UNITED STATES COURT OF APPEAL

FOR THE NINTH CIRCUIT

NO. 98-16950

OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES,

Appellants/Defendants,

v.

UNITED STATES OF AMERICA

Appellee/Plaintiff.

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

EXCERPTS OF RECORD
VOLUME VII

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EXCERPTS OF RECORD

VOLUME I

EXCERPTS OF RECORD

VOLUME II

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VOLUME V

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VOLUME VI

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VOLUME VII

EXCERPTS OF RECORD

VOLUME VIII

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0089 CRB
C 98-0245 CRB

DEFENDANTS' REQUEST FOR JUDICIAL NOTICE
[FED. R. EVID. 201]

Date: September 28, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

Defendants Oakland Cannabis Buyers' Cooperative and Jeffrey Jones hereby request the Court to take judicial notice pursuant to Federal Rule of Evidence 201 of the following:

1. Declaration of Marcus A. Conant, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit A. It is appropriate for a court to take judicial notice of a court file in a related case in the same district. Fed. R. Evid. 201; *Cagan v. Intervest Midwest Real Estate Corp.*, 774 F. Supp. 1089, 1091 n. 1 (N.D. Ill. 1991).

2. Declaration of Neil M. Flynn, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit B. *Id.*

3. Declaration of Milton N. Estes, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit C. *Id.*

4. Declaration of Arnold S. Leff, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit D. *Id.*

5. Declaration of Howard D. Maccabee, Ph.D., M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit E. *Id.*

6. Declaration of Debasish Tripathy, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit F. *Id.*

7. Declaration of Stephen Eliot Follansbee, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit G. *Id.*

8. Declaration of Stephen O'Brien, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit H. *Id.*

9. Declaration of Donald W. Northfelt, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit I. *Id.*

10. Declaration of Virginia I. Cafaro, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit J. *Id.*

11. Declaration of Robert C. Scott, III, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit K. *Id.*

12. Declaration of Rebecca Nikkel previously filed in case No. C 98-00086 CRB, a true and correct copy of which is attached hereto as Exhibit L. A court must take judicial notice of a previous filing in the same case. Fed. R. Evid. 201; *United States v. Gariano*, 1993 U.S. Dist. LEXIS 11515, *13.

8. Declaration of Lucia Y. Vier previously filed in case No. C 98-00087 CRB, a true and correct copy of which is attached hereto as Exhibit M. *Id.*

9. Declaration of Edward Neil Brundridge previously filed in case No. C 98-00088 CRB, a true and correct copy of which is attached hereto as Exhibit N. *Id.*

10. Declaration of Ima Carter previously filed in case No. C 98-00088 CRB, a true and correct copy of which is attached hereto as Exhibit O. *Id.*

Dated: September 12, 1998

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF MARCUS A. CONANT, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF MARCUS A. CONANT, M.D.

I, Dr. Marcus A. Conant, declare as follows:

1. I am a physician licensed to practice in the State of California and a clinical professor of dermatology at the University of California Medical Center in San Francisco ["UCSF"], where I have taught for more than 30 years. I am also Medical Director of the largest private HIV/AIDS practice in the San Francisco Bay Area. Since establishing that practice, my colleagues and I have treated some 5,000 HIV-infected men and women, and we currently provide care for approximately 3,000 AIDS patients in both our clinic and our research facility.

2. I received a bachelor's degree in 1957 and a doctorate in 1961, both from Duke University. I subsequently completed an internship in internal medicine at the Duke University Medical Center (1961-1962), and a residency in dermatology at UCSF in San Francisco (1964-1967). I received further training at the School of Aerospace Medicine in San Antonio, Texas, and served in the United States Air Force from 1962 to 1964, as both a Medical Officer and a Flight Surgeon. I continued to serve as an Air Force Reserve Officer until 1967.

3. Since joining the UCSF faculty as a Clinical Instructor in 1967, I have held numerous positions, including Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor of Dermatology, a post I have held since 1984. I was Chief of both the Dermatology Clinic and the Dermatology Inpatient Service from 1967 through 1970, Co-Director of the Medical Center's Kaposi's Sarcoma Clinic (1981-1985), and Director of its AIDS Clinical Research Center (1983-1985). I am currently an Adjunct Professor at its Mount Zion Medical Center as well.

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4. Throughout my career, I have also been a consultant to numerous agencies and service providers, both public and private, including San Francisco General Hospital, the U S Public Health Service Hospital, UC Medical Center's Director of Hospitals and Clinics, and the California State Assembly Ways and Means Committee's AIDS Task Force. I have been appointed to similar task forces and committees of the Fifth Congressional District, the California State Department of Health Services, the California Medical Association, the San Francisco Medical Society, the American Academy of Dermatology, and the City of San Francisco. In 1983, I represented the United States at the World Health Organization meeting on AIDS. I served as Medical Director of the National Public Health Project Against AIDS for several years. I am currently a member of United States Senator Dianne Feinstein's AIDS Committee.

5. I have authored and co-authored some 70 articles in scholarly and professional journals, most of which deal with the diagnosis and treatment of AIDS and AIDS-related conditions. My work has been published in the Journal of the American Medical Association, New England Journal of Medicine, Western Journal of Medicine, Journal of the American Academy of Dermatology, Journal of Infectious Disease, American Journal of Clinical Pathology, Journal of Clinical Immunology, Journal of Osteopathic Medicine, American Journal of Oral Medicine, Public Health Reports, Clinical Research, American Journal of Pathology, and The Lancet. My colleagues and I have contributed chapters to medical textbooks, research publications, clinical protocols and conference reports. I am a frequent presenter at national and international conferences and congresses.

6. Many of the therapies used in the treatment of AIDS-related conditions can cause symptoms and medical complications which themselves are physically painful and medically dangerous. The most frequently cited example is chemotherapy, which is often a

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first-line treatment in the aggressive treatment of cancer. Chemotherapy has also been used in the treatment of several common AIDS-related conditions, including lymphoma and Kaposi's sarcoma. Chemotherapy -- administering medications such as adriamycin, fluorouracil, cytotoxin and methotrexate, usually in combination -- has proven to be highly effective in the treatment of many cancers, extending lives and relieving the symptoms of many individuals whose conditions were once considered hopeless. These medications have been approved by the FDA. Nonetheless, chemotherapy protocols used in the treatment of cancer often cause nausea and retching which is sometimes thoroughly disabling. They can result in severe weight loss, which itself has troubling implications not only for the efficacy of the treatment, but for a patient's health generally. The medications are indeed toxic. Administration of these drugs always includes considering potential adverse effects, advising the patient of the risks and providing information and treatment to reduce harmful or undesirable side effects. Acknowledgment and clinical treatment of those effects are standard and necessary parts of the chemotherapy protocols.

7. Other drugs frequently prescribed in the treatment of AIDS-related conditions have the potential to cause adverse medical conditions. Among them are AZT, ddI, ddC and d4T, all of which are approved by the FDA. More recently, physicians have prescribed a class of drugs known as "protease inhibitors," often in combination with other medications. The results have been very promising. Physicians are seeing positive clinical results, and laboratory findings (blood tests) show remarkable improvements. Many patients report great relief from physical suffering. These drugs are now approved by the FDA. One common AIDS-related condition is wasting syndrome, which undermines both the immune system generally and a patient's ability to withstand the effects of other therapies. The FDA has

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approved the use of Somatropin (human growth syndrome), as well as Megace and Marinol, to reverse the disabling effects of wasting syndrome.

8. As with all medications, further research is essential to our understanding of these medications. As research continues, the use of these medications (*e.g.*, dosages, means of ingestion, combination therapies) will be refined to maximize the potential for treatment and minimize adverse reactions. That is the very nature of research. There are always risks. As scientists, we identify those risks and provide information to reduce and ultimately eliminate those risks. As healers, we advise our patients accordingly and work with them to address their individual medical needs. Caution and candor are essential to maintaining scientific integrity and providing effective treatment.

9. Medical marijuana has been used extensively by physicians throughout the United States in the treatment of cancer and AIDS patients. It stimulates the appetite and promotes weight gain, in turn strengthening the body, combating chronic fatigue, and providing the stamina and physical well-being necessary to endure or withstand both adverse side effects of ongoing treatment and other opportunistic infections. It has been shown effective in reducing nausea, neurological pain and anxiety, and in stimulating appetite. When these symptoms are associated with (or caused by) other therapies, marijuana has been useful in facilitating compliance with more traditional therapies. It may also allow individual patients to engage in normal social interactions and avoid the despair and isolation which frequently accompanies long-term discomfort and illness. In glaucoma patients, marijuana has been effective in decreasing inter-ocular pressure. The evidence behind these findings is both scientific and anecdotal. The research in this area has been documented and published in the leading scientific journals, including the New England Journal of Medicine and Annals of Internal Medicine.

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10. In my practice, marijuana has been of greatest benefit to patients with wasting syndrome. I do not routinely recommend marijuana to my patients, nor do I consider it the first line of defense against AIDS-related symptoms. However, for some patients, marijuana proves to be the only effective medicine for stimulating appetite and suppressing nausea, thus allowing the AIDS patient to recover lost body mass and become healthier. Likewise, for some of my patients undergoing chemotherapy, when conventional drugs fail to relieve the severe nausea and vomiting, I often find that marijuana provides the patient with the ability to eat and to tolerate aggressive cancer treatments. As with any medication, I am aware of the potential for abuse and I am cautious in the information I provide. Some of my patients are using marijuana, which I learn in the course of my treatment. I advise those patients of the risks that marijuana may pose. In some instances, I have counseled patients to discontinue or decrease their use of marijuana. In patients with a history of substance abuse, I am especially vigilant in recommending caution. Physicians have always been held to that standard, whether the medication is Valium, morphine, Xanax, or marijuana. Safeguards to decrease the incidence and effects of substance abuse are already in effect. Medical practices in prescribing and recommending all treatments are monitored and subject to professional and legal guidelines.

11. It is the sanctity of the doctor-patient relationship that enables this counseling and guidance to take place. The unique nature of that relationship has been recognized throughout history. Legally, ethically and clinically, a physician has unique duties to a patient in his or her care. When I treat a patient with a potentially terminal condition, I provide the information and treatment that can literally determine whether my patient lives or dies. My duty is to provide accurate and complete information and treat each patient according to his or her individual symptoms, medical history and clinical responses. Each

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patient's medical needs are unique, as are his/her responses to specific therapies. Confidential communication is essential to this process.

12. As a physician responsible for the care and well-being of my patients, I cannot ignore information which might affect my assessment of a patient's condition or assist me in providing the best care possible. If I have knowledge that a patient is smoking marijuana, I would be seriously remiss if I failed to address the medical consequences with that patient. If I have information that limited use of marijuana may provide relief from disabling symptoms, I feel duty-bound to provide that information. If I believe, in my clinical judgment, that the risks to that patient may be reduced if the marijuana is ingested by means other than smoking (*e.g.*, by eating baked goods or drinking a tea with marijuana infusion), I have a duty to provide that information as well. That knowledge is based on my scientific knowledge, clinical judgment, and common sense.

13. My knowledge and clinical judgment are informed by all credible sources, including the federal Food and Drug Administration. I was one of the principal investigators of an FDA-supervised trial conducted by Unimed, Inc. on the safety and efficacy of Marinol as an appetite stimulant in HIV/AIDS patients suffering from wasting syndrome. Marinol is a form of THC, one of the key active components of marijuana; it is essentially a marijuana extract. It was approved by the FDA five years ago, and has been widely prescribed by physicians treating both AIDS and cancer patients.

14. The current edition of the Physician's Desk Reference, the most widely-used and comprehensive authority on prescription medications, states that:

> Marinol (dronabinol) is indicated for the treatment of:
> 1. anorexia associated with weight loss in patients with AIDS; and
> 2. nausea and vomiting associated with cancer chemotherapy in patients who

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have failed to respond adequately to conventional antiemetic treatments [1]

Stedman's Medical Dictionary, another highly respected and widely-used reference work, as part of its definition of "cannabis," includes the following:

> C[annabis] was formerly used as a sedative and analgesic; now available for restricted use in management of iatrogenic[2] anorexia, especially that associated with oncologic chemotherapy and radiation therapy.[3]

I am aware of no medical report that would indicate serious adverse effects arising from the clinical use of Marinol.

15. I am aware, however, that Marinol (like any medication) is not effective in treating all patients. In some cases, the reason is simple: Marinol is taken orally, in pill form. Patients suffering from severe nausea and retching cannot tolerate the pills and thus do not benefit from the drug. There are likely other reasons why smoked marijuana is sometimes more effective than Marinol. The body's absorption of the chemical may be faster or more complete when inhaled. Means of ingestion is often critical in understanding treatment efficacy. Research has revealed, for example, that insulin, which is critical in the treatment of diabetes, is rendered ineffective when taken orally. Medications commonly used to treat asthma and lung infections are routinely administered through inhalers. Marinol is not currently available in any form other than pills. These are scientific facts which inform my clinical practice. I cannot ignore them or deprive my patients of that knowledge.

16. I am aware that federal government officials have issued threats of criminal, civil and administrative sanctions against physicians who recommend the use of marijuana or

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[1] *Physicians' Desk Reference*, 50th Edition (1996: Medical Economics), p. 2232.

[2] "Iatrogenic" conditions are those which result from medical treatments or procedures, such as chemotherapy-related nausea or weight loss.

[3] Spraycar, M. (ed.), *Stedman's Medical Dictionary*, 26th edition (1995: Williams & Wilkins), p. 269.

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counsel and advise patients regarding the clinical risks and benefits of marijuana. They have repeatedly stated that providing counsel and advice regarding the clinical use of marijuana is a violation of federal law. I see these public pronouncements as a threat to the integrity of my medical practice. While there are certainly limitations on my ability to obtain or prescribe medications, I cannot ethically withhold information or scientific data which may be of benefit to my patients. If I am prohibited from advising my patients on any matter affecting their health, I am unable to exercise clinical judgment and provide effective treatment.

17. Such interference in my communications with individual patients can do immeasurable damage to my relationship with specific patients, thereby undermining my ability to provide effective treatment generally. Without the element of mutual trust and protected confidentiality, many of my patients will be unable or unwilling to provide me with information essential to my medical assessment. As a result, I am disarmed in my struggle against illness and suffering. They are deprived of basic medical information which could inform their behavior and relieve their disabilities. In light of the recent government threats, I have already limited my discussions with patients and directed my staff (including other physicians) to use extreme caution when obtaining medical histories or answering patient inquiries about marijuana. Even this degree of wariness and apprehension has a chilling effect on my rapport with patients. They see me as part of their fight for life. Government threats disarm me in that struggle, and it is my patients who will ultimately suffer.

18. I have already stated that marijuana has proven effective in addressing many symptoms caused by medically prescribed treatments. The adverse affects of these therapies are particularly troubling to both the patient and the physician. In my practice, I frequently recommend treatments which, in the short term, may result in increased discomfort and visible suffering. They may also have adverse implications for the patient's long-term health

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I cannot, in good faith, recommend these procedures and medications without a professional commitment to decrease, prevent or reduce the effects of these conditions.

19. Failure to consider every possible means of alleviating adverse side effects has very serious implications. When a patient can no longer tolerate the adverse consequences, she or he will cease treatment. I have seen it many times in my own practice and my colleagues report it consistently. It is a tragic fact which we monitor and assess constantly. In the case of chemotherapy and many AIDS medications, terminating treatment can mean an early and often painful death. It results in hopelessness where there should be, or could be, hope. As a scientist and a healer, preventable suffering and unnecessary despair are unacceptable.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed this 14 day of February, 1997 in San Diego, California.

MARCUS A. CONANT, M.D.

EXHIBIT B

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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DECLARATION OF NEIL M. FLYNN, M.D.

I, Dr. Neil M. Flynn, declare as follows:

1. I am a Professor of Clinical Medicine in the Division of Infectious Diseases of the Department of Internal Medicine at the University of California at Davis School of Medicine. I also serve as attending physician in the University Medical Center's AIDS and Related Disorders Clinic. I received my B.A. in bacteriology from the University of California at Los Angeles in 1970, graduated from the Ohio State University Medical School in 1973, and did my internship and residency in internal medicine at Loma Linda University Hospital from 1973-76. I completed a fellowship in infectious diseases at the University of California at Davis from 1976-78 and was awarded my Master of Public Health from the University of California, Berkeley, in 1994. I am licensed to practice medicine in the State of California.

2. I am a member in good standing of several professional societies including the American Public Health Association; Infectious Diseases Society of America; American College of Physicians; and the American Society for Microbiology. I am board certified in Internal Medicine and in Infectious Diseases.

3. In addition, I have served on numerous hospital and medical school committees at the University of California, Davis (UCD). Currently, I am the Chairperson for the UCD Human Subjects Review Committee, and a member of the Chancellor's Committee on AIDS. Previously, I have served as a member of the Department of Internal Medicine Quality Assurance Committee, the Medical Director of the AIDS & Related Disorders Clinic, and Chair of the Infection Control Committee.

4. Among the awards I have received are the ACP Humanitarian Award (1995), Sacramento Regional Pride Award (1991), Lambda Community Award (1988), Kaiser

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Foundation Hospitals Award for Excellence in Teaching Clinical Sciences (1986), Outstanding Staff Award at UCD Medical Center (1982-83), and the Roessler Foundation Research Scholarship Award (1972-73). I have successfully sought hundreds of thousands of dollars in grant money to pursue research on HIV and AIDS since establishing the UCD Clinic in 1983.

5. The continuation of this research depends upon my ability to obtain future grants from both private and public sources. I am the principal author or co-author of numerous articles and book chapters in the area of infectious diseases. My writings have appeared in such journals as *The New England Journal of Medicine*, *Journal of the American Medical Association*, *Western Journal of Medicine*, *Life Sciences*, *Annals of the New York Academy of Sciences*, and *Journal of Acquired Immune Deficiency Syndromes*. I have also delivered numerous lectures at professional symposia, in this and other countries, including the Third through Tenth International Conferences on AIDS.

6. Through the University's AIDS Clinic and the Center for AIDS Research, Education and Services (CARES), a private, non-profit clinic for treatment of HIV infection and disease, I participate in the care of approximately 1,500 AIDS patients. I am the primary physician for 200 AIDS patients.

7. Intractable nausea and wasting syndrome are frequent symptoms associated with AIDS and the treatment of AIDS. The nausea, which can last for days, weeks or months, is one of the most severe forms of discomfort or pain that the human being can experience. It destroys the quality of life of the patient, whose sole objective is to make it through the next hour, the next day. Racked by intense vomiting and queasiness, time for the patient seems to stand still. Wasting can take a similar psychological and physical toll.

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8. For patients suffering intractable nausea and/or wasting, my first concern is to relieve these symptoms. If I fail to do so, the patient is increasingly likely to decide that life is simply intolerable. I have had patients whose nausea and/or wasting were so disabling that they preferred death. As a physician, I try my utmost to avoid this end result.

9. Fortunately, I often can relieve the patient's acute suffering and, thereby, restore her quality of life to an acceptable level. My first line of therapy for acute nausea involves the use of Compazine or Reglan. Sometimes these traditional anti-emetics do not work, either because they fail to reduce the nausea and/or the patient does not tolerate them well. The drugs themselves have side effects, and can cause impairments in a patient's fine and gross motor skills. As a result, patients sometimes move in a slow, stiffened manner. Their faces may appear frozen. And they can develop severe muscle contractions. Many of these side effects are similar to those experienced by patients treated with Thorazine and Haldol. I have also tried prescribing a newer drug called ondansetron which was developed specifically for the treatment of chemotherapy-induced nausea. The success of ondansetron varies greatly among patients. Lastly, benzodiazepines can be tried.

10. If I am unable to relieve the patient's nausea with the above remedies, I next prescribe Marinol, a synthetic version of THC, one of the main active compounds found in marijuana. Marinol is also helpful in stimulating appetite in patients suffering from AIDS wasting, as are other drugs, Megace, anabolic steroids, and human growth hormone.

11. If Marinol does not provide adequate relief from nausea and/or wasting, I may suggest that the patient try a related remedy, marijuana. I firmly believe that medical marijuana is medically appropriate as a drug of last resort for a small number of seriously ill patients. Over 20 years of clinical experience persuade me of this fact. The anecdotal evidence is overwhelming. Almost every patient I have known to have tried marijuana

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achieved relief from symptoms with it. That success rate far surpasses that for Compazine. Accordingly, as with any other medication that I consider potentially beneficial to my patients, I must discuss the option of medical marijuana in detail when appropriate. Anything less is malpractice.

12. For those patients for whom I believe marijuana is an appropriate remedy, I discuss the various ways in which marijuana can be ingested. Smoking marijuana is the most direct, rapid, and accurate delivery of the drug. But smoking has the drawback of putting particulate matter in the patient's lungs. This is of concern to me because studies show that AIDS patients who are heavy cigarette smokers shorten their life spans by about 2 years. It is not unreasonable to surmise that heavy marijuana smoking could lead to similar results. Nevertheless, smoking may be the most accurate way to deliver a number of drugs, including nicotine or marijuana. Furthermore, there are ways of reducing particulate intake, for example through the use of water pipes which tend to filter the smoke, and consumption of unadulterated marijuana.

13. I inform my patients that they may try eating marijuana. But this, too, is not without difficulties similar to those experienced by many patients who try Marinol. Eating marijuana (or ingesting a Marinol capsule) can cause unpredictable results because the absorption of the THC can either be rapid or delayed, depending on whether the patient ingests the marijuana on a full stomach. The same is true for drinking marijuana tea.

14. In my experience, the unpleasant side effects that some patients experience from marijuana, however it is ingested, are far less severe than the side effects experienced from Compazine and Reglan and similar drugs. Nor do I have to worry about harmful drug interactions with patients who use therapeutic doses of marijuana: to my knowledge, there are none. If a patient presents with both nausea and anxiety, I can prescribe Compazine and

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Valium. However, marijuana can effectively treat both conditions simultaneously It is not at all clear to me that the combination of Compazine and Valium, both of which are toxic, the latter of which is addictive, is better than marijuana alone.

15. As the above approach illustrates, I begin treating my AIDS patients by listening to their complaints and concerns. For symptoms such as intractable nausea and wasting syndrome, I first prescribe those medications that are legal. If these medications do not work, or prove intolerable, I then discuss the option of medical marijuana, which appears near the bottom of my cascade of options. But because I consider marijuana a legitimate medical option at all, I stand squarely in the cross-hairs of the federal government's official policy against medical marijuana and the doctors who recommend it. The government's threats to sanction physicians who, in their best medical judgment, recommend marijuana to treat a seriously ill patient are threats against me.

16. AIDS medicine is my profession and my passion. I have dedicated myself to this disease since 1983 when I opened the Clinic at U.C. Davis. Thus, I am deeply concerned about civil and criminal sanctions that loom over me. I do not want my job to be taken away by some government official who has a different medical paradigm than I, many of my colleagues, or for that matter, the majority of California voters. If I lost my Schedule II license, 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.

17. I feel compelled and coerced by the government threats to withhold information, recommendations, and advice to patients regarding the use of medical marijuana. This state of affairs is unacceptable in medicine. My patients come to me seeking relief from pain or suffering or the threat of death or disability. Their complex and severe

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illnesses are often complicated by difficult personal situations. The government's threats inject yet another complication into the mix.

18. The threats erect a barrier between me and the patient. Yet the patient's trust is essential if I am to provide the best medical care possible. If, in an attempt to protect me from government sanctions, patients refrain from discussing the fact that they find relief from marijuana, I lose an opportunity to suggest that they try Marinol (if they have not done so already). Marinol, which is legal and covered by health insurance, can save the patient considerable money and anxiety, if it works. Similarly, if patients do not inform me that they can only control their nausea with marijuana, I remain ignorant of the full extent of the side effects of their illness or medications and miss the chance to change patients' bothersome medications in order to lessen or eliminate the nausea for which they have resorted to marijuana.

19. More fundamentally, I need to know how much pain my patients suffer. If I don't know this, I cannot perform my job effectively. If a patient, because of the government's threats, fails to inform me that s/he uses marijuana for nausea or wasting, but the marijuana is not very effective (although perhaps more effective and less deleterious than prescription medications), perhaps the patient is not using potent enough marijuana. As a physician, it is my duty to inquire into this possibility, and, where appropriate, suggest trying a different type of marijuana.

20. Protease inhibitors, the newest and perhaps most effective drugs in the battle against AIDS, are beginning to lose their efficacy in some AIDS patients. When this happens, wasting syndrome, a potentially deadly process, begins. Body mass lost to wasting is difficult to regain. Therefore, it is preferable to stop wasting as early in the process as possible. To effectively treat wasting, I must know when wasting starts and at what pace it occurs. Thus, it

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is important to know if a patient is combating wasting with marijuana. Such behavior signals that I should consider prescribing other drugs, such as Megace or anabolic steroids. The government's threats, however, hamper the free exchange of information and advice necessary to an accurate and comprehensive diagnosis of the patient's condition.

21. The government's threats have been the subject of discussion among my colleagues who provide care to AIDS patients in the greater Sacramento area. As a general policy, a group of physicians who treat approximately 1,200 AIDS patients decided to speak with their seriously ill patients about the benefits and drawbacks of medical marijuana, but not to record this information to protect the patient from government recrimination which could cause them far greater harm than the use of the drug itself. The policy also aimed to protect physicians and the institutions with which they are affiliated from government sanctions or liability. Such a policy -- don't chart, just tell -- flies in the face of how doctors are trained, and is not necessarily in the patient's best interest. If salient facts regarding the patient's medical condition and treatment do not appear in the patient's chart, a consulting physician or the patient's next physician may be deprived of critical facts necessary to provide adequate care. Doctors need every bit of information available to treat their seriously ill patients.

22. The absence of information in a patient's chart also robs doctors of the ability to scientifically study the efficacy of marijuana in the treatment of various symptoms. If only every fifth patient chart accurately reflects the fact that Compazine failed as an anti-nauseant and the patient successfully resorted to medical marijuana, while, in reality every third patient presented with this history, the medical landscape which scientists analyze is deeply distorted. What we cannot see we conclude to be nonexistent. Thus, the government's calls for further research of marijuana are undermined by its concurrent threats against physicians which

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result in the suppression of the data on which such research depends. The failure to record medical history in patient charts risks perverting scientific attempts to assess the use and efficacy of marijuana.

23. Doctors neither want to overdramatize nor obfuscate what they learn from their patients. Doctors should be free to record the information they learn and their ideas as they arise. We frequently do not understand everything we see or hear the first time we see or hear it. In my patient charts I sometimes write "Puzzling" or "not clear" if I am unsure of the significance of what I am observing or being told. I then can follow up and try to discover its true significance.

24. Physicians often consult with one another and discuss our various options of treatment and talk anecdotally about our patients' therapies, including their use of marijuana. We try to find the most effective, least toxic medications for our patients. When faced with a choice of equivalency, we opt for the least toxic treatment. When one medication is more toxic than another, but is also more effective, we discuss this fact with patients, and they pick the preferred course of action. Medicine is a constant process of adjustment. When advising a patient, I do not simply have my next move in mind, I have my next three or four moves in mind. I develop a sequence of options, in case my next move doesn't work. "If this hasn't worked in 2-3 days," I tell the patient, "we'll try something else."

25. Two of my colleagues have told me that they feel so constrained by the government threats that they will not talk with their seriously ill patients about marijuana until the issue is resolved legally.

26. The government's policy and threats make criminals out of people who are suffering from life-threatening illnesses. This stigmatization is unnecessary. The government permits doctors to prescribe narcotics, such as morphine, for the relief of pain.

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To single out doctors who recommend or patients who use medical marijuana -- a substance almost certainly less addictive than many narcotics, not to mention alcohol and nicotine -- is irrational. Benzodiazapines and barbiturates are more addictive, and far more dangerous than marijuana with respect to their ability to induce death due from overdose.

27. The federal government and the public have little to fear from physicians abusing their recommendations or prescriptions of marijuana. The vast majority of physicians dispense morphine or Valium, much more powerful drugs, without incident. It has traditionally been the province of state governments to curb abusive practices of physicians. In California, the Board of Medical Quality Assurance polices the state's medical practitioners. If a physician administers drugs in an irresponsible manner, an investigation will ensue. If the abuse is egregious, the doctor's license to practice will be revoked. There is no reason to believe that these same policing mechanisms would not be effective for marijuana.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Sacramento, California, this 13 day of February, 1997.

Neil Flynn MD
NEIL M. FLYNN, M.D.

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EXHIBIT C

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DECLARATION OF MILTON N. ESTES, M.D.

I, Dr. Milton N. Estes, declare as follows:

1. I am a physician licensed to practice in the State of California. I received both my undergraduate and medical degrees from the University of Chicago and completed my post-graduate medical training at St. Luke's Hospital, San Francisco. I am board certified by the American Board of Family Practice, and licensed to practice in the State of California. I am a member of the American Academy of Family Physicians, the California Academy of Family Physicians, the California Medical Association, and the Marin Medical Society.

2. From 1971 through 1974, I was Medical Director of the Orange Cove Family Health Center, a federally funded health clinic serving rural farm workers. Since 1974, I have maintained a private family practice in Mill Valley, California. In recent years, I have become the largest private provider of HIV care in Marin County. Since 1995, I have been Medical Director and Senior Physician for the Forensic AIDS Project. The Forensic AIDS Project, operated by the Department of Public Health of the City and County of San Francisco, provides early intervention, education, and medical care for inmates who are HIV-positive or who have AIDS.

3. I am presently an Attending Physician with active duties at Marin General Hospital. My previous hospital experience includes being Chair of the Department of Family Practice at Marin General Hospital, and Attending Physician at both Ross General and Mt. Zion Hospitals, and the California Pacific Medical Center (San Francisco).

4. My academic appointments include Clinical Instructor in Family Practice and Assistant Clinical Professor of Family Medicine at the University of California-Davis (1972-84), and Associate Clinical Professor in the Department of Obstetrics, Gynecology & Reproductive Medicine at the University of California-San Francisco (1983-present).

