UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DR. MARCUS CONANT, *et al.*,	)	Case No. 00-17222
	)	
Plaintiffs-Appellees,	)	
	)	
v.	)	
	)	
EDWARD H. JURITH, *et al.*,	)	
	)	
Defendants-Appellants.	)	
___________________________________	)	

—

On Appeal from the United States District Court
for the Northern District of California
Honorable William H. Alsup, Case No. C 97-0139 WHA (WDB)

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CORPORATE DISCLOSURE STATEMENT

Neither Bay Area Physicians for Human Rights nor Being Alive: People with HIV/AIDS Action Coalition, Inc. has parent companies, subsidiaries, or affiliates that have issued shares to the public.

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JURISDICTIONAL STATEMENT

Plaintiffs-appellees agree with the jurisdictional statement of defendants-appellants, except that final judgment was entered on September 7 rather than September 8, 2000. SER 794.

ISSUE PRESENTED FOR REVIEW

Whether, in light of the federal threats against physicians who recommend (but do not prescribe) medical marijuana to patients, the district court properly enjoined the government from (i) revoking a physician's registration to prescribe controlled substances merely because the physician, based on a sincere medical judgment, recommends medical marijuana to a patient; and (ii) initiating any investigation of a physician based solely on that ground.

STATEMENT OF THE CASE

The plaintiff classes in this case include prominent and respected physicians and seriously ill patients suffering from cancer, AIDS, and other conditions, as well as a physicians' group and a patients' group. ER 99-118, 264. This lawsuit challenges the federal government's policy of forbidding any physician "recommendation" of marijuana – a term the government has construed to be so broad as to censor any meaningful discussion of marijuana between California physicians and patients. The challenged policy responded to the November 1996

approval by California voters of Proposition 215 (the Compassionate Use Act of 1996), which provides that state laws criminalizing marijuana possession and cultivation do not apply to seriously ill patients who have received the "recommendation" or "approval" of a physician. ER 98-99; Cal. Health & Safety Code §11362.5(d).

During several decades of widespread physician recommendations of medical marijuana, federal officials never punished a physician for such recommendations. Until shortly before the November 1996 election, no federal official had even threatened such action. On December 30, 1996, however, soon after Proposition 215 passed, the government issued an official response, which included a threat that recommending – not just prescribing – Schedule I controlled substances, *i.e.*, marijuana, "will lead to administrative action by the Drug Enforcement Administration to revoke the practitioner's registration." ER 166.

Plaintiffs filed this suit on January 14, 1997 (ER 1), and challenge the government's medical marijuana policy on two grounds. First, by threatening to enforce federal law in a manner that would punish physicians who seek to communicate with their patients, using their best medical judgment in the context of a bona-fide doctor-patient relationship, the government violated the First

Amendment's protection of freedom of speech. Second, defendants lack statutory authority for the policy. ER 133-34.

In April 1997, the Honorable Fern M. Smith issued a temporary restraining order and then a preliminary injunction against the government's policy of punishing physicians. SER 36-39; ER 91.

Subsequently, the Honorable William H. Alsup issued a final decision on cross-motions for summary judgment. ER 260. In that decision, the district court rejected the government's construction of the Controlled Substances Act ("CSA"), which read the CSA "to allow the Administrator of the Drug Enforcement Agency to revoke a physician's registration if he or she merely recommends marijuana to a patient." ER 275. In finding this construction untenable, the trial court relied on an extensive First Amendment analysis that showed "serious constitutional doubts" if the statute were given the construction urged by the government. ER 269, 276-82.

Accordingly, the district court permanently enjoined the government "from (i) revoking a class-member physician's DEA registration merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground." ER 283. The trial court further ordered that the "injunction applies whether or not the

physician anticipates that the recommendation will, in turn, be used by the patient to obtain marijuana in violation of federal law." *Id.*

STATEMENT OF FACTS

I. MEDICAL MARIJUANA IS A RECOGNIZED TREATMENT FOR CERTAIN PATIENTS AND SYMPTOMS.

A. The Plaintiffs In This Case.

We emphasize at the outset that, as the trial court recognized in granting the preliminary injunction, this case "is **not** about doctors prescribing, growing, or distributing marijuana," but rather "is about the ability of doctors, on an individualized basis, to give advice and recommendations to bona fide patients suffering from serious, debilitating illnesses regarding the possible benefits of personal, medical use of small quantities of marijuana." ER 52 (emphasis added). In short, the case concerns distribution of medical **information**, not distribution of drugs.

The named plaintiffs include the following distinguished physicians in California, among others: Dr. Marcus Conant directs the largest private HIV/AIDS practice in the country, has treated 5,000 persons infected with HIV, and is the author or co-author of more than 70 publications on the treatment of AIDS. SER 55, 56, ¶¶1, 5. Dr. Neil Flynn is a Professor of Clinical Medicine at the University

of California at Davis, an attending physician in the University's AIDS Clinic where he participates in the care of 1,500 AIDS patients, and the author of numerous publications on infectious diseases. SER 90, 91, ¶¶5, 6. Dr. Debasish Tripathy specializes in treating breast cancer, is an Assistant Clinical Professor of Medicine at the University of California at San Francisco, and actively conducts research into breast cancer treatment. SER 141, ¶¶2, 3.

The patient plaintiffs include Judith Cushner, the director of a pre-school program in San Francisco, who was diagnosed with breast cancer in 1989 at the age of 45. SER 73, ¶¶1-3. Ms. Cushner used small amounts of medical marijuana to relieve the nausea caused by her cancer treatments, thus enabling her to continue her treatment. SER 75-76, ¶¶10, 12. Plaintiff Keith Vines is an Assistant District Attorney who served as a drug prosecutor, and a decorated Air Force Officer. SER 148, 149, ¶¶1, 2, 4, 5. Mr. Vines has been HIV-positive since 1983, at one time lost more than 40 pounds due to his illness, and uses modest amounts of marijuana to stimulate his appetite and allow him to take the AIDS drugs that are essential to his survival. SER 151, 153-54, ¶¶11, 20.

B. Efficacy Of Medical Marijuana.

Advice and recommendations regarding medical marijuana have long been in the mainstream of medical practice in the United States. *See* Brief of *Amici*

American Public Health Association, *et al.* ("APHA Brief"). Based on research and experience, physicians have concluded that marijuana is an appropriate treatment for certain patients. Marijuana, of course, is not approved for physician **prescription**. But physicians recommend treatments ranging from vitamins to chicken soup to red wine (for cardiac health), none of which are federally approved prescription medications.

Marijuana's efficacy in treating certain conditions has been recognized by many sources, including a report of the government's own Institute of Medicine (in a study commissioned by the White House Office of National Drug Control Policy) and a report of the British House of Lords. *See* APHA Brief. The opinion of the *New England Journal of Medicine* is typical:

> The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana.

SER 780. A 1990 Harvard survey of more than 2,000 oncologists found that 44 percent had recommended marijuana to cancer patients undergoing chemotherapy. SER 30-35. A vast body of research supports the observations of clinicians concerning medical use of marijuana. SER 1-29.

C. <u>Use Of Medical Marijuana In Treating Certain Symptoms.</u>

1. Nausea And Vomiting.

Marijuana can be an especially effective treatment for nausea and vomiting in patients with cancer or AIDS. As Dr. Tripathy states: "The nausea and retching associated with chemotherapy [for cancer] are often disabling and intractable." SER 142, ¶5. Retching, which can last for days after treatment, can literally tear the esophagus and fracture ribs. Vomiting results in severe fluid loss. Because of chemotherapy's side effects, many cancer patients eat almost nothing because they cannot stand the sight or smell of food. In Dr. Tripathy's experience, with each successive treatment, these patients lose weight and strength. *See id.*

Several physician plaintiffs relate that, because of the severity of chemotherapy's side effects, some patients discontinue treatment, even though they know that ceasing treatment could lead to death. *See* SER 63, ¶19; SER 92, ¶8; SER 123, ¶7; SER 145, ¶13. Ms. Cushner describes her experience with breast cancer patients who "abandon[ed] medical procedures to find some relief" from the side effects and relates that to her knowledge "none of those women are alive today." SER 75-76, ¶10. Patients who do not respond to conventional drugs intended to prevent nausea and vomiting are particularly prone to abandon chemotherapy regimens. Doctors find that some patients cannot swallow or ingest

pills, for instance patients with cancer of the colon, stomach, or throat. *See* SER 123, ¶9; SER 142, ¶6. In such cases, medical marijuana may be the **only** effective form of treatment.

2. Wasting Syndrome.

Patients with AIDS, while benefitting tremendously from new drug therapies, face a barrage of side effects caused by those medicines. AIDS, and some of the medications often used to treat it, cause severe nausea, making it difficult to swallow and retain pills. SER 85-86, ¶13. Patients are required to eat, both to prevent weight loss and because some medications must be taken on a full stomach. SER 86, ¶14; *see also* SER 215, ¶4. The nausea and vomiting can be so severe that plaintiff physician Milton Estes observes that patients "have terminated potentially life-saving treatment because the side effects of their treatment seemed to them worse than the disease." SER 86, ¶15.

Many AIDS patients are also beset by "wasting syndrome," a condition characterized by severe progressive weight loss and breakdown of muscle tissue. As Mr. Vines relates, wasting syndrome can be devastating:

> I lost more than 40 pounds of lean body mass. My bones became brittle and my joints, for lack of nourishment, ached with pain. I tried to stay fit by exercising regularly. But nothing seemed to stave off my progressive deterioration.

