exempt from general provisions of law which otherwise prohibit possession or cultivation of marijuana. Provides physicians shall not be punished or denied any right or privilege for recommending marijuana to a patient for medical purposes. Declares that the measure not be construed to supersede prohibitions of conduct endangering others nor to condone diversion of marijuana for nonmedical purposes. Contains severability clause. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local government: Because this measure restricts the use of marijuana to only those persons for whom it is prescribed by a licensed physician, it would probably have no significant state or local fiscal impact.

Initiative text:

SECTION 1. Section 11362.5 is added to the Health and Safety Code, to read:

11362.5. (a) This section shall be known and may be cited as the Compassionate Use Act of 1996.

(b)(1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:

(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that 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.

(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.

(C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(2) Nothing in this act shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.

(c) 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.

(d) Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

(e) For the purposes of this section, "primary caregiver" means the individual designated by the person exempted under this act who has consistently assumed responsibility for the housing, health, or safety of that person.

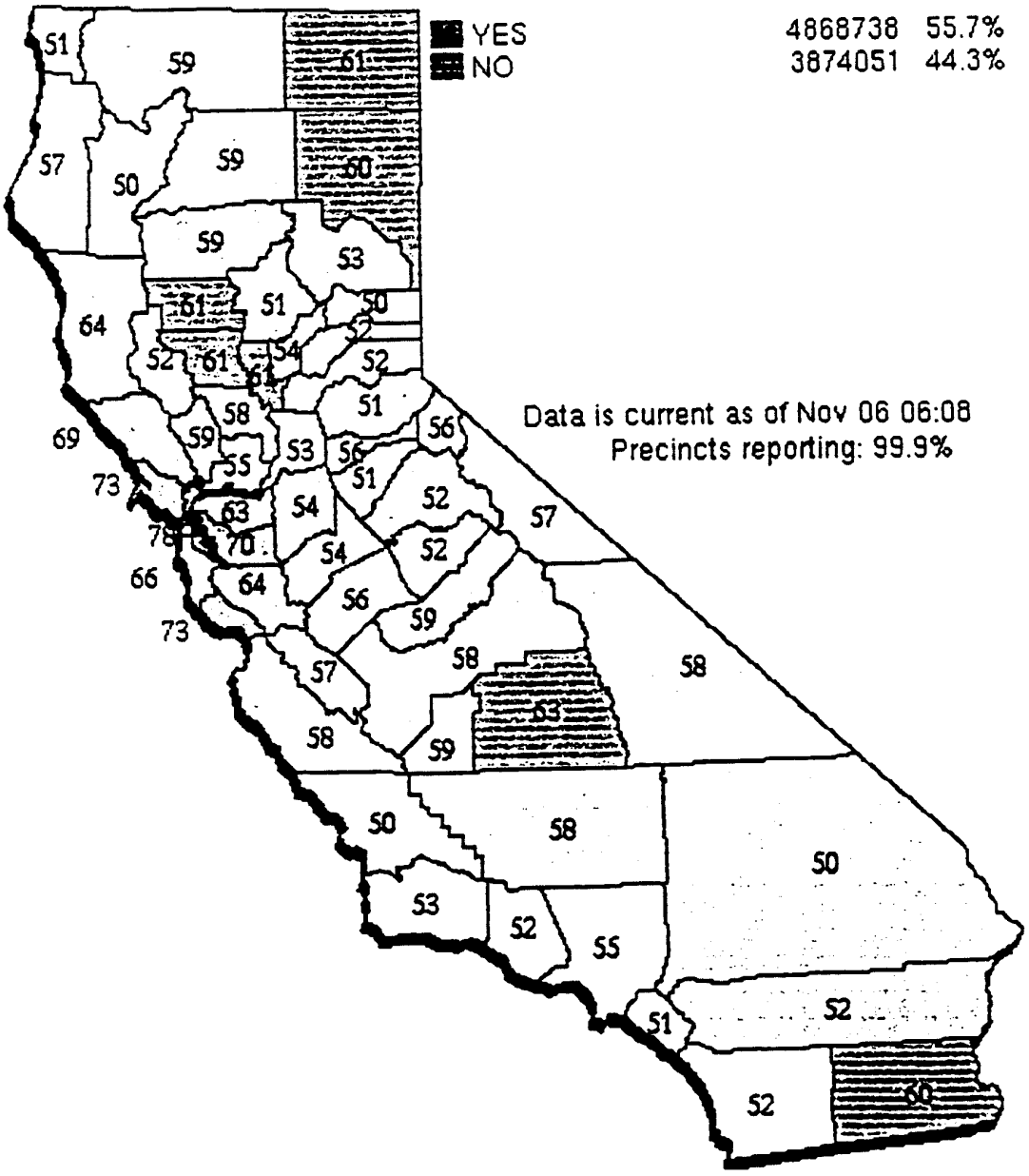
SECTION 2. If any provision of this measure or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or applications of the measure which can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

For more information, contact: Californians for Medical Rights
1250 Sixth St., Suite 202, Santa Monica, CA 90401
(310) 394-2952 fax: (310) 451-7494

1996 General Election Returns for

Proposition 215 - Marijuana

The number in each county indicates the percentage of the vote cast as indicated by the color.



ER0441

Ex. B

OAKLAND CITY COUNCIL

RESOLUTION NO. 72379 C. M. S.

RESOLUTION ENDORSING AB - 1529, "THE MEDICAL MARIJUANA BILL" and the "COMPASSIONATE USE INITIATIVE OF 1996"

WHEREAS, marijuana has been shown to alleviate nausea and pain associated with cancer and;

WHEREAS, marijuana has been shown to helped people with AIDS to relieve stress and depression, eliminate nausea, reduce and manage pain and fight the "wasting away" syndrome by stimulating the appetite and;

WHEREAS, marijuana has been shown to control spasticity from multiple sclerosis and paralysis and;

WHEREAS, marijuana has been shown to arrest the advance of glaucoma and:

WHEREAS, marijuana has been shown to relieve the pain of arthritis and rheumatism and;

WHEREAS, marijuana has been shown to block epileptic seizures and help migraine headaches and;

WHEREAS, AB - 1529 and the "Compassionate Use Initiative of 1996" will not legalize the personal use of marijuana;

LET IT BE RESOLVED that the Oakland City Council endorses the passage of AB - 1529, "THE MEDICAL MARIJUANA BILL"; and let it be

FURTHER RESOLVED that the Oakland City Council endorses the "Compassionate Use Initiative of 1996".

I certify that the foregoing is a full, true and correct copy of a Resolution passed by the City Council of the City of Oakland, California on December 12, 1995

CEDA FLOYD
City Clerk and Clerk of the Council

Per Margie Sosa *Deputy*

C AKLAND CITY COUN CIL

RESOLUTION NO. 72516 C. M. S.

INTRODUCED BY COUNCILMEMBER _____

RESOLUTION ENDORSING H.R. 2618, SUPPORTING THE ACTIVITIES OF THE OAKLAND CANNABIS BUYER'S CLUB AND DECLARING THAT THE INVESTIGATION AND ARREST OF INDIVIDUALS INVOLVED WITH THE MEDICAL USE OF MARIJUANA SHALL BE A LOW PRIORITY FOR THE CITY OF OAKLAND

WHEREAS, marijuana has been shown to help alleviate pain and discomfort in people suffering from a variety of illnesses including AIDS, cancer, glaucoma, and multiple sclerosis; and,

WHEREAS, marijuana has alleviated the suffering of people with chronic illnesses when no other medications have been effective; and,

WHEREAS, the use of marijuana is presently unlawful even under the supervision of physician; and

WHEREAS, the illegal purchase of marijuana by people already suffering with chronic illnesses subjects them to further suffering in the form of potential arrest and prosecution: and

WHEREAS, Representative Barney Frank (MA) and local co-sponsors Representative Ronald Dellums and Pete Stark have introduced H.R. 2618 which would allow physicians to prescribe marijuana for medical purposes and would insure the production of marijuana to meet the need for medical use: and

WHEREAS, the Oakland Cannabis Buyer's Club provides a way for patients needing to purchase marijuana for medical use to do so with greater ease and less risk of arrest and prosecution; and

WHEREAS, the City of Oakland wishes to declare its desire not to expend City resources in any investigation, detention, arrest or prosecution arising out of alleged violations of state and federal law regarding the distribution of marijuana for compassionate medical use; and

WHEREAS, the Oakland City Council passed Resolution 72379 C.M.S. endorsing state legislation AB 1529, "The Medical Marijuana Bill" and the "Compassionate Use Initiative of 1996:" now, therefore, be it

RESOLVED: That the Oakland City Council endorses of the passage of H.R. 2618; and be it further

RESOLVED: That the Oakland City Council authorizes the City Manager to instruct the City's federal lobbyists to work in support of H.R. 2618; and be it further

RESOLVED: That, the Mayor and City Council hereby declare that it shall be the policy of the City of Oakland that the investigation and arrest of members of the Oakland Cannabis Buyers' Club for purchasing, selling and distributing marijuana for medical purposes shall be a low priority; and be it further

RESOLVED: That, the Mayor and City Council hereby declare that it shall be the policy of the City of Oakland that the investigation and arrest of persons for planting, cultivating, purchasing, and/or possessing marijuana shall be a low priority for the City of Oakland if such persons have been medically diagnosed as suffering from an illness or injury, the symptoms of which may be alleviated by the medicinal use of marijuana; and be it further

RESOLVED: That, the Mayor and City Council hereby declare that it shall be the policy of the City of Oakland that the investigation and arrest of persons for cultivating, purchasing, possessing and/or distributing marijuana shall be a low priority for the City of Oakland if such persons purchase or possess marijuana for, and/or distribute marijuana to patients, whose physicians have determined that they are suffering physical pain that may be alleviated by the medicinal use of marijuana; and be it further

RESOLVED: That, the Mayor and City Council call upon the Alameda County District Attorney to cease prosecution of persons involved in the medical use of marijuana; and be it further

RESOLVED: That if any provision of this resolution is declared by a court of competent jurisdiction to be contrary to any statute, regulation or judicial decision, or its applicability to any agency, person or circumstances is held invalid, the validity of the remainder of this resolution and it applicability to any other agency, person or circumstance shall not be affected.

IN COUNCIL, OAKLAND, CALIFORNIA, MAR 12 1996, 19 ____

PASSED BY THE FOLLOWING VOTE:

AYES- BAYTON, CHANG, DE LA FUENTE, ~~JORDAN~~, MILEY, RUSSO, SPEES, ~~WOODS-JONES~~ and PRESIDENT HARRIS — 7

NOES-NONE

ABSENT-NONE

ABSTENTION-NONE

Excused - Jordan/Woods-Jones-2

ATTEST: Ceda Floyd
CEDA FLOYD
City Clerk and Clerk of the Council
of the City of Oakland, California

ECO-244 (1.95)

O KLAND CITY COUN IL

RESOLUTION NO. 72881 C. M. S.

INTRODUCED BY COUNCILMEMBER _____

BJP:trc

RESOLUTION ESTABLISHING A WORKING GROUP TO DISCUSS AND MAKE RECOMMENDATIONS TO THE CITY COUNCIL REGARDING THE MEDICAL MARIJUANA POLICY OF THE CITY OF OAKLAND

WHEREAS, marijuana has been shown to help alleviate pain and discomfort in people suffering from a variety of illnesses including AIDS, cancer, glaucoma, and multiple sclerosis; and

WHEREAS, marijuana has alleviated the suffering of people with chronic illnesses when no other medications have been effective; and

WHEREAS, the use of marijuana is currently unlawful even under the supervision of a physician, and

WHEREAS, the illegal purchase of marijuana by people already suffering chronic illnesses subjects them to further suffering in the form of potential arrest and prosecution; and

WHEREAS, the Oakland Cannabis Buyers Club provides a way for patients needing to purchase marijuana for medical use to do so with greater ease and less risk of arrest and prosecution; and

WHEREAS, the Oakland City Council passed Resolution 72516 C.M.S., supporting the activities of the Oakland Cannabis Buyers Club and declaring it to be the policy of the City of Oakland that the arrest of individuals involved with the medical use of marijuana shall be a "low priority" for the City of Oakland; and

WHEREAS, to the extent permitted by applicable law, the City of Oakland wishes not to expend any City resources, including but not limited to those of the Oakland Police Department, in any investigation, detention, arrest, and/or prosecution arising out of alleged violations of state or federal law regarding the cultivation, distribution, sale, purchase, and/or possession of marijuana for medicinal purposes; now therefore, be it

RESOLVED: that a Working Group be established to discuss and make recommendation to the City Council regarding refinement of the City's medical marijuana policy; and be it

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900-445 (* 93)

FURTHER RESOLVED: that said Working Group shall consist of representatives designated by the City Manager and interested members of the public; and be it

FURTHER RESOLVED: that said Working Group shall consider legislative and administrative methods to insure enforcement of and compliance with the City's medical marijuana policy; and be it

FURTHER RESOLVED: that said Working Group shall consider the feasibility of any other matters pertaining to the City's medical marijuana policy; and be it

FURTHER RESOLVED: that said Working Group shall report to the Public Safety, Health, Human Services and the Family Committee no later than October 1, 1996, concerning the results of its discussions and any recommendations regarding the refinement of the City's medical marijuana policy.

I certify that the foregoing is a full, true and correct copy of a Resolution passed by the City Council of the City of Oakland, California on July 30, 1996.

CEDA FLOYD
City Clerk and Clerk of the Council

Per Margie Sosa *Deputy*

C .KLAND CITY COUNC

RESOLUTION NO. 73555 C.M.S.

RESOLUTION SUPPORTING MEDICAL MARIJUANA ACTIVITIES IN THE CITY OF OAKLAND AND DECLARING THAT THE INVESTIGATION AND/OR ARREST OF INDIVIDUALS INVOLVED WITH THE CULTIVATION, MANUFACTURE, AND/OR TRANSPORTATION OF MEDICAL MARIJUANA PRODUCTS SHALL BE A LOW PRIORITY FOR THE CITY OF OAKLAND

WHEREAS, on November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, by a YES vote of 55.7 percent, and the residents of Oakland voted YES for Proposition 215 by an overwhelming 79.3 percent; and

WHEREAS, marijuana had been shown to help alleviate pain and discomfort in people suffering from a variety of illnesses including AIDS, cancer, glaucoma, and multiple sclerosis when no other medications have been effective; and

WHEREAS, cultivation of medicinal strains of marijuana, the manufacture of medical cannabis products such as oral preparations, and the transportation of marijuana and cannabis products for medical purposes may remain illegal notwithstanding the passage of Proposition 215; and

WHEREAS, there is a need to ensure that patients have access to a safe and affordable supply of medical grade marijuana and cannabis products; and

WHEREAS, the Oakland City Council passed Resolution 72379 C.M.S. endorsing the Compassionate Use Act of 1996 and similar measures; and

WHEREAS, the Oakland City Council passed Resolution 72516 C.M.S. supporting the activities of the Oakland Cannabis Buyers Club and declaring it to be the policy of the City of Oakland that the investigation and arrest of certain individuals involved with the medical use of marijuana shall be a low priority for the City of Oakland; and

WHEREAS, the Oakland City Council passed Resolution 72881 C.M.S. establishing a Working Group to make recommendations regarding the City's medical marijuana policy; and

WHEREAS, to the extent permitted by applicable law, the City of Oakland wishes not to expend any City resources, including but not limited to those of the Oakland Police Department, in any investigation, detention, arrest, and/or prosecution arising out of alleged violations of state or federal law regarding the cultivation, manufacture, or transportation of marijuana or cannabis products for medical purposes; now therefore, be it

RESOLVED: that the Mayor and City Council hereby declare that it shall be the policy of the City of Oakland that the investigation, detention, arrest, or prosecution of a person and/or that person's primary caregiver for the cultivation, manufacture, or transportation of marijuana or cannabis products shall be a low priority for the City of Oakland if such person has been medically diagnosed as suffering from a serious illness or injury, the symptoms of which may be alleviated by the medicinal use of marijuana and such cultivation, manufacture and/or transportation of marijuana or cannabis products is for the personal medical use of such person upon the written or oral recommendation or approval of a physician; and, be it further

RESOLVED: that the Mayor and City Council hereby declare that it shall be the policy of the City of Oakland that investigation, detention, arrest, and/or prosecution of persons for the cultivation, manufacture or transportation of marijuana or cannabis products shall be a low priority for the City of Oakland if such persons cultivate, manufacture, or transport marijuana or cannabis products for patients whose physicians have determined that they are suffering from a serious illness or injury, the symptoms of which may be alleviated by the medicinal use of marijuana and have recommended or approved medical marijuana use for such patients; and be it further

RESOLVED: that the Mayor and City Council call upon the Alameda County District Attorney not to prosecute persons involved with the possession, purchase, distribution, cultivation, manufacture or transportation of marijuana or cannabis products for medical use; and be it further

RESOLVED: that if any provision of this Resolution is declared by a court of competent jurisdiction to be contrary to any statute, regulation, or judicial decision, or its applicability to any agency, person, or circumstance is held invalid, the validity of the remainder of this resolution and its applicability to any other agency, person, or circumstances shall not be affected.

IN COUNCIL, OAKLAND, CALIFORNIA, JUN 03 1997, 19___

PASSED BY THE FOLLOWING VOTE:

AYES- BRUNNER, CHANG, DE LA FUENTE, MILEY, NADEL, REID, RUSSO, SPEES, and PRESIDENT HARRIS — 9

NOES- None

ABSENT- None

ABSTENTION- None

ATTEST: Ceda Floyd

CEDA FLOYD
City Clerk and Clerk of the Council
of the City of Oakland, California

OAKLAND CITY COUNCIL

RESOLUTION NO. 74039 C.M.S.

RESOLUTION CALLING UPON FEDERAL AUTHORITIES TO DESIST THEIR EFFORTS TO TERMINATE THE OPERATIONS OF THE OAKLAND CANNABIS BUYERS' COOPERATIVE

WHEREAS, in November 1996 the voters of the State of California passed Proposition 215, the Compassionate Use Act of 1996, to "ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes" by a YES vote of 55.7 percent, and the residents of Oakland voted YES for Proposition 215 by an overwhelming 79.3 percent; and

WHEREAS, the City Council of the City of Oakland finds that many of its City residents are suffering from life-threatening or serious illnesses whose painful symptoms are alleviated by the ingestion of cannabis; and

WHEREAS, the City of Oakland has repeatedly expressed its support for access to a safe and affordable supply of marijuana for medicinal purposes and the operations of the Oakland Cannabis Buyers' Cooperative in Resolution Nos. 72379 C.M.S., 72516 C.M.S., 72881 C.M.S., and 73555 C.M.S.; and

WHEREAS, the City Council finds that the Oakland Cannabis Buyers' Cooperative has served the aforementioned residents with a well-organized, safe, and responsible opportunity to obtain cannabis in furtherance of a course of medical treatment; and

WHEREAS, federal law enforcement authorities have threatened to disrupt and prevent ill Oakland residents' access to cannabis by filing suit to enjoin the Oakland Cannabis Buyers' Cooperative from supplying medical marijuana and to shut down its operations; and

WHEREAS, the federal law enforcement policy impairs public safety by encouraging a market for street narcotic peddlers to sell cannabis to Oakland's ill citizens; now therefore be it

RESOLVED: the Mayor and the Oakland City Council urge the federal government to desist from any and all actions that pose obstacles to access to cannabis for Oakland residents whose physicians have determined that their health will benefit from the use of marijuana and recommended medical marijuana use for such residents; and be it

FURTHER RESOLVED: the Mayor and the Oakland City Council endorse Senator John Vasconcello's call for a statewide summit on the distribution of medical marijuana; and be it

FURTHER RESOLVED: the Mayor and the Oakland City Council urge the Alameda County Board of Supervisors to declare a state of medical emergency; and be it

FURTHER RESOLVED: the Mayor and the Oakland City Council express their support of the furtherance of medical marijuana research; and be it

FURTHER RESOLVED: copies of this resolution shall be forwarded to Senators Boxer and Feinstein and Congressman Ron Dellums urging the federal policy-makers to dismiss current lawsuits impacting California's cannabis buyers' clubs and cooperatives.

I certify that the foregoing is a full, true and correct copy of a Resolution passed by the City Council of the City of Oakland, California on January 27, 1998

CEDA FLOYD
City Clerk and Clerk of the Council

Per _____ *Deputy*

ADMINISTRATIVE MEMO
Oakland Police Department

TO	DATE	NUMBER	DUE DATE
BUREAU COMMANDERS (BFO)	11 Dec 96	-	-
SUBJECT: MEDICINAL USE OF MARIJUANA			

The City Council has adopted a resolution in support of the medicinal use of marijuana as a means of alleviating pain and discomfort for individuals suffering from medical illnesses.

In accordance with the subsequent directive of the City Manager to handle medicinal marijuana activity (in violation of Health and Safety Code 11357, relating to the possession of marijuana, and 11358, relating to the cultivation of marijuana) as a low priority, the following procedures will be implemented immediately:

- Citizen calls for service requesting police intervention at sites where such activity is occurring shall be assigned a "D" priority by Communications Division staff.

- At both field and dispatch levels, every effort shall be made to obtain and record the identity of the reporting citizen(s).

- Field units receiving a dispatched assignment or initiating a contact with persons purportedly involved in the use of marijuana for medicinal purposes shall summon a command-level officer to the scene if an enforcement action (citation or arrest) for the 11357 H&S or 11358 H&S violation is intended.

- The command officer shall evaluate the facts and exercise the discretion and decision-making required to resolve the incident, in accordance with the low-priority policy.

- If an enforcement action is to be taken, the command officer shall promptly notify his/her Bureau Commander and provide him with a written summary of the incident and a copy of all pertinent documents.

- Incidents involving persons who wish to make citizen arrests for the law violation shall be handled in the normal manner.

- Discretion to arrest will be left with the officer and commander at the scene, based upon the facts presented to them at the time. The marijuana should be turned in as evidence for follow-up investigation by the Vice/Narcotics Section.

There are varied and opposing views--professional, legal and medical in nature--regarding the practice of medicinal use of marijuana as a means of alleviating symptoms and controlling chronic pain of patients with specific medical conditions.

Nevertheless, the recent passage of Proposition 215 by California voters has now created law. Federal and state officials are reviewing the initiative and may issue guidelines in the near future. In the interim, the Department will continue its participation on a City working group to identify and resolve local implementation issues. As agreements are reached or decisions made, additional procedural guidelines will be set forth in Departmental publications or communications.

Interim training to all commanders in general and BFO commanders in particular shall be provided over the next 3-4 weeks by Lieutenant Peterson.

Joseph Samuels, Jr.
Chief of Police

CITY OF OAKLAND

Memorandum

TO: Bureau of Field Operations
ATTN: Command Staff
FROM: Vice/Narcotics Section
DATE: 12 Dec 96

RE: Medicinal Marijuana Enforcement

Attached is a copy of an administrative memorandum you will be receiving shortly outlining Chief's Samuels' guidelines for the enforcement of Proposition 215. It is similar to the guidelines dealing with the needle exchange issue. The primary people you will come into contact with will be members of the Oakland Cannabis Buyer's Club (CBC) who are working with us (to the extent they can) to find a way to make this thing work until the issue is settled in the courts.

Clients of the CBC are being issued new photo identification cards with a 24-hour number to contact to verify they are medicinal members. The City's working group has agreed to accept these new cards as a legitimate means of verifying identification if the person has no driver's license, etc. You may come into contact with older ID cards until the transition is complete; these more than likely will be valid.. I would assume non-CBC members will claim in some fashion to be medicinal marijuana users; they may, or may not, have some form of doctor verification.

In evaluating whether an arrest should be made, you should consider the intent of Proposition 215 and the City Council's resolution supporting it and setting a low priority on enforcement. Each case should be decided on its own merits.

It is requested the identification cards not be seized without a valid need. All information on the card should be listed on the report. The marijuana should be seized and turned into criminalistics. All such incidents require a report in addition to any citation which may be issued. Follow-up responsibility for verifying the medicinal use will rest with the Vice/Narcotics charging officers. The DA will make charging decisions. Ultimately, a court order will have to be initiated by the patient/suspect if no charges are filed.

I realize this is confusing; feel free to call me anytime, day or night. I will try to provide some guidance based upon what I know about the issue.

Peter A. Peterson
Lieutenant of Police
Vice/Narcotics Section

Ex. C

Medicinal Cannabis User Initial Questionnaire

Today's Date _____

Identifying Data

Last name_____, **First name** _____ **Middle Initial** __
Address _____ **City** _____ **State** ____ **Zip** _____
Res Ph _____-_____-_____ **Work Ph** _____-_____-_____ **ext**____ **Fax** _____-_____-____
Birthdate (MMDDYY)_____ **SS#**___-__-____ **Sex M_ F_ Ethnic Wh_B_Hisp_Or_ NatAm_**
Other _____ **Education** _____**Occupation(s)**_____ **Unemployed_ Disabled_**
Marital Status: **Single_ Mar_ Sep_ Div_ W_** Living situation:_ **Alone _ Couple_ Group_ Apartment_ House_ Institution_ Homeless_**
Health Insurance **None_ Medicaid_ Medicare_ Workers Compensation_ Other health plan._**
(specify)_____ **ID Number** _____ **GroupNumber**_____
Address _____ **City** _____ **State** ___ **Zip** _____ **Phone** ___-___-____**x** _____
Referred by: **Self _ Name**_____ **Institution** _____
Address _____ **City** _____ **State** __ **Zip**_____
Phone ___-___-____**x** _____ **Fax** ___-___-____ **Pager** ___-___-____

Chief Complaint(s) circle and rank in importance: example: AIDS related illness 1 anorexia 2

1. **Alcoholism**
2. **Alcohol Abuse**
3. **Sedative/Opiate Habit**
4. **Cocaine or Speed Habit**
5. **Nicotine Habit**
6. **AIDS related illness**
7. **Cancer & cancer Rx**
8. **Anorexia**
9. **Nausea**
10. **Vomiting**
11. **Diarrhea**
12. **Irritable bowel**
13. **Colitis**
14. **Cron's disease**
15. **Gastritis**
16. **Pancreatitis**
17. **Hepatitis**
18. **Peptic Ulcer**
19. **Antibiotic**
20. **Asthma**
21. **Sinusitis**
22. **Cough**
23. **Anxiety**
24. **Panic attacks**
25. **Insomnia**
26. **Mania**
27. **Depression**
28. **Lethargy**
29. **Weakness**
30. **Chronic Fatigue Syndrome**
31. **Epilepsy**
32. **Delirium Tremens**
33. **Dementia**
34. **Multiple Sclerosis**
35. **Huntington's Chorea**
36. **Cerebral Palsy**
37. **Brain Trauma**
38. **Spinal Cord Injury**
39. **Muscle spasm**
40. **Parkinson's disease**
41. **Tremor**
42. **Periphal neuropathy**
43. **Tic doloroux**
44. **Tourette's syndrome**
45. **Glaucoma**
46. **Menstrual cramps**
47. **Labor pains**
48. **Migraine**
49. **Meniere's Disease**
50. **Hypertension**
51. **Itching**
52. **Hiccough**
53. **Arthritis**
54. **Carpal Tunnel Syndrome**
55. **Lupus, scleroderma**
56. **Amyloidosis**
57. **Conjunctivitis**
58. **Other Pain (specify source)**____
59. **External Use** ____
60. **Drug Side Effect control (specify)**____
61. **Decrease Use of Other Drugs (specify)**_____
62. **Substitute for Other Drugs (specify)** _____
63. **Other** _____

Chief Complaint _____ ICD9-CM Diagnoses _____ _____ _____
History ofPresent Illness: **(date of onset, course)** _____
PastMedicalHistory: **(Allergies & adverse drug reactions):**_____
Family Medical History:_____
Social History: _____ **Drug law arrests/convictions: None_ Yes (specify)** _____
Cannabis type preferred: **Sinsemilla_ Mexican_ Hashish_ No preference Other**_____
Age or date Use Begun:_____ Marinol ®**(dronabinol) 2.5 mg _ 5 mg _ 10 mg _ result (+)_ (0)_ (-)_**
Route: **Oral_ Inhaled: Joint_ Pipe_ Water Pipe_ Vaporizer_ Other (specify):**_____
Frequency: **Monthly_ Weekly_ Semiweekly_ Daily_ Twice a day_ 3 x a day _ 4 x a day _more _**
Other drugs using- **Rx and Over the Counter**_____
Has your physician discussed your use of cannabis with you? **Yes _ No _ Discussed any non prescribed psychoactive drugs? (including alcohol and tobacco) Yes _ No _ Remarks** _____
Completed by:_____

Ex. D

Medical Admissions Criteria
to Cannabis Buyers' Cooperative
Tod H. Mikuriya, M.D.
Medical Coordinator

Because of the vacuum of clinical knowledge about the therapeutic applications of cannabis caused by cannabis prohibition a widespread condition of ignorance exists. While it is acknowledged that there exists a range of illnesses on the dimension of seriousness objectively, there is none to the person afflicted who is seeking relief. Exclusion because the condition does not appear on a list developed by a group of non-medical politicians or bureaucrats merely perpetuate this clinical ignorance. Therefore the medical criteria are to be inclusive limited only by contemporary classifications of illness.

Medical Criteria
Persons shall have a verified specific diagnosis by a licensed physician that is included within the latest revision of the International Classification of Diseases ICD-9. Or the Diagnostic Statistical Manual DSM-IV vague statements about conditions, disorders, or syndromes without specific information or not recognized by either ICD-9 or DSM-IV are not acceptable.

Mental Disorders Admissions Protocol

Since the inception of Cannabis Buyers' Cooperatives some have expressed concern about the possibility of adverse effects on individuals suffering from emotional or mental disorders.

In clinical interviews I have conducted with members and patients in my psychiatric practice it is my impression that while many definitely benefit from cannabis there are others for whom use of cannabis is contraindicated.

The Cannabis Buyers' Cooperative Protocols seek to both address these concerns and study more fully the effects of cannabis on emotional and mental disorders.

All persons seeking membership in the Cooperative for treatment of conditions listed in DSM-IV or emotional or mental conditions listed in ICD-9 shall be reviewed by mental health professional after verification by intake staff.

Individuals in whom the use of cannabis is or has been problematic shall be excluded. This group includes persons suffering from cannabis related disorders.

Additionally, other emotional and mental conditions may be worsened by the use of cannabis. Some persons are involved in treatment requiring abstinence from cannabis especially those involved in twelve step recovery programs.

Cases where verification or suitability for the program is in dispute shall be reviewed by a panel of volunteer psychiatrists who will make final determination.

Adverse Effects of Cannabis

As with any drug, cannabis is a tool. There will always be individuals that experience adverse consequences from any drug use. The abuse of cannabis had been recognized for millennia. These problems were described by O'Shaughnessey during his observations in India in 1839 which included references in the Persian medical literature. With widespread non medical use of the drug for the past thirty years, psychiatrists have developed classifications of cannabis presented in the latest Diagnostic and Statistical Manual, Revision IV (DSM-IV).

Intoxication/Overdose

Overdose is most common by the oral route since the time from taking the drug until the experience of effects begin is from one to three or more hours. Inexperienced and ignorant first time users will have an unforgettable experience.

The effects of overdose have been numerously described in general, clinical, and scientific literature. Cannabis overdose comprises the majority of listings in the Surgeon General's list, 19th century precursor of the Indicus Medicus. American literary accounts in books: FizHugh Ludlows Hashish Eater and an essay on Hashish by Victor Robinson M.D are expressly devoted to cannabis. Descriptions of experience with the drug as part of travel to areas of indigenous use may be found in English and European literature over the past three centuries. Scientific and medical descriptions of effects of cannabis overdose have been numerous extensive. Before and after its removal in 1937.
The effects of overdose are from the stimulation and sedation of the central nervous system. Stimulation with a flooding of ideas and images that are vivid and rapidly changing. Attention and concentration are markedly impaired. Time perception is significantly altered with minutes seeming like hours. There may be distortion of spatial perception. Secondary physical effects, aside from a speeding up of the heart rate is generally no more than that associated with mild to moderate exercise.

Cannabis-Induced Disorders
292.89 Cannabis Intoxication

A. Recent use of cannabis.
B. Clinically significant maladaptive behavior or psychological changes (e.g. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.
C. Two (or more) of the following signs, developing within 2 hours of cannabis use: (1) conjunctivae injection (2) increased appetite (3) dry mouth (4) tachycardia.
D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

E. Specify if:
With Perceptual Disturbances: This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of delirium. Intact reality testing means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, with Hallucinations should be considered.

292.81 Cannabis Intoxication Delirium
292.11 Cannabis-Induced Psychotic Disorder, With Delusions Specify if with onset during intoxication.
292.89 Cannabis-Induced Anxiety Disorder, Specify if: with onset during Intoxication.

Continuing or chronic use.
Use or abuse? Cannabis, like any other drug, is a tool. Properly utilized with realistic expectations and awareness of its properties, cannabis is a safe and effective medicine. Improperly used with unrealistic expectations and ignorance, adverse effects may result. The onset of unwanted effects may be obvious or insidious. The general etiology is some emotional discomfort for which cannabis is taken to relieve producing undesirable consequences from using the drug itself.
Paranoia and delusional thinking are not uncommon effects of cannabis both acute and chronically. In the acute experience it appears to be from the perceptual distortions of space, time and feelings of detachment.
In chronic use paranoid and delusional thinking appear to be the consequences of the suppression of feelings, the dulling of feelings may alienate the cannabis users from others by diminishing empathetic capabilities. This emotional insensitivity then results in conflict through misperception. Misperception results from the dulling of affect that is important contextual collateral information source. An effective relief of emotional distress then becomes an impediment to relationships with the cannabis user. Feelings are an integral dimension of social perception that convey important contextual information. Cannabis, as an effective sedative and antidepressant, has this undesirable side effect when misused. The relief afforded by the drug may be paid for by complications caused by avoiding dealing with the causes of the emotional pain as well as diminished functioning while under its influence.
Cognitive impairment by continuing or overuse of cannabis creates a form of mild dementia that may persist for up to several weeks after discontinuing the drug.

Individuals sensitive to the drug report a persistent " hangover" that diminishes the ability to pay attention and concentrate. The onset may be insidious, subtle, and gradual. This condition is reversible with abstinence from cannabis.

304.30 Cannabis Dependence

A maladaptive pattern of cannabis use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

(1) tolerance, as defined by either of the following;
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   (b) markedly diminished by either of the following;

(2) withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance.
   (b) the same (or a closely related) substance is take to relieve or avoid withdrawal symptoms.

(3) cannabis is often taken in larger amounts or over a longer period than was intended.

(4) there is a persistent desire or unsuccessful efforts to cut down or control cannabis use.

(5) a great deal of time is spent in activities necessary to obtain cannabis (e.g. visiting multiple dealers or driving long distances), use the substance (e.g. chain smoking) or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of cannabis use

(7) cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been cause or exacerbated by the substance.

305.20 Cannabis Abuse

A. Maladaptive pattern of cannabis use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:

1) recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; cannabis related absences, suspensions, or expulsions from school; neglect of children or household)

2) recurrent cannabis use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by cannabis use)

3) recurrent cannabis related legal problems (e.g. arrests for cannabis relate disorderly conduct)

4) continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, forgotten promises)

B. The symptoms have never met the criteria for Cannabis Dependence for this class of substance.

232.9 Cannabis Related Disorder not Otherwise Specified

The Cannabis Related not Otherwise Specified category is for disorders associated with the use of cannabis that are not classifiable as one of the disorders listed above.

EX. E

OAKLAND CANNABIS BUYERS' COOPERATIVE

INFORMATION FORM
(Please print clearly)

Name_____

Street Address _____Apt. Number_____

City _____, State_____ Zip Code_____

Phone Number (_____)_____Date of Birth_____

Driver License #_____State_____ Gender (M or F)____

Caregiver_____DL#_____DOB_____

Physician's Name _____DX #_____

Address, City, State _____PHD#_____

Phone (_____)_____

Specific Diagnosis _____

_____ ICD9 CODE_____

Medication(s)_____

_____

How do you use cannabis? Smoke hi grade___smoke lo grade___edibles___tinture__

Are you politically active?_____

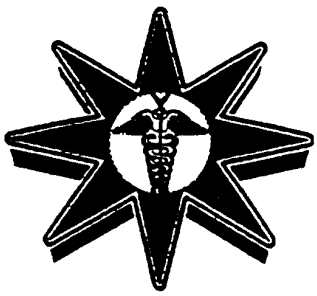
_____ _____
Member Signature Date

_____ _____
Intake By Member #

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401 Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534 Email ocbc@rxcbc.org Web www.rxcbc.org

Ex. F

OAKLAND CANNABIS BUYERS' COOPERATIVE



Authorization for Release of Patient Status
(Please print clearly)

I,_____ hereby authorize my treating physician,
print patient name

Dr._____ to release to the Oakland Cannabis
print physician name
Buyers' Cooperative, my current patient status.

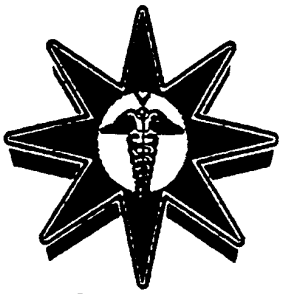
_____ Date _____
Member/ patient signature

Membership number_____

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401 Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534 Email ocbc@rxcbc.org Web www.rxcbc.org

Ex. G

Health and Safety Code 11362.5
PHYSICIAN'S STATEMENT



This certifies that _____ is a patient under my
print patient's name

medical care and supervision for the treatment of _____.
Diagnosis

I have discussed the medical benefits and risks of cannabis use with the patient as a treatment for these medical conditions. I recommend cannabis use for my patient.

If my patient chooses to use cannabis therapeutically, I will continue to monitor his/her medical condition and to provide advice on his/her progress.

I understand that I may be contacted to verify the information in this letter. My patient authorizes me to discuss their medical condition and the contents of this letter, for verification purposes only. I am a physician licensed to practice medicine in the state of California.

_____
Patient's Signature

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (print) N.P./P.A. Signature (optional)

_____ _____
Physician CA License No. N.P./P.A. Name (optional-print)

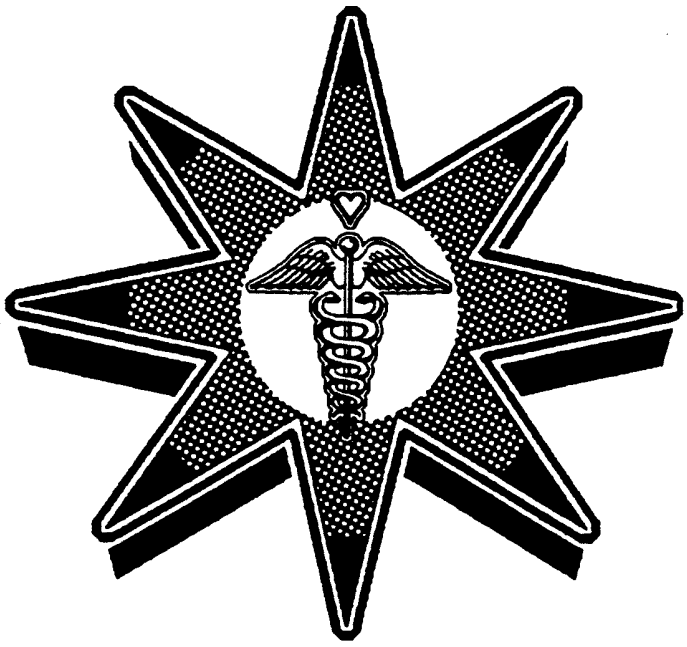
_____
(street)

_____
(City)

( )_____
Phone Number

Oakland Cannabis
buyers' Cooperative

Ex. H



Compassion

Officer- This crop of medical herb is being grown in its entirety for my personal medical use, and is intended to be free of toxic chemical, fungus, and mold contamination. This crop is safe for use by people with HIV/AIDS and other patients. Any excess will be given to the Oakland Cannabis Buyers' Cooperative. Thank you for your courage and care. If there are any questions regarding this garden please call 1-888-304-1260 (law enforcement use only).