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5. I serve on several professional and community boards, include many years as a member of the Oncology Committee (1990-present), Bioethics Committee (1993-present), and AIDS Task Force (1986-present) at Marin General Hospital, as well as the Medical Advisory Board of the Coalition for the Medical Rights of Women (1984-1987). I currently serve as both the chair of Marin General Hospital's AIDS Task Force and the Marin Medical Society's AIDS Committee. I have been a member of the Marin AIDS Advisory Commission since its inception in 1987. For the past twenty years, I have lectured widely on issues of medical ethics, HIV and AIDS. In 1989, I was named Physician of the Year by the Marin Medical Society. In 1990, I received the Benjamin Dreyfus Award from the Marin Chapter of the American Civil Liberties Union; and in 1992, I received the Martin Luther King Humanitarian Award by the Marin County Human Rights Commission.

6. Last month, one of the most prestigious medical journals in the world, *The New England Journal of Medicine*, published an editorial that confirmed what practicing clinicians have long known: that relatively small amounts of marijuana can provide striking relief from intractable nausea, vomiting, pain, and anorexia that frequently plague persons suffering from cancer, AIDS, and other serious illnesses.

7. Shortly before that editorial, the nation's top law enforcement officials, joined remarkably by the Secretary of Health and Human Services, announced before cameras that they would bring the full force of government authority to bear on physicians who in their best medical judgment recommend medical marijuana to their seriously ill patients.

8. As a result of the government's public threats, I do not feel comfortable even discussing the subject of medical marijuana with my patients. I feel vulnerable to federal sanctions that could strip me of my license to prescribe the treatments my patients depend upon, or even land me behind bars. I am worried that a government agent, posing as a patient,

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will try to infiltrate my office in order to provoke a statement that the federal government considers dangerous but which I, as well as thousands of my colleagues, the *New England Journal of Medicine* and the voters of California, regard as sound medicine. As a result, I am somewhat less trusting of new patients. I am also concerned that a former patient who may himself feel vulnerable, or one who suffers an emotional disturbance (perhaps caused by the stress, anguish or dementia of late-stage AIDS) might make out-of-context reports to federal authorities that dovetail with the government's official policy regarding medical marijuana. Because of these fears, the discourse about medical marijuana has all but ceased at my medical office. If perchance the issue of medical marijuana does arise, I make no notes of the substance of the conversation for fear of government reprisal. My patients bear the brunt of this loss in communication.

9. Restrictions on the flow of relevant information between doctor and patient are, by definition, counter-therapeutic. It is critical for physicians to know what their seriously ill patients ingest. But this knowledge is generally provided by the patients themselves. That will occur only if patients trust their physician to maintain professional confidences and to use that information not to judge, but to treat. The dialogue that ensues from this atmosphere of trust continues throughout the course of treatment. I do not treat the patient as an anonymous subject; rather, the patient and I work together. We discuss together the symptoms and possible treatments. It is a critical collaborative effort.

10. Physician-colleagues work collaboratively as well. As doctors, we share and assess our observations, experiences, ideas, and knowledge. Government threats inhibit the discourse among physicians which is critical to advance our understanding of disease and the efficacy of certain treatments. Physicians are naturally reluctant to discuss any subject which

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implies or is associated with potentially illegal practices. Thus, the current threats stifle the free flow of ideas that medicine has traditionally depended upon to improve health care.

11. My fear of discussing medical marijuana precludes the climate of trust that must be established between doctor and patient. Imposed silence on any relevant issue, including the use of marijuana, leaves both patient and doctor with unspoken (and thus unanswered) questions: "What else is *not* being disclosed or addressed?" "Are we overlooking information which could be critical to medical treatment?"

12. I care for an increasing number of patients with HIV in various stages of illness. Over the years, through cautious trial and error, close observation, ongoing consultation and persistent research, AIDS researchers and front-line physicians (like myself) have developed an increasingly effective arsenal of drugs and protocols to combat HIV and AIDS. Only a few years ago, a positive test for HIV was perceived as the first step toward inevitable death. Today, our years of research have resulted in significant advances in drug therapies; there appear to be treatments which have brought us, as healers and as a community, within sight of the day when we eliminate the HIV virus and thus substantially improve the quality of life and extend the lives of persons inflicted with this epidemic.

13. However, the treatments of today, like those of previous years, are not without unknown or unintended effects. Some of my patients routinely take almost a dozen different medications each day to combat the virus and the opportunistic infections which prey on the body's compromised immune system. This daily regimen of medication poses serious problems for a significant number of my seriously ill patients. First, by definition, these pills must be swallowed. One of the frequent symptoms of HIV-related illness is severe and chronic nausea, such that swallowing pills on a regular basis can be difficult, if not impossible. To make matters worse, nausea is a common side effect of the medications

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themselves. Thus, a debilitating and demoralizing cycle sets in: the patient must repeatedly swallow pills which induce nausea, which is addressed, in turn, by yet another round of pills.

14. The inability to swallow can have devastating consequences for both treatment compliance and the patient's general health. Not only must patients be able to ingest medications, they must be able to eat and hold down food in order to obtain the nutrition essential to anyone's health. The need for regular and adequate nutrition is even more critical in patients whose compromised immune systems render them vulnerable, especially when accompanied by late-stage wasting syndrome. Moreover, some of the medications prescribed for HIV/AIDS patients must be taken on a full stomach to allow full absorption and maximum efficacy. Thus, a premium is placed on the patient's ability to swallow both medications and food. Chronic and severe nausea and loss of appetite caused by the illness and/or clinical therapies pose severe obstacles to a patient's well-being.

15. In my experience as an HIV/AIDS physician, a significant number of patients use marijuana as both an anti-emetic (anti-nauseant) or appetite stimulant. For persistent nausea, I often prescribe Compazine or Marinol, a synthetic form of THC (the active compound found in marijuana), both of which are FDA-approved. But some patients do not tolerate these medications well. Many have complained of feeling dysphoric using Marinol or find the duration of effect unduly long. These adverse effects are of concern to me, not only because of the immediate effects on patient comfort and functioning, but also because they may signal greater difficulties in patients' inability to comply with medical protocols, now and in the future. Especially with the new generation of AIDS drugs, strict compliance with daily protocols is absolutely crucial. Missing even a small number of doses can allow a drug-resistant strain of HIV to resurge, thus undermining or eliminating the effectiveness of the treatment. In circumstances where a patient is unable to comply with medical protocols, it

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is incumbent on the physician to work with the patient to find alternative therapies. My inability to explore and identify alternative therapies for unsuccessful medicines can cause patients to stop treatment altogether. I know of patients who have terminated potentially life-saving treatment because the side effects of their treatment seemed to them worse than the disease.

16. Before the government issued public threats against physicians, I discussed the medical use of marijuana with seriously ill patients who raised the issue. If patients had not tried other medications first, then it was my practice to recommend anti-emetics and/or Marinol. For patients who found other medications unsatisfactory, and for whom I believed medical marijuana could be, on the whole, beneficial, I provided counsel on the risks and benefits associated with various means of ingestion.

17. I am struck by the vehemence with which federal officials have attacked both treating physicians and the seriously ill patients who use medical marijuana. Those who suffer from chronic and severe illnesses need, above all, a broad range of therapeutic options from which to select a treatment (or treatments) that provide the greatest relief. In my experience, the government generally acknowledges this need. However, its recent policies (*i.e.*, regarding cannabis) stray from its logical deference to medical reality. Recent pronouncements by the DEA and the Department of Justice contradict and belie the spirit of their official stance regarding experimental drugs, off-label use of drugs approved for limited purposes, and compassionate use protocols for experimental drugs which, while promising, are still in the early stages of testing. For example, the Food and Drug Administration permits AIDS physicians like myself to prescribe a variety of experimental drugs. Although early reports are promising, little is known with respect to their efficacy or the long-term effects.

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18. Protease inhibitors, currently the most promising drugs in the fight against AIDS, fall within this category. Historically, the FDA has made provisions for physicians to prescribe drugs for conditions other than those for which they were initially approved. The FDA also has a compassionate use protocol which makes available to seriously and terminally ill patients those medications whose efficacy has not yet been scientifically demonstrated. Even if the FDA chooses to ignore medical experience and continue its prohibition against marijuana, it is remarkable that marijuana has not been made available under these provisions.

19. Marinol, which is essentially a marijuana derivative, has been approved for several years. Therefore, common sense tells us that there is a presumptive medical benefit to be derived from cautious use. Moreover, despite clinical studies (admittedly limited, yet far more extensive than those conducted on other FDA-approved substances), no credible research has revealed serious health risks which would justify the restrictions currently in place.

20. I have practiced medicine for almost 30 years. In that time, I have never been subjected to intimidation on the level of General McCaffrey's recent threats. I have worked hard to establish relationships with my patients that facilitate effective treatment and safeguard their privacy and integrity. The proscription against recommending the private use of marijuana, or even providing clinical information about the known risks and benefits, compromises my ability to provide sound medical treatment and relief from human suffering.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed in San Francisco, California, this 13 day of February, 1997.

MILTON N. ESTES, M.D.

EXHIBIT D

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DECLARATION OF ARNOLD S. LEFF, M.D.

I, DR. ARNOLD S. LEFF, declare as follows:

1. I am a physician licensed to practice in the State of California and have been practicing medicine for 11 years in Santa Cruz, California.

2. I received a B.S. in zoology from the University of Cincinnati in 1963. I received an M.D. from the University of Cincinnati Medical School in 1967. I completed an Internship in internal medicine at the University of Cincinnati Medical Center Hospitals in 1968. In 1969, I completed an internal medicine Fellowship in clinical pharmacology, also at the Medical Center Hospitals.

3. From 1971-72 I was Deputy Associate Director for the White House Drug Abuse Office under President Richard Nixon. In that position, I worked on a number of different areas of drug policy including: developing drug abuse programs for the Department of Defense and State Department; establishing drug treatment programs in foreign countries; implementing drug testing and treatment programs for U.S. military troops; and consulting with local law enforcement officials on implementing drug treatment programs. From 1972-75 I was a consultant to the White House Drug Abuse Office on these and other issues. During the late 1970s, I advised President Jimmy Carter's Administration on national drug policy.

4. I have had experience in drug control policy and public health in other positions as well, including as Director of Health Services for Contra Costa County, California from 1979-83.

5. Throughout those years, I also held teaching positions on medical school faculties. I was an Assistant Clinical Professor at the University of Cincinnati College of

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Medicine from 1971-79, and an Associate Clinical Professor at the University of California from 1979-84.

6. I am currently a family practitioner with an emphasis on caring for geriatric and AIDS patients. My practice includes approximately 4,000 patients overall. I have been an AIDS specialist since 1985, and currently treat approximately 110 patients for AIDS and AIDS-related conditions.

7. For many of my AIDS patients, I prescribe Marinol, a synthetic version of a primary active ingredient of marijuana, to combat severe nausea and to stimulate appetite. In some cases, however, Marinol is inappropriate because patients cannot tolerate or effectively absorb it. A significant number of my patients find that Marinol is too strong and makes them dysphoric ("high"). Many of these patients find that by smoking medical marijuana they are able to limit the dose, thereby avoiding an unwelcome dysphoric feeling.

8. I currently treat at least 20 patients for whom I believe marijuana is medically appropriate in responding to treatment-induced nausea or for appetite stimulation. In my medical judgment, in some cases medical marijuana may be the only effective medicine.

9. I am aware of threats by federal government officials against physicians who provide their patients with information regarding the potential risks or benefits of the medical use of marijuana. Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana. I have postponed discussions about the use of medical marijuana and approach such discussions with trepidation. I am fearful and reluctant to engage in even limited communications regarding medical marijuana, yet I feel a duty to provide my patients with complete medical advice.

///

10. Despite my extensive experience in drug policy and medicine, I am at a loss to justify the federal government's policy of denying sick and terminal patients a medicine that can be helpful.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Santa Cruz, California, this 13 day of February, 1997.

Arnold S. Leff, M.D.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF HOWARD D. MACCABEE, Ph.D., M.D. Date: March 21, 1997 Time: 10:00 a.m.

ER1487

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DECLARATION OF HOWARD D. MACCABEE, Ph.D., M.D.

I, DR. HOWARD D. MACCABEE, declare as follows:

1. I am a physician licensed to practice in the State of California. I have been Medical Director of the Radiation Oncology Center in Walnut Creek, California, for 17 years. I am also an Assistant Clinical Professor of Medicine at the University of California at San Francisco ("UCSF").

2. I received a B.S. from Purdue University in Lafayette, Indiana in 1961. I received a Ph.D. from the University of California at Berkeley in 1966. My dissertation research was on radiation biophysics. After extensive research in the areas of physics and medicine, I attended the University of Miami School of Medicine, where I earned an M.D. in 1975. I then completed my Internship at UCSF in 1976, followed by a three-year Residency in radiation oncology, also at UCSF.

3. I am board certified in therapeutic radiology and am a member of several professional societies. I have published 25 articles on diverse scientific and medical topics.

4. I have also studied the ethical aspects of the doctor-patient relationship and am on the bioethics committees of John Muir Medical Center and the Alameda-Contra Costa County Medical Association. I have chaired symposia on this issue between 1988 and 1994 in Contra Costa County.

5. In my practice, I commonly use radiation therapy to treat the whole spectrum of solid malignant tumors. Radiation therapy is often used after surgery or chemotherapy, as a second stage in treatment. Sometimes, however, radiation therapy is used concurrently with chemotherapy, or even as the first or only modality of treatment.

6. I treat approximately 20 patients each day and provide follow-up care and/or consultation with another 5 or so patients a day. I currently have approximately 2,000

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patients in various stages of follow-up to their initial treatment. Most of these are long-term survivors.

7. Because of the nature of some cancers, I must sometimes irradiate large portions of my patients' abdomens. Such patients often experience nausea, vomiting, and other side effects. Because of the severity of these side effects, some of my patients choose to discontinue treatment altogether, even when they know that ceasing treatment could lead to death.

8. During the 1980s, I participated in a state-sponsored study of the effects of marijuana and THC (an active ingredient in marijuana) on nausea. It was my observation during this time that some patients smoked marijuana while hospitalized, often with the tacit approval of physicians. I also observed that medical marijuana was clinically effective in treating the nausea of some patients.

9. During my career as a physician, I have witnessed cases where patients suffered from nausea or vomiting that could not be controlled by prescription anti-emetics. I frequently hear similar reports from colleagues treating cancer and AIDS patients. As a practical matter, some patients are unable to swallow pills because of the side effects of radiation therapy or chemotherapy, or because of the nature of the cancer (for instance, throat cancer). For these patients, medical marijuana can be an effective form of treatment.

10. I occasionally have patients who inquire about the use of medical marijuana. I have always considered it my ethical duty as a physician to provide every patient with the full truth as I know it. This duty includes informing patients about treatment options that I personally do not provide. For example, although I do not prescribe chemotherapy, it is my ethical obligation to discuss this treatment option with patients who are also considering undergoing radiation treatment. Because of the threats by federal officials against physicians

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who provide information to patients regarding the potential risks or benefits of the medical use of marijuana, I have had to reexamine this basic ethical principle for the first time in my professional career.

11. Due to fear caused by the threats of federal officials, I feel compelled and coerced to withhold information, refuse to make recommendations, and modify for non-clinical reasons my advice to patients regarding use of medical marijuana. Since the threats, I have not had any patients ask about medical marijuana. When I do receive such an inquiry, however, I will temper what I say to avoid the risk of government sanction. Based on my years of practice, I am concerned that my reticence in providing information will adversely affect the doctor-patient relationship, a result which is both regrettable and ethically substandard.

12. I understand that one of the reasons behind the threats is to deter physicians who may inappropriately recommend the use of medical marijuana. The threat of abuse in this context is no greater than the threat posed by doctors who misprescribe or otherwise act irresponsibly with regard to any drug. There will always be a small number of doctors who behave irresponsibly; those individual doctors should certainly be sanctioned, but not at the expense of the ability of responsible doctors to provide important medical information to their patients.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Walnut Creek, California, this 14th day of February, 1997.

Howard D. Maccabee

EXHIBIT F

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF DEBASISH TRIPATHY, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF DEBASISH TRIPATHY, M.D.

I, DR. DEBASISH TRIPATHY, declare as follows:

1. I am a physician licensed to practice in the State of California. I received a B.S. degree in chemical engineering from the Massachusetts Institute of Technology in Cambridge, Massachusetts in 1981, and earned my medical degree at Duke University School of Medicine in Durham, North Carolina in 1985. I subsequently completed an internship and residency in internal medical at Duke University Medical Center, followed by a clinical fellowship in hematology and oncology, and then a post-doctoral fellowship in cancer research, both at the University of California-San Francisco ["UCSF"].

2. I have been a member of the UCSF faculty since 1991, first as a Clinical Instructor, and then (since 1993) as Assistant Clinical Professor of Medicine. I am certified by the American Board of Internal Medicine in the areas of Internal Medicine, Clinical Hematology, and Medical Oncology. I am an active member in good standing of the American Society of Clinical Oncology. I serve on the Board of Directors of Cancer Support Community, a nonprofit agency which has provided free support and advice to cancer patients and their families for the past 20 years. I am a Contributing Editor of *Breast Diseases: A Year Book Quarterly.*

3. My clinical research and publications have focused on the diagnosis and treatment of breast cancer. I am currently involved in several major research studies assessing the efficacy of specific therapies in several patient groups, including those with metastatic breast cancer. I am the Principle Investigator on fifteen of those studies. I am the author and co-author of several chapters appearing in standard medical texts. I have also published widely in scholarly and professional journals, including Annals of Internal Medicine, Journal of Clinical Oncology, Breast Cancer Research Treatment, Journal of

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Clinical Outcomes Management, and Clinical Research.

4. Since 1993, I have been a physician at the UCSF Mount Zion Breast Care Center in San Francisco. My practice is devoted exclusively to breast cancer patients. I treat more than 1,000 patients. Approximately 100 of these patients are currently undergoing chemotherapy, a treatment utilizing various combinations of powerful medications. In some cases, the therapeutic dose of the medication we use is not far from the potentially lethal dose. Although chemotherapy is a widely used treatment in the treatment of many cancers, it can also cause severe adverse affects which some patients are simply unable to tolerate. The most common adverse effects of chemotherapy are nausea and retching.

5. The nausea and retching associated with chemotherapy are often disabling and intractable. The severity of the symptoms and their medical consequences vary from patient to patient. In many cases, the immediate results are weight loss, fatigue, and chronic discomfort. The consequences can be far graver in patients whose health and functioning is already compromised. For example, the dangers associated with weight loss and malnutrition are greater in patients whose cancer has metastasized and attacked other parts of the body.

6. For most chemotherapy patients, relief from nausea is obtained through one of several medications, including Compazine or Ondansetron, a recently developed medication specifically used for relieving chemotherapy-induced nausea. In my practice, I often rely on these medications as first-line treatment for my chemotherapy patients. They are legally available and clinically effective in many patients. For those who cannot tolerate them in pill form (*e.g.*, certain patients with cancer of the colon, stomach, throat or esophagus), these and some of the other anti-nauseants are available in other forms. Compazine, for example, can be administered intravenously, intramuscularly or in suppository form. Nonetheless, these FDA-approved medications are not effective in some patients. There is no singular formula

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for treating illness -- *I. e.*, no "best medicine" which is appropriate or advisable for all patients. Indeed, the phrase "best medicine" belies the concept of individualized treatment.

7. Another medication often used to combat nausea is Marinol, a synthetic form of THC, which is one of the key active ingredients in marijuana. In my opinion, Marinol is often the third or fourth line treatment for chemotherapy-induced nausea. I generally prescribe Marinol only after Compazine or Ondansetron have proven unsuccessful in "refractory" patients -- *i.e.*, those who are resistant to traditional treatments. It is often in that patient group (those who do not respond to commonly effective treatments) that clinicians see the greatest variation. Individual responses to medication may be idiosyncratic, unexpected or otherwise unique. In those patients, cautious trial and error is essential to effective treatment. Therapies must be modified or "customized' to the unique needs and responses on the individual. Some degree of experimentation, closely monitored, is clinically appropriate.

8. Marinol is FDA-approved as an appetite stimulant and for relief from nausea associated with chemotherapy. I have prescribed Marinol to some of my patients and it has proven effective in some cases. However, scientific and anecdotal reports consistently indicate that smoking marijuana is a therapeutically preferable means of ingestion. Marinol is available in pill form only. Moreover, Marinol contains only one of the many ingredients found in marijuana (THC). It may be that the beneficial effects of THC are increased by the cumulative effect of additional substances found in cannabis. That is an area for future research. For whatever reason, smoking appears to result in faster, more effective relief, and dosage levels are more easily titrated and controlled in some patients.

9. Still, patient preferences between Marinol and marijuana are not uniform. I have had patients who stopped smoking marijuana and returned to Marinol to address their nausea. Some report bothersome side effects, including the grogginess reported by some

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Marinol users. Still others, whose fellow patients have endorsed marijuana, have been reluctant to try it for legal, social or philosophical reasons. They cite the moral stigma attached to marijuana as an illegal "drug," their concern that others will learn of their "drug" use, and practical concerns about violating the law.

10. Means of ingestion is often critical to the efficacy of specific treatments. For example, insulin is far more effective when injected. Many medications are inhaled, while others are administrated intravenously or intramuscularly. DDAVP, a synthetic pituitary hormone, is administered through a rhinal tube, through which the patient sniffs the substance.

11. Like many substances, the efficacy of Marinol is particularly variable in refractory patients. Clinicians report a range of factors which appear to increase the difficulty of identifying effective treatment. For example, younger cancer patients seem to have more difficulty with the adverse effects of chemotherapy, possibly because they generally have more acute sensory reflexes. Adverse reactions are also more common among patients with co-existing conditions. They may present with more complicated symptom pictures, and their bodies may already be weakened by the effects of pre-existing illness. Emotional and psychiatric disorders, not uncommon in seriously or terminally ill patients, may also render traditional side-effect medications less effective.

12. In my practice, the most common treatment-induced symptom reported is nausea, which is fairly subjective, and therefore difficult to measure. Because there has been relatively little research conducted on this subject, I believe that physicians have a duty to provide their suffering patients with all clinical information available. From a moral and humane point of view, my duty increases when the suffering is caused by treatments which I have recommended and administered. When I consider chemotherapy for my patients, I

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factor in the possibility of disabling adverse reactions, as well as my ability to reduce or eradicate unwanted effects. In some instances, the balance between the risks and benefits of a proposed treatment is very close. If the information I provide does not include all possible means of reducing adverse effects, my patients must make decisions with incomplete information. In other words, the balance between the pros and cons of chemotherapy (or any treatment) may be thrown off. The patient's decisions regarding treatment may therefore be ill-informed and medically regrettable. When the treatment (*e.g.*, chemotherapy) is intended to prolong life and cure cancer, the choice to forego potentially life-saving treatment can literally be fatal.

13. The balance of risks and benefits is a process which continues throughout treatment. There are patients whose adverse reactions are seemingly intolerable. It is not unusual for those patients to consider terminating therapy; some of them discontinue treatments midway through the therapeutic protocol. For them, the suffering caused by the chemotherapy outweighs the potential long-term benefits of completing the full cycle. In many cases, incomplete therapy is of little use in fighting cancer. The decision to stop treatment can shorten lives. If I believe that marijuana might reduce their suffering and allow them to complete treatment, I must provide that information.

14. I do not generally initiate discussions about marijuana, but I am ethically bound to answer questions posed by my patients. When asked, I advise my patients about the benefits and risks (both scientific and legal) inherent in the use of marijuana for medicinal purposes. Were it clearly legal, I would include marijuana as one of the medical options available in treating persistent treatment-induced nausea. I have not provided written recommendations for marijuana to my patients, but that decision is not based upon independent clinical judgment. It is colored by political and legal implications, as well as

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threats of criminal sanctions.

15. There is one additional consideration which must be addressed in this discourse. The medical benefits of marijuana are generally limited to its use in treating cancer patients and late-stage AIDS patients suffering from wasting syndrome. I am aware of no clinical or scientific reports indicating short-term risks posed by marijuana when used in small amounts. Any discussion of adverse consequences appears to focus on the effects of long-term use (*e.g.*, adverse effects on the lungs), and even those concerns are speculative. That fact must be a factor in balancing the risks and benefits. In populations with short life expectancies, the risks become less imminent and the benefits more paramount.

16. Many medications administered to combat cancer and other serious (potentially fatal) illnesses are far more toxic than marijuana. That is a consideration which I, as a healer, must acknowledge in caring for every patient in my practice. It defies common sense and sound medical practice to withhold any information which might minimize the effects of those treatments. The recent government threats to prosecute physicians for recommending, or even advising, their patients regarding marijuana place me in an unacceptable and unethical position: to fulfill my duties as a healer, I make myself vulnerable to legal sanctions which are not grounded in science or the healing arts. The government's recently announced policies jeopardize both the integrity of my practice and the quality of care received by the many patients who depend on me.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct and this declaration was executed this 13th day of February, 1997, in San Francisco, California.

2/13/97
DEBASISH TRIPATHY, M.D.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF STEPHEN ELIOT FOLLANSBEE, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF STEPHEN ELIOT FOLLANSBEE, M.D.

I, Dr. Stephen E. Follansbee, declare as follows:

1. I am a physician licensed to practice in the State of California. I graduated *cum laude* from Pomona College in 1970, and earned a Master's degree from Harvard University in 1972. In 1977, I was awarded a doctorate *magna cum laude* from the University of Colorado School of Medicine. I subsequently completed an Internship at San Francisco General Hospital (1977-1978), a Residency at the University of California-San Francisco ["UCSF"] (1978-1980), and a Fellowship at UCSF's Division of Infectious Diseases (1980-1982). I am board-certified in both Internal Medicine and Infectious Diseases by the American College of Physicians.

2. I am currently Chief of Staff at Davies Medical Center in San Francisco. I am also Medical Director of the Institute for HIV Treatment and Research at Davies Medical Center, a position I have held for the past nine years. In 1982 I entered the private practice of infectious diseases in San Francisco. That practice has become Infectious Diseases Associates Medical Group, Inc., and I am a full-time employee of that medical corporation at this time. One year later, in 1983, I became an Attending Physician on Ward 86 (Division of AIDS) at San Francisco General Hospital and in that capacity, a part-time (hourly) employee of the University of California, San Francisco. I am currently on staff at Davies Medical Center, California Pacific Medical Center, St. Luke's Hospital, and San Francisco General Hospital Medical Center. I am also an Associate Clinical Professor of Medicine at UCSF's School of Medicine.

3. My work as both a researcher and a physician extends into the larger community, as well. Since 1990, I have been the Assistant Director of the Bay Area Community Consortium, whose primary purpose has been to promote AIDS-education and

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research. For more than 10 years, I have served as Medical Adviser to FOCUS: A Guide to AIDS Research and Counseling, a publication of the AIDS Health Project in San Francisco. I am currently a member of the Institutional Review Board of Project Inform.

4. I am a member of several professional societies, including the Infectious Diseases Society of America, the Bay Area Infectious Diseases Society, and Bay Area Physicians for Human Rights. I am the author, principle author or co-author of approximately 40 articles and research studies on the subjects of respiratory illnesses, opportunistic infections, epidemiology, and the study and treatment of AIDS-related conditions with a range of clinical therapies. These studies have been published in scholarly and professional peer review journals, including the New England Journal of Medicine, Annals of Internal Medicine, Journal of Infectious Diseases, Clinical Infectious Diseases, Annals of Neurology, Annals of Plastic Surgery, Journal of Experimental Medicine, Western Journal of Medicine, Virology, and the Journal of Reconstructive Microsurgery. My colleagues and I have also authored book chapters, research reports, and educational publications. Several additional manuscripts are currently in print.

5. For a long time, I resisted going to medical school, largely because I naively regarded doctors as glorified auto-mechanics. I assumed that the practice of medicine involved the rote following of established procedures to fix broken or ailing parts, and that creativity and nuance were neither valued nor necessary. I could not have been more wrong. Medicine, particularly the treatment of the seriously ill, is an art that places a premium on the physician's ability to recognize and respond to each patient as a unique individual. It requires the application of general scientific knowledge to the specific needs and conditions presented in an individual with a unique and complex medical history. I cannot know in advance what will constitute the best treatment for any patient. Rather, I must make educated guesses about

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what may work best, then observe the patient closely and, when necessary or appropriate, refine and modify the treatment plan in order to strike or maintain optimal conditions for improvement. Certain treatment options work well in some patients but not others; or the treatment works well, but only for a limited period, after which it loses it efficacy. Some patients tolerate various options equally well, in which case I must assess (and likely re-assess) which among them will provide the greatest benefits to my patient.

6. When a patient suffers from nausea, retching, or persistent weight loss ("wasting syndrome"), I do not consider medical marijuana as my first treatment option. It has always been my practice to first attempt to identify the cause of the problem, and prescribe the necessary therapy for treatable causes. If there are no directly treatable causes, symptomatic therapy may be necessary. For nausea or retching, I start with anti-nausea medications, of which there are several available by the oral, rectal, or on occasion the intravenous route. For wasting syndrome due to poor appetite, after altering the medications that may be contributing to this problem, I have prescribed Marinol since it was USA-FDA approved for this indication. I begin with Marinol because it is legally available and it is often an effective treatment in relieving these symptoms. However, in my clinical experience, a significant number of patients find that Marinol is not as effective as marijuana; it does not provide the same relief. Because the Marinol capsule is not as quickly or efficiently absorbed, it can be less effective than marijuana. My patients frequently report that Marinol can create a dysphoria that they dislike. As a practical matter, the very symptoms which Marinol is intended to address (*e.g.*, nausea and retching) often make oral ingestion of any medication intolerable or ineffective. Marinol is currently available in capsule form only. Marijuana, on the other hand, can be ingested by inhaling it, eating it in baked goods, or drinking marijuana tincture in a tea.

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7. The federal government's threats against physicians who discuss or recommend medical marijuana can have, and are indeed having, several negative repercussions on the quality of care that physicians can provide their seriously ill patients.

8. Medical students are taught that proper diagnosis and treatment require a detailed and accurate patient history. That chart will follow the patient wherever he or she goes. If properly maintained, it provides critical information to all future health providers. Each treating physician necessarily relies on the information contained in that chart in diagnosing and devising a safe course of treatment for that patient.