SER 149, ¶7. Dr. Conant explains that wasting syndrome leads to other complications and often death because it "undermines both the immune system generally and a patient's ability to withstand the effects of other therapies." SER 57, ¶7. For patients who do not respond to or tolerate conventional prescription drugs, marijuana can be the **only** treatment that will stimulate appetite and alleviate nausea and vomiting, allowing the AIDS patient to become healthier. SER 59, ¶10; SER 119, ¶8; SER 133, ¶7; SER 137-38, ¶6.

3. Chronic Pain.

Marijuana can also be an effective medication in the field of pain care. Chronic, persistent pain is a disabling and often life-threatening condition, and alleviating pain is often a medical imperative, as pain specialists attest. SER 184-85, ¶12; SER 195, ¶6. Marijuana can be used to manage symptoms and side effects and to augment other analgesics. Opioids – the standard treatment for chronic and severe pain – induce nausea, vomiting, or retching in many patients, which in turn can lead to malnourishment, wasting, and a general decline in patient health. SER 186, ¶¶15-16; SER 196-97, 200, ¶¶10, 16; SER 208, ¶6.

When patients do not respond to traditional drugs, physicians have found that marijuana often can provide "immediate relief with significantly fewer adverse effects." SER 187, ¶19. Marijuana can also function as an analgesic or co-

analgesic for patients who do not respond to traditional pain therapies. SER 187-88, ¶20; SER 196-99, ¶¶10-14; SER 219, ¶15. Marijuana often has the added benefit of reducing a pain patient's opiate intake, thereby potentially lessening the effects of narcotic use. SER 202, ¶19. Both the Institute of Medicine and the British Medical Association have recognized the important roles that cannabinoids, a group of compounds found in marijuana, can serve in treating pain. SER 187-88, ¶20; SER 196-97, 201, ¶¶10, 18.

II. THE EFFECT OF CALIFORNIA PROPOSITION 215.

Against the backdrop of widespread recognition of the valuable uses of medical marijuana, California voters approved Proposition 215 in November 1996. The legal change was relatively modest. The Compassionate Use Act renders state laws prohibiting marijuana possession or cultivation inapplicable to seriously ill persons who have received the "recommendation" or "approval" of a physician for the medical use of marijuana. Cal. Health & Safety Code §11362.5(d). Under the Act, a "recommendation" does **not** provide a means for the patient to obtain marijuana and does **not** authorize or cause the distribution of marijuana.

The Act provides for no specific form that a "recommendation" must take. Both the Act and the analysis by the Legislative Analyst make clear that the physician recommendation can be oral or in writing, and that the Act does not

require a physician **prescription**. SER 663. Physicians routinely **recommend** treatments of various sorts by, for instance, expressing the opinion that a patient might benefit from more exercise, a healthier diet, or the use of complementary therapies such as acupuncture, various herbs, or other non-western medical treatments. In the ordinary course of providing medical advice just as they did prior to passage of Proposition 215, physicians provide recommendations that now by operation of state law make possession and cultivation laws inapplicable to patients. This occurs regardless of whether the physician intends to confer protection under Proposition 215 or even is aware of the law's existence.

A physician's recommendation or approval is not the equivalent of a prescription, which provides the patient with a written order to a pharmacy to dispense drugs. Proposition 215 does not treat medical marijuana like a standard medicine that a physician may well **both** recommend **and** prescribe; a physician recommendation or approval provides a patient not with a means of **obtaining** the drug, but merely with a means of establishing that the patient is exempt from state law penalties that apply to any other use of marijuana. The patient has sole responsibility for deciding whether or not to follow the physician's advice, and any decision to acquire marijuana rests entirely in the patient's hands. Most important, under Proposition 215, a recommendation, unlike a prescription, does not authorize

a pharmacy or anyone else to **provide** marijuana to the patient. Thus, Proposition 215 does not empower doctors to distribute drugs – only information.

The Drug Enforcement Administration ("DEA") has itself recognized this commonsense distinction between recommendations and prescriptions. In a letter to a member of Congress several months before passage of Proposition 215, then-DEA Administrator Thomas Constantine explained that the CSA prevents physicians from **dispensing** or **prescribing** marijuana, but not **recommending** it:

> Whether the proposed California referendum would permit a practitioner to act in contravention of Federal law, thereby putting his or her DEA registration in jeopardy is unclear. The referendum only authorizes a practitioner to "recommend" the use of marijuana by a patient. This is a term which is not found in the CSA, and is not defined in the referendum. **The CSA controls the manufacture, distribution and dispensing (which includes prescribing) of marijuana by a registrant, and does not address merely recommending its use.**

SER 668 (emphasis added).

III. THE GOVERNMENT'S RESPONSE TO PROPOSITION 215.

A. <u>Defendants Vigorously Oppose Proposition 215's Message.</u>

Proposition 215 deeply disturbed federal officials who feared two consequences from California's decision to chart a course different than federal law: (i) the potential for increased distribution of drugs, and (ii), most importantly, the initiative's effect upon federal efforts to convey a uniform message concerning

marijuana's dangers. On this latter point, federal officials feared that their educational efforts would be undermined by a message that marijuana has a legitimate role to play in providing care to seriously ill persons – a message conveyed both by highly respected physicians recommending the medical use of marijuana and by the initiative itself condoning the use of marijuana for medical purposes.

In its opening brief (at 4-9, 26-32), the government extensively discusses its fear that marijuana distribution would increase. There can be no doubt that the government is empowered to pursue the parts of its policy that target actual distribution, for instance, seizing imported marijuana and blocking domestic shipments of marijuana. *See* ER 166-67. Plaintiffs have never challenged the government's authority to take such steps.

It is the second concern that gave rise to this law suit: the government's fear of the message that would be sent by Proposition 215. Administrator Constantine, for instance, expressed the view that physician discussions of the medical benefits of marijuana undermine the federal message that marijuana is harmful:

> **[S]tarting in the early 1970s, when we tried to send consistent messages to people, and especially young people, of all of the dangers of marijuana as a substance**, both to them and their families and to their future, we now have a message being delivered to them that marijuana is a medicine. . . . **We could have a physician saying to a 16- or 15-year old**

> **kid, "We believe for your migraine headaches, marijuana might be an appropriate substance to be utilized."** . . . I mean, **the conflict in that message for vulnerable people at a vulnerable stage of their life is immense**.

SER 737 (emphases added). Federal officials were particularly concerned about the message sent by doctors, who are role models. SER 373:14-375:6; SER 508:5-10. In other words, the government was concerned about medical information provided by doctors precisely because it convincingly contradicted the government's preferred message that marijuana has no legitimate uses.

Defendants equally feared that the existence of Proposition 215 itself (with its attendant publicity) undermined the federal message on marijuana. Then-Director of the Office of National Drug Control Policy Barry McCaffrey testified to Congress: "The California and Arizona initiatives compete with anti-marijuana messages and can contribute to our youth reaching incorrect conclusions about this drug." SER 675; *see also* SER 426:21-427:3; SER 707. Administrator Constantine believed that "the problem" was "the discourse of the idea that it's not a dangerous substance, and that it cannot create a great deal of harm." SER 380:9-19. Then-Secretary of Health and Human Services Donna Shalala stated:

> Research tells us that the key to protecting young people from marijuana is clear and consistent anti-drug messages. . . . With its false and fraudulent messages that "marijuana is medicine" and "marijuana can be good for you," proposition 215 undermines these critical drug prevention efforts.

SER 683-84; *see also* SER 573:6-18; SER 679; SER 687; SER 693; SER 710; SER 761; SER 779; SER 782; SER 785.

B. <u>The Government's Policy With Respect To Proposition 215.</u>

Director McCaffrey considered Proposition 215 a "threat to the national drug strategy," that "strikes in the heart and soul of" the strategy. SER 767; SER 689. Government officials accordingly committed themselves to block the implementation or minimize the impact of the Proposition. An update circulated to officials working on a response to both Proposition 215 and Proposition 200, an Arizona drug initiative, states that opponents of the Propositions sought to "blunt the negative consequences, including obtaining the repeal, of Propositions 200 and 215." SER 761. This effort was not directed solely at preventing increased distribution of drugs. As an Assistant Attorney General put it: "The California and Arizona ballot initiatives send the wrong message at the wrong time, and we are working with other federal agencies and our state and local law enforcement partners to develop a strategy to counteract their impact." SER 766.

More specifically, a statement released by Director McCaffrey states: "The problem is, there will be a small group of doctors recommending marijuana to people." SER 707. Although it took some time to settle on threatening physicians as a means to deal with this "problem," Director McCaffrey early on recognized the

importance of physician recommendations. As he put it in an interview with A.M. Rosenthal of the *New York Times* just days after passage of Proposition 215, "some people are [going to recommend marijuana] and the real question is what are we going to do about them and the answer is, we don't know, but for sure we're not getting rolled on this." SER 700.

The government considered a range of options for responding to the Compassionate Use Act. SER 762-63. Given the infeasibility of all the other proposals, the government turned to taking action against physicians, and specifically to trying to suppress physician recommendations of medical marijuana by eliding the difference between recommendations and prescriptions.

On December 30, 1996, the administration produced an official policy entitled "The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200." ER 165-71. The Administration's Response featured first and most prominently threats against physicians, including:

> a practitioner's action of **recommending** or prescribing Schedule I controlled substances [*i.e.*, marijuana] is not consistent with the "public interest" (as that phrase is used in the Controlled Substances Act) and **will lead to administrative action by the Drug Enforcement Administration to revoke the practitioner's registration**.