_____

Name, Grower
Oakland Cannabis Buyers' Cooperative

_____

Jeffrey W. Jones
Agent of Oakland Cannabis Buyers' Cooperative

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401 Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534 Email ocbc@rxcbc.org Web www.rxcbc.org

EX. 1

OAKLAND CANNABIS BUYERS' COOPERATIVE

Membership and Informed Consent

Compassion

I, (print clearly)_____, hereby consent to the benefits provided by the Oakland Cannabis Buyers' Co-op (OCBC).

I understand that the OCBC has made no efforts in encouraging me to produce or use any substances for my medical condition. I have been informed by an authorized representative of OCBC that I should continue to seek professional medical advice prior to and during my use of any cannabis product I may acquire through OCBC.

I understand that the OCBC was organized to fill the necessity of medical cannabis. Prompting the passing of the Oakland City Council Resolution Number 72516 C.M.S. which supports the OCBC operations. I further understand that circumstances may require defense of authorization in a court of law and agree to participate in such defense to the extent necessary and practicable.

I understand that the OCBC reserves the right to refuse service(s) to members.

I affirm that I am above eighteen (18) years of age or have the consent of my parent/guardian, and that I have a medical condition(s) as attested to on my information form.

I understand that my contributions to OCBC, through products I may acquire from the organization, are used to insure continued operation of the OCBC and that this transaction, in no way, constitutes commercial promotion.

I understand that medical marijuana, while being a well-known effective therapeutic agent, is still illegal in this country. Therefore, by signing this form, all members of OCBC are committing an act of collective Federal civil resistance.

I authorize the OCBC to acknowledge the fact of my membership, when needed, for the preservation of my medical rights under the Oakland Resolution # 72516 and the Compassionate use Act of 1996.

_____ _____

Member Signature Date

_____ _____

Intake By Member #

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401 Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534 Email ocbc@rxcbc.org Web www.rxcbc.org

Ex. J

Oakland Cannabis Buyers' Cooperative

Compassion

Shawn Malvo

222 Anyplace
Oakland CA 94612

CDL: XXXXXXXXXXXX
DOB: 12/05/65
ISSUE DATE: 10/24/97

Member # 167

Certificate of Membership

This is to certify that on file with the undersigned officer of the Oakland Cannabis Buyers' Cooperative is a signed statement of a licensed Physician ackowledging and assenting to cannabis therapy for the patient identified on the reverse hereof, who, having satisfied all conditions of membership, is recognized as a Member in good standing of the

Oakland Cannabis Buyers' Cooperative

with all benefits and subject to all conditions as same shall from time to time be established by the Oakland CBC in accordance with its rules and Protocols. Presentation of this card shall be evidence that said patient's Physician would consider prescribing cannabis if he/she were legally able to do so, assents to the theraputic use, and has agreed to monitor and provide medical advice on the patient's progress.

Hours: M & F 11am - 7pm T, W, TH 11am - 1pm, 5pm - 7pm

Office # (510) 832-5346

24 hr Emergency voicemail/pager service (for Law Enforcement use only) 1-888-340-1260.

[redacted]

Jeffrey W. Jones
Executive Director

EX. K

Safe Use of Cannabis
1996 Tod H. Mikuriya, M.D.

Dosage and Route of Administration

Starting with a small amount and **gradually** increasing the dose is the key to avoiding unwanted mental side effects. This is called titration- self-titration if adjusted by the user.

Mental Effect Impatience and overdosing with oral cannabis is the most frequent mention of the drug in medical literature of the 1800's. Oral cannabis over-dosage is much more intense and longer lasting than from the inhaled route. Because of the two to three hours before onset of effects, a common mistake of the inexperienced is to repeat the oral dose with the consequence of overdosing.

Over-dosage

Should you take too much cannabis you may expect the mental effects of time distortion, racing thoughts, disorientation, speeding heart rate, dry mouth, and reddened eyes. The greater the dose, the greater intensity and longer these stimulant effects will last before sinking into a deep sleep. No lasting harm will result but the experience will not be forgotten.

Other Adverse Effects

Other adverse mental effects are a prolonged dullness after use of paranoia and a fear of loss of control. Cannabis, an effective relaxant, can cause an alienation or detachment. The price of relief of tension may be a dulling or suppression of feelings. Insensitivity to feelings of other or situations may result.

Set and Setting

The result of the drug is a combination of set (expectations), setting, personality, and the drug.

Best case: Enjoying a puff or two sitting at home with a friend at the end of the day.
Worst case: Taking a puff driving down the freeway, then looking sideways into the eyes of a cop.

Personality and Individual Difference

Individuals with personalities that are prone to substance abuse, allergy, sensitivity, or adverse reactions to other medicines should exert greater caution and try the drug only if absolutely necessary

Dependence and Withdrawal

Because cannabis is such an effective medicine for the relief of many uncomfortable conditions, using the
drug on a continuing basis is not uncommon. One must decide issues of personal risks/benefits of continuing using cannabis.

Withdrawal from chronic cannabis use produces several nights of more intense dreaming and possibly some slightly increased nervousness during the day. Some increased nervousness during the day. Some increase in exercise, if possible, and/or small amounts of other sedatives will ease the transition from cannabis dependence.

EX. L

Principals of Responsible Cannabis Use

I. **No Driving**
The responsible consumer of cannabis does not operate a motor vehicle or other dangerous machinery while impaired by cannabis or - like other responsible citizens-any other substance or condition, including some medicines and fatigue. Although cannabis is said by most experts to be safer than many prescription drugs, responsible cannabis users never operate motor vehicles in an impaired condition. Public safety demands not only that impaired drivers be taken off the road, but also that objective measures of impairment other than chemical testing be developed and used.

II. **Set and Setting**
The responsible cannabis user will carefully consider his or her set and setting, regulating use accordingly. "Set" refers to the consumer's values, attitudes, experience and personality. "Setting" means the consumer's physical and social circumstances. The responsible cannabis consumer will be vigilant as to conditions-time, place, mood, etc- and should not hesitate to say no when those conditions are not conducive to a safe, pleasant and/or productive experience.

III. **Resist Abuse**
Use of cannabis to the extent that it impairs health, personal development or achievement is abuse, is resisted by responsible cannabis users. Abuse means harm. Some cannabis use is harmful; most is not. That which is harmful should be discouraged; that which is not, need not be. Wars have been waged in the name of eradicating "drug abuse," but instead of focusing on abuse, enforcement measures have been diluted by targeting all drug use, whether abusive or not. If Marijuana abuse is to be targeted, it is essential that clear standards be developed to identify it.

IV. **Respect Other's Rights**
The responsible cannabis user does not violate the rights of others, observes accepted standards of courtesy and propriety and respects the preferences of those who wish to avoid cannabis entirely. No one may violate the rights of others, and no substance use excuses any such violation. Regardless of the cannabis' legal status, responsible users will adhere to emerging tobacco smoking protocols in public and private places.

Public Law 91-513
91st Congress, H. R. 18583
October 27, 1970

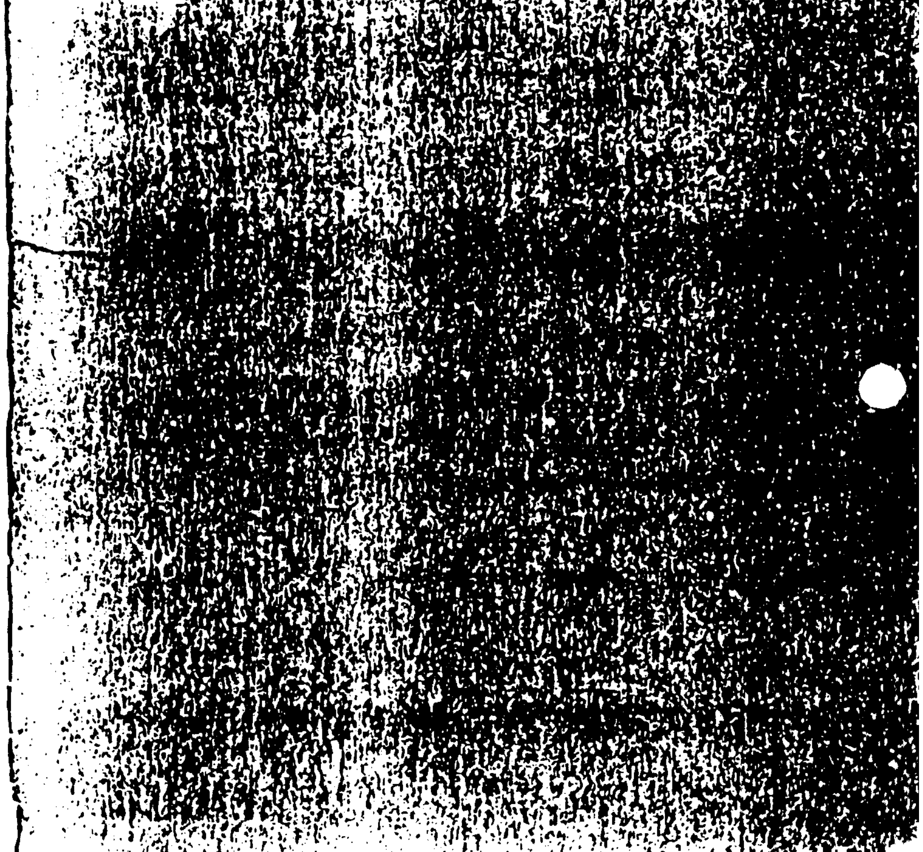
An Act

ER0471

marihuana: a signal of misunderstanding

First Report of the National Commission on Marihuana and Drug Abuse

March 1972



National Commission on Marihuana and Drug Abuse
801 19th Street N.W.
Washington, D.C. 20006

March 22, 1972

To The President and Congress of the United States:

As Chairman of the National Commission on Marihuana and Drug Abuse, I am pleased to submit to you our first year Report in conformance with the mandate contained in Section 601 of Public Law 91-513, The Comprehensive Drug Abuse Prevention and Control Act of 1970.

This Report "Marihuana, A Signal of Misunderstanding" is an all-inclusive effort to present the facts as they are known today, to demythologize the controversy surrounding marihuana, and to place in proper perspective one of the most emotional and explosive issues of our time. We on the Commission sincerely hope it will play a significant role in bringing uniformity and rationality to our marihuana laws, both Federal and State, and that it will create a healthy climate for further discussion, for further research and for a continuing advance in the development of a public social policy beneficial to all our citizens.

Whatever the facts are we have reported them. Wherever the facts have logically led us, we have followed and used them in reaching our recommendations. We hope this Report will be a foundation upon which credibility in this area can be restored and upon which a rational policy can be predicated.

By Direction of the Commission

Raymond P. Shafer

Raymond P. Shafer
Chairman

The President
The President of the Senate
The Speaker of the House

ER0472

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.00

since they are the most profitable means of employing its manpower and resources in this area.

Indeed, the time consumed in arresting possessors is inefficiently used when contrasted with an equal amount of time invested in apprehending major dealers. Although a credible effort to eliminate supply requires prohibitions of importation, sale and possession-with-intent-to-sell, the enforcement of a proscription of possession for personal use is minimally productive.

As noted, most law enforcement officials, district attorneys and judges recognize the ineffectiveness of the possession penalty as a deterrent. Its perpetuation results in the making of what is commonly referred to as "cheap" cases that have little or no impact on deterring sale.

The marihuana supply system can be viewed as a pyramid with the major bulk of marihuana entering the system at the top of the pyramid and then descending to the base which represents the user population. Common sense dictates where law enforcement should devote its efforts. To remove the profit from the traffic requires arresting sellers, not users. The oft-heard argument that the police need possession penalties to compel users to reveal their sources is not convincing. "Turning informants" at the base of the pyramid is of marginal value and limited utility in reaching upwards toward the apex. Further, the National Survey showed that 60% of the users don't "buy" marihuana but get it from a friend. The volume of traffic in the drug at these levels is at best minimal.

In short, personal possession arrests and even casual sales, which now account for more than 95% of the marihuana arrests at the state and local level, occur too low in the chain of distribution to diminish the supply very effectively.

In addition to the misallocation of enforcement resources, another consequence of prohibition against possession for personal use is the social cost of criminalizing large numbers of users. Our empirical study of enforcement of state and federal marihuana laws indicates that almost all of those arrested are between the ages of 18 and 25, most have jobs or are in school, and most have had no prior contact with the criminal justice system. The high social cost of stigmatizing such persons as criminals is now generally acknowledged by the public at large as well as by those in the criminal justice system.

According to the National Survey, 53% of the public was unwilling to give young users a criminal record and 87% objected to putting them in jail. The nation's judges expressed an overwhelming disinclination to sentence and convict users for marihuana possession. Of these judges only 13% thought it was appropriate to incarcerate an adult for possession and only 4% would jail a juvenile for marihuana possession. This disinclination is reflected in the low percentage of

arrested users who are convicted, and the even lower percentage who are jailed.

Even among the nation's prosecutors, a substantial majority favor the present trend toward avoiding incarceration for first offenders. Most jurisdictions have devised informal procedures for disposing of cases in lieu of prosecution. Our empirical study shows that 48% of the adult cases, and 70% of the juvenile cases, were dropped from the system at some point between arrest and conviction. The picture displayed is one of a large expenditure of police manpower to enforce a law most participants further along the line are not anxious to apply.

Other disturbing consequences of laws proscribing possession for personal use are the techniques required to enforce them. Possession of marihuana is generally a private behavior; in order to find it, the police many times must operate on the edge of constitutional limitations. Arrests without probable cause, illegal searches and selective enforcement occur often enough to arouse concern about the integrity of the criminal process.

Yet another consequence of marihuana possession laws is the clogging of judicial calendars. President Nixon has noted that one of the major impediments to our nation's efforts to combat serious crimes is the fact that the judicial machinery moves so slowly. Swift arrests, prosecution, trial and sentence would significantly improve the deterrent effect of law. Yet the judicial system is overloaded with petty cases, with public drunkenness accounting for about 50% of all non-traffic offenses.

In his March 1971 address to the National Conference on the Judiciary, President Nixon said:

> What can be done to break the logjam of justice today, to ensure the right to a speedy trial—and to enhance respect for law? We have to find ways to clear the courts of the endless stream of "victimless crimes" that get in the way of serious consideration of serious crimes. There are more important matters for highly skilled judges and prosecutors than minor traffic offenses, loitering and drunkenness.

To this list we would add marihuana possession, which accounts for a rising percentage of judicial caseloads. In Chicago alone, during the last half of 1970, there were more than 4,000 possession arrests.

A final cost of the possession laws is the disrespect which the laws and their enforcement engender in the young. Our youth cannot understand why society chooses to criminalize a behavior with so little visible ill-effect or adverse social impact, particularly when so many members of the law enforcement community also question the same laws. These young people have jumped the fence and found no cliff. And the disrespect for the possession laws fosters a disrespect for all law and the system in general.

On top of all this is the distinct impression among the youth that some police may use the marihuana laws to arrest people they don't like for other reasons, whether it be their politics, their hair style or their ethnic background. Whether or not such selectivity actually exists, it is perceived to exist.

For all these reasons, we believe that the possession offense is of little functional benefit to the discouragement policy and carries heavy social costs, not the least of which is disrespect and cynicism among some of the young. Accordingly, even under our policy of discouraging marihuana use, the better method is persuasion rather than prosecution. Additionally, with the sale and use of more hazardous drugs on the increase, and crimes of violence escalating, we do not believe that the criminal justice system can afford the time and the costs of implementing the marihuana possession laws. Since these laws are not mandatory in terms of achieving the discouragement policy, law enforcement should be allowed to do the job it is best able to do: handling supply and distribution.

A criminal fine or similar penalty for possession has been suggested as a means of alleviating some of the more glaring costs of a total prohibitory approach yet still retaining the symbolic disapproval of the criminal law. However, most of the objections raised above would still pertain: the possibilities of invasion of personal privacy and selective enforcement of the law would continue; possessors would still be stigmatized as criminals, incurring the economic and social consequences of involvement with the criminal law; the symbolic status of marihuana smoking as an anti-establishment act would be perpetuated.

On the other hand, a fine most likely would deter use no more than does the present possibility of incarceration. It would continue to impede treatment for heavy and very heavy use and would persist in directing law enforcement away from the policy's essential aim which is to halt illegal traffic in the drug.

For all these reasons, we reject the total prohibition approach and its variations.

REGULATION

Another general technique for implementing the recommended social policy is regulation. The distinguishing feature of this technique is that it institutionalizes the availability of the drug. By establishing a legitimate channel of supply and distribution, society can theoretically control the quality and potency of the product. The major alternatives within this approach lie in the variety of restraints which can be imposed on consumption of the drug and on the informational requirements to which its distribution can be subject.

We have given serious consideration to this set of alternatives; however, we are unanimously of the opinion that such a scheme, no matter how tightly it might restrict consumption, is presently unacceptable.

1. Adoption of a Regulatory Scheme at this Time Would Inevitably Signify Approval of Use

In rejecting the total prohibition approach, we emphasized the symbolic aspects. In essence, we do not believe prohibition of possession for personal use is necessary to symbolize a social policy disapproving the use. Theoretically, a tightly controlled regulatory scheme, with limited distribution outlets, significant restraints on consumption, prohibition of advertising and compulsory labeling, could possibly symbolize such disapproval. Our regulatory policy toward tobacco is beginning slowly to reflect a disapproval policy toward cigarette smoking. Nonetheless, given the social and historical context of such a major shift in legal policy toward marihuana, we are certain that such a change would instead symbolize approval of use, or at least a position of neutrality.

The Commission is concerned that even neutrality toward use as a matter of policy could invest an otherwise transient phenomenon with the status of an accepted behavior. If marihuana smoking were an already ingrained part of our culture, this objection would be dispelled. However, we do not believe that this is the case. We are inclined to believe, instead, that the present interest in marihuana is transient and will diminish in time of its own accord once the major symbolic aspects of use are deemphasized, leaving among our population only a relatively small coterie of users. With this possibility in mind, we are hesitant to adopt either a policy of neutrality or a regulatory implementation of our discouragement policy. The law would inevitably lose its discouragement character and would become even more ambiguous in its rationale and its enforcement.

The effect of changing a social policy direction may be seen with tobacco policy. In recent years, society has ostensibly adopted a policy of discouraging cigarette smoking. This new policy has been implemented primarily in the information area through prohibition of some forms of advertising and through compulsory labeling. Yet, the volume of cigarettes used increased last year. We believe that the failure of the new policy results from the fact that it supplants one that formerly approved use. This set of circumstances argues against any policy which would be regarded as approval of use, including a regulatory scheme. It is always extremely difficult to transform a previously acceptable behavior into a disapproved behavior.

2. Adoption of a Regulatory Scheme Might Generate a Significant Public Health Problem

We noted above that institutionalizing availability of the drug would inevitably increase the incidence of use, even though that in-

- Transfer of a small amount of marihuana for no remuneration is a misdemeanor punishable by up to one year in jail and a $1,000 fine for first offense and by up to two years in jail and a $2,000 fine for second offense (Congress singled out marihuana in this way to allow misdemeanor treatment of casual transfers and permitted first offender treatment, as allowed for possession for personal use).

The Commission recommends *only* the following changes in federal law:

- POSSESSION OF MARIHUANA FOR PERSONAL USE WOULD NO LONGER BE AN OFFENSE, BUT MARIHUANA POSSESSED IN PUBLIC WOULD REMAIN CONTRABAND SUBJECT TO SUMMARY SEIZURE AND FORFEITURE.
- CASUAL DISTRIBUTION OF SMALL AMOUNTS OF MARIHUANA FOR NO REMUNERATION, OR INSIGNIFICANT REMUNERATION NOT INVOLVING PROFIT WOULD NO LONGER BE AN OFFENSE.

The Commission further recommends that federal law be supplemented to provide:

- A PLEA OF MARIHUANA INTOXICATION SHALL NOT BE A DEFENSE TO ANY CRIMINAL ACT COMMITTED UNDER ITS INFLUENCE, NOR SHALL PROOF OF SUCH INTOXICATION CONSTITUTE A NEGATION OF SPECIFIC INTENT.

Commissioners Rogers and Carter believe that the legal system must be utilized directly to discourage *the person* from using marihuana rather than being utilized only indirectly as in the case of contraband.

This civil fine would not be reflected in a police record, nor would it be considered a criminal act for purposes of future job consideration, either in the private sector or for government service.

Agreeing with the other Commissioners that the casual transfers of marihuana for no profit should be treated in the same manner as possession for one's own use, Congressmen Rogers and Carter do not agree that it should extend to transfers involving remuneration. They prefer the limiting language of the Comprehensive Drug Abuse Prevention and Control Act of 1970 which does not include the term "or insignificant remuneration not involving a profit."

Apart from the addition of the civil fine to the contraband recommendation in the respects set out above, Congressmen Carter and Rogers are in complete agreement with the statutory recommendations set out in the Report.

Commissioner Ware concurs completely with the statements made by Congressmen Rogers and Carter but wishes to reemphasize that the social policy and legal scheme adopted is applicable only to marihuana and should not be construed to embrace other psychoactive drugs. The policy set forth in this Report, subject to the already noted comments of the two Congressional Commissioners, makes sense for marihuana on the basis of what is known about the drug and in the absence of any conclusive showing which would verify

RECOMMENDATIONS FOR STATE LAW

Under existing state marihuana laws, cultivation, distribution and possession with intent to distribute are generally felonies and in most states possession for personal use is a misdemeanor. The Commission strongly recommends uniformity of state laws and, in this regard, endorses the basic promise of the Uniform Controlled Substances Act, drafted by the National Conference of Commissioners on Uniform State Laws. The following are our recommendations for a uniform statutory scheme for marihuana, by which we mean, as under existing federal law, only the natural cannabis plant and its various parts, not the synthetic tetrahydrocannabinol (THC):

Existing Law

- CULTIVATION, SALE OR DISTRIBUTION FOR PROFIT AND POSSESSION WITH INTENT TO SELL WOULD REMAIN FELONIES (ALTHOUGH WE DO RECOMMEND UNIFORM PENALTIES).

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some of the anecdotal law enforcement testimony heard by the Commission regarding criminal behavior exhibited while under the influence of marihuana.

Commissioner Ware feels that some penalty short of criminalizing the user, such as a civil fine or some type of intensive drug education, will act as a positive deterrent toward minimizing the incidence of marihuana use especially among the young. Further, he is opposed to the use of *any* drug for the express purpose of getting intoxicated, and includes alcohol within this category. The Commissioner feels that what is needed is an internalizing of discipline among our citizenry, with the legal system assisting this process through the use of disincentives.

Commissioners Hughes, Senator from Iowa, and Javits, Senator from New York, feel that the Commission has taken a major, highly laudable step in recommending that the private use of marihuana be taken out of the criminal justice system. They concur in its threshold judgment that overall social policy regarding this drug should seek to discourage use, while concentrating primarily on the prevention of irresponsible use. They disagree, however, with three specific recommendations relating to the implementation of this discouragement policy.

First, they would eliminate entirely the contraband provision from the partial prohibitory model adopted by the Commission. They want it eliminated first because its legal implications are confusing and the subject of disagreement even among lawyers. Whether or not possession of a given substance is criminal, possession of material designated as contraband makes that possession *unlawful*. Also, marihuana designated as contraband would be subject to government search and seizure, even though the underlying possession is no longer criminal. The provision—which does not apply to marihuana held for personal use within the home—is considered by both Commissioners to be an unnecessary "symbol" of the discouragement policy. It will not foster elimination of the misunderstanding and mistrust which is a hallmark of our current marihuana policy.

Commissioner Hughes and Javits seek to eliminate it also because as a practical matter it serves no useful law enforcement purpose within the overall partial prohibitory model. If marihuana held for personal use within the home is not contraband, why should marihauna held for personal use within one's

Private Activities

- POSSESSION IN PRIVATE OF MARIHUANA FOR PERSONAL USE WOULD NO LONGER BE AN OFFENSE.
- DISTRIBUTION IN PRIVATE OF SMALL AMOUNTS OF MARIHUANA FOR NO REMUNERATION OR INSIGNIFICANT REMUNERATION NOT INVOLVING A PROFIT WOULD NO LONGER BE AN OFFENSE.

Public Activities

- POSSESSION IN PUBLIC OF ONE OUNCE OR UNDER OF MARIHUANA WOULD NOT BE AN OFFENSE, BUT THE MARIHUANA WOULD BE CONTRABAND SUBJECT TO SUMMARY SEIZURE AND FORFEITURE.
- POSSESSION IN PUBLIC OF MORE THAN ONE OUNCE OF MARIHUANA WOULD BE A CRIMINAL OFFENSE PUNISHABLE BY A FINE OF $100.
- DISTRIBUTION IN PUBLIC OF SMALL AMOUNTS OF MARIHUANA FOR NO REMUNERATION OR INSIGNIFICANT REMUNERATION NOT INVOLVING A PROFIT WOULD BE A CRIMINAL OFFENSE PUNISHABLE BY A FINE OF $100.
- PUBLIC USE OF MARIHUANA WOULD BE A CRIMINAL OFFENSE PUNISHABLE BY A FINE OF $100.
- DISORDERLY CONDUCT ASSOCIATED WITH PUBLIC USE OF OR INTOXICATION BY MARIHUANA WOULD BE A MISDEMEANOR PUNISHABLE BY UP TO 60 DAYS IN JAIL, A FINE OF $100, OR BOTH.

automobile be contraband? The area of operation of the contraband provision is extremely narrow. If one possesses *more* than one ounce of marihuana in public, it may be seized without regard to the contraband doctrine since such possession is a criminal violation.

Since the contraband provision does not apply to marihuana possession and use in private, the only effective area covered by the contraband provision is the area of possession in public of *less* than one ounce. The Commission has chosen to remove the stigma of the criminal sanction in this kind of case. To impose instead a contraband provision, which it is argued is in the nature of a civil "in rem" seizure which does not operate against the person, is to cloud the issue and to weaken the force of the basic decriminalization. A persuasive justification simply has not been made.

Both Commissioners seek to eliminate it also because they believe that the voice of the Commission should be loud and clear that the preservation of the right of privacy is of paramount importance and cannot be casually jeopardized in the pursuit of some vague public or law enforcement interest which has not been defined and justified with clarity and precision.

The second area of disagreement with the Commission's recommendations concerns the casual distribution of marihuana and the not-for-profit sale. As understood:

- OPERATING A VEHICLE OR DANGEROUS INSTRUMENT WHILE UNDER THE INFLUENCE OF MARIHUANA WOULD BE A MISDEMEANOR PUNISHABLE BY UP TO ONE YEAR IN JAIL, A FINE OF UP TO $1,000, OR BOTH, AND SUSPENSION OF A PERMIT TO OPERATE SUCH A VEHICLE OR INSTRUMENT FOR UP TO 180 DAYS.
- A PLEA OF MARIHUANA INTOXICATION SHALL NOT BE A DEFENSE TO ANY CRIMINAL ACT COMMITTED UNDER ITS INFLUENCE NOR SHALL PROOF OF SUCH INTOXICATION CONSTITUTE A NEGATION OF SPECIFIC INTENT.
- A PERSON WOULD BE ABSOLUTELY LIABLE IN CIVIL COURT FOR ANY DAMAGE TO PERSON OR PROPERTY WHICH HE CAUSED WHILE UNDER THE INFLUENCE OF THE DRUG.

DISCUSSION OF FEDERAL RECOMMENDATIONS

The recommended federal approach is really a restatement of existing federal policy. From official testimony and record evaluation, we know that the federal law enforcement authorities, principally the Federal Bureau of Narcotics and Dangerous Drugs and the Bureau of Customs, do not concentrate their efforts on personal possession cases. The avowed purpose of both Bureaus is to eliminate major traffickers and sources of supply. For the most part, the federal

(1) The totally donative transfer is not subject to criminal penalty, regardless of where it takes place.

(2) The transfer of *small* amounts for *insignificant* remuneration *not involving a profit* is not subject to criminal penalty (except if it is accomplished in public, in which case it is subject to criminal sanction), but

(3) The transfer of *"large* amounts" for *"significant"* remuneration not involving a profit is subject to criminal penalty.

Footnote 4 on page 158 of the Report, the Commission refers to a Report of The Senate Judiciary Committee on the Comprehensive Drug Abuse Prevention and Control Act of 1970. In substance, it implies that within the meaning of the Act, transfers of more than one or two marihuana cigarettes in return for 50 cents or one dollar to cover cost are not intended to be covered as casual transfers, but rather are to be treated as unlawful sales.

Commissioners Hughes and Javits feel that the Commission has failed to set forth a clear standard which will adequately inform the public of their obligations under the law. The recommendation and its discussion in the Report are confusing and fail to provide the individual with sufficient guidance to allow him to act without having to dodge in and out of illegality. It also undermines a basic, stated objective of the Commission i.e., to concentrate the weight of the criminal sanction upon significant supply and distribution activities, rather than upon casual consumption.

Moreover, proscribing even the most casual not-for-profit transfers when they occur in public is, in their opinion, wrong. Such transfers are necessarily inci-

UNITED STATES DEPARATMENT OF JUSTICE
Drug Enforcement Administration

In The Matter Of
MARIJUANA RESCHEDULING PETITION

Docket No. 86-22

OPINION & RECOMMENDED RULING, FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION OF ADMINISTRATIVE LAW JUDGE

Francis L. Young
Administrative Law Judge

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September 6, 1988

CONTENTS

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I. INTRODUCTION

This is a rulemaking pursuant to the Administrative Procedure Act, 5 U.S.C. § 551, *et seq.*, to determine whether the marijuana plant (*Cannabis sativa L.*) considered as a whole may lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act (the Act). 21 U.S.C. 801, *et seq.* None of the parties is seeking to "legalize" marijuana generally or for recreational purposes. Placement in Schedule II would mean, essentially, that physicians in the United States would not violate Federal law by prescribing marijuana for their patients for legitimate therapeutic purposes. It is contrary to Federal law for physicians to do this as long as marijuana remains in Schedule I.

This proceeding had it origins on May 18, 1972 when the National Organization for the Reform of Marijuana Laws (NORML) and two other groups submitted a petition to the Bureau of Narcotics and Dangerous Drugs (BNDD)[1]

In September, 1972 the Director of BNDD announced his refusal to accept the petition for filing, stating that he was not authorized to institute proceedings for the action requested because of the provisions of the Single

1 The powers and authority granted by the Act to the Attorney General were delegated to the Director of BNDD and subsequently to the Administrator of DEA. 28 C.F.R. § 0.100, *et seq.*, predecessor agency to the Drug Enforcement Administration (DEA or the Agency), asking that marijuana be removed from Schedule I and freed of all controls entirely, or be transferred from Schedule I to Schedule V where it would be subject to only minimal control. The Act by its terms had placed marijuana in Schedule I thereby declaring, as a matter of law, that it had no legitimate use in therapy in the United States and subjecting the substance to the strictest level of controls. The Act had been in effect for just over one year when NORML submitted its 1972 petition.

Convention on Narcotic Drugs, 1961. NORML appealed this action to the United States Court of Appeals for the District of Columbia Circuit. The court held that the Director had erred in rejecting the petition without "a reflective consideration and analysis," observing that the Director's refusal "was not the kind of agency action that promoted the kind of interchange and refinement of views that is the lifeblood of a sound administrative process." *NORML v. Ingersoll*, 162 U.S. App. D.C. 67, 497 F.2d 654, 659 (1974). The court remanded the matter in January 1974 for further proceedings not inconsistent with its opinion, "to be denominated a consideration on the merits." *Id.*

A three-day hearing was held at DEA[2] by Administrative Law Judge Lewis Parker in January 1975. The judge found in NORML's favor on several issues but the Acting Administrator of DEA entered a final order denying NORML's petition "in all respects." NORML again petitioned the court for review. Finding fault with DEA's final order the court again remanded for further proceedings not inconsistent with its opinion. *NORML v. DEA*, 182 U.S. App. D.C. 144, 559 F.2d 735 (1977). The Court directed the then-Acting Administrator of DEA to refer NORML's petition to the Secretary of the Department of Health, Education and Welfare (HEW) for findings and, thereafter, to comply with the rulemaking procedures outlined in the Act. 21 U.S.C. §811 (a) and (b).

On remand the Administrator of DEA referred NORML's petition to HEW for scientific and medical evaluation. On June 4, 1979 the Secretary of HEW advised the Administrator of the results of the HEW evaluation and recommended that marijuana remain in Schedule I. Without holding any further hearing the Administrator of DEA proceeded to issue a final order ten days later denying NORML's petition and declining to initiate proceedings to transfer marijuana from Schedule I. 44 *Fed. Reg.* 36123 (1979). NORML went back to the Court of Appeals.

When the case was called for oral argument there was discussion of the then-present status of the matter. DEA had moved for a partial remand. The court found that "reconsideration on all the issues in this case would be appropriate" and again remanded it to DEA, observing: "We regrettably find it necessary to remind respondents [DEA and HEW] of an agency's obligation on remand not to do anything which is contrary to either the letter or spirit of the mandate construed in the light of the opinion of [the] court deciding the case." (Citations omitted.) *NORML v. DEA, et al.*, No. 79-1660, United States Court of Appeals for the District of Columbia Circuit, unpublished order filed October 16, 1980. DEA was directed to refer all the substances at issue to the Department of Health and Human Services (HHS), successor agency to HEW, for scientific and medical findings and recommendations on scheduling. DEA did so and HHS has responded. In a letter dated April

2 DEA became the successor agency to BNDD in a reorganization carried out pursuant to Reorganization Plan No. 2 of 1973, eff. July 1, 1973. 38 *Fed. Reg.* 15932 (1973).

1, 1986 the then-Acting Deputy Administrator of DEA requested this administrative law judge to commence hearing procedure as to the proposed rescheduling of marijuana and its components.

After the judge conferred with counsel for NORML and DEA, a notice was published in the *Federal Register* on June 24, 1986 announcing that hearings would be held on NORML's petition for the rescheduling of marijuana and its components commencing on August 21, 1986 and giving any interested person who desired to participate the opportunity to do so. 51 *Fed. Reg.* 22964 (1986).

Of the three original petitioning organizations in 1972 only NORML is a party to the present proceeding. In addition the following entities responded to the *Federal Register* notice and have become parties, participating to varying degrees: the Alliance for Cannabis Therapeutics (ACT Cannabis Corporation of America (CCA) and Carl Eric Olsen, all seeking transfer of marijuana to Schedule II; the Agency, National Federation of Parents for Drug-Free Youth (NFP) and the International Association of Chiefs of Police (IACP), all contending that marijuana should remain in Schedule I.

Preliminary prehearing sessions were held on August 21 and December 5, 1986 and on February 20, 1987.[3] During the preliminary stages, on January 20, 1987, NORML filed an amended petition for rescheduling. The new petition abandoned NORML's previous requests for the complete descheduling of marijuana or rescheduling to Schedule V. It asks only that marijuana be placed in Schedule II.

At a prehearing conference on February 20, 1987 this amended petition was discussed.[4] All parties present stipulated, for the purpose of this proceeding, that marijuana has a high potential for abuse and that abuse

3 Transcripts of these three preliminary prehearing sessions are included in the record.

4 The transcript of this prehearing conference and of the subsequent hearing sessio comprise 15 volumes numbered as follows:

Vol. I	Prehearing Conference, October 16, 1987
Vol. II	Cross-Examination, November 19, 1987
Vol. III	Cross-Examination, December 8, 1987
Vol. IV	Cross-Examination, December 9, 1987
Vol. V	Cross-Examination, January 5, 1988
Vol. VI	Cross-Examination, January 6, 1988
Vol. VII	Cross-Examination, January 7, 1988
Vol. VIII	Cross-Examination, January 26, 1988
Vol. IX	Cross-Examination, January 27, 1988
Vol. X	Cross-Examination, January 28, 1988
Vol. XI	Cross-Examination, January 29, 1988
Vol. XII	Cross-Examination, February 2, 1988
Vol. XIII	Cross-Examination, February 4, 1988
Vol. XIV	Cross-Examination, February 5, 1988
Vol. XV	Oral Argument, June 10, 1988

Pages of the transcript are cited herein by volume and page, *e.g.* "Tr. V-96"; "G-" identifies an Agency exhibit.

of the marijuana plant may lead to severe psychological or physical dependence. They then agreed that the principal issue in this proceeding would be stated thus:

> Whether the marijuana plant, considered as a whole,[5] may lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act.

Two subsidiary issues were agreed on, as follows:

> 1. Whether the marijuana plant has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.
>
> 2. Whether there is a lack of accepted safety for use of the marijuana plant under medical supervision.

As stated above, the parties favoring transfer from Schedule I to Schedule II are NORML, ACT, CCA and Carl Eric Olsen. Those favoring retaining marijuana in Schedule I are the Agency, NFP and IACP.

During the Spring and Summer of 1987 the parties identified their witnesses and put the direct examination testimony of each witness in writing in affidavit form. Copies of these affidavits were exchanged. Similarly, the parties assembled their proposed exhibits and exchanged copies. Opportunity was provided for each party to submit objections to the direct examination testimony and exhibits proffered by the others. The objections submitted were considered by the administrative law judge and ruled on. The testimony and exhibits not excluded were admitted into the record. Thereafter hearing sessions were held at which witnesses were subjected to cross-examination. These sessions were held in New Orleans, Louisiana on November 18 and 19, 1987; in San Francisco, California on December 8 and 9, 1987; and in Washington, D.C. on January 5 through 8 and 26 through 29, and on February 2, 4 and 5, 1988. The parties have submitted proposed findings and conclusions and briefs. Oral arguments were heard by the judge on June 10, 1988 in Washington.

5 Throughout this opinion the term "marijuana" refers to "the marijuana plant, considered as a whole".

II. RECOMMENDED RULING

It is recommended that the proposed findings and conclusions submitted by the parties to the administrative law judge be rejected by the Administrator except to the extent they are included in those hereinafter set forth, for the reason that they are irrelevant or unduly repetitious or not supported by a preponderance of the evidence. 21 C.F.R. § 1316.65(a)(1).

III. ISSUES

As noted above, the agreed issues are as follows:

Principle issue:

> Whether the marijuana plant, considered as a whole, may lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act.

Subsidiary issues:

> 1. Whether the marijuana plant has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.
>
> 2. Whether there is a lack of accepted safety for use of the marijuana plant under medical supervision.

IV. STATUTORY REQUIREMENTS FOR SCHEDULING

The Act provides (21 U.S.C. § 812(b)) that a drug or other substance may not be placed in any schedule unless certain specified findings are made with respect to it. The findings required for Schedule I and Schedule II are as follows:

> **Schedule I.**
>
> (A) The drug or other substances has a high potential for abuse.
>
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
>
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

Schedule II

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

(C) Abuse of the drug or other substances [sic] may lead to severe psychological or physical dependence.

As noted above the parties have stipulated, for the purposes of this proceeding, that marijuana has a high potential for abuse and that abuse of it may lead to severe psychological or physical dependence. Thus the dispute between the two sides in this proceeding is narrowed to whether or not marijuana has a currently accepted medical use in treatment in the United States, and whether or not there is a lack of accepted safety for use of marijuana under medical supervision.

The issues as framed here contemplate marijuana's being placed only in Schedule I or Schedule II. The criteria for placement in any of the other three schedules established by the Act are irrelevant to this proceeding.

V. ACCEPTED MEDICAL USE IN TREATMENT CHEMOTHERAPY

With respect to whether or not marijuana has a "currently accepted medical use in treatment in the United States" for chemotherapy patients, the record shows the following facts to be uncontroverted.

Findings of Fact

1. One of the most serious problems experienced by cancer patients undergoing chemotherapy for their cancer is severe nausea and vomiting caused by their reaction to the toxic (poisonous) chemicals administered to them in the course of this treatment. This nausea and vomiting at times becomes life threatening. The therapy itself creates a tremendous strain on the body. Some patients cannot tolerate the severe nausea and vomiting and discontinue treatment. Beginning in the 1970's there was considerable doctor-to-doctor communication in the United States concerning patients known by their doctors to be surreptitiously using marijuana with notable success to overcome or lessen their nausea and vomiting.

2. Young patients generally achieve better control over nausea and vomiting from smoking marijuana than do older patients, particularly when the older patient has not been provided with detailed information on how to smoke marijuana.