9. The government's gag on physicians discourages doctors from maintaining a comprehensive written record of the patient and the care she or he receives. I am personally very nervous about creating a detailed record of my patient histories with respect to the use of marijuana, medically or otherwise, for fear of government reprisal against me, my medical practice, or the hospital of which I am Chief of Staff. The government's threats expose me to criminal and civil sanctions, including the loss of my DEA license to prescribe schedule II drugs, without which I could not practice infectious disease medicine. I fear the loss of government research grants, both to myself and to my colleagues and the facilities I am associated with. I also fear that, on the basis of my record-keeping, my patients might be denied coverage under Medicare or MediCal, which is so often the only means for them to receive continued medical treatment for any illness or ailment.

10. Information about a patient's drug use -- licit and illicit -- is an important part of that patient's history (medical, psychiatric and social) that a physician must consider to provide safe, appropriate and effective medical care. It is common practice to learn about a patient's use of tobacco and alcohol, as well his/her history of substance abuse or dependence. That information, which may be embarrassing or shameful or involve illegal behavior, can

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only be fully disclosed in an atmosphere of trust and safety. That is one very important reason that I spend a great deal of time making my office a safe and confidential place for my patients. I make sure they understand that our discussions are confidential and their files are secure.

11. There are many instances in which a conversation about medical marijuana with a seriously ill patient is medically warranted. First, there are possible health risks of ingesting marijuana. The physician must be able to provide that information to a seriously ill patient; s/he must also advise that patient on how s/he might reduce or eliminate those risks. For example, patients with HIV or AIDS may suffer from respiratory problems that may be exacerbated by smoking any substance, whether tobacco or marijuana. I have these concerns with patients suffering from pulmonary aspergillosis, an infection of the lungs seen often among AIDS patients. In such circumstances, the physician might wish to dissuade the patient from smoking marijuana, encouraging the patient to try alternative treatments, including ingesting marijuana as a tincture or in baked form. Providing that advice is part of my duty to treat and prevent unnecessary illness and suffering.

12. There may be other risks associated with marijuana. Marijuana sold on the street may contain fungaspores and other impurities that pose little danger to healthy users but can compromise the health of a seriously ill patient, particularly a patient whose immune system is weakened. A physician might wish (quite properly) to dissuade the patient from using marijuana and encourage the patient to try alternative treatments. Failing that, the doctor might encourage the patient to avoid marijuana from unknown street sources; or to bake the marijuana to kill fungaspores before ingesting; or to smoke the marijuana through a water pipe to decrease exposure to impurities.

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13. Finally, a patient who is not accustomed to marijuana, or a patient who habitually ingests more than is medically indicated, may experience adverse effects from THC. The obvious concern is that the over-medicated patient may forget to take his or her other medications. This is true with every drug which causes drowsiness, including many medications used to relieve pain or to treat anxiety, trauma, seizure disorders, allergies, and a range of psychiatric conditions. To assess the risks to a particular patient, the atmosphere of candor and confidentiality must be unquestioned by either doctor or patient. Only then can a physician feel free to ask, and the patient feel comfortable in answering, questions regarding marijuana use. As with any medication, the physician must consider that information in her/his individualized assessment regarding that medication, its dosage, the route of administration, and the possible interactions with other medications. Ultimately, my decision must be explained to the patient -- that, too, is a necessary part of the doctor-patient relationship.

14. After candid and thorough discussions with my patients, I have refused to write letters recommending medical marijuana for several patients, generally because I believe that those patients are not proper candidates for this medicine. There are also patients I have counseled not to *smoke* marijuana when their particular circumstances or conditions pose risks which, in my clinical opinion, outweigh the potential medical benefits. In those situations, I often counsel the patients to try a different means of ingesting the marijuana -- for example, by baking it or using a water pipe.

15. Since the government's initial threats in December, my conversations have been curtailed. Because of these threats, I have been reluctant to raise the issue of marijuana, or even use the word, with my seriously ill patients. I feel extremely vulnerable to intrusive actions by the government which will undermine my clinical judgment and the integrity of my

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practice. I am, frankly, fearful that a government agent will masquerade as a patient in an attempt to monitor my practices and, if possible, develop evidence to imply wrongdoing or unethical practice. I am concerned that overzealous officials might seek to prosecute or sanction me as an example to individual physicians and the medical profession. I believe that my concerns are well-founded. Reports of DEA agents appearing in physicians' offices are already spreading through the medical community.

16. If I discuss marijuana with a patient (upon the patient's initiative or my own), s/he may well report that marijuana has helped reduce nausea or combat wasting syndrome. Having learned that, I am cast between the Scylla of legal sanctions and the Charybdis of medical care. To acknowledge that the patient's report is not uncommon -- supported by medical research and echoed by the *New England Journal of Medicine* -- may lead the patient to request that I recommend marijuana as a part of treatment. If I respond honestly, based on my medical knowledge and clinical experience, I may be inclined to recommend marijuana. In doing so, though, I risk sanction by the federal government.

17. If I decline to answer the patient's question, 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. This result stands at odds with my dedication to the art of healing; it results in my refusal to relieve that patient -- already seriously ill and struggling to remain alive -- from additional, unnecessary pain, suffering, and hopelessness.

18. It might be suggested that I parrot the views of General Barry McCaffrey and Attorney General Janet Reno, that "smoke is not medicine," and "marijuana has no known medical use but is a highly dangerous drug." To adopt such an obviously ill-informed position would undoubtedly alienate the patient, who through personal experience (and

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perhaps some background research) knows otherwise. Many of my patients use aerosolized medicines and would be right to question why one form of inhalation is efficacious while another is not. If the patient senses that his/her physician has been dishonest or disingenuous or is withholding critical information, s/he may well terminate the relationship and discontinue treatment. Alternatively, patients may try to read my mind and discern my true opinion. No patient should be forced to read a doctor's mind. Alternatively, patients may simply consider me sorely misinformed, and so, with good reason, may question or reject my medical advice on other serious issues. Either way, sound medicine suffers. More importantly, the patient's health is jeopardized. I cannot practice medicine in an ethical and honest manner if ill-informed government policies mandate that I be dishonest with those who seek my help.

19. A core tenet of medical practice is to "do no harm." In that spirit, I believe that acts of omission are often as profound (and as potentially damaging) as acts of commission. If a seriously ill patient is suffering severe nausea or chronic loss of appetite as a result of his/her illness or treatment, and such symptoms or side effects compromise his/her ability to tolerate other, traditional therapies, or to withstand a second or third cycle of chemotherapy for lymphoma, or simply to maintain the physical or psychological strength to fight for life, I do significant and inexcusable harm if I fail to counsel and treat that patient in accordance with my best medical judgment.

20. My increased reluctance to discuss medical marijuana with seriously ill patients recently led a patient's wife, who was with him in my office, to raise the issue herself. This placed me in an extremely difficult situation. I felt gagged by the government, yet ethically obligated to act as a physician. The patient and his wife, in turn, expressed terrible guilt at having placed me in a moral dilemma. That should never occur in a proper

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clinical setting. No simple question about medical treatment should place a physician in a conflict of that sort; and no patient should ever be dissuaded from requesting reasonable (indeed appropriate) medical information. That is the chilling affect of government interference in clinical practice.

21. Adjusting treatment options to best serve a patient's individual needs is what sound medical practice requires. Government officials evince a stunning disregard for the healing arts when they attack medical marijuana with the assertion that patients deserve "the *best* available medicine." We all want and deserve the *best* treatment. But in medicine, the best is always a personal best; it is not determined by a simple formula. The government's contention -- that marijuana can never be the best, or even an appropriate medicine -- is simply wrong. This contention fails to recognize that physicians typically value and depend upon a range of medical treatments, that no one medicine is best for all patients. To speak of the *best* medicine makes little sense unless viewed in the context of treatment options. For some seriously ill patients suffering extreme nausea, Marinol may be the best treatment available for them. But that does not make Marinol the "best" medicine for anyone else. The government's references to the "best" medicine are facile and without any clinical or practical meaning. In my experience, Marinol does not work well for all patients. The same applies to virtually any medication, aspirin and penicillin included. For certain seriously ill patients, marijuana may in fact be the best medicine, or the only medicine. The federal government now prohibits me from informing those patients of this fact.

22. Even if it were true, as the government contends, that marijuana is not the "best" medicine, the government itself acknowledges that an important role is served by second-, third-, and even fourth-line drugs. Federal regulations require that manufacturers of certain drugs state that they are considered a secondary or tertiary treatment option for certain

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conditions. The treatment of pneumocystis pneumonia with Mepron is one such example. Nonetheless, these medications are not proscribed or criminalized because they are not generally (or even usually) the "best" medications available. The government instead relies on the informed judgment of physicians to determine whether, when, and how to dispense these drugs.

23. Marijuana, by history and for clinically sound reasons, is one of these so-called second or third-line medications. To proscribe any potentially-effective treatment, including marijuana, as a treatment option, flies in the face of longstanding government policy and medical practice. It also deprives the healer of the full clinical armamentarium -- *i.e.*, the entire range of treatment options available in the practice of medicine. The federal government has in place detailed procedures for authorizing the use of experimental drugs. Many experimental drugs, including retrovirals and growth hormone, have been licensed by the Food and Drug Administration having had much less information than the medical profession has about marijuana.

24. A large percentage of my patients are infected by the HIV virus; a significant number suffer from conditions and opportunistic infections which have come to define AIDS. I have provided care for a population that, until very recently, was considered hopeless. They were perceived as suffering from a terminal illness that progressively and painfully destroyed the immune system, rendering them thoroughly disabled -- blind, demented, incontinent, and unable to attend to their most basic needs. The physical agony and mental anguish that often accompanies AIDS results in some patients' desire to die. I know of no physician who relishes the thought of a patient dying. Indeed, as a doctor, I work daily to stave off death and to provide my patients with the means to control their pain and maintain their autonomy and

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dignity. As our knowledge and treatments become refined and more plentiful, the certain death we saw only a few years ago is no longer an accepted fate for my patients.

25. Patients who seek my advice regarding the benefits of medical marijuana are evidence that there is hope. They have a very strong desire to survive their illness and to function as normally and productively as possible. Some of the medications that have led to this renewed optimism and have recently been licensed by the USA-FDA produce side effects (nausea and vomiting) that can be alleviated by the medical use of marijuana, and may not respond to other first-line or second-line agents. These patients ask me about marijuana not because they want to get high, but because they are fighting for their lives, which includes an honest search for the best available means to do so. Government threats against the physicians who struggle with these patients will inevitably thwart the patients' efforts. They may, in fact, remove their doctors from the healing process when vulnerable individuals are most in need of their counsel. Denying information and treatment advice to a seriously ill patient, when that medicine could promote and facilitate critical medical treatment, may needlessly hasten the patient's death.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed this 13 day of February, 1997 in San Francisco, California.

STEPHEN ELIOT FOLLANSBEE, M.D.

ER1511

EXHIBIT H

23

ORIGINAL
FILED
FEB 14 1997
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CLERK, U.S. DISTRICT COURT
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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF STEPHEN O'BRIEN, M.D. Date: March 21, 1997 Time: 10:00 a.m.

ER1513

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DECLARATION OF STEPHEN O'BRIEN, M.D.

I, DR. STEPHEN O'BRIEN, declare as follows:

1. I am a physician licensed to practice in the State of California and currently practicing medicine at the East Bay AIDS Center in Berkeley, California.

2. I received my B.A. and B.S. from the University of Washington at Seattle in 1986. I graduated from the University of Washington Medical School in 1990 and did a residency in internal medicine at the University of California at San Francisco ("UCSF") from 1990-93.

3. After completing my residency, I was employed at UCSF as a Clinical Instructor in Medicine from 1993-94 and an Assistant Clinical Professor of Medicine from 1994-95. From 1993-95 I was Co-Director for UCSF HIV Managed Care.

4. I am board certified in internal medicine. I currently maintain a private medical practice which is devoted almost solely to treating AIDS patients. I specialize in the treatment of patients in the advanced stages of AIDS. I have approximately 200 patients, about 70 percent of whom have T-Cell counts below 100. T-Cells are one measure of the strength of the immune system. A normal T-Cell count is 500-1,500. One measure of AIDS is having a T-Cell count below 200. A T-Cell count below 100 usually indicates an advanced stage of AIDS during which the patient is most at risk for opportunistic infections.

5. Many patients with advanced AIDS experience nausea, wasting syndrome, and severe pain. My usual protocol is to prescribe Compazine, Marinol, or Reglan for nausea; Megace or Marinol to stimulate appetite; and pain medication ranging from Tylenol and Tylenol with Codeine to Morphine. For most patients, these medications are at least partially effective.

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6. In some cases, prescription drugs are ineffective in reducing nausea, wasting syndrome, or severe pain. This failure can result from a number of factors, including a patient's inability to effectively absorb a drug or to swallow a pill.

7. I estimate that use of medical marijuana is a medically appropriate, and sometimes preferable, form of treatment as a last resort for 25 percent of my patients for persistent nausea, as an appetite stimulant to combat wasting syndrome, and for adjunctive pain control. I have seen medical marijuana be clinically effective in diminishing nausea and increasing appetite, thereby keeping patients alive. The recent introduction of the most promising new AIDS drugs, known as "protease inhibitors," presents a further opportunity for the use of medical marijuana because most of the toxicity from these drugs is abdominal and creates nausea and other gastrointestinal problems. The use of medical marijuana can make it possible for patients to tolerate the protease inhibitors and remain alive. For some patients, medical marijuana is the only effective medicine for nausea and wasting syndrome.

8. It is difficult to make clinical assessments about the efficacy of marijuana in controlling pain, largely because of the subjective judgment involved in quantifying any form of pain. A number of patients have informed me that although prescription drugs for pain make them drowsy and they sometimes forget about the pain, medical marijuana numbs the pain without seriously impairing their ability to continue functioning. I have observed patients become more functional after switching from prescription pain medication to medical marijuana.

9. It would be irresponsible of me in my role as a physician to deny to patients for whom no other drug is effective information about the potential benefits, as well as the risks, of marijuana use. Because so many of my patients are in the advanced stages of a life-

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threatening illness, information I can provide about medical marijuana can mean the difference between life and death.

10. I have also found that many of my patients began using marijuana prior to starting treatment with me. For those patients, it is critical that I engage in a frank and open dialogue about medical marijuana. This informs my determination of treatment options. For instance, patients with asthma often should not be smoking marijuana. I must also be able to provide my patients with information about the risks and benefits of continued use so that they can make an informed decisions.

11. I am aware of threats by federal officials against physicians who counsel patients regarding the medical use of marijuana. Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana. Because of these threats I have withheld such information, recommendations, and advice. I am fearful and reluctant to engage in even limited communications regarding medical marijuana.

12. The atmosphere of fear promoted by federal officials has affected the relationship between me and some of my patients. A number of patients are concerned that I may be limiting my discussions and that our communication now involves less than full disclosure on my part. This is particularly disturbing because of the nature of advanced AIDS care, which requires the active participation of patients and the strong, unyielding support of physicians.

13. The use of medical marijuana for AIDS patients is particularly appropriate because the Food and Drug Administration has relaxed its traditionally strict approval procedures for many AIDS drugs. Although the FDA typically requires many clinical studies before approval, AIDS drugs have sometimes been approved on the basis of a single study or

less rigorous scientific evidence than is the norm. Indeed, at least one drug, ddC, was released and subsequently withdrawn from its original indication after later studies cast doubt on its effectiveness. Because AIDS is a life-threatening illness, it is appropriate to allow the use of drugs that have not undergone traditional FDA approval.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Berkeley, California, this 13 day of February, 1997.

Stephen O'Brien, M.D.

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EXHIBIT 1

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF DONALD W. NORTHFELT, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF DONALD W. NORTHFELT, M.D.

I, DR. DONALD W. NORTHFELT, declare as follows:

1. I am a physician licensed to practice in the State of California, an Assistant Clinical Professor of Medicine at the University of California, San Diego, and an AIDS oncologist and AIDS primary care physician at the Pacific Oaks Medical Group in Palm Springs, California.

2. I received a B.S. in geology with high distinction from the University of Minnesota, Minneapolis in 1978. I then attended the California Institute of Technology in Pasadena, and received an M.S. in geochemistry in 1980. I received my medical degree from the University of Minnesota, Minneapolis in 1985. I completed an Internship and Residency at the University of California, Los Angeles in 1988. I then did a fellowship in hematology and oncology at the University of California, San Francisco from 1988 through 1991.

3. Among other positions I have held since receiving my M.D., I was an Assistant Clinical Professor of Medicine at the University of California, San Francisco, from 1991-95. During my eight years in San Francisco, I specialized in the treatment of AIDS.

4. I am the author or co-author of over 35 peer-reviewed publications, 16 book chapters, and 18 other publications on the treatment of AIDS. I also frequently lecture on specialized AIDS care. I am a member of a number of professional societies, including the American Society of Clinical Oncology, and a Fellow in the American College of Physicians.

5. My current practice focuses on care for AIDS patients and, in particular, AIDS patients suffering from cancer. I presently provide treatment for approximately 200 cancer patients and 300 AIDS patients.

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6. I frequently prescribe chemotherapy for my cancer patients, which often provokes severe nausea and vomiting. Although many patients respond to prescription anti-nausea drugs like Compazine or Reglan, these drugs are not effective for some patients. Approximately 10 percent of my patients currently undergoing chemotherapy experience severe nausea despite aggressive standard antiemetic therapy. On a few occasions where prescription drugs are unable to control the nausea and vomiting, patients have discontinued chemotherapy, even at the risk of death from progressive cancer. I believe that medical marijuana may be appropriate for some cancer patients who cannot obtain relief from the antiemetics and appetite stimulants that are currently available by prescription.

7. In my AIDS practice, I prescribe aggressive treatments combining several different drugs -- a so-called cocktail -- that are recently emerging as the first effective treatment for AIDS. These drugs often cause severe nausea and vomiting. These side effects are even more serious when the patient is suffering from AIDS wasting syndrome, which causes a steady, uncontrolled weight loss. With these new treatments, nausea and vomiting pose a particular risk, since failing to ingest even a small number of doses can lead to resurgence of a resistant strain of the HIV virus, thus jeopardizing the entire treatment. For many patients, traditional anti-nausea drugs and appetite stimulants like Megace and Marinol are effective, but for a few, medical marijuana proves to be the only viable treatment option.

8. I currently treat at least twelve patients for whom I believe marijuana could be a medically appropriate form of treatment for nausea and vomiting caused by chemotherapy or for nausea and loss of appetite in AIDS patients.

9. I am aware of threats by federal government officials against physicians who provide information to patients regarding the potential risks or benefits of the medical use of marijuana. The government's threats against doctors have made it difficult for me to discuss

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the topic candidly with my patients. Many patients in my practice present questions about the appropriateness of marijuana use for their illnesses (AIDS and cancer). Because the government's threats have been rather vague as to what might constitute grounds for revocation of DEA certification, I have felt uncomfortable in providing any specific information about the benefits or the risks of marijuana in response to these patients' inquiries. I am fearful to engage in any discussion of the topic because of my concern over loss of certification. The threats have thus interfered with my ethical obligation to provide full and accurate clinical information regarding a therapeutic option to a patient who requests it.

10. As a result, the government's threats have impeded progress in treatment of my patients with AIDS and cancer by denying them the possibility of having their suffering relieved by marijuana. In addition, those with nausea and poor appetite not afforded the possibility of improvement through marijuana use are more likely to become malnourished and suffer additional debility and illness as a result.

11. I am also concerned that the atmosphere surrounding this issue has interfered with the ability of patients to be completely candid. A comprehensive and accurate medical history of a patient is important as the cornerstone of the physician's understanding of that patient's health status. The history provides the basis for evaluating the patient's overall health as well as determining the diagnosis of any illness that the patient may be suffering. The history provides direction for the physical examination and any subsequent laboratory testing. Trust between patient and physician is important to the therapeutic process in order to allow for free exchange of information vital to an understanding of the patient's illness and to confidence in the judgment and advice imparted by the physician in evaluation and treatment of that illness. Full disclosure from the patient about his/her health and habits is

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important because information about these topics may contribute substantially to the physician's understanding of the patient's condition, confirm a specific diagnosis, and therefore indicate the prognosis and therapy for the disorder in question. When such information is withheld from the physician, the result may be delay or failure of appropriate diagnosis and treatment with potentially catastrophic consequences for the patient.

12. Significant deleterious medical outcomes may result if patients are unable or unwilling to disclose to the treating physician basic facts of their lifestyle. For example, marijuana use by an AIDS patient may result in development of a life-threatening disseminated fungal infection (aspergillosis). Disclosure of the marijuana use to the physician would permit information to be provided which could reduce the risk of this infection. Conversely, failure to disclose marijuana use might lead to delay in diagnosis and treatment of aspergillosis due to the physician's lack of recognition that the patient is at risk for the infection.

13. The government's threats have also instilled fear and guilt in seriously, chronically, and terminally ill patients in my AIDS and cancer practices. This has caused them to become demoralized and experience feelings of hopelessness, which impairs their desire and ability to comply with recommendations and treatments intended to improve their health. As a result, their health status has not improved or has actually declined.

14. The medical ethical tenet of beneficence obligates physicians to recommend those treatments most likely to produce the desired results in the individual patient under their care. In my view, this obligation is even more imperative in the situation where the treatment is intended to alleviate suffering. Patients in my AIDS and cancer practices may suffer

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unnecessarily from pain, nausea, and poor appetite with subsequent weight loss and weakness if marijuana had the potential to alleviate these problems but this information was withheld.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at PALM SPRINGS California, this 14 day of February, 1997.

2/14/97

Donald W. Northfelt, M.D.

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EXHIBIT J

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF VIRGINIA I. CAFARO, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF VIRGINIA I. CAFARO, M.D.

I, DR. VIRGINIA I. CAFARO, declare as follows:

1. I am a physician licensed to practice in the State of California and State of New York, an Attending Physician at the Conant Medical Group, a Clinical Instructor at the University of California at San Francisco ("UCSF"), and an Attending Physician at UCSF Mount Zion Medical Center.

2. I received my B.S. from Wagner College in Staten Island, New York, in 1977. I received an M.S. in physiology from Georgetown University in Washington, D.C. in 1982. I graduated from the Medical College of Virginia in 1986. From 1986-89 I was a resident in internal medicine at the Albert Einstein College of Medicine in New York City. I completed a fellowship in infectious diseases at UCSF/Mount Zion from 1990-92.

3. After completing my residency, I was employed at UCSF as a Clinical Instructor in Medicine from 1993-94 and an Assistant Clinical Professor of Medicine from 1994-95. From 1993-95 I was Co-Director for the Mount Zion HIV Clinic. In 1996, I was appointed to the Mayor's HIV Health Service Planning Council.

4. I currently treat approximately 1,000 patients, the vast majority of whom (90-95%) have AIDS or HIV-related conditions. In addition to my direct care responsibilities, I am conducting research into a number of issues related to infectious diseases, including the role of antiretroviral agents and other therapies in the cure of HIV.

5. A number of my AIDS patients use medical marijuana as part of their treatment. Many of these individuals have been ill for many years, some of them their entire adult lives. They have tried countless therapies -- some traditional and others experimental -- to relieve their pain, reduce disabling symptoms caused by repeated infections, and regain the strength and the hope they had prior to exposure to this virus.

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6. To properly treat a patient, a physician must obtain a reliable and complete medical history. Such information, which includes the patient's drug history, is essential to prompt and proper diagnoses and medical intervention. To obtain it, it is my duty to create an atmosphere of candor and absolute confidentiality. This atmosphere has generally enabled me to obtain frank information from my patients and to provide honest and complete medical advice. In my practice, I have never been prohibited, by the federal government or anyone else, from providing my clinical knowledge to patients who might benefit as a result. In the past months, that has changed. I am now aware of threats by federal officials to sanction and even criminally prosecute physicians who counsel their patients about the risks and benefits of medical marijuana.

7. Marijuana, when ingested in proper doses, has proven to be effective in the treatment of nausea and retching. It is also effective as an appetite stimulant, which is critical for patients suffering from wasting syndrome. One of the active ingredients in marijuana, THC, is legally available as a pill called Marinol. In some patients, Marinol provides relief from nausea and enables patients to eat, regain weight and muscle mass, and improve their general health. Other medications can also be prescribed for nausea and retching. Some patients, however, do not respond to any such prescription drugs, but have successfully treated their nausea and loss of appetite by ingesting marijuana. Although Marinol is related to marijuana and contains one of its key ingredients, it is not the same substance and is often less effective clinically than marijuana itself. The reasons for this are not fully understood, but one factor is likely the means of ingestion. Marinol is currently available in pill form only. Many patients cannot tolerate medications taken orally. Moreover, the absorption and efficacy of Marinol is unreliable and unpredictable. By contrast, inhaled marijuana is easier to control and absorption rates may be more consistent.

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8. These are just some of the factors to be considered in the discourse on medical marijuana. Prior to the government's recent threats, they were part of the ongoing dialogue between doctor and patient. That dialogue has now been effectively curbed. In treating and advising new patients, for example, I do not provide as broad a view of their treatment options as I used to. Since the threats by federal officials, I have avoided directly broaching the subject of medical marijuana even with patients who could, in my clinical judgment, obtain marked relief with the use of marijuana. When the discussion does take place, it is now limited to providing clinical and scientific data. Further, my patients are fearful of placing me at risk, which is not a concern any patient should have.

9. My patients' health is my paramount concern. The federal government has evidently chosen to subordinate health needs to political expediency. As a physician, if anything, this increases my duty to work with my patients to maintain trust and identify effective interventions. I also feel duty-bound to challenge the federal policy through the courts in the interests of my patients.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed at San Francisco, California, this 14 day of February, 1997.

Virginia I. Cafaro, M.D.

EXHIBIT K

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF ROBERT C. SCOTT, III, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF ROBERT C. SCOTT, III, M.D.

I, DR. ROBERT C. SCOTT, III, declare as follows:

1. I am a physician licensed to practice in the State of California and have been practicing medicine for 20 years in Oakland, California.

2. I received a B.S. from Parsons College in Fairfield, Iowa, in 1963. I received an M.S. in 1965 and an M.Ed. in 1968, both from the University of Illinois at Urbana. I earned my medical degree from the University of California at San Francisco Medical School in 1974. I completed an Internship in medicine at Emory University in Atlanta, Georgia, the following year. I then did a Residency in internal medicine at Stanford University Hospitals from 1975-77.

3. I am on the medical staff of the Alta Bates Medical Center and the Summit Medical Center. I am a member of a number of local, state, and national organizations of physicians, including the American College of Physicians, American Association of Internal Medicine, National Medical Association, Alameda-Contra Costa Medical Association, and HIV Clinical Trials Researchers. I was a founding member of Bay Area Physicians for Human Rights.

4. I practice internal medicine and have over 2,000 patients. My practice is located in a poor city, and most of my patients are indigent, retired, and on fixed incomes.

5. Approximately 350 of my patients are infected with HIV. Many of them suffer from severe nausea, progressive anorexia, or chronic pain. I generally prescribe drugs such as Marinol, Compazine, or Tigan for nausea; Megace or Marinol for anorexia; and Vicadin, Demorol, or Duragesic for pain.

6. In my experience, one or more of these drugs is often effective in alleviating these symptoms in most patients. I have found, however, that in some patients these

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conventional prescription drugs are inappropriate either because patients cannot tolerate them or because the drugs are ineffective in reaching the central nervous system. Patients frequently complain that Marinol causes haziness or a sense of dizziness or vertigo, among other undesirable side effects. Some of these patients are able to titrate (adjust the quantity) marijuana to obtain relief without the potential negative side effects. I also have patients taking "protease inhibitors" who successfully use marijuana to alleviate the gastrointestinal side effects of these drugs, such as nausea, diarrhea, and bloating. I currently treat at least 75 patients for whom I believe medical marijuana is a medically appropriate form of treatment for nausea, anorexia, or pain. For some patients, I believe that medical marijuana may be the only effective medicine. I believe it is my duty as a doctor to provide information about potential medical benefits, as well as risks, of marijuana use for patients for whom it is medically appropriate.

7. Because of the nature of my patient population, the expense of drugs such as Marinol is also a relevant issue. Most of my patients are uninsured or underinsured. Medicare does not pay for drugs, and MediCal provides only limited payment.

8. Many of my patients used marijuana prior to consulting me. It is important to my evaluation of their conditions that I discuss their use of marijuana, or any other substances that potentially affect their medical history or current conditions. It is also important to patients' personal decisions about medical marijuana use that I discuss with them the risks and benefits of medical marijuana.

9. In all aspects of my practice, a secure physician-patient relationship is critical to providing high quality medical care. I depend on my patients to provide me with all information that might have an affect on their health. They depend on me to provide full information about treatment options so that they can make informed choices.

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10. I am aware of threats by federal officials against physicians who provide information to patients regarding the potential risks or benefits of the medical use of marijuana. Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana. I am particularly fearful that the federal government might send in someone posing as a patient in an attempt to gather evidence against me, even though I always act in my best medical judgment. Because of this fear, I have instituted an application procedure for new patients Any patient who desires to consult with me must fill out a form with relevant information I then decide whether to treat this patient. Since instituting this application procedure, I have turned away a couple of prospective patients because I was suspicious of their motives. In general, I am much more careful in my discussions with new and longstanding patients, and am fearful and reluctant to engage in even limited communications regarding medical marijuana.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge

Executed at Oakland, California, this 14 day of February, 1997.

Robert C. Scott, III, M.D.

EXHIBIT L

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Attorneys for Proposed Defendant and Counterclaimant-in-Intervention Rebecca Nikkel

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. MARIN ALLIANCE FOR MEDICAL MARIJUANA; and LYNETTE SHAW, Defendants. AND RELATED ACTIONS	No. C 98-00086 CRB DECLARATION OF REBECCA NIKKEL IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, REBECCA NIKKEL, declare as follows:

1. I am a member of the Marin Alliance for Medical Marijuana in Fairfax, California (the "Marin Alliance"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the matters set forth in this declaration and could and would

testify competently to them if called on by the Court to do so.

2. I am 44 years old. I have fibromyalgia and multiple sclerosis. I was diagnosed with multiple sclerosis in June 1998. Both of these conditions cause me to experience severe muscle spasms which are very painful.

3. The pain caused by these conditions changes, depending on other stressors in my environment. For example, warm weather causes me to experience more muscle spasms. For the last six months, I have experienced pain from muscle spasms on a daily basis. The pain can be continuous at times. Recently, I have been experiencing tingling in my arms and hands, and the pain has been very intense particularly in my right hand.