ER 166 (emphases added). This threat is directly contrary to DEA's prior position that the CSA "does not address merely recommending [marijuana's] use." SER

668. The Administration's Response was announced at a televised press conference attended by three cabinet-level officials – Director McCaffrey, Secretary Shalala, and then-Attorney General Janet Reno. ER 153.

The government's policy constantly shifted and changed, and, in the district court's words, was marked by its "fickle iterations." ER 79. On February 27, 1997, the government issued a letter to Medical Leaders attempting to clarify its policy. The letter stated that a physician may "discuss[] with a patient the risks and alleged benefits of the use of marijuana," ER 175, yet only added to the confusion by failing to define or even mention the term "recommend" but ambiguously warning that "physicians may not intentionally provide their patients with oral or written statements in order to enable them to obtain [marijuana] in violation of federal law." ER 175.

Beyond the two "official" policy pronouncements of December 1996 and February 1997, various federal officials provided their own wide-ranging interpretations of the federal response. *Compare, e.g.*, SER 720 (Administrator Constantine stating to Congress that "those doctors who prescribe or recommend Schedule I substances are violating Federal law") *with* SER 165-66, ¶9 (Director McCaffrey's assurances to San Francisco Medical Society that government would not pursue most doctors who recommended medical marijuana).

Indeed, Director McCaffrey admits that he is "still puzzling" over the status of a recommendation, is "not sure what any of it means," is "not sure in isolation I know what a recommendation is," and "do[es]n't know what the recommendations mean." SER 441:18-442:3, 443:20-444:2, 451:17-18, 478:17-22.

After several contradictory attempts to define the policy during this litigation, defendants eventually settled upon an interpretation of the term "recommendation" of such astonishing breadth as to include any statement that might conceivably be construed as favoring the use of marijuana: "Where a physician advises, counsels, suggests, or 'urges as advisable or expedient' that a patient use marijuana for medical treatment, or presents marijuana 'as worthy of confidence, acceptance, use, etc.,' the physician has recommended marijuana." SER 788.

Prior to the injunction in this case, federal authorities began to enforce the government's policy. It is undisputed that DEA agents interrogated and searched the pharmacy records of a physician who allegedly wrote a single marijuana recommendation. ER 183; *see also* SER 127, ¶5.

III. DEFENDANTS' THREATS CAUSED PHYSICIANS TO CENSOR COMMUNICATIONS WITH PATIENTS, CREATING A RISK TO PATIENTS' LIVES AND WELL-BEING.

The federal government's threats against physicians for communicating medical judgments to patients are unprecedented. According to Dr. Estes, in three

decades of practice, "I have never been subjected to intimidation on the level of General McCaffrey's recent threats." SER 88, ¶20. Defendants' threats severely intimidated physicians. Dr. Flynn states:

> If I lost my Schedule II license [to prescribe drugs], my ability to provide care for people with AIDS – 80% of my patients – would be severely compromised. I write 30-50 narcotic prescriptions per month for my seriously ill patients. I would no longer be able to do so if my DEA license were revoked.

SER 94, ¶16.

Clinicians therefore began to censor the advice and information they offered to patients. As Dr. Estes explains: "As a result of the government's public threats, I do not feel comfortable even discussing the subject of medical marijuana with my patients." SER 83, ¶8; *see also* SER 272:12-22, 273:11-25. Other physicians testified in a similar manner. *See* SER 105-06, ¶15; SER 128, ¶10; SER 139, ¶10; SER 225:7-226:18; SER 234:7-21, 235:24-237:14, 239:20-240:20, 247:3-18, 248:3-7; SER 256:11-257:1, 258:17-259:5; SER 284:2-285:8; SER 295:17-296:5; SER 302:8-25, 303:12-304:14, 305:23-306:7, 309:22 to 310:13.

The government has stipulated that its policy affected physician speech. It is stipulated that prior to passage of Proposition 215, physicians had discussed and recommended the medical use of marijuana for certain patients. ER 180, ¶10. It is also stipulated that in reaction to the Administration's Response, a reasonable

physician would have a genuine fear of losing her DEA license if she recommended marijuana to patients. ER 181, ¶13. Moreover, it is stipulated that physicians have reacted to the Administration's Response by censoring their conversations with patients and withholding information, recommendations, or advice regarding use of medical marijuana. ER 180-81, ¶11.

Physicians' self-censorship in the face of government intimidation jeopardizes patient care. SER 576. The Brief of *Amici* California Medical Association, *et al.* ("CMA Brief"), examines this subject in depth. In brief, it is undisputed that for many patients, discussions with their physicians are the primary or only source of sound medical advice and information. ER 182, ¶17. As plaintiff physician Stephen O'Brien puts it, for patients "in the advanced stages of a life-threatening illness, information [a physician] can provide about medical marijuana can mean the difference between life and death." SER 133-34, ¶9. Some patients credit their ability to receive information about medical marijuana with saving their lives by allowing them to tolerate chemotherapy or AIDS medications. *See, e.g.*, SER 79-80, ¶¶22-23; SER 115-16, ¶11.

Self-censorship drives a wedge between physicians and patients, leaving a patient more likely to disregard critical medical advice. Plaintiff physician Stephen Follansbee explains: "If I decline to answer a patient's question [about marijuana], I

risk losing that patient's trust and confidence, sending the message that there are issues regarding that patient's health that are off-limits; that, at some level, I hold the patient's well-being subordinate to issues of politics." SER 106, ¶17. Similarly, physicians' self-censorship inhibits patient honesty. *See* SER 84, ¶9.

Among the undisputed consequences of the Administration's Response is that it has led some physicians to omit medically relevant information from patient medical records. ER 181, ¶12. In the words of Dr. Follansbee, [t]he government's gag on physicians discourages doctors from maintaining a comprehensive written record of the patient and the care she or he receives." SER 103, ¶9. It is undisputed that accurate charts are necessary to provide sound medical care to the patient in the future, and the failure to accurately chart a patient's care could jeopardize the patient's life and health. ER 182, ¶19.

The effects of the government's threats continued even after entry of the preliminary injunction. As Dr. Conant stated in his deposition:

> The first time I heard the General's response, I was frightened and felt that my ability to have open discussions with my patients in the privacy of an exam room, which I consider one of the most sacrosanct part of medicine, was being threatened.
>
> Now, I consider that it's being threatened, and the policy's so confusing, I have no idea what I can or cannot do.

SER 278:19-279:1.

SUMMARY OF ARGUMENT

The government admits that the First Amendment protects physicians who publish articles or speak on television advocating the medical use of marijuana. The government further recognizes that individuals suffering from cancer or AIDS have a right to read and receive this information. Defendants, however, stake out the extraordinary position that when one of these patients meets with a physician to seek treatment and request advice about the appropriateness of medical marijuana, the First Amendment poses no obstacle to forbidding the conversation.

In fact, First Amendment protection remains as robust in the examination room as in any other context regardless of whether the doctor's opinion is at odds with the government's official position. For both physicians and patients, a frank, open, and uncensored dialogue is essential to effective medical treatment. It is also essential to the free exchange of ideas, as informed by the particular expertise of the treating physician. The government's license revocation policy violates the First Amendment rights of both physicians and patients as it is unconstitutionally vague, thereby chilling all physician speech about marijuana; constitutes impermissible viewpoint discrimination by silencing a message specifically because it contradicts the government's preferred message about drugs; broadly restricts speech without a legitimate justification; and cannot be justified as responding to incitement or

criminal conduct. The government is free to pursue its drug policies by punishing illegal conduct – including the use, possession or distribution of marijuana – but the strong First Amendment interest in uncensored physician-patient speech mandates that the government not pursue its policy goals by interfering with physicians' medical advice simply because the government thinks it "sends the wrong message."

The government's other claims in this litigation are equally lacking in merit. As we demonstrate below, the CSA does not provide the statutory authority to regulate the speech at issue. Moreover, the scope of the injunction is warranted in order to provide protection against the government's threats to sanction physicians who use their best medical judgment in treating their patients.

ARGUMENT

I. THE GOVERNMENT'S PROHIBITION ON PHYSICIAN RECOMMENDATIONS OF MEDICAL MARIJUANA VIOLATES THE FIRST AMENDMENT.

A. Physician Medical Advice Is Protected By The First Amendment.

Through its policy of revoking the prescription licenses of physicians who recommend medical marijuana, the government seeks to prohibit certain forms of

communication in the medical examination room. Courts, however, have long recognized that the First Amendment protects speech between a physician and patient. In a context markedly similar to the present case, government officials once banned physician **distribution** of contraceptive devices, leading some zealous government officials to conclude they could also prohibit **recommending** the use of contraception. Justice Douglas' words on this subject apply equally to the controversy facing this Court:

> [The government] may not contract the spectrum of available knowledge. However noxious [a person's] ideas might have been to the authorities, the freedom to learn about them, fully to comprehend their scope and portent, and to weigh them against the tenets of the conventional wisdom, may not be abridged. Our system of government requires that we have faith in the ability of the individual to decide wisely, if only he is fully apprised of the merits of a controversy.

Eisenstadt v. Baird, 405 U.S. 438, 457-58 (1972) (Douglas, J., concurring) (citations omitted).