3. Marijuana cigarettes in many cases are superior to synthetic THC capsules in reducing chemotherapy-induced nausea and vomiting. Marijuana has an important, clear advantage over synthetic THC capsules in that the natural marijuana is inhaled and generally takes effect more quickly than the synthetic capsule which is ingested and must be processed through the digestive system before it takes effect.

4. Attempts to orally administer the synthetic THC capsule to a vomiting patient presents obvious problems — it is vomited right back up before it can have any effect.

5. Many physicians, some engaged in medical practice and some teaching in medical schools, have accepted smoking marijuana as effective in controlling or reducing the severe nausea and vomiting (emesis) experienced by some cancer patients undergoing chemotherapy for cancer.

6. Such physicians include board-certified internists, oncologists and psychiatrists. (Oncology is the treatment of cancer through the use of highly toxic chemicals, or chemotherapy.)

7. Doctors who have come to accept the usefulness of marijuana in controlling or reducing emesis resulting from chemotherapy have done so as the result of reading reports of studies and anecdotal reports in their professional literature, and as the result of observing patients and listening to reports directly from patients.

8. Some cancer patients who have acknowledged to doctors that they smoke marijuana for emesis control have indicated in their discussions that, although they may have first smoked marijuana recreationally, they accidentally found that doing so helped reduce the emesis resulting from their chemotherapy. They consistently indicated that they felt better and got symptomatic relief from the intense nausea and vomiting caused by the chemotherapy. These patients were no longer simply getting high, but were engaging in medically treating the illness, albeit with an illegal substance. Other chemotherapy patients began smoking marijuana to control their emesis only after hearing reports that the practice had proven helpful to others. Such patients had not smoked marijuana recreationally.

9. This successful use of marijuana has given many cancer chemotherapy patients a much more positive outlook on their overall treatment, once they were relieved of the debilitating, exhausting and extremely unpleasant nausea and vomiting previously resulting from their chemotherapy treatment.

10. In about December 1977 the previously underground patient practice of using marijuana to control emesis burst into the public media in New Mexico when a young cancer patient, Lynn Pearson, began publicly to discuss his use of marijuana. Mr. Pearson besought the New Mexico legislature to pass legislation making marijuana available legally to seriously ill patients whom it might help. As a result, professionals in the public health sector in New Mexico more closely examined how marijuana might be made legally available to assist in meeting what now openly appeared to be a widely recognized patient need.

11. In many cases doctors have found that, in addition to suppressing nausea and vomiting, smoking marijuana is a highly successful appetite stimulant. The importance of appetite stimulation in cancer therapy cannot be overstated. Patients receiving chemotherapy often lose tremendous amounts of weight. They endanger their lives because they lose interest in food and in eating. The resulting sharp reduction in weight may well affect their prognosis. Marijuana smoking induces some patients to eat. The benefits are obvious, doctors have found. There is no significant loss of weight. Some patients will gain weight. This allows them to retain strength and makes them better able to fight the cancer. Psychologically, patients who can continue to eat even while receiving chemotherapy maintain a balanced outlook and are better able to cope with their disease and its treatment, doctors have found.

12. Synthetic anti-emetic agents have been in existence and utilized for a number of years. Since about 1980 some new synthetic agents have been developed which appear to be more effective in controlling and reducing chemotherapy-induced nausea and vomiting than were some of those available in the 1970's. But marijuana still is found more effective for this purpose in some people than any of the synthetic agents, even the newer ones.

13. By the late 1970's in the Washington, D.C. area there was a growing recognition among health care professionals and the public that marijuana had therapeutic value in reducing the adverse effects of some chemotherapy treatments. With this increasing public awareness came increasing pressure from patients and doctors for information about marijuana and its therapeutic uses. Many patients moved into forms of unsupervised self-treatment. While such self-treatment often proved very effective, it has certain hazards, ranging from arrest for purchase or use of an illegal drug to possible serious medical complications from contaminated sources or adulterated materials. Yet, some patients are willing to run these risks to obtain relief from the debilitating nausea and vomiting caused by their chemotherapy treatments.

14. Every oncologist known to one Washington, D.C. practicing internist and board-certified oncologist has had patients who used marijuana with great success to prevent or diminish chemotherapy-induced nausea and vomiting. Chemotherapy patients reporting directly to that Washington doctor that they have smoked marijuana medically vomit less and eat better than patients who do not smoke it. By gaining control over their severe nausea and vomiting these patients undergo a change of mood and have a better mental outlook than patients who, using the standard anti-emetic drugs, are unable to gain such control.

15. The vomiting induced by chemotherapeutic drugs may last up to four days following the chemotherapy treatment. The vomiting can be intense, protracted and, in some instances, is unendurable. The nausea which follows such vomiting is also deep and prolonged. Nausea may prevent a patient from taking regular food or even much water for periods of weeks at a time.

16. Nausea and vomiting of this severity degrades the quality of life for these patients, weakening them physically, and destroying the will to fight the cancer. A desire to end the chemotherapy treatment in order to escape the emesis can supersede the will to live. Thus the emesis, itself, can truly be considered a life-threatening consequence of many cancer treatments. Doctors have known such cases to occur. Doctors have known other cases where marijuana smoking has enabled the patient to endure, and thus continue, chemotherapy treatment with the result that the cancer has gone into remission and the patient has returned to a full, active satisfying life.

17. In San Francisco chemotherapy patients were surreptitiously using marijuana to control emesis by the early 1970's. By 1976 virtually every young cancer patient receiving chemotherapy at the University of California in San Francisco was using marijuana to control emesis with great success. The use of marijuana for this purpose had become generally accepted by the patients and increasingly by their physicians as a valid and effective form of treatment. This was particularly true for younger cancer patients, somewhat less common for older ones. In 1979 about 25% to 30% of the patients seen by one San Francisco oncologist were using marijuana to control emesis, about 45 to 50 patients per year. Such percentages and numbers vary from city to city. A doctor in Kansas City who sees about 150 to 200 new cancer patients per year found that over the 15 years from 1972 to 1987 about 5% of the patients he saw, or a total of about 75, used marijuana medicinally.

18. By 1987 marijuana no longer generated the intense interest in the world of oncology that it had previously, but it remains a viable tool, commonly employed, in the medical treatment of chemotherapy patients. There has evolved an unwritten but accepted standard of treatment within the community of oncologists in the San Francisco, California area which readily accepts the use of marijuana.

19. As of the Spring of 1987 in the San Francisco area, patients receiving chemotherapy commonly smoked marijuana in hospitals during their treatments. This in-hospital use which takes place in rooms behind closed doors, does not bother staff, is expected by physicians and welcomed by nurses who, instead of having to run back and forth with containers of vomit, can treat patients whose emesis is better controlled than it would be without marijuana. Medical institutions in the Bay area where use of marijuana obtained on the streets is quite common, although discrete, include the University of California at San Francisco Hospital, the Mount Zion Hospital and the Franklin Hospital. In effect, marijuana is readily accepted throughout the oncologic community in the Bay area for its benefits in connection with chemotherapy. The same situation exists in other large metropolitan areas in the United States.

20. About 50% of the patients seen by one San Francisco oncologist during the year 1987 were smoking marijuana medicinally. This is about 90 to 95 individuals. This number is higher then during the previous ten years due to the nature of this physician's practice which includes patients from the "Tenderloin" area of San Francisco, many of whom are suffering from

AIDS-related lymphosarcoma. These patients smoke marijuana to control their nausea and vomiting, not to "get high." They self-titrate, *i.e.*, smoke the marijuana only as long as needed to overcome the nausea, to prevent vomiting.

21. The State of New Mexico set up a program in 1978 to make marijuana available to cancer patients pursuant to an act of the State legislature. The legislature had accepted marijuana as having medical use in treatment. It overwhelmingly passed this legislation so as to make marijuana available for use in therapy, not just for research. Marijuana and synthetic THC were given to patients, administered under medical supervision, to control or reduce emesis. The marijuana was in the form of cigarettes obtained from the Federal government. The program operated from 1979 until 1986, when funding for it was terminated by the State. During those seven years about 250 cancer patients in New Mexico received either marijuana cigarettes or THC. Twenty or 25 physicians in New Mexico sought and obtained marijuana cigarettes or THC for their cancer patients during that period. All of the oncologists in New Mexico accepted marijuana as effective for some of their patients. At least ten hospitals were involved in this program in New Mexico, in which cancer patients smoked their marijuana cigarettes. The hospitals accepted this medicinal marijuana smoking by patients. Voluminous reports filed by the participating physicians make it clear that marijuana is a highly effective anti-emetic substance. It was found in the New Mexico program to be far superior to the best available conventional anti-emetic drug, Compazine, and clearly superior to synthetic THC pills. More than 90% of the patients who received marijuana within the New Mexico program reported significant or total relief from nausea and vomiting. Before the program began cancer patients were surreptitiously smoking marijuana in New Mexico to lessen or control their emesis resulting from chemotherapy treatments. They reported to physicians that it was successful for this purpose. Physicians were aware that this was going on.

22. In 1978 the Louisiana legislature became one of the first State legislatures in the nation to recognize the efficacy of marijuana in controlling emesis by enacting legislation intended to make marijuana available by prescription for therapeutic use by chemotherapy patients. This enactment shows that there was widespread acceptance in Louisiana for the therapeutic value of marijuana. After a State Marijuana Prescription Review Board was established, pursuant to that legislature, it became apparent that, because of Federal restrictions, marijuana could be obtained legally only for use in cumbersome, formal research programs. Eventually a research program was entered into by the State, utilizing synthetic THC, but without much enthusiasm, since most professionals who had wanted to use marijuana clinically, to treat patients, had neither the time, resources nor inclination to get involved in this limited, formal study. The original purpose of the Louisiana legislation was frustrated by the Federal authorities. Some patients, who had hoped to obtain marijuana for medical use legally after enactment of the State legislation, went outside the law and obtained it illicitly. Some physicians in Louisiana accept marijuana as having a distinct medical value in the treatment of nausea and vomiting associated with certain types of chemotherapy treatments.

23. In 1980 the State of Georgia enacted legislation authorizing a therapeutic research program for the evaluation of marijuana as a medically recognized therapeutic substance. Its enactment was supported by letters from a number of Georgia oncologists and other Georgia physicians, including the Chief of Oncology at Grady Hospital and staff oncologists at Emory University Medical Clinic. Sponsors of the legislation originally intended the enactment of a law making marijuana available for clinical, therapeutic use by patients. The bill was referred to as the "Marijuana-as-Medicine" bill. The final legislation was crafted, however, of necessity, merely to set up a research program in order to obtain marijuana from the one legitimate source available — the Federal government, which would not make the substance available for any purpose other than conducting a research program. The Act was passed by an overwhelming majority in the lower house of the legislature and unanimously in the Senate. In January, 1983 an evaluation of the program, which by then had had 44 evaluable marijuana smoking patient-participants, accepted marijuana smoking as being an effective anti-emetic agent.

24. In Boston, Massachusetts in 1977 a nurse in a hospital suggested to a chemotherapy patient, suffering greatly from the therapy and at the point of refusing further treatment, that smoking marijuana might help relieve his nausea and vomiting. The patient's doctor, when asked about it later, stated that many of his younger patients were smoking marijuana. Those who did so seemed to have less trouble with nausea and vomiting. The patient in question obtained some marijuana and smoked it, in the hospital, immediately before his next chemotherapy treatment. Doctors, nurses and orderlies coming into the room as he finished smoking realized what the patient had been doing. None of them made any comment. The marijuana was completely successful with this patient, who accepted it as effective in controlling his nausea and vomiting. Instead of being sick for weeks following chemotherapy, and having trouble going to work, as had been the case, the patient was ready to return to work 48 hours after that chemotherapy treatment. The patient thereafter always smoked marijuana, in the hospital, before chemotherapy. The doctors were aware of it, openly approved of it and encouraged him to continue. The patient resumed eating regular meals and regained lost weight, his mood improved markedly, he became more active and outgoing and began doing things together with his wife that he had not done since beginning chemotherapy.

25. During the remaining two years of this patient's life, before his cancer ended it, he came to know other cancer patients who were smoking marijuana to relieve the adverse effects of their chemotherapy. Most of these patients had learned about using marijuana medically from their doctors who, having accepted its effectiveness, subtly encouraged them to use it.

26. A Boston psychiatrist and professor, who travels about the country, has found a minor conspiracy to break the law among oncologists and nurses in every oncology center he has visited to let patients smoke

marijuana before and during cancer chemotherapy. He has talked with dozens of these health care oncologists who encourage their patients to do this and who regard this as an accepted medical usage of marijuana. He has known nurses who have obtained marijuana for patients unable to obtain it for themselves.

27. A cancer patient residing in Beaverton, Michigan smoked marijuana medically in the nearby hospital where he was undergoing chemotherapy from early 1979 until he died of his cancer in October of that year. He smoked it in his hospital room after his parents made arrangements with the hospital for him to do so. Smoking marijuana controlled his post-chemotherapy nausea and vomiting, enabled him to eat regular meals again with his family, and he became outgoing and talkative. His parents accepted his marijuana smoking as effective and helpful. Two clergymen, among others, brought marijuana to this patient's home. Many people at the hospital supported the patient's marijuana therapy, none doubted its helpfulness or discouraged it. This patient was asked for help by other patients. He taught some who lived nearby how to form the marijuana cigarettes and properly inhale the smoke to obtain relief from nausea and vomiting. When an article about this patient's smoking marijuana appeared in a local newspaper, he and his family heard from many other cancer patients who were doing the same. Most of them made an effort to inform their doctors. Most physicians who knew their patients smoked marijuana medicinally approved, accepting marijuana's therapeutic helpfulness in reducing nausea and vomiting.

28. In October 1979 the Michigan legislature enacted legislation whose underlying purpose was to make marijuana available therapeutically for cancer patients and others. The State Senate passed the bill 29-5, the House of Representatives 100-0. In March 1982 the Michigan legislature passed a resolution asking the Federal Congress to try to alter Federal policies which prevent physicians from prescribing marijuana for legitimate medical applications and prohibit its use in medical treatments.

29. In Denver, Colorado a teenage cancer patient has been smoking marijuana to control nausea and vomiting since 1986. He has done this in his hospital room both before and after chemotherapy. His doctor and hospital staff know he does this. The doctor has stated that he would prescribe marijuana for this patient if it were legal to do so. Other patients in the Denver area smoke marijuana for the same purpose. This patient's doctor, and nurses with whom he comes in contact, understand that cancer patients smoke marijuana to reduce or control emesis. They accept it.

30. In late 1980 a three year old boy was brought by his parents to a hospital in Spokane, Washington. The child was diagnosed as having cancer. Surgery was performed. Chemotherapy was begun. The child became extremely nauseated and vomited for days after each chemotherapy treatment. He could not eat regularly. He lost strength. He lost weight. His body's ability to ward off common infections, other life-threatening infections, significantly decreased. Chemotherapy's after-effects caused the child great suffering. They caused his watching parents great suffering. Several standard, available anti-emetic agents were tried by the child's doctors. None of them succeeded in controlling his nausea and vomiting. Learning of the existence of research studies with THC or marijuana the parents asked the child's doctor to arrange for their son to be the subject of such a study so that he might have access to marijuana. The doctor refused, citing the volume of paperwork and record-keeping detail required in such programs and his lack of administrative personnel to handle it.

31. The child's mother read an article about marijuana smoking helping chemotherapy patients. She obtained some marijuana from friends. She baked cookies for her child with marijuana in them. She made tea for him with marijuana in it. When the child ate these cookies or drank this tea in connection with his chemotherapy, he did not vomit. His strength returned. He regained lost weight. His spirits revived. The parents told the doctors and nurses at the hospital of their giving marijuana to their child. None objected. They all accepted smoking marijuana as effective in controlling chemotherapy induced nausea and vomiting. They were interested to see the results of the cookies.

32. Soon this child was riding a tricycle in the hallways of the Spokane hospital shortly after his chemotherapy treatments while other children there were still vomiting into pans, tied to intravenous bottles in an attempt to re-hydrate them, to replace the liquids they were vomiting up. Parents of some of the other patients asked the parents of this "lively" child how he seemed to tolerate his chemotherapy so well. They told of the marijuana use. Of those parents who began giving marijuana to their children, none ever reported back encountering any adverse side effects. In the vast majority of these cases, the other parents reported significant reduction in their children's vomiting and appetite stimulation as the result of marijuana. The staff, doctors and nurses at the hospital knew of this passing on of information about marijuana to other parents. They approved. They never told the first parents to hide their son's medicinal use of marijuana. They accepted the effectiveness of the cookies and the tea containing marijuana.

33. The first child's cancer went into remission. Then it returned and spread. Emotionally drained, the parents moved the family back to San Diego, California to be near their own parents. Their son was admitted to a hospital in San Diego. The parents informed the doctors, nurses and social workers there of their son's therapeutic use of marijuana. No one objected. The child's doctor in San Diego strongly supported the parent's giving marijuana to him. Here in California, as in Spokane, other parents noticed the striking difference between their children after chemotherapy and the first child. Other parents asked the parents of the first child about it, were told of the use of marijuana, tried it with their children, and saw dramatic improvement. They accepted its effectiveness. In the words of the mother of the first child: "...When your kid is riding a tricycle while his other hospital buddies are hooked up to IV needles, their heads hung over

vomiting buckets, you don't need a federal agency to tell you marijuana is effective. The evidence is in front of you, so stark it cannot be ignored."[6]

34. There is at least one hospital in Tucson, Arizona where medicinal use of marijuana by chemotherapy patients is encouraged by the nursing staff and some physicians.

35. In addition to the physicians mentioned in the Findings above, mostly oncologists and other practitioners, the following doctors and health care professionals, representing several different areas of expertise, accept marijuana as medically useful in controlling or reducing emesis and testified to that effect in these proceedings:

a. *George Goldstein, Ph.D.*, psychologist, Secretary of Health for the State of New Mexico from 1978 to 1983 and chief administrator in the implementation of the New Mexico program utilizing marijuana;

b. *Dr. Daniel Dansak*, psychiatrist and former head of the New Mexico program utilizing marijuana;

c. *Dr. Tod Mikuriya*, psychiatrist and editor of *Marijuana: Medical Papers*, a book presenting an historical perspective of marijuana's medical use;

d. *Dr. Normal Zinberg*, general psychiatrist and professor of Psychiatry at Harvard Medical School since 1951;

e. *Dr. John Morgan*, psychopharmacologist, Board-certified in Internal Medicine, Full Professor and Director of Pharmacology at the City University of New York;

f. *Dr. Philip Jobe*, Neuropsychopharmacologist with a practice in Illinois and former Professor of Pharmacology and Psychiatry at the Louisiana State University School of Medicine in Shreveport, Louisiana, from 1974 to 1984;

g. *Dr. Arthur Kaufman*, formerly a general practitioner in Maryland, currently Vice President of a private medical consulting group involved in the evaluation of the quality of care of all the U.S. military hospitals throughout the world, who has had extensive experience in drug abuse treatment and rehabilitation programs;

h. *Dr. J. Thomas Ungerleider*, a Full Profession of Psychiatry at the University of California in Los Angeles with extensive experience in research on the medical use of drugs;

i. *Dr. Andrew Weil*, Ethnopharmacologist, Associate Director of Social Perspectives in Medicine at the College of Medicine at the University of Arizona, with extensive research on medicinal plants; and

j. *Dr. Lester Grinspoon*, a practicing psychiatrist and Associate Professor at Harvard Medical School.

6 Affidavit of Janet Andrews, ACT rebuttal witness, par. 98.

36. Certain law enforcement authorities have been outspoken in their acceptance of marijuana as an antiemetic agent. Robert T. Stephan, Attorney General of the State of Kansas, and himself a former cancer patient, said of chemotherapy in his affidavit in this record, "The treatment becomes a terror." His cancer is now in remission. He came to know a number of health care professionals whose medical judgement he respected. They had accepted marijuana as having medical use in treatment. He was elected Vice President of the National Association of Attorneys General (NAAG) in 1983. He was instrumental in the adoption by that body in June 1983 of a resolution acknowledging the efficacy of marijuana for cancer and glaucoma patients. The resolution expressed the support of NAAG for legislation then pending in the Congress to make marijuana available on prescription to cancer and glaucoma patients. The resolution was adopted by an overwhelming margin. NAAG's President, the Attorney General of Montana, issued a statement that marijuana does have accepted medical uses and is improperly classified at present. The Chairman of NAAG's Criminal Law and Law Enforcement Committee, the Attorney General of Pennsylvania, issued a statement emphasizing that the proposed rescheduling of marijuana would in no way affect or impede existing efforts by law enforcement authorities to crack down on illegal drug trafficking.

37. At least one court has accepted marijuana as having medical use in treatment for chemotherapy patients. On January 23, 1978 the Superior Court of Imperial County, California issued orders authorizing a cancer patients to possess and use marijuana for therapeutic purposes under the direction of a physician. Another order authorized and directed the Sheriff of the county to release marijuana from supplies on hand and deliver it to that patient in such form as to be usable in the form of cigarettes.

38. During the period of 1978-1980 polls were taken to ascertain the degree of public acceptance of marijuana as effective in treating cancer and glaucoma patients. A poll in Nebraska brought slightly over 1,000 responses — 83% favored making marijuana available by prescription, 12% were opposed, 5% were undecided. A poll in Pennsylvania elicited 1,008 responses — 83.1% favored availability by prescription, 12.2% were opposed, 4.7% were undecided. These two surveys were conducted by professional polling companies. The *Detroit Free Press* conducted a telephone poll in which 85.4% of those responding favored access to marijuana by prescription. In the State of Washington the State Medical Association conducted a poll in which 80% of the doctors belonging to the Association favored controlled availability of marijuana for medical purposes.

Discussion

From the foregoing uncontroverted facts it is clear beyond any question that many people find marijuana to have, in the words of the Act, an "accepted medical use in treatment in the United States" in effecting relief for cancer patients. Oncologists, physicians treating cancer patients accept this. Other medical practitioners and researchers accept this. Medical faculty professors accept it. Nurses performing hands-on patient care accept it.

Patients accept it. As counsel for CCA perceptively pointed out at oral argument, acceptance by the patient is of vital importance. Doctors accept a therapeutic agent or process only if it "works" for the patient. If the patient does not accept, the doctor cannot administer the treatment. The patient's informed consent is vital. The doctor ascertains the patient's acceptance by observing and listening to the patient. Acceptance by the doctor depends on what he sees in the patient and hears from the patient. Unquestionably, patients in large numbers have accepted marijuana as useful in treating their emesis. They have found that it "works." Doctors, evaluating their patients, can have no basis more sound than that for their own acceptance.

Of relevance, also, is the acceptance of marijuana by state attorneys general, officials whose primary concern is law enforcement. A large number of them have no fear that placing marijuana in Schedule II, thus making it available for legitimate therapy, will in any way impede existing efforts of law enforcement authorities to crack down on illegal drug trafficking.

The Act does not specify by whom a drug or substance must be "accepted [for] medical use in treatment" in order to meet the Act's "accepted" requirement for placement in Schedule II. Department of Justice witnesses told the Congress during hearings in 1970 preceeding [sic] passage of the Act that "the medical profession" would make this determination, that the matter would be "determined by the medical community." The Deputy Chief Counsel of BNDD, whose office had written the bill with this language in it, told the House Subcommittee that "this basic determination ... is not made by any part of the federal government. It is made by the medical community as to whether or not the drug has medical use or doesn't."[7]

No one would seriously contend that these Justice Department witnesses meant that the entire medical community would have to be in agreement on the usefulness of a drug or substance. Seldom, if ever, do all lawyers agree on a point of law. Seldom, if ever, do all doctors agree on a medical question. How many are required here? A majority of 51%? It would be unrealistic to attempt a plebescite of all doctors in the country on such a question every time it arises, to obtain a majority vote.

In determining whether a medical procedure utilized by a doctor is actionable as malpractice the courts have adopted the rule that it is acceptable for a doctor to employ a method of treatment supported by a respectable minority of physicians.

In *Hood v. Phillips* 537 S.W. 2d 291 (1976) the Texas Court of Civil Appeals was dealing with a claim of medical malpractice resulting from a surgical

7 Drug Abuse Control Amendments - 1970: Hearings on H.R. 11701 and H.R. 13743 Before the Subcommittee on Public Health and Welfare of the House Committee on Interstate and Foreign Commerce, 91st Congress, 2d Sess. 678, 696, 718 (1970) (Statement of John E. Ingersoll, Director, BNDD).

procedure claimed to have been unnecessary. The court quoted from an Arizona court decision holding that:

> a method of treatment, as espoused and used by ... a respectable minority of physicians in the United States cannot be said to be an inappropriate method of treatment or to be malpractice as a matter of law even though it has not been accepted as a proper method of treatment by the medical profession generally. *Ibid.* at 294.

Noting that the Federal District court in the Arizona case found a "respectable minority" composed of sixty-five physicians throughout the United States, the Texas court adopted as "the better rule" to apply in its case, that

> a physician is not guilty of malpractice where the method of treatment used is supported by a respectable minority of physicians. *Ibid.*

In *Chumbler v. McClure*, 505 F.2d 489 (6th Cir. 1974) the Federal courts were dealing with a medical malpractice case under their diversity jurisdiction, applying Tennessee law. The Court of Appears said:

> ...The most favorable interpretation that may be placed on the testimony adduced at trial below is that there is a division of opinion in the medical profession regarding the use of Premarin in the Treatment [sic] of cerebral vascular insufficiency, and that Dr. McClure was alone among neurosurgeons in Nashville in using such therapy. The test for malpractice and for community standards is not to be determined solely by a plebiscite. Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city who follow one of the accepted schools. 505 F.2d at 492 (Emphasis added). See also, *Leech v. Bratliar*, 275 F. Supp. 897 (D. Ariz., 1967).

How do we ascertain whether there exists a school of thought supported by responsible medical authority, and thus "accepted"? We listen to the physicians.

> The court and jury must have a standard measure which they are to use in measuring the acts of a doctor to determine whether he exercised a reasonable degree of care and skill; they are not permitted to set up and use any arbitrary or artificial standard of measurement that the jury may wish to apply. The proper standard of measurement is to be established by testimony of physicians, for it is a medical question. *Hayes v. Brown*, 133 S.E. 2d. 102 (Ga., 1963) at 105.

As noted above, there is no question but that this record shows a great many physicians, and others, to have "accepted" marijuana as having a medical use in the treatment of cancer patients' emesis. True, all physicians have not "accepted" it. But to require universal, 100% acceptance would be unreasonable. Acceptance by "a respectable minority" of physicians is all that can reasonably be required. The record here establishes conclusively that at least "a respectable minority" of physicians has "accepted" marijuana as having a "medical use in treatment in the United States." That others may not makes no difference.

The administrative law judge recommended this same approach for determining whether a drug has an "accepted medical use in treatment" *In The Matter Of MDMA Scheduling*, Docket No. 84-48. The Administrator, in his first final rule in that proceeding, issued on October 8, 1986[8] declined to adopt this approach. He ruled, instead, that DEA's decision on whether or not a drug or other substance had an accepted medical use in treatment in the United States would be determined simply by ascertaining whether or not "the drug or other substance is lawfully marketed in the United States pursuant to the Federal Food, Drug and Cosmetic Act of 1938 ..."[9]

The United States Court of Appeals for the First Circuit held that the Administrator erred in so ruling.[10] That court vacated the final order of October 8, 1986 and remanded the matter of MDMA's scheduling for further consideration. The court directed that, on remand, the Administrator would not be permitted to treat the absence of interstate marketing approval by FDA as conclusive evidence on the question of accepted medical use under the Act.

In his third final rule[11] on the matter of the scheduling of MDMA the Administrator made a series of findings of fact as to MDMA, the drug there under consideration, with respect to the evidence in that record. On those findings he based his last final rule in the case.[12]

8 51 *Fed. Reg.* 36552 (1986).

9 *Ibid.*, at 36558.

10 *Grinspoon v. Drug Enforcement Administration*, 828 F.2d 881 (1st Cir., 1987).

11 53 *Fed. Reg.* 5156 (1988). A second final rule had been issued on January 20, 1988. It merely removed MDMA from Schedule I pursuant to the mandate of the Court of Appeals which had voided the first final rule placing it there. Subsequently the third final rule was issued, without any further hearings, again placing MDMA in Schedule I. There was no further appeal.

12 In neither the first nor the third final rule in the MDMA case does the Administrator take any cognizance of the statements to the Congressional committee by predecessor Agency officials that the determination as to "accepted medical use in treatment" is to be made by the medical community and not by any part of the federal government. See page 27, above. It is curious that the Administrator makes no effort whatever to show how the BNDD representatives were mistaken or to explain why he now has abandoned their interpretation. They wrote that language into the original bill.

The third final rule dealing with MDMA is dealing with a synthetic, "simple", "single-action" drug. What might be appropriate criteria for a "simple" drug like MDMA may not be appropriate for a "complex" substance with a number of active components. The criteria applied to MDMA, a synthetic drug, are not appropriate for application to marijuana, which is a natural plant substance.

The First Circuit Court of Appeals in the MDMA case told the Administrator that he should not treat the absence of FDA interstate marketing approval as conclusive evidence of lack of currently accepted medical use. The court did not forbid the Administrator from considering the absence of FDA approval as a factor when determining the existence of accepted medical use. Yet, on remand, in his third final order, the Administrator adopted by reference 18 of the numbered findings he had made in the first final order. Each of these findings had to do with requirements imposed by FDA for approval of a new drug application (NDA) or of an investigational new drug exemption (IND). These requirements deal with data resulting from controlled studies and scientifically conducted investigations and tests.

Among those findings incorporated into the third final MDMA order from the first, and relied on by the Administrator, was the determination and recommendation of the FDA that the drug there in question was not "accepted." In relying on the FDA's action the Administrator apparently overlooked the fact that the FDA clearly stated that it was interpreting "accepted medical use" in the Act as being equivalent to receiving FDA approval for lawful marketing under the FDCA. Thus the Administrator accepted as a basis for his MDMA third final rule the FDA recommendation which was based upon a statutory interpretation which the Court of Appeals had condemned.

The Administrator in that third final rule made a series of further findings. Again, the central concern in these findings was the content of test results and the sufficiency or adequacy of studies and scientific reports. A careful reading of the criteria considered in the MDMA third final order reveals that the Administrator was really considering the question: Should the drug be accepted for medical use?; rather than the question: Has the drug been accepted for medical use? By considering little else but scientific test results and reports the Administrator was making a determination as to whether or not, in his opinion, MDMA ought to be accepted for medical use in treatment.

The Agency's arguments in the present case are to the same effect. In a word, they address the wrong question. It is not for this Agency to tell doctors whether they should or should not accept a drug or substance for medical use. The statute directs the Administrator merely to ascertain whether, in fact, doctors have done so.

The MDMA third final order mistakenly looks to FDA criteria for guidance in choosing criteria for DEA to apply. Under the Food, Drug and Cosmetic

Act the FDA is deciding — properly, under that statute — whether a new drug should be introduced into interstate commerce. Thus it is appropriate for the FDA to rely heavily on test results and scientific inquiry to ascertain whether a drug is effective and whether it is safe. The FDA must look at a drug and pass judgement on its intrinsic qualities. The DEA, on the other hand, is charged by 21 U.S.C. § 812(b)(1)(B) and (2)(B) with ascertaining what it is that other people have done with respect to a drug or substance: "Have they accepted it?:" not "Should they accept it?"

In the MDMA third final order DEA is actually making the decision that doctors have to make, rather than trying to ascertain the decision which doctors have made. Consciously or not, the Agency is undertaking to tell doctors what they should or should not accept. In so doing the Agency is acting beyond the authority granted in the Act.

It is entirely proper for the Administrator to consider the pharmacology of a drug and scientific test results in connection with determining abuse potential. But abuse potential is not in issue in this marijuana proceeding.

There is another reason why DEA should not be guided by FDA criteria in ascertaining whether or not marijuana has an accepted medical use in treatment. These criteria are applied by FDA pursuant to Section 505 of the Federal Food, Drug and Cosmetic Act (FDCA), as amended.[13] When the FDA is making an inquiry pursuant to that legislation it is looking at a synthetically formed new drug. The marijuana plant is anything but a new drug. Uncontroverted evidence in this record indicates that marijuana was being used therapeutically by mankind 2000 years before the Birth of Christ.[14]

Uncontroverted evidence further establishes that in this country today "new drugs" are developed by pharmaceutical companies possessing resources sufficient to bear the enormous expense of testing a new drug, obtaining FDA approval of its efficacy and safety and marketing it successfully. No company undertakes the investment required unless it has a patent on the drug, so it can recoup its development costs and make a profit. At oral argument Government counsel conceded that "the FDA system is constructed for pharmaceutical companies. I won't deny that."[15]

Since the substance being considered in this case is a natural plant rather than a synthetic new drug, it is unreasonable to make FDA-type criteria determinative of the issue in this case, particularly so when such criteria are irrelevant to the question posed by the Act: Does the substance have an accepted medical use in treatment?

13 21 U.S.C. § 355.

14 Alice M. O'Leary, direct, par., 9.

15 Tr. XV-37.

Finally, the Agency in this proceeding relies in part on the FDA's recommendation that the Administrator retain marijuana in Schedule I. But, as in the MDMA case, that recommendation is based upon FDA's equating "accepted medical use" under the Act with being approved for marketing by FDA under the Food, Drug and Cosmetic Act, the interpretation condemned by the First Circuit in the MDMA case. See Attachment A, p. 24, to exhibit G-1 and exhibit G-2.

The overwhelming preponderance of the evidence in this record establishes that marijuana has a currently accepted medical use in treatment in the United States for nausea and vomiting resulting from chemotherapy treatments in some cancer patients. To conclude otherwise, on this record, would be unreasonable, arbitrary and capricious.

VI. ACCEPTED MEDICAL USE IN TREATMENT GLAUCOMA

Findings of Fact

The preponderance of the evidence establishes the following facts with respect to the accepted medical use of marijuana in the treatment of glaucoma.

1. Glaucoma is a disease of the eye characterized by the excessive accumulation of fluid causing increased intraocular pressure, distorted vision and, ultimately, blindness. In its early stages this pressure can sometimes be relieved by the administration of drugs. When such medical treatment fails adequately to reduce the intraocular pressure (IOP), surgery is generally resorted to. Although useful in many cases, there is a high incidence of failure with some types of surgery. Further, serious complications can occur as a result of invasive surgery. Newer, non-invasive procedures such as laser trabeculoplasty are thought by some to offer much greater efficacy with fewer complications. Unless the IOP is relieved and brought to a satisfactory level by one means or another, the patient will go blind.

2. Two highly qualified and experienced ophthalmologists in the United States have accepted marijuana as having a medical use in treatment for Glaucoma. They are John C. Merritt, M.D. and Richard D. North, M.D. Each of them is both a clinician, treating patients, and a researcher. Dr. Merritt is also a professor of ophthalmology. Dr. North has served as a medical officer in ophthalmology for the Department of Health, Education and Welfare and has worked with the Public Health Service and FDA.

3. Dr. Merritt's experience with glaucoma patients using marijuana medicinally includes one Robert Randall, and insofar as the evidence here establishes per petitioners' briefs, an unspecified number of other patients, something in excess of 40.

4. Dr. North has treated only one glaucoma patient using marijuana medicinally — the same Robert Randall mentioned immediately above. Dr. North had monitored Mr. Randall's medicinal use of marijuana for nine years as of May, 1987.

5. Dr. Merritt has accepted marijuana as having an important place in the treatment of "End Stage" glaucoma. "End Stage" glaucoma, essentially, defines a patient who has already lost substantial amounts of vision; available glaucoma control drugs are no longer able adequately to reduce the intraocular pressure (IOP) to prevent further, progressive sight loss; the patient, lacking additional IOP reductions, will go blind.

6. Robert S. Hepler, M.D., is a highly qualified and experienced ophthalmologist. He has done research with respect to the effect of smoking marijuana on glaucoma. In December 1975 he prescribed marijuana for the same Robert Randall mentioned above as a research subject. Dr. Hepler found that large dosages of smoked marijuana effectively reduced Robert Randall's IOP into the safe range over an entire test day. He concluded that the only known alternative to preserve Randall's sight which would avoid the significant risks of surgery is to include marijuana as part of Randall's prescribed medical regimen. He further concluded in 1977 that, if marijuana could have been legally prescribed, he would have prescribed it for Randall as part of Randall's regular glaucoma maintenance program had he been Randall's personal physician. Nonetheless, in 1987 Dr. Hepler was of the opinion that marijuana did not have a currently accepted medical use in the United States or the treatment of glaucoma.

7. Four glaucoma patients testified in these proceedings. Each has found marijuana to be of help in controlling IOP.

8. In 1984 the treatment of glaucoma with Cannabis was the subject of an Ophthalmology Grand Rounds at the University of California, San Francisco. A questionnaire was distributed which queried the ophthalmologists on cannabis therapy for glaucoma patients refractory to standard treatment. Many of them have glaucoma patients who have asked about marijuana. Most of the responding ophthalmologists believed that THC capsules or smoked marijuana need to be available for patients who have not benefitted significantly from standard treatment.

9. In about 1978 an unspecified number of persons in the public health service sector in New Mexico, including some physicians, accepted marijuana as having medical use in treating glaucoma.

10. A majority of an unspecified number of ophthalmologists known to Arthur Kaufman, M.D., who was formerly in general practice but now is employed as a medical program administrator, accept marijuana as having medical use in treatment of glaucoma.

11. In addition to the physicians identified and referred to in the findings above, the testimony of patients in this record establishes that no more than three or four other physicians consider marijuana to be medically useful in the treatment of glaucoma in the United States. One of those physicians actually wrote a prescription for marijuana for a patient, which of course, she was unable to have filled.

12. There are test results showing that smoking marijuana has reduced the IOP in some glaucoma patients. There is continuing research underway in the United States as to the therapeutic effect of marijuana on glaucoma.

Discussion

Petitioners' briefs fail to show that the preponderance of the evidence in the record with respect to marijuana and glaucoma establishes that a respectable minority of physicians accepts marijuana as being useful in the treatment of glaucoma in the United Stats.

This conclusion is not to be taken in any way as criticism of the opinions of the ophthalmologists who testified that they accept marijuana for this purpose. The failure lies with petitioners. In their briefs they do not point out hard, specific evidence in this record sufficient to establish that a respectable minority of physicians has accepted their position.

There is a great volume of evidence here, and much discussion in the briefs, about the protracted case of Robert Randall. But, when all is said and done, his experience presents but one case. The record contains sworn testimony of three ophthalmologists who have treated Mr. Randall. One of them tells us of a relatively small number of other glaucoma patients whom he has treated with marijuana and whom he knows to have responded favorably. Another of these three doctors has successfully treated only Randall with marijuana. The third testifies, despite his successful experience in treating Randall, that marijuana does not have an accepted use in such treatment.

In addition to Robert Randall, Petitioners point to the testimony of three other glaucoma patients. Their case histories are impressive, but they contribute little to the carrying of Petitioners' burden of showing that marijuana is accepted for medical treatment of glaucoma by a respectable minority of physicians. See pages 421-426 above.

Petitioners have placed in evidence copies of a number of newspaper clippings reporting statements by persons claiming that marijuana has helped their glaucoma. The administrative law judge is unable to give significant weight to this evidence. Had these persons testified so as to have been subject to cross examination, a different situation would be presented. But these newspaper reports of extra-judicial statements, neither tested by informed inquiry nor supported by a doctor's opinion, are not entitled to much weight. They are of little, if any, materiality.

Beyond the evidence referred to above there is little other "hard" evidence, pointed out by Petitioners, of physicians accepting marijuana for treatment of glaucoma. Such evidence as that concerning a survey of a group of San Francisco ophthalmologists is ambiguous, at best. The relevant document establishes merely that most of the doctors on the

grand rounds, who responded to an inquiry, believed that the THC capsule or marijuana ought to be available.

In sum, the evidence here tending to show that marijuana is accepted for treatment of glaucoma falls far, far short of the quantum of evidence tending to show that marijuana is accepted for treatment of emesis in cancer patients. The preponderance of the evidence here, identified by petitioners in their briefs, does not establish that a respectable minority of physicians has accepted marijuana for glaucoma treatment.