4. I have tried many traditional medicines to alleviate the pain caused by these severe muscle spasms, but none of them has worked effectively. For example, I have tried baclofen, which caused my legs to become very weak. While using baclofen, I was not able to walk. I have tried other conventional medicines, none of which has worked effectively to alleviate my pain. I have also had allergic reactions and developed over time a hypersensitivity to many traditional medicines. On one occasion, I went into anaphylactic shock and nearly died as a result of an allergic reaction to a conventional drug.

5. Because of these harmful, painful and life-threatening experiences, I do not want to continue risking my life by trying new conventional medicines. I am afraid to try

new medicines because of the violent allergic reactions and side effects I have experienced in the past.

6. My doctor gave me a written recommendation for the use of cannabis to alleviate the pain caused by the muscle spasms. I have used cannabis, and it helps me tremendously. The cannabis is the only medicine which effectively and safely alleviates the pain caused by the muscle spasms. The use of cannabis is a medical necessity for me. No other conventional medicine effectively manages the pain I experience from the muscle spasms.

7. I understand that the federal government has threatened to prosecute doctors who recommend the use of cannabis to patients. For this reason, I have been hesitant to discuss with my doctors the use of cannabis to treat my condition. I have only felt comfortable discussing the use of cannabis with two of my doctors. One of these two doctors told me that she believes that cannabis is the safest drug she could ever give to me. As a result of my experience with traditional medicines and cannabis, I agree with my doctor that cannabis is the safest drug she can give me to alleviate my pain.

8. I have been a member of the Marin Alliance since December 1997, and I visit it every ten (10) days. For this reason, I know that I visited the Marin Alliance several times during the period of May to June 1998. If the Marin Alliance and the other defendant clubs are closed, I will

suffer immediate harm because I will have nowhere legally to obtain cannabis.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of August, 1998 at Santa Rosa, California.

Rebecca Nikkel

ER1539

EXHIBIT M

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. UKIAH CANNABIS BUYER'S CLUB; CHERRIE LOVETT; MARVIN LEHRMAN; and MILDRED LEHRMAN, Defendants. AND RELATED ACTIONS	No. C 98-00087 CRB DECLARATION OF LUCIA Y. VIER IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, LUCIA Y. VIER, declare as follows:

1. I am a member of the Ukiah Cannabis Buyer's Club in Ukiah, California (the "Ukiah Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the matters set forth in this declaration and could and would

testify competently to them if called on by the Court to do so.

2. I am 48 years old. In March 1998, I was diagnosed with squamous cell cancer. My doctor found a cancerous tumor in my pelvic area and cancerous spots in my lungs. I am in stage four of the cancer, and my doctors have told me that with treatment I may have a year to a year and a half to live. I underwent radiation treatments and am now being treated with chemotherapy.

3. In or about March 1998, my doctor gave me a written recommendation for cannabis. The chemotherapy caused me to experience nausea, and it has made it almost impossible for me to taste food. I use cannabis to stimulate my appetite. I am a small person, approximately four feet eleven inches tall, and I weigh approximately 87 pounds. It is therefore crucial that I maintain my weight. The cannabis is very effective at stimulating my appetite. Without cannabis, I would not want to and I would not be able to eat the amount of food that is necessary to maintain my health. For this reason, the use of cannabis is a medical necessity for me. I do not know of any traditional medicines that would stimulate my appetite effectively, and my doctor has not tried to prescribe any drug for this reason other than cannabis.

4. In addition, the cannabis helps me get through the day. Without cannabis, my days would drag on and be a lot harder and longer. The cannabis relaxes me and helps me be more productive.

5. If the Ukiah Club and the other defendant clubs are closed, I will suffer immediate harm. I cannot imagine how I would survive day to day without the use of cannabis. If I were forced to go without cannabis, I believe I would rapidly lose weight and my day to day pain would increase. I also believe that without cannabis, I would not be able to survive as long as my doctors' prognosis.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6 day of August, 1998 at Santa Rosa, California.

Lucia Y. Vier

Lucia Y. Vier

EXHIBIT N

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Attorneys for Proposed Defendants and Counterclaimants-in-Intervention Edward Neil Brundridge and Ima Carter

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. OAKLAND CANNABIS BUYERS' COOPERATIVE, and JEFFREY JONES, Defendants. AND RELATED ACTIONS	No. C 98-00088 CRB DECLARATION OF EDWARD NEIL BRUNDRIDGE IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, EDWARD NEIL BRUNDRIDGE, declare as follows:

1. I am a member of the Oakland Cannabis Buyers' Cooperative in Oakland, California (the "Oakland Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the

matters set forth in this declaration and could and would testify competently to them if called on by the Court to do so.

2. I am 58 years old. I had Hepatitis C which caused damage to my liver. As a result, I am not able to take many traditional medications.

3. I have severe arthritis in my right knee. The arthritis is so extensive that I have had to use a cane for the past year. My doctor wanted to prescribe ibuprofen to relieve the swelling caused by the arthritis, but I am allergic to ibuprofen. I understand that ibuprofen is what my doctor generally recommends to alleviate the swelling associated with arthritis. To alleviate the pain caused by the arthritis, I have tried other traditional medicines. These medicines were not effective in relieving that pain. I was either allergic to the traditional medications or they did not alleviate my pain.

4. I have successfully used cannabis, however, to alleviate this pain. In addition, cannabis also allows me to be alert, which many of the traditional medicines do not. Cannabis is the only medicine I have used which effectively alleviates the pain caused by the arthritis.

5. The traditional medicines I have tried either do not work or are so strong that I cannot participate in the activities that I need to do every day. These necessary daily activities include driving, taking my dog out for walks, shopping, talking to other people, taking

care of my finances, riding public transportation, doing the dishes, cleaning my house, reading and answering the telephone. Cannabis, however, alleviates the pain without preventing me from functioning in my daily life.

6. I also suffer from insomnia. The cannabis helps me sleep and relieves my anxiety. Without cannabis, I would not be able to sleep. Conventional sleeping pills are highly addictive, and, for that reason, I am not able to take them. I cannot handle conventional sleeping medications and my doctor will not prescribe them for me.

7. My doctor told me that I will need to enter the liver institute very soon, which will put me in line for a liver transplant in the next several years. This news has caused me to suffer from anxiety and extreme depression. I am presently seeing a therapist for treatment for these conditions. As a result of my anxiety and depression, I no longer had an appetite. I use cannabis to relieve the stress of my depression and to give me an appetite. I once went without cannabis, and I lost 30 pounds in three weeks. I am presently taking Prozac, which helps alleviate my anxiety and depression, but it does nothing to stimulate my appetite.

8. Cannabis is the only drug that effectively gives me an appetite. Without using cannabis, I believe I would not be alive today. For this reason, the use of cannabis is a medical necessity for me. There is no drug other than cannabis that alleviates my pain and

depression and gives me the appetite I need to stay alive. I have tried many traditional drugs, none of which is effective in alleviating my pain and stimulating my appetite. Many of these traditional drugs were not effective because I was allergic to them.

9. There is another reason that I cannot take many traditional medicines. I am a recovering drug abuser and alcoholic. I cannot take many traditional pain relievers because of these addictions. I become easily addicted to traditional pain killers.

10. My doctor recommended that I use cannabis, but he was afraid to give me a written recommendation for fear of prosecution by the government and therefore would not give me a written recommendation for cannabis. Nevertheless, he telephoned the Oakland Club and gave it an oral recommendation for cannabis for me. I feel that my private relationship with my doctor has been damaged because of the government's threat of prosecution and the fear it has caused in my doctor to treat me with the only effective medicine for alleviating my pain and stimulating my appetite: cannabis. Because of this fear, I feel that my doctor has been reluctant to discuss cannabis as a possible treatment and he has been reluctant to prescribe it.

11. In addition, I feel that my privacy rights have been violated as a result of plaintiff's action to close the Oakland Club and the other defendant clubs to prevent the

medicinal use of cannabis. I live in constant fear that I will be prosecuted concerning my use of cannabis and that my doctor will be prosecuted for recommending that I use cannabis. I also fear that my private conversations with my physician and my medical records will be made public as a result of the relief sought by plaintiff. If the Oakland Club and the other defendant clubs are closed, I will suffer immediate harm since I will not be able legally to obtain cannabis, which is the only effective treatment available to alleviate my pain and stimulate my appetite.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 5th day of August, 1998 at San Francisco, California.

Edward Neil Brundridge

ER1549

EXHIBIT O

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. OAKLAND CANNABIS BUYERS' COOPERATIVE, and JEFFREY JONES, Defendants. AND RELATED ACTIONS	No. C 98-00088 CRB DECLARATION OF IMA CARTER IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, IMA CARTER, declare as follows:

1. I am a member of the Oakland Cannabis Buyers' Cooperative in Oakland, California (the "Oakland Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the

matters set forth in this declaration and could and would testify competently to them if called on by the Court to do so.

2. I am 55 years old. I suffer from several different conditions and injuries which cause me significant and constant pain. I use cannabis for several of these conditions: congenital scoliosis, fibromyalgia and cervical nerve damage which I suffered as a result of being involved in several car accidents in which I was rear-ended. These conditions which include cervical nerve damage in C4 through C7 of my spine, cause me enormous pain in my back. This pain is marked by frequent muscle spasms, and a recurring shooting pain in my head. Cannabis is the only drug in my experience that has effectively treated this pain.

3. I have tried numerous traditional medicines for these conditions, none of which was effective. For example, I took steroids and anti-inflammatory drugs. These drugs have caused me to bleed internally.

4. I have also tried rhizotomy, which is a laser treatment. During this treatment, a laser beam was burned into the cervical nerves to create scar tissue. The treatment required that I be awake during it and it was excruciatingly painful. It is my understanding that physicians have now discontinued prescribing rhizotomy treatments because they are unbearably painful and useless. The rhizotomy treatments did not relieve my back pain. This pain feels like a hot burning pain going down my left arm into my hand.

5. In addition, I underwent breast reduction surgery to relieve the scoliosis pain in my back. I also tried many different forms of physical therapy, including various exercises, ultrasound, ice packs, jacuzzi treatments and others. None of these even touched the recurring shooting pain I experience in my head.

6. I also have a therapeutic electrical neuro-stimulator (a "TENS") unit that controls some of my pain from the cervical nerve damage and scoliosis. However, the TENS unit does not stop or dull in any way the shooting pain that occurs in my head at frequent intervals. I am presently taking morphine as prescribed by my doctor, but it--like the TENS unit--does not stop or dull in any way the frequent pain in my head.

7. I first tried cannabis on the recommendation of my nutritionist, and it is the only drug that I have used that has dulled or stopped the pain. I was once forced to go without cannabis. During this period of time, the pain was completely disabling and prevented me from being able to function. During this time, I could not leave my bedroom due to the pain that recurred every few minutes, and therefore I could not do any of my regular daily activities, such as answering the phone, doing the dishes, running errands, watching television, reading and taking care of my finances.

8. I was afraid to ask my doctor for a recommendation for cannabis. I was afraid of alienating him by asking him for a drug which I understood the government was threatening to prosecute doctors for prescribing. When I asked him, I

was nervous and upset. Nevertheless, I asked my doctor to give me a written recommendation for cannabis and he agreed. My doctor monitors my use of cannabis by seeing me frequently and discussing my treatment. In addition, he renews my letter of referral every few months. I feel that my private relationship with my doctor is endangered because of the government's threat of prosecution. The fear it has caused me makes me unable to speak freely with my doctor about my condition and my medical needs when a nurse or assistant is present. Because of this fear I had been reluctant to discuss openly and extensively with my doctor the possibility of using cannabis to treat my condition.

9. In addition, I feel that my privacy rights have been violated as a result of plaintiff's action to close the Oakland Club and the other defendant clubs to prevent the medicinal use of cannabis. I live in constant fear that I will be prosecuted for my use of cannabis and that my doctor will be prosecuted for recommending that I use cannabis. I also fear that my private conversations with my physician and my medical records will be made public as a result of the relief sought by plaintiff. If the Oakland Club is closed, I will not be able legally to obtain cannabis, which is the only effective treatment available to alleviate my pain and frequent muscle spasms associated with congenital scoliosis, fibromyalgia and nerve damage.

10. As described above, I have previously gone without using cannabis. If the Oakland Club and other defendant

clubs are shut down or I am in some other way prohibited from obtaining cannabis, I will suffer immediate harm. Using cannabis is a medical necessity for me. When I am not using cannabis, I am completely incapacitated and cannot leave my room. Without cannabis, I experience intense intervals of pain in my head that occur every few minutes. There is no drug other than cannabis that alleviates these shooting pains. I have tried many traditional drugs, including morphine, steroids, rhizotomy treatments and breast reduction surgery, none of which has alleviated the shooting pains.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 4th day of August, 1998 at Oakland, California.

Ima Carter

Ima Carter

FRANK W. HUNGER
Assistant Attorney General
ROBERT S. MUELLER, III (Cal. BN 59775)
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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON,

Defendants.

AND RELATED ACTIONS

Nos. C 98-0085 CRB RELATED
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0245 CRB

PLAINTIFF'S MOTIONS IN LIMINE TO EXCLUDE DEFENDANTS' AFFIRMATIVE DEFENSES

Date: September 28, 1998
Time: 2:30 p.m.
Courtroom of the Hon. Charles R. Breyer

ER1556

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NOTICE OF MOTION

PLEASE TAKE NOTICE that on September 28, 1998, at 2:30 p.m., in the United States Courthouse at 450 Golden Gate Avenue, San Francisco, California, in the courtroom normally occupied by the Honorable Charles R. Breyer, plaintiff, the United States of America, will move in limine to exclude the defendants, the Oakland Cannabis Buyers' Cooperative ("OCBC") and Jeffrey Jones in Case No. C 98-0088 CRB (collectively the "OCBC defendants"); and defendants Marin Alliance for Medical Marijuana ("Marin Alliance") and Lynnette Shaw in Case No. C 98-0086 CRB (collectively the "Marin Alliance defendants"), from presenting evidence regarding the affirmative defenses of medical necessity, substantive due process, or joint users. As is demonstrated below, the OCBC and Marin Alliance defendants have failed to present any competent evidence regarding these affirmative defenses that is sufficient to present to a jury and, in any event, they fail as a matter of law. The Court should therefore hold these defendants in civil contempt of the May 19, 1998 Preliminary Injunction Orders and grant the relief sought by the United States.

PRELIMINARY STATEMENT

From the time this Court entered its Preliminary Injunction Orders on May 19, 1998, the OCBC and Marin Alliance defendants have publicly announced that they would defy these injunctions, and the record now reveals their widespread, open, and notorious violations of the Courts's lawful decrees. While the Orders to Show Cause entered by the Court on September 3, 1998, focus on two specific days, it is obvious from the numbers of distributions of marijuana conducted on these days, as well as the nature of the defenses asserted by the OCBC and Marin Alliance defendants, that the transactions for which these defendants have been called to account for are merely the tip of a very large iceberg. For example, only two days after the Court entered the Preliminary Injunction Orders on May 19, nearly two hundred persons "visited" the OCBC, and the OCBC defendants do not contest that they distributed marijuana to these persons on that date. Instead, the OCBC and Marin Alliance defendants raise affirmative defenses which, as we

demonstrate below, fail as a matter of fact and law. Under these circumstances, the time has come for the Court to vindicate its authority, reject the affirmative defenses put forward by the OCBC and Marin Alliance defendants, and grant the relief sought by the United States.

ARGUMENT

I. STANDARDS

Absent a stay, "all orders and judgments of courts must be complied with promptly." Maness v. Meyers, 419 U.S. 449, 458 (1975). The Ninth Circuit's rule regarding contempt therefore "has long been whether defendants have performed 'all reasonable steps within their power to insure compliance' with the court's orders." Stone v. City and County of San Francisco, 968 F.2d 850, 856 (9th Cir. 1992) (quoting Sekaquaptewa v. MacDonald, 544 F.2d 396, 404 (9th Cir. 1976), cert. denied, 430 U.S. 931 (1977)), cert. denied, 506 U.S. 1081 (1993). Once the moving party has met its initial burden of establishing a prima facie case by clear and convincing evidence that the contemnors violated a specific and definite order of the court, the burden of production shifts to the non-moving party to prove either substantial compliance with the court's order or inability to comply. United States v. Rylander, 460 U.S. 752, 757 (1983). To satisfy this burden, the non-moving party must show "categorically and in detail" either substantial compliance or inability to comply. See Donovan v. Mazzola, 716 F.2d 1226, 1240 (9th Cir. 1983), cert. denied, 464 U.S. 1040 (1984).

A parties' subjective intent is irrelevant in civil contempt proceedings. See, e.g., In re Crystal Palace Gambling Hall, Inc., 817 F.2d 1361, 1365 (9th Cir. 1987). The sole question is whether a party complied with the district court's order. See, e.g., McComb v. Jacksonville Paper Co., 336 U.S. 187, 191 (1949). In assessing whether an alleged contemnor took "every reasonable step" to comply with the terms of an injunction, a district court can consider (1) a history of noncompliance and (2) a failure to comply despite the pendency of the contempt motion. Stone, 968 F.2d at 857. A district court has "wide latitude in determining whether there has been a contemptuous defiance of its order." Gifford v. Heckler, 741 F.2d 263, 266 (9th Cir.1984).

II. THE OCBC AND MARIN ALLIANCE DEFENDANTS' FAILURE TO CONTEST THAT THEY DISTRIBUTED MARIJUANA, AND USED THEIR PREMISES FOR THE PURPOSE OF DISTRIBUTING MARIJUANA, ON MAY 21 AND 27, 1998, CONSTITUTES AN EVIDENTIARY ADMISSION

In their responses to the Court's Show Cause Orders, neither the OCBC nor Marin Alliance defendants deny that they distributed marijuana, and used their respective premises for the purpose of distributing marijuana, on May 21 and 27, 1998, respectively. Rather, they strain to avoid acknowledging these facts by referring, for example, to "alleged" distributions of marijuana and "visits" to the OCBC, as opposed to actual distributions and use of marijuana on their premises. OCBC Response to Show Cause Order in Case No. C 98-0088 CRB ("OCBC Resp.") at 1, 4.[1] While these circumlocutions may represent an attempt to avoid admissions for criminal law purposes, they do not suffice as denials in these civil contempt proceedings. As set forth above, the non-moving party in contempt proceedings must prove "categorically and in detail" substantial compliance or inability to comply with a court's order. Donovan, 716 F.2d at 1240.

Moreover, the Supreme Court has often stated that, in civil cases, the "'[f]ailure to contest an assertion * * * is considered evidence of acquiescence * * * if it would have been natural under the circumstances to object to the assertion in question.'" Baxter v. Palmigiano, 425 U.S. 308, 319 (1976) (quoting United States v. Hale, 422 U.S. 171, 176 (1975)). This is because, as Justice Brandeis explained, "'[c]onduct which forms a basis for inference is evidence. Silence is often evidence of the most persuasive character." United States ex rel. Bilokumsky v. Tod, 263 U.S. 149, 153-54 (1923). See also 3A J. Wigmore, Evidence s 1042 (Chadbourn rev. 1970) ("A failure to assert a fact, when it would have been natural to assert it, amounts in effect to an assertion of

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[1] Indeed, the only possible inference that can be drawn from defendants' declarations and other evidence is that they are engaged in the distribution of marijuana. Thus, the OCBC defendants state, for example, that their evidence "establishes that "that OCBC is a professional and well-managed organization which provides a safe place for seriously ill persons to receive physician-approved medical cannabis * * * * Its mission is to provide seriously ill patients with a safe and reliable source of medical cannabis products and plants." OCBC Resp. at 7.

the non-existence of the fact.") (cited with approval in Baxter, 425 U.S. at 319 n.3). Courts therefore have followed the "well recognized" principle that "adverse inferences may properly be drawn from silence by parties in civil cases." Watson v. Perry, 918 F. Supp. 1403, 1415-16 (W.D. Wash. 1996), aff'd, 124 F.3d 1124 (9th Cir. 1997).

Here, where the Court has ordered the OCBC and Marin Alliance defendants to show cause why they should not be held in contempt for distributing marijuana and using their respective premises for this purpose, on May 21 and 27, 1998, respectively, there can be no debate that it would have been "natural under the circumstances" for the defendants to deny these allegations, if they were able to do so. But the OCBC and Marin Alliance have made no such denials in their responses, and have never taken issue, as a factual matter, with the United States' evidence that they have distributed marijuana and maintained their respective premises for this purpose following the entry of the May 19, 1998 Preliminary Injunction Orders. Under these circumstances, the defendants' failure to contest these facts may properly be "considered evidence of acquiescence." Baxter, 425 U.S. at 319; Hale, 422 U.S. at 176.

Accordingly, the OCBC and Marin Alliance defendants are left only with their affirmative defenses of medical necessity, substantive due process, and joint users in responding to the Court's Show Cause Orders. As we demonstrate below, none of these alleged defenses, both as a matter of fact and law, can withstand scrutiny.

III. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO OFFER EVIDENCE SUFFICIENT TO GO TO A JURY ON THEIR DEFENSE OF MEDICAL NECESSITY, AND THE DEFENSE IS UNAVAILABLE TO THEM AS A MATTER OF LAW

The OCBC and Marin Alliance defendants have failed to offer any competent evidence establishing that each and every person to whom they distributed marijuana on May 21 and 27, 1998, respectively, could establish the defense of medical necessity, and that the defendants were aware of the circumstances of their conditions when they sold them marijuana. In its May 13, 1998 Memorandum and Order, the Court made clear what kind of evidentiary showing would be necessary for the defendants to maintain a defense of medical necessity. Borrowing the Court's

language, "for the defense to be available here, defendants would have to prove that *each and every patient* to whom it provide[d] marijuana [on May 21, 1998] is in danger of imminent harm; that cannabis will alleviate the harm for that patient; and that the patient had no other alternatives, for example, that no other legal drug could have reasonably averted the harm." United States v. Cannabis Cultivators Club, 5 F. Supp.2d 1086, 1102 (N.D. Cal. 1998) (emphasis supplied). This is because, the Court held, "the defense of necessity has never been allowed to exempt a defendant from the criminal laws on a blanket basis." Id.

The OCBC and Marin Alliance defendants have failed to make this required evidentiary showing. The OCBC defendants, for example, have submitted declarations from Kenneth Estes, Ima Carter, David Sanders, and Yvonne Westbrook, who were listed in the press conference statement issued by the OCBC, see OCBC Resp. at 3-4, as well as three other patients of the OCBC, Robert T. Bonardi, Albert Dunham, and Harold Sweet, and two officials of the club who also are customers, Michael M. Alcalay, M.D., and Laura Galli, R.N. Id. Under these circumstances, the Court may properly assume that, with the exception of Mr. Sanders,[2] the OCBC distributed marijuana to these individuals on May 21.[3] Yet, with the exception of the declaration of Dr. Alcalay, none of these proffered declarations is accompanied by competent medical testimony regarding whether there alternative, legal drugs that are available to treat the symptoms in question.

Moreover, the OCBC defendants have offered no evidence whatsoever regarding the medical conditions and treatments of the remaining 175-plus persons to whom (it is safe to assume) they distributed marijuana on May 21, with the exception of the chart attached to the declaration of Dr. Alcalay. Instead, the OCBC defendants simply submit declarations from Dr.

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[2] Mr. Sanders declares that he was not present at the OCBC on May 21. Declaration of David Sanders ¶ 3.

[3] The OCBC defendants attempt to have it both ways insofar as none of these individuals expressly states that they were provided marijuana by the OCBC on May 21.

Alcalay and James D. McClelland, the Chief Financial Officer of the OCBC,[4] who purport to describe the medical conditions and necessities of OCBC members. For example, Dr. Alcalay states that:

> Although every patient's experience is unique, some general comments apply to ***many*** patients. ***Some*** Cooperative members have tried other legal medications to alleviate their conditions, but these other medications do not work for them. For ***other*** members, other medications have intolerable negative side effects they have chosen not to endure. ***Some*** members' experiences with other legal medications is that, while they are somewhat effective, they are not nearly as effective at relieving their symptoms as medical cannabis.

Declaration of Michael M. Alcalay, M.D. ("Alcalay Dec.") ¶ 20 (emphasis supplied).[5] Likewise, Mr. McClelland states that "***many*** patient-members of the Cooperative have no reasonable legal alternative to obtaining medical cannabis from the Cooperative." Declaration of James D. McClelland ("McClelland Dec.") ¶ 12 (emphasis supplied).

This Court has already ruled, however, that such generalized statements are insufficient to establish the medical necessity defense for the defendants. In pertinent part, the Court held that similar statements made at the preliminary injunction stage, to the effect that "for many" people, legals drugs are not effective, "is not the same as saying that for each and every person to whom [the OCBC] provide[s] * * * marijuana, legal drugs are not effective such that marijuana is a necessity." 5 F. Supp.2d at 1102.

And the OCBC defendants' submission of declarations from several physician's fails for the same reason. Almost exclusively, these doctors make generalized statements regarding the

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[4] Mr. McClelland's declaration should be stricken to the extent he is put forward as an expert under Fed. R. Evid. 702. Mr. McClelland has no medical degree or training, and is not competent to offer medical opinions regarding the OCBC's customers.

[5] The OCBC defendants make much of Dr. Alcalay's calculation that 66% of the patients who "came" to the OCBC on May 21, 1998 suffered from HIV and/or AIDS; 4% suffered from cancer; 2% suffered from glaucoma; 1% suffered from multiple sclerosis; and "almost" 20% suffered from disorders involving chronic pain. OCBC Resp. at 8-9; Alcalay Dec. ¶ 23. But 66% + 4% + 1% + 2% +20% does not equal 100% (and, indeed, there may be some overlap in the categories). The OCBC defendants apparently do not wish to highlight that among the persons to whom they distributed marijuana on that day included persons suffering from "general anxiety disorder," rotator cuff syndrome, stress, and headaches.

alleged medical efficacy of marijuana, but none discusses the particular medical condition of a person to whom the OCBC distributed marijuana on May 21, or any other day. Nor have the OCBC defendants established that they had knowledge of the alleged medical necessity for any specific "patient-member" based a review of these individuals' medical records at the time they distributed marijuana to them.

At bottom, none of the evidence offered by the OCBC defendants discusses the specific medical conditions and circumstances of each and every of the 191 persons who "visited" the club on May 21, including whether each and every of these customers was facing an "imminent harm," and whether each and every person had tried alternative, legal medications. These evidentiary omissions are fatal to the OCBC defendants' invocations of the medical necessity defense.

The evidence submitted by the Marin Alliance defendants is even weaker. The only evidence offered by these defendants is the declaration of defendant Lynnette Shaw, who states simply that "[e]ach of the members [of the Marin Alliance] has presented documentation establishing that they suffer from one or more serious medical conditions for which their physician has recommended or approved the use of medicinal cannabis." Declaration of Lynnette Shaw ¶ 10. No competent medical testimony is provided by the Marin Alliance defendants. Here again, sweeping, nonspecific statements of the sort made by Ms. Shaw "[are] not the same as saying that for each and every person to whom [the OCBC] provide[s] * * * marijuana, legal drugs are not effective such that marijuana is a necessity." 5 F. Supp.2d at 1102. Accordingly, the OCBC and Marin Alliance defendants have failed to demonstrate there is sufficient evidence to go to a jury on this issue.

In addition, as we have demonstrated in our prior pleadings, the defendants' invocation of the medical necessity defense, regardless of any factual showing that they might make, fails as a matter of law. While we will not repeat each of these arguments here, we briefly address three of them.

First, the statutory scheme of the Controlled Substances Act abrogates any defense of medical necessity for marijuana, or any other substance in Schedule I. As we have demonstrated in our prior pleadings, Congress itself placed marijuana in Schedule I,[6] which means that the substance has "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use * * * under medical supervision." 21 U.S.C. § 812(b)(1). Congress also prevented practitioners from prescribing substances in Schedule I, id. §§ 829(a)-(c); indicated that the only legitimate medical or scientific use for a substance in Schedule I is in the context of a controlled research project approved by the Secretary of Health and Human Services and registered with the DEA, id. § 823(f); and established an exclusive statutory framework wherein controlled substances that have been placed in Schedule I (or any other schedule) may be rescheduled, or removed from the five schedules, in recognition of the fact that the schedules may sometimes need to be modified to reflect changes in scientific knowledge and patterns of abuse of particular drugs. Id. § 811(a). Under these circumstances, Congress has abrogated any possibility of a defense of medical necessity here. See generally 1 Walter LaFave & Austin W. Scott, Jr., *Substantive Criminal Law* § 5.4, at 631 (1986).[7]

Indeed, the medical testimony submitted by the OCBC defendants actually serves to underscore this point. A cursory review of this evidence demonstrates that, at a trial, the OCBC defendants would attempt to prove, as a general matter, the medical efficacy of marijuana.

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[6] See 21 U.S.C. § 812 Schedule I(c)(10).

[7] In addition, just this past week, the House of Representatives passed a Joint Resolution (House Joint Resolution 117), in which it was resolved that "Congress continues to support the existing Federal legal process for determining the safety and efficacy of drugs and opposes efforts to circumvent this process by legalizing marijuana, and other Schedule I drugs, for medical use without valid scientific evidence and the approval of the Food and Drug Administration * * * *." 144 Cong. Rec. H7719-01 (September 15, 1998); 144 Cong. Rec. H7783-02 (September 15, 1998). This Joint Resolution further underscores Congress's binding legislative determination that marijuana currently has no medical value, and that the only avenue to change marijuana's placement as a Schedule I controlled substance is through the section 811 rescheduling process.

Congress, however, has reserved any such determination to the Drug Enforcement Administration ("DEA") and Secretary of Health and Human Services, see 21 U.S.C. § 811(a), with review in the court of appeals, 21 U.S.C. § 877. Based on this statutory scheme, ***every*** court of appeals to have considered the issue has held that this is the exclusive avenue by which to challenge the placement of a drug in Schedule I (or any other schedule, for that matter). See, e.g., United States v. Burton, 894 F.2d 188, 192 (6th Cir.); cert. denied, 498 U.S. 857 (1990); United States v. Greene, 892 F.2d 453, 455 (6th Cir. 1989), cert. denied, 495 U.S. 935 (1990); United States v. Fry, 787 F.2d 903, 905 (4th Cir.), cert. denied, 479 U.S. 861 (1986); United States v. Wables, 731 F.2d 440, 450 (7th Cir. 1984); United States v. Fogarty, 692 F.2d 542, 548 & n.4 (8th Cir. 1982), cert. denied, 460 U.S. 1040 (1983); United States v. Middleton, 690 F.2d 820, 823 (11th Cir. 1982), cert. denied, 460 U.S. 1051 (1983); United States v. Kiffer, 477 F.2d 349, 356-57 (2d Cir. 1972), cert. denied, 414 U.S. 831 (1973).