More recently, the Supreme Court confirmed the First Amendment protection afforded the physician-patient dialogue in the context of medical advice concerning abortion. *See Rust v. Sullivan*, 500 U.S. 173, 198-200 (1991). Although the Court in *Rust* ultimately held that the government may impose restrictions on physician speech when it enlists private speakers to convey its own

message, *see Rosenberger v. Rector and Visitors of Univ. of Va.*, 515 U.S. 819, 833 (1995); *Legal Services Corp. v. Velazquez*, ___ U.S.___, 121 S.Ct. 1043, 1048 (2001), the Supreme Court was clear that physicians in private practice have a First Amendment right to discuss abortion – or any other subject – with their patients. *Rust*, 500 U.S. at 198-200.[1]

Our history and tradition demonstrate an unswerving recognition of the sanctity of physician-patient dialogue. *See* CMA Brief; *see also Trammel v. United States*, 445 U.S. 40, 51 (1980) (discussing doctor-patient and lawyer-client testimonial privileges and noting they are "rooted in the imperative need for confidence and trust"). The highly personal and often controversial nature of the issues to be discussed makes it imperative that the government not be permitted to

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[1] *See also Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 776 F. Supp. 1422, 1428-29 n.9 (D. Guam 1990) (restrictions on physician speech "are constitutionally infirm insofar as they would make criminal any discussion between a woman and her doctor concerning the need for, and access to, an abortion"), *aff'd on other grounds*, 962 F.2d 1362 (9th Cir. 1992); *Planned Parenthood v. City of Wichita*, 729 F. Supp. 1282, 1288 (D. Kan. 1990) ("The physician counseling a pregnant woman enjoys a constitutional [First Amendment] right to dispense medical information on the basis of her individual circumstances"); *Meyer v. Massachusetts Eye & Ear Infirmary*, 330 F. Supp. 1328, 1331-32 (D. Mass. 1971) (doctor's allegation that hospital's policy prevents him from disclosing range of treatment options states cause of action under First Amendment); *New York v. Sullivan*, 889 F.2d 401, 414 (2d Cir. 1989) (Cardamone, J., concurring) (restrictions on physician speech would be invalid as applied to private physician); *Planned Parenthood v. Sullivan*, 913 F.2d 1492, 1503-04 (10th Cir. 1990).

prescribe an orthodoxy relating to the information and advice a physician provides a patient. The First Amendment protects the right of physicians to disagree with the government's orthodoxy and to make that disagreement known to their patients not just in the context of a general political discussion but in the more relevant context of providing sound medical advice. Regardless of official government policy on such sensitive questions as contraception, abortion, sexually transmitted diseases, or sexual practices, physicians must remain free to discuss these questions with their patients and to provide their patients with their considered medical opinions and recommendations free of government restrictions having nothing to do with medicine and everything to do with politics. The same is true of opinions, advice, and recommendations concerning the medical use of marijuana. That the government considers marijuana to have no currently accepted medical use does not change the right of doctors to express a contrary view.

Indeed, a physician precluded by government fiat from discussing medical marijuana cannot discharge the well established professional and ethical duties that **require** doctors to provide full, uncensored information about all treatment options. SER 665. This principle, with deep roots in the medical tradition, is grounded solidly in the common law. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990). Doctors in California, as in the majority of

states, risk liability if they fail to provide patients with all material information about their medical treatment options. *See Cobbs v. Grant*, 8 Cal.3d 229, 241-43 (1972); *Arato v. Avedon*, 5 Cal.4th 1172, 1186-87 (1993).

B. Patients Have A First Amendment Right To Receive Information.

Patients' interests in receiving information from physicians are also protected by the First Amendment, which secures not only a speaker's right to speak, but the audience's right to be spoken to. *First Nat'l Bank of Boston v. Bellotti*, 435 U.S. 765, 783 (1978); *Bd. of Educ. v. Pico*, 457 U.S. 853, 867 (1982). Government distortion of the doctor-patient dialogue therefore infringes the patient's right to receive uncensored medical information. *See Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 756-57 (1976).

Under the government's policy, instead of receiving reliable advice tailored to their own medical condition from a skilled physician, patients are left to educate themselves, with information gleaned from friends or the media, about the risks and benefits of medical marijuana. This tragedy of forcing patients to make critical medical choices in a government-induced informational vacuum is prohibited by the First Amendment's assurance that "freedom of speech may [not] be abridged [simply because] the speaker's listeners could come by his message by some other means." *Id.* at 757 n.15. Nor may the government justify restricting speech based

on some paternalistic notion that patients cannot make informed choices once they have been provided the relevant information. *See id.* at 769-70.

C. <u>The Government's License Revocation Policy Is Unconstitutionally Vague, Thereby Chilling Protected Speech.</u>

1. The Government's Policy Is Vague In Violation Of The First Amendment.

Statutes and governmental policies that govern conduct or expose those affected by them to sanction must satisfy certain basic principles of clarity. This is particularly true when First Amendment values are implicated. "Because First Amendment freedoms need breathing space to survive, government may regulate in the area only with narrow specificity." *NAACP v. Button*, 371 U.S. 415, 433 (1963). To this end, "we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). When policies have "uncertain meanings," affected persons will "steer far wider of the unlawful zone" than they would "if the boundaries of the forbidden areas were clearly marked." *Baggett v. Bullitt*, 377 U.S. 360, 372 (1964) (internal quotation marks omitted). But, "[f]ree speech may not be so inhibited." *Id.*

The government claims it does not seek to prohibit physician discussions, but its license revocation policy suffocates physicians by failing to distinguish

between permissible "discussions" and forbidden "recommendations" with the narrow specificity the Constitution requires. Originally, the government's official policy stated simply that "recommending . . . [marijuana] will lead to administrative action," without defining the term "recommend." ER 166. The government then issued a letter to Medical Leaders that pointedly omitted reference to the critical term "recommendation." ER 175. Making matters worse, as we showed above, various officials have provided their own contradictory interpretations of the policy. *See supra* at 17.

The government's ultimate definition of "recommendation" in the lower court encompassed a doctor who "suggests" the use of marijuana or "presents marijuana 'as worthy of confidence, acceptance, use, etc.'" SER 788. Under this definition, can a physician convey the simple, true proposition that anecdotal evidence suggests that marijuana can sometimes alleviate nausea – or does this present marijuana as "worthy of use"? In light of the government's sweeping prohibition, one struggles to imagine permissible "discussions" other than those parroting the federal view that marijuana can never serve any patient's medical needs.

In its brief to this Court, the government understandably ignores its earlier broad and vague definition of "recommendation." But even at this late date, the government cannot describe with clarity what physician speech will lead to

revocation proceedings. At one point, the government argues that "recommendation" is a term defined solely by California law, upon which the federal government now takes no position. Opening Brief at 23-24. In the next breath, the government maintains that its policy should **not** be interpreted to mean that "registration revocation proceedings would be commenced only where physicians make 'recommendations' within the meaning of California law." *Id.* at 37. Such inconsistency does not give physicians "a reasonable opportunity to know what is prohibited" under *Grayned*.

Worse still, the government paints a deceptive picture with its maneuver to dodge any responsibility for the vagueness of its policy by disclaiming "the asserted vagueness of a term that is not contained in federal law at all, but in Proposition 215." Opening Brief at 36. The Administration's Response, based upon the **federal** Controlled Substances Act, was issued by the Director of the Office of **National** Drug Policy "[a]t the direction of the **President**." ER 165 (emphasis added). This federal policy is at issue, not Proposition 215. California law does not restrict or regulate speech, and thus the heightened need for clear definition and certain boundaries on physician "recommendations" does not apply. As the basis for a potential defense or exemption under **state** criminal law, the term "recommend" is construed broadly to favor the criminal defendant on a case by

case basis. *See People v. Davis*, 29 Cal.3d 814, 828 (1981). In stark contrast, when the term "recommend" is adopted by the **federal** government as the touchstone of sanctionable speech, the Constitution requires "narrow specificity."

The First Amendment also requires regulations restricting protected speech to clearly delineate what a speaker is forbidden from communicating so that the speaker's liability is not contingent upon the meaning inferred by an audience or enforcement officials. Two important Supreme Court cases illustrate this principle. In *Buckley v. Valeo*, the Supreme Court considered the validity of a statute that placed a $1,000 annual limit on any person's "expenditure[s] . . . relative to a clearly identified candidate." 424 U.S. 1, 41 (1976). The Court construed the law to restrict only those expenditures that "in express terms advocate the election or defeat of a clearly identified candidate." *Id*. at 44. The "soft money" contributions left unregulated often do offer implicit endorsements of candidates and therefore are not inherently deserving of First Amendment protection (by the logic of *Buckley*), but in order to give meaningful protection to issue advocacy, the Court carved out a broader, bright line zone of protection.

Similarly, in *Thomas v. Collins*, the Court struck down a statute placing restrictions on soliciting workers for membership in a labor union because a speaker advocating only generally that workingmen should "unite for collective

bargaining" and avoiding the words "'solicit,' 'invite,' [and] 'join'" could not possibly avoid the idea of solicitation. 323 U.S. 516, 534 (1945).

> [T]he supposedly clear-cut distinction between discussion, laudation, general advocacy, and solicitation puts the speaker in these circumstances wholly at the mercy of the varied understanding of his hearers and consequently of whatever inference may be drawn as to his intent and meaning. Such a distinction offers no security for free discussion.

Id. at 535.

The blurred distinction between discussion and recommendation in the government's policy impermissibly places physicians in the same untenable position as the union official in *Thomas*. No physician could safely assume that a statement ("marijuana appears beneficial for you" or "marijuana is the most effective substance I know of to treat your condition") would not be understood by a patient (or an undercover DEA agent posing as a patient) as a prohibited "recommendation," leading to license revocation. The "supposedly clear-cut distinction" between discussion of marijuana and recommendation puts the physician wholly at the mercy of the varied understanding of others.