VII. ACCEPTED MEDICAL USE IN TREATMENT MULTIPLE SCLEROSIS, SPASTICITY AND HYPERPARATHYROIDISM

Findings of Fact

The preponderance of the evidence clearly establishes the following facts with respect to marijuana's use in connection with multiple sclerosis, spasticity and hyperparathyroidism.

1. MS is the major cause of neurological disability among young and middle-aged adults in the United States today. It is a life-long disease. It can be extremely debilitating to some of its victims but it does not shorten the life span of most of them. Its cause is yet to be determined. It attacks the myelin sheath, the coating or insulation surrounding the message-carrying nerve fibers in the brain and spinal cord. Once the myelin sheath is destroyed, it is replaced by plaques of hardened tissue know as sclerosis. During the initial stages of the disease nerve impulses are transmitted with only minor interruptions. As the disease progresses, the plaques may completely obstruct the impulses along certain nerve systems. These obstructions produce malfunctions. The effects are sporadic in most individuals and the effects often occur episodically, triggered either by malfunction of the nerve impulses or by external factors.

2. Over time many patients develop spasticity, the involuntary and abnormal contraction of muscle or muscle fibers. (Spasticity can also result from serious injuries to the spinal cord, not related to multiple sclerosis.)

3. The symptoms of MS vary according to the area of the nervous system which is affected and according to the severity of the disease. The symptoms can include one or more of the following: weakness, tingling, numbness, impaired sensation, lack of coordination, disturbances in equilibrium, double vision, loss of vision, involuntary rapid movement of the eyes (nystagmus), slurred speech, tremors, stiffness, spasticity, weakness of limbs, sexual dysfunction, paralysis, and impaired bladder and bowel functions.

4. Each person afflicted by MS is affected differently. In some persons, the symptoms of the disease are barely detectable, even over long periods of time. In these cases, the persons can live their lives as if they did not suffer from the disease. In others, more of the symptoms are present and acute, thereby limiting their physical capabilities. Moreover, others may experience sporadic, but acute, symptoms.

5. At this time, there is no known prevention or cure for MS. Instead, there are only treatments for the symptoms of the disease. There are very few drugs specifically designed to treat spasticity. These drugs often cause very serious side effects. At the present time two drugs are approved by FDA as "safe" and "effective" for the specific indication of spasticity. These drugs are Dantrium and Lioresal baclofen.

6. Unfortunately, neither Dantrium nor Lioresal is a very effective spasm control drug. Their marginal medical utility, high toxicity and potential for serious adverse effects make these drugs difficult to use in spasticity therapy.

7. As a result, many physicians routinely prescribe tranquilizers, muscle relaxants, mood elevators and sedatives such as Valium to patients experiencing spasticity. While these drugs do not directly reduce spasticity they may weaken the patient's muscle tone, thus making the spasms less noticeable. Alternatively, they may induce sleep or so tranquilize the patient that normal mental and physical functions are impossible.

8. A healthy, athletic young woman named Valerie Cover was stricken with MS while in her early twenties. She consulted several medical specialists and followed all the customary regimens and prescribed methods for coping with this debilitating disease over a period of several years. None of these proved availing. Two years after first experiencing the symptoms of MS her active, productive life — as a Naval officer's wife and mother — was effectively over. The Social Security Administration declared her totally disabled. To move about her home she had to sit on a skateboard and push herself around. She spent most of her time in bed or sitting in a wheelchair.

9. An occasional marijuana smoker in her teens, before her marriage, she had not smoked it for five years as of February 1986. Then a neighbor suggested that marijuana just might help Mrs. Cover's MS, having read that it had helped cancer patient's [sic] control their emesis. Mrs. Cover acceded to the suggestion.

10. Just before smoking the marijuana cigarette produced by her neighbor, Mrs. Cover had been throwing up and suffering from spasms. Within five minutes of smoking part of the marijuana cigarette she stopped vomiting, no longer felt nauseous and noticed that the intensity of her spasms was significantly reduced. She stood up unaided.

11. Mrs. Cover began smoking marijuana whenever she felt nauseated. When she did so it controlled her vomiting, stopped the nausea and increased her appetite. It helped ease and control her spasticity. Her limbs were much easier to control. After three months of smoking marijuana she could walk unassisted, had regained all of her lost weight, her seizures

became almost nonexistent. She could again care for her children. She could drive an automobile again. She regained the ability to lead a normal life.

12. Concerned that her use of this illegal substance might jeopardize the career of her Navy officer husband, Mrs. Cover stopped smoking marijuana several times. Each time she did so, after about a month, she had retrogressed to the point that her MS again had her confined to bed and wheelchair or skateboard. As of the Spring of 1987 Mrs. Cover had resumed smoking marijuana regularly on an "as needed" basis. Her MS symptoms are under excellent control. She has obtained a full-time job. She still needs a wheelchair on rare occasions, but generally has full use of her limbs and can walk around with relative ease.

13. Mrs. Cover's doctor has accepted the effectiveness of marijuana in her case. He questioned her closely about her use of it, telling her that it is the most effective drug known in reducing vomiting. Mrs. Cover and her doctor are now in the process of filing an Investigational New Drug (IND) application with FDA so that she can legally obtain the marijuana she needs to lead a reasonably normal life.

14. Martha Hirsch is a young woman in her mid-thirties. She first exhibited symptoms of MS at age 19 and it was diagnosed at that time. Her condition has grown progressively worse. She has been under the care of physicians and hospitalized for treatment. Many drugs have been prescribed for her by her doctors. At one point in 1983 she listed the drugs that had been prescribed to her. There were 17 on the list. None of them has given her the relief from her MS symptoms that marijuana has.

15. During the early stages in the development of her illness Ms. Hirsch found that smoking marijuana improved the quality of her life, keeping her spasms under control Her balance improved. She seldom needed to use her cane for support. Her condition lately has deteriorated. As of May 1987 she was experiencing severe, painful spasms. She had an indwelling catheter in her bladder. She had lost her locomotive abilities and was wheelchair bound. She could seldom find marijuana on the illegal market and, when she did, she often could not afford to purchase it. When she did obtain some, however, and smoked it, her entire body seemed to relax, her spasms decreased or disappeared, she slept better and her dizzy spells vanished. The relaxation of her leg muscles after smoking marijuana has been confirmed by her personal care attendant's examination of them.

16. The personal care attendant has told Ms. Hirsch that she, the attendant, treats a number of patients who smoke marijuana for relief of MS symptoms. In about 1980 another patient told Ms. Hirsch that he knew many patients who smoke marijuana to relieve their spasms. Through him she met other patients and found that marijuana was commonly used by many MS patients. Most of these persons had told their doctors about their doing so. None of those doctors advised against the practice and some encouraged it.

17. Among the drugs prescribed by doctors for Ms. Hirsch was ACTH. This failed to give her any therapeutic benefit or to control her spasticity. It did

produce a number of adverse effects, including severe nausea and vomiting, which, in turn, were partly controlled by rectally administered antiemetic drugs.

18. Another drug prescribed for her was Lioresal, intended to reduce her spasms. It was not very effective in so doing. But it did cause Ms. Hirsch to have hallucinations. On two occasions, while using this drug, Ms. Hirsch "saw" a large fire in her bedroom and called for help. There was no fire. She stopped using that drug. Ms. Hirsch has experienced no adverse reactions with marijuana.

19. Ms. Hirsch's doctor has accepted marijuana as beneficial for her. He agreed to write her a prescription for it, if that would help her obtain it. She has asked him if he would file an IND application with the FDA for her. He replied that the paperwork was "overwhelming." He indicated willingness to help in this undertaking after Ms. Hirsch found someone else willing to put the paperwork together.

20. When Greg Paufler was in his early twenties, employed by Prudential Insurance Company, he began to experience the first symptoms of MS. His condition worsened as the disease intensified. He had to be hospitalized. He lost the ability to walk, to stand. Diagnosed as having MS, a doctor prescribed ACTH for him, an intensive form of steroid therapy. He lost all control over his limbs and experienced severe, painful spasms. His arms and legs became numb.

21. ACTH had no beneficial effects. The doctor continued to prescribe it over many months. ACTH made Paufler ravenously hungry and he began gaining a great deal of weight. ACTH caused fluid retention and Paufler became bloated, rapidly gaining weight. His doctor thought Paufler should continue this steroid therapy, even though it caused the adverse effects mentioned plus the possibility of sudden heart attack or death due to respiratory failure. Increased dosages of this FDA-approved drug caused fluid to press against Paufler's lungs making it difficult for him to breathe and causing his legs and feet to become swollen. The steroid therapy caused severe, intense depression marked by abrupt mood shifts. Throughout, the spasms continued and Paufler's limbs remained out of control. The doctor insisted that ACTH was the only therapy likely to be of any help with the MS, despite its adverse effects. Another, oral steroid was eventually substituted.

22. One day Paufler became semi-catatonic while sitting in his living room at home. He was rushed to the hospital emergency room. He nearly died. Lab reports indicated, among other things, a nearly total lack of potassium in his body. He was given massive injections of potassium in the emergency room and placed on an oral supplement. Paufler resolved to take no more steroids.

23. From time to time, prior to this point, Paufler had smoked marijuana socially with visiting friends, seeking some relief from his misery in a temporary "high." He now began smoking marijuana more often. After some weeks he found that he could stand and then walk a bit. His doctor dismissed the idea that marijuana could be helpful with MS, and Paufler,

himself, was skeptical at first. He began discontinuing it for a while, then resuming.

24. Paufler found that when he did not smoke marijuana his condition worsened, he suffered more intense spasms more frequently. When he smoked marijuana, his condition would stabilize and then improve; spasms were more controlled and less severe; he felt better; he regained control over his limbs and could walk totally unaided. His vision, often blurred and unfocused, improved. Eventually he began smoking marijuana on a daily basis. He ventured outdoors. He was soon walking half a block. His eyesight returned to normal. His central field blindness cleared up. He could focus well enough to read again. One evening he went out with his children and found he could kick a soccer ball again.

25. Paufler has smoked marijuana regularly since 1980. Since that time his MS has been well controlled. His doctor has been astonished at Paufler's recovery. Paufler can now run. He can stand on one foot with his eyes closed. The contrast with his condition, several years ago, seems miraculous. Smoking marijuana when Paufler feels an attack coming on shortens the attack. Paufler's doctor has looked Paufler in the eye and told him to keep doing whatever it is he's doing because it works. Paufler and his doctor are exploring the possibility of obtaining a compassionate IND to provide legal access to marijuana for Paufler.

26. Paufler learned in about 1980 of the success of one Sam Diana, a MS patient, in asserting the defense of "medical necessity" in court when charged with using or possessing marijuana. He learned that doctors, researchers and other MS patients had supported Diana's position in the court proceeding.

27. Irvin Rosenfeld has been diagnosed as having Pseudo Pseudo Hypoparathyroidism. This uncommon disease causes bone spurs to appear and grow all over the body. Over the patient's lifetime hundreds of these spurs can grow, any one of which can become malignant at any time. The resulting cancer would spread quickly and the patient would die.

28. Even without development of a malignancy, the disease causes enormous pain. The spurs press upon adjacent body tissue, nerves and organs. In Rosenfeld's case, he could neither sit still nor lie down, nor could he walk without experiencing pain. Working in his furniture store in Portsmouth, Virginia, Mr. Rosenfeld was on his feet moving furniture all day long. The lifting and walking caused serious problems as muscles and tissues rubbed over the spurs of bone. He tore muscles and hemorrhaged almost daily.

29. Rosenfeld's symptoms first appeared about the age of ten, various drugs were prescribed for him for pain relief. He was taking extremely powerful narcotics. By the age of 19 his therapy included 300 mg. of Sopor (a powerful sleeping agent) and very high doses of Dilaudid. He was found to be allergic to barbiturates. Taking massive doses of pain control drugs, as prescribed, made it very difficult for Rosenfeld to function normally. If he took enough of them to control the pain, he could barely concentrate on his schoolwork. By the time he reached his early twenties Rosenfeld's

monthly drug intake was between 120 to 130 Dilaudid tablets, 30 more Sopor sleeping pills and dozens of muscle relaxants.

30. At college in Florida Rosenfeld was introduced to marijuana by classmates. He experimented with it recreationally. He never experienced a "high" or "buzz" or "floating sensation" from it. One day he smoked marijuana while playing chess with a friend. It had been very difficult for him to sit for more than five or ten minutes at a time because of tumors in the back of his legs. Suddenly he realized that, absorbed in his chess game, and smoking marijuana, he had remained sitting for over an hour — with no pain. He experimented further and found that his pain was reduced whenever he smoked marijuana.

31. Rosenfeld told his doctor of his discovery. The doctor opined that it was possible that the marijuana was relieving the pain. Something ce tainly was — there was a drastic decrease in Rosenfeld's need for suc.. drugs as Dilaudid and Demerol and for sleeping pills. The quality of pain relief which followed his smoking of marijuana was superior to any he had experienced before. As his dosages of powerful conventional drugs decreased, Rosenfeld became less withdrawn from the world, more able to interact and function. So he has continued to the present time.

32. After some time Rosenfeld's doctor accepted the fact that the marijuana was therapeutically helpful to Rosenfeld and submitted an IND application to FDA to obtain supplies of it legally for Rosenfeld. The doctor has insisted, however, that he not be publicly identified. After some effort the IND application was granted. Rosenfeld is receiving supplies of marijuana from NIDA. Rosenfeld testified before a committee of the Virginia Legislature in about 1979 in support of legislation to make marijuana available for therapeutic purposes in that State.

33. In 1969, at age 19, David Branstetter dove into the shallow end of a swimming pool and broke his neck. He became a quadriplegic, losing control over the movement of his arms and legs. After being hospitalized fc 18 months he returned home. Valium was prescribed for him to redu.. the severe spasms associated with his condition. He became mildly addicted to Valium. Although it helped mask his spasms, it made Branstetter more withdrawn and less able to take care of himself. He stopped taking Valium for fear of the consequences of long-term addiction. His spasms then became uncontrollable, often becoming so bad they would throw him from his wheelchair.

34. In about 1973 Branstetter began smoking marijuana recreationally. He discovered that his severe spasms stopped whenever he smoked marijuana. Unlike Valium, which only masked his symptoms and caused him to feel drunk and out of control, marijuana brought his spasmodic condition under control without impairing his faculties. When he was smoking marijuana regularly he was more active, alert and outgoing.

35. Marijuana controlled his spasms so well that Branstetter could go out with friends and he began to play billiards again. The longer he smoked marijuana the more he was able to use his arms and hands. Marijuana also improved his bladder control and bowel movements

36. At times the illegal marijuana Branstetter was smoking became very expensive and sometimes was unavailable. During periods when he did not have marijuana his spasms would return, preventing Branstetter from living a "normal" life. He would begin to shake uncontrollably, his body would feel tense, and his muscles would spasm.

37. In 1979 Branstetter was arrested and convicted of possession of marijuana. He was placed on probation for two years. During that period he continued smoking marijuana and truthfully reported this, and the reason for it, to his probation officer whenever asked about it. No action was taken against Branstetter by the court or probation authorities because of his continuing use of marijuana, except once in the wake of his publicly testifying about it before the Missouri legislature. Then, although adverse action was threatened by the judge, nothing was actually done.

38. In 1981 Branstetter and a friend, a paraplegic, participated in a research study testing the therapeutic effects of synthetic THC on spasticity. Placed on the THC Branstetter found that it did help control his spasms but appeared to become less effective with repeated use. Also, unlike marijuana, synthetic THC has a powerful mind-altering effect he found annoying. When the study ended the researcher strongly suggested that Branstetter continue smoking marijuana to control his spasms.

39. None of Branstetter's doctors have told him to stop smoking marijuana while several, directly and indirectly, have encouraged him to continue. Branstetter knows of almost 20 other patients, paraplegics, quadriplegics and MS suffers, who smoke marijuana to control their spasticity.

40. In 1981 a State of Washington Superior Court judge, sitting without a jury, found Samuel D. Diana not guilty of the charge of unlawful possession of marijuana. In so doing the judge upheld Diana's defense of medical necessity. Diana had been a MS patient since at least 1973. He testified that smoking marijuana relieved his symptoms of double vision, tremors, unsteady walk, impaired hearing, tendency to vomit in the morning and stiffness in the joints of his hands and legs.

41. Among the witnesses was a physician who had examined defendant Diana before and after he had used marijuana. This doctor testified that marijuana had been effective therapeutically for Diana, that other medication had proven ineffective for Diana and that, while marijuana may have some detrimental effects, Diana would receive more benefit than harm from smoking it. The doctor was not aware of any other drug that would be as effective as marijuana for Mr. Diana. Other witnesses included three persons afflicted with MS who testified in detail as to marijuana's beneficial effect on their illness.

42. In acquitting defendant Diana of unlawful possession of marijuana the trial judge found that the three requirements for the defense of medical necessity had been established, namely: defendant's reasonable belief that his use of marijuana was necessary to minimize the effects of MS; the benefits derived from its use are greater than the harm sought to be

prevented by the controlled substances law; and no drug is as effective as marijuana in minimizing the effects of the disease in the defendant.

43. *Denis Petro, M.D.*, is a neurologist of broad experience, ranging from active practice in neurology to teaching the subject in medical school and employment by FDA as a medical officer reviewing IND's and NDA's. He has also been employed by pharmaceutical companies and has served as a consultant to the State of New York. He is well acquainted with the case histories of three patients who have successfully utilized marijuana to control severe spasticity when other, FDA-approved drugs failed to do so. Dr. Petro knows of other cases of patients who he has determined, have effectively used marijuana to control their spasticity. He has heard reports of additional patients with MS, paraplegia and quadriplegia doing the same. There are reports published in the literature known to Dr. Petro, over the period at least 1970-1986, of clinical tests demonstrating that marijuana and THC are effective in controlling or reducing spasticity in patients.

44. Large numbers of paraplegic and quadriplegic patients, particularly in Veterans Hospitals, routinely smoke marijuana to reduce spasticity. While this mode of treatment is illegal, it is generally tolerated, if not openly encouraged, by physicians in charge of such wards who accept this practice as being of benefit to their patients. There are many spinal cord injury patients in Veterans hospitals.

45. Dr. Petro sought FDA approval to conduct research with spasticity patients using marijuana. FDA refused but, for reasons unknown to him, allowed him to make a study using synthetic THC. He and colleagues made such a study. They concluded that synthetic THC effected a significant reduction in spasticity among MS patients, but study participants who had also smoked marijuana reported consistently that marijuana was more effective.

46. Dr. Petro accepts marijuana as having a medical use in the treatment of spasticity in the United States. If it were legally available and he was engaged in an active medical practice again, he would not hesitate to prescribe marijuana, when appropriate, to patients afflicted with uncontrollable spasticity.

47. Dr. Petro presented a paper to a meeting of the American Academy of Neurology. The paper was accepted for presentation. After he presented it, Dr. Petro found that many of the neurologists present at this most prestigious meeting were in agreement with his acceptance of marijuana as having a medical use in the treatment of spasticity.

48. *Dr. Andrew Weil*, a general medical practitioner in Tucson, Arizona, who also teaches at the University of Arizona College of Medicine, accepts marijuana as having a medical use in the treatment of spasticity. In MS patients the muscles become tense and rigid because their nerve supply is interrupted. Marijuana relieves this spasticity in many patients, he has found. He would prescribe it to selected patients if it were legally available.

49. *Dr. Lester B. Collins, III*, a neurologist, then treating about 20 MS patients a year, seeing two or three new ones each year, stated in 1983 that he had no doubt that marijuana worked symptomatically for some

MS patients. He said that it does not alter the course of the disease but it does relieve the symptoms of spasticity.

50. *Dr. John P. Morgan*, Board-certified in Internal Medicine, Professor of Medicine and Director of Pharmacology at CCNY Medical School in New York and Associated Professor of Medicine and Pharmacology at Mt. Sinai School of Medicine accepts marijuana as having medical use in the treatment in the United States. If he were practicing medicine and marijuana were legally available he would prescribe it when indicated to patients with legitimate medical needs.

Discussion

Based upon the rationale set out in pages 422 to 426, above, the administrative law judge concludes that, within the meaning of the Act, 21 U.S.C. § 812 (b)(2)(B), marijuana "has a currently accepted medical use in treatment in the United States" for spasticity resulting from MS and other causes. It would be unreasonable, arbitrary and capricious to find otherwise. The facts set out above, uncontroverted by the Agency, establish beyond question that some doctors in the United States accept marijuana as helpful in such treatment for some patients. The record here shows that they constitute a significant minority of physicians. Nothing more can reasonably be required. That some doctors would have more studies and test results in hand before accepting marijuana's usefulness here is irrelevant.

The same is true with respect to the hyperparathyroidism from which Irvin Rosenfeld suffers. His disease is so rare, and so few physicians appear to be familiar with it, that acceptance by one doctor of marijuana as being useful in treating it ought to satisfy the requirement for a significant minority. The Agency points to no evidence of record tending to establish that marijuana is not accepted by doctors in connection with this most unusual ailment. Refusal to acknowledge acceptance by a significant minority, in light of the case history detailed in this record, would be unreasonable, arbitrary and capricious.

VIII. ACCEPTED SAFETY FOR USE UNDER MEDICAL SUPERVISION

With respect to whether or not there is "a lack of accepted safety for use of [marijuana] under medical supervision," the record shows the following facts to be uncontroverted.

Findings of Fact

1. Richard J. Gralla, M.D., an oncologist and Professor of Medicine who was an Agency witness, accepts that in treating cancer patients oncologists can use the cannabinoids with safety despite their side effects.

2. Andrew T. Weil, M.D., who now practices medicine in Tucson, Arizon and is on the faculty of the College of Medicine, University of Arizona, wa a member of the first team of researchers to perform a Federal Govern ment authorized study into the effects of marijuana on human subject This team made its study in 1968. These researchers determined tha marijuana could be safety used under medical supervision. In the 20 year since then Dr. Weil has seen no information that would cause him to recon sider that conclusion. There is no question in his mind but that marijuan is safe for use under appropriate medical supervision.

3. The most obvious concern when dealing with drug safety is the po sibility of lethal effects. Can the drug cause death?

4. Nearly all medicines have toxic, potentially lethal effects. But marijuan is not such a substance. There is no record of in the extensive r literature describing a proven, documented cannabis-induced fata...y.

5. This is a remarkable statement. First, the record on marijuana encon passes 5,000 years of human experience. Second, marijuana is now use daily by enormous numbers of people throughout the world. Estimate suggest that from twenty million to fifty million American routinely, albe illegally, smoke marijuana without the benefit of direct medical supe vision. Yet, despite this long history of use and the extraordinarily hig numbers of social smokers, there are simply no credible medical repor to suggest that consuming marijuana has caused a single death.

6. By contrast aspirin, a commonly used, over-the-counter medicin causes hundreds of deaths each year.

7. Drugs used in medicine are routinely given what is called an LD-5 The LD-50 rating indicates at what dosage fifty percent of test animal receiving a drug will die as a result of drug induced toxicity. A number researchers have attempted to determine marijuana's LD-50 rating in te animals, without success. Simply stated, researchers have been unabl to give animals enough marijuana to induce death.

8. At present it is estimated that marijuana's LD-50 is around 1:20, 1:40,000. In layman terms this means that in order to induce death marijuana smoker would have to consume 20,000 to 40,000 times as muc marijuana as is contained in one marijuana cigarette. NIDA-supplie marijuana cigarettes weight approximately .9 grams. A smoker woul theoretically have to consume nearly 1,500 pounds of marijuana with about fifteen minutes to induce a lethal response.

9. In practical terms, marijuana cannot induce a lethal response as result of drug-related toxicity.

10. Another common medical way to determine drug safety is called th therapeutic ratio. This ratio defines the difference between a therapeut cally effective dose and a dose which is capable of inducing adverse e fects.

11. A commonly used over-the-counter produce like aspirin has a ther peutic ratio of around 1:20. Two aspirins are the recommended dose f adult patients. Twenty times this dose, forty aspirins, may cause a leth

reaction in some patients, and will almost certainly cause gross injury to the digestive system, including extensive internal bleeding.

12. The therapeutic ratio for prescribed drugs is commonly around 1:10 or lower. Valium, a commonly used prescriptive drug, may cause very serious biological damage if patients use ten times the recommended (therapeutic) dose.

13. There are, of course, prescriptive drugs which have much lower therapeutic ratios. Many of the drugs used to treat patients with cancer, glaucoma and MS are highly toxic. The therapeutic ratio of some of the drugs used in antineoplastic therapies, for example, are regarded as extremely toxic poisons with therapeutic ratios that may fall below 1:1.5. These drugs also have very low LD-50 ratios and can result in toxic, even lethal reactions, while being properly employed.

14. By contrast, marijuana's therapeutic ratio, like its LD-50, is impossible to quantify because it is so high.

15. In strict medical terms marijuana is far safer than many foods we commonly consume. For example, eating ten raw potatoes can result in a toxic response. by comparison, it is physically impossible to eat enough marijuana to induce death.

16. Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care.

17. Some of the drugs most widely used in chemotherapy treatment of cancer have adverse effects as follows:

> *Cisplatin*, one of the most powerful chemotherapeutic agents used on humans — may cause deafness, may lead to life-threatening kidney difficulties and kidney failure; adversely affects the body's immune system, suppressing the patient's ability to fight a host of common infections.
>
> *Nitrogen Mustard*, a drug used in therapy for Hodgkin disease — nauseates; so toxic to the skin that, if dropped on the skin, this chemical literally eats it away along with other tissues it contacts; if this drug gets on or under the skin the patient may suffer serious injury including temporary, and in extreme cases, permanent, loss of use of the arm.
>
> *Procarbizine*, also use for Hodgkin disease has known psychogenic, *i.e.*, emotional, effects.
>
> *Cytoxin*, also known as Cyclophosphamide — suppresses patient's immune system response; results in serious bone marrow depletion; studies indicate this drug may also cause other cancers, including cancers of the bladder.
>
> *Adriamycian*, has numerous adverse effects and is difficult to employ in long term therapies because it destroys the heart muscle.

While each of these agents has its particular adverse effects, as indicated above, they also cause a number of similar, disturbing adverse effects. Most of these drugs cause hair loss. Studies increasingly indicate

all of these drugs my cause other forms of cancer. Death due to kidney, heart or respiratory failure is a very real possibility with all of these agents and the margin for error is minimal. Similarly, there is a danger of overdosing a patient weakened by his cancer. Put simply, there is very great risk associated with the medical use of these chemical agents. Despite these high risks, all of these drugs are considered "safe" for use under medical supervision and are regularly administered to patients on doctor's orders in the United States today.

18. There have been occasional instances of panic reaction in patients who have smoked marijuana. These have occurred in marijuana-naive persons, usually older persons, who are extremely anxious over the forthcoming chemotherapy and troubled over the illegality of their having obtained the marijuana. Such persons have responded to simple person-to-person communication with a doctor and have sustained no long term mental or physical damage. If marijuana could be legally obtained, and administered in an open, medically-supervised session rather than surreptitiously, the few instances of such adverse reactions doubtless would be reduced in number and severity.

19. Other reported side effects of marijuana have been minimal. Sedation often results. Sometimes mild euphoria is experienced. Short periods of increased pulse rate and of dizziness are occasionally experienced. Marijuana should not be used by persons anxious or depressed or psychotic or with certain other health problems. Physicians could readily screen out such patients if marijuana were being employed as an agent under medical supervision.

20. All drugs have "side effects" and all drugs used in medicine for their therapeutic benefits have unwanted, unintended, sometimes adverse effects.

21. In medical treatment "safety" is a relative term. A drug deemed "safe" for use in treating a life-threatening disease might be "unsafe" if prescribed for a patient with a minor ailment. The concept of drug "safety" is relative. Safety is measured against the consequences a patient would confront in the absence of therapy. The determination of "safety" is made in terms of whether a drug's benefits outweigh its potential risks and the risks of permitting the disease to progress.

22. In the context of glaucoma therapy, it must be kept in mind that glaucoma, untreated, progressively destroys the optic nerve and results in eventual blindness. The danger, then, to patients with glaucoma is an irretrievable loss of their sight.

23. Glaucoma is not a mortal disease, but a highly specific, selectively incapacitating condition. Glaucoma assaults and destroys the patient's most evolved and critical sensory ability, his or her vision. The vast majority of patients afflicted with glaucoma are adults over the age of thirty. The onset of blindness in middle age or later throws patients into a wholely alien world. They can no longer do the work they once did. They are unable to read a newspaper, drive a car, shop, walk freely and do all the myriad

things sighted people take for granted. Without lengthy periods of retaining, adaptation and great effort these individuals often lose their sense of identity and ability to function. Those who are young enough or strong-willed enough will regain a sense of place, hold meaningful jobs, but many aspects of the life they once took for granted cannot be recaptured. Other patients may never fully adjust to their new, uncertain circumstances.

24. Blindness is a very grave consequence. Protecting patients from blindness is considered so important that, for ophthalmologists generally, it justifies the use of toxic medicines and uncertain surgical procedures which in other contexts might be considered "unsafe." In practice, physicians often provide glaucoma patients with drugs which have many serious adverse effects.

25. There are only a limited number of drugs available for the treatment of glaucoma. All of these drugs produce adverse effects. While several government witnesses lightly touched on the side effects of these drugs, none provided a full or detailed description of their known adverse consequences.

26. The adverse physical consequences resulting from the chronic use of commonly employed glaucoma control drugs include a vast range of unintended complications from mild problems like drug induced fevers, skin rashes, headaches, anorexia, asthma, pulmonary difficulties, hypertension, hypotension and muscle cramps to truly serious, even life-threatening complications including the formation of cataracts, stomach and intestinal ulcers, acute respiratory distress, increases and decreases in heart rate and pulse, disruption of heart function, chronic and acute renal disease, and bone marrow depletion.

27. Finally, each FDA-approved drug family used in glaucoma therapy is capable of producing a lethal response, even when properly prescribed and used. Epinephrine can lead to elevated blood pressure which may result in stroke or heart attack. Miotic drugs suppress respiration and can cause respiratory paralysis. Diuretic drugs so alter basic body chemistry they cause renal stones and may destroy the patient's kidneys or result in death due to heart failure. Timolol and related beta-blocking agents, the most recently approved family of glaucoma control drugs, can trigger severe asthma attacks or cause death due to sudden cardiac arrhythmias often producing cardiac arrest.

28. Both of the FDA-approved drugs used in treating the symptoms of MS, Dantrium and Lioresal, while accepted as "safe" can, in fact, be very dangerous substances. Dantrium or dantrolene sodium carries a boxed warning in the *Physician's Desk Reference (PDR)* because of its very high toxicity. Patients using this drug run a very real risk of developing symptomatic hepatitis (fatal and nonfatal). The list of sublethal toxic reactions also underscores just how dangerous Dantrium can be. The *PDR*, in part, notes Dantrium commonly causes weakness, general malaise and fatigue and goes on to note the drug can also cause constipation, GI bleeding, anorexia, gastric irritation, abdominal cramps, speech disturbances, seizure, visual disturbances, diplopia, tachycardia, erratic blood pressure, mental confusion, clinical depression, renal disturbances, myalgia, feelings of suffocation and death due to liver failure.

29. The adverse effects associated with Lioresal baclofed are somewhat less severe, but include possibly lethal consequences, even when the drug is properly prescribed and taken as directed. The range of sublethal toxic reactions is similar to those found with Dantrium.

30. *Norman E. Zinberg, M.D.*, one of Dr. Weil's colleagues in the 1968 study mentioned in finding 2, above, accepts marijuana as being safe for use under medical supervision. If it were available by prescription he would use it for appropriate patients.

31. *Lester Grinspoon, M.D.*, practicing psychiatrist, researcher and Associate Professor of Medicine at Harvard Medical School, accepts marijuana as safe for use under medical supervision. He believes its safety is its greatest advantage as a medicine in appropriate cases.

32. *Tod H. Mikuriya, M.D.*, a psychiatrist practicing in Berkeley, California who treats substance abusers as inpatients and outpatients, accepts marijuana as safe for use under medical supervision.

33. *Richard D. North, M.D.*, who has treated Robert Randall for glaucoma with marijuana for nine years, accepts marijuana as safe for use by his patient under medical supervision. Mr. Randall has smoked ten marijuana cigarettes a day during that period without any evidence of adverse mental or physical effects from it.

35. *John C. Merrill, M.D.*, an expert in ophthalmology, who has treated Robert Randall and others with marijuana for glaucoma, accepts marijuana as being safe for use in such treatment.

35. *Deborah B. Goldberg, M.D.*, formerly a researcher in oncology and now a practicing physician, having worked with many cancer patients, observed them, and heard many tell of smoking marijuana successfully to control emesis, accepts marijuana as proven to be an extremely safe anti-emetic agent. When compared with the other, highly toxic chemical substance routinely prescribed to cancer patients, Dr. Goldberg accepts marijuana as clearly safe for use under medical supervision. (See finding 17 above.)

36. *Ivan Silverberg, M.D.*, board certified in oncology and practicing that specialty in the San Francisco area, has accepted marijuana as a safe anti-emetic when used under medical supervision. Although illegal, it is commonly used by patients in the San Francisco area with the knowledge and acquiesence of their doctors who readily accept it as being safe for such use.

37. It can be inferred that all of the doctors and other health care professionals referred to in the findings in Section V, VI and VII, above, who tolerate or permit patients to self-administer illegal marijuana for therapeutic benefit, accept the substances as safe for use under medical supervision.

Discussion

The Act at 21 U.S.C. § 812(b)(1)(C), requires that marijuana be retained in Schedule I if "[t]here is a lack of accepted safety for use of [it] under medical supervision." If there is no lack of such safety, if it is accepted that this substance can be used with safety under medical supervision, then it is unreasonable to keep it in Schedule I.

Again we must ask — "accepted" by whom? In the MDMA proceeding the Agency's first Final Rule decided that "accepted" here meant, as in the phrase "accepted medical use in treatment," that FDA had accepted the substance pursuant to the provisions of the Food, Drug and Cosmetic Act. 51 *Fed. Reg.* 36555 (1986). The Court of Appeals held that this was error. On remand, in its third Final Rule on MDMA, the Agency made the same ruling as before, relying essentially on the same findings, and on others of similar nature, just as it did with respect to "accepted medical use." 53 *Fed. Reg.* 5156 (1988).

The administrative law judge finds himself constrained not to follow the rationale in that MDMA third Final Order for the same reasons as set out above in Section V with respect to "accepted medical use" in oncology. See page 421 to 426. Briefly, the Agency was looking primarily at the results of scientific tests and studies rather than at what physicians had, in fact, accepted. The Agency was wrongly basing its decision on a judgement as to whether or not doctors ought to have accepted the substance in question as safe for use under medical supervision. The criteria the Agency applied in the MDMA third Final Rule are inappropriate. The only proper question for the Agency here is: Have a significant minority of physicians accepted marijuana as safe for use under medical supervision?

The gist of the Agency's case against recognizing marijuana's acceptance as safe is to assert that more studies, more tests are needed. The Agency has presented highly qualified and respected experts, researchers and others, who hold that view. But, as demonstrated in the discussion in Section V above, it is unrealistic and unreasonable to require unanimity of opinion on the question confronting us. For the reasons there indicated, acceptance by a significant minority of doctors is all that can reasonably be required. This record makes it abundantly clear that such acceptance exists in the United States.

Findings are made above with respect to the safety of medically supervised use of marijuana by glaucoma patients. Those findings are relevant to the safety issue even though the administrative law judge does not find accepted use in treatment of glaucoma to have been shown.

Based upon the facts established in this record and set out above one must reasonably conclude that there is accepted safety for use of marijuana under medical supervision. To conclude otherwise, on this record, would be unreasonable, arbitrary and capricious.

IX. CONCLUSION AND RECOMMENDED DECISION

Based upon the foregoing facts and reasoning, the administrative law judge concludes that the provisions of the Act permit and require the transfer of marijuana from Schedule I to Schedule II. The judge realizes that strong emotions are aroused on both sides of any discussion concerning the use of marijuana. Nonetheless, it is essential for this Agency, and its Administrator, calmly and dispassionately to review the evidence of record, correctly apply the law, and act accordingly.

Marijuana can be harmful. Marijuana is abused. But the same is true of dozens of drugs or substances which are listed in Schedule II so that they can be employed in treatment by physicians in proper cases, despite their abuse potential.

Transferring marijuana from Schedule I to Schedule II will not, of course, make it immediately available in pharmacies throughout the country for legitimate use in treatment. Other government authorities, federal and State, will doubtless have to act before that might occur. But this Agency is not charged with responsibility, or given authority, over the myriad other regulatory decisions that may be required before marijuana can actually be legally available. This agency is charged merely with determining the placement of marijuana pursuant to the provisions of the Act. Under our system of laws the responsibility of other regulatory bodies are the concerns of those bodies, not of this Agency.

There are those who, in all sincerity, argue that the transfer of marijuana to Schedule II will "send a signal" that marijuana is "OK" generally for recreational use. This argument is specious. It presents no valid reason for refraining from taking an action required by law in light of the evidence. If marijuana should be placed in Schedule II, in obedience to the law, then that is where marijuana should be placed, regardless of misinterpretation of the placement by some. The reason for the placement can, and should, be clearly explained at the time the action is taken. The fear of sending such a signal cannot be permitted to override the legitimate need, amply demonstrated in this record, of countless sufferers for the relief marijuana can provide when prescribed by a physician in a legitimate case.

The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasoning, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefit of this substance in light of the evidence in this record.

The Administrative law judge recommends that the Administrator conclude that the marijuana plant considered as a whole has a currently accepted medical use in treatment in the United States, that there is no lack

of accepted safety for use of it under medical supervision and that it may lawfully be transferred from Schedule I to Schedule II. The judge recommends that the Administrator transfer marijuana from Schedule I to Schedule II.

Francis L. Young
Administrative Law Judge

September 6, 1988

105TH CONGRESS
2D SESSION

H. RES. 372

Expressing the sense of the House of Representatives that marijuana is a dangerous and addictive drug and should not be legalized for medicinal use.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 26, 1998

Mr. MCCOLLUM (for himself, Mr. HASTERT, Mr. PORTMAN, Mr. COBLE, Mr. BUYER, Mr. CHABOT, Mr. BARR of Georgia, Mr. HUTCHINSON, and Mr. GEKAS) submitted the following resolution; which was referred to the Committee on the Judiciary, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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RESOLUTION

Expressing the sense of the House of Representatives that marijuana is a dangerous and addictive drug and should not be legalized for medicinal use.