Second, during the August 31, 1998 hearing, the Court indicated that it considered the Ninth Circuit's decision in United States v. Aguilar, 883 F.2d 662 (9th Cir. 1989), cert. denied, 498 U.S. 1046 (1991), to be the "most instructive * * * in the context of the medical necessity defense." August 31, 1998 Transcript of Proceedings at 44. Aguilar is not only instructive, it is controlling here In that case, the defendants had been convicted of violating various provisions of the immigration laws for their participation in the "sanctuary movement," which was aimed at smuggling, transporting, and harboring refugees from Central America. On appeal, the defendants contended that they were entitled to an instruction on necessity at trial because the Immigration and Naturalization Service ("INS") had continually frustrated the ability of these individuals to obtain refugee status.

The Ninth Circuit rejected this contention, holding that the defendants had failed to avail themselves of reasonable, legal alternatives to their actions. Aguilar, at 693-94. In particular, the Ninth Circuit found that the defendants had "failed to appeal to the judiciary to correct any alleged improprieties by the INS and the immigration court." Id. at 693. In addition, the court rejected

the defendants' claim that this alternative was unavailable to them because "newly arriving refugees needed immediate help," determining that they could have pursued a provisional remedy in the courts, or initiated an action on behalf of the aliens, seeking initial provisional relief and ultimate permanent relief. Id. at 694. The Ninth Circuit concluded that "this legal alternative nullifies the existence of necessity for all the underlying crimes stated * * * *." Id.

Similarly here, the OCBC and Marin Alliance defendants had the right to appeal from the Court's Preliminary Injunction Orders. See 28 U.S.C. § 1292(a)(1). Moreover, to the extent they believed that immediate relief was necessary, these defendants could have moved to modify the Preliminary Injunction Orders to allow for the distribution of marijuana in particular circumstances or cases. See Fed. R. Civ. P. 60(b).[8] And if these defendants believed an emergency was present, they could have sought expedited relief from the Court under the Local Rules. See Local Rule 7-10 (allowing for expedited motions); Local Rule 7-11 (allowing for ex parte motions).

These legal alternatives foreclose, as a matter of law, the OCBC and Marin Alliance defendants' invocation of the medical necessity defense. Their sole attempt to meet this prong of the necessity test is to argue that, generally, their members had no other legal or safe method of acquiring marijuana from other sources. This is manifestly not the test for medical necessity. To the extent these defendants had legal alternatives to violating the Preliminary Injunction Orders through the court process, their invocation of the defense of necessity cannot stand. See Aguilar, 883 F.2d at 693-94. See also United States v. Dorell, 758 F.2d 427, 431 (9th Cir. 1985) (holding that, while "[t]hose who wish to protest in an unlawful manner frequently are impatient with less visible and more time-consuming alternatives," such impatience "does not constitute the 'necessity' that the defense of necessity requires.").

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[8] The United States does not concede, of course, that any such modification of the Preliminary Injunction Orders would be appropriate under the Controlled Substances Act.

Third, as we have demonstrated previously, we are aware of no case in which a court has offered a medical necessity instruction in the context of distribution, rather than mere possession, and the defendants have cited to none. On the contrary, the majority in People v. Peron, 59 Cal. App. 4th 1383, 70 Cal. Rptr. 2d 20 (1997), review denied (Feb. 25, 1998), expressly declined to adopt the notion that distribution is a "necessary antecedent" to possession. Id. at 1390-1396, 70 Cal. Rptr. 2d at 25-28 (holding that sale or distribution of marijuana remains illegal under California law even following the passage of Proposition 215). This same result should be reached here.

For all these reasons, the Court should grant the United States' motion in limine preventing the OCBC and Marin Alliance defendants from presenting any evidence regarding the defense of medical necessity.

IV. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO OFFER EVIDENCE SUFFICIENT TO GO TO A JURY ON THEIR DEFENSE OF SUBSTANTIVE DUE PROCESS

For the same reasons, the OCBC and Marin Alliance defendants have failed to offer any competent evidence establishing that each and every person to whom they distributed marijuana on May 21 and May 27, 1998, respectively, could establish a claim based on substantive due process. Again, in its May 13, 1998 Memorandum and Order, the Court made clear what kind of evidentiary showing would be necessary for the defendants to maintain a defense of substantive due process. Borrowing the Court's language, "[i]n order for the Court to conclude that defendants have a substantive due process defense to [civil contempt], the Court would have to find that the substantive due process right of *each and every patient* to whom the defendants [distributed marijuana on May 21 or May 27, 1998 was] violated if the government prevents defendants from doing so." 5 F. Supp.2d at 1103 (emphasis supplied). Thus, although this Court noted that a defense based on substantive due process "may be available in a contempt proceeding where the trier of fact is presented with a particular transaction to a particular patient under a

particular set of facts," the Court made clear that such a defense "is not available, however, to exempt generally the distribution of marijuana from the federal drug laws." Id.

The OCBC and Marin Alliance fall far short of making this required evidentiary showing. Thus, although the OCBC defendants admit that 191 persons "visited" the club on May 21, and provide a chart which merely lists the medical diagnoses for these individuals, they offer no evidence regarding the specific medical circumstances and conditions of these patients. OCBC Resp. at 12 (simply asserting that "[a]ll of the patients have medical conditions which require the use of cannabis"). The Marin Alliance defendants, on the other hand, offer no evidence whatsoever regarding those persons to whom they distributed marijuana on May 27. Response of Defendants Marin Alliance for Medical Marijuana and Lynnette Shaw to Order to Show Cause in Case No. C 98-0086 CRB ("Marin Resp.") at 3 ("[Marin Alliance] and Shaw *contend* that each patient/member of the Marin Alliance for Medical Marijuana has a serious medical condition for which cannabis provides relief." (emphasis supplied)).

These bare, unsupported assertions fail to satisfy the burden required of the defendants in responding to the Court's Show Cause Orders. Rather than provide specific, detailed evidence regarding each and every person to whom they distributed marijuana on May 21 and 27, 1998, the OCBC and Marin Alliance defendants once again rely upon generalized statements concerning the alleged medical efficacy of marijuana. The OCBC and Marin Alliance defendants thus have failed to demonstrate there is sufficient evidence to go to a jury on this issue.[9]

Furthermore, as we have demonstrated in our prior pleadings, the OCBC and Marin Alliance, as a matter of law, cannot establish that the use of marijuana for medical purposes is "so

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[9] These defendants also have failed to demonstrate that they have standing to raise this claim on behalf of their patients. See, e.g., Warth v. Seldin, 422 U.S. 490, 499 (1975) (a party "must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties"). Although in Singleton v. Wulff, 428 U.S. 106 (1976), the Supreme Court held that a physician could assert the privacy rights of female patients in abortion cases, this narrow exception to the general rule of standing should not be extended to the instant cases, where the defendants are not physicians.

rooted in the traditions and conscience of our people as to be ranked as fundamental." Washington v. Glucksberg, 117 S. Ct. 2258, 2268 (1997). In Carnohan v. United States, 616 F.2d 1120 (9th Cir. 1980), a controlling case which the OCBC defendants once again fail to address, the Ninth Circuit held that a patient does not have a substantive due process right to any particular form of treatment. In pertinent part, the court held that the "[c]onstitutional rights of privacy and personal liberty do not give individuals the right to obtain laetrile free of the lawful exercise of the government's police power." Id. at 1122. The Ninth Circuit's decision in Carnohan, which constitutes binding precedent here, is consistent with that of every other court of appeals to have considered the issue. See, e.g., Sammon v. New Jersey Bd. of Medical Examiners, 66 F.3d 639, 645 n.10 (3d Cir. 1995) ("In the absence of extraordinary circumstances, state restrictions on a patient's choice of a particular treatment also have been found to warrant only rational basis review."); Mitchell v. Clayton, 995 F.2d 772, 775-76 (7th Cir. 1993) ("[A] patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider"); Rutherford v. United States, 616 F.2d 455, 457 (10th Cir.) ("[T]he decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health."), cert. denied, 449 U.S. 937 (1980). See also Smith v. Shalala, 954 F. Supp. 1, 3 (D.D.C. 1996) (quoting Carnohan for proposition that there was no substantive due process right "to obtain unapproved drugs free of the lawful exercise of government police power.").[10]

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[10] The defendants did contend during the March 24, 1998 hearing that the right in question is "not a constitutional right to select medicine, but a constitutional right to select the effective medicine that's been presented." March 24, 1998 Transcript of Proceedings at 84. This is a distinction without a difference. Certainly the advocate of laetrile in Carnohan, or the plaintiff suffering from advanced stage Hodgkin's lymphoma in Smith, believed the drugs which they wished to use was the only effective medicine to treat their respective cancers. The Ninth Circuit and other courts nonetheless rejected, as a matter of law, the substantive due process arguments raised by the plaintiffs in those cases.

The Marin Alliance defendants attempt to meet this issue by arguing that the government does not have a rational basis for the restriction on the distribution of marijuana for medical use. Marin Resp. at 4. Assuming this contention is properly before the Court, section 841(a)(1)'s prohibition on the distribution of marijuana easily passes this standard.

The Supreme Court has made clear that, "'[w]hen Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation, even assuming, arguendo, that judges with more direct exposure to the problem might make wiser choices.'" Jones v. United States, 463 U.S. 354, 370 (1983) (quoting Marshall v. United States, 414 U.S. 417, 427 (1974)). When it enacted the Controlled Substances Act in 1970, Congress placed marijuana in Schedule I, where it remains today. 21 U.S.C. § 812 Schedule I(c)(10). In addition, recognizing that the schedules may sometimes need to be modified to reflect changes in scientific knowledge and patterns of abuse of particular drugs, Congress established a statutory framework under which controlled substances that have been placed in Schedule I (or any other schedule) may be rescheduled, or removed from the five schedules. Id. § 811(a). Under this statutory and regulatory framework, any interested party they can file a petition to have marijuana rescheduled, see id.; 21 C.F.R. §§ 1308.44(a), with review in a court of appeals. See 21 U.S.C. § 877. Thus, for example, the DEA Administrator's 1992 decision not to reschedule marijuana, based on his finding that the record demonstrated that marijuana had "no currently accepted medical use in treatment in the United States," and had to remain in Schedule I, 57 Fed. Reg. 10,499 (Mar. 26, 1992), was upheld by a unanimous panel of the D.C. Circuit. Alliance for Cannabis Therapeutics v. Drug Enforcement Admin., 15 F.3d 1131 (D.C. Cir. 1994). In pertinent part, that court held that the Administrator's findings were "consistent with the view that only rigorous scientific proof can satisfy the [Controlled Substances Act's] 'currently accepted medical use requirement.'" Id. at 1137.[11]

[11] The petitioners did not seek Supreme Court review.

Given this statutory framework, Congress' placement of marijuana in Schedule I satisfies the rational basis test. As the Second Circuit has held, "[t]he very existence of the statutory scheme indicates that, in dealing with the 'drug' problem, Congress intended flexibility and receptivity to the latest scientific information to be the hallmarks of its approach. This * * * is the very antithesis of the irrationality [defendants] attribute[] to Congress." Kiffer, 477 F.2d at 357. Accord National Organization for the Reform of Marijuana Laws v. Bell, 488 F. Supp. 123, 142 (D.D.C. 1980) (three-judge panel) (same).

Nor does the Marin Alliance's "expert" testimony in any way alter this conclusion. In his declaration, Christopher P.M. Conrad merely states that, "[b]ased upon my research and review of scientific studies and relevant evidence, it is my opinion that there is virtually no scientific basis for the placement of cannabis in Schedule I." Declaration of Christopher P.M. Conrad ("Conrad Dec.") ¶ 11.[12] This bare assertion cannot in any way undermine the considered judgment of Congress in placing marijuana in Schedule I. As the Sixth Circuit has made clear, a section 811 petition, "and not the judiciary, is the appropriate means by which defendant should challenge Congress's classification of marijuana as a Schedule I drug." Greene, 892 F.2d at 456.

For all these reasons, the Court should grant the United States' motion in limine preventing the OCBC and Marin Alliance defendants from presenting any evidence regarding the defense of substantive due process.

V. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO OFFER EVIDENCE SUFFICIENT TO GO TO A JURY ON THEIR DEFENSE OF JOINT USERS

Nor have the OCBC or Marin Alliance defendants offered any competent evidence supporting their continued invocation of the defense of "joint users." The defendants contend they have submitted evidence "that as to the transactions alleged, the patient-members are joint users

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[12] Mr. Conrad's declaration should be stricken to the extent he is put forward as an expert under Fed. R. Evid. 702. Mr. Conrad offers only general statements regarding his background, does not provide any academic credentials, and does not identify the "scientific studies and relevant evidence" which he has considered.

within the meaning of [United States v. Swiderski, 548 F.2d 445 (2d Cir. 1977)]." OCBC Resp. at 12. Even assuming *arguendo* that Swiderski is good law in the Ninth Circuit, which is an open question, see United States v. Wright, 593 F.2d 105, 108 (9th Cir.1979), a close examination of the "evidence" submitted by the defendants reveals that it falls far short of the specific, factual showing required by the Second Circuit in Swiderski.

As a preliminary matter, the Marin Alliance defendants have offered no evidence whatsoever in support of this alleged defense. Instead, they merely refer the Court to pages 17-19 of the Defendants' Memorandum in Opposition to Plaintiff's Motion to Show Cause, and for Summary Judgment, filed August 14, 1998. See Marin Resp. at 6. Yet this memorandum itself was bereft of any evidentiary showing regarding the joint user defense. The Marin Alliance defendants therefore have failed to provide the Court with "sworn declarations outlining the factual basis for any affirmative defenses which they wish to offer," as this Court required in its September 3, 1998 Order to Show Cause.

The OCBC defendants' evidentiary showing, while marginally stronger, also is insufficient as a matter of fact and law. The OCBC defendants point the Court to two declarations, submitted by Dr. Alcalay, the club's Medical Director, and Mr. McClelland, the Chief Financial Officer of the OCBC, who state, in identical language, that:

> The patient-members of the Cooperative are joint participants in a cooperative effort to obtain and sell medical cannabis. Patient-members of the Cooperative jointly acquire marijuana for medical purposes to be shared among themselves and not with anyone else. No third persons are involved other than "primary caregivers" who are responsible for the housing, health, or safety of the patient. Any payment made to the Cooperative constitutes reimbursement for administrative expenses and operations which all patient-members who utilize the services of the Cooperative agree to share.

Alcalay Dec. ¶ 30; McClelland Dec. ¶ 18. The OCBC defendants also note that all members of the club agree to a "Statement of Conditions," which states, inter alia, that "[a]s a Member of the Oakland Cannabis Buyers' Cooperative, you are a joint participant in a cooperative effort to obtain and share medical cannabis. Each transaction in which you participate is not a 'sale' or 'distribution,' but a sharing of jointly obtained medical cannabis." McClelland Dec. ¶¶ 18-19 &

Exhibit 4. The OCBC defendants assert that these statements establish that "[n]o 'distribution' takes place because the Cooperative and its patient-members jointly acquire the cannabis for medical purposes to be shared among themselves and not with anyone else." OCBC Resp. at 13.

These conclusory assertions do not come close to the factual showing required by Swiderski. In that case, the factual record revealed that a man and woman had simultaneously and jointly purchased cocaine in a hotel room with the intent of sharing it only between themselves. 548 F.2d at 448. Under this narrow set of facts, the Second Circuit held that:

> [W]here two individuals simultaneously and jointly acquire possession of a drug for their own use, intending only to share it together, their only crime is personal drug abuse simple joint possession, without any intent to distribute the drug further. Since both acquire possession from the outset and neither intends to distribute the drug to a third person, neither serves as a link in the chain of distribution.

Id. at 450. The Second Circuit was careful to caution, however, that "[o]ur holding here is limited to the passing of a drug between joint possessors who *simultaneously acquired possession* at the outset for their own use." Id. at 450-51 (emphasis supplied).

The Ninth Circuit has refused to extend the scope of the Swiderski ruling to cases which do not involve joint and simultaneous acquisition. In Wright, the Ninth Circuit affirmed a district court's denial of a Swiderski instruction in a case in which two individuals had allegedly intended to purchase and use heroin jointly, but only one of the two individuals -- the defendant -- had actually procured the heroin. In pertinent part, the Ninth Circuit held that, even assuming that Swiderski was good law,[13] "[t]his is not a case in which two individuals proceeded together to a place where they *simultaneously* purchased a controlled substance for their personal use. Here Wright operated as the link between the person with whom he intended to share the heroin and the drug itself." 593 F.2d at 108 (emphasis supplied). Therefore, because the defendant had not

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[13] As we note above, the Wright court expressly declined to express an opinion as to whether Swiderski was good law in the Ninth Circuit. 593 F.2d at 108. Other circuits have also declined to adopt the reasoning of Swiderski. See United States v. Speer, 30 F.3d 605, 608 (5th Cir. 1994) ("This Circuit has not adopted the Swiderski doctrine nor have we found that any other circuit has done so."), cert. denied, 513 U.S. 1028 (1994), 513 U.S. 1098 (1995).

"simultaneously and joint acquire[d] possession" of the heroin, "[h]is actions exceeded the scope of the rule propounded in Swiderski." Id.

Here, neither the OCBC or Marin Alliance defendants offer a scintilla of evidence that they and their customers *simultaneously acquired* marijuana, as Swiderski and Wright require. This evidentiary failure is fatal to their invocation of the joint user defense. As this Court held in granting the government's motions for preliminary injunctions:

> Swiderski involved a simultaneous purchase by a husband and wife who testified they intended to use the controlled substance immediately. Applying Swiderski to a medical marijuana cooperative would extend Swiderski to a situation in which the controlled substance is not literally purchased simultaneously for immediate consumption. In light of the fact that Swiderski has never been so extended, and in light of the fact that it has not been adopted by the Ninth Circuit, the Court concludes that it is reasonably likely that such a defense would not prevail at a trial addressing whether injunctive relief should be granted.

5 F. Supp.2d at 1101. See also United States v. Washington, 41 F.3d 917, 920 (4th Cir. 1994) (affirming district court's denial of Swiderski instruction because "[a] defendant who purchases a drug and shares it with a friend has 'distributed' the drug even though the purchase was part of a joint venture to use drugs"). The OCBC defendants have offered no factual evidence which in any way alters this conclusion.[14]

Moreover, the sheer volume of customers at the OCBC on May 21, 1998 -- 191 -- dictates rejection of the joint user defense. In order to satisfactorily establish such a defense, the OCBC defendants would have to show that the club and all 191 members who obtained marijuana from the club on May 21, 1998, simultaneously purchased and jointly acquired the marijuana. Common sense reveals the absurdity of any such assertion, and those courts which have considered similar attempts to extend Swiderski have rejected them. See, e.g., United States v.

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[14] The OCBC defendants also fail to satisfy the requirement that the drug not be distributed to third parties. See, e.g., Wright, 593 F.2d at 108; Swiderski, 548 F.2d at 450. Putting aside the absurdity of the OCBC defendants' apparent assertion that they do not distribute to third parties because all 1300-plus club members "jointly acquire" marijuana, these defendants admit they distribute marijuana to "primary caregivers," who have not "jointly acquired" the drug with the club. OCBC Resp. at 14; Alcalay Dec. ¶ 30. Based on this fact alone, the joint user defense is unavailable to these defendants.

Rush, 738 F.2d 497, 514 (1st Cir. 1984) (declining to extend Swiderski "to situations where more than a couple of defendants and a small quantity of drugs are involved."), cert. denied, 470 U.S. 1004 (1985); United States v. Taylor, 683 F.2d 18, 21 (1st Cir.) (finding Swiderski inapplicable to complex marijuana distribution organization), cert. denied, 459 U.S. 945 (1982). What the defendants are urging is to transform an extremely narrow defense applicable to a handful of small-time buyers into a gaping exemption that major distributors of controlled substances (which the defendants are) could use to their advantage. This cannot have been the intention of the Swiderski court.

The OCBC defendants also make the argument that "Swiderski's rationale applies with equal force to the use of medical cannabis in compliance with state and local laws," and that "[j]udicial resistance to expansion of the Swiderski doctrine clearly has been based on concerns about its possible use as a 'cover' for illicit drugs." OCBC Resp. at 13. The OCBC defendants cite no authority in support of this assertion and, not surprisingly, there is none. In essence, the OCBC defendants are arguing that, because they are allegedly complying with Proposition 215 and Oakland Ordinance No. 12706,[15] Swiderski should provide them with immunity from the requirements federal law. But there is nothing in the text of Swiderski (or any other authority for that matter) that in any way hinges on application of state or local law. And even if there were, this Court has already ruled that "[a] state law which purports to legalize the distribution of marijuana for any purpose, however, even a laudable one, nonetheless directly conflicts with federal law, 21 U.S.C. § 841(a)(1)." 5 F. Supp.2d at 1100.

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[15] While not necessary for the Court to resolve this issue, we note that the California Court of Appeal in Peron held that Proposition 215 did not legalize the distribution of marijuana under state law, and that a cannabis distribution organization similar to the defendants here did not meet Proposition 215' definition of a "primary caregiver." 59 Cal. App. 4th at 1390-96, 70 Cal. Rptr. 2d at 25-28.

For all these reasons, the Court should grant the United States' motion in limine preventing the OCBC and Marin Alliance defendants from presenting any evidence regarding the defense of joint users.

VI. THE DEFENDANTS' OBJECTIONS TO THE COURT'S SHOW CAUSE ORDERS AND CONTEMPT PROCEDURES ARE WITHOUT FOUNDATION

Finally, the OCBC defendants raise a number of objections to the Court's Show Cause Orders and contempt procedures. As we demonstrate below, none of these objections has merit.

A. The Court's Show Cause Orders Provide the OCBC and Marin Alliance Defendants With Ample Notice of The Alleged Violations of The May 19, 1998 Preliminary Injunction Orders

The OCBC defendants first contend that the government's evidentiary showing "does not provide specific notice or evidence of the charges, thereby impairing defendants' ability to respond to the specific charges and to present evidence concerning their defenses." OCBC Resp. at 3. For example, the OCBC defendants assert that, "[g]iven the vagueness of these allegations and the government's failure to identify the individuals to whom it is alleged cannabis was distributed, defendants lack sufficient information to admit or deny these specific allegations." Id. at 3 n.2. See also id. at 4 ("Because many patients visited the Cooperative on [May 21, 1998], defendants cannot identify the specific persons to whom Agent Ott alleges cannabis was distributed.").

These contentions fundamentally misapprehend the procedure employed in civil contempt proceedings and the plain language of this Court's Show Cause Orders. It is the Show Cause Orders, and not the initial evidentiary showing made by the United States, to which the defendants must respond in these contempt proceedings. And the Show Cause Orders entered by the Court could not be more clear. In granting the government's motion for an order to show cause against the OCBC defendants, the Court determined that the United States had made a prima facie case that the OCBC defendants were in violation of the Court's Preliminary Injunction Order, and therefore ordered the OCBC defendants "to show cause why they should not be held in civil contempt of the Court's May 19, 1998 Preliminary Injunction Order by distributing marijuana and

by using the premises of 1755 Broadway Avenue, Oakland, California, for the purpose of distributing marijuana, on May 21, 1998 * * * *." Order to Show Cause in Case No. C 98-0088 CRB at 4. Likewise, in granting the government's motion for an order to show cause against the Marin Alliance defendants, the Court determined that the United States had made a prima facie case that the Marin Alliance defendants were in violation of the Court's Preliminary Injunction Order, and therefore ordered the Marin Alliance defendants "to show cause why they should not be held in contempt of the Court's May 19, 1998 Preliminary Injunction Order by distributing marijuana and by using the premises of 6 School Street Plaza, Fairfax, California, for the purpose of distributing marijuana, on May 27, 1998 * * * *." Order to Show Cause in Case No. C 98-0086 CRB at 3.

The Show Cause Orders thus provided the defendants with ample notice of the alleged contemptuous actions; namely, that on May 21 and 27, 1998, respectively, the OCBC and Marin Alliance defendants had distributed marijuana, and used their respective premises for the purpose of distributing marijuana, in violation of the Court's May 19, 1998 Preliminary Injunction Orders. In other words, the Court's Show Cause Orders did not carve out a subset of the defendants' marijuana distributions on the May 21 and 27, 1998, but rather require the OCBC and Marin Alliance defendants to justify *any and all* such distributions on these respective dates. All of this information is in the possession of the defendants. Consequently, there is no merit to the defendants' somewhat ironic suggestion that, because they cannot determine which of the numerous distributions of marijuana in which they engaged on the dates in question are the subject of the Court's Show Cause Orders.

B. The Contempt Procedures Adopted by the Court are Consistent With Ninth Circuit Precedent

The OCBC defendants next appear to challenge the Court's determination that their right to a jury trial is subject to a motion in limine by the United States, arguing that, "[i]f the Court determines that it should proceed, the defendants are entitled to a jury trial." OCBC Resp. at 6.

This argument ignores established Ninth Circuit precedent. In Peterson v. Highland Music, Inc., 140 F.3d 1313 (9th Cir. 1998), the Ninth Circuit reaffirmed that "'[a] trial court may in a contempt proceeding narrow the issues by requiring that affidavits on file be controverted by counter-affidavits and may thereafter treat as true the facts set forth in uncontroverted affidavits.'" Id. at 1324 (quoting Hoffman v. Beer Drivers & Salesmen's Local Union No. 888, 536 F.2d 1268, 1277 (9th Cir. 1976)). Moreover, where the affidavits offered in support of a finding of contempt are uncontroverted, a district court's decision not to hold a full-blown evidentiary hearing does not violate due process. Id. The contempt procedures adopted by the Court here is fully consistent with this precedent.

C. There is No Basis for Immunity in these Cases

Finally, the OCBC and Marin Alliance defendants complain that the instant contempt proceedings infringe upon their customers' Fifth Amendment rights, and request that the Court provide immunity "to witnesses willing to come forward with * * * evidence." OCBC Resp. at 3. As we have demonstrated in our prior pleadings, "[a] defendant has no absolute right not to be forced to choose between testifying in a civil matter and asserting his Fifth Amendment privilege." Keating v. Office of Thrift Supervision, 45 F.3d 322, 326 (9th Cir.), cert. denied, 516 U.S. 827 (1995). It therefore is "permissible for the trier of fact to draw adverse inferences from the invocation of the Fifth Amendment in a civil proceeding." Id. (citing Baxter, 425 U.S. at 318). Furthermore, a district court lacks authority to itself grant immunity under the federal immunity statute, 18 U.S.C. § 6003. See United States v. Doe, 465 U.S. 605, 616-17 (1984). Accordingly, there is no basis for immunity in these actions.

CONCLUSION

For the reasons set forth above, the Court should grant the United States' motion in limine to exclude the affirmative defenses offered by the OCBC and Marin Alliance defendants, hold defendants in civil contempt of the May 19, 1998 Preliminary Injunction Orders, and enter the relief proposed by the United States.

Respectfully submitted,

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Assistant Attorney General

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Attorneys for Plaintiff
UNITED STATES OF AMERICA

Dated: September 21, 1998

CERTIFICATE OF SERVICE

I, Mark T. Quinlivan, hereby certify that on this 21st day of September, 1998, I caused to be served a copy of the foregoing Plaintiff's Motion in Limine to Exclude Affirmative Defenses, and the accompanying [Proposed] Order, upon counsel for the defendants, by the following means:

By facsimile transmission, and by overnight delivery:

Oakland Cannabis Buyer's Cooperative; Jeffrey Jones

James J. Brosnahan
Annette P. Carnegie
Andrew A. Steckler
Christina A. Kirk-Kazhe
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Robert A. Raich
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Marin Alliance for Medical Marijuana; Lynnette Shaw

William G. Panzer
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and by first-class mail, postage prepaid:

Cannabis Cultivators Club; Dennis Peron

J. Tony Serra
Brendan R. Cummings
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Attorney for Defendants
MARIN ALLIANCE FOR MEDICAL
MARIJUANA; LYNNETTE SHAW

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATORS' CLUB; and DENNIS PERON, Defendants. AND RELATED ACTIONS.	Nos. C 98-0085 CRB C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0245 CRB OPPOSITION OF DEFENDANTS MARIN ALLIANCE FOR MEDICAL MARIJUANA AND LYNNETTE SHAW TO PLAINTIFF'S MOTIONS IN LIMINE TO EXCLUDE DEFENDANTS' AFFIRMATIVE DEFENSES IN CASE NO. C 98-0086 CRB Date: September 28, 1998 Time: 2:30 p.m. Courtroom of the Hon. Charles R. Breyer

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

Defendants MARIN ALLIANCE FOR MEDICAL MARIJUANA and LYNNETTE SHAW, (hereinafter "MAMM" and "SHAW"), hereby oppose the Motions in Limine filed by plaintiff United States in the above-captioned action. In support of said opposition, defendants herein submit the following:

I. THE GOVERNMENT MISCHARACTERIZES THE SCOPE OF THE PRELIMINARY INJUNCTION AND THE TYPE OF ACTIVITY THAT WOULD CONSTITUTE A VIOLATION.