2. The Vagueness Of The Government's Policy Has Impermissibly Chilled Protected Speech.

The abundance of evidence documenting the extent to which physicians abandoned lawful speech in the wake of the government's revocation policy,

steering well clear of anything that could possibly be confused with a "recommendation," provides ample illustration of the policy's vagueness. Physician plaintiff Howard Maccabee left no doubt about the policy's effect: "when I receive an inquiry about medical marijuana I will avoid giving medical advice or recommendations that I would otherwise make, in order to avoid government sanction." SER 178, ¶5. Dr. Flynn explains that, in the face of ambiguities in the policy, some Sacramento area physicians "now absolutely refuse to discuss this subject with their patients for fear of federal sanctions," while others "will speak about it only in general terms but censor their speech when it comes to advising patients about marijuana." SER 170, ¶6. Still other physicians began omitting medically relevant information from patient medical records for fear that it would be evidence of a recommendation. ER 181. The San Francisco Medical Society received numerous inquiries from confused physicians asking what they "could and could not say to patients regarding medical marijuana," but could only respond that "the federal government's policy was opaque and that it was best to act with extreme caution." SER 163-64, ¶¶3-4.

Even the government concedes that physician speech is predictably chilled in this case. The government stipulated below that "a reasonable physician would have a genuine fear of losing his or her DEA registration" upon recommending

marijuana. ER 181, ¶13. The government also conceded that the policy has had a chilling effect on physician speech, as physicians "have reacted to the Administration's Response by censoring their conversations with patients, withholding information, recommendations or advice" regarding medical marijuana. ER 180-81, ¶11.[2]

Where "a statute's literal scope . . . is capable of reaching expression sheltered by the First Amendment, the [vagueness] doctrine demands a greater degree of specificity than in other contexts." *Smith v. Goguen*, 415 U.S. 566, 573 (1974). Physicians, like the government itself, are unable to determine the scope of the license revocation policy; that the result is the suppression of medical information "sheltered by the First Amendment" is not only dangerous for patients but violates the Constitution.

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[2] Given these concessions, the government's suggestion that this case is not justiciable must be rejected. Having acknowledged that physician speech is reasonably chilled by its policy, the government cannot seriously argue that a physician must step forward and be punished before relief can be granted. *See, e.g., Dombrowski v. Pfister*, 380 U.S. 479, 486 (1965) ("because of the sensitive nature of constitutionally protected expression, we have not required that all of those subject to overbroad regulations risk prosecution to test their rights"); *Bland v. Fessler*, 88 F.3d 729, 736- 37 (9th Cir. 1996) (quoting *Dombrowski*, 380 U.S. at 486) ("That one should not have to risk prosecution to challenge a statute is especially true in First Amendment cases, '[f]or free expression – of transcendent value to all society, and not merely to those exercising their rights – might be the loser.'").

D. **The Revocation Policy Is A Viewpoint-Based Restriction On Information Concerning The Medical Use Of Marijuana In Violation Of The First Amendment.**

There is a second, independent, reason for the policy's unconstitutionality: The government seeks to silence a viewpoint that contradicts its own. The policy singles out a specific message – that marijuana has medical benefits – and prohibits it in order to preserve the potency of the government's own anti-drug message. "It is axiomatic that the government may not regulate speech based on its substantive content or the message it conveys." *Rosenberger*, 515 U.S. at 828. That is, the government cannot limit speech "when the specific motivating ideology or the opinion or perspective of the speaker is the rationale for the restriction." *Id.* at 829. This is particularly true when the government is motivated by hostility to the opinion. *See Texas v. Johnson*, 491 U.S. 397, 414 (1989). "When the government targets not subject matter but particular views taken by speakers on a subject, the violation of the First Amendment is all the more blatant." *Rosenberger*, 515 U.S. at 829; *see also FCC v. League of Women Voters*, 468 U.S. 364, 383-84 (1984) ("A regulation of speech that is motivated by nothing more than a desire to curtail expression of a particular point of view on controversial issues of general interest is the purest example of a law . . . abridging the freedom of speech.") (internal quotation marks omitted; ellipses in original).

Evidence documenting that the government's threats against doctors emanate from a desire to protect the government's official message that marijuana is uniformly and always dangerous is overwhelming. *See supra* at 13-15. The government candidly acknowledges that the mere existence of Proposition 215 and of physicians recommending the medical use of marijuana sends the "wrong" message to the public. The license revocation policy effectively silences that message, violating the First Amendment by "manipulat[ing] the choices of its citizens, not by persuasion or direct regulation, but by depriving the public of the information needed to make a free choice." *Central Hudson Gas v. Pub. Serv. Com'n*, 447 U.S. 557, 575 (1980) (Blackmun, J., concurring).

There can be no doubt that the government's policy is designed to punish a disfavored message (that marijuana may have medical value to the physician's patient) while advocating its own favored message (that marijuana has no medical value) and encouraging others to mouth the government's favored message by leaving it unregulated. "If there is a bedrock principle underlying the First Amendment, it is that the government may not prohibit the expression of an idea simply because society [or the government] finds the idea itself offensive or disagreeable." *Johnson*, 491 U.S. at 414.

E. <u>The Government's Attempt To Restrain Speech Cannot Withstand The Scrutiny Required By The First Amendment.</u>

The government relies on what it apparently believes is its almost limitless ability to regulate physician communications touching on the medical use of marijuana. This position elides several important distinctions.

"It is properly within the **state's** police power to regulate and license professions, especially when public health concerns are affected." *National Ass'n for the Advancement of Psychoanalysis v. California Bd. of Psychology*, 228 F.3d 1043, 1054 (9th Cir. 2000) (emphasis added). The federal government, however, lacks a similar statutory mandate. Although the CSA permits the federal government to take measures to control drug distribution (*e.g.*, prohibiting **prescriptions** for marijuana), it does not confer regulatory power to control the content of medical advice, even if the government purports to be protecting patients from dangerous or improper information. That task rests exclusively with the states. *See infra* at 52-53; CMA Brief.

Moreover, even where regulatory authority exists, this Court has squarely recognized that the "communication that occurs" during medical treatment is speech and "is entitled to constitutional protection." *National Ass'n for the Advancement of Psychoanalysis*, 228 F.3d at 1054. Any regulatory restriction on

speech must be content neutral and not discriminate on the basis of viewpoint. In the medical context, a state's general licensing passes constitutional muster because it is content neutral, but this Court would not uphold a government effort to "dictate what can be said between [treatment providers] and patients during treatment." *Id.* at 1055.

The federal government's lack of regulatory authority over medical advice, combined with the viewpoint discrimination of its policy, puts to rest the government's arguments concerning regulation of professional speech. But, even ignoring the lack of federal authority and the policy's viewpoint discrimination, the government's argument runs afoul of the First Amendment. Defendants rely entirely upon a single case, *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992), to urge that censorship of protected speech is permitted whenever part of a "reasonable" regulation. Opening Brief at 34. Extending *Casey*'s holding – that a state may require physicians to provide certain information to women seeking abortions where it was part of the state's reasonable regulation of the practice of medicine – the government contends that the Supreme Court has implicitly authorized a reasonableness standard for wholesale abrogation of First Amendment rights under regulatory power.

The state officials in *Casey* intended to advance their legitimate goals by injecting **more** speech into the marketplace of ideas, "aimed at ensuring a decision that is mature and informed." *Casey*, 505 U.S. at 883. By contrast, the government's policy here seeks to keep information out of the hands of patients to ensure an uninformed, knee-jerk decision consistent with government policy. The First Amendment does not tolerate this suppression of ideas. As Justice Brandeis wrote:

> [i]f there be time to expose through discussion the falsehood and fallacies, to avert the evil by the processes of education, the remedy to be applied is **more speech, not enforced silence**. Only an emergency can justify repression.

Whitney v. California, 274 U.S. 357, 377 (1927) (Brandeis, J., concurring).

The government's claim that its regulation of physicians does not violate the First Amendment must also be considered in light of who is doing the regulating and what they seek to regulate. The decision to forbid recommendations was made not by the Food and Drug Administration to ensure health and safety. Nor was the decision made by state officials charged with ensuring the safe practice of medicine. Instead, the decision was made by high-level law enforcement and drug policy officials charged with controlling drug distribution and concerned that their "message" on drug use not be diluted. Nor is this a case where a regulation has an

incidental effect on speech; the effect on speech is the whole purpose of the policy. Although the federal government can control what drugs are legally available, it may not control what people say about their efficacy.[3]

Even were the government's argument accepted in its best possible light (*i.e.*, even if one assumes the existence of regulatory authority and an important governmental purpose), the means it uses must be a "reasonable response to the threat" which will alleviate the harm "in a direct and material way." *Turner Broadcasting v. FCC*, 512 U.S. 622, 624 (1994). Here, the government offers no evidence whatsoever that silencing of physicians is a reasonable response to the

[3] These factors distinguish this case from *Gentile v. State Bar of Nevada*, 501 U.S. 1030 (1991). There, the Court rejected the use of a clear and present danger standard in favor of balancing the judiciary's legitimate interest in regulating the statements of attorneys participating in trials – an interest that was viewed in the context of courts' longstanding history of regulating the practice of law – against the First Amendment rights of attorneys to speak to the press. Here, however, the federal government's interest in regulating physician speech is not an interest in regulating the practice of medicine – a function that has long been the province of the states, not the federal government – but in preventing the distribution and use of drugs. The government seeks to further that interest indirectly by silencing physicians who disagree with the government's view that marijuana has no medical benefit and to punish physicians who refuse to follow the government's edict by revoking their prescription drug license under the guise of regulating the practice of medicine. Whatever right the state, acting through competent medical boards, may have to regulate physicians' speech, that is not a right that may be claimed by the federal government in this context where its undeniable motive has nothing to do with the practice of medicine and everything to do with silencing those who disagree with its view on the medical efficacy of marijuana.

threat of drug distribution, and fails to point out how its policy will alleviate the purported problem in a direct way.