Whereas certain drugs are listed on Schedule I of the Controlled Substances Act if they have a high potential for abuse, lack any currently accepted medical use in treatment, and are unsafe, even under medical supervision;

Whereas the consequences of addiction to Schedule I drugs are well documented, particularly with regard to physical health, highway safety, criminal activity, and domestic violence;

Whereas marijuana—which along with crack cocaine, heroin, PCP, and more than 100 other drugs, has long been classified as a Schedule I drug—is both dangerous and addictive, with research clearly demonstrating that smoked marijuana impairs normal brain functions and damages the heart, lungs, reproductive, and immune systems;

Whereas before any drug can be approved as a medication in the United States, it must meet extensive scientific and medical standards established by the Food and Drug Administration, and marijuana has not been approved by the Food and Drug Administration to treat any disease or condition;

Whereas a review by the Annals of Internal Medicine of more than 6,000 articles from the medical literature evaluating the potential medicinal applications of marijuana concluded that marijuana is not a medicine, that its use causes significant toxicity, and that numerous safe and effective medicines are available, which means that the use of crude marijuana for medicinal purposes is unnecessary and inappropriate;

Whereas on the basis of the scientific evidence and the testimony of the American Medical Association, the American Cancer Society, the National Multiple Sclerosis Association, the American Academy of Ophthalmology, the National Eye Institute, and the National Institute of Drug Abuse, marijuana has not met the necessary standards to be approved as medicine;

Whereas the States of Arizona and California, through State initiatives in 1996, legalized the sale and use of marijuana for "medicinal" use, while the State of Washington in 1997 rejected an initiative to legalize the sale and use of marijuana for "medicinal" use;

Whereas after the initiative in Arizona, the legislature of the State of Arizona, with the support of a majority of the citizens of the State, passed legislation to prevent the dispensing of any substance as medicine which had not first been approved as medicine by the Food and Drug Administration, thereby preventing marijuana from being dispensed in the State;

Whereas these States and a majority of States in the United States, as well as the District of Columbia, have been targeted by out-of-State organizations which advocate drug legalization for "medical" marijuana initiatives in 1998 and 1999, and these organizations have provided the majority of the financial support for these State initiatives;

Whereas some individuals and organizations who support "medical" marijuana initiatives do oppose drug legalization, prominent pro-legalization organizations have admitted their strategy is to promote drug legalization nationally through State "medical" marijuana initiatives, and, as such, are seeking to exploit the public's compassion for the terminally ill to advance their agenda;

Whereas marijuana use by 8th, 10th, and 12th graders declined steadily from 1980 to 1992, but, from 1992 to 1996, such use dramatically increased—by 253 percent among 8th graders, 151 percent among 10th graders, and 84 percent among 12th graders—and the average age of first-time use of marijuana is now younger than it has ever been;

Whereas according to the 1997 survey by the Center on Addiction and Substance Abuse at Columbia University, 500,000 8th graders began using marijuana in the 6th and 7th grades;

Whereas according to that same 1997 survey, youths between the ages of 12 and 17 who use marijuana are 85 times more likely to use cocaine than those who abstain from marijuana and 60 percent of adolescents who use marijuana before the age of 15 will later use cocaine;

Whereas the rate of drug use among youth is linked to their perceptions of the risks which are related to drugs and, in that regard, the glamorization of marijuana and the ambiguous cultural messages about marijuana use are contributing to a growing acceptance of marijuana use among adolescents and teenagers;

Whereas surveys taken in the wake of State "medical" marijuana initiatives indicate a more approving attitude toward marijuana use among teenagers than prior to the initiatives; and

Whereas the evidence of the last 2 years indicates that the more the public learns about the facts behind the "medical" marijuana campaign, the more strongly opposed the public becomes to such initiatives: Now, therefore, be it

Resolved, That—

(1) the United States House of Representatives is unequivocally opposed to legalizing marijuana for medicinal use, and urges the defeat of State initiatives which would seek to legalize marijuana for medicinal use; and

(2) the Attorney General of the United States should submit a report to the Committee on the Judiciary of the House of Representatives before the

end of the 90-day period beginning on the date of the adoption of this resolution on—

(A) the total quantity of marijuana eradicated in the United States beginning with 1992 through 1997; and

(B) the annual number of arrests and prosecutions for Federal marijuana offenses beginning with 1992 through 1997.

○

July 10, 1995

ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION
Department of Justice
Washington, D.C. 20537

DEAR SIR: The undersigned Jon Gettman hereby petitions the Administrator to initiate proceedings for the repeal of a rule or regulation pursuant to section 201 of the Controlled Substances Act.

Attached hereto and constituting a part of this petition are the following:

(A) The proposed rules in the form proposed by the petitioner.

(B) A statement of the grounds which the petitioner relies for the repeal of the rules, and,

(C) a summary of any relevant medical or scientific evidence known to the petitioner.

All notices to be sent regarding this petition should be addressed to:

Jon Gettman

[original address withheld from reference text, contact now through counsel.]

Respectfully yours,

Jon Gettman

Exhibit A.

The proposed rules for repeal, in the form proposed by the petitioner:

The rules placing marihuana in schedule I [21 CFR 1308.11(d)(17)], tetrahydrocannabinols in schedule I [21 CFR 1308.11(d)(25)], Dronabinol in schedule II [21 CFR 1308.12(f)(1)] and Nabilone in schedule II [21 CFR 1308.12(f)(2)] are repealed because there is no scientific evidence that they have sufficient abuse potential to warrant schedule I or II status under the Controlled Substances Act.

Petitioner's Note:

This is not necessarily a petition for the removal of the listed drugs and substances from scheduling under the CSA, but a petition to have them removed from schedules I and II.

Should the Department of Health and Human Services confirm the scientific and medical basis for this petition, a consideration of the appropriate scheduling of marijuana should be made at that time, on the basis of the HHS evaluation and in accordance with existing law.

Exhibit B

A statement of the grounds which the petitioner relies for the repeal of the rules.

This exhibit consists of 8 abstracts, each followed by a list of sources cited in the corresponding sections of Exhibit C which summarize the evidence supporting these assertions and additional evidence in support of the repeal of the rules in question.

Section 1) Actual or Real Potential for Abuse

The assertion that any use of a presently illegal drug constitutes drug abuse is far too broad, lacks scientific validity, and does not allow for a distinction between truly dangerous and non-dangerous drugs.

The accepted contemporary legal convention for evaluating the abuse potential of a drug or substance is the relative degree of self-administration the drug induces in animal subjects.

Marijuana does not induce self-administration in animal subjects. Therefore, the dependence liability of marijuana is, at least, significantly lower than well-known drugs of abuse which do induce self-administration in animals, such as heroin, cocaine, and amphetamines.
References Cited in Section 1.

(DELETED)

THERE FOLLOW 7 MORE SECTIONS WITH EXHAUSTIVE MEDICAL REFERENCES.

Exhibit A.

The proposed rules for repeal, in the form proposed by the petitioner:

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Section 2) Pharmacology.

Contrary to prior assertions by the DEA, the chemistry, toxicology, and pharmacology of marijuana has been subjected to extensive study and peer review, and have been well-characterized in scientific literature.

The effects of marijuana smoke on the lungs have been extensively studied. While marijuana smoke has more tar and carbon monoxide than tobacco smoke, in several other areas marijuana smoke is demonstrably less harmful than tobacco smoke, as in effect on small airway function, effect on bronchoalveolar lavage (BAL) macrophages, effect on phagocytic behavior or the respiratory burst of human pulmonary alveolar macrophages, and oxidant release of pulmonary alveolar macrophages. The tar in marijuana smoke can be reduced by filtration (such as with a waterpipe), and many gas-phase cytotoxins in the smoke are water soluble. The carbon monoxide levels produced by marijuana smoke are influenced by breathholding, which provides a diminishing return in contributions to plasma levels of the drug's active ingredient and thus can be reduced by changes in smoking techniques. Efforts to promote safer marijuana use through the use of waterpipes and changes in smoking habits are impossible under existing, schedule 1 based, policy.

The absorption of THC from marijuana smoke is well characterized, and variables such as dosage stability, route of administration, bioavailability, puff volume, THC content, and breathholding time have all been investigated for their effect on absorption.

The pharmacology, toxicology, and chemistry of marijuana and its constituent chemicals have been published in scientific journals, and structure activity relationships for the cannabinoids have been established and correlated with animal tests. A stable pharmacological profile of the substance's effects is available, as is epidemiological data on the incidence and prevalence of minor side effects. The substance has a well-established and extremely low toxicity. There are no cases of overdose on record.

This knowledge allows scientists to make valid assertions about marijuana on the basis of research on its separate constituent parts

Prior hypotheses that marijuana's mechanism of action involved cell membrane perturbation have been abandoned by the scientific community on two grounds, 1)

extremely serious problems with method affect the validity of findings supporting the hypotheses, and 2) a receptor-based mechanism of action has been determined, localized and characterized over the last seven years.

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Section 3) Scientific knowledge on marijuana's mechanism of action

Most popular assertions about marijuana's affect on the human body and brain are based on what is now viewed by the scientific community as a discredited hypothesis.

The discovery of a cannabinoid receptor system in the human body began a scientific revolution that radically altered contemporary knowledge about marijuana's effects on the body and brain.

The cannabinoid receptor system accounts for almost all of marijuana's characteristic effects, as well as the substance's low toxicity.

The receptor has also been cloned, an endogenous ligand has been identified, and an antagonist has also been discovered. A structure-activity relationship for the ligand has also been established.

The cannabinoid receptor system responds to continued exposure to marijuana by reducing the number of receptors available for binding; the discovery of this tolerance mechanism for marijuana discredits the prior hypothesis that tolerance to marijuana resulted from a desensitization of brain cells, and supports the assertion that tolerance to marijuana does not contribute to a dangerous dependence liability.

The existence of the cannabinoid receptor system has clarified concern over marijuana's possible effects on the immune system, giving credence to claims that such effects pose no threat to human health.

The existence of the receptor system explains why marijuana has never been proven to cause brain damage.

The discovery of the receptor system and the resulting research provides great promise for development of a new class of effective pharmaceutical drugs, and may enable scientists to learn more about the chemistry of emotions.

These new research findings contradict many of the DEA's on-record findings of fact about marijuana, findings which have been used in the past to block reconsideration of marijuana's scheduling status.

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Section 4) History and current pattern of abuse.

It has long been recognized that marijuana is no more dangerous than alcohol, caffeine, and nicotine, other drugs whose use is far more prevalent in the United States than marijuana

Marijuana use remains a widespread, persistent, and unregulated social practice among all age groups in the United States. Nearly 80% of marijuana users do not use other illegal drugs.

There is no evidence that this widespread use indicates equally widespread abuse of marijuana.

The credibility of government provided information about marijuana and health decreases as age and education increases, discrediting the hypotheses that marijuana use is inversely dependent on risk perception.

Marijuana's schedule I status has failed to keep marijuana away from school-age children.

The prevalence of alcohol and tobacco use by school-age youths exceeds and precedes marijuana use. Targeting marijuana use as a convenient battleground for the prevention of "drug abuse" is like closing the barn door after the horses have already left the barn.

Marijuana use alone results in less emergency room visits per 100,000 population than common household painkillers or benzodiazepines.

Marijuana law enforcement efforts persist as the dominant supportive force in the supply and distribution of marijuana in the United States.

Marijuana's schedule I status instigates international competition to supply illicit marijuana to American users.

Marijuana arrests continue to consume law enforcement resources; arrests continue on the level of several hundred thousand per year.

The efforts to legitimize marijuana's schedule I status at all costs results in several errors in reasoning popular in anti-marijuana warnings. Examples include: 1) National surveys do not support the assertion that people must be scared of marijuana not to use it, 2) Marijuana users are portrayed as polydrug users, when in fact a majority do not use other illegal drugs, 3) Unfounded and inaccurate comparisons are used to defend the erroneous assertion that marijuana is now more potent that the marijuana available in the 1970's, and 4) research hypotheses are presented to the public as findings of fact, such

as claims that marijuana harms every biological system to which it is exposed

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Marijuana's schedule I status and the high priority it places on domestic and international marijuana eradication has the unintended effect of transforming domestic law enforcement activity into a massive market and price support mechanism for entrepreneurs here and abroad.

Marijuana's schedule I status mandates high priority for domestic marijuana eradication efforts; the nearly impossible task presented to law enforcement results in extreme measures and increasing federalization of local and state judicial authority.

One of the results of the DEA's domestic marijuana eradication program is that in the mid 1990's domestic marijuana cultivation is now so extensive and decentralized that the DEA admits they can no longer estimate how much marijuana is grown in the United States. If they have lost hope of even estimating how much is grown, they have abandoned hope of ever eliminating marijuana cultivation in the United States, and of ever enforcing marijuana's schedule I status as a completely prohibited substance. The purpose of schedule I is to regulate the manufacture of drugs and substances with the highest potential for abuse; without control of domestic marijuana cultivation such regulation is impossible.

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Section 6. Public Health

DAWN statistics indicate that marijuana does not present enough of a significant danger to public health to be considered a schedule I drug, as reflected by emergency room visits per capita and the inadequacy of the drug in contributing to suicide.

HHS asserts that youths who use marijuana ought to realize that their marijuana use will make them end up like all drug users, standing in line for emergency medical services.

The connection of marijuana use to the use of other illegal drugs, known as the gateway theory, is considered by its creator as a descriptive association, not a prediction of illegal drug use on the part of marijuana users.

Alcohol and tobacco are the first drugs used by school aged use, and it is likely that problem alcohol drinking occurs between marijuana use and the use of other illegal drugs in those individuals who do use other illegal drugs.

Social scientists believe the policy implications of their study of teenage drug use is that prevention policies must aim to delay the age of first use of drugs by school aged youths. Individuals who try marijuana for the first time after age 20 rarely if ever use other illegal drugs

Marijuana users are not a homogenous group. Marijuana use is not a predictor in of itself of anything, and there is no research indicating that marijuana use is necessarily an indication of any underlying emotional or psychological deficit or syndrome.

The variables that most explain teenage use of alcohol, marijuana, and tobacco are availability and prior use.

Many common factors associated with the use of drugs by school aged youths have little if any correlation with teenage drug use in well constructed research studies, including (a) substance use by parents, (b) personality traits, (c) intelligence (d) social personality traits, (e) parental relations, (f) affect, (g) participation in structured activities, (j) self-esteem, (k) general values, (l) school performance, (m) stress management skills, (n) non-peer, non-family attitudes about drug use, (o) church attendance, (p) availability (q) academic expectations, (r) drug use by extended relatives, (s) drug use by siblings, and (t) socioeconomic status.

Social science research provides empirical evidence to support the assertion that marijuana has a low potential for abuse unsuited for schedule I classification under the Controlled Substances Act A recent convergence between pharmacology and behavioralism lend support to a theoretical model evaluating the effects of drug, set and setting on the use of drugs. Self administration is an indication that drug plays a predominant role among those three variables; the lack of self-administration in the case of marijuana, supported by the empirical social data, supports the assertion that in regards to manjuana abuse, set and setting play a more important role than the pharmacological substance itself.

Discussion of public health policies based on longitudinal studies of drug use includes consideration of harm-reduction policies which would require the end of marijuana's schedule I status to succeed

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Section 7) Psychic or physiological dependence liability

It was widely acknowledged when the Controlled Substances Act was passed into law that marijuana did not have the severe dependence liability required by schedules I or II, and that marijuana's placement in schedule I was meant to be temporary pending the review of current research by a forthcoming national commission, which recommended marijuana's decriminalization.

When marijuana's status as a schedule I drug was reviewed in the mid 1980's, marijuana's retention in schedule I was based on a presumption that marijuana may have a severe dependence liability.

The U.S. Court of Appeals has ruled that the Controlled Substances Act mandates that a drug's abuse potential is the primary criterion in determining a drug or substance's appropriate schedule.

Marijuana use has never fit the conventional definitions of drug dependence, and the some of the nation's most respected pharmacologists indicate that marijuana does not produce much of a drug dependency problem in the U.S.

The discarded cell membrane-perturbation theory held that marijuana produced dependency by stimulating the pleasure centers of the brain.

Modern research has characterized the pleasure/reward system in the brain, and the key role of the neurotransmitter dopamine in this systems natural operation. Drugs which affect dopamine production have reinforcing characteristics which explain self-administration in animal models. Research has indicated that heroin, cocaine, amphetamines, and many other drugs of abuse affect dopamine production in the brain.

Research made possible by the receptor system breakthrough and other advances in neurobiological research indicates that marijuana has no effect on dopamine production, explaining why animals will not self-administer marijuana and providing further support for the assertion that marijuana has a significantly low potential for abuse to justify lower

scheduling under existing provisions of the Controlled Substances Act, and that schedule I status is in contravention of federal law.

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Section 8) Related or Precursor Chemicals

DEA maintains that the presence of numerous cannabinoid substances in marijuana makes it impossible to generalize about marijuana on the basis of cannabinoid research, and that marijuana and its constituent parts are more dangerous to use than THC, the principle psychoactive ingredient in marijuana.

Modern research firmly establishes the interrelationship of the cannabinoid family of chemicals unique to marijuana, bound together both by chemical similarity and by a common mechanism of action in the human body.

There are no significant reports of abuse of the synthetic THC pill approved by the DEA in the late 1980's for nausea associated with chemotherapy.

Modern cannabinoid research including research on marijuana, is based on the validity of assertions based on scientific research on marijuana's separate cannabinoid constituents

DEA is not authorized under the Controlled Substances Act to make scientific or medical determinations, and must accept the paradigms and conventions of the scientific community

The scientific community recognizes the treatment of cannabinoids as a group for classification purposes This relationship is explicit in all cannabinoid research, and is the basis for the development of new therapeutic drugs

There is no scientific basis for an assertion that marijuana had a greater dependence liability than D9-THC.

There is no scientific basis for an assertion that any cannabinoid compound has a greater dependence liability than D9-THC.

There is no basis for distinguishing between the scheduling of marijuana, cannabinoids, and D9-THC on the basis of dependence liability or potential for abuse.

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Petition for Repeal of a Rule. Exhibit B, Statement of Facts
Jon Gettman - Petitioner

Exhibit C is omitted for the Court's convenience. This exhibit is approximately 300 pages. Defendants can make this exhibit available at the Court's request.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS	Nos. C 98-0085 CRB C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0089 CRB C 98-0245 CRB PLAINTIFF'S POST-HEARING MEMORANDUM Hearing Held: March 24, 1998 Hon. Charles R. Breyer

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PRELIMINARY STATEMENT

The question presented by these cases is whether the rule of law should prevail over the objections of a set of defendants who may zealously and sincerely believe that federal law is incorrect and should be changed, or who may mistakenly believe that federal law somehow has been altered by the California initiative known as Proposition 215. The United States, acting pursuant to express statutory authorization, has established that each of the defendants in these six actions has engaged in open, flagrant, unambiguous, and uncontroverted violations of the Controlled Substances Act, 21 U.S.C. §§ 841(a)(1); 846; 856(a)(1). Based on equally clear statutory authority, the United States has further established that these violations should be enjoined, both preliminarily and permanently. Id. § 882(a).

In response to the government's overwhelming factual and legal case, the defendants have offered only strained or unsupportable legal theories and vague equitable or political considerations, muddying the issues and attempting to delay action by this Court. None of the defendants' arguments has any merit. In this Post-Hearing Memorandum, the United States responds to the questions raised by the Court during the March 24, 1998 hearing in this matter, as well as several of the arguments raised by the defendants during this hearing. After consideration of these additional points, the Court should reject all of the defendants' arguments, apply and uphold federal law, and grant the United States not only a preliminary injunction, but summary judgment as well.

ARGUMENT

I. THE CONTROLLED SUBSTANCES ACT BARS DEFENDANTS' ACTIVITIES

In their briefs and during the hearing on this matter, the defendants have contended that "there can be peaceful coexistence with the Controlled Substances Act and the activities of the defendants" because "it was not the manifest intent of Congress to reach the class of activities that have been carried out by the defendant." Transcript of March 24, 1998 Proceedings ("Transcript") at 94, 97-98. Defendants argue that Congress was only concerned with "the *illegal* importation,

manufacture, distribution and possession of controlled substances," 21 U.S.C. § 801(2) (emphasis supplied), and urge that "sharing [of] medical cannabis for the relief of seriously-ill and terminally-ill patients who have obtained a recommendation and/or approval of a physician" does not fall within this framework. Transcript at 94.

This argument finds no support in the language, structure, or legislative history of the Controlled Substances Act. Section 841(a)(1), by its terms, makes it unlawful for ***any*** person "to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance," except as otherwise authorized by the Act. Nowhere does section 841(a)(1) provide an exception, under federal law, for conduct which may be lawful under state law. Indeed, in United States v. Rosenberg, 515 F.2d 190 (9th Cir.), cert. denied, 423 U.S. 1031 (1975), the Ninth Circuit categorically rejected any contention that "the Constitution somehow requires that the state of California must first find [a defendant's] acts were unauthorized before federal prosecution is permissible." Id. at 198 n.14. The defendant in Rosenberg, a medical doctor, had challenged his conviction for distributing controlled substances on the ground, *inter alia*, that the Controlled Substances Act did not apply to him because his prescriptions were within the legal limits established by California law, and because he was allegedly acting within the course of professional conduct. The Ninth Circuit disagreed, holding that: "If the Constitution allows the federal government to regulate the dispensation of drugs, it allows it to do so ***in every case***, and not just where more than a certain quantity of drugs are involved. * * * The question of whether ***federal*** criminal laws have been violated is a ***federal*** issue to be determined in ***federal*** courts." Id. (emphasis supplied). This decision forecloses the defendants' argument here.

Nor is there any merit to the defendants' interpretation and reliance on 21 U.S.C. § 903. Section 903 provides as follows:

> No provision of [the Controlled Substances Act] shall be construed as indicating an intent on the part of Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict

> between that provision of [the Act] and that State law so that the two cannot consistently stand together.

21 U.S.C. § 903. By its terms, "[s]ection 903's intent and function is clear -- none of the federal anti-drug statutes, including Section 841, are intended to prevent the states from also criminalizing or regulating illegal drugs." United States v. Leal, 75 F.3d 219, 227 (6th Cir. 1996). In other words, states are free to enact their own regulatory scheme for controlled substances, and even go beyond that which federal law proscribes. But nothing in the text of section 903 supports defendants' novel argument that "Congress in [section] 903 has said that the states can carve out of the jurisdiction of the Controlled Substances Act a portion of that activity which is especially needed for them," Transcript at 62, and the defendants have cited no case which so holds.

On the contrary, in United States v. Leal, the Sixth Circuit expressly rejected an argument nearly identical to that advanced by the defendants here. The defendant in Leal, a pharmacist, had been convicted of distributing controlled substances in violation of section 841(a)(1) by running a "pill mill." Relying on Michigan law, which held that a pharmacist had no duty to identify addicted customers or their "over-prescribing" physicians, the defendant argued that he could not be convicted under section 841 unless the Controlled Substances Act preempted this state law doctrine, a result he contended was barred by section 903. The Sixth Circuit deemed this argument to be "meritless," holding that "there is no conflict between federal law and state law here. It is perfectly possible for a state to hold that a pharmacist is not liable in tort for failing to do what a federal criminal statute says he must do." 75 F.3d at 227. The court made clear, however, that, regardless of the duties imposed on pharmacists by state law, "the duty imposed by federal law on pharmacists dealing with controlled substances is unequivocal. If a state law purported to eliminate this duty, it would be void under the Supremacy Clause." Id.

Similarly here, there is no positive conflict between federal and California law. As the Sixth Circuit explained in Leal, it is "perfectly possible" for a state to legalize for purposes of state law that which remains unlawful under federal law. Here, the State of California, by voter

initiative, has chosen to decriminalize the possession and cultivation of marijuana by patients and "caregivers" for purported medical purposes. The federal prohibition on the distribution and cultivation of marijuana, however, remains "unequivocal." Indeed, as in Leal, if Proposition 215 were somehow to be read to vitiate this statutory proscription, "it would be void under the Supremacy Clause." Id. The defendants' reliance upon section 903, therefore, is entirely misplaced.

The defendants' contention that, as a factual matter, they would be able to prove that all their activities occurred intrastate, also is misplaced. As we have demonstrated previously, because Congress made express legislative findings when it passed the Controlled Substances Act that, as a class of activities, the intrastate manufacture, distribution, and possession of controlled substances affect interstate commerce, 21 U.S.C. §§ 801(2)-(6), "the courts have no power 'to excise, as trivial, individual instances' of the class." Perez v. United States, 402 U.S. 146, 154 (1971). Rather, in such circumstances, "[t]he only question for the courts then is whether the class is within the reach of the federal power." Maryland v. Wirtz, 392 U.S. 183, 192-93 (1968). Here, the Ninth Circuit has consistently held that the Controlled Substances Act is within the reach of Congress's Commerce Clause authority,[1] as has every other court of appeals.[2]

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[1] See United States v. Bramble, 103 F.3d 1475, 1479-80 (9th Cir. 1996); United States v. Tisor, 96 F.3d 370, 373-75 (9th Cir. 1996), cert. denied, 117 S. Ct. 1012 (1997); United States v. Kim, 94 F.3d 1247, 1249-50 (9th Cir. 1996); United States v. Staples, 85 F.3d 461, 463 (9th Cir. 1996), cert. denied, 117 S. Ct. 318 (1996); United States v. Visman, 919 F.2d 1390, 1393 (9th Cir. 1990), cert. denied, 502 U.S. 969 (1991); United States v. Montes-Zarate, 552 F.2d 1330, 1331-32 (9th Cir. 1977), cert. denied, 435 U.S. 947 (1978); United States v. Rodriquez-Camacho, 468 F.2d 1220, 1221-22 (9th Cir. 1972), cert. denied, 410 U.S. 985 (1973).

[2] See, e.g., United States v. Edwards, 98 F.3d 1364, 1369 (D.C. Cir. 1996), cert. denied, 117 S. Ct. 1437 (1997); United States v. Lerebours, 87 F.3d 582, 584-85 (1st Cir. 1996), cert. denied, 117 S. Ct. 694 (1997); Proyect v. United States, 101 F.3d 11, 13-14 (2d Cir. 1996); United States v. Leshuk, 65 F.3d 1105, 1112 (4th Cir. 1995); United States v. Lopez, 459 F.2d 949, 951-53 (5th Cir.), cert. denied, 409 U.S. 878 (1972); United States v. Tucker, 90 F.3d 1135, 1139-41 (6th Cir. 1996); United States v. Westbrook, 125 F.3d 996, 1008-10 (7th Cir.), cert. denied, 118

(continued...)

Finally, we wish to respond to the Court's query as to whether there is any evidence that Congress, when it enacted the Controlled Substances Act in 1970, considered the medical value of marijuana. The complete answer, of course, is provided by the text and structure of the Act. See Bailey v. United States, 516 U.S. 137, 144 (1995) ("We start, as we must, with the language of the statute."). By placing marijuana in Schedule I,[3] Congress, by definition, determined that the drug has "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use under medical supervision." 21 U.S.C. § 812(b)(1). The plain meaning of the Controlled Substances Act, therefore, reveals Congress's consideration and rejection of the medical use of marijuana.[4] See Estate of Cowart v. Nicklos Drilling Co., 505 U.S. 469, 475 (1992) ("[W]hen a statute speaks with clarity to an issue, judicial inquiry into the statute's meaning, in all but the most extraordinary circumstance, is finished.").[5]

Moreover, as the Administrator of the Drug Enforcement Administration ("DEA") concluded in his Final Rule of March 26, 1992, "[t]he pattern of initial scheduling of drugs in the Controlled Substances Act, viewed in light of the prior legal status of these drugs under the [Food,

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[2](...continued)
S. Ct. 643 (1997); United States v. Bell, 90 F.3d 318, 321 (8th Cir. 1996); United States v. Wacker, 72 F.3d 1453, 1475 (10th Cir. 1995), cert. denied, 117 S. Ct. 136 (1996); United States v. Jackson, 111 F.3d 101, 102 (11th Cir.), cert. denied, 118 S. Ct. 200 (1997).

[3] See 21 U.S.C. § 812 Schedule I(c)(10); 21 C.F.R. § 1308.11(d)(19).

[4] Congress also has rejected four bills which would provide for the therapeutic use of marijuana under certain specified circumstances. See H.R. 2618, 104th Cong., 1st Sess. (1995); H.R. 2232, 99th Cong., 1st Sess. (1985); H.R. 2282, 98th Cong., 1st Sess. (1983); H.R. 4498, 97th Cong., 1st Sess. (1981). A fifth bill, H.R. 1782, 105th Cong., 1st Sess. (1997), is currently pending in the House.

[5] The legislative history of the Act also reveals that Congress was sensitive to the arguments of those who advocated the deregulation of marijuana. See H. Rep. No. 1444, 81st Cong., 2d Sess. 12, *reprinted in* 1970 U.S.C.C.A.N. 4566, 4577-78 ("The extent to which marihuana should be controlled is a subject upon which opinions diverge widely. There are some who not only advocate its legalization but would encourage its use; at the other extreme there are some State which have established the death penalty for distribution of marihuana to minors.").

Drug, and Cosmetic Act], convinces me that Congress equated the term 'currently accepted medical use in treatment in the United States' as used in the Controlled Substances Act with the core FDCA standards for acceptance of drugs for medical use." 57 Fed. Reg. 10499, 10504 (March 26, 1992). In other words, when it placed drugs into the five schedules, Congress placed those drugs which had been previously approved by the Food and Drug Administration ("FDA") through the new drug approval process ("NDA") into Schedules II-V, along with those drugs with established medical uses, but without approved NDA's. In contrast, Congress placed those drugs which had not received an NDA, or were without established medical uses, in Schedule I. Id. Congress's very act of placing controlled substances into the five schedules, therefore, strongly supports the conclusion that Congress was aware of and considered the medical use of marijuana when it passed the Controlled Substances Act.

II. ABSTENTION IS INAPPROPRIATE

During the hearing on this matter, the defendants stated that, "What we are asking the Court to do in this matter is to abstain from hearing this case in order to allow the state courts and the state legislature and, in fact, the state authorities to take the discrepancies which have been noted in the state law and try and have them comport with the federal law." Transcript at 63-64. Stated differently, the defendants ask this Court to abstain "until the people of California can demonstrate to the [federal] government that that wiggle room that is present in the Controlled Substances Act allots for the medicinal use of marijuana as something separate and apart from the illicit use of marijuana * * * *." Id. at 65.

Neither of these entreaties provides a basis for this Court to abstain. As we have repeatedly made clear, no matter how Proposition 215 is interpreted by the California courts or implemented by state or local officials, the defendants' activities, as alleged in the complaint and as documented by the government's evidence, will continue to be prohibited by the Controlled Substances Act. Because Congress placed marijuana in Schedule I of the Controlled Substances Act, where it remains today, the ***only*** way in which marijuana may be lawfully distributed or

cultivated is in the context of a controlled research setting conducted pursuant to a protocol that has been approved by the Secretary of Health and Human Services, acting through the Food and Drug Administration ("FDA"), and where the researcher has been registered with the DEA. See 21 U.S.C. § 823(f); 21 C.F.R. § 1301.13(e)(1). The defendants are not (and do not purport to be) acting pursuant to this statutory framework, nor do they even allege that such a scenario is on the horizon. Hence, these actions do not involve the situation where "federal courts should abstain from decision when difficult and unsettled questions of state law must be resolved before a substantial federal question can be decided." Hawaii Housing Auth. v. Midkiff, 467 U.S. 229, 236 (1984). Again, this case involves only the application of federal law -- the Controlled Substances Act.[6]

Moreover, the abstention doctrine, which is an "extraordinary and narrow exception to the duty of a District Court to adjudicate a controversy properly before it," Colorado River Water Conservation Dist. v. United States, 424 U.S. 800, 813 (1976), would be particularly inappropriate in these actions, where the United States is seeking to enforce an Act of Congress, and where "[h]arm to the public interest is presumed." Federal Trade Comm'n v. World Wide Factors, Inc., 882 F.2d 344, 346 (9th Cir. 1989). Indeed, the defendants cannot point to a single case in which a district court has abstained in a federal criminal or statutory enforcement action brought by the United States or one of its agencies, and we are aware of none.

At bottom, the defendants ask this Court to deny the requested injunction "and force [the government] to a dialogue." Transcript at 68. This is not the role or function of the federal

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[6] Even if Proposition 215 could somehow be read to conflict with the Controlled Substances Act, abstention would still be inappropriate, for the state law would be void under the Supremacy Clause. See Leal, 75 F.3d at 227. In such circumstances, the Ninth Circuit has made clear that "Burford and Pullman abstentions are generally inappropriate when the case concerns preemption." Hotel Employees & Restaurant Employees Int'l Union v. Nevada Gaming Comm'n, 984 F.2d 1507, 1512 (9th Cir. 1993) (citing Stikes v. Chevron USA, Inc., 914 F.2d 1265, 12700 (9th Cir. 1990), cert. denied, 500 U.S. 917 (1991); and Knudsen Corp. v. Nevada State Dairy Comm'n, 676 F.2d 374, 377 (9th Cir. 1982)).

courts. Accordingly, there is no basis for this Court to abstain from its "virtually unflagging obligation to exercise the jurisdiction given [it]." Colorado River, 424 U.S. at 817.

III. THE DEFENDANTS' MEDICAL NECESSITY AND JOINT PURCHASER DEFENSES CANNOT STAND

The defendants' medical necessity and joint purchaser defenses fail on several grounds. As a preliminary matter, both defenses fail because, quite simply, there is no basis on which the Court could possibly determine that these defenses are applicable to the defendants. Both of these defenses are extraordinarily narrow exceptions to the statutory prohibitions of the federal drug laws. The defense of necessity, for example, requires a showing that a defendant acted to "prevent imminent harm," United States v. Schoon, 971 F.2d 193, 195 (9th Cir. 1991), cert. denied, 504 U.S. 990 (1992), and that there were no reasonable, legal alternatives to violating the law. United States v. Bailey, 444 U.S. 394, 410 (1980). In Bailey, for example, the Supreme Court explained that, "in the context of prison escape, the escapee is not entitled to claim a defense of duress or necessity *unless and until* he demonstrates that, given the imminence of the threat, violation of [the statute] was his *only* reasonable alternative." Id. at 410 (emphasis supplied).

Similarly, the joint purchaser defense "is limited to the passing of a drug between joint purchasers who simultaneously acquired possession at the outset for their own use." United States v. Swiderski, 548 F.2d 445, 450-51 (2d Cir. 1977). Thus, in United States v. Wright, 593 F.2d 105 (9th Cir. 1979), the Ninth Circuit, without deciding whether Swiderski was good law in this circuit,[7] held that the defense was inapplicable where the controlled substance in question had not been both simultaneously and jointly acquired. Id. at 108.

Ordinarily then, a court would consider these defenses only based upon an a particularized, individualized factual showing by each defendant(s). But the defendants in these actions have

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[7] As we have pointed out previously, the Ninth Circuit expressed no opinion in Wright as to whether Swiderski is good law. Id. at 108. See also United States v. Speer, 30 F.3d 605, 608 (5th Cir. 1994) ("This Circuit has not adopted the Swiderski doctrine nor have we found that any other circuit has done so."), cert. denied, 513 U.S. 1098 (1995); United States v. Washington, 41 F.3d 917, 920 n.2 (4th Cir. 1994) (same).

failed to even attempt to make either showing. Instead, the defendants seek to interpose these defenses broadly on behalf of all of their thousands of customers, arguing that, "if the clubs themselves and all of the members of the clubs have this defense, then their activities should not be enjoined." Transcript at 74. As this Court correctly observed, the defendants are asking "to consider [the defense of medical necessity] on a blanket basis * * * *." Transcript at 72.

Under these circumstances, and in the absence of any particularized, individualized factual showing, the defendants' invocation of the medical necessity and joint purchaser defenses can only be considered on a facial basis. See, e.g. Florida League of Professional Lobbyists v. Meggs, 87 F.3d 457, 459 (11th Cir.) ("Because Appellant has failed to allege a specific unconstitutional application, its challenge must be characterized as a facial -- as distinct from as-applied -- challenge."), cert. denied, 117 S. Ct. 516 (1996). This is a test which the defendants have not and cannot meet. A facial challenge to a legislative enactment "is, of course, the most difficult to mount successfully" because the party making the challenge must "establish that no set of circumstances exists under which the Act would be valid." United States v. Salerno, 481 U.S. 739, 745 (1987). With respect to medical necessity, the defendants would have to establish that each and every one of the thousands of customers of the six defendant clubs was suffering from a condition that could not be relieved by *any* other available legal treatment, and that the customer was in such peril and imminent danger that violation of section 841(a)(1) was their only reasonable alternative. The defendants have made no attempt to meet this burden, nor could they.[8] The declarations supplied by the United States are sufficient to demonstrate that it is possible to purchase marijuana

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[8] For similar reasons, defendants also lack standing to assert the defense of medical necessity on behalf of their customers. Although the defendants are correct in asserting that, in United v. Newcomb, 6 F.3d 1129 (6th Cir. 1993), the Sixth Circuit concluded that the justification defense "should be understood to apply when a defendant is acting out of harm to a third party," the court expressly limited this holding to situations in which the other factors necessary for a defense of medical necessity to apply are present. Id. at 1136. Here, again, the defendants have made no such showing. Indeed, to countenance the defendants' argument here would be to potentially immunize the entire marijuana distribution network in California, with every grower, transporter, and/or dealer making a similar claim that they were acting to avoid harm to third parties.

from the defendant clubs for virtually any alleged condition, without offering proof that there are no other available treatments, and without offering proof that the customer in question was faced with an "imminent" harm.

Likewise, with respect to the joint purchaser defense, the defendants would have to establish that each and every one of their thousands of customers "simultaneously acquire[d] possession [of marijuana] at the outset for their own use." Swiderski, 548 F.2d at 450-51. Again, the defendants have made no effort to make such a showing, nor could they. The declarations supplied by the United States establish that the defendants are engaged in the ongoing and widespread *distribution* of marijuana, not the joint and simultaneous acquisition of marijuana. The declarations supplied by the United States further establish that it is quite common, if not the ordinary practice, for individuals to purchase marijuana from the defendants without having any ongoing relationship with the club. Under these circumstances, the defendants have completely failed to establish that the joint purchaser defense is applicable. See, e.g., United States v. Rush, 738 F.2d 497, 514 (1st Cir. 1984) (declining to extend Swiderski rule "to situations where more than a couple of defendants and a small quantity of drugs are involved"), cert. denied, 470 U.S. 1004 (1985); United States v. Taylor, 683 F.2d 18, 21 (1st Cir.) (finding Swiderski inapplicable to complex marijuana distribution organization), cert. denied, 459 U.S. 945 (1982).

The common law defense of medical necessity also is unavailable to the defendants for a more fundamental reason. "The defense of necessity is available only in situations wherein the legislature has not itself, in its criminal statute, made a determination of values. If it has done so, its decision governs." 1 Walter LaFave & Austin W. Scott, Jr., Substantive Criminal Law § 5.4, at 631 (1986). Here, by placing marijuana in Schedule I, Congress, by definition, determined that the substance has "no currently accepted medical use in treatment in the United States." 21 U.S.C. § § 812(b)(1). In addition, since the passage of the Controlled Substances Act, Congress has rejected legislation that would have allowed for the medical use of marijuana in certain specified

circumstances.[9] As a statutory matter then, Congress has specifically addressed and rejected the possible medical uses of marijuana. The defense of medical necessity, therefore, is unavailable to the defendants. See State v. Hanson, 468 N.W.2d 77, 78-79 (Minn. Ct. App. 1991) (criminal prohibition on possession, sale, or cultivation of marijuana and statutory provision allowing therapeutic research with marijuana only for cancer patients "show conclusively that the possible medical uses of marijuana have been brought to the legislature's attention," thereby foreclosing necessity defense for patient suffering from seizures).

Finally, even assuming they could overcome these hurdles, the defendants have failed to demonstrate that there are no legal, reasonable alternatives available outside of the open and widespread distribution of marijuana. On the contrary, we have shown that there are several legal alternatives available to the defendants. As discussed in detail in our earlier briefs, if the defendants believe the current medical and scientific evidence supports the conclusion that marijuana should be rescheduled, they can file a petition under the framework set forth in section 811 of the Controlled Substances Act, see 21 U.S.C. § 811; 21 C.F.R. §§ 1308.44(a), with review in a court of appeals. See 21 U.S.C. § 877. In addition, to the extent the defendants purport to speak for persons who believe that they would benefit from using marijuana as medicine, such persons may seek to participate in a research project that has been approved by the FDA and registered with the DEA under section 823(f).[10] Cf. United States v. Burton, 894 F.2d 188, 191 (6th Cir.) (potential participation in now-discontinued research program was reasonable legal alternative sufficient to defeat medical necessity defense), cert. denied, 498 U.S. 857 (1990). Finally, the defendants can petition Congress to move marijuana from Schedule I. See Schoon,

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[9] See H.R. 2618, 104th Cong., 1st Sess. (1995); H.R. 2232, 99th Cong., 1st Sess. (1985); H.R. 2282, 98th Cong., 1st Sess. (1983); H.R. 4498, 97th Cong., 1st Sess. (1981). A similar bill is currently pending in the House of Representatives. See H.R. 1782, 105th Cong., 1st Sess. (1997).

[10] There currently is one such research project underway, which is based in the San Francisco Bay area.

971 F.2d at 198 ("Where the targeted harm is the existence of a law or policy, our precedents counsel that this reasonableness requirement [in judging whether legal alternatives exist] is met simply by the possibility of congressional action."). The existence of any of these options is sufficient to foreclose the defendants' medical necessity defense here.