In its Motions in Limine, the government fails to recognize the scope of the Court's Preliminary Injunction. The government argues as if the Preliminary Injunction enjoined these defendants from distributing marijuana, and ignores the additional directive of the Preliminary Injunction that defendants are enjoined from distributing marijuana *in violation of the Controlled Substances Act*. For example, the government states that Shaw and MAMM "have publicly announced that they would defy these injunctions..." *Government Motion*, at 1:17). Yet the declarations submitted by the government fail to support this allegation. The government offered the following evidence against MAMM and SHAW:

1. A recorded telephone message stated that MAMM was still open under the medical necessity defense;

2. An unidentified female answered a telephone stating "Marin Alliance" and informed an undercover DEA agent of the requirements to become a member of the Marin Alliance for Medical Marijuana;

3. MAMM maintained a web site which provided information about how to become a member and information about Proposition 215;

4. Defendant SHAW stated that the Marin Alliance for Medical Marijuana was open and expressed her belief that a jury would understand the idea of the medically necessary use of marijuana; and

5. An undercover DEA agent observed 14 people between the ages of "late teens/early twenties to elderly" enter the premises of the Marin Alliance for Medical Marijuana over a 2 1/2 hour period, some of whom rolled and smoked what appeared to be marijuana cigarettes outside the office.[1]

None of this evidence supports the government's characterization of 'public announcements of defiance' and "widespread, open, and notorious violations of the Court's lawful decrees". *Government Motion*, at 1:18. Rather it helps to illustrate the essential schism between the government's and the defendants' respective positions. The government believes that *all* distribution of marijuana is *always* in violation of the Controlled Substances Act, while the defendants, without admitting that any distribution has taken place, (see section II, below), submit that marijuana may be distributed for medical purposes without violating the Controlled Substances Act and that, in fact, in order for the Controlled Substances Act to lawfully proscribe medical marijuana, the government must establish a rational basis for its total restriction, (see section III, below).

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[1]This last contention by the government is a further example of its propensity for mischaracterization. In his investigation report, Agent Nyfeler wrote that he observed "several people exit the club, roll their own cigarettes, and smoke them in the area dirctly [sic] outside the club". (See Nyfeler DEA-6 Report of Investigation, attached hereto as Exhibit A). Nowhere in the actual report does it indicate in any way that the cigarettes appeared to be marijuana, smelled like marijuana, or were smoked like marijuana as opposed to tobacco.

II. THE GOVERNMENT SHOULD NOT BE ALLOWED TO BENEFIT FROM ITS OWN FAILURE TO IDENTIFY SPECIFIC TRANSACTIONS

In the Court's May 13, 1998, *Memorandum and Order*, the Court anticipated that "if the federal government alleges that defendants have violated the injunction, there will be specific facts and circumstances before the Court from which the Court can determine if the jury should be given a necessity instruction as a defense to the alleged violation of the injunction." *Memorandum and Order*, at 21:5. The Court further noted, in addressing the Substantive Due Process argument that "[s]uch a defense may be available in a contempt proceeding where the trier of fact is presented with a particular transaction to a particular patient under a particular set of facts." *Memorandum and Order*, at 23:3.

The government has failed to present the Court or MAMM and SHAW with any allegation of a specific transaction under a specific set of facts. Rather, the government has merely alleged that 14 people in the age group of "late teens/early twenties to elderly" entered the Marin Alliance for Medical Marijuana office and some of them, (defendants have no idea how many or of which ages), later exited and rolled and smoked cigarettes. (Exhibit A, attached hereto).

The government tries to overcome this obvious factual insufficiency by arguing that MAMM and SHAW have admitted distribution of marijuana on May 27, 1998, by failing to deny it. *Government Motion*, Argument II, at 3:1. A review of MAMM and SHAW's Response to the Order to Show Cause reveals that the government again mischaracterizes the defense submission. The

Response specifically states that MAMM and SHAW do not admit that the government has established that any distribution of marijuana has taken place. *Response*, at 2:3. Furthermore, in her Declaration SHAW specifically denied that marijuana was smoked outside the MAMM office on May 27, 1998, or at any time. *Declaration of Lynnette Shaw in Support of Response to Order to Show Cause*, para. 9.

The government's position essentially is that because MAMM and SHAW are unable to ascertain the identity of particular persons based on the inarguably vague "descriptions" provided by the government, the defendants should be precluded from presenting a defense. The Court should not allow the government to play such games when the health and well being of sick and dying individuals is at stake.

III. THE GOVERNMENT MUST SHOW A RATIONAL BASIS FOR DENYING ACCESS TO MEDICAL MARIJUANA

In its effort to preclude SHAW and MAMM from presenting a Substantive Due Process argument, the government relies on a circular argument, essentially maintaining that the fact that Congress placed marijuana in Schedule I establishes proof that it had a rational basis to do so. MAMM and SHAW admit that the "rational basis" standard is a fairly easy one to meet. However it is a standard that *must* be met if the government is to lawfully deny medical marijuana to any patient. See *Euclid v. Ambler Realty Co.*, 272 U.S. 365, 395 (1926); *Patel v. Penman*, 103 F.3d 868, 874 (9th Cir. 1996); *Bateson v. Geisse*, 857 F.2d 1300, 1303 (9th Cir.1988); *Carnohan v. United States*,

616 F.2d 1120, 1122 (9th Cir. 1980); *Sammon v. New Jersey Bd. of Medical Examiners*, 66 F.3d 639, 645 n.10 (3rd Cir.1995); *People v. Privitera*, 23 C.3d 697, 707-708, cert. denied, 444 U.S. 949 (1979).

For all of its protestations regarding the framework developed by Congress and the petitioning process, the government has glaringly failed to submit any scientific evidence to support its contention that a rational basis exists to ban medical marijuana. It is not surprising that the government is employing a strategy to avoid, at all costs, an open and fair review of the scientific evidence. SHAW and MAMM herein make an offer of proof that should this Court or any impartial jury review the evidence they will reach the same conclusion of virtually every previous comprehensive study, and will find, in the words of Judge Francis L. Young, that "marihuana, in its natural form, is one of the safest therapeutically active substances known to man.... One must reasonably conclude that there is accepted safety for use of marihuana under medical supervision. To conclude otherwise, on the record, would be unreasonable, arbitrary, and capricious." *In the Matter of Marijuana Rescheduling, Docket 86-22, Opinion, Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge*, Washington, DC: Drug Enforcement Administration (6 September 1988).

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IV. THE COURT SHOULD NOT STRIKE THE DECLARATION OF CHRISTOPHER P. M. CONRAD

The government asks this Court to strike the Declaration of Christopher P. M. Conrad because, the government argues, "Mr. Conrad offers only general statements regarding his background, does not provide any academic credentials, and does not identify the 'scientific studies and relevant evidence' which he considered". *Government Motion*, at 15, n.12.

A review of Mr. Conrad's Declaration reveals that he has provided substantially more than "general statements regarding his background", including the authorship of two books relevant to the issues in this case, testimony before the National Academy of Science Institute of Medicine hearings on medical marijuana, and his recognition as an expert by numerous courts in California. The fact that he has gained his expertise though investigation, observation, research, and self education, rather than attending a university program in medical marijuana, (assuming such a program even exists), does not preclude him from qualifying as an expert.

Rule 702 of the Federal Rules of Evidence provides as follows:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

There is no requirement that a qualifying expert must provide academic credentials. The Rule recognizes that one may

gain expertise "by knowledge, skill, experience, training, or education".

There is also no requirement that an expert must state all materials he or she has assimilated in gaining expertise or in helping to form opinions. If the government questions Mr. Conrad's credentials or the studies and other evidence he has reviewed in forming his opinion, the appropriate procedure is for the government to make the inquiry in the form of cross-examination. Rule 705 of the Federal Rules of Evidence anticipates this issue in providing as follows:

> The expert may testify in terms of opinion or inference and give reasons therefor without first testifying to the underlying facts or data, unless the court requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination.

V. CONCLUSION

Defendants MAMM and SHAW should be allowed to present the defenses as stated in their Response to the Order to Show Cause. Additionally, the government should bear the burden of establishing a rational basis for its total ban on the medicinal use of marijuana.

Dated: September 25, 1998

Respectfully submitted,

WILLIAM G. PANZER
Attorney for Defendants
MARIN ALLIANCE FOR MEDICAL MARIJUANA; LYNNETTE SHAW

A

ER1595

U.S. Department of Justice
Drug Enforcement Administration

REPORT OF INVESTIGATION

1. Program Code	2. Cross File / Related Files	3. File No. [redacted]	4. G-DEP Identifier [redacted]
5. By: Bill Nyfeler, S/A At: San Francisco FD	☐	6. File Title [redacted]	
7. ☐ Closed ☐ Requested Action Completed ☐ Action Requested By		8. Date Prepared 5/27/98	

9. Other Officers: N/A

10. Report Re: Surveillance of Marin Alliance for Medical Marijuana

DETAILS

1. On May 27, 1998, at approximately 9:30 AM, surveillance was established by S/A Bill Nyfeler at the Marin Alliance for Medical Marijuana (MAMM), 6 Old School Street Plaza, Suite 210, Fairfax, CA.

2. At approximatley 9:54 AM, S/A Nyfeler observed the first person enter the MAMM. Over the next two hours, 13 more people (14 total) entered the MAMM. These people varied in age from late teens/early twenties to elderly. S/A Nyfeler observed several people exit the club, roll their own cigarettes, and smoke them in the area dirctly outside the club.

3. Surveillance was terminated at approximately 12:01 PM.

INDEXING

[redacted]

11. Distribution:	12. Signature (Agent)	13. Date
Division [redacted] District Other	Bill Nyfeler, S/A 14. Approved (Name and Title) Dale W. Shepherd Group Supervisor	5/27/98 15. Date 5/27/98

DEA Form -6 (Aug. 1994)

DEA SENSITIVE
Drug Enforcement Administration **1-Prosecutor**

Previous edition dated 5/80 may be used.

PROOF OF SERVICE BY MAIL

The undersigned hereby declares:

I am employed in the City of Oakland, County of Alameda, am over the age of 18 years, and am not a party to the within action; my business address is 370 Grand Avenue, Suite 3, Oakland, California, 94610. On September 25, 1998, I served the attached:

OPPOSITION OF DEFENDANTS MARIN ALLIANCE FOR MEDICAL MARIJUANA AND LYNNETTE SHAW TO PLAINTIFF'S MOTIONS IN LIMINE TO EXCLUDE DEFENDANTS' AFFIRMATIVE DEFENSES IN CASE NO. C 98-0086 CRB; ORDER (Proposed)

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

Counsel for Plaintiff:	Mark T. Quinlivan U.S. Dept. of Justice 910 E Street, N.W. Washington D.C. 20530
Counsel for Defendants Oakland Cooperative; Jeffrey Jones:	Robert A. Raich 1970 Broadway, Suite 1200 Oakland, CA 94612
Counsel for Intervenors:	Thomas V. Loran III Pillsbury, Madison & Sutro 235 Montgomery Street San Francisco, CA 94104

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 25, 1998, at Oakland, California.

/s/

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1970 Broadway, Suite 1200
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Attorneys for Defendants
OAKLAND CANNABIS BUYERS'
COOPERATIVE AND JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
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APPLICATION FOR USE IMMUNITY FOR STATEMENTS OR TESTIMONY OF DEFENDANT AND DEFENSE WITNESSES IN CASE NO. C 98-0088 CRB

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

TO ALL PARTIES HEREIN AND THEIR ATTORNEYS OF RECORD:

In anticipation of trial on the government's allegations that defendants are in contempt of this Court's Preliminary Injunction Order, defendants Jeffrey Jones and the Oakland Cannabis Buyers' Cooperative ("defendants") bring this Application For Use Immunity For Statements Or Testimony Of Defendant And Defense Witnesses In Case No. C 98-0088 CRB. This request for use immunity is based upon two related grounds. First, as to defendant Jeffrey Jones, use immunity is necessary to protect both his right of liberty from civil incarceration, "the most fundamental of all constitutional rights," and his Fifth Amendment privilege not to incriminate himself. Second, defendants request that this Court grant use immunity for any statements or testimony offered by defense witnesses because this testimony may be necessary to avoid a distortion of the fact-finding process and thus to safeguard defendants' due process right to a fair trial.

This application is necessary because at oral argument on August 31, 1998, in response to the Court's request, the government announced its intention *not* to grant use immunity for any testimony which may be offered by defendant or defense witnesses. This Court has the discretion to grant use immunity to defendant and to defense witnesses to avoid any distortion of the fact-finding process in the show cause proceedings and to ensure that defendants receive a fair trial.

INTRODUCTION

On August 31, 1998, the government asserted in open court that it would refuse to immunize from use in any possible subsequent criminal proceedings any statements or testimony which may be offered by defense witnesses in these show cause proceedings. As a direct result, many patients who may have obtained cannabis from the cooperative after May 19, 1998 (the date of the Preliminary Injunction Order) are afraid to come forward to offer testimony in these show cause proceedings. Similarly, some of these patients' doctors are also unwilling to offer testimony in these proceedings without immunity. The government has asserted in its moving papers, however, that the medical necessity defense and other defenses should not be available to the defendant cannabis buyers' cooperatives unless they can establish the applicability of these defenses to *each and every* member who obtained cannabis from a cooperative on a given day. The government also has argued that "competent medical testimony," over and above what has already been provided, is necessary to defendants' defenses. Should the government continue to assert such arguments in these proceedings, and should the Court be receptive to these arguments, use immunity for defense witnesses' statements or testimony will be necessary to avert any distortion of the fact-finding process and thus to safeguard defendants' due process right to a fair trial.

STATEMENT OF FACTS

On August 31, 1998, at oral argument this Court asked the government whether it would provide use immunity for statements or testimony of any defense witness. *See* Transcript of Proceedings of August 31, 1998 at 85. The government replied that it would not do so. *Id.*

Defendants recognize that this Court issued an Order to Show Cause why they should not be held in contempt for allegations of marijuana distributions which may have occurred in violation of the Controlled Substances Act on May 21, 1998, two days after this Court's Preliminary Injunction Order issued. *See* Declaration of Andrew A. Steckler ("Steckler Decl.") at ¶ 2. In light of this Order, defendants have diligently attempted to obtain sworn declarations of patient-members who came to the Oakland Cannabis Buyers' Cooperative (the "Cooperative") on May 21, 1998 and of their referring doctors. Steckler Decl. at ¶ 3; Declaration of Michael M. Alcalay, M.D., M.P.H. ("Alcalay Decl.") at ¶ 26. Many of these patients and their doctors, however, are afraid, or are unwilling, to

sign any declaration as a result of the federal government's announced intention not to immunize any such declarations or testimony offered in this proceeding from use in any possible subsequent criminal proceedings. Steckler Decl. at ¶ 4. Alcalay Decl. at ¶ 26. If these statements and testimony were immunized from use in any possible future criminal prosecution many of these patients and their doctors would sign declarations or testify detailing for the Court their medical conditions and their dire need for medical cannabis to alleviate their conditions. *Id.*

The government has asserted in its moving papers that defendants are obligated "to present 'specific facts' which either controverts the evidence submitted by the United States or supports their alleged defenses of medical necessity, substantive due process, and joint users with respect to *each and every* individual to whom they distributed marijuana after May 19, 1998." Plaintiff's Consolidated Replies In Support Of Motion To Show Cause Why Non-Compliant Defendants Should Not Be Held In Contempt at 9-10 (emphasis in original). The government has given no indication it intends to abandon this argument. Indeed, in its most recent filing in this case, the government has made the fact of the defendants' alleged failure to present specific evidence as to each and every patient who visited the Cooperative on May 21, 1998, the very centerpiece of its argument. Plaintiff's Motions In Limine To Exclude Defendants' Affirmative Defenses ("Gov't's In Limine Mot.") at 4-7, 11, 12, 21. The government has also argued that defendants have not submitted sufficient "competent medical testimony." Gov't's In Limine Mot. at 5.

ARGUMENT

This Court has the power to grant use immunity covering all statements or testimony offered by defendant and defense witnesses in any show cause proceedings, and to ensure that any such statements or testimony may not be used in any possible subsequent criminal proceedings. The Court's authority to grant this immunity is based on two separate, but related, lines of authority—both of which are rooted in defendants' due process right to a fair trial. Each is discussed in turn below.

I. THIS COURT SHOULD GRANT USE IMMUNITY TO STATEMENTS OR TESTIMONY BY DEFENDANT JEFFREY JONES IN ORDER TO PROTECT BOTH HIS PRIVILEGE AGAINST SELF-INCRIMINATION AND HIS CONSTITUTIONAL RIGHT TO BE FREE FROM CIVIL INCARCERATION.

Courts have the power and the discretion to confer use immunity to statements or testimony by a defendant or a party when he would otherwise be forced to choose between two conflicting constitutional rights and to wholly abandon one of these rights. This judicial power exists not only despite, but precisely because, the government has failed to confer such immunity.

In *Simmons v. United States*, 390 U.S. 377 (1968), the Supreme Court considered the situation in which a criminal defendant was faced with a choice between two constitutional rights. The defendant in *Simmons* confronted the following dilemma: whether to testify at a pre-trial evidentiary suppression hearing in order to establish the requisite standing requirement to bring a Fourth Amendment motion to suppress illegally obtained evidence (thereby waiving his Fifth Amendment privilege against self-incrimination), or whether to exercise his Fifth Amendment right not to testify at the suppression hearing (thereby foregoing his Fourth Amendment right to challenge illegally obtained evidence). The Supreme Court concluded that:

> In these circumstances, we find it intolerable that one constitutional right should have to be surrendered in order to assert another. We therefore hold that when a defendant testifies in support of a motion to suppress evidence on Fourth Amendment grounds, his testimony may not thereafter be admitted against him at trial on the issue of guilt unless he makes no objection.

Id. at 394. Subsequent courts have applied this judicial use immunity doctrine to immunize from use in future proceedings testimony that is predicate to a Speech and Debate Clause defense, *In re Grand Jury Investigation*, 587 F. 2d 589, 597 (3d Cir. 1978), as well as testimony predicate to a double jeopardy defense. *United States v. Inmon*, 568 F.2d 326, 332-33 (3d Cir. 1977), *cert. denied*, 444 U.S. 859 (1979).

The Third Circuit also applied the *Simmons* judicial use immunity in a case directly analogous to that presented here. In *United States v. Perry*, 788 F.2d 100 (3rd Cir.), *cert. denied*, 479 U.S. 864 (1986), the criminal defendant confronted the dilemma of whether (1) to offer favorable testimony at his bail hearing, which testimony was required as a result of the presumption of dangerousness arising under the Bail Reform Act, or (2) to safeguard his Fifth Amendment right

not to testify at all. The *Perry* Court first noted that "[t]he absence of statutory authority to grant use-fruits immunity is not dispositive, however, because the Supreme Court has long recognized that the courts may prevent the use at trial of testimony by a defendant that was necessary for the vindication of a constitutional right." *Id.* at 115 (citing *Simmons*, 390 U.S. at 393-94, *Government of the Virgin Islands v. Smith*, 615 F.2d 964, 969-70 (3d Cir. 1980) (discussed *infra*), and *United States v. Herman*, 589 F.2d 1191, 1196, 1203-04 (3d Cir. 1978), *cert. denied*, 441 U.S. 913 (1979) (discussed *infra*)). The Court found that the trial court should have granted use immunity even over the objection of the prosecution, reasoning as follows:

> Under the Bail Reform Act the defendant's testimony may be necessary to vindicate *the most fundamental of all constitutional rights, the right of liberty from civil incarceration*. The availability of a judicial grant of use-fruits immunity with respect to a defendant's testimony in rebutting the presumption is both appropriate, and in this case necessary to avoid holding that [the Bail Reform Act] violates the fifth amendment.

Perry, 788 F.2d at 116 (emphasis added). The granting of judicial use immunity in *Perry* enabled the defendant there to avoid the dilemma of "suffering a grave invasion of a constitutional right or risking self-incrimination by attempting to vindicate that right." *Id.*

The same dilemma confronts defendant Jeffrey Jones in this case. At a minimum Jeffrey Jones faces potential monetary fines if this Court were to find him in civil contempt. *International Union, UMWA v. Bagwell*, 512 U.S. 821, 828 (1994). But Jeffrey Jones also faces in civil contempt proceedings the risk of civil incarceration. *Id.* This is precisely the same risk the *Perry* Court concluded was sufficient to warrant the Court's granting use immunity so that the defendant would not be forced to abandon his privilege not to offer any statements which may be used against him in any possible subsequent criminal proceedings. Here, this Court too should provide immunity to defendants' testimony in order to "vindicate the most fundamental of all constitutional rights, [his] right of liberty from civil incarceration." *Perry*, 788 F.2d at 116.

II. THIS COURT SHOULD GRANT USE IMMUNITY TO STATEMENTS OR TESTIMONY BY DEFENSE WITNESSES TO PROTECT DEFENDANTS' RIGHT TO DUE PROCESS AND A FAIR TRIAL.

Many courts have recognized the fact that the government alone cannot be relied upon to decide when and under what circumstances use immunity should be conferred to protect a

defendant's right to due process and a fair trial. The government is an adversary seeking a particular result, and it is with that result in mind that the government decides whether to grant or to refuse use immunity. Courts, unlike the government, must be relied upon to protect the defendants' due process rights to a fair trial. *See, e.g., United States v. Alessio*, 528 F.2d 1079, 1082 (9th Cir.), *cert. denied*, 426 U.S. 948 (1976). ("Of course, whatever power the government possesses may not be exercised in a manner which denies the defendant the due process guaranteed by the Fifth Amendment").

In *United States v. Herman*, 589 F.2d 1191 (3d Cir. 1978), *cert. denied*, 441 U.S. 913 (1979) the Court recognized that in certain cases a court may exercise its "inherent authority to effectuate the defendant's compulsory process right by conferring a judicially fashioned immunity upon a witness whose testimony is essential to an effective defense." *Herman*, 589 F.2d at 1204. The Court also recognized that the due process clause might compel a court's granting use immunity to defense witnesses where government actions denying use immunity to defense witnesses were undertaken with the "deliberate intention of distorting the judicial fact finding process." *Id.* The Court stated in *Herman*: "It would seem that a case in which clearly exculpatory testimony would be excluded because of a witness's assertion of the fifth amendment privilege would present an even more compelling justification for such a grant [of judicial immunity] than that accepted in *Simmons* itself." *Id.* at 1204. A year later, in *Government of the Virgin Islands v. Smith*, 615 F.2d 964, 969-70 (3d Cir. 1980), the Third Circuit found sufficient evidence in the case before it to constitute a prima facie showing, under either of the *Herman* due process theories, that judicial use immunity was required to safeguard the defendant's right to a fair trial. *Id.* at 973-74. The Court held that "a court has inherent authority to immunize a witness capable of providing clearly exculpatory evidence on behalf of a defendant . . . ." *Id.*

The Ninth Circuit similarly has recognized and approved the Court's inherent power to grant use immunity to defense witnesses when necessary to protect a defendant's due process right to a fair trial. *See, e.g., United States v. Lord*, 711 F.2d 887, 890-92 (9th Cir. 1983); *United States v. Westerdahl*, 945 F.2d 1083, 1085-87 (9th Cir. 1991). In *Lord*, the Court applied the reasoning and logic of *Herman* and *Smith* to find on the facts before it that the defendant may have been denied a fair trial as a result of the failure to provide use immunity to the testimony of a defense witness. The

Court determined that the defendant had established a prima facie showing that the defense witness's testimony was relevant. *Lord*, 711 F.2d at 891. The Court also determined that "[t]he record [could] also be read to suggest that prosecutorial misconduct caused [the defense witness] to invoke his fifth amendment privilege against self-incrimination." *Id.* In *Lord*, the evidence suggested that the prosecutor had told the defense witness that whether he was prosecuted depended on his testimony and that the prosecutor had told the witness about the self-incrimination privilege. *Id.* The Court found that "an unrebutted prima facie showing of prosecutorial misconduct that could have prevented a defense witness from giving relevant testimony justifies remand for an evidentiary hearing . . . on whether the prosecutor intentionally distorted the fact-finding process by deliberately causing [the defense witness] to invoke his fifth amendment privilege." *Id.* Although the Court relied upon the possibility of the prosecutor's distortion of the fact-finding process, it also stated that "the key issue in the analysis of defense use immunity is whether the defendant was denied a fair trial." *Lord*, 711 F.2d at 892.

Subsequent cases have applied the same analysis. In *Westerdahl*, the Ninth Circuit found that the defendant had satisfied both elements of what has become known as the *Lord* test—(1) that the evidence sought from the nonimmunized witness was relevant and (2) that the government distorted the judicial fact-finding process by denying immunity to the potential witness. *Westerdahl*, 945 F.2d at 1086. In *Westerdahl*, the nonimmunized defense witness would have testified that the defendant had not committed the robbery that was at issue in the case; his testimony was therefore clearly relevant. *Id.* In its discussion of the second part of the *Lord* test, the Court stated that "[prosecutorial] misconduct is not confined solely to situations in which the government affirmatively induces a witness not to testify in favor of a defendant." *Id.* at 1087. In *Westerdahl*, the government had granted use immunity to two witnesses who testified that the defendant had committed the crime, but had refused to grant such immunity to the defendant's witness. *Id.* The Court stated that this "is the type of fact-finding distortion we intended to prevent in *Lord*." *Id.* Because the defendant therefore had satisfied both parts of the *Lord* test, the Court ruled that "an evidentiary hearing should have been held to determine whether the government intentionally distorted the fact-finding process." *Id.*

Here, defendants satisfy both parts of the *Lord* test. First, the testimony of patient-members who came to the Cooperative on May 21, 1998, and their doctors is directly relevant to whether these patients had a medical necessity and/or a constitutionally protected fundamental right to medical cannabis. As the Court stated in *Westerdahl*, "[t]his evidence is clearly relevant to the fact-finding process." *Westerdahl*, 945 F.2d at 1086. Second, the government repeatedly argues that, in order for their defenses to be available to them, defendants must show that cannabis is medically necessary for *each and every* patient-member who came to the Cooperative after May 19, 1998, and that *each and every* member has a fundamental right to this medicine. However, as is plain from the evidence already submitted to this Court, many of these patients and their doctors will not come forward and provide testimony unless their statements or testimony is immunized. The government has refused to grant use immunity to these defense witnesses. Therefore, if the government intends to continue to argue that defendants have a burden to come forward with evidence concerning each and every member, and to come forward with an even stronger showing of "competent medical testimony," then this constitutes at least a prima facie showing of the government's intentional distortion of the fact-finding process. Under *Lord* and its progeny, judicially conferred use immunity for defense witnesses is therefore required.[1]

For the foregoing reasons, this Court should grant use immunity to defense witnesses. In the alternative, at the least this Court should conduct an evidentiary hearing to determine the extent to which the government has attempted and is attempting to distort the fact-finding process by not granting use immunity to defense witnesses.

CONCLUSION

For all of the foregoing reasons, defendants respectfully request this Court to grant defendant Jeffrey Jones and the defense witnesses use immunity for any relevant testimony they are prepared to provide the Court in these proceedings. In the alternative, defendants respectfully request that this

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[1] The government here is doing far more than simply asking for an adverse inference from the invocation of the Fifth Amendment in a civil proceeding. *See* Gov't's In Limine Mot. at 22. It has made this invocation the very centerpiece of its arguments.

Court conduct an evidentiary hearing to determine the extent to which the government has attempted to distort the fact-finding process in these proceedings.

Dated: September 25, 1998

JAMES J. BROSNAHAN
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By: _____
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OAKLAND CANNABIS BUYERS'
COOPERATIVE AND JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98 0089 CRB
C 98 0245 CRB

DECLARATION OF ANDREW A. STECKLER IN SUPPORT OF APPLICATION FOR USE IMMUNITY FOR STATEMENTS OR TESTIMONY OF DEFENDANT AND DEFENSE WITNESSES IN CASE NO. C 98-0088 CRB

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

I, ANDREW A. STECKLER, declare:

1. I am a member of the bar of the State of California, and an associate at the law firm of Morrison & Foerster LLP, and represent defendants Jeffrey Jones and the Oakland Cannabis Buyers' Cooperative in this matter. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. On September 3, 1998, this Court issued an Order To Show Cause why defendants should not be held in contempt for allegations of marijuana distribution which may have occurred in violation of the Controlled Substances Act on May 21, 1998, two days after this Court's Preliminary Injunction Order issued.

3. In light of this Show Cause Order, defendants and their counsel have diligently attempted to obtain sworn declarations of patient-members who came to the Oakland Cannabis Buyers' Cooperative on May 21, 1998 and of their referring doctors.

4. Many of these patients and their doctors are afraid to, or will not, sign any declaration in light of the federal government's announced intention not to immunize their declarations or testimony from use in any possible subsequent criminal proceedings. Many of these same witnesses would provide testimony in these proceedings if their statements or testimony were immunized from use in any possible future proceedings.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 25th day of September, 1998, at San Francisco, California.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0245 CRB

DEFENDANTS' OPPOSITION TO GOVERNMENT'S MOTION IN LIMINE TO EXCLUDE DEFENDANTS' AFFIRMATIVE DEFENSES IN CASE NO. C 98-0088 CRB

Date: October 5, 1998
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INTRODUCTION

In their Response To Show Cause Order In Case No. C 98-0088 CRB ("Response To Show Cause Order"), defendants have set forth detailed and specific evidence establishing that they are not in contempt of this Court's Preliminary Injunction Order ("Order"). This evidence establishes that defendants have taken all reasonable steps to comply with the Order. Defendants' evidence also establishes each element of defendants' defenses—medical necessity, substantive due process, and the joint users' defenses. At a minimum, defendants have presented sufficient evidence in response to the order to show cause such that the allegations of contempt must be resolved by a jury trial.

The government, by contrast, has failed to introduce a scintilla of evidence which addresses, let alone controverts, any of the defendants' evidence. For example, the government has not offered any evidence that cannabis does not alleviate imminent and serious medical conditions associated with cancer and AIDS. The government has not even attempted to claim that defendants' medical declarants are wrong on the science. Instead, the government mistakenly takes the position that defendants must be found in contempt because they have failed to introduce declarations from each and every member of the Cooperative. Ninth Circuit precedent clearly holds, however, that (1) substantial compliance with a court order is a defense to civil contempt, and (2) the plaintiff has the burden to establish by clear and convincing evidence that defendants are not in substantial compliance with the order.

The government has failed even to address, by argument, many of the specific facts establishing the defendants' defenses. For example, the government simply ignores at least eight specific patient declarations that establish that medical cannabis is the *only* effective medicine for these patients and that they face serious imminent harm if they do not receive it. This evidence is compelling, and the government simply fails to acknowledge it. Meanwhile, the government asks this Court to preclude the defendants' opportunity to present this abundant evidence and their defenses to a jury. The government fails to show why this Court should take that drastic step, especially in light of the fact that this Court has already stated defendants would have a right to a jury trial in any contempt proceedings.

Because the defendants have set forth specific facts that establish each and every element of all of their defenses, and because the government has failed to introduce *any* evidence in response, or to adequately address these facts, this Court should deny the government's motions *in limine*.