Moreover, in the First Amendment context, a regulatory restriction on speech must be narrowly tailored to have the least possible impact on protected speech. *See, e.g., United States v. Playboy Entertainment Group*, 529 U.S. 803, 813-14 (2000) (even where government has compelling interest for content-based regulation of speech, regulation will not stand where its goal may be accomplished by less restrictive alternative); *Reno v. ACLU*, 521 U.S. 844 (1997); *Crawford v. Lungren*, 96 F.3d 380, 386 (9th. Cir. 1996); *see also Gentile*, 501 U.S. at 1054, 1075-76 (even where court employs balancing test, court must "balance whether the practice in questions [furthers] an important or substantial governmental interest unrelated to the suppression of expression and whether the limitation of First Amendment freedoms [is] no greater than is necessary or essential to the protection of the particular governmental interest involved") (internal quotation marks omitted); *Western States Medical Center v. Shalala*, 238 F.3d 1090, 1093 (9th Cir. 2001) (FDA regulation prohibiting pharmacists from promoting or advertising particular compounded drugs violated Constitution because not "narrowly tailored").

Here, the government's policy represents an effective ban on meaningful physician-patient discussions of medical marijuana – one that is not remotely

calculated to protect the speech rights of physicians or patients. No matter how much one credits the government's argument concerning the dangers of marijuana and the necessity of preventing **distribution** of drugs, the broad sweep of the ban on physician speech about marijuana violates the First Amendment. Recommendations of marijuana constitute speech and are not, unlike prescriptions, orders to dispense drugs.[4] Forbidding physicians from recommending marijuana to patients is a broad prohibition not reasonably calibrated to advance the government's interest in preventing the use and distribution of marijuana.

Finally, it bears emphasis that even a reasonable, narrowly tailored regulation of speech cannot survive where, as here, the prohibition is either vague or discriminates on the basis of viewpoint. *See Legal Services Corp.*, 121 S.Ct. at 1048. As demonstrated above, the policy fails on grounds of both vagueness and viewpoint discrimination, and it must be struck down regardless of the importance of the government's interest or the tailoring of the policy.

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[4] It appears that the court in *Pearson v. McCaffrey*, 139 F. Supp.2d 113, 121 (D.D.C. 2001) did not recognize this critical distinction.

F. <u>The Government May Not Justify Censorship By Characterizing Physician Recommendations As Incitement.</u>

Much of the government's argument for the need to trump First Amendment rights rests on its claim that a recommendation "may promote illegal drug activity" and therefore contravene the public interest. Opening Brief at 30. The government's statutory duty to guard the "public interest" can never include censorship of speech because it merely "promotes" illegal conduct – the Constitution defines a higher public interest in free speech about any matter so long as it does not actually **incite** illegal conduct. The Supreme Court, in *Brandenburg v. Ohio*, 395 U.S. 444, 447 (1969), erected a formidable barrier to government action against advocacy of unlawful action:

> [T]he constitutional guarantees of free speech and free press do not permit a State to forbid or proscribe advocacy . . . of law violation except where such advocacy is directed to inciting or producing imminent lawless action and is likely to incite or produce such action.

The *Brandenburg* rule is highly protective of speech. It is based on the fundamental First Amendment principle that a free society must tolerate not only dissent, but speech that actively confronts and subverts any orthodoxy prescribed by the government. Even where speech promotes or lauds criminal activity, the solution is not censorship.

Brandenburg allows the government to restrict only that speech which commands or orders immediate illegal activity. Incitement involves more than making illegal conduct attractive, more even than "teaching . . . the moral propriety or even moral necessity" for illegal conduct. *Id.* at 448 (internal quotation marks omitted). Physicians in this case seek protection in order to explain the potential benefits of marijuana to patients who fit the appropriate medical profile. At worst, these physicians can be accused of painting illegal and dangerous conduct in attractive terms. Alone, this is not enough to cross the *Brandenburg* line. *See, e.g., Herceg v. Hustler Magazine, Inc.*, 814 F.2d 1017, 1022-23 (5th Cir. 1987) (magazine article "paint[ing] in glowing terms the pleasures supposedly achieved" by autoerotic asphyxiation protected, even where a boy hanged himself while reading it); *Waller v. Osbourne*, 763 F. Supp. 1144, 1151 (M.D. Ga. 1991) (speaker advocated "moral propriety or even moral necessity for a resort to suicide"), *aff'd without opinion*, 958 F.2d 1084 (11th Cir. 1992); *High Ol' Times, Inc. v. Busbee*, 456 F. Supp. 1035, 1040 (N.D. Ga. 1978) (holding that magazine advocating recreational drug use by minors engages in protected speech), *aff'd*, 621 F.2d 141 (5th Cir. 1980). Physicians do not claim a right to prescribe marijuana or order patients to use it, only a right to recommend it as an effective

and beneficial course of treatment. Under the express terms of *Brandenburg*, this does not move their speech into unprotected territory.

Physicians' speech here is also protected by *Brandenburg*'s two additional requirements. First, there must be a danger of **imminent** lawless action. 395 U.S. at 447. The nature of the physician-patient relationship calls for consideration and evaluation by the patient of the information or recommendation provided by the physician. Moreover, because the patient must take additional steps to obtain marijuana, there is ample time for reflection and the consideration of opposing views. Any illegal conduct will certainly not be imminent, and therefore, cannot be forbidden as incitement.

Second, in order for words to constitute incitement, the speaker must **intend** to bring about the discussed action. *Id.* at 447 (advocacy must be "**directed**" to producing lawless action). One cannot infer intent to cause a patient to violate federal law from the simple fact that a physician has informed a patient that, given the circumstances of his or her particular case, marijuana may be useful in treating the patient's condition.

The government is right that doctors with the specific intent to aid and abet criminal activity are subject to prosecution and that the First Amendment does not forbid restraining speech "done in violation of [a state's] valid law for the **sole**

immediate purpose of continuing a violation of law." *Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 501 (1949) (emphasis added). But in *Giboney*, the Court specifically distinguished picketing activity that had illegal conduct as its "sole" and "immediate" objective and served as "an essential and inseparable part" of a criminal offense from cases where the relationship between speech and criminal conduct was more tenuous, and therefore protected. *Id.* at 502; *see also Thomas*, 323 U.S. at 547 (where speech could be separated into illegal and legal parts, appropriate remedy is to "stop the evil, but permit the speech").

Speech only loses its protection when it moves past the abstract advocacy found in *Brandenburg* such that it can be categorized as a direct attempt to influence immediate action through instructing others how to commit an unlawful act. A physician's sincere medical advice does not have the requisite nexus with criminal conduct to fall outside the parameters of First Amendment protection. The lower court correctly divided protected recommendations from those that aid and abet illegal activity by limiting the injunction in this case to recommendations "based on a sincere medical judgment." ER 283. The district court specifically stated: "The First Amendment is not a license to circumvent the federal drug laws." ER at 281. Thus, "[p]hysicians who issue insincere recommendations without a medical basis and with knowledge that they would be used to illegally obtain

marijuana would be subject to DEA revocation." ER at 282. The image of physicians as drug dealers conjured up by the government is irrelevant to the case at hand.

A physician's sincere advice or recommendation, made in the course of a bona fide physician-patient relationship, does not have criminal conduct as an objective at all, let alone as its "sole" and "immediate" objective. Many physicians believe that medical marijuana is a viable – indeed sometimes the only effective – treatment for certain conditions, and they feel duty-bound to convey this information to patients. *See supra* at 7-10. The physician class recommends marijuana not for the end of criminal conduct, but to provide patients with the best available advice and information. Equally important, sincere physician recommendations are neither "essential" to nor "inseparable" from the act of using, possessing, or distributing marijuana. As the district court found, physicians can and do recommend marijuana without it leading to the illegal acquisition of marijuana (ER 279-80), and patients can and do obtain and use marijuana, within the protections of Proposition 215, without the prior step of securing the recommendation of a physician, including through federally approved programs. *See* SER 617; APHA Brief. Thus, physician recommendations are not the

"'source of diversion' of drugs into illicit channels." Opening Brief at 35.[5] The current injunction does not prevent regulation of physicians who speak for the "sole immediate purpose" of violating the law, and therefore is consistent with both *Giboney* and the First Amendment. Contrary to the Supreme Court's holding in *Thomas*, the government here seeks to stop the federally declared evil of marijuana use and possession by forbidding legitimate physician speech. The First Amendment does not allow such censorship.

II. THE CONTROLLED SUBSTANCES ACT DOES NOT AUTHORIZE PHYSICIAN LICENSE REVOCATION BASED SOLELY UPON A RECOMMENDATION OF MARIJUANA.