The defendants complain that a rescheduling petition under 21 U.S.C. § 811 does not present a viable legal alternative because, "[i]nstead of getting immediate relief from the symptoms of [a] debilitating disease, [one must] go to Washington and file a petition." Transcript at 78. But this is no answer. Like the defendants here, the defendants in United States v. Richardson, 588 F.2d 1235 (9th Cir. 1978), cert. denied, 440 U.S. 947 (1979), raised the medical necessity defense on the basis of an "emergency" -- that laetrile "was needed in the United States to treat cancer patients." Id. at 1239. The Ninth Circuit nonetheless held that, because the defendants could have sought to "have the FDA classification of Laetrile set aside or to have it approved as a new drug," the defense of necessity was unavailable. Id.

Nor is there any merit to the defendants' argument that Richardson is distinguishable because, in contrast to the situation at issue here, there was a petition to reclassify Laetrile pending at the time that case was decided. See Transcript at 77. As in Richardson, a petition to reclassify marijuana is currently pending before the DEA, and has been referred to the Secretary of Health and Human Services for evaluation. Hence, there is no principled basis to distinguish between the two cases.[11]

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[11] Defendants' assertion that the section 811 process is not meaningful because a prior petition took 22 years to be resolved is misleading. As even a cursory review of the attendant litigation reveals, the resolution of that petition presented numerous novel legal questions, ultimately resulting in five trips to the D.C. Circuit, see Alliance for Cannabis Therapeutics v. Drug Enforcement Admin., 15 F.3d 1131, 1133 (D.C. Cir. 1994), that have now been clarified and are unlikely to be revisited again. Ultimately, the D.C. Circuit upheld the DEA Administrator's determination that marijuana should remain in Schedule I. Id. at 1134-37.

We also wish to respond to the Court's query as to how long the currently pending

(continued...)

IV. THERE IS NO SUBSTANTIVE DUE PROCESS RIGHT TO DISTRIBUTE OR CULTIVATE MARIJUANA

Binding authority forecloses the defendants' substantive due process argument. As we have demonstrated previously, even if the defendants had standing to make such a claim, the Ninth Circuit, consistent with virtually every other court to have considered the issue, has held that a patient does not have a substantive due process right to any particular form of treatment. In Carnohan v. United States, 616 F.2d 1120 (9th Cir. 1980), the Ninth Circuit affirmed the dismissal of a declaratory judgment action in which the plaintiff had sought to secure the right to obtain and use laetrile for the prevention of cancer. In pertinent part, the court held that the "[c]onstitutional rights of privacy and personal liberty do not give individuals the right to obtain laetrile free of the lawful exercise of the government's police power. Id. at 1122. In so ruling, the Ninth Circuit cited with approval the Tenth Circuit's decision in Rutherford v. United States, 616 F.2d 455 (10th Cir.), cert. denied, 449 U.S. 937 (1980), in which that court had held that, "the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health." Id. at 457.

This prevailing view has been adopted by almost every court to have considered the question.[12] Most recently, in Smith v. Shalala, 954 F. Supp. 1 (D.D.C. 1996), a plaintiff who

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[11](...continued)
rescheduling petition may take. After consulting with DEA and FDA on this issue, it is simply impossible to predict how long this process may take. On December 17, 1997, DEA referred the petition to the Secretary of Health and Human Services ("HHS"), upon determining that the petition raised scientific and medical issues that had not previously been evaluated by HHS as part of any prior scheduling action. **The United States simply cannot predict when HHS will complete its scientific and medical evaluation of the petition, or how long it would take DEA to conduct a rulemaking, if appropriate.**

[12] See, e.g., Sammon v. New Jersey Bd. of Medical Examiners, 66 F.3d 639, 645 n.10 (3d Cir. 1995); Mitchell v. Clayton, 995 F.2d 772, 775-76 (7th Cir. 1993); Sifre v. Robles, 917 F. Supp. 133, 137 (D.P.R. 1996); United States v. Vital Health Products, Ltd., 786 F. Supp. 761, 777 (continued...)

suffered from an advanced stage of Hodgkin's lymphoma sought an injunction barring the FDA from prohibiting the Burzynski Cancer Institute from treating him with Antineoplastons, an experimental anti-cancer agent, positing "the right of a competent terminally ill cancer patient to choose among available treatments that he or she can accept and endure." Id. at 2. The district court denied the requested injunction, finding no merit to any of the plaintiff's constitutional arguments. Most pertinent here, the court explicitly relied upon and quoted from the Ninth Circuit's decision in Carnohan in holding that there was no substantive due process right "to obtain unapproved drugs free of the lawful exercise of government police power." Id. at 3 (quoting Carnohan, 616 F.2d at 1122).

The defendants attempt to distinguish this governing body of authority by contending that the right in question is "not a constitutional right to select medicine, but a constitutional right to select the effective medicine that's been presented." Transcript at 84. But this merely begs the question. Certainly the advocates of laetrile, or the plaintiff suffering from advanced stage Hodgkin's lymphoma in Smith, believed the drugs which they wished to use was the only effective medicine to treat their respective cancers. As such, this is a distinction without a difference, and in no way undermines the preclusive effect of Carnohan.

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[12](...continued)
(E.D. Wis. 1992), aff'd, 985 F.2d 563 (7th Cir. 1993) (Mem.); Kulsar v. Ambach, 598 F. Supp. 1124, 1126 (W.D.N.Y. 1984). But see Andrews v. Ballard, 498 F. Supp. 1038, 1052-53 (S.D. Tex. 1980) (finding a constitutionally protected right to acupuncture treatments).

V. DEFENDANTS' ASSERTION OF UNCLEAN HANDS IS BASELESS

Defendants' assertion that the United States has come to this Court with "unclean hands" is without foundation. None of the alleged offending actions withstand scrutiny. First, the defendants' complaint that the United States has brought civil injunction actions against them, rather than criminal proceedings, has no merit. Congress has given the Attorney General the explicit statutory right to enforce the Controlled Substances Act by way of a civil injunction action, 21 U.S.C. § 882(a), and several courts have recognized this form of relief. See, e.g., United States v. Leasehold Interest in 121 Nostrand Avenue, 760 F. Supp. 1015, 1035 (E.D.N.Y. 1991); United States v. Williams, 416 F. Supp. 611, 614 (D.D.C. 1976); United States v. Chemicals for Research and Industry, No. C 96-2382 SI (N.D. Cal. Nov. 26, 1996).

Next, the defendants' contention that the government's entitlement to preliminary injunctive relief is undermined by the alleged delay in bringing these actions is foreclosed by binding precedent. "The government is not subject to the defense of laches when enforcing its rights." United States v. Menatos, 925 F.2d 333, 335 (9th Cir. 1991) (citing United States v. Summerlin, 310 U.S. 414, 416 (1940); and United States v. McLeod, 721 F.2d 282, 285 (9th Cir. 1983)). Nor, in any event, have the defendants shown that they suffered any prejudice by this alleged delay.

The defendants also are flat-out wrong when they repeatedly represent to this Court that the National Commission on Marijuana and Drug Abuse "studied [the medical use of marijuana] for two years, and in 1972, came out with its report which essentially said marijuana was a safe drug that had medical -- that had potential medical uses." Transcript at 43. As the accompanying excerpt from National Commission report reveals, the Commission made ***no*** findings, affirmatively or negatively, as to the medical efficacy of marijuana. Rather, the Commission concluded that "[i]ncreased support of studies which ***evaluate*** the efficacy of marihuana in the treatment of physical impairments and disease is recommended." First Report of the National Commission on Marihuana and Drug Abuse, Marihuana: A Signal of Misunderstanding at 176 (1972) (emphasis

those in which "a federal statute is being enforced by the agency charged with that duty * * * *." Id. In this latter situation:

> The function of a court in deciding whether to issue an injunction authorized by a statute of the United States to enforce and implement Congressional policy is a different one from that of the court when weighing claims by two private litigants.
>
> * * * *
>
> Once Congress, exercising its delegated powers, has decided the order of priorities in a given area, it is for the courts to enforce them when asked.

Id. at 174-75. Thus, "[w]here an injunction is authorized by statute, and the statutory conditions are satisfied * * *, the agency to whom the enforcement of the right has been entrusted is not required to show irreparable injury. *No specific or immediate showing of the precise way in which violation of the law will result in public harm is required.*" Id. at 176 (emphasis supplied).

Stated differently, where an injunction is specifically authorized by an Act of Congress, and where the Attorney General or any agency of the United States is seeking to enforce that statutory mandate, "the passage of the statute is itself an implied finding by Congress that violations will harm the public." United States v. Nutri-Cology, Inc., 982 F.2d 394, 398 (9th Cir. 1992). In such circumstances, once the government has met the "probability of success" prong of the preliminary injunction test, "further inquiry into irreparable injury is unnecessary." Id. In other words, the statutory presumption of irreparable injury is irrebuttable. See United States v. Alameda Gateway, Inc., 953 F. Supp. 1106, 1109 (N.D. Cal. 1996) ("In statutory enforcement actions * * * [t]he court only inquires as to the possibility of irreparable harm when the government fails to establish a likelihood of success on the merits.").

Here, the defendants have not disputed the facts establishing violations of the Controlled Substances Act; namely, that they are engaged in the ongoing and widespread cultivation and distribution of marijuana. Rather, they have only presented legal arguments in defense of their actions. Because, as we have demonstrated above and elsewhere, each of those legal defenses is meritless, the United States has more than met its burden of demonstrating that it is likely to

succeed on the merits of these actions. As a result, "further inquiry into irreparable injury is unnecessary" in these cases. Nutri-Cology, 982 F.2d at 398.

The defendants argue, however, that in Miller v. California Pacific Medical Center, 19 F.3d 449 (9th Cir. 1994) (en banc), the Ninth Circuit, "narrowed the holdings of [Odessa Union Warehouse and others] and said: 'The government need not prove irreparable injury only when the statutory violation is conceded.'" Transcript at 116. This is a misreading of Miller. In that case, the en banc Ninth Circuit expressly quoted from Nutri-Cology for the proposition that, when the government has met the "probability of success" prong in statutory enforcement actions, the court will presume it has met the "irreparable injury" prong as well, thereby ending its inquiry. 19 F.3d at 459 (quoting Nutri-Cology, 982 F.2d at 398).

Again, because the United States has more than met its burden of demonstrating a likelihood of success on the merits, irreparable injury must be presumed. Accordingly, the United States has satisfied the more rigorous test for the issuance of preliminary injunctive relief. Id. at 456 (moving party entitled to preliminary injunction when it demonstrates "a combination of probable success on the merits and the possibility of irreparable injury"). Under these circumstances, the Court should grant the requested injunction.

VII. THE PUBLIC INTEREST FAVORS THE REQUESTED INJUNCTION

The public interest also weighs strongly in favor of the requested injunctions. In passing the Act, Congress expressly found that "[t]he illegal importation, manufacture, distribution, and possession and improper use of controlled substances have a substantial and detrimental effect of the health and general welfare of the American people." 21 U.S.C. § 801(2). As such, "[h]arm to the public interest is presumed." World Wide Factors, 882 F.2d at 346 (citing Odessa Union Warehouse, 833 F.2d at 175-76). See Able v. United States, 44 F.3d 128, 132 (2d Cir. 1995) (per curiam). Moreover, an Act of Congress is presumptively constitutional, and this "presumption of constitutionality * * * [is] an equity to be considered in favor of [the Government] in balancing

hardships." Walters v. National Ass'n of Radiation Survivors, 468 U.S. 1323, 1324 (1984) (Rehnquist, Circuit Justice).

Indeed, in enacting the Controlled Substances Act, Congress established a complex regulatory scheme designed to protect the American public from harmful and dangerous drugs. Under this process, *any* interested person may submit a petition asking the DEA Administrator to initiate a rulemaking proceeding to reschedule a controlled substance, 21 U.S.C. § 811; 21 C.F.R. §§ 1308.44(a). Once a petition has been accepted, the DEA Administrator is required to refer the petition to the Secretary of Health and Human Services, acting through the FDA, for a medical and scientific evaluation, and the FDA's recommendation on scientific and medical matters is binding on the DEA Administrator. 21 U.S.C. § 811(b). Finally, if the petitioner disagrees with the ultimate decision of the DEA Administrator, he or she may further seek further review in a court of appeals. 21 U.S.C. § 877. The process for seeking FDA marketing approval under the Food, Drug and Cosmetic Act, 21 U.S.C. § 301, et seq., is similar, and also allows for ultimate review in a court of appeals.

A judicial determination as to the medical efficacy of marijuana in this case, as the defendants request, would seriously undermine the longstanding framework of these statutory schemes. As we discussed at oral argument, the arguments advanced by the defendants today are the same as those put forth by the advocates of laetrile just one decade ago, and are likely to be the same as those advanced by the proponents of other drugs in the near future, as evidenced by the Smith v. Shalala litigation. Indeed, marijuana is far from the only Schedule I controlled substance for which a medical value is claimed. For example, some commentators have argued in favor of a substantive due process right or medical necessity for the use of heroin to treat intractable cancer pain,[13] and legislation authorizing such treatment has been introduced in Congress.[14] Against this

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[13] See, e.g., Suzanne Marcus Stoll, Comment, *Why Not Heroin? The Controversy Surrounding the Legalization of Heroin for Therapeutic Purposes*, 1 J. Contemp. Health L. & (continued...)

backdrop, there can be no doubt that, were this Court to make a judicial determination that marijuana has medical value, it would open the door for the proponents of other drugs, using the same legal arguments, to proceed directly to district court and completely bypass the statutory framework established by Congress. It therefore comes as no surprise that every court of appeals to have considered the issue has held that the decision as to whether or not marijuana has medical value must be presented first in the context of a section 811 petition.[15]

In addition, as the Supreme Court made clear in United States v. Rutherford, 442 U.S. 544 (1979), the government's interest in enforcing the statutory schemes established by Congress to determine whether a particular treatment is safe, reliable, and effective does not disappear, but rather is heightened, in the context of those individuals with serious or even terminal illnesses. In Rutherford, a unanimous Supreme Court, speaking through Justice Marshall, rejected any notion that the FDA's new drug approval process was not applicable to those who were terminally ill. Justice Marshall reasoned that:

> [T]here is a special sense in which the relationship between drug effectiveness and safety has meaning in the context of incurable illnesses. An otherwise harmful drug can be dangerous to any patient if it does not produce its purported effect. But if an individual suffering from a potentially fatal disease rejects conventional therapy in favor of a drug with no demonstrable curative properties, the consequences can be irreversible.

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[13](...continued)
Pol'y 173, 176 (1985); Eugene L. Shapiro, *The Right of Privacy and Heroin Use for Painkilling Purposes By The Terminally Ill Cancer Patient*, 21. Ariz. L. Rev. 41 (1979).

[14] See S. 67, 101st Cong., 1st Sess. (1989); H.R. 5290, 98th Cong. 2d Sess. (1984).

[15] See United States v. Kiffer, 477 F.2d 349 (2d Cir. 1972), cert. denied, 414 U.S. 831 (1973); United States v. Fry, 787 F.2d 903, 905 (4th Cir.), cert. denied, 479 U.S. 861 (1986); United States v. Burton, 894 F.2d 188, 192 (6th Cir. 1990); cert. denied, 498 U.S. 857 (1990; United States v. Greene, 892 F.2d 453, 455-45 (6th Cir. 1989), cert. denied, 495 U.S. 955 (1990); United States v. Wables, 731 F.2d 440, 450 (7th Cir. 1984); United States v. Fogarty, 692 F.2d 542, 548 n. (8th Cir. 1982), cert. denied, 460 U.S. 1040 (1983); United States v. Middleton, 690 F.2d 820, 823 (11th Cir. 1982), cert. denied, 460 U.S. 1051 (1983).

442 U.S. at 556 (internal citation omitted). This interest is only heightened in these actions, where marijuana has not only been rejected by the FDA as medicine, but also, by virtue of its placement in Schedule I, has been determined by Congress to have a "high potential for abuse," "no currently accepted medical use in treatment in the United States," and a "lack of accepted safety for use under medical supervision." 21 U.S.C. § 812(b)(1).

Finally, the arguments advanced by the amicus local authorities in no way undermines this conclusion. With all due respect, these arguments should be made to Congress, not to this Court.

VII. THE COURT SHOULD ENTER SUMMARY JUDGMENT FOR THE UNITED STATES

In addition to seeking preliminary injunctions, the United States has moved for summary judgment. The Ninth Circuit has held that, in cases in which the factual record at the preliminary injunction stage is unequivocal, a court may "convert a decision on a preliminary injunction into a final disposition on the merits by granting summary judgment on the basis of the factual record available at the preliminary injunction stage." Air Line Pilots Ass'n v. Alaska Airlines, Inc., 898 F.2d 1393, 1397 n.4 (9th Cir. 1990). These cases present such a situation. As we have demonstrated here and elsewhere, the factually incontrovertible record in these cases demonstrate that the defendants' ongoing cultivation and distribution of marijuana constitute open, flagrant, and unambiguous violations of federal law, even assuming *arguendo* that the defendants clubs are operating within the requirements of Proposition 215. The United States, therefore, is entitled permanent injunctive relief, and summary judgment as a matter of law.

CONCLUSION

For the reasons set forth above, and for the reasons set forth in our prior memoranda, and in open court, the United States respectfully requests that this Court enter the requested injunction and judgment in favor of the United States.

Respectfully submitted,

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UNITED STATES OF AMERICA

Dated: April 16, 1998

CERTIFICATE OF SERVICE

I, Mark T. Quinlivan, hereby certify that on this 16th day of April, 1998, I served a copy of the foregoing Plaintiff's Post-Hearing Memorandum, and the Declaration of Mark T. Quinlivan; by overnight delivery, upon the following counsel specially appearing for defendants:

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS	Nos. C 98-0085 CRB C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0089 CRB C 98-0245 CRB DECLARATION OF MARK T. QUINLIVAN Hearing Held: March 24, 1998 Hon. Charles R. Breyer

I, MARK T. QUINLIVAN, do hereby declare and say as follows:

1. I am currently employed as a Trial Attorney in the Federal Programs Branch, Civil Division, United States Department of Justice, and am counsel of record in the above-captioned cases. I make this declaration based on personal knowledge, and on information made available to me in the course of my official duties.

2. Attached hereto as Exhibit 1 is a copy of the Addendum to the First Report of the National Commission on Marihuana and Drug Abuse, Marihuana: A Signal of Misunderstanding (March 1972), which discusses therapeutic uses on page 176.

I declare under penalty of perjury that the foregoing is true and correct.

MARK T. QUINLIVAN

Executed this 15 day of April 1998

ER0573

EXHIBIT 1

marihuana: a signal of misunderstanding

First Report of the National Commission on Marihuana and Drug Abuse

March 1972

National Commission on Marihuana and Drug Abuse
801 19th Street N.W.
Washington, D.C. 20006

March 22, 1972

To The President and Congress of the United States:

As Chairman of the National Commission on Marihuana and Drug Abuse, I am pleased to submit to you our first year Report in conformance with the mandate contained in Section 601 of Public Law 91-513, The Comprehensive Drug Abuse Prevention and Control Act of 1970.

This Report "Marihuana, A Signal of Misunderstanding" is an all-inclusive effort to present the facts as they are known today, to demythologize the controversy surrounding marihuana, and to place in proper perspective one of the most emotional and explosive issues of our time. We on the Commission sincerely hope it will play a significant role in bringing uniformity and rationality to our marihuana laws, both Federal and State, and that it will create a healthy climate for further discussion, for further research and for a continuing advance in the development of a public social policy beneficial to all our citizens.

Whatever the facts are we have reported them. Wherever the facts have logically led us, we have followed and used them in reaching our recommendations. We hope this Report will be a foundation upon which credibility in this area can be restored and upon which a rational policy can be predicated.

By Direction of the Commission

Raymond P. Shafer

Raymond P. Shafer
Chairman

The President
The President of the Senate
The Speaker of the House

addendum

The previous Chapter recommended a social policy oriented toward the discouragement of marihuana use and presented a set of proposals for the legal implementation of that policy. In addition to these legal recommendations for federal and state action, the Commission believes certain other recommendations should be presented for action.

Ancillary Recommendations

These recommendations are presented in three categories: (1) legal and law enforcement, (2) medical, and (3) other. Some of these recommendations apply to other drugs as well and will be discussed further in our second Report. However, we consider it useful to make recommendations now so that policy planners can be informed of the implications of what has been studied to date.

Foremost among the Commission's conclusions is a need for consistency between federal and state laws affecting marihuana distribution and use, and uniformity of marihuana laws among the states. The administration of all marihuana laws must be mutally reenforcing so that *total* governmental response to marihuana is both equitable and understandable.

Legal and Law Enforcement Recommendations

I. Federal

RECOMMENDATION: FEDERAL LAW ENFORCEMENT AGENCIES, ESPECIALLY THE BUREAU OF NARCOTICS AND DANGEROUS DRUGS AND THE BUREAU OF CUSTOMS, SHOULD IMPROVE THEIR STATISTICAL REPORTING SYSTEMS SO THAT POLICIES MAY BE PLANNED AND RESOURCES ALLOCATED ON THE BASIS OF ACCURATE AND COMPREHENSIVE INFORMATION.

In an effort to obtain information relating to enforcement of the marihuana laws including arrest, prosecution, sentencing and conviction data, the Commission found that sufficient information was available about prosecution and court action, but not about the activities of the law enforcement agencies. We were confronted by and large with inadequate statistical information and little or no in-depth evaluation.

The statistical reporting procedures of the Bureau of Narcotics and Dangerous Drugs and the Bureau of Customs are not uniform, making it extremely difficult to assess the effectiveness of the two principal drug enforcement agencies of the Federal Government. The Bureau of Narcotics and Dangerous Drugs keeps centralized files but the Bureau of Customs maintains its files on a regional basis. In both Bureaus, statistical information is kept only in its raw form; that is, number of arrests, number of seizures and so on. Very little analysis exists of the procedures leading to arrest, of the characteristics of persons arrested, and of the law enforcement strategies involved in the arrest. For law enforcement personnel to understand more fully *how* they are carrying out their functions so that internal assessments of particular policies can be made, sophisticated statistics must be maintained.

Both the Bureau of Narcotics and Dangerous Drugs and the Bureau of Customs are aware of these problems. Both were extremely helpful to the Commission and its research staff in seeking useful information from the mass of raw statistics. However, the information from the available statistics is incomplete and of limited utility for policy planning purposes.

In support of this priority recommendation, Congress is urged to provide additional and adequate funding for this area, at the same time requiring both agencies to utilize a common reporting system so that information can be more easily shared between them.

In addition, it is recommended that the Federal Bureau of Investigation, in its Uniform Crime Reports, requests the state agencies to

identify marihuana cases separately from narcotic cases and report them as a separate component.

RECOMMENDATION: THE FEDERAL BUREAU OF NARCOTICS AND DANGEROUS DRUGS SHOULD INCREASE ITS TRAINING PROGRAMS OF STATE AND LOCAL POLICE WITH SPECIAL EMPHASIS ON THE TRAINING IN THE DETECTION OF TRAFFICKING CASES.

The Commission's interviews with state and local police officials revealed a consistent desire to upgrade the quality of their investigations. Since the Federal Bureau of Narcotics and Dangerous Drugs, through its National Training Institute, has been performing this task well, it is recommended that the funds be granted by the Congress to extend the range of the educational program offered and increase the number of persons trained.

RECOMMENDATION: INCREASED BORDER SURVEILLANCE, A TIGHTENING OF BORDER PROCEDURES, AND A REALISTIC ERADICATION PROGRAM TO DIMINISH THE SUPPLY OF DRUGS COMING INTO THE COUNTRY, COUPLED WITH A MORE EFFECTIVE PROGRAM FOR DIMINISHING THE DOMESTIC PRODUCTION AND DISTRIBUTION OF MARIHUANA, ARE REQUIRED.

The Commission, as part of its mandate, studied drug trafficking patterns along the borders of the United States. An analysis of border marihuana seizures was also made. The results of both studies indicated that proportionately larger seizures were made along the borders at locations where there were no manned checkpoints. The Commission therefore recommends that more vigorous effort be made by federal agencies to interdict smugglers along the entire border while continuing their efforts at the formal checkpoints.

In discussions with representatives of other countries, a common observation made by foreign officials has been this country's somewhat indifferent attitude about the eradication of our home-grown marihuana, an attitude that is not appreciated by other countries under pressure from the United States to destroy their crops. Since this Administration has wisely made illicit trafficking in all drugs a foreign policy priority, we recommend that priority be supported by an equally assiduous effort to eradicate marihuana within our borders.

We recommend further that preclearance procedures be eliminated so that Customs personnel may more effectively control smuggling of marihuana and other drugs. Preclearance is a procedure whereby passengers and their baggage destined for the United States are inspected by U.S. Customs, Immigration and Agriculture officials *prior* to departure from a foreign location. This practice is in effect in Ber-

muda, Montreal, Nassau, Toronto, Vancouver, Winnipeg and the Virgin Islands. Other locations are petitioning for the same privilege.

An inherent weakness in the preclearance procedure is that Customs personnel stationed outside the United States have no authority for search, seizure and arrest. This fact is well-known to the professional smuggler who uses it to his advantage. Since we have been informed that preclearance creates a gap in Customs' interdiction process, reason dictates that the procedure be eliminated in the interest of tighter control.

II. State

RECOMMENDATION: ALL STATES SHOULD ADOPT THE UNIFORM CONTROLLED SUBSTANCES ACT TO ACHIEVE UNIFORMITY WITH REGARD TO MARIHUANA AND OTHER DRUG LAWS, WITH THE EXCEPTION THAT THE LEGAL RESPONSE TO POSSESSION FOR ONE'S OWN USE BE UNIFORMLY ADOPTED IN ACCORDANCE WITH OUR RECOMMENDATION IN CHAPTER V OF THIS REPORT.

As noted earlier, one of the greatest needs in the entire drug area is uniformity of state laws with regard to structure and penalties. While this recommendation applies to all drugs and not just marihuana, we feel it essential to make this recommendation now to help deemphasize the marihuana problem. Significant differences in penalties among the states constitute a valid source of irritation and conflict among various segments of our population. In an age of high mobility, it is unconscionable that penalties should vary so greatly in response to the same behavior.

RECOMMENDATION: EACH STATE SHOULD ESTABLISH A CENTRALIZED COMPULSORY REPORTING AND RECORD-KEEPING AUTHORITY SO THAT ADEQUATE AND ACCURATE STATISTICS OF ARRESTS, SENTENCES AND CONVICTIONS ON A STATEWIDE BASIS ARE AVAILABLE.

Several states have systems for maintaining records of drug arrests on a statewide basis. Accurate reporting and compilation of these cases permit the state to assess accurately the impact of law enforcement on drug offenders. The Law Enforcement Assistance Administration of the Department of Justice should assist the states to establish compulsory statistical reporting centers so that individual state needs are met and a clearer picture of the national trends can be ascertained. Efficient state record-keeping will have an additional benefit of increasing the reliability of the Uniform Crime Reports compiled by the Federal Bureau of Investigation.

RECOMMENDATION: THOSE STATES REQUIRING PHYSICIANS TO REPORT DRUG USERS SEEKING MEDICAL ASSISTANCE SHOULD CHANGE SUCH REQUIREMENTS TO INSURE THE CONFIDENTIALITY OF THE DRUG USER'S IDENTITY, SO THAT PERSONS NEEDING MEDICAL HELP WILL FEEL FREE TO SEEK IT.

Seventeen states* currently require physicians to report to a government agency information on those persons treated by them who are dependent on, or are habitual users of drugs. No common pattern emerges among these states.

After reviewing these statutes, the Commission believes that the disadvantages of maintaining such reporting systems outweigh the benefits to society or the individual. Fear of disclosure to the police discourages many persons from seeking needed medical help. Furthermore, the requirement makes the physician an informant and an agent of law enforcement.

While a need exists for reliable statistics regarding the number and nature of those persons being treated, the Commission does not feel that identification of the individual user is necessary. We again emphasize that society should encourage persons in need of medical attention to seek out authorized practitioners without having to fear legal repercussions for such action.

III. International

RECOMMENDATION: IF THE UNITED STATES SHOULD BECOME A SIGNATORY OF THE PROPOSED PSYCHOTROPIC CONVENTION, WE RECOMMEND THAT CANNABIS BE REMOVED FROM THE EXISTING SINGLE CONVENTION AND CONSIDERATION BE GIVEN TO LISTING IT IN THE PSYCHOTROPIC CONVENTION AMONG DRUGS WHICH HAVE SIMILAR EFFECTS.

Under the Single Convention on Narcotic Drugs, 1961, of which the United States became a signatory in 1967, cannabis, with the exception of its leaves and stems, is included with narcotic drugs and cocaine. While that categorization had some justification in 1961 when knowledge about marihuana was more limited, this justification no longer exists. More importantly, tetrahydrocannabinol(THC), the psychoactive ingredient in cannabis, is not included in the Single Convention and is proposed for inclusion in the Psychotropic Convention.

The Commission sees little sense in having the potent psychoactive ingredient in cannabis covered in one Convention and the natural

*California, Connecticut, Hawaii, Idaho, Iowa, Massachusetts, Michigan, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Vermont, Virginia, Washington.

product in another. Logic dictates combining the active ingredient with the plant form under one international control scheme. The Commission concludes that cannabis is more appropriately included in an international agreement which would control the hallucinogens, stimulants, depressants, and other drugs rather than in the Single Convention, which includes the narcotics and cocaine.

Medical Recommendations

I. Research Coordination and Emphasis

RECOMMENDATION: FULLER COORDINATION OF THE MARIHUANA RESARCH CONDUCTED BY GOVERNMENTAL AND PRIVATE AGENCIES IS NEEDED TO REDUCE THE DUPLICATION OF EFFORT, ASSURE A DIVERSITY OF NEW APPROACHES AND NEW OBJECTIVES, AND TO PROVIDE EFFICIENT INTEGRATION OF FINDINGS INTO THE AVAILABLE BODY OF KNOWLEDGE.

The Commission recognizes the need for studies of chronic, heavy users of marihuana in this country. Among the required areas of information are the user's sociologic background (family dynamics, social stresses, impact of socioeconomic status), and medical status (documentation of physiological and psychological parameters, including pulse rate, blood pressure, electro-cardiogram, electroencephalogram, mental status examination, psychological tests). Epidemiological studies are also needed. Such studies should be directed toward understanding the life histories of chronic, heavy users, and identifying the effects of marihuana on the life patterns of these individuals.

The Commission recommends that intensive research be conducted on the carcinogenic properties of the components of marihuana smoke, in both animals and man. Further work should be conducted to analyze the effect of marihuana smoking on pulmonary function. The Commission-sponsored study in Boston and the study of heavy long-term users in Jamaica both indicated there was some decrement in measurable lung function capacity.

In addition to these physiological studies, investigations on the effects of marihuana-smoking on the bronchial epithelium and mucous membranes of the mouth, throat and lips should be undertaken. The relationship of marihuana smoking to cardiac diseases, particularly coronary artery disease, should be studied. Although such studies have been conducted in connection with tobacco use, they have not been performed on a significant scale with regard to marihuana use.

Some clinical investigators have voiced concern regarding the effect of marihuana-smoking on the peripheral vascular system. In order to accomplish the initial phase of this investigation, the Com-

mission recommends that thermographic studies be carried out on extremities of chronic, heavy marihuana users.

There are many unanswered questions about the effects of marihuana upon the brain. These include reported alterations upon the neuronal systems which produce effects resembling those of both psychedelic drugs and alcohol. Studies of the biogenic amines which appear to be neurotransmitters in the emotional areas of the brain are needed.

The Commission in the course of its work has encouraged cooperation among various federal agencies concerned with marihuana. Continuing and formalized informational exchange among federal agencies and the state, local and private agencies which have a professional concern with marihuana can be helpful to all of them. We recommend that an appropriate federal agency, such as the Special Action Office for Drug Abuse Prevention in the White House, serve as the catalyst in developing a permanent program for assembling and exchanging marihuana-related information.

II. Detection of Marihuana in the Human Body

RECOMMENDATION: RESEARCH EFFORTS TO DEVELOP AN INEXPENSIVE, EASY METHOD FOR DETECTING AND QUANTIFYING THE PRESENCE OF MARIHUANA IN THE BLOOD, BREATH OR URINE OF A PERSON SUSPECTED OF BEING INTOXICATED SHOULD BE ACCELERATED.

In keeping with the necessity to detect and punish persons who are operating vehicles and other dangerous equipment under the influence of marihuana, it is important for law enforcement officials to have a swift, easy-to-use mechanism that will determine with a high degree of certainty whether the person is acting under the influence of marihuana. The Commission understands that the Department of Transportation and other federal agencies are working toward this goal and we strongly recommend that this research be continued as a priority item.

III. International Cooperation

RECOMMENDATION: AN ACCELERATED PROGRAM FOR FUNDING FOREIGN RESEARCH SHOULD BE UNDERTAKEN IMMEDIATELY.

For the purposes of definitive research on the effects of heavy and very heavy marihuana use, the Commission has found that the United States fortunately does not have significant numbers of people who have been exposed over a long period of time to such use. The National Institute of Mental Health has cooperated with the Commission in

supplying data from its major foreign studies of chronic cannabis users in Jamaica and Greece. For medical research purposes, an analysis of data derived from populations in other countries with 10, 20 or 30 years of experience with heavy marihuana use will provide useful information about probable consequences if the incidence of marihuana use in the United States were to continue and increase, and if more people engaged in heavy, long-term use.

IV. Therapeutic Uses

RECOMMENDATION: INCREASED SUPPORT OF STUDIES WHICH EVALUATE THE EFFICACY OF MARIHUANA IN THE TREATMENT OF PHYSICAL IMPAIRMENTS AND DISEASE IS RECOMMENDED.

Historical references have been noted throughout the literature referring to the use of cannabis products as therapeutically useful agents. Of particular significance for current research with controlled quality, quantity and therapeutic settings, would be investigations into the treatment of glaucoma, migraine, alcoholism and terminal cancer. The NIMH-FDA Psychotomimetic Advisory Committee's authorization of studies designed to explore the therapeutic uses of marihuana is commended.

V. Community-Based Treatment

RECOMMENDATION: COMMUNITY-BASED TREATMENT FACILITIES SHOULD BE PROMOTED IN CARING FOR PROBLEM DRUG USERS UTILIZING EXISTING HEALTH CENTERS WHEN POSSIBLE AND APPROPRIATE.

In studying marihuana, the Commission has obtained information about a number of treatment centers and services. The wide range of agencies and the variety of goals and techniques present a confusing array of services available to drug users, varying widely in their effectiveness. Uniform criteria for evaluating the "success" of these programs is urgently needed.

The medical members of the Commission believe that some of the techniques being used may pose as much potential harm as good. Many young people who are experiencing profound difficulties resulting from the use of drugs may suppose they are being treated and helped, when in reality they are not. In some cases, the short-term benefit may be disruptive to the long-term welfare of the individual. In the rush to provide treatment facilities, many programs have been given impressive credientials without meeting minimal medical standards. It is essential that treatment facilities have, as their primary orientation, the well-being of the individual under treatment.

VI. Training Programs

RECOMMENDATION: PUBLIC HEALTH COURSES ON THE SOCIAL ASPECTS OF DRUG USE SHOULD BE INCLUDED IN THE CURRICULA OF THE SCHOOLS OF THE HEALTH PROFESSIONS.

The Commission recommends that schools of the health professions include in their curricula courses on the social, public health and therapeutic aspects of drug use as appropriate to the educational purpose of the individual school. The National Survey indicated that the public views the family physician as an important source of information about drugs. Next to school personnel, physicians were mentioned most often in this connection. Persons involved in the health professions must be provided with information about non-medical as well as the medical aspects of drug use.

Other Recommendations

I. Reclassification of Cannabis

RECOMMENDATION: THE COMMISSION RECOGNIZES THAT SEVERAL STATE LEGISLATURES HAVE IMPROPERLY CLASSIFIED MARIHUANA AS A NARCOTIC, AND RECOMMENDS THAT THEY NOW REDEFINE MARIHUANA ACCORDING TO THE STANDARDS OF THE RECENTLY ADOPTED UNIFORM CONTROLLED SUBSTANCES LAW.

Scientific evidence has clearly demonstrated that marihuana is not a narcotic drug, and the law should properly reflect this fact. Congress so recognized in the Comprehensive Drug Abuse Prevention and Control Act of 1970, as did The Conference of Commissioners on Uniform State Laws in the Uniform Controlled Substances Law.

In those states where the Uniform Controlled Substances Law has not yet been adopted, twelve of which continue to classify marihuana as a "narcotic", the Commission recommends that the legislatures distinguish marihuana from the opiates and list it in a separate category. The consequence of inappropriate definition is that the public continues to associate marihuana with the narcotics, such as heroin. The confusion resulting from this improper classification helps to perpetuate prejudices and misinformation about marihuana.

II. Information

RECOMMENDATION: A SINGLE FEDERAL AGENCY SOURCE SHOULD DISSEMINATE INFORMATION AND

MATERIALS RELATING TO MARIHUANA AND OTHER DRUGS. THE NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION SHOULD BE CHARGED WITH THIS RESPONSIBILITY.

A great proliferation of drug information materials has occurred in recent years. These materials are currently distributed by a number of federal agencies. Some of these materials conflict with each other. The result is a confusion and uncertainty on the part of the public about the accuracy of all these statements. The public should have one federal source from which to obtain drug information. The National Clearinghouse for Drug Abuse Information appears best suited to perform this task.

III. Education

RECOMMENDATION: THE SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION IN THE WHITE HOUSE SHOULD BE RESPONSIBLE FOR THE COORDINATION, DEVELOPMENT AND CONTENT REVIEW OF ALL FEDERALLY-SUPPORTED DRUG EDUCATIONAL MATERIALS AND SHOULD ISSUE A REPORT AS SOON AS POSSIBLE, EVALUATING EXISTING DRUG EDUCATION MATERIALS.

The Commission has studied many programs of drug education throughout the country. Some are irrelevant, others are poorly designed, still others are misleading, and a good many of them are of questionable value. A few are excellent. The Federal Government must provide assistance to the states and school districts in this matter, and should provide the leadership in developing sample programs in cooperation with educational systems. An evaluation of existing programs by The Special Action Office for Drug Abuse Prevention of the White House could be very helpful in improving the standards of drug education.

IV. Voluntary Sector Participation

RECOMMENDATION: THE COMMISSION NOTES THE SIGNIFICANT ROLE PLAYED BY THE VOLUNTARY SECTOR OF THE AMERICAN COMMUNITY IN INFLUENCING THE SOCIAL, RELIGIOUS AND MORAL ATTITUDES OF OUR NATION'S CITIZENS AND RECOMMENDS THAT THE VOLUNTARY SECTOR BE ENCOURAGED TO TAKE AN ACTIVE ROLE IN SUPPORT OF OUR RECOMMENDED POLICY OF DISCOURAGING THE USE OF MARIHUANA.

Already very active in drug education and prevention activities, the social agencies, service clubs, church groups, and other non-govern-

mental bodies have been extremely helpful in attending to the difficult problems of drug abuse. The local and personal nature of such organizations gives them an advantage over state and federal governments in the development of attitudes by our citizens.

The policy which we here recommend, indeed *any* policy which might be recommended, will inevitably encounter widespread and earnest objections. The fullest efforts of all citizens of good will will be required to attend to the massive problem of drug abuse in a calm, just, responsible and effective manner. The help of the voluntary agencies in working toward this end is earnestly invited and urgently needed.

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Specially appearing for Defendants
OAKLAND CANNABIS BUYERS'
COOPERATIVE; JEFFREY JONES,
MARIN ALLIANCE FOR MEDICAL
MARIJUANA, and LYNNETTE SHAW

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATORS' CLUB; and DENNIS PERON,

Defendants.

AND RELATED ACTIONS.

Nos. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98-00089 CRB
C 98-00245 CRB

ADDENDUM TO DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION, PERMANENT INJUNCTION AND FOR SUMMARY JUDGEMENT

No Hearing Scheduled

THE REASONS THE GOVERNMENT IS SEEKING INJUNCTIVE RELIEF IN THIS CASE.