ARGUMENT

I. THIS COURT SHOULD DENY THE GOVERNMENT'S MOTION TO PRECLUDE DEFENDANTS' DEFENSES BECAUSE DEFENDANTS HAVE SET FORTH DETAILED AND SPECIFIC FACTS THAT ESTABLISH EACH ELEMENT OF ALL OF THEIR DEFENSES.

Only under extraordinary circumstances may a court rule *in limine* to preclude a defendant's ability to present its defenses at trial. In fact, a district court may preclude a defense by a motion *in limine* only where the evidence is insufficient *as a matter of law* to support the proffered defense. *United States v. Aguilar*, 883 F.2d 662, 692-95 (9th Cir. 1989), *cert. denied*, 498 U.S. 1046 (1991). In *United States v. Contento-Pachon*, 723 F.2d 691 (9th Cir. 1984), the Ninth Circuit reversed a lower court's decision to exclude evidence of a defendant's duress defense. *Id.* at 693. The Court started with the premise that "[f]act-finding is usually a function of the jury, and the trial court rarely rules on a defense as a matter of law." *Id.* The Ninth Circuit stated that only if the evidence is insufficient as a matter of law to support the defense should the court exclude that evidence. *Id.* The Court found that, because the defendant had presented evidence sufficient to raise triable issues of fact on all elements of the duress defense, the district court erred in precluding this defense by pre-trial motion. *Id.* at 695. The Court stated that "the trier of fact should have been allowed to consider the credibility of the proffered evidence" establishing defendant's duress defense. *Id.*[1] Here, as in *Contento-Pachon*, defendants have presented evidence sufficient to raise triable issues of fact on all of their defenses.

[1] The trial court had erred when it rejected, as a matter of law, the sufficiency of the defendant's offer of proof, which attempted to establish that he smuggled cocaine because his life and the lives of his family had been threatened, and that he had no reasonable means of escape because he believed the Colombian police were corrupt. *Id.* at 694.

In this circuit, the quantum of evidence sufficient to support a jury instruction on a defense is quite low.[2] "In general, '[a] defendant is entitled to have the judge instruct the jury on his theory of defense, provided that it is supported by law and has *some foundation* in the evidence.'" *United States v. Duran*, 59 F.3d 938, 941 (9th Cir.), *cert. denied*, 116 S. Ct. 535 (1995) (emphasis added) (citing *United States v. Mason*, 902 F.2d 1434, 1438 (9th Cir. 1990)). Although the evidence constituting all of defendants' affirmative defenses here is abundant and it remains unrebutted by the government, "[a] defendant is entitled to jury instructions on any defense providing a legal defense to the charges against him and which has some foundation in the evidence, even though the evidence may be weak, insufficient, inconsistent, or of doubtful credibility." *People of the Territory of Guam v. Agualo*, 948 F.2d 1116, 1117 (9th Cir. 1991) (quotations and citations omitted). In fact, failure to give such an instruction when some evidence supports it is reversible error. *Id.*[3]

As set forth more fully below, defendants' evidence establishes triable issues of fact on each of their defenses. Accordingly, defendants are entitled to present their evidence to a jury.[4] *Contento-Pachon*, 723 F.2d at 695. Because a reasonable jury could rule in defendants' favor on the basis of the proffered evidence, it would be inappropriate to preclude any of defendants' defenses prior to a plenary trial. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

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[2] The same showing applies to a court's decision whether to instruct a jury on a defense or to permit or exclude *in limine* the presentation of evidence constituting a defense. *See United States v. Chesney*, 10 F.3d. 641, 644 n.2 (9th Cir. 1993), *cert. denied*, 114 S. Ct. 1414 (1994).

[3] "Where the accused asserts an affirmative defense, sanctioned by the law as justification or excuse for the criminal act charged, and offers some credible evidence in support thereof, the existence of such matter of defense is generally for the determination of the jury." 75 Am. Jur. 2D Trial § 829 (1991).

[4] The right to present an adequate defense is safeguarded by the Fifth and Fourteenth Amendments. *Chambers v. Mississippi*, 410 U.S. 284, 302 (1973) (defendant's Fourteenth Amendment due process rights were violated by court's refusal to allow him to cross-examine his own hostile witness or to present three key witnesses). *See also Crane v. Kentucky*, 106 S. Ct. 2142, 2146 (1986) (blanket exclusion of proffered testimony deprived defendant of fair trial). In *Crane*, the court added that it was "break[ing] no new ground in observing that an essential component of procedural fairness is an opportunity to be heard. That opportunity would be an empty one if the State were permitted to exclude competent, and reliable evidence . . . central to the defendant's claim of innocence." *Crane*, 106 S. Ct. at 2146-47.

II. A TRIAL IS REQUIRED ON DEFENDANTS' DEFENSES BECAUSE DEFENDANTS HAVE DENIED THE ALLEGATIONS OF CONTEMPT, THEY HAVE CONTROVERTED THE GOVERNMENT'S AFFIDAVITS, AND THEY HAVE REQUESTED A CONTEMPT HEARING.

On the basis of the detailed declarations and response they filed to the Court's Order to Show Cause ("Show Cause Order"), defendants are entitled to a full trial on the issue of whether they are in contempt.

First, in their response to the Show Cause Order, defendants made it abundantly clear that they deny any distributions of marijuana in violation of the Court's Preliminary Injunction Order ("Order"). The government's claim that defendants' response to the Show Cause Order "do[es] not suffice as denials in these civil contempt proceedings[,]" Plaintiff's Motions In Limine To Exclude Defendants' Affirmative Defenses ("Government's Motion") at 3, is nonsense. The government simply ignores the fact that defendants have set forth "categorically and in detail" facts establishing their substantial compliance with this Court's Order. *Donovan v. Mazzola*, 716 F.2d 1226, 1240 (9th Cir. 1983), *cert. denied*, 464 U.S. 1040 (1984).

Second, where the affidavits offered in support of a finding of contempt are *uncontroverted*, a district court's decision not to hold a full-blown evidentiary hearing does not violate due process. *Peterson v. Highland Music, Inc.*, 140 F.3d 1313, 1324 (9th Cir. 1998). Here, however, the government's affidavits are clearly controverted by voluminous factual issues presented in declarations defendants submitted in response to the Show Cause Order. Moreover, unlike here, neither of the parties in *Peterson* requested a hearing to present live testimony. *Peterson*, 140 F.3d at 1324.[5] *See also Thomas, Head and Greisen Employees Trust v. Buster*, 95 F.3d 1449, 1458 (9th Cir. 1996) (defendants not entitled to contempt hearing because they did not request one nor did they

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[5] The defendants in *Peterson* did not dispute that they had violated the district court's order to return master sound recordings to the plaintiff. Here, by contrast, defendants seriously dispute any violation of the Court's Order. The defendants in *Peterson* instead offered a series of excuses and explanations for their contemptuous conduct, some of which were patently contradicted by their subsequent conduct. *See Peterson*, 140 F.3d at 1323. Here, by contrast, defendants do not offer any excuses. Instead, they rely primarily on affirmative defenses that *justify* their conduct (see *infra*).

submit admissible evidence to support their claim that they did not violate the court's injunction). In fact, both *Peterson* and the Ninth Circuit authority upon which it relies reaffirm the general rule that "a district court ordinarily should not impose contempt sanctions solely on the basis of affidavits." *Peterson*, 140 F.3d at 1324 (citing *Hoffman, et al. v. Beer Drivers & Salesmen's*, 536 F.2d 1268, 1276-77 (9th Cir. 1976)).

Other cases similarly have held that a court must hold a contempt hearing where the evidence alleged to constitute contempt is in dispute. *See, e.g., Pennwalt Corp. v. Durland Wayland, Inc.*, 708 F.2d 492, 495 (9th Cir. 1983) ("In this circuit a civil contempt proceeding is a trial within the meaning of Fed. R. Civ. P. 43(a) rather than a hearing on a motion within the meaning of Fed. R. Civ. P. 43(e); . . . the issues may not be tried on the basis of affidavits") (citations and quotations omitted); *United States v. Alter*, 482 F.2d 1016, 1023-24 (9th Cir. 1973) (defendant made showing that the legal issues were not simple and that full resolution of the controversy would require an evidentiary hearing for civil contempt). The Court in *Alter* relied in part on *Cooke v. United States*, 267 U.S. 517, (1925), in which the Supreme Court stated:

> Due process of law . . . in the prosecution of contempt . . . requires that the accused should be advised of the charges and have a reasonable opportunity to meet them by way of defense or explanation. We think this includes . . . the right to call witnesses to give testimony, relevant either to the issue of complete exculpation or in extenuation of the offense and in mitigation of the penalty to be imposed.

Alter, 482 F.2d at 1024 (citing *Cooke*, 267 U.S. at 537). Due process requires no less in the current proceedings.[6]

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[6] Courts in other circuits similarly require plenary trials to determine disputed evidentiary issues in contempt proceedings. *See, e.g., Mercer v. Mitchell*, 908 F.2d 763, 766-767 (11th Cir. 1990) (in civil contempt proceedings defendant must be afforded a hearing at which he can call witnesses and testify in order to show cause why he should not be held in contempt); *N.L.R.B. v. Cincinnati Bronze, Inc.*, 829 F.2d 585, 589 (6th Cir. 1987) (alleged contemnor is entitled to an impartial hearing with an opportunity to present a defense); *Washington Metro. Area Transit Auth. v. Amalgamated Transit Union*, 531 F.2d 617, 620 (D.C. Cir. 1976) ("full" hearing is required anytime a "civil contemnor . . . asserts a genuine issue of material fact"); *Sanders v. Monsanto Co.*, 574 F.2d 198, 199-200 (5th Cir. 1978) (a court must hold a hearing on a civil contempt motion because it is highly factual, approximating a trial on the merits).

III. A JURY MUST DETERMINE THE SHARPLY CONTESTED FACTUAL ISSUES SURROUNDING THE CONTEMPT ALLEGATIONS.

Defendants have based their conduct since May 19, 1998, on their good faith and reasonable reliance on this Court's Preliminary Injunction Order. This Order promised a jury trial in any proceeding in which it is alleged defendants have violated the Order. The Order also provided for the availability of their several defenses. At a minimum, defendants have presented evidence sufficient to raise a doubt as to whether they have substantially complied with the Order. Therefore, a jury should determine whether they are in fact in contempt.

A. This Court Has Already Determined And Stated That A Jury Trial Would Be Afforded To Determine Any Allegations Of Contempt.

The Preliminary Injunction Order at issue in these proceedings incorporated by reference this Court's Memorandum and Order dated May 13, 1998. *See* Order at 1. The Memorandum and Order explicitly contemplated both a jury trial in the event of contempt allegations, and the availability of several defenses at this jury trial. The Court stated: "[i]f the Court issues an injunction, *defendants have a right to a jury in any proceeding in which it is alleged that they have violated the injunction.*" Memorandum and Order dated May 13, 1998 ("Mem. Op. & Order") at 24 (emphasis added). As to a medical necessity defense, the Court stated:

> The Court is not ruling, however, that the defense of necessity is wholly inapplicable to these lawsuits. If a preliminary or permanent injunction is granted, and the federal government alleges that defendants have violated the injunction, *there will be specific facts and circumstances before the Court* from which the Court can determine if the jury should be given a necessity instruction as a defense to the alleged violation of the injunction. As such facts are not presently before the Court, it is premature for the Court to decide whether such a defense is available.

Id. at 21 (emphasis added). As set forth in their Response To Show Cause Order and below, defendants now have presented the specific facts and circumstances that support their assertion of a medical necessity defense.

This Court further recognized that a substantive due process defense might be available "in a contempt proceeding where the trier of fact is presented with *a particular transaction to a particular patient under a particular set of facts*." *Id.* at 23 (emphasis added). Defendants similarly have

presented facts supporting this instruction. Finally, the Court cautioned "that it is not ruling that defendants are not entitled to [a joint users] defense at trial or in a contempt proceeding for violation of a preliminary or permanent injunction . . . ." *Id.* at 18-19. Defendants' evidence raises triable issues of fact with regard to whether their patient-members are actually joint possessors as opposed to "participants [in] the web of drug abuse." *United States v. Swiderski*, 548 F.2d 445, 450 (2d Cir. 1977).

B. Defendants Have In Good Faith Reasonably Relied On The Court's Preliminary Injunction Order In Conjunction With Its Memorandum And Order.

The parties to the prior proceedings that resulted in the Preliminary Injunction Order were obligated to comply with that Order which incorporated the Memorandum and Order. These parties had every reason, therefore, to rely on the unequivocal statements in the Memorandum and Order to the effect that: (1) they would be entitled to a jury trial in any proceeding in which it is alleged that they have violated the injunction; and (2) that the defenses specifically left open by the Court in its Memorandum could be available to them at that trial. Defendants' good faith and substantial compliance with the Order, therefore, was founded upon their reasonable reliance on the Court's Order. Therefore, this Court should find that defendants are not in contempt.

A district court has "wide latitude in determining whether there has been a contemptuous defiance of its order." *Gifford v. Heckler*, 741 F.2d 263, 266 (9th Cir. 1984). The contempt determination must be based on a full hearing and presentation of all relevant evidence. "Prior to issuing a coercive civil contempt order, a court should weigh all the evidence properly . . . ." *Falstaff Brewing Corp. v. Miller Brewing Co.*, 702 F.2d 770, 781 n. 6 (9th Cir. 1983). Moreover, "[p]rocess of contempt is a severe remedy, and should not be resorted to where there is fair ground of doubt as to the wrongfulness of the defendant's conduct." *KSM Fastening Sys., Inc., v. H.A. Jones Co., Inc.*, 776 F.2d 1522, 1525 (Fed. Cir. 1985) (citations and quotations omitted). Here, at a minimum, there are substantial grounds for doubt as to the wrongfulness of defendants' conduct—specifically as defined by the Order they are alleged to have violated. Therefore, defendants are entitled to present their evidence and defenses to a jury for determination as to the contempt allegations.

C. The Government Has Failed To Prove By Clear And Convincing Evidence That Defendants Are Not In Good Faith And Substantial Compliance With The Preliminary Injunction Order.

"[A] party should not be held in contempt if its action appears to be based on a good faith and reasonable interpretation of the court's order. The moving party must demonstrate by clear and convincing evidence that the contemnor violated the court's order." *Prince of Peace Enter., Inc. v. Kwok Shing Import-Export, Inc.*, 1997 U.S. Dist. LEXIS 14125, *11 (N.D. Cal. 1997) (citations omitted) (no showing of clear and convincing evidence that respondents violated the court order); *see also Peterson*, 140 F.3d at 1323 (burden on movant by clear and convincing evidence standard). Moreover, in order to succeed on a motion for civil contempt, a plaintiff must show by clear and convincing evidence that the defendant has not substantially complied with a court order. *Wolfard Glassblowing Co. v. Vanbragt*, 118 F.3d. 1320, 1322 (9th Cir. 1997); *see also National Advertising Co. v. City of Orange*, 861 F.2d 246, 250 (9th Cir. 1988) (substantial compliance with court's injunction is a defense to civil contempt, and a finding of contempt is inappropriate where the party has taken all reasonable steps to comply). Hence, the burden remains on the government to introduce admissible evidence to prove that defendants are not in substantial compliance with the Court's Order and that any violation was not based on a good faith reasonable interpretation of the Court's Order.

Despite the fact that the burden of proof remains on the government, defendants have presented detailed and specific evidence demonstrating that, under a good faith and reasonable interpretation of the Court's Order, they are in substantial compliance with the Order. *See* Response To Show Cause Order at 6-14. In addition to their affirmative defenses (discussed *infra* at 9-19), defendants have presented specific evidence concerning the stringency of their admission criteria—both upon initial application to the Cooperative and at each subsequent visit. *See, e.g.*, Declaration of Laura A. Galli, R.N. ("Galli Decl.") at ¶¶ 4-9; Declaration of James D. McClelland ("McClelland Decl.") at ¶¶ 3-11, Exhibits 1-3. The government nowhere addresses any of this evidence.

Instead of responding in any meaningful way to the evidence defendants have submitted, the government merely argues that defendants cannot prove that their defenses apply to each and every member of the Cooperative. The government asks this Court to treat these proceedings as an all-or-nothing proposition—if defendants cannot establish that *each and every* patient who came to the

Cooperative on May 21, 1998 had a medical necessity for cannabis, then defendants must be held in contempt. However, the law is clear in this circuit that substantial compliance with a court order is a complete defense to civil contempt allegations. *See Vertex Distribution, Inc. v. Falcon Foam Plastics, Inc.*, 689 F.2d 885, 891 (9th Cir. 1982). In *Vertex*, the district court refused to hold defendants in contempt when they had substantially complied with a consent judgment. The original consent judgment required defendants to include a perched bird on the 'F' in "Falcon" whenever possible and practical. *Vertex*, 689 F.2d at 890. In support of its motion for contempt, plaintiff submitted evidence of several of defendants' ads which did not contain the perched bird. *Id.* Defendant submitted evidence that they had included the perched bird on many more advertisements, forms, and signs. *Id.* at 891. The Ninth Circuit agreed with the district court's refusal to hold defendants in contempt because defendants had substantially complied with the consent judgment. *Id.* The Court held that this substantial compliance was a valid defense to the contempt charge. *Id.* *See also In re Dual-Deck Video Cassette Recorder Antitrust Litig. Go-Video, Inc., v. The Motion Picture Ass'n of America, et al.*, 10 F.3d 693, 695 (9th Cir. 1993) (holding that the party alleging contempt "failed to prove by clear and convincing evidence that under a good faith, reasonable interpretation of the protective order, [defendant] did not substantially comply with the order").

Similarly, here the government has "failed to prove by clear and convincing evidence that under a good faith, reasonable interpretation of the [Order, defendants] did not substantially comply with the order." *Go-Video, Inc.*, 10 F.3d at 695. Therefore, this Court should find that defendants are not in contempt. At a minimum, defendants are entitled to a trial on these issues.

IV. DEFENDANTS HAVE SET FORTH FACTS THAT ESTABLISH EACH ELEMENT OF THEIR DEFENSES.

Defendants have submitted detailed declarations which set forth each element of their defenses specifically left open by this Court. The government has presented no evidence whatsoever to controvert the defendants' evidence. Moreover, the government fails to address many of the facts set forth in defendants' evidence. Finally, the government has failed to show that no reasonable jury can find in defendants' favor based on the facts they have presented. Therefore, defendants are entitled to a trial on their defenses. *See Matsushita*, 475 U.S. at 587.

A. **Defendants Have Set Forth Specific Evidence Establishing That Any Cannabis They Distributed On May 21, 1998 Was A Medical Necessity To Their Members.**

As set forth in detail in their Response To Show Cause Order at 7-11, defendants have presented specific evidence with regard to each element of their medical necessity defense. First, defendants' evidence establishes that they are faced with a choice of evils. Response to Show Cause Order at 7-9. Second, the declarations submitted confirm that defendants have acted to prevent imminent harm to their patient-members. *Id.* at 9-10. Third, defendants' evidence establishes a direct causal relationship between defendants' supplying medical cannabis and the harms they seek to avert. *Id.* at 10. Fourth, the evidence proves that there are no legal alternatives to the distribution of medical cannabis to these members. *Id.*

The government fails to provide this Court any evidence whatsoever that contradicts the medical necessity evidence presented by defendants. Moreover, the government wholly fails to address the factual issues raised by the defendants' evidence. The government merely asserts, for instance, that "with the exception of the declaration of Dr. Alcalay, none of these proffered declarations is accompanied by competent medical testimony regarding whether there [are] alternative, legal drugs that are available to treat the symptoms in question." Government's Motion at 5. This assertion fails in several respects. *First*, the government cites to no authority (and defendants are not aware of any) which holds that, in order to present a medical necessity defense at trial, a defendant must offer "competent medical testimony" from a physician. In fact, a patient is competent to testify and discuss her own medical condition; this type of evidence is routinely received. *See* Fed. R. Evid. 701; *Dallis v. Aetna Life Ins. Co.*, 768 F.2d 1303, 1306 (11th Cir. 1985) (lay witnesses may testify as to the general nature of their own physical condition or the state of their own health). *Second*, in any event, defendants have offered many detailed declarations from medical doctors (some of whom have referred patients to the Oakland Cannabis Buyers' Cooperative ("OCBC")—a few of whom visited the Cooperative on May 21) concerning the necessity of cannabis for many medical conditions. The government has not even attempted to claim that defendants'

medical declarants are wrong on the science.[7] In fact, the government has failed to present this Court with *any medical testimony whatsoever*. Defendants' medical testimony remains completely unchallenged by the government. *Third*, defendants expect to be able to offer even more medical evidence at trial, especially if and when defense witnesses are granted immunity for their testimony.[8]

The government's oft-repeated claim that the defendants' failure to file 191 declarations somehow precludes their ability to assert the medical necessity defense also fails. *See* Government's Motion at 5, 7. First, the government offers no authority for this proposition. Indeed, defendants are not required to make such a showing in order to be entitled to present evidence of this defense at trial. *See, e.g., Agualo*, 948 F.2d at 1117 (instruction on defense required when some foundation in the evidence); *Go-Video, Inc.*, 10 F.3d at 695 (substantial compliance with court order is a defense to civil contempt). Second, despite the government's claim, the Declaration of Michael M. Alcalay, M.D. ("Alcalay Decl.") at ¶¶ 20-29, and the Declaration of James D. McClelland at ¶¶ 12-17, do in fact establish triable issues of fact with regard to all elements of the medical necessity defense for patient-members of the Cooperative. Third, the government's contention that this Court has already ruled that "such generalized statements [regarding many Cooperative members] are insufficient to establish the medical necessity defense" (Government's Motion at 6) in order to present this defense at trial is simply mistaken. The government lifts the Court's language from a very different context—a discussion of whether the federal government is likely to prevail at trial on its claim that

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[7] Indeed, "[s]ilence is often evidence of the most persuasive character[,]" *United States ex rel. Bilokumsky v. Tod*, 263 U.S. 149, 153-54 (1923), as the government itself has argued. *See* Government's Motion at 3.

[8] The government has refused to provide use immunity for testimony of defense witnesses in any possible subsequent criminal proceedings. Many patients and doctors who would provide testimony in these contempt proceedings are unwilling to do so in light of the government's refusal to grant use immunity for their testimony. In its *in limine* motion, the government hinges its arguments on the fact that defendants have failed to present declarations from each and every one of their patient-members and from their doctors. While defendants dispute that such a showing is necessary in these proceedings, and certainly not at this stage of the proceedings, they have separately filed their Application For Use Immunity For Statements Or Testimony Of Defendant And Defense Witnesses. For the reasons stated therein, the government's claims that "a district court lacks authority to itself grant immunity" and that "there is no basis for immunity in these actions[,]" Government's Motion at 22, is simply a misstatement of the law.

there is no medical necessity in the context of deciding whether to issue the preliminary injunction. *United States v. Cannabis Cultivators Club*, 5 F. Supp. 2d 1086, 1102 (N.D. Cal. 1998). The "likely to prevail at trial" standard in the context of deciding whether to grant injunctive relief is manifestly different than the much lower standard that must be met in order for defendants to be able to present a defense at trial.

Instead of either addressing the defendants' specific evidence or submitting its own evidence to controvert it, the government resorts to several well-worn (in this case) legal arguments—arguments *unconnected in any way to the declarations of Alcalay, McClelland, Bonardi, Westbrook, Estes, Dunham, Sweet, and Galli.* These legal arguments also fail.

First, the government argues that "the statutory scheme of the Controlled Substances Act abrogates any defense of medical necessity for marijuana, or any other substance in Schedule I." Government's Motion at 8. This Court, however, has correctly recognized that *United States v. Burton*, 894 F.2d 188, 192 (6th Cir.), *cert. denied*, 498 U.S. 857 (1990), suggests the contrary. *See* Transcript of Proceedings of August 31 at 51-55. The government's claim that Congress has abrogated any possibility of a medical necessity defense here is simply wrong. As the Sixth Circuit has explained:

> [*United States v. Bailey*, 444 U.S. 394 (1980),] teaches that Congress's failure to provide specifically for a common-law defense in drafting a criminal statute does not necessarily preclude a defendant charged with violating that statute from relying on such a defense. This conclusion is unassailable; statutes rarely enumerate the defenses to the crimes they describe . . . .

United States v. Newcomb, 6 F.3d 1129, 1134 (6th Cir. 1993) (holding necessity defense available to defendant charged with violations of federal firearm possession statutes). Nothing in the Controlled Substances Act prohibits the medical necessity defense. The government continues to confuse a determination on a petition to reschedule a controlled substance pursuant to 21 U.S.C. § 811 with a party's ability to present a common law necessity defense to a statutory crime. All the cases relied upon by the government simply hold that a court should not determine whether marijuana should be reclassified pursuant to § 811(a). *See* Government's Motions at 9. As this Court has correctly recognized, neither *Burton* nor the other circuit courts cited by the government have held that Congress precluded the medical necessity defense in the context of medical cannabis.

Second, the government argues that the factual situation presented in *Aguilar* is sufficiently similar to the facts here such that this Court should preclude the necessity defense as a matter of law. In *Aguilar*, the Ninth Circuit affirmed the district court's *in limine* ruling prohibiting defendants from raising a necessity defense to allegations of smuggling aliens into the country in violation of various immigration statutes. There, the Court ruled that the defendants had failed to establish that there were no legal alternatives to their conduct. *Aguilar*, 883 F.2d at 693. Specifically, they failed to appeal to the judiciary to correct the INS procedures that had given rise, in part, to their imminent harm. *Id.* The Court recognized that a lawsuit brought by other refugees had *already* effected changes in INS procedures, thereby effectively ameliorating the imminent harm those refugees faced. *Id.* The Court concluded, therefore, that there was a legal alternative that clearly would have prevented the very same imminent harm the *Aguilar* defendants sought to avoid by breaking the law. The Court ruled as a matter of law that defendants failed to establish all the required elements of a necessity defense. *Id.*

Here, defendants' evidence establishes that no other alternative effectively can prevent the serious and imminent *medical* harm they seek to avoid. Unlike the defendants in *Aguilar*, here defendants have presented detailed and specific evidence that they have no alternatives to medical cannabis for relieving their *current* serious medical conditions. *See* Alcalay Decl. at ¶ 7 ("To combat the nausea I have tried several prescription drugs including Marinol and Atarax, but none of them have worked for me. Marinol did not work well for me because it was nearly impossible to time its effect or to achieve the right dosage. It would take up to an hour or more to take effect, and I had trouble finding the correct dosage . . . . Atarax was not as effective as cannabis in alleviating my nausea"), ¶ 8 ("Cannabis has been the only medicine that has worked for me to control the nausea and vomiting caused by my AIDS medications"); Declaration of Robert T. Bonardi ("Bonardi Decl.") at ¶ 13 ("Cannabis is . . . the only medicine that has worked for me"); Declaration of Albert Dunham ("Dunham Decl.") at ¶ 4 ("I have tried medicine other than cannabis to combat these [health] problems, but they always had adverse side effects on my body, primarily by inducing vomiting"); Declaration of Kenneth Estes ("Estes Decl.") at ¶ 11 ("I have tried many prescription drugs [including] . . . Valium, Motrin, codeine, Vicodin, Darvocet, and many others. They either did not

work, or had side effects that made me not want to use them"); Galli Decl. at ¶ 16 ("Over the years I have tried many medications and treatments to try to alleviate my nausea symptoms, but nothing worked for me"); McClelland Decl. at ¶ 12 (for members of the Cooperative other medications either do not work, or they have intolerable negative side effects, or they are not nearly as effective as cannabis); Declaration of David Sanders ("Sanders Decl.") at ¶ 2 ("[Cannabis] works when nothing else does work at alleviating some of my symptoms [associated with AIDS]"); Declaration of Harold Sweet ("Sweet Decl.") at ¶ 8 ("Though I have tried other drugs and treatments for my glaucoma, no other drug or treatment works for me"); Declaration of Yvonne Westbrook ("Westbrook Decl.") at ¶¶ 4-7 (prescription drugs do not work or have intolerable side effects). Defendants here have made a much stronger showing on each element of their necessity defense, including the no-reasonable-alternatives element found lacking in *Aguilar*.[9]

In the face of this mountain of evidence, the government conveniently ignores it, stating: "[Defendants'] sole attempt to meet this [legal alternatives] prong of the necessity test is to argue that, generally, their members had no other legal or safe method of acquiring marijuana from other sources." Government's Motion at 10. To the contrary, as set forth above, defendants have introduced detailed and specific evidence that other legal medicines do not work for their members. The government simply ignores these facts.[10]

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[9] The recent decision in *United States v. Diana*, Nos. CR-98-068-RHW, CR-98-069-RHW, CR-98-070-RHW, and CR-98-072-RHW (E.D. Wash. Sept. 21, 1998), is similarly distinguishable. There the defendant asserting the medical necessity defense had given up on cannabis alternatives in the early 1970s, and his doctor since 1981 had never prescribed any medication. Defendants' patient-members herein, however, have submitted detailed declarations that explain that they have tried alternative medications and treatments much more recently, but that they do not work to relieve their conditions. Also, the Court in *Diana* found it significant that defendant there had been found with 175 marijuana plants, the equivalent of 17,500 grams. Defendants' evidence, by contrast, proves that patient-members are permitted a maximum of seven grams of medical cannabis per day (unless the member lives outside the Bay Area and makes no more than one visit to the Cooperative per week) and that defendants "are able to monitor these Members by [their] purchase tracking system." McClelland Decl. at ¶ 20, Exhibit 5.

[10] The defendants have similarly established that the grave harm their patient-members seek to avoid is imminent. *See* Response To Show Cause Order at 9-10. None of the "legal" alternatives the government suggests, *see* Government's Motion at 10, constitute a reasonable alternative in light of the imminent "medical" harm these members face.