The district court held that the CSA should not be construed to grant the government the sweeping authority it claims, as this interpretation would raise serious constitutional doubts. ER 269, 276-82. We have already established the conflicts between the government's policy and the First Amendment. With those

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[5] The government suggests that physicians have a duty to inform patients that they may not rely on the physician's recommendation under Proposition 215. See Opening Brief at 23. In effect, the government asks physicians to lie to their patients about state law. The consequences of a recommendation for purposes of the patient's criminal liability come about **by operation of law**. The physician does nothing other than provide sincere medical advice. What the government really wants is to conscript physicians in an attempt to undercut the efficacy of a state enactment that the government opposes. This is improper.

conflicts in mind, we turn to the proper interpretation of the CSA and demonstrate that the district court's statutory interpretation is correct.

The CSA grants the Attorney General authority to regulate the "manufacture," "dispens[ing]" and "distribution" of controlled substances. *See* 21 U.S.C. §§822(a). The terms "dispense" and "distribute" refer to "transfer" of a controlled substance. 21 U.S.C. §802(8).[6] The primary mechanism for regulating the transfer of controlled substances is the prescription, *i.e.*, "an order for medication which is dispensed to or for an ultimate user." 21 C.F.R. §1300.01(b)(35) (2001).

The Attorney General registers practitioners "to dispense . . . controlled substances in schedule II, III, IV, or V." 21 U.S.C. §823(f). Such registration does not authorize practitioners to prescribe marijuana, because marijuana is a Schedule I substance. 21 U.S.C. §812(c). The CSA also vests power in the Attorney General to deny or revoke a physician's registration to prescribe controlled substances. 21 U.S.C. §824. The revocation may destroy a physician's

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[6] "Dispense" means "deliver a controlled substance . . . by, or pursuant to the lawful order of, a practitioner," 21 U.S.C. §802(10), and "distribute" means to "deliver (other than administering or dispensing) a controlled substance." 21 U.S.C. §802(11). "Deliver" means "the actual, constructive, or attempted transfer of a controlled substance." 21 U.S.C. §802(8).

livelihood, but it plays no role in preventing a physician from prescribing marijuana because the registration does not grant such authority.

As pertinent here, one of the permissible grounds for revocation is that the physician "has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section." 21 U.S.C. §824(a)(4). Section 823(f), in turn, provides that the "public interest" is determined by considering the following five factors:

> (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.
> (2) The applicant's experience in dispensing or conducting research with respect to controlled substances.
> (3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.
> (4) Compliance with applicable State, Federal, or local laws relating to controlled substances.
> (5) Such other conduct which may threaten the public health and safety.

The government submits that "under the plain language of the statute" (Opening Brief at 28), the DEA – which has been delegated authority by the Attorney General, *see* 28 C.F.R. §0.100(b) – may revoke the registration of physicians who recommend marijuana because such recommendations constitute "conduct which may threaten the public health and safety." Because the text of the CSA is unambiguous, the government argues, there is no room for interpreting it to

avoid constitutional doubts. Opening Brief at 33. The text of the statute, however, is far from unambiguous.

First, the statute provides that a registration may be revoked if a practitioner "has committed such acts as would render **his registration** under section 823 . . . inconsistent with the public interest." The government explains, correctly, that "[t]he Act thus authorizes the Attorney General to revoke a physician's authorization if the physician abuses the authority conferred by that registration." Opening Brief at 27. But there is no logical connection between the "authority conferred by that registration" and a physician's recommendation of marijuana. Marijuana may not be prescribed through a registration, which allows a physician to prescribe only non-Schedule I medications. The most natural interpretation of the language of the revocation provision is that, as the government itself suggests, revocation is appropriate if the physician has abused, or is likely to abuse, **authority conferred by a registration**. Access to marijuana is not granted by registration, nor denied by de-registration.

Moreover, the government disclaims authority to revoke the registration of practitioners merely because they hold the same view as the *New England Journal of Medicine*, *i.e.*, that marijuana may be an appropriate treatment for some patients. The government is not contending that practitioners who hold such views about the

efficacy of marijuana may have their registrations revoked because they are likely to abuse the authority that registration confers with respect to **other** medicines.

Second, although the language of the fifth factor in 21 U.S.C. §823(f) – "[s]uch other conduct which may threaten the public health and safety" – is broad in the abstract, this language must be read in context. The first four factors involve state licensing, state discipline, drug law convictions, and compliance with drug laws, *i.e.*, factors that indicate the practitioner has abused or is likely to abuse the authority conferred by the registration. Basic canons of construction require that the phrase "such other conduct" must be interpreted to refer to similar conduct to that described by the provisions that precede it, not as a limitless provision that makes the rest of the provisions superfluous. *See Circuit City Stores, Inc. v. Adams*, ___ U.S. ___, 121 S.Ct. 1302, 1308-09 (2001) (under statutory construction rule of *ejusdem generis*, if "general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the specific words") (internal quotation marks omitted). This is particularly true because under defendants' reading of the "public interest" provision, the CSA would expand from a statute regulating the "manufacture," "dispensing" and "distribution" of controlled substances to a mandate for unfettered federal oversight of medical practice.

The CSA was never intended to overturn the long-established rule that regulation of the practice of medicine and public health is a state and not a national function. *See Linder v. United States*, 268 U.S. 5, 18 (1924) ("Obviously, direct control of medical practice in the states is beyond the power of the federal government."); *Glover v. Bd. of Medical Quality Assurance*, 231 Cal.App.3d 203, 207 (1991) (discussing standard of medical care as matter of state, not federal, law).

The "public interest" ground for license revocation was added to the CSA in 1984 when Congress enacted the Dangerous Drug Diversion Control Act (P.L. 98-473, 98 Stat. 2070). The statutory amendment sought to address abuse **of the authority conferred by CSA registration** – *i.e.*, "prescription drugs [being] diverted by legitimate medical distributors to the illicit drug market," and so sought expanded authority to punish physicians "who write or dispense prescriptions in a way that is threatening to the public health or safety." 130 Cong. Rec. H9681 (daily ed. Sep. 18, 1984) (remarks of Rep. Gilman). Congress understood that federal regulation of physician prescription licenses under the CSA is "entirely separate from a physician's State license to practice medicine." S. Rep. No. 225, 98th Cong., 2d Sess., *reprinted in* 1984 U.S.C.A.A.N. 3182, 3449 n.40. Nothing in the legislative history of the CSA set out by the government (Opening Brief at 28-32)

suggests that the purpose of the pertinent 1984 amendment was to provide a means for the federal government to punish physicians who practice medicine in a manner the government does not like, rather than to provide expanded means of addressing the abuse by practitioners of registration authority itself.

The CSA provides no general authority for regulating medical practice – even the medical practice of offering information to patients that the government finds contrary to some broad notion of the public interest. In California, the recommendation of marijuana as a potentially efficacious treatment for certain medical conditions is within the scope of the practice of medicine. *See* Cal. Health & Safety Code §11362.5(c) ("no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes"). Thus, even without considering the constitutional issues, the better interpretation of the CSA revocation statute is that it does not extend to practitioners who recommend marijuana.

At the least, the government's view that the "public interest" provision is unambiguous cannot be accepted, and the statute must be interpreted so as to avoid conflict with the Constitution. "[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly

contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988) (citing *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490, 499-501, 504 (1979)); *see also I.N.S. v. St. Cyr*, ___ U.S. ___, 121 S.Ct. 2271, 2279 (2001). The rule requiring courts to avoid statutory interpretations that raise constitutional doubts is especially strong in the area of government intrusions upon free speech because "[t]he values enshrined in the First Amendment plainly rank high in the scale of our national values." *Catholic Bishop*, 440 U.S. at 501 (internal quotation marks omitted). Where the government's proposed interpretation raises serious First Amendment concerns, courts **must** read the statute more narrowly if possible. *See, e.g., Frisby v. Schultz*, 487 U.S. 474, 482-83 (1988) (refusing to find in statute implied power to regulate speech where such interpretation raises First Amendment issues); *Tashima v. Administrative Office of the United States Courts*, 967 F.2d 1264, 1271 (9th Cir. 1992) (government refusal to fund legal defense of federal judge who disagrees with official government policy raises First Amendment issues, requiring court to adopt statutory interpretation avoiding constitutional question).

III. THE CURRENT INJUNCTION IS AN APPROPRIATE REMEDY.

The government claims that the scope of the lower court's injunction is impermissible, even in the face of a violation of the First Amendment and the

demonstrable harm to numerous patients and physicians – a harm that can be remedied **only** through a robust injunctive remedy. We start with a review of what is not in dispute, and then show why the government's objection that the injunction violates separation of powers principles should be rejected.

A. The Injunction Is Justified Under The Circumstances Of This Case.

The government has stipulated to the basic elements of the harm facing plaintiffs: A reasonable physician would fear losing her DEA registration upon recommending marijuana, and a number of plaintiff physicians feared loss of their DEA registrations for even discussing marijuana. ER 181, ¶¶13-14. The government also stipulates to the following facts demonstrating harm to constitutionally protected speech and to patient care: Physicians have reacted to the government's policy by censoring conversations with patients, and withholding information and recommendations regarding medical marijuana (ER 180-81, ¶11), yet "[f]or many patients, discussions with their physicians are the primary or only source of sound medical advice and information." ER 182, ¶17. Some physicians "have reacted to the Administration's Response by omitting medically relevant information from some patient medical records" (ER 181, ¶12), yet "[a]ccurate

charts are necessary to provide sound medical care to the patient in the future." ER 182, ¶19.