The Court assumes that the government is seeking injunctive relief in this case, rather than initiating criminal prosecution of the Defendants, from the purest of motives: to resolve the legal issues without subjecting Defendants to the opprobrium and discomfort of a criminal arrest and trial. As Mr. Serra suggested in oral argument, however, the government's motives in conducting the "War on Drugs" have seldom been pure. Their real motive may well be to avoid the submission of the Defendants' defenses to a California jury. If injunctive relief is granted in this case, the government may well succeed in subverting the constitutional rights of the Defendants to trial by jury. The premise for the exercise of jurisdiction under 28 U.S.C. § 882(a) is that the Defendants are engaged in "violations of this subchapter." The violations alleged are the sale or distribution of marijuana, the manufacture of marijuana, the possession of marijuana with the intent to manufacture and distribute the substance, the maintenance of premises for the purpose of manufacturing and distributing marijuana, and "conspiring" to engage in the above violations.

If criminal prosecution were directly pursued for the violations alleged, the Defendants would clearly have the right to a jury trial. The alleged offenses are all felonies punishable by in excess of six months imprisonment. The Sixth Amendment guaranty of jury trial in all "criminal prosecutions" applies to all cases in which punishment in excess of six months' imprisonment is *possible. Baldwin v. New York*, 399 U.S. 66 (1970); *Blanton v. City of North Las Vegas*, 489 U.S. 538 (1989).

In a prosecution for criminal contempt for violation of an injunction, however, where no punishment is specified in advance, the availability of the constitutional right to jury trial turns on whether the actual sentence imposed exceeds six months. *Frank v. United States*, 395 U.S. 147 (1969). Thus, prosecutors can preclude the availability of jury trial in criminal contempt proceedings by inserting in the order to show cause a provision that the sentence will not exceed six months' imprisonment. *United States v. Agajanian*, 852 F.2d 56, 58 (2nd Cir. 1988); *United States v. Marthaler*, 571 F.2d 1104, 1105 (9th Cir. 1978).

The issuance of injunctive relief in this case thus carries the risk of transforming a potential criminal prosecution of the Defendants into contempt proceedings, to deprive them of the full protection of the Sixth Amendment right to trial by jury. Although 21 U.S.C. Sec. 882(b) purports to preserve the right to jury trial, it replaces the Sixth Amendment right with the less expansive protection of a *civil* jury. Section 882(b) provides: "In case of an alleged violation of an injunction or restraining order issued under this section, trial shall, upon demand of the accused, be by a jury in accordance with the *Federal Rules of Civil Procedure.*" (Emphasis supplied).

Unlike the guaranty of a jury of twelve in criminal prosecutions (Fed. R. Crim. Proc., Rule 23(b)), Rule 48 of the Federal Rules of Civil Procedure permits the seating of a jury "of not fewer than six and not more than twelve members." The Federal Rules of Civil Procedure also permit Special Verdicts and Judgment As a Matter of Law (Fed.R.Civ.Proc., Rules 49, 50) which would subvert the Sixth Amendment right to a jury trial in criminal cases. Summary Judgment is unavailable in a criminal prosecution, because the defendant has an absolute right to have the jury resolve the ultimate question of guilt or innocence, operating as the conscience of the community. In a jury trial conducted "in accordance with the Federal Rules of Civil Procedure," however, the right to jury resolution of Defendants' defenses could be completely subverted by the granting of Summary Judgment or the directing of a verdict.

Section 882(a) does not limit suits for injunctive relief to actions brought by the United States. Injunctive relief may also be sought by other parties. In the event any other party sought injunctive relief, however, the Defendants' right to jury trial in a subsequent contempt action would be fully protected by Section 3691 of Title 18, United States Code, which provides:

> Whenever a contempt charged shall consist in willful disobedience of any lawful writ, process, order, rule, decree, or command of any district court of the United States by doing or omitting any act or thing in violation thereof, and the act or thing done or omitted also constitutes a criminal offense under any act of Congress, or under the laws of any state in which it was done or omitted, the accused, upon demand therefor, shall

> be entitled to trial by a jury, *which shall conform as near as may be to the practice in other criminal cases.* (Emphasis supplied).

Because this action for injunctive relief is brought by the United States, however, the protection of Section 3691 is rendered inapplicable:

> This section shall not apply to contempts committed in the presence of the court, or so near thereto as to obstruct the administration of justice, *nor to contempts committed in disobedience of any lawful writ, process, order, rule, decree, or command entered in any suit brought or prosecuted in the name of, or on behalf of, the United States.* (Emphasis supplied).

Compare 18 U.S.C. Sec. 402, which likewise exempts contempts of decrees entered in suits brought by the United States, further providing that such cases of contempt "may be punished in conformity to the prevailing usages at law."

In light of the difference between criminal prosecution for the violations alleged, and a prosecution for criminal contempt for violating an injunction prohibiting these same violations, the Court must ask the government what they hope to gain by the issuance of an injunction in this case. The only plausible answer will expose the true purpose of these proceedings: to avoid the submission of the question of criminal responsibility of the Defendants to the full rigor of the right to jury trial and other procedural protections available in criminal prosecutions.

That answer suggests the Court should be reluctant to permit the use of the injunctive remedy in this case. As the leading authority on federal practice sums it up:

> As a general rule, courts also are reluctant to issue injunctions against the commission of a crime even when no question of federalism is present. This hesitance is tied to the notion that for the court to act would interfere with the prosecutor's exercise of discretion to decide whether to prosecute a particular violation. Furthermore, as explained by one commentator:
>
> > [T]wo major justifications have been asserted for the rule that equity will not enjoin a crime: the desire to protect defendants' rights to safeguards of criminal procedure * * * and the adequacy of the criminal remedy to protect the plaintiff's interests. If the criminal law forbids certain conduct, and provides sanctions of fine or imprisonment for disobedience, what purpose will

> be served by an injunction against the same conduct, under pain of contempt punishment? Enjoining a crime may seem not only superfluous, but also unmindful of legislative determination of the appropriate sanction for the enforcement of a given statutory command. [Citing *Developments in the Law -- Injunctions,* 78 Harv.L.Rev. 994, 1016 (1965).]
>
> Of course, in keeping with the discretionary character of injunctive relief, if the court finds that the prosecution of the criminal charge is not an adequate remedy, as when the conduct is creating a widespread public nuisance or a national emergency, the fact that a crime is involved should not prevent the court from entering an injunction.

Wright, Miller & Kane, *Federal Practice and Procedure, Civil,* § 2942, pp. 70-71 (1995).

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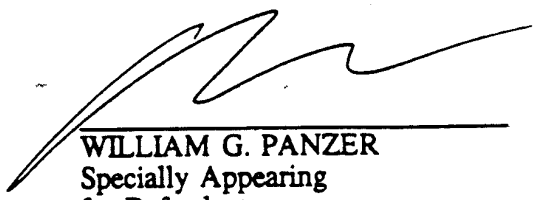
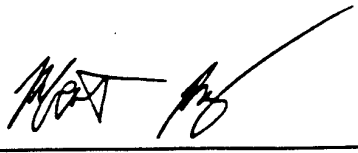
Dated: April 17, 1998

Respectfully submitted,



WILLIAM G. PANZER
Specially Appearing
for Defendants
MARIN ALLIANCE FOR MEDICAL MARIJUANA; LYNNETTE SHAW; OAKLAND CANNABIS BUYERS' COOPERATIVE; JEFFREY JONES



ROBERT A. RAICH
Specially Appearing
for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE; JEFFREY JONES

PROOF OF SERVICE BY MAIL

The undersigned hereby declares:

I am employed in the City of Oakland, County of Alameda, am over the age of 18 years, and am not a party to the within action; my business address is 370 Grand Avenue, Suite 3, Oakland, California, 94610. On April 17, 1998, I served the attached:

ADDENDUM TO DEFENDANTS' SUPPLEMENTAL JOINT MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFF'S MOTIONS FOR PRELIMINARY INJUNCTION, PERMANENT INJUNCTION AND FOR SUMMARY JUDGEMENT

on the parties in said action by placing a true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Oakland, California, addressed as follows:

Mark T. Quinlivan
U.S. Dept. of Justice
901 E Street, N.W.
Washington D.C. 20530

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on April 17, 1998, at Oakland, California.

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATORS CLUB; and DENNIS PERON,

Defendants.
/

AND RELATED ACTIONS
/

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0089 CRB
C 98-0245 CRB

MEMORANDUM AND ORDER

INTRODUCTION

The issue presented by these related lawsuits is whether defendants' admitted distribution of marijuana for use by seriously ill persons upon a physician's recommendation violates federal law, 21 U.S.C. § 841(a), and if so, whether defendants' conduct in this regard should be enjoined pursuant to the injunctive relief provisions of the federal Controlled Substances Act. See 21 U.S.C. § 882(a). This is the only issue before the Court. These lawsuits, for example, do not challenge the constitutionality of Proposition 215, the medical marijuana initiative, as a whole. Nor do they reflect a decision on the part of the federal government to seek to enjoin a local governmental agency from carrying out the humanitarian mandate envisioned by the citizens of this State when they voted to approve this law.

COF IS MAILED TO PARTIES OF RECORD

These cases also do not present the question of whether all conduct exempt from prosecution under the state drug laws by Proposition 215 violates federal law. For example, the Court is not deciding whether a seriously ill person who possesses marijuana for personal use upon a physician's recommendation is in violation of federal law. Rather, the sole issue here is whether defendants' conduct, which may be lawful under state law, may nevertheless violate federal law and can thus be enjoined.

Finding that there is a strong likelihood that defendants' conduct violates the Controlled Substances Act, the Court concludes that the Supremacy Clause of the United States Constitution requires that the Court enjoin further violations of the Act.

BACKGROUND

A. Proposition 215 and the Federal Drug Laws.

In November 1996, 56% of those participating in the state-wide election voted in favor of Proposition 215, the "Medical Use of Marijuana" initiative, known also as the "Compassionate Use Act" (the "Act"). The Act makes it legal under California law for seriously ill patients and their primary caregivers to possess and cultivate marijuana for use by the seriously ill patient if the patient's physician recommends such treatment. In particular, it exempts a seriously ill patient, or the patient's primary caregiver, from prosecution under California Health and Safety Code § 11357, relating to the possession of marijuana, and § 11358, relating to the cultivation of marijuana. See California Health & Safety Code § 11362.5(d).

As a result of the passage of Proposition 215, several individuals, including defendants, organized "medical cannabis dispensaries" to meet the needs of seriously ill patients. These nonprofit dispensaries provide marijuana to seriously ill patients upon a physician's recommendation. According to defendants, these patients previously had to purchase marijuana, if they were able to purchase it at all, on the black market at exorbitant prices and of questionable quality.

At the time that California's voters approved the initiative, federal law – the Comprehensive Drug Abuse Prevention and Control Act of 1970 (the "Controlled Substances

Act") -- did, and still does, strictly prohibit the manufacture and distribution of marijuana, and the possession of marijuana with the intent to manufacture or distribute. See 21 U.S.C. § 841(a)(1). In particular, the Controlled Substances Act established a comprehensive regulatory scheme which placed controlled substances in one of five "Schedules" depending on each substance's potential for abuse, the extent to which each may lead to psychological or physical dependence, and whether each has a currently accepted medical use in the United States. See 21 U.S.C. § 812(b). Congress determined that "Schedule I" substances have a "high potential for abuse," "no currently accepted medical use in treatment in the United States," and a lack of accepted "safety for use of the drug or substance under medical supervision." 21 U.S.C. § 812(b)(1). Schedule I substances are strictly regulated; no physician may dispense any Schedule I controlled substance to any patient outside of a strictly controlled research project registered with the DEA, and approved by the Secretary of Health and Human Services, acting through the Food and Drug Administration ("FDA"). See 21 U.S.C. § 823(f). Congress placed marijuana in Schedule I at the time it passed the Controlled Substances Act and its designation has not changed since then. See 21 U.S.C. § 812(c)(c)(10).

B. The California Courts and Proposition 215.

In People v. Trippet, 56 Cal. App. 4th 1532 (1997), the California Court of Appeal, First District, interpreted Proposition 215 for the first time in a published decision. It held that although Proposition 215 does not exempt a seriously ill patient and her primary caregiver from Health and Safety Code § 11360, which prohibits the transportation of marijuana, a defendant in a criminal case might have a Proposition 215 defense to a charge of illegally transporting marijuana if "the quantity transported and the method, timing and distance of the transportation are reasonably related to the patient's current medical needs." Trippet, 56 Cal. App. 4th at 1550-51. The court reasoned that Proposition 215 would make no sense if a patient's primary caregiver would be guilty of a crime for "carrying otherwise legally cultivated and possessed marijuana down a hallway to the patient's room." Id. at 1550.

Three months later, a different division of the same court decided People ex rel. Lungren v. Peron, 59 Cal. App. 4th 1383 (1997). A unanimous court held that the defendants in that action, Dennis Peron and the San Francisco Cannabis Cultivators Club, both defendants here, are not primary caregivers within the meaning of the statute. A majority of that court disagreed with Trippet by also holding that while Proposition 215 exempts seriously ill patients and their caregivers from California law prohibiting the possession and cultivation of marijuana (Health & Safety Code § 11357, § 11358), it does not, under any circumstances, exempt them from Health and Safety Code § 11359 and § 11360, which prohibit the sale or giving away of marijuana. Id. at 1392. The California Supreme Court denied review of that decision on February 25, 1998.

C. The Federal Lawsuits.

Less than a month after the Peron decision, and more than a year after California's voters approved Proposition 215, the United States filed six separate lawsuits against six independent cannabis dispensaries and individuals associated with the management of the dispensaries.[1] The federal government alleges that defendants' manufacture and distribution of marijuana, and possession with the intent to manufacture and distribute marijuana, violates 21 U.S.C. § 841(a)(1); defendants' use of a facility (i.e., the locations of the dispensaries) for the purpose of manufacturing and distributing marijuana violates 21 U.S.C. § 856(a)(1); and that the individual defendants' conspiracy to violate the Controlled Substances Act violates 21 U.S.C. § 846. The lawsuits seek to preliminarily and permanently enjoin defendants' conduct pursuant to the statute which provides the federal district courts with jurisdiction to enjoin violations of the Controlled Substances Act. See 21 U.S.C. § 882(a).

On the same day the federal government filed its lawsuits, it filed motions for a preliminary injunction, permanent injunction and summary judgment in each action. In support of its motions, the government submitted the affidavits of several government agents

[1]The defendants in the related actions are: Cannabis Cultivators Club and Dennis Peron (98-0085); Marin Alliance for Medical Marijuana and Lynette Shaw (98-0086); Ukiah Cannabis Buyers' Club, Cherrie Lovett, Marvin Leherman and Mildred Leherman (98-0087); Oakland Cannabis Buyers' Cooperative and Jeffrey Jones (98-0088); Flower Therapy Medical Marijuana Club, John Hudson, Mary Palmer and Barbara Sweeney (98-0089); and Santa Cruz Cannabis Buyers Club (98-0245).

who attest to their undercover purchases of marijuana from defendants at the various defendant dispensaries.

The six lawsuits were randomly assigned to various judges of this District. Pursuant to Local Rule 3-12, all six were reassigned to this Court as related cases. The Court held a status conference on January 30, 1998, to address defendants' request for additional time to respond to the federal government's motions. At the status conference, and in their papers in support of their request for a continuance, defendants advised the Court that they strenuously dispute the factual assertions in the affidavits with respect to the sale of marijuana to non-seriously ill persons and persons without a physician's recommendation, and contend that much of the federal government's evidence was obtained in violation of the fourth amendment. Over the federal government's objection, the Court granted defendants an extension of time to respond. The Court further ordered that

> [f]or purposes of plaintiff's motions, the parties shall assume that defendants' alleged conduct falls squarely within that permitted by California Proposition 215, California Health & Safety Code § 11362.5. For example, the parties shall assume that all defendants are "primary caregivers" within the meaning of the statute, that all persons to whom defendants distribute or dispense marijuana are seriously ill, and that a physician has determined that the person's health would benefit from the use of marijuana and has made an oral or written recommendation to that effect. Whether the government illegally obtained the evidence upon which it bases its motions shall not be addressed at this time.

February 9, 1998 Order. By its Order, the Court sought to avoid a factual dispute as to whether Proposition 215 applies to defendants' conduct.

Prior to the hearing on the federal government's motions, defendants filed a motion to dismiss for lack of jurisdiction on the ground that Congress does not have authority under the Commerce Clause to regulate defendants' conduct. Defendants also moved to dismiss on the ground that the Court should abstain pursuant to various abstention doctrines.

The Court also received memoranda in opposition to the federal government's motion from *amici curiae* City and County of San Francisco, as represented by the San Francisco District Attorney, and other cities in which defendant dispensaries are located. The City and County of San Francisco and the other cities urge the Court not to adopt the injunctive relief sought by the federal government because of the adverse consequences an injunction would

have on the public health of their citizens. In particular, the San Francisco District Attorney asks the Court to limit any injunction so as not to exclude distribution to those patients for whom marijuana is a medical necessity, possibly by the City and County of San Francisco itself. See Memorandum of *Amicus Curiae* District Attorney of San Francisco at 11.

The Court held a hearing on all pending motions on March 24, 1998. All parties, and *amici curiae* San Francisco District Attorney, argued at the hearing. The Court requested that the parties submit additional briefing on issues raised at the hearing and took the matter under submission on April 16, 1998.

DISCUSSION

The Supremacy Clause of Article VI of the United States Constitution mandates that federal law supersede state law where there is an outright conflict between such laws. See Gibbons v. Ogden, 22 U.S. 1, 210 (1824); Free v. Bland, 369 U.S. 663, 666 (1962); Industrial Truck Ass'n, Inc. v. Henry, 125 F.3d 1305, 1309 (9th Cir. 1997) (state law is preempted "where it is impossible to comply with both state and federal requirements, or where state law stands as an obstacle to the accomplishment and execution of the full purpose and objectives of Congress"). Recognizing this basic principle of constitutional law, defendants do not contend that Proposition 215 supersedes federal law, 21 U.S.C. § 841(a). Indeed, Proposition 215 on its face purports only to exempt certain patients and their primary caregivers from prosecution under certain California drug laws – it does not purport to exempt those patients and caregivers from the federal laws. One of the ballot arguments in favor of the initiative in fact states: "Proposition 215 allows patients to cultivate their own marijuana simply because federal law prevents the sale of marijuana and a state initiative cannot overrule those laws." Peron, 59 Cal. App. 4th at 1393 (quoting Ballot Pamphlet, Proposed Amends. to Cal. Const. with arguments to voters, Gen. Elec. (Nov. 5, 1996) p. 60).

Defendants argue instead that the Court should dismiss the federal government's actions on abstention grounds and on the ground that 21 USC § 841(a) exceeds Congress's authority under the Commerce Clause. Assuming that the Court has jurisdiction, defendants' arguments fall into three categories: (1) defendants have not violated the federal law; (2)

defendants have valid defenses to their violation of the law; and (3) equitable principles preclude injunctive relief. We now turn to each of these arguments.

I. Jurisdiction.

A. Abstention.

We start with the proposition that the federal courts have an "unflagging obligation" to exercise their jurisdiction. See Colorado River Water Conservation Dist. v. United States, 424 U.S. 800, 817 (1976); Miofsky v. Superior Court, 703 F.2d 332, 338 (9th Cir. 1983). While the defendants have asked the Court to abstain, abstention is an "extraordinary and narrow exception to the duty of a district court to adjudicate a controversy properly before it." Colorado River Water Conservation Dist, 424 U.S. at 813 (quoting County of Allegheny v. Frank Mashuda Co., 360 U.S. 185, 189 (1959)). Defendants contend that the "extraordinary and narrow" exception to this duty exists here under Burford, Pullman or Colorado River, abstention doctrines.

1. Burford Abstention.

Burford abstention is based on comity. It may be appropriate if the lawsuit involves difficult questions of state law, resolution of which is a matter of substantial local concern transcending the result in the case at bar. Federal courts may abstain in such cases if federal adjudication would be disruptive of state efforts to establish a coherent policy with respect to the matter at issue. See New Orleans Public Service, Inc. v. City Council of New Orleans, 491 U.S. 350, 362 (1989); Burford v. Sun Oil Co., 319 U.S. 315, 334 (1943). Burford abstention is appropriate only if the following factors are met:

> (1) that the state has concentrated suits involving the local issue in a particular court; (2) the federal issues are not easily separable from complicated state law issues with which the state courts have special competence; and (3) that federal review might disrupt state efforts to establish a coherent policy.

Tucker v. First Maryland Savings & Loan, Inc., 942 F.2d 1401, 1404-05 (9th Cir. 1991).

Defendants contend that questions of who is a "primary caregiver" within the meaning of Health and Safety Code § 11362.5, and precisely what conduct is permitted by Proposition 215, are difficult and uncertain issues of state law. For example, defendants contend that there is a question whether Proposition 215 exempts the transportation as well as cultivation

and use of medical marijuana from California's drug laws. Compare Peron, 59 Cal. App. 4th at 1393-95 with Trippet, 56 Cal. App. 4th at 1550-51. They also assert that "medical marijuana" is "a policy problem of substantial import," the importance of which transcends the result in this case. They assert that "[b]y potentially invalidating Proposition 215 on preemption grounds, this court would effectively halt California's attempt to make section 11362.5 compatible with federal law." Defendants' Memorandum in Support of Motion to Dismiss at 7.

These lawsuits, however, are not appropriate candidates for Burford abstention. At a minimum, the second requirement for such abstention is not present. The federal issue -- whether defendants' conduct violates federal law -- is unrelated to the state questions identified by defendants, whether defendants' conduct is legal under state law. Proposition 215 may exempt defendants' conduct from prosecution under California's criminal laws and, for purposes of the federal government's motion, the Court has assumed that it does. But the only issue in these lawsuits is whether defendants' conduct violates federal law. See New Orleans Public Service, Inc., 491 U.S. at 362 (Burford abstention is inappropriate where federal issues control).

None of the cases cited by defendants in support of Burford abstention involved a lawsuit, such as these, where the resolution of the state law issues was immaterial. In Fireman's Funds Ins. Co. v. Quackenbush, 87 F.3d 290 (9th Cir. 1996), for example, the Ninth Circuit affirmed the district court's application of Burford abstention to an action challenging the constitutionality of Proposition 103 (insurance rate rollback initiative) because the federal issues were "intimately conjoined" with difficult and unresolved issues of state law. Id. at 297. Here, in contrast, the scope of Proposition 215 is not at issue since the constitutionality of the initiative is not being challenged. All that is at issue in these actions is whether defendants' conduct violates federal law. The Court need not examine state law to answer that question.

2. Pullman Abstention.

Defendants' opposition memorandum argued that abstention is appropriate under an

additional doctrine, Railroad Comm'n of Texas v. Pullman Co, 312 U.S. 496 (1941). Under Pullman abstention a federal court may defer hearing a case when "'a federal constitutional issue . . . might be mooted or presented in a different posture by a state court determination of pertinent state law.'" C-Y Development Co. v. City of Redlands, 703 F.2d 373, 377 (9th Cir. 1983) (quoting County of Allegheny v. Frank Mashuda Co., 360 U.S. 185, 189 (1959)). A lawsuit must meet three criteria for Pullman abstention to be appropriate:

> (1) the complaint must touch a sensitive area of social policy into which the federal courts should not enter unless there is no alternative to adjudication; (2) a definitive ruling on the state issues by a state court could obviate the need for constitutional adjudication by the federal court; and (3) the proper resolution of the potentially determinative state law issue is uncertain.

Kollsman v. City of Los Angeles, 737 F.2d 830, 833 (9th Cir. 1984). Defendants submit that the Court should abstain until the California courts have had an opportunity to define more clearly what state law permits in order to minimize any conflict between state and federal laws.

Pullman abstention is nonetheless inappropriate because the second criterion, and therefore the third, are inapplicable. As stated above, whether state law permits defendants' conduct, and to what extent it permits defendants' conduct, is immaterial. The issue here is whether that conduct is prohibited by federal law. Thus, a definitive ruling on the state issues, i.e., the scope of Proposition 215, will not obviate the need for deciding the constitutional issues presented by this lawsuit, including the alleged due process right to be free from pain.

3. Colorado River Abstention.

In the interest of "wise judicial administration," federal courts may stay a case involving a question of federal law where a concurrent state action is pending in which substantially similar issues are raised. See Colorado River Water Conservation Dist. v. United States, 424 U.S. 800, 817 (1976). "[F]ederal abstention and deference to parallel state proceedings is appropriate under Colorado River even when none of the more established doctrines apply." Fireman's Fund, 87 F.3d at 297. While no one factor is determinative, the Supreme Court has listed a number of factors to consider in deciding whether such abstention

is appropriate. These factors include, "the desireabilty of avoiding piecemeal litigation," and "the order in which the jurisdiction was obtained by the concurrent forums," Colorado River, 424 U.S. at 818-19; whether the state court proceedings are adequate to protect the federal litigant's rights," Moses H. Cone Memorial Hospital v. Mercury Construction Corp., 460 U.S. at 23; and the risk of conflicting results. See Colorado River, 424 U.S. at 818.

Defendants assert that the state proceeding in People v. Peron is substantially similar to these actions since it involves a challenge to the same conduct at issue here and seeks the same relief sought here -- an injunction.

The Court concludes, however, that the People v. Peron proceeding is not substantially similar. First, it does not involve all the parties to this lawsuit. Thus, the federal government's interests in these actions with respect to the defendants who are not defendants in Peron may not be adequately represented by that proceeding. Second, the issues are different. In Peron, the State seeks to enjoin defendant Peron's conduct on the ground that it violates state law; that is, that it does not fall within the conduct permitted by Proposition 215. Here, in contrast, the federal government seeks to enjoin defendants' conduct on the ground that it violates federal law; it is immaterial whether that conduct falls within that permitted by Proposition 215. Since the issues are not similar there is no risk of conflicting results. None of the cases cited by defendants involved a situation like here, where the federal government seeks to enforce federal law in federal court. In such a situation, this Court is required to exercise its jurisdiction.

B. Interstate Commerce Clause.

Since there is no basis for abstention, we now turn to the question of jurisdiction. Congress has the authority to regulate an activity pursuant to the Commerce Clause of the United States Constitution if the activity regulated falls into one of three categories:

> First, Congress may regulate the use of the channels of interstate commerce. . . . Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities. . . . Finally Congress' commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce.

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United States v. Lopez, 514 U.S. 549, 558-59 (1995) (citations omitted). In Lopez, the Supreme Court held that the Gun-Free School Zones Act of 1990 ("School Zones Act") exceeds Congress's Commerce Clause authority. The School Zones Act made it a federal offense "for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone." 18 U.S.C. § 922(q)(1)(A)(1988 ed. Supp. V). The Court held that the School Zones Act "has nothing to do with 'commerce' or any sort of economic activity . . . . and is not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." Id. at 561. It noted that neither the statute nor the legislative history included any congressional findings regarding the effects of gun possession in a school zone on interstate commerce, and rejected the government's theories as to such effects. Id. at 562.

Defendants contend that this Court is without jurisdiction to hear these related cases because Congress does not have the authority to regulate defendants' conduct under the Commerce Clause, just as it does not have authority to regulate possession of a firearm in a school zone. They submit that all of their activities are purely intrastate; therefore, pursuant to Lopez, the Controlled Substances Act is unconstitutional as applied to them.

Congress has the power "to declare that an entire class of activities affects commerce." Maryland v. Wirtz, 392 U.S. 183, 192 (1968). "The only question for the courts then is whether the class is within the reach of the federal power." Id.; see also United States v. Darby, 312 U.S. 100, 120-21 (1941) (where "Congress itself has said that a particular activity affects the commerce," the only function of a court "[i]n passing on the validity of legislation . . . is to determine whether the particular activity regulated or prohibited is within the reach of the federal power"). "Where the class of activities is regulated and that class is within the reach of federal power, the courts have no power 'to excise, as trivial, individual instances' of the class." Perez v. United States, 402 U.S. 146, 154 (1971).

Congress has made detailed findings that the intrastate manufacture, distribution, and possession of controlled substances, as a class of activities, "have a substantial and direct

effect upon interstate commerce." 21 U.S.C. § 801(3). In particular, Congress found that, "after manufacture, many controlled substances are transported in interstate commerce, id. § 801(3)(A); that "controlled substances distributed locally usually have been transported in interstate commerce immediately before their distribution," id. § 801(3)(B); that "controlled substances possessed commonly flow through interstate commerce immediately prior to such possession," id. § 801(4); that "[l]ocal distribution and possession of controlled substances contribute to swelling the interstate traffic in such substances," id. § 801(4); and that "[c]ontrolled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate," id. § 801(5). Therefore, "[f]ederal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic." Id. § 801(6). Since Lopez was decided, the Ninth Circuit has held that Congress's enactment of the Controlled Substances Act is constitutionally permissible under the Commerce Clause. See United States v. Bramble, 103 F.3d 1475, 1479-80 (9th Cir. 1996); United States v. Tisor, 96 F.3d 370, 373-75 (9th Cir. 1996), cert. denied, 117 S.Ct. 1012 (1997); United States v. Kim, 94 F.3d 1247, 1249-50 (9th Cir. 1996); United States v. Staples, 85 F.3d 461, 463 (9th Cir.), cert. denied, 117 S.Ct. 318 (1996).

Defendants respond that the Ninth Circuit cases are inapplicable to the facts of these actions because those cases involved (1) conduct that was prohibited under state law; and (2) intrastate illicit drug trafficking activities in the same "class of activities" as those interstate activities prohibited by the Controlled Substances Act. Here, in contrast, defendants argue that their conduct -- the distribution of marijuana to seriously ill patients for the patient's personal medical use -- is not within that class of activities and does not substantially effect interstate commerce.

There can be no debate that when Congress passed the Controlled Substances Act it was primarily concerned with traditional for-profit drug trafficking rather than the not-for-profit supply of medical marijuana to seriously patients in accordance with state law. Even assuming, however, that defendants' activities are within a different "class of activities" from

that which Congress expressly considered, their activities are not within a class that, by its nature, does not have a substantial effect on interstate commerce. Whereas defendants' conduct in the particular instances at issue here may not have had any effect on intrastate commerce, and for purposes of the federal government's motion the Court assumes that at an evidentiary hearing defendants could prove that all marijuana was cultivated locally, distributed locally, and consumed locally by California residents, it is not true that the class of activities within which defendants' conduct falls -- non-profit distribution of medical marijuana -- necessarily does not affect interstate commerce.

Medical marijuana may be grown locally, or out of the state or country, and there is nothing in the nature of medical marijuana that limits it to intrastate cultivation. Similarly, it may be transported across state lines and consumed across state lines. In Lopez, in contrast, the class of activities prohibited -- mere possession of a firearm near a school -- does not have a substantial effect on interstate commerce. This case, unlike Lopez, is not about mere possession but rather about distribution, a class of activities that, even if done for the humanitarian purpose of serving the legitimate health care needs of seriously ill patients, can affect interstate commerce.

To hold that the Controlled Substances Act is unconstitutional as applied here would mean that in every action in which a plaintiff seeks to prove a defendant violated federal law, an element of every case-in-chief would be that the defendant's specific conduct at issue, based on facts proved at an evidentiary hearing or trial, substantially affected interstate commerce. No case so holds and the Court declines to do so for the first time here. Accordingly, the Court has jurisdiction to hear this matter.

II. The Federal Government's Motion.

We now turn to the relief sought by the federal government and whether the federal government has met its burden.

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A. The Motion for a Preliminary Injunction is the Only Motion Before the Court.

The federal government styled its moving papers as a motion for "preliminary injunction, permanent injunction and summary judgment." It filed this hybrid motion the same day it filed the six related lawsuits. Defendants correctly object to the motion for summary judgment on the ground that the Federal Rules of Civil Procedure permit a motion for summary judgment by a plaintiff "at any time after the expiration of 20 days from the commencement of the action." Fed.R.Civ.P. 56(a). The federal government's motion for summary judgment was thus premature. The federal government contends that it orally renoticed the motions during the scheduling conference on January 30, 1998. The Court's February 9, 1998 Order, however, set the briefing schedule for the federal government's motion for preliminary injunction only; it made no mention of a motion for summary judgment. If the federal government believed the Court was in error, it had an obligation to so notify the Court and the defendants at that time. As it failed to do so, the only federal government motion pending is the motion for a preliminary injunction.

B. Preliminary Injunction Standard.

The general standards for a preliminary injunction are well-established. The court considers: (1) likelihood of success on merits; (2) possibility of irreparable harm to the moving party if the injunction is not granted; (3) the balance of hardships; and (4) in certain cases, whether the public interest will be advanced by granting preliminary relief. See Miller v. California Pacific Medical Center, 19 F.3d 449, 456 (9th Cir. 1994); United States v. Odessa Union Warehouse Co-op, 833 F.2d 172, 174 (9th Cir. 1987). The moving party must show "either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits, the balance of hardships tipping sharply in its favor, and at least a fair chance of success on the merits." Miller, 19 F.3d at 456 (quoting Senate of California v. Mosbacher, 968 F.2d 974, 977 (9th Cir. 1992). "These two formulations represent two points on a sliding scale in which the required degree of irreparable harm increases as the probability of success decreases." Odessa Union, 833 F.2d at 174.

The standard is modified somewhat when the federal government seeks to enforce a statute:

> In statutory enforcement cases where the government has met the "probability of success prong" of the preliminary injunction test, we presume it has met the "possibility of irreparable injury" prong because the passage of the statute is itself an implied finding by Congress that violations will harm the public. Therefore, further inquiry into irreparable injury is unnecessary. However, in statutory enforcement cases where the government can make only a "colorable evidentiary showing" of a violation, the court must consider the possibility of irreparable injury.

United States v. Nutri-cology, Inc., 982 F.2d 394, 398 (9th Cir. 1992). Since this is an action by the federal government to enforce a statute, the injunction must be granted if the federal government establishes a probability of success on the merits since, in such cases, the possibility of irreparable harm is presumed.

Defendants argue that the Ninth Circuit has suggested that if the defendants do not concede a statutory violation, the presumption of irreparable harm does not apply. See Miller, 19 F.3d at 459 (noting that in Odessa Union "the traditional requirement of irreparable injury was inapplicable because the parties conceded that the federal statute involved was violated"). Miller, however, specifically held that the presumption applies if the defendant concedes the statutory violation or the government demonstrates "that it is likely to prevail on the merits." Id. at 460.

Defendants also contend that the presumption of irreparable harm, even if it may apply, is rebuttable. In Miller and Nutri-cology, however, the Ninth Circuit held that if the government establishes a likelihood of success on the merits, "further inquiry into irreparable harm is unnecessary." Miller, 19 F.3d at 495; Nutri-cology, 982 F.2d at 398. Such a presumption is not unique to government statutory enforcement actions. In copyright actions, the party claiming infringement enjoys a similar presumption of irreparable harm upon a showing of likelihood of success on the merits. See, e.g., Apple Computer v. Formula Int'l Inc., 725 F.2d 521, 525 (9th Cir. 1984).

Thus, before deciding whether the presumption of irreparable injury applies in these cases, the Court must determine if the federal government has established a probability of success on the merits, or only a colorable evidentiary showing, or neither.

C. Probability of Success on the Merits.

Federal law prohibits the knowing or intentional manufacture, distribution, or possession with intent to manufacture or distribute a controlled substance. See 21 U.S.C. § 841(a). It is undisputed that marijuana is a controlled substance within the meaning of § 841(a). It is equally undisputed that defendants distribute marijuana. Defendants do not challenge the federal government's evidence to the extent it establishes that defendants provide marijuana to seriously ill patients or their primary caregivers for personal use by the patient upon a physician's recommendation.

Defendants contend that the federal government has nonetheless not established a probability of success on the merits because it has not proved that federal law applies to defendants' conduct. In particular, defendants submit that (1) federal law applies only to illicit or illegal distribution of marijuana, and not to medical marijuana which is legal under state law; (2) defendants are "joint users" and therefore cannot be guilty of "distribution"; and (3) defendants are exempt from the law as "ultimate users." Defendants argue alternatively that even if the law applies to their conduct, the common law defense of necessity justifies their conduct and, in any event, the statute as applied violates substantive due process.

1. Whether Federal Law Reaches Defendants' Conduct.

a. Proposition 215 and Federal Law.

Section 903 of the Controlled Substances Act provides that no provision of the Act

> shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.

21 U.S.C. § 903. Defendants argue that this section places the burden on the federal government to prove that state law, Health and Safety Code § 11362.5, is in positive conflict with federal law, 21 U.S.C. § 841(a), and that there is no way the two can stand together. The federal government cannot meet that burden, they contend, because "[i]t is unreasonable to believe that use of medical marijuana by this discrete population for this limited purpose

[medical treatment] will create a significant drug problem." Conant v. McCaffrey, 172 F.R.D. 681, 694 n.5 (N.D. Cal. 1997).

Defendants' argument misapprehends the scope of Proposition 215, federal law, and these lawsuits. Defendants are correct that Proposition 215 does not conflict with federal law, but not for the reasons advanced by defendants, i.e., that medical marijuana is not illegal. Proposition 215 does not conflict with federal law because on its face it does not purport to make legal any conduct prohibited by federal law; it merely exempts certain conduct by certain persons from the California drug laws. Thus, whether defendants' conduct falls within the scope of Proposition 215 is immaterial. Defendants do not argue, as they cannot, that simply because state law does not prohibit their conduct federal law may not do so. See United States v. Rosenberg, 515 F.2d 190, 198 n.14 (9th Cir. 1975).

Notwithstanding the operative language of Proposition 215, its declared purpose -- "[t]o ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes" . . . and that such patients and their primary caregivers are not subject to criminal prosecution or sanction," Health & Safety Code § 11362.5(A) & (B) -- suggests that California's voters want to exempt medical marijuana from prosecution under federal, as well as state law, even if that is not what they enacted. A state law which purports to legalize the distribution of marijuana for any purpose, however, even a laudable one, nonetheless directly conflicts with federal law, 21 U.S.C. § 841(a). Section 841 prohibits the distribution of marijuana except for use in an approved research project. It does not exempt the distribution of marijuana to seriously ill persons for their personal medical use.

b. Joint Users Defense.

In United States v. Swiderski, 548 F.2d 445 (2d Cir. 1977), defendants, husband and wife, were charged with violating 21 U.S.C. § 841(a) by possessing cocaine with intent to distribute. See id. at 447. The Second Circuit held that "a statutory 'transfer' could not occur between two individuals in joint possession of a controlled substance simultaneously acquired for their own use." United States v. Wright, 593 F.2d 105, 107 (9th Cir. 1979) (discussing Swiderski). The court thus concluded that the trial judge erred by denying "the

jury the opportunity to find that the defendants, who bought the drugs in each other's physical presence, intended merely to share the drugs" and thus, not to distribute them. Id.; Swiderski, 548 F.2d at 450.

Defendants contend that like the defendants in Swiderski, they have not violated the federal law prohibiting the distribution of marijuana. At a trial on the merits they submit that they will prove that their control of medical marijuana is established "through a cooperative enterprise, shared equally among all of the members thereto, for the exclusive medicinal use of each of them, individually" and that no third parties are involved and "nor is anyone else brought into a 'web' of drug use." They also contend that they "do not give money to others for the purposes of procuring drugs for recreational use," rather, they "act in concert as cooperatives to ensure the safe and affordable access to cannabis for medicinal purposes for each of the members." Defendants' Opposition Memorandum at 21. For purposes of the federal government's motion for preliminary injunction, the Court will assume that defendants could produce evidence to support their offer of proof.

Swiderski, and the other cases cited by defendants, involved the question of whether the defendants in those actions were entitled to a "joint users" jury instruction. The issue here, however, is whether the federal government has established that it is likely to prevail at trial in establishing that Swiderski does not apply to defendants' conduct. The Court concludes that it has. Swiderski involved a simultaneous purchase by a husband and wife who testified they intended to use the controlled substance immediately. Applying Swiderski to a medical marijuana cooperative would extend Swiderski to a situation in which the controlled substance is not literally purchased simultaneously for immediate consumption. In light of the fact that Swiderski has never been so extended, and in light of the fact that it has not been adopted by the Ninth Circuit, the Court concludes that it is reasonably likely that such a defense would not prevail at a trial addressing whether injunctive relief should be granted.