In order to cure these and other harms, the lower court fashioned an injunction with a clear line between protected medical speech and illegal conduct. A recommendation based upon "sincere medical judgment" is protected – *i.e.*, when the physician has a legitimate medical purpose (even one the government may disagree with), the physician's speech cannot by definition have the "sole and immediate purpose" of illegal conduct, to use the *Giboney* phraseology. In contrast, a statement with no purpose other than aiding a patient's acquisition of marijuana is not protected.[7] And, quite sensibly, the legality of a physician's advice does not turn on the patient's understanding or plans to act. ER 283. As discussed above, physicians may not be asked to calibrate their speech to predict the various possible reactions their patients may have to that speech. *See Thomas*, 323 U.S. at 534-35.[8] As the government repeatedly emphasizes, the CSA seeks to

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[7] The government claims that the injunction restricts it from punishing "physicians who have criminally violated" the CSA. Opening Brief at 43. This is plainly wrong. A recommendation made for a purpose other than "sincere medical judgment" is unprotected.

[8] The importance of this rule is illustrated by the government's concession that there would be no grounds for revocation of a physician's license if a patient reacted to the physician recommendation by seeking to enroll in a federally
(continued...)

limit the manufacture, distribution, and dispensing of controlled substances. The injunction here, by protecting the dispensing of **information** upholds the First Amendment while doing nothing to contravene or undermine federal law.

B. <u>The Injunction Is Appropriate To Remedy A First Amendment Violation.</u>

In light of the government's serious constitutional violation and the stipulated harm to physicians and patients, an injunction is necessary to protect physician-patient communications from the chilling effect of investigations or administrative proceedings. The threat of investigations alone suffices to intimidate many physicians and to deter them from even speaking about marijuana. *See* SER 609 (expert report noting: "A physician's career can be effectively destroyed merely by the fact that a governmental body has investigated his or her practice"). An injunction that sets out a bright-line rule is necessary to reverse the chilling effect created by the government's unconstitutional actions, and such a remedy comports fully with the Supreme Court's teachings in *Buckley* and *Thomas*.

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[8] (...continued)
approved research project or obtained and used marijuana in a country where it is legal to do so. Opening Brief at 41-42. By this logic, any given physician statement is perfectly legal if the patient chooses to travel to Canada to follow the physician's advice, but becomes grounds for administrative action if the patient follows the same course of action in California. With this level of uncertainty, most physicians would understandably withhold **any** advice concerning marijuana use.

Once liability is established, "[t]he district court has considerable discretion to fashion appropriate injunctive relief, particularly where the public interest is involved." *United States v. Akers*, 785 F.2d 814, 823 (9th Cir. 1986). This discretion is based on the "'fundamental principle'" in our system "'that when the end is required, the means are given.'" *United States v. Original Knights of Ku Klux Klan*, 250 F. Supp. 330, 350 (E.D. La. 1965) (three-judge court) (opinion by Wisdom, J.) (quoting *Prigg v. Com. of Pennsylvania*, 41 U.S. (16 Pet.) 539 (1842) (opinion by Story, J.)).

Nor is the government correct that the injunction relating to investigations violates separation of powers principles. Courts enjoin executive investigations and the threat of punishment when the exercise of constitutional rights is at stake – especially First Amendment rights. *See, e.g., Dombrowski*, 380 U.S. at 497 (reversing lower court's refusal to enjoin prosecutions based on protected First Amendment activity); *Pierce v. Society of Sisters*, 268 U.S. 510, 530, 535 (1925) (upholding injunction preventing state officials "from threatening or attempting to enforce" statute making it misdemeanor to fail to send child to public school because enforcement of statute would violate Fourteenth Amendment right to liberty); *Pollard v. Roberts*, 283 F. Supp. 248, 259 (E.D. Ark.) (three-judge court) (enforcement of subpoena by prosecutor of financial records of political party

enjoined because of First Amendment protections), *aff'd*, 393 U.S. 14 (1968) (per curiam). Investigators' "latitude does not extend so far as to permit impingement on associational rights of people on the mere suspicion that the information sought may constitute or lead to evidence that some of the people" violated the law. *Pollard*, 283 F. Supp. at 257-58; *cf. Gibson v. Florida Legislative Investigation Committee*, 372 U.S. 539, 557 (1963) (reversing contempt citation for refusing to produce NAACP membership records in response to investigative subpoena issued by investigative committee of state legislature based on First Amendment protections).

The notion of carving out "breathing space" for First Amendment speech is not the least bit novel. "Our profound national commitment to the free exchange of ideas, as enshrined in the First Amendment, demands that the law of libel carve out an area of 'breathing space' so that protected speech is not discouraged." *Harte-Hanks Communications v. Connaughton*, 491 U.S. 657, 686 (1989) (quoting *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 342 (1974) and *Button*, 371 U.S. at 433). The United States, in the context of litigating Fourth Amendment issues in *Dickerson v. United States*, construed this doctrine of "breathing space" for First Amendment rights quite expansively, noting that the Supreme Court has "adopted constitutional prophylactic rules to safeguard constitutional rights," in particular in

the First Amendment context. SER 791-92. The United States managed to convince even the dissenting justices of strongly protective "First Amendment rules that we have adopted to ensure 'breathing space' for expression." *Dickerson v. United States*, 530 U.S. 428, 459 (2000) (Scalia, J., and Thomas, J., dissenting). It is within this tradition of First Amendment protection that the district court issued a prophylactic remedy.

To be sure, it is unusual to enjoin governmental investigations, just as patent violations of the First Amendment of the sort before this Court are thankfully unusual. But the government overlooks both the circumstances of this case, where federal officials have explicitly threatened draconian punishment of physicians for providing medical advice, and the Supreme Court precedent permitting such injunctions in appropriate cases. Indeed, when federal officials threatened to investigate the immigration status of foreign-born voters who requested bilingual ballots, the Ninth Circuit reversed a lower court finding that it "lacked jurisdiction to enjoin" an investigation by a United States Attorney. *Olagues v. Russoniello*, 797 F.2d 1511, 1519 (9th Cir. 1986) (en banc), *vacated on ground of mootness*, 484 U.S. 806 (1987). In order to remedy the chilling effect on foreign born voters who feared INS investigations of themselves and their families, the Court held that a district court has jurisdiction "to enjoin a preliminary investigation by a United

States Attorney." *Id.* On those rare occasions when governmental zeal or prejudice overcomes sound judgment, an injunction is sometimes necessary to cure the harm caused by the government's overreaching.

The cases the government cites cast no doubt on the proposition that, in the face of concrete harm to First Amendment interests, courts are empowered to enjoin administrative actions and investigations. For example, in *Jett v. Castaneda*, 578 F.2d 842, 845 (9th Cir. 1978), the Court merely found that there was no "power to monitor executive investigations **before a case or controversy arises**." (Emphasis added.) Most of the other cases the government relies upon expressly leave open the possibility of judicial involvement in appropriate circumstances, and none of these cases forecloses that possibility.

It is very much to the point that plaintiffs are faced with an unconstitutional **policy**, not an unconstitutional **statute**. Federal courts have certainly not hesitated to enjoin the enforcement of statutes that violate the First Amendment. *See, e.g., Sable Communications of California, Inc. v. FCC*, 492 U.S. 115, 117-19 (1989); *Let's Help Florida v. McCrary*, 621 F.2d 195, 199 (5th Cir. 1980), *aff'd*, 454 U.S. 1130 (1982). Here that remedy is not open. The remedy necessary to thaw the chill defendants intentionally created is that entered by the lower court in its sound discretion.

CONCLUSION

For the foregoing reasons, the judgment and injunction entered by the district court should be affirmed.

DATED: September 25, 2001

Respectfully submitted,

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STATEMENT OF RELATED CASES

Defendants have appealed both the district court's ruling that plaintiffs are entitled to attorneys' fees in this case under the Equal Access to Justice Act because the government's position was not substantially justified and the finding as to the amount of reasonable fees. Docket Number 01-16339. Plaintiffs have cross-appealed with respect to the method used to calculate the cost of living adjustment in setting the appropriate hourly rate. Docket Number 01-16546.

CERTIFICATE OF COMPLIANCE

I certify that this answering brief is proportionately spaced in Times New Roman font, 14 point type, and that this brief contains 13,888 words, exclusive of the corporate disclosure statement, table of contents, table of authorities, certificate of compliance, statement of related cases, and certificate of service. This certification is based upon the word count of the word processing system used in preparing this brief.

Dated: September 25, 2001

By: ________________________________

Jonathan Weissglass

CERTIFICATE OF SERVICE

CASE: **Conant, et al. v. Jurith, et al.**

CASE NO: **U.S. Court of Appeals for the Ninth Circuit, 00-17222**

I am employed in the City and County of San Francisco, California. I am over the age of eighteen years and not a party to the within action; my business address is 177 Post Street, Suite 300, San Francisco, California 94108. On September 25, 2001, I served the following documents:

BRIEF FOR APPELLEES
SUPPLEMENTAL EXCERPTS OF RECORD

on the parties, through their attorneys of record, by placing true copies thereof in sealed envelopes addressed as shown below for service as designated below:

By Federal Express: I am readily familiar with the practice of Altshuler, Berzon for the collection of overnight courier deliveries and I caused each such envelope to be delivered to Federal Express Corporation at San Francisco, California, with whom we have a direct billing account to be delivered to the office of the addressee on the next business day. I deposited this package at the Kearny Street location.

ADDRESSEE	PARTY
Dana J. Martin Civil Division Department of Justice 601 D Street, N.W., Room 9108 Washington, D.C. 20530-0001	Defendants-Appellants

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this August 31, 2001, at San Francisco, California.

Harmony Simmons