The Court cautions, however, that it is not ruling that defendants are not entitled to such a defense at trial or in a contempt proceeding for violation of a preliminary or

permanent injunction, or that defendants could not as a matter of law defeat a motion for summary judgment with evidence of mere possession. The Court's ruling is narrow. Based on defendants' offer of proof, which does not include any detailed factual allegations, the Court concludes that the federal government is likely to prevail at trial.

c. Ultimate User Defense.

Defendants contend that they have not violated the Controlled Substances Act because they are "ultimate users." An "ultimate user" is "a person who has lawfully obtained, and who possesses, a controlled substance for his own use or for the use of a member of his household." 21 U.S.C. § 802(25). Defendants are not ultimate users because they have not lawfully obtained the marijuana at issue. As stated above, the fact that it may be lawful under state law for defendants to cultivate and possess marijuana for medical purposes, does not make it lawful under federal law -- the only law at issue here. At present, the only way in which marijuana may be lawfully obtained is in a controlled research setting conducted pursuant to a FDA approved protocol, and where the researcher has been registered with the DEA. See 21 U.S.C. § 823(f); 21 C.F.R. § 1301.13(e).

2. The Medical Necessity Defense.

Defendants argue that even if the Controlled Substances Act prohibits their conduct, the injunction must nevertheless be denied because they are entitled to the common law defense of necessity. To invoke the defense, defendants must prove (1) that they were faced with a choice of evils and chose the lesser evil; (2) they acted to prevent imminent harm; (3) they reasonably anticipated a direct causal relationship between their conduct and the harm to be averted; and (4) that there were no legal alternatives to violating the law. See United States v. Aguilar, 883 F.2d 662, 693 (9th Cir. 1989). Several state courts have recognized the applicability of the necessity defense in marijuana criminal prosecutions. See, e.g., State v. Harding, 801 P.2d 563 (Idaho 1990); State v. Diana, 604 P.2d 1312 (Wash. App. 1979); State v. Bachman, 595 P.2d 287 (Hawaii 1979).

Defendants submit that they can prove each element of the defense. First, their members will die, go blind, or suffer severe pain without cannabis; yet, obtaining cannabis

"is, for many difficult or impossible to obtain." Thus, defendants contend, they are faced with two evils, letting their members die, go blind or suffer severe pain, or risk running afoul of federal law and that they have chosen the lesser evil. They can meet the second and third requirements, they argue, because the harm to be averted is imminent and life-threatening and supplying cannabis to their members is necessary to prevent that harm. Finally, they assert they have no reasonable alternative; for many people legal drugs simply do not work in treating their symptoms and they have no legal or safe alternative to obtaining marijuana

The federal government responds that defendants do have a legal and reasonable alternative -- a petition to reschedule marijuana from a Schedule I to a Schedule II controlled substance. See 21 U.S.C. § 811(a). Rescheduling to Schedule II would permit physicians to prescribe marijuana for therapeutic purposes. The Court doubts whether a rescheduling petition is a reasonable alternative for all seriously ill patients whose physicians have recommended marijuana for therapeutic purposes. For example, such a petition was filed in 1972 and did not receive a final ruling from the Administrator of the Drug Enforcement Agency until 1992, and a final decision on appeal until 1994. See Alliance for Cannabis Therapeutics v. Drug Enforcement Administrator, 15 F.3d 1131 (D.C. Cir. 1994). Needless to say, it hardly seems reasonable to require an AIDS, glaucoma, or cancer patient to wait twenty years if the patient requires marijuana to alleviate a current medical problem.

The Court, however, need not dispositively decide whether a reasonable alternative exists. The Court concludes that the federal government is likely to prevail at trial on its claim that the defense of necessity does not preclude the granting of the injunctive relief sought here. As the federal government points out, the defense of necessity has never been allowed to exempt a defendant from the criminal laws on a blanket basis. To put it another way, for the defense to be available here, defendants would have to prove that each and every patient to whom it provides cannabis is in danger of imminent harm; that the cannabis will alleviate the harm for that particular patient; and that the patient had no other alternatives, for example, that no other legal drug could have reasonably averted the harm. Defendants do not contend that they could offer such proof. For example, they state that they could offer

evidence that "for many" people, legal drugs are not effective. That is not the same as saying that for each ~~of every~~ person to whom they provide, and will provide, marijuana, legal drugs are not effective such that marijuana is a necessity.

The Court is not ruling, however, that the defense of necessity is wholly inapplicable to these lawsuits. If a preliminary or permanent injunction is granted, and the federal government alleges that defendants have violated the injunction, there will be specific facts and circumstances before the Court from which the Court can determine if the jury should be given a necessity instruction as a defense to the alleged violation of the injunction. As such facts are not presently before the Court, it is premature for the Court to decide whether such a defense is available.

By concluding that medical necessity is not an appropriate defense to the issuance of an injunction, the Court is not placing defendants in the difficult position of deciding whether to go forward with their conduct, which they sincerely believe is absolutely necessary, or abiding by the injunction. As defendants point out, with or without the injunction they must decide whether to violate federal law; they are bound by federal law even in the absence of an injunction.

4. Substantive Due Process.

The Due Process Clause of the United States Constitution "provides heightened protection against government interference with certain fundamental rights and liberty interests." Washington v. Glucksberg, 117 S.Ct. 2258, 2267 (1997). Where a "fundamental liberty interest" is involved, government action restricting that interest must be "narrowly tailored to serve a compelling [federal government] interest." Id. at 2268; see also id. ("the Fourteenth Amendment 'forbids the government to infringe . . . "fundamental" liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest'" (citation omitted)). A fundamental liberty interest must be "'deeply rooted in this Nation's history and tradition,'" and "'implicit in our concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'" Id. (citation omitted). The right must also be "carefully described." Id.

Defendants contend that the preliminary injunction should be denied because the relief sought -- an order enjoining defendants from the manufacture or distribution, or possession with intent to distribute marijuana, or conspiring to do the same -- violates their substantive due process rights. In particular, defendants assert that such an injunction would infringe their fundamental right to be free from unnecessary pain, to receive palliative treatment for a painful medical condition, to care for oneself, and to preserve one's own life. See generally Washington v. Glucksberg, 117 S.Ct. 2258, Deshaney v. Winnebago Cty. So. Serv. Dept., 498 U.S. 189, 200 (1989). They argue that they are not asserting a constitutional right to the medical drug of their choice, even if the drug had not been proved effective, as was the case in the actions challenging federal government's restrictions on laetrile, see, e.g. Rutherford v. United States, 616 F.2d 455 (10th Cir. 1980); Carnohan v. United States, 616 F.2d 1120 (9th Cir. 1980), but rather that they have a right to "a demonstrated and effective treatment as recommended by their physician that can alleviate their agony, preserve their sight, and save their lives." Defendants' Supplemental Opposition Memorandum at 9.

The Court concludes that the federal government is likely to prevail at trial on the issue of whether defendants have a fundamental right to medical marijuana. The Court, however, is not ruling as a matter of law that no such right exists. It holds that on the record presently before the Court, defendants have not established that the right to such treatment is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." Washington v. Glucksberg, 117 S.Ct. at 2268 (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937)). Nor have defendants established that they have standing to assert such a defense as to their distribution of marijuana to seriously ill persons other than themselves.

Moreover, the Court need not dispositively resolve this constitutional issue because even assuming defendants had established that such a fundamental right exists, and that they have standing to assert such a right, this defense, like the defense of necessity, is inapplicable to this injunction action. Defendants are asking the Court to deny the injunction and, in effect, exempt their conduct from the federal laws as a whole. In order for the Court to conclude that defendants have a substantive due process defense to an injunction barring

them from violating federal law, the Court would have to find that the substantive due process right of each and every patient to whom the defendants will dispense marijuana in the future will be violated if the government prevents defendants from doing so. Such a defense may be available in a contempt proceeding where the trier of fact is presented with a particular transaction to a particular patient under a particular set of facts. See Washington v. Glucksberg, 117 S.Ct. at 2275 n.24 (holding that Washington State's ban on assisted suicide is not unconstitutional as applied to terminally ill patients generally, but that the Court's decision does not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge"). It is not available, however, to exempt generally the distribution of medical marijuana from the federal drug laws.

D. Whether the Preliminary Injunction Should Be Granted.

For the foregoing reasons, the Court concludes that the federal government has established that it is likely to prevail on the merits of its claim that defendants are in violation of federal law. As set forth above, in a statutory enforcement action brought by the federal government, irreparable harm is presumed if the government establishes that it is likely to prevail on the merits. Nutri-cology, 982 F.2d at 398 ("further inquiry into irreparable injury is unnecessary"); see also id. ("the passage of the statute is itself an implied finding by Congress that violations will harm the public").

Defendants argue that injunctive relief is nonetheless unwarranted because this Court is sitting as a court of equity and must therefore consider the traditional defenses to the granting of equitable relief, including the unclean hands of the moving party. They contend that these principles, plus the fact that the federal government is seeking injunctive relief at all, require the denial of injunctive relief.

1. The Propriety of Seeking Injunctive Relief.

The government rarely seeks injunctions pursuant to 21 U.S.C. § 882(a). The Court has located only five published opinions in which the federal government sought relief based on the statute. See, e.g. United States v. Leasehold Interest in 121 Nostrand Avenue, 760

F.Supp. 1015, 1035 (E.D.N.Y. 1991); United States v. Williams, 416 F.Supp. 611, 614 (D.D.C. 1976). At oral argument, and in their supplemental memoranda, defendants insist that the federal government has chosen to bring a civil injunctive action rather than charge defendants with a violation of the criminal laws, in order to deprive defendants of the same right to a jury trial to which they would be entitled in a criminal action.

Defendants do not contend that the government is attempting to deprive them of a right to a jury in general. 21 U.S.C. § 882(b) provides that "[i]n case of an alleged violation of an injunction or restraining order issued under this section, trial shall, upon demand of the accused, be by a jury in accordance with the Federal Rules of Civil Procedure." 21 U.S.C. § 882(b) (emphasis added). If the Court issues an injunction, defendants have a right to a jury in any proceeding in which it is alleged that they have violated the injunction. Defendants instead contend that a jury trial in accordance with the Federal Rules of Civil Procedure will provide them with fewer procedural protections than a criminal trial. For example, in civil proceedings a party may make a motion for summary judgment; no such procedure, however, is available in a criminal trial; and in a civil proceeding, under Federal Rule of Civil Procedure 48, a jury may be composed of six persons, whereas in a criminal trial a defendant is guaranteed a trial by a jury of twelve.

These procedural differences do not compel a conclusion that the federal government is acting in bad faith. First, in any contempt proceeding, the Court will determine the appropriate number of jurors, up to twelve, which still must return a unanimous verdict. See Fed.R.Civ.P. 48 ("[u]nless the parties otherwise stipulate, (1) the verdict shall be unanimous"). Second, even assuming that the federal government could bring a motion for summary judgment in a contempt proceeding -- and it is not clear from the plain language of section 882(b) that it could -- summary judgment may be granted, and a party denied the right to a jury, only if no reasonable jury could find for the nonmoving party. See Matsushita Elec. Ind. Co. v. Zenith Radio, 475 U.S. 574, 587 (1986).

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b. Unclean Hands

The "clean hands" doctrine

> insists that one who seeks equity must come to the court without blemish. . . . This maxim "is a self-imposed ordinance that closes the doors of a court of equity to one tainted with an inequitableness or bad faith relative to the matter in which he seeks relief, however improper may have been the behavior of the defendant." . . . This rule applies to the government as well as to private litigants. . .

Equal Employment Opportunity Comm'n v. Recruit U.S.A., 939 F.2d 746, 752 (9th Cir. 1991) (citations omitted). Defendants contend that the federal government comes before this Court with unclean hands because it refuses to acknowledge that marijuana has a medical use and reschedule it as a Schedule II controlled substance which would permit seriously ill patients to be treated with marijuana.

The federal government's conduct is "unclean," defendants assert, because the federal government itself has commissioned studies which have established marijuana's medical efficacy and then ignored these studies. Defendants highlight the fact that while the federal government continues to maintain that there are no medically accepted uses for marijuana, the DEA is simultaneously distributing marijuana to eight people under the Investigative New Drug program for medical purposes. Those eight people were enrolled years ago, defendants submit, before the "war on drugs," and the DEA has refused to enroll any more patients, not because of concerns as to the safety of marijuana, but for political reasons. Defendants also point out that in 1970, Congress appropriated a million dollars for a commission to recommend appropriate marijuana legislation. Public Law 91-513, § 601(e)(Oct. 27, 1970). The commission, known as the "Shafer Commission," recommended decriminalizing possession and casual distribution of small amounts of marijuana. See Marihuana: A Signal of Misunderstanding: First Report of the National Commission on Marihuana and Drug Abuse, 152 (1972). Congress, however, refused to reschedule marijuana. Finally, defendants argue that the DEA ignored the recommendation of its own Administrative Law Judge that marijuana be changed to a Schedule II controlled substance See Defendants' Supplemental Opposition Memorandum at 23.

The federal government disputes that the Shafer Commission recommended decriminalizing marijuana. Rather, it contends the Commission merely recommended increased support for studies to evaluate the efficacy of medical marijuana. See First Report, supra, at 176.

The fact remains, however, that medical marijuana advocates have been unsuccessful in convincing the federal government decision makers that marijuana should be reclassified as a Schedule II controlled substance and thus made available to seriously ill patients upon a physician's recommendation. That does not mean that the federal government has acted with unclean hands. Indeed, as late as 1994, a federal court of appeal affirmed the Drug Enforcement Agency Administrator's decision not to reschedule. See Alliance for Cannabis Therapeutics v. Drug Enforcement Administrator, 15 F.3d 1131 (D.C. Cir. 1994).

The federal government has advised the Court that a petition for reclassification has been filed and that on December 17, 1997, the DEA referred the petition to the Secretary of Health and Human Services ("HHS") upon determining that the petition raised scientific and medical issues that had not previously been evaluated by HHS as part of any prior scheduling action. See Federal Government's Post-Hearing Memorandum at 13. One would expect the Secretary to act expeditiously on the petition in light of the expressed concerns of the citizens of California.

CONCLUSION

Because of the Supremacy Clause of the United States Constitution, the only issue before the Court is whether defendants' conduct violates federal law. The Court concludes that the federal government has established that it is likely that it does. As these lawsuits are brought to enforce a statute, namely, the Controlled Substances Act, irreparable harm is presumed and the injunction must be granted.

Once again, however, the Court must caution as to what this decision does not do. The Court has not declared Proposition 215 unconstitutional. Nor has it enjoined the possession of marijuana by a seriously ill patient for the patient's personal medical use upon a physician's recommendation. Nor has the Court foreclosed the possibility of a medical

necessity or constitutional defense in any proceeding in which it is alleged a defendant has violated the injunction issued herein.

Finally, the San Francisco District Attorney has raised the issue of possible local governmental distribution of medical marijuana. Such a question is not before the Court and, in any event, is purely speculative as it is uncertain whether the federal government would even seek to enjoin such conduct by a local government entity under strictly controlled conditions. For example, as the San Francisco District Attorney mentioned at oral argument, the distribution of clean needles to heroin addicts violates federal law, see 21 U.S.C. § 863, yet the federal government has not filed suit to enjoin the City and County of San Francisco's distribution of such needles. Indeed, HHS recently stated that community programs promoting the distribution of clean needles reduces the spread of AIDS and does not encourage drug use. See Health and Human Services Press Release, "Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use" (April 20, 1998). From this publicly stated position, one could conclude that the federal government will not enforce the drug paraphernalia statute in light of local community efforts to prevent the spread of AIDS. The Court recognizes that local governmental distribution of medical marijuana to seriously ill patients raises political issues which may not require judicial intervention.

Attached to this Memorandum and Order is a proposed form of preliminary injunction in 98-00085. The injunction in each case will be identical except for the name of the defendants and the location of the dispensary. The parties are directed to file a written submission with this Court by 5:00 pm on Monday, May 18, 1998 as to the form of the order. The Court will issue the preliminary injunction shortly thereafter.

IT IS SO ORDERED.

Dated: May 13, 1998

CHARLES R. BREYER
UNITED STATES DISTRICT JUDGE

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS	Nos. C 98-0085 CRB RELATED C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0089 CRB C 98-0245 CRB PLAINTIFF'S RESPONSE TO MEMORANDUM OPINION AND ORDER Hearing Held: March 24, 1998 Hon. Charles R. Breyer

RESPONSE

The United States is in general agreement with the [Proposed] Order set forth by the Court in its Memorandum Opinion and Order of May 13, 1998, with the following modifications.

1. Any order issued by the Court should expressly provide that the injunction extends to successors of enjoined parties. Such a provision is necessary because, as the Second Circuit has recently held, "an organization and its agents may not circumvent a valid court order merely by making superficial changes in the organization's name or form, and in appropriate circumstances a

court is authorized to enforce its order against a successor of the enjoined organization." People v. Operation Rescue Nat'l, 80 F.3d 64, 70 (2d Cir.), cert. denied, 117 S. Ct. 85 (1996). Moreover, as the Second Circuit indicated, such a provision is allowed for under Rule 65(d) of the Federal Rules of Civil Procedure. See, e.g., Golden State Bottling Co. v. NLRB, 414 U.S. 168, 179 (1973); Regal Knitwear Co. v. NLRB, 324 U.S. 9, 14 (1945); Walling v. James V. Reuter, Inc., 321 U.S. 671, 674 (1944); E. & J. Gallo Winery v. Gallo Cattle Board, 967 F.2d 1280, 1298 (9th Cir. 1992); Interstate Commerce Comm'n v. Rio Grande Growers Coop, 564 F.2d 848, 849 (9th Cir. 1977).

We therefore propose that the injunction and order issued by the Court include the following language:

> "Pursuant to Fed. R. Civ. P. 65(d), this injunction shall bind the defendants, their officers, agents, servants, employees, successors, and attorneys, and upon those persons in active concert or participation with them who receive notice of the order by personal service or otherwise."

We have no objection to paragraph 4 of the Court's [Proposed] Order.

2. Following entry of this Court's Memorandum Opinion and Order on May 13, 1998, at least two defendants have stated that the defendant cannabis clubs which they are associated with would violate any injunction issued by the Court, with no apparent modification to their unlawful practices. See, e.g., *Pot Clubs Vow to Defy Judge's Order Citing Federal Laws, Court Is Demanding They Stop Giving out Medical Marijuana*, San Francisco Examiner, May 15, 1998 (attached as Exhibit 1 to Declaration of Mark T. Quinlivan ("Quinlivan Dec.")); *Federal Judge Orders 6 Cannabis Clubs Closed*, Los Angeles Times, May 15, 1998 (attached as Exhibit 2 to Quinlivan Dec.). Defendant Dennis Peron has stated that, "[w]e're allowed to argue the medical necessity defense if we break the injunction, *which we plan to do*." See Exhibit 1 to Quinlivan Dec. (emphasis supplied). Likewise, defendant Jeffrey Jones has stated that, "[w]e have no plans to shut our agency down." See Exhibit 2.

Under these circumstances, this Court should adopt the approach taken by the Eastern District of Pennsylvania in United States v. Roach, 947 F. Supp. 872 (E.D. Pa. 1996). In that case, like here, the court was faced with the threat that the defendants would violate any injunction that it issued. The court therefore included language in the preliminary injunction making clear that "disobedience of the Preliminary Injunction or resistance to this Court's order may subject any Defendant or person within the scope of this Preliminary Injunction to criminal or civil prosecution for contempt of Court and the imposition of such sanctions as the Court deems proper. These sanctions may include incarceration or detention, the posting of a bond, monetary penalties, payment of damages to [the plaintiff] or aggrieved persons, payment of reasonable attorney's fees and costs to plaintiff, and other sanctions deemed appropriate by the Court." Id. at 878. The court further provided that: "The United States Marshall Service is empowered to enforce this Preliminary Injunction." Id. See also 28 U.S.C. §§ 566(a), (c) (United States Marshal is to enforce, inter alia, orders issued by federal courts); United States v. Krapf, 285 F.2d 647, 649 (3d Cir. 1960) (duties of United States Marshal "include both the execution of the lawful process and orders of the courts of the United States and the general enforcement, maintenance and administration of federal authority").

Accordingly, we propose that the Court include the following language in its Preliminary Injunction:

> "Disobedience of the Preliminary Injunction or resistance to this Court's order may subject any Defendant or person within the scope of this Preliminary Injunction to prosecution for contempt of Court and the imposition of such sanctions as the Court deems proper. The United States Marshal is empowered to enforce this Preliminary Injunction including, but not limited to, effectuating closure of the defendant cannabis clubs."

3. Finally, this Court should enter a separate order denying the defendants' motions to dismiss for lack of jurisdiction or for abstention, and ordering the defendants' to answer the government's complaints within 20 days of entry of the Preliminary Injunction.

Respectfully submitted,

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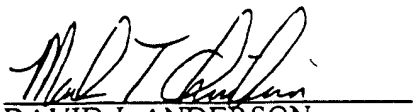
Deputy Assistant Attorney General



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UNITED STATES OF AMERICA

Dated: May 18, 1998

CERTIFICATE OF SERVICE

I, Mark T. Quinlivan, hereby certify that on this 19th day of May, 1998, I served a copy of the foregoing Plaintiff's Response to Memorandum Opinion and Order, and the Declaration of Mark T. Quinlivan; by overnight delivery, upon the following counsel specially appearing for defendants:

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UNITED STATES DISTRICT COURT
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SAN FRANCISCO HEADQUARTERS

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS	Nos. C 98-0085 CRB RELATED C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0089 CRB C 98-0245 CRB DECLARATION OF MARK T. QUINLIVAN Hearing Held: March 24, 1998 Hon. Charles R. Breyer

I, MARK T. QUINLIVAN, do hereby declare and say:

1. I am a Trial Attorney with the Federal Programs Branch, Civil Division, United States Department of Justice, and am counsel of record for the plaintiff in the above-captioned related actions. I make this declaration based on personal knowledge, and on information made available to me in the course of my official duties.

2. Attached hereto as Exhibit 1 is a true and correct copy of an article entitled *Pot Clubs Vow to Defy Judge's Order Citing Federal Laws, Court Is Demanding They Stop Giving out Medical Marijuana*, which appeared on May 15, 1998, in the San Francisco Examiner.

3. Attached hereto as Exhibit 2 is a true and correct copy of an article entitled *Federal Judge Orders 6 Cannabis Clubs Closed*, which appeared on May 15, 1998, in the Los Angeles Times.

I declare under penalty of perjury that the foregoing is true and correct.

MARK T. QUINLIVAN

Executed this 18th day of May 1998

EXHIBIT 1

5/15/98 SFEX A8
5/15/98 S.F. Examiner A8
1998 WL 5184628
(Publication page references are not available for this document.)

San Francisco Examiner

Friday, May 15, 1998

NEWS

Pot clubs vow to defy judge's order Citing federal laws, court is demanding they stop giving out medical marijuana

Ray Delgado
EXAMINER STAFF

Another crushing blow for proponents of medical marijuana, another defiant pledge to keep going.

But keeping the doors open to four pot clubs across Northern California isn't going to be so easy in the wake of the strongest legal setback yet delivered by a federal judge.

On Thursday, U.S. District Court Judge Charles Breyer sided with the federal government's argument that the Cannabis Healing Center and three other clubs in Northern California are violating federal drug laws and he ordered the clubs shut down.

The preliminary injunction goes into effect once Breyer reviews arguments from both parties and signs the injunction, which could occur as early as Monday afternoon. What happens after that will be up to the clubs.

"It's the saddest day for medical marijuana that I can envisage," said Tony Serra, an attorney for local club founder Dennis Peron. "I believe Judge Breyer's decision is morally bankrupt."

Several of the clubs, including the S.F. operation, have

vowed to defy the injunction and risk a raid by federal marshals if Breyer then holds them in contempt and orders them forcibly shut down.

But Breyer could also allow the clubs to remain open while ordering a contempt hearing. That trial would allow the defense to present a number of legal challenges that could keep the clubs open.

"We're allowed to argue the medical necessity defense if we break the injunction, which we plan to do," said Peron, who predicted that his act of defiance would be followed by undercover federal marshals trying to purchase marijuana with a doctor's note next week.

Breyer's ruling expressly avoided deciding on the legality of a sick person possessing pot for medical use or the possibility that local governments might take over the distribution of medical marijuana, an idea floated by San Francisco District Attorney Terence Hallinan. California's Proposition 215, passed by voters in 1996, legalized the cultivation and medical use of marijuana by patients with AIDS, cancer, glaucoma and a variety of other illnesses.

The Justice Department filed civil suits in January seeking to halt operations of six clubs: Peron's Cannabis Cultivators Club and Flower Therapy Medical Marijuana Club in San Francisco, and similar operations in Oakland, Santa Cruz, Ukiah and Fairfax. The Flower Therapy and Santa Cruz clubs have since closed and the Cannabis Cultivators Club renamed itself the Cannabis Healing Center.

The other 11 clubs in the state, including major ones in Los Angeles and San Jose, were not named in the suits but could now become targets.

U.S. Attorney Michael Yamaguchi hailed Breyer's decision and asked the clubs to close down voluntarily.

"Federal law is clear and Judge Breyer's opinion is clear - the distribution or cultivation of marijuana is unlawful," Yamaguchi said. "I call on all of the marijuana distribution clubs in California to take

cognizance of this order and voluntarily shut down."

Also praising the decision was state Attorney General Dan Lungren, a leader in the effort to shut the clubs down through legal challenges and enforcement efforts soon after they opened.

"We're pleased by the court's decision," said Matt Ross, spokesman for Lungren's office. "It's consistent with what we have always held, which is that cannabis buyers' clubs are not allowed under state or federal law."

Ross said the attorney general's office would continue to fight in state Superior Court for a preliminary injunction to close down the Cannabis Healing Center.

Organizers at three of the four cannabis clubs mentioned in the decision vowed to defy the order while the director of the fourth one, the Ukiah Cannabis Buyer's Club, said he was still weighing the risks.

"We're looking at alternatives and seeing what we can do," said Marvin Lehrman, director of the Ukiah club, which treats 200 patients regularly. "It's a daily feeling we have that we're facing down the federal government and they can come at any moment. I see them as being heavy-handed and mean-spirited, but I'm not afraid of them."

Oakland Cannabis Club Executive Director Jeff Jones said he would defy the order and was awaiting his day in court.

"What we're doing here is a necessity to patients," Jones said. "Because of Prop. 215, we feel that what we're doing here is within the law."

Robert Raich, attorney for the Oakland club, said the judge's decision opened up a variety of legal avenues to pursue in defense of the clubs, most notably arguing that marijuana is a medical necessity for sick patients and that citizens have constitutional rights to be free from pain and to dictate their own medical treatment.

Those arguments would be heard before a jury and must be

either accepted or rejected unanimously, a chance Peron is willing to take.

"We believe we can defend ourselves," Peron said. "If we do so successfully, we'll bring this issue into the national arena. We're going to have our day in court."

---- INDEX REFERENCES ----

KEY WORDS: COURT ORDERS; FEDERAL COURTS; MARIJUANA; ORGANIZATIONS; DRUG LAWS

EDITION: FIRST

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EXHIBIT 2

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Los Angeles Times

Friday, May 15, 1998

Metro Desk

California and the West Federal Judge Orders 6 Cannabis Clubs Closed

MARY CURTIUS
TIMES STAFF WRITER

SAN FRANCISCO -- A federal judge ordered six Northern California cannabis clubs to shut down Thursday after finding them in violation of federal law for selling marijuana to patients with AIDS and other illnesses.

The ruling prompted the U.S. Justice Department to urge other California cannabis clubs to close their doors too.

"Federal law is clear, and [U.S. District] Judge [Charles] Breyer's opinion is clear--the distribution or cultivation of marijuana is unlawful," Michael Yamaguchi, the U.S. attorney for the state's Northern District, said in a statement.

Breyer issued the first federal court ruling in the wake of California's much-disputed medical marijuana law, finding that pot is an illegal drug under federal law and that federal law supersedes the initiative passed by state voters.

Breyer ordered the Northern California clubs to close by Monday.

But operators of the two largest clubs vowed to defy the judge and keep selling pot.

"We have no plans to shut our agency down," said Jeff Jones, director of the Oakland Cannabis Buyers Co-operative.

Dennis Peron, spokesman for the San Francisco Cannabis Healing Center, said he looks forward to being held in contempt of court.

"Then, at last, we will finally get out in front of a jury. It is our chance to reach out to the common people," said Peron, a Republican candidate for governor.

There are about a dozen cannabis clubs across the state selling marijuana to thousands of people with AIDS, cancer and other illnesses. The largest Southern California club, the Cannabis Resource Center, is in West Hollywood.

Thom Mrozek, spokesman for the U.S. attorney in Los Angeles, said prosecutors will review the judge's ruling to see if it affects Southern California clubs. Mrozek said the office has not filed lawsuits against any Southland club.

"I'm sure they will go after the rest of the clubs now," said Peter Baez, former director of the Santa Clara cannabis club.

That club, once touted as a model by Santa Clara County officials, closed this month after Baez was arrested on suspicion of selling marijuana to someone who did not have a doctor's recommendation. Baez is now facing several felony drug counts.

"The government made the Northern California clubs their test case because it is the main stomping ground for medical marijuana," Baez said. "They figured that if they could be victors over those clubs, the rest will be easy targets."

In his ruling, Breyer said Proposition 215, passed by California voters in 1996, could not take precedence over federal drug laws. The judge rejected the arguments of club operators who said they are entitled to furnish the drug because their customers cannot survive without marijuana to ease pain and the side effects of therapy.

Breyer said a "medical necessity" defense might be available in individual cases, but can't be used by a club that distributes marijuana to many patients with different diseases.

"A state law which purports to legalize the distribution of marijuana for any purpose . . . even a laudable one . . . directly conflicts with federal law," the judge wrote.

Proposition 215 allowed patients with certain serious illnesses to possess marijuana for medical use.

The initiative said patients who have a doctor's recommendation, or the patients' caregivers, could grow and use marijuana for treatment. Some advocates for medical marijuana say that eating or smoking the drug quells nausea and combats wasting sickness common to AIDS sufferers by improving their appetites.

Despite the initiative, the state attorney general's office has opposed the operation of medical marijuana clubs and has mounted legal battles against Peron's and others.

In January, federal prosecutors filed civil lawsuits to halt operation of six clubs--two in San Francisco and one each in Oakland, southern Marin County, Santa Cruz and Ukiah. Two clubs, one in San Francisco and another in Santa Cruz, have since closed.

---- INDEX REFERENCES ----

KEY WORDS: COURT RULINGS; MARIJUANA; CLUBS; MEDICAL TREATMENTS; BUSINESS CLOSINGS; PROPOSITION 215 (MARIJUANA DECRIMINALIZATION)

NEWS SUBJECT: Health; Metro Section (HLT MTR)

STORY ORIGIN: SAN FRANCISCO

EDITION: HOME EDITION

Word Count: 636
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END OF DOCUMENT

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

OAKLAND CANNIBAS BUYERS' COOPERATIVE and JEFFREY JONES,

Defendants.
_____/

No. C 98-00088 CRB

PRELIMINARY INJUNCTION ORDER

For the reasons stated in its Memorandum and Order dated May 13, 1998, it is hereby ORDERED as follows:

1. Defendants Oakland Cannibas Buyers' Cooperative and Jeffrey Jones are hereby preliminarily enjoined, pending further order of the Court, from engaging in the manufacture or distribution of marijuana, or the possession of marijuana with the intent to manufacture and distribute marijuana, in violation of 21 U.S.C. § 841(a)(1); and

2. Defendants Oakland Cannibas Buyers' Cooperative and Jeffrey Jones are hereby preliminarily enjoined from using the premises at 1755 Broadway, Oakland, California for the purposes of engaging in the manufacture and distribution of marijuana; and

3. Defendant Jeffrey Jones is hereby preliminarily enjoined from conspiring to violate the Controlled Substances Act, 21 U.S.C. § 841(a)(1) with respect to the manufacture or distribution of marijuana, or the possession of marijuana with the intent to manufacture and distribute marijuana.

4. It shall not be a violation of this injunction for defendants to seek and obtain legal advice from their attorneys.

5. Pursuant to Federal Rule of Civil Procedure 65(d), this injunction shall bind the defendants, their officers, agents, servants, employees, successors, and attorneys, and those persons in active concert or participation with them who receive notice of the order by personal service or otherwise.

IT IS SO ORDERED.

Dated: May 19, 1998

CHARLES R. BREYER
UNITED STATES DISTRICT JUDGE

United States District Court
For the Northern District of California

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Attorneys for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS.	Nos. C 98-00085 CRB C 98-00086 CRB C 98-00087 CRB C 98-00088 CRB C 98-00089 CRB C 98-00245 CRB ANSWER TO COMPLAINT BY DEFENDANTS OAKLAND CANNABIS BUYERS' COOPERATIVE AND JEFFREY JONES DEMAND FOR JURY TRIAL

Defendants OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES (hereinafter "Defendants") reply to plaintiff's Complaint for Declaratory Relief, and Preliminary and Permanent Injunctive Relief as follows:

1. Defendants admit that plaintiff purports to bring a legal action under sections of the Controlled Substances Act, 21 USC § 801, *et seq.*, but Defendants deny the remaining allegations set forth in Paragraph 1.

2. Defendants deny the Court has jurisdiction under 28 USC § 1355(a). Defendants

admit that plaintiff has pleaded claims under theories alleged in Paragraph 2, that this Court has jurisdiction over the claims alleged, and that venue lies in this district. Notwithstanding the foregoing, Defendants deny that plaintiff's claims for relief have any merit whatsoever.

3. Defendants admit the allegation set forth in Paragraph 3.

4. Defendants admit the allegations set forth in Paragraph 4.

5. Defendants admit the allegations set forth in Paragraph 5.

6. Defendants admit the allegations set forth in Paragraph 6.

7. Defendants admit the allegations set forth in Paragraph 7.

8. Defendants deny the allegations set forth in Paragraph 8 to the extent the quoted language is taken out of context. Defendants specifically deny that the findings excerpted in Paragraph 8 represent all of the Congressional findings in 21 USC § 801 that are pertinent to this action.

9. Defendants admit the allegations set forth in Paragraph 9.

10. Defendants admit the allegations set forth in Paragraph 10.

11. Defendants admit the allegations set forth in Paragraph 11.

12. Defendants admit the allegations set forth in Paragraph 12.

13. Defendants admit the allegations set forth in Paragraph 13.

14. Defendants admit the allegations set forth in Paragraph 14.

15. Defendants admit the allegations set forth in Paragraph 15.

16. Defendants admit the allegations set forth in Paragraph 16.

17. Defendants admit the allegations set forth in Paragraph 17.

18. Defendants deny the allegations set forth in Paragraph 18.

19. Defendants deny the allegations set forth in Paragraph 19.

20. Defendants deny the allegations set forth in Paragraph 20.

21. Defendants deny the allegations set forth in Paragraph 21.

22. Defendants deny the allegations set forth in Paragraph 22.

23. In answer to Paragraph 23, Defendants incorporate by reference their responses to Paragraphs 1 through 22.

24. Defendants deny the allegations set forth in Paragraph 24.

25. Defendants deny the allegations set forth in Paragraph 25.

26. In answer to Paragraph 26, Defendants incorporate by reference their responses to Paragraphs 1 through 25.

27. Defendants deny the allegations set forth in Paragraph 27.

28. Defendants deny the allegations set forth in Paragraph 28.

29. In answer to Paragraph 29, Defendants incorporate by reference their responses to Paragraphs 1 through 28.

30. Defendants deny the allegations set forth in Paragraph 30.

31. Defendants deny the allegations set forth in Paragraph 31.

FIRST AFFIRMATIVE DEFENSE

The Complaint fails to state a claim against Defendants upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

Plaintiff's claims are barred by the doctrine of unclean hands.

THIRD AFFIRMATIVE DEFENSE

Plaintiff's claims are barred by the doctrine of laches.

FOURTH AFFIRMATIVE DEFENSE

Plaintiff's claims are barred by the doctrines of waiver and estoppel.

FIFTH AFFIRMATIVE DEFENSE

Plaintiff has suffered no damage whatsoever as a result of any conduct by Defendants.

SIXTH AFFIRMATIVE DEFENSE

Defendants' actions are lawful under the doctrine of necessity.

SEVENTH AFFIRMATIVE DEFENSE

The statutes and regulations upon which plaintiff relies are, as applied herein, in violation of the Commerce Clause of the United States Constitution.

EIGHTH AFFIRMATIVE DEFENSE

The statutes and regulations upon which plaintiff relies are, as applied herein, in violation of the Substantive Due Process rights of life, freedom from intractable pain, bodily integrity, and

access to medical treatment, as recognized by the United States Constitution.

NINTH AFFIRMATIVE DEFENSE

The statutes and regulations upon which plaintiff relies are, as applied herein, in violation of the rights afforded criminal defendants, as recognized in the Fourth, Fifth, and Sixth Amendments to the United States Constitution.

TENTH AFFIRMATIVE DEFENSE

Defendants' actions are not unlawful distribution, but rather constitute joint possession or joint use.

ELEVENTH AFFIRMATIVE DEFENSE

Defendants' actions are lawful as activities of ultimate users.

TWELFTH AFFIRMATIVE DEFENSE

Defendants' actions about which plaintiff complains are the result of entrapment.

THIRTEENTH AFFIRMATIVE DEFENSE

Defendants' actions cause no irreparable injury.

FOURTEENTH AFFIRMATIVE DEFENSE

The balancing of hardships tips in favor of Defendants' actions.

FIFTEENTH AFFIRMATIVE DEFENSE

Defendants' actions are lawful, as consistent with the public interest.

SIXTEENTH AFFIRMATIVE DEFENSE

Defendants' actions lawfully constitute the exercise of a fundamental right protected by the Ninth Amendment to the United States Constitution.

SEVENTEENTH AFFIRMATIVE DEFENSE

Defendants' actions lawfully constitute an exercise of power retained by the State of California, and by the people of the State of California, under the Tenth Amendment to the United States Constitution.

EIGHTEENTH AFFIRMATIVE DEFENSE

Any alleged act or omission giving rise to this action was committed or omitted without the knowledge of the Defendants.

NINETEENTH AFFIRMATIVE DEFENSE

Any alleged act or omission giving rise to this action was committed or omitted without the consent of the Defendants.

WHEREFORE, Defendants pray for judgment as follows:

1. That plaintiff take nothing by reason of its Complaint;

2. That the Complaint be dismissed with prejudice;

3. That no declaration issue finding Defendants in violation of the Controlled Substances Act;

4. That no permanent injunction issue;

5. That the Court award Defendants their costs incurred herein; and

6. That the Court order such other and further relief as it may deem just and proper.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Defendants demand a trial by jury of all issues properly tried to a jury.

Dated: June 18, 1998

ROBERT A. RAICH
Attorney for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES

PROOF OF SERVICE BY MAIL

I am employed in the City of Oakland, County of Alameda, am over the age of eighteen years, and am not a party to the within action. My business address is 1970 Broadway, Suite 1200, Oakland, California 94612. On the date this proof is signed, I mailed the attached:

ANSWER TO COMPLAINT BY DEFENDANTS OAKLAND CANNABIS BUYERS' COOPERATIVE AND JEFFREY JONES

by placing a true copy thereof in a sealed envelope, with postage fully prepaid, in the United States mail addressed to the following counsel:

United States of America

Mark T. Quinlivan
U.S. Department of Justice
901 E Street, N.W., Room 1048
Washington, D.C. 20530

Cannabis Cultivator's Club, et al.

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Brendan R. Cummings
Pier 5 North
San Francisco, California 94111

Marin Alliance for Medical Marijuana, et al.

William G. Panzer
370 Grand Avenue, Suite 3
Oakland, California 94610

Ukiah Cannabis Buyer's Club, et al.

Susan B. Jordan
515 South School Street
Ukiah, California 95482

David Nelson
106 North School Street
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Flower Therapy Medical Marijuana Club, et al.

Helen Shapiro
Carl Shapiro
404 San Anselmo Avenue
San Anselmo, California 94960

Santa Cruz Cannabis Buyers Club

Kate Wells
2600 Fresno Street
Santa Cruz, California 95062

///

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: June 18, 1998

Robert A. Raich