Third, the government continues to assert the senseless argument that, while the medical necessity instruction may be available in the context of possession of cannabis, it is not available in the context of distribution. Government's Motion at 11. Again, the government fails to acknowledge the established principle that the necessity defense necessarily justifies otherwise unlawful conduct when undertaken to prevent harm to a third party. *See Aguilar*, 883 F.2d at 693 (necessity defense applies when defendants assisted third parties); *Contento-Pachon*, 723 F.2d at 695 ("[t]he defense of necessity is usually invoked when the defendant acted in the interest of the general welfare"); *United States v. Simpson*, 460 F.2d 515, 517-18 (9th Cir. 1972) ("[t]he theoretical basis of the justification defenses is the proposition that, in many instances, society benefits when one acts to prevent another from intentionally or negligently causing injury to people or property"). Thus, the act of distributing medical cannabis to prevent imminent harm to a third party clearly falls within the parameters of the necessity defense.

B. Defendants Have Set Forth Specific Evidence Establishing That Their Patient-Members Have A Fundamental Right To Medical Cannabis.

Defendants similarly have presented detailed and specific evidence establishing that the prohibition against distribution to OCBC's patient-members would violate their substantive due process rights. *See* Response To Show Cause Order at 11-12. Specifically, defendants have presented evidence relating to the role of medical cannabis in our "[n]ation's history, legal traditions and practices." *Washington v. Glucksberg*, __ U.S. __, 117 S. Ct. 2258, 2262 (1997). *See* Declaration of Lester Grinspoon, M.D. ("Grinspoon Decl.") at ¶¶ 9-14. Moreover, as set forth above and in their Response To Show Cause Order, defendants have established the fact that their patient-members require medical cannabis for their medical conditions, and that their physicians have recommended that they use cannabis for these conditions.[11] *See* Response To Show Cause Order at

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[11] The government's contention that defendants "offer no evidence regarding the specific medical circumstances and conditions of . . . patients [who visited the Cooperative on May 21, 1998,]" Government's Motion at 12, is belied by the Alcalay Decl. at ¶ ¶ 5-8, the Westbrook Decl. at ¶¶ 3-8, the Estes Decl. at ¶¶ 3-7, the Carter Decl. at ¶¶ 2-7, and the Dunham Decl. at ¶¶ 3-5. The government's contention that defendants fail to "provide specific, detailed evidence" regarding

(Footnote continues on following page.)

11-12. At a minimum, defendants are entitled to present this evidence at trial to prove that these patients have fundamental liberty interests to be free from pain and to preserve their lives. *See, e.g.*, Alcalay Decl. at ¶ 6 ("[t]he cannabis kept me alive . . . [;] I have since recovered from a very serious and life-threatening illness"); Bonardi Decl. at ¶ 13 ("I believe that without cannabis I would have continued to starve").[12] In response, the government has failed to present any evidence that the Controlled Substances Act, as applied to defendants, is "narrowly tailored to serve a compelling [government] interest[,]" as required. *Glucksberg*, 117 S. Ct. at 2268.

The laetrile cases relied on by the government are inapposite for at least three reasons. First, defendants do not assert the right to a particular treatment as did the parties in *Rutherford v. United States*, 616 F.2d 455 (10th Cir.), *cert. denied*, 449 U.S. 937 (1980), and *Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980). Rather, defendants assert the fundamental liberty interests to be free from unnecessary pain, to receive palliative treatment for painful medical conditions, to care for oneself, and to preserve one's own life. *See, e.g.*, *Glucksberg*, 117 S. Ct. at 2288, 2303, 2311.

Second, in the laetrile cases the government had satisfied the court that laetrile had been found to be a "new drug" which had to be regulated to keep commerce free from deleterious, adulterated and misbranded articles. *Carnohan*, 616 F.2d at 1121. There the government had made some showing to satisfy even the rational basis standard of review—to show that the regulation was reasonably related to protecting the public health. Here, the government has introduced no evidence concerning the harmfulness of cannabis. Indeed, all the evidence before the Court submitted by defendants suggests that medical cannabis is a very safe medicine. *See, e.g.*, Grinspoon Decl. at ¶¶ 8,

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(Footnote continued from previous page.)

patients who visited the Cooperative on May 21, 1998, is simply false. *See* Government's Motion at 12.

[12] Despite the government's claim, defendants have standing to assert the claims of their patient-members. *See NAACP v. Button*, 371 U.S. 415, 428 (1963) (organization has standing to assert the corresponding rights of its members); *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977) (association has standing to bring suit on behalf of its members); *California First Amendment Coalition v. Calderon*, 1998 U.S. App. LEXIS 16859, *11 (9th Cir. 1998) (same). The government's attempt to distinguish *Singleton v. Wulff*, 428 U.S. 106 (1976), on the basis that defendants are not physicians is unpersuasive.

31, 32. This evidence is unrebutted by the government. Thus, defendants have made a strong showing, unlike plaintiff in *Carnohan*, "that government regulation of [cannabis] bears no reasonable relation to the legitimate state purpose of protecting the public health." *Carnohan*, 616 F.2d at 1122.

Third, defendants here have introduced evidence, again unrebutted by the government, that medical cannabis has played a role in our "[n]ation's history, legal traditions and practices[,]" *Glucksberg*, 117 S. Ct. at 2262, at least between 1840 and 1937. *See* Grinspoon Decl. at ¶¶ 10-13. No such evidence had been introduced regarding laetrile, nor could it have been.

Instead of introducing any evidence to justify either a compelling government interest or a rational basis standard of review, the government merely recites its mantra: "When it enacted the Controlled Substances Act in 1970, Congress placed marijuana on Schedule I, where it remains today." Government's Motion at 14. Over and over the government asks this Court simply to defer to Congress, without citing any medical evidence whatsoever. But where legislation infringes upon fundamental rights, the courts have a duty to look beyond legislative findings to determine independently whether the infringement is justified under the Constitution. "A legislature appropriately inquires into and may declare the reasons impelling legislative action but the judicial function commands analysis of whether . . . the legislation is consonant with the Constitution." *Landmark Communications, Inc. v. Virginia*, 435 U.S. 829, 844 (1978). Furthermore, "courts are obligated to assure that, in formulating its judgments, Congress has drawn reasonable inferences, based on substantial evidence." *California Prolife Council Political Action Committee v. Scully, et al.*, 989 F. Supp. 1282, 1299 (E.D. Cal. 1998) (quotations and citations omitted) (deference to a legislative finding cannot limit judicial inquiry when constitutional rights are at stake). A court cannot simply defer to Congress when constitutional rights are at stake.

Finally, the government wrongly argues that defendants' evidence is insufficient because it does not establish a fundamental right to medical cannabis for *each and every* patient-member who visited the Cooperative on May 21, 1998. Again, this is not the quantum of proof required to establish a triable issue of fact in response to an order to show cause. *Agualo*, 948 F.2d at 1117. Again, the government confuses the Court's discussion of the showing required to defeat a preliminary injunction with the much lower showing required to establish sufficient evidence to

present a defense at trial. Indeed, the government misquotes the Court to make its point. Whereas the Court stated, in the context of the availability of a constitutional defense, "[i]n order for the Court to conclude that defendants have a substantive due process defense *to an injunction*. . .[,]" Mem. Op. & Order at 22 (emphasis added), the government quoted the Court as stating: "'[i]n order for the Court to conclude that defendants have a substantive due process defense to [civil contempt] . . . .'" Government's Motion at 11 (citing Mem. Op. & Order at 22). In the best light, the government mistakes the differing burdens in the different contexts.

C. Defendants Have Set Forth Specific Evidence Establishing That Their Patient-Members Are Joint Users Of Medical Cannabis.

The government concedes that the OCBC defendants' have made an evidentiary showing with regard to the joint users defense. Government's Motion at 16. Indeed, defendants have made a detailed showing supporting this defense as set forth in their Response To Show Cause Order at 12-14. *See* Alcalay Decl. at ¶¶ 23-25, 30-32; McClelland Decl. at ¶¶ 18-20, Exhibits 4 & 5.

The government takes pains, however, to restrict the joint user defense to the specific factual situation present in *United States v. Swiderski*, 548 F.2d 445 (2d Cir. 1977), the joint use of cocaine by a husband and a wife. But the fact that it was a husband and a wife who jointly purchased cocaine in *Swiderski*, or even that it was only two people who did so, is not necessary to the holding in that case. As the government itself notes, the Second Circuit held in *Swiderski* that:

> [W]here two individuals simultaneously and jointly acquire possession of a drug for their own use, intending only to share it together, their only crime is personal drug abuse—simple joint possession, without any intent to distribute the drug further. Since [they] acquire possession from the outset and [they do not] intend[] to distribute the drug to a third person, neither serves as a link in the chain of distribution.

Id. at 450. The *Swiderski* Court emphasized that determining whether the joint users defense applies in a particular case involves a fact-dependent inquiry. *Id.* Nothing in *Swiderski* limits its holding to two joint purchasers. Indeed, the Court's rationale for its holding—that purchasers for joint use do not have the "unwanted effect of drawing additional participants into the web of drug abuse"—suggests that the defense may apply just as convincingly to more than two joint users of a controlled substance, as here. *Swiderski*, 548 F.2d at 450.

Defendants have submitted evidence sufficient to raise a triable fact as to each of the elements of the *Swiderski* joint user defense. Most significantly, they have submitted evidence that the OCBC defendants are comprised of a *cooperative* of members (indeed it is a cooperative by definition) in which, legally, the organization consists of all its individual members. *See* McClelland Decl. at ¶ 4, Exhibit 2 (Bylaws of the OCBC). Whether this evidence in fact is sufficient for defendants to prevail on the joint user defense at trial is a question for the jury to determine.[13] That is not the same question as whether defendants have adduced facts sufficient to raise a triable issue of fact as to this defense. To be entitled to the defense, defendants need only show "some foundation in the evidence." *Duran*, 59 F.3d at 941. The evidence of the cooperative structure of defendants' organization is one of the several facts, discussed above, that presents a triable factual issue under the joint users defense. The government, for its part, fails to address this evidence, other than to note that the Cooperative members are not two members, husband and wife. This distinction is not sufficient to preclude the presentation of the joint users defense to the jury.[14]

CONCLUSION

Because defendants are in good faith and substantial compliance with the Court's Order they should not be held in contempt. Moreover, based on the detailed evidence submitted by defendants, at a minimum defendants are entitled to a jury trial on the specific facts and circumstances

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[13] The Court answered this is the same question in the negative in its determination that "it is reasonably likely that such a defense would not prevail at trial . . ." in deciding to issue the preliminary injunction. Mem. Op. & Order at 18. The Court went on to "caution[], however, that it is not ruling that defendants are not entitled to such a defense at trial or in a contempt proceeding for violation of a preliminary or permanent injunction . . . . The Court's ruling is narrow. Based on defendants' offer of proof, which does not include any detailed factual allegations, the Court concludes that the federal government is likely to prevail at trial." *Id.* at 18-19. Now, of course, not only is the context different such that defendants need only show "some foundation in the evidence" for the defense, *Agualo*, 948 F.2d at 1117, but defendants have in fact presented detailed factual allegations setting forth this defense.

[14] The Court in *United States v. Wright*, 593 F.2d 105, 108-09 (9th Cir. 1979), affirmed the district court's denial of the joint users defense instruction after presentation of the facts to the jury. Thus, *Wright* does not support the government's claim that the entire defense should be precluded outright, before the facts are presented at trial.

concerning their alleged contempt, and on the applicability of their defenses to those charges. The government's motions *in limine* therefore should be denied.

Dated: September 28, 1998

JAMES J. BROSNAHAN
ANNETTE P. CARNEGIE
ANDREW A. STECKLER
CHRISTINA KIRK-KAZHE
MORRISON & FOERSTER LLP

By: _____
Andrew A. Steckler

Attorneys for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE and JEFFREY JONES

PROOF OF SERVICE BY FACSIMILE TRANSMISSION
(N.D. Local Rule 5-3)

I declare that I am employed with the law firm of Morrison & Foerster LLP, whose address is 425 Market Street, San Francisco, California, 94105; I am not a party to the within cause; I am over the age of eighteen years; and that the document described below was transmitted by facsimile transmission to a facsimile machine maintained by the person on whom it is served at the facsimile machine telephone number as last given by that person on any document which he or she has filed in the cause.

I further declare that on the date hereof I served a copy of:

DEFENDANTS' OPPOSITION TO GOVERNMENT'S MOTION IN LIMINE TO EXCLUDE DEFENDANTS' AFFIRMATIVE DEFENSES IN CASE NO. C 98-0088 CRB

[PROPOSED] ORDER GRANTING DEFENDANTS' APPLICATION FOR USE IMMUNITY FOR STATEMENTS OR TESTIMONY OF DEFENDANT AND DEFENSE WITNESSES IN CASE NO C 98-0088 CRB

APPLICATION FOR USE IMMUNITY FOR STATEMENTS OR TESTIMONY OF DEFENDANT AND DEFENSE WITNESSES IN CASE NO. C 98-0088 CRB

DECLARATION OF ANDREW A. STECKLER IN SUPPORT OF APPLICATION FOR USE IMMUNITY FOR STATEMENTS OR TESTIMONY OF DEFENDANT AND DEFENSE WITNESSES IN CASE NO. C 98-0088 CRB

on the following by sending a true copy from Morrison & Foerster's facsimile transmission telephone number (415) 268-7520 and that the transmission was reported as complete and without error. The transmission report, which is attached to this proof of service, was properly issued by the transmitting facsimile machine.

Opposing Counsel:

Mark T. Quinlivan
U.S. Department of Justice
901 E Street, N.W., Room 1048
Washington, D.C. 20530
(202) 616-8470

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed at San Francisco, California, this 28th day of September, 1998.

Susan Romo
(typed)

(signature)

PROOF OF SERVICE BY OVERNIGHT DELIVERY
(N.D. Local Rule 5-3)

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on the following by placing a true copy thereof enclosed in a sealed envelope with delivery fees provided for, addressed as follows for collection by United Parcel Service at Morrison & Foerster LLP, 425 Market Street, San Francisco, California, 94105, in accordance with Morrison & Foerster's ordinary business practices:

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Washington, D.C. 20530

NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 066 6

Intevenor-Patients Thomas V. Loran III, Esq. Pillsbury Madison & Sutro LLP 235 Montgomery Street San Francisco, CA 94104 NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 067 5	Cannabis Cultivator's Club, et al. J. Tony Serra/Brendan R. Cummings Serra, Lichter, Daar, Bustamante, Michael & Wilson Pier 5 North, The Embarcadero San Francisco, CA 94111
Marin Alliance for Medical Marijuana, et al. William G. Panzer 370 Grand Avenue, Suite 3 Oakland, CA 94610 NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 065 7	Flower Therapy Medical Marijuana Club, et al. Helen Shapii NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 064 8 Carl Shapiro 404 San Anselmo Avenue San Anselmo, CA 94960
Ukiah Cannabis Buyer's Club, et al. Susan B. Jordar NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 063 9 515 South School Street Ukiah, CA 95482 David Nelson 106 North School Street Ukiah, CA 95482 NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 062 0	Oakland Cannabis Buyers Cooperative, et al. Gerald F. Uelmen NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1050 061 1 Santa Clara University School of Law Santa Clara, CA 95053 Robert A. Raich NEXT DAY AIR TRACKING NUMBER 1Z 907 025 01 1048 150 8 A Professional Law Corporation 1970 Broadway, Suite 1200 Oakland, CA 94612

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed at San Francisco, California, this 28th day of September, 1998.

Susan Romo
(typed)

(signature)

COPY

9.30 98

ORIGINAL FILED

SEP 30 1998

RICHARD W. WIEKING
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0245 CRB

AMENDED DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H.

I, MICHAEL M. ALCALAY, declare:

1. I am Medical Director of the Oakland Cannabis Buyers' Cooperative (the "Cooperative" or "OCBC"). As Medical Director I am familiar with the policies and procedures of the OCBC. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I am a Board-certified pediatrician. I graduated from U.C.L.A. medical school in 1968. I received a Masters Degree in public health in 1973 from the University of California Berkeley School of Public Health. I practiced as a pediatrician in the Northern California Kaiser Hospitals until 1995 when I became ill.

3. In addition to my work as a physician, from 1987 through 1993, I was also an award winning producer of a nationally syndicated weekly medical program entitled "AIDS in Focus".

4. As Medical Director of the Cooperative I attend regular board meetings and consortium meetings. Other duties include acting as liaison between the Cooperative and patient-members' authorizing physicians. As a result of my duties as Medical Director, I am knowledgeable about many Cooperative patients and their medical conditions. On May 21, 1998, I was present at the Cooperative at the time of the scheduled press conference.

5. I am also a patient-member of the Cooperative. I learned I was HIV-positive in 1986. I was first diagnosed with AIDS in 1993. In 1995, I became very seriously ill with an AIDS-related condition called cryptosporidium. I contracted this disease from drinking the local water supply. Cryptosporidium caused me to have constant diarrhea, I experienced a dramatic loss of my appetite, and I also suffered generally from apathy. I rapidly lost thirty pounds as I dropped from weighing 165 pounds to 135 pounds. At one point visiting nurses came regularly to my home so that I could be fed intravenously. I was suffering from the classic "wasting syndrome" that is associated with many AIDS patients.

6. When I eventually medicated myself with cannabis, I regained my appetite, and I was finally able to regain weight again. The cannabis kept me alive until a therapy could be found to eradicate the microbe from my body. The cannabis also caused a dramatic improvement in my spirits. I have since recovered from a very serious and life-threatening illness.

7. I have been required to take a lot of different medications to treat my AIDS condition, including the drug AZT and a variety of different protease inhibitors. I need these medications in order to live. But these medicines cause nausea and vomiting. To combat the nausea I have tried several prescription drugs including Marinol and Atarax, but none of them have worked for me. Marinol did not work well for me at all because it was nearly impossible to time its effect or to achieve the right dosage. It would take up to an hour or more to take effect, and I had trouble finding the correct dosage as a result of this long lag time in its kicking in. Atarax was not as effective as cannabis in alleviating my nausea.

8. Cannabis has been the only medicine that has worked for me to control the nausea and vomiting caused by my AIDS medications. It starts to provide relief after only a few minutes of inhaling just a little bit.

9. The goal of the Cooperative is to provide seriously ill patients with a safe and reliable source of medical cannabis products and plants. The Cooperative is open to all patients with a verifiable letter of diagnosis and recommendation or approval from a doctor for medical cannabis use. A complete Mission Statement is attached to the Declaration of James D. McClelland as Exhibit 1.

10. The Cooperative consists of one class of patient-members. According to the Cooperative's Bylaws, to qualify for membership an applicant must comply with the Protocols of the Oakland Cannabis Buyers' Cooperative. A copy of the OCBC Bylaws and Articles of Incorporation is attached to the Declaration of James D. McClelland as Exhibit 2.

11. Before a patient is accepted for membership into the Cooperative, he or she must complete an extensive screening process. This process is described in detail in the Oakland Cannabis Buyers' Cooperative Protocols ("Protocols"), a copy of which is attached to the Declaration of James D. McClelland as Exhibit 3.

12. According to the stated policies and procedures of the Cooperative, all applicants first must satisfy the threshold requirement of providing authorization from a treating physician assenting to cannabis therapy for one or more medical conditions listed on the Medicinal Cannabis User Initial Questionnaire (Exhibit C to the Protocols). Upon acceptance of the doctor's note by Intake staff, the

prospective member undergoes an extensive screening process to determine whether the applicant meets the Medical Admissions Criteria (Exhibit D to the Protocols). Each applicant must fill out and submit the Cooperative Information Form (Exhibit E to the Protocols).

13. If, upon screening by the Cooperative Intake staff member the applicant does not qualify for membership, he or she will be denied membership to the Cooperative.

14. If the applicant does appear to qualify for membership, a staff nurse must independently verify the physician's approval of cannabis use. It is the OCBC's policy and practice that an applicant not be admitted to membership in the Cooperative unless and until the applicant's physician's approval is verified by the staff nurse.

15. The Cooperative schedules a staff nurse to be on duty throughout every weekday business hour of the Cooperative.

16. Shortly after an applicant is admitted to membership in the Cooperative, he or she is issued a laminated membership card. A copy of a membership card is attached as Exhibit J to the Protocols. Each time a patient-member comes to the Cooperative he or she must present this membership card along with secondary valid photo identification.

17. Each time a patient-member comes to the Cooperative to receive medicine, the patient-member must pass three separate security check-points. At each of the check-points the member must present two forms of identification described in paragraph 17. First, the member must present identification to a security guard at the front door to the Cooperative. Second, a second security guard examines the member's identification at the member room door leading into the sales area of the Cooperative. Finally, a Cooperative staff member always checks the patient-member's identification again at the point of sale.

18. I am personally aware that patient-members of the Cooperative suffer from debilitating and often deadly diseases, including HIV and/or AIDS, cancer, arthritis, multiple sclerosis, and glaucoma—to name a few. I have seen and am aware that medical cannabis provides relief to patient-members as a pain reliever, an appetite stimulant, an anti-nauseant, and as relief from spasticity. Medical cannabis relieves intraocular eye pressure in patient-members who suffer from glaucoma.

19. As Medical Director, I have reviewed and am generally familiar with the medical circumstances that have led Cooperative members to seek medical cannabis. Although every patient's experience is unique, some general comments apply to many patients. Some Cooperative members have tried other legal medications to alleviate their conditions, but these other medications do not work for them. For other members, other medications have intolerable negative side effects they have chosen not to endure. Some members' experiences with other legal medications is that, while they are somewhat effective, they are not nearly as effective at relieving their symptoms as medical cannabis.

20. I am aware that Cooperative patient-members suffering from AIDS-related "wasting syndrome" (including myself) and those with cancer undergoing chemotherapy experience nausea and severe appetite deficits. Patients such as myself suffer these same conditions also as a result of having to take multiple medications to treat AIDS, some of them new or experimental. I am aware that medical cannabis relieves these symptoms in patients and enables them to eat. Medical cannabis prolongs some of these patients' lives (including my own). Cannabis enables these patients to take the other medications (in the case of AIDS patients) or to continue to undergo the intensive chemotherapy (in the case of cancer patients) in order to stay alive. For these patients, other medicines either do not work at all (or they are not nearly as effective as medical cannabis) or they cause severe adverse side effects that medical cannabis does not cause. I believe, based on personal experience, that supplying medical cannabis to these patient-members is necessary to avert imminent and often life-threatening harm.

21. I am aware that the patient-members who suffer from multiple sclerosis or quadriplegia experience debilitating spasticity and/or constant pain. Unless medicated these patients will be forced to live with uncontrollable muscular spasticity or to endure debilitating pain throughout every day. For many of these patients, other medications or treatments either do not work at all, they are not nearly as effective as medical cannabis, or they cause severe adverse side effects that medical cannabis does not cause. Thus, many of these patient-members have no reasonable alternative to medical cannabis.

22. On May 21, 1998, approximately 191 patients came to the Cooperative. Sixty-six percent of the patients who came to the Cooperative suffered from HIV and/or AIDS, 4 % of patients who came to the Cooperative suffered from cancer, 2 % of patients who came to the Cooperative suffered from glaucoma, 1 % of patients who came to the Cooperative suffered from multiple sclerosis, and almost 20 % of patients who came to the Cooperative suffered from disorders involving chronic pain, such as quadriplegia.

23. For each and every patient-member who came to the Cooperative on May 21, 1998, there exists in the OCBC files written confirmation that a treating California physician acknowledged and assented to cannabis therapy to treat the patient's medical condition or conditions.

24. The OCBC maintains, in the normal course of business, a database which contains information concerning its patient-members, including their diagnosis. I am familiar with the manner in which this information is gathered and entered into the database. Intake workers and volunteers who are qualified to do so, review documents in the patient's file, including personal information provided by the patient, the intake questionnaire containing the patient's diagnosis, and the information confirming that a licensed California doctor has made the diagnosis and has recommended the use of medical cannabis. Information concerning the diagnosis, the IC-9 (a standardized code used by physicians to classify a patient's medical condition), as well as the patient's name and treating physician are entered into the computer. Attached hereto as Exhibit A is a true and correct copy of a printout from OCBC's database concerning the patients who were present at the Cooperative on May 21, 1998. This printout contains the patient's identification number, the patient's specific diagnosis, and the IC-9 code.

25. Numerous attempts have been made to obtain sworn declarations of patient-members who came to the Cooperative on May 21, 1998. Many of these patients, however, are afraid to sign any declaration as a result of the federal government's announced intention not to immunize any such declarations offered in this proceeding from use in any possible subsequent criminal proceedings. Many of these patients would sign declarations detailing for the Court their medical condition and their dire need of medical cannabis to alleviate their condition if these statements were immunized.

26. One of the patient-members who came to the Cooperative on May 21, 1998, is now deceased. She died from cancer.

27. I have reviewed and am familiar with the medical records and OCBC files relating to the patients who visited the Cooperative on May 21, 1998. Numerous California physicians have rendered a medical opinion approving cannabis treatment for these patients.

28. Many patient-members' lives may be put in jeopardy if they were forced to try to obtain cannabis from criminal street dealers. This is what would happen if the OCBC were forced to close down. They may be placed in danger both because the act of purchasing from street dealers is inherently dangerous and because impurities in marijuana purchased on the street may be harmful to their fragile health. There is also the danger that this method of obtaining cannabis will certainly lead to exposure to dangerous drugs sold on the street, which may in turn lead to temptations or opportunities which have no place at the OCBC. Some patient-members may choose to forego their medication if they have no choice but to turn to street dealers for cannabis.

29. The patient-members of the Cooperative are joint participants in a cooperative effort to obtain and share medical cannabis. Patient-members of the Cooperative jointly acquire marijuana for medical purposes to be shared among themselves and not with anyone else. No third persons are involved other than "primary caregivers" who are responsible for the housing, health, or safety of the patient. Any payment made to the Cooperative constitutes reimbursement for administrative expenses and operations which all patient-members who utilize the services of the Cooperative agree to share. Attached to the Declaration of James D. McClelland as Exhibit 4 is a true and correct copy of the Oakland Cannabis Buyers' Cooperative Statement Of Conditions under which each and every member agrees to receive his or her medicine.

30. The Cooperative prohibits the smoking of cannabis on its premises; therefore, patient-members who smoke medical cannabis cannot immediately consume their medicine in the presence of other patient-members.

31. Last month, the City of Oakland designated the Oakland Cannabis Buyers' Cooperative to administer the City's Medical Cannabis Distribution Program. Attached to the Declaration of James D. McClelland as Exhibit 5 is a true and correct copy of this designation along

with supporting documents which helped satisfy the City of Oakland that the Cooperative is a bona fide corporation safely and lawfully engaged in activities benefiting the citizens of Oakland.

32. I understand and believe that currently the federal government will not enroll any additional patients in any federal program studying the medical use of cannabis.

33. I understand and believe that currently pending are petitions to reschedule medical cannabis from Schedule I to Schedule II of the Controlled Substances Act, but that none of these petitions have yet been granted.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 30th day of September at San Francisco, California.

Michael M. Alcalay

Michael M. Alcalay

EXHIBIT A

Combined Summary

5/21/98	2	Carcinoma of Rt Lung	162.9
5/21/98	7	ARC, Epilepsy, Stress	042.
5/21/98	7	ARC, Epilepsy, Stress	042
5/21/98	19	HIV	042.
5/21/98	26	HIV	042.
5/21/98	31	HIV	042.
5/21/98	32	Arthritis	716.90
5/21/98	36	AIDS	042.
5/21/98	38	HIV	042.
5/21/98	39	Back pain, Dorsal Kyphosis	732.8
5/21/98	52	Severe Anxiety	300.00
5/21/98	65	AIDS	042.
5/21/98	82	HIV	042.
5/21/98	92	Meniere's Disease	386.0
5/21/98	110	Paranoid Schizophrenia	295.9
5/21/98	124	Cervical Spondylosis	756.9
5/21/98	138	Epididymitis	604.90
5/21/98	139	AIDS	042.
5/21/98	166	AIDS	042.
5/21/98	167	AIDS	042.
5/21/98	167	AIDS	042.
5/21/98	168	HIV	042.
5/21/98	172	AIDS	042.
5/21/98	174	AIDS	042.
5/21/98	175	HIV	042.
5/21/98	177	HIV	042.
5/21/98	186	Paralysis Lower Extremities (Polio)	344.9
5/21/98	189	Acute Anxiey, Depression	295.9
5/21/98	190	HIV	042.
5/21/98	193	AIDS	042.
5/21/98	195	AIDS	042.
5/21/98	198	AIDS	042.
5/21/98	207	Bipolar Disorder	296.4
5/21/98	210	AIDS	042.
5/21/98	212	Thyroid Carcinoma	226.
5/21/98	212	Thyroid Carcinoma	226.
5/21/98	213	Scoliosis, Back Pain	737.30
5/21/98	215	Glaucoma	365.9
5/21/98	219	Neuropathy Entrapment	355.9
5/21/98	229	HIV	042.
5/21/98	246	AIDS	042.
5/21/98	249	Glaucoma	365.9
5/21/98	252	AIDS	042.
5/21/98	265	AIDS	042.
5/21/98	284	AIDS	042.
5/21/98	284	AIDS	042.
5/21/98	297	HIV	042.

Combined Summary

5/21/98	297	HIV	042.
5/21/98	304	HIV	042.
5/21/98	313	AIDS	042.
5/21/98	317	AIDS	042.
5/21/98	358	AIDS	042.
5/21/98	359	HIV	042.
5/21/98	374	Amputation	897.4
5/21/98	382	HIV	042.
5/21/98	388	HIV	042.
5/21/98	404	AIDS	042.
5/21/98	410	Lumbar Strain	724.0
5/21/98	410	Lumbar Strain	724.0
5/21/98	451	HIV	042.
5/21/98	472	Lung Cancer	162.9
5/21/98	492	AIDS	042.
5/21/98	495	AIDS	042.
5/21/98	502	AIDS	042.
5/21/98	510	AIDS	042.
5/21/98	514	Multiple Sclerosis	340.
5/21/98	565	HIV	042.
5/21/98	571	Multiple Herniated Discs	722.6
5/21/98	578	Hepatitus C, Cerviel DTD Seizure D	715.00
5/21/98	586	AIDS	042.
5/21/98	587	Cluster Migraines	346.10
5/21/98	606	AIDS	042.
5/21/98	620	Neurofibromatosis	237.7
5/21/98	654	AIDS	042.
5/21/98	654	AIDS	042.
5/21/98	654	AIDS	042.
5/21/98	661	HIV	042.
5/21/98	664	HIV	042.
5/21/98	674	AIDS	042.
5/21/98	674	AIDS	042.
5/21/98	677	AIDS	042.
5/21/98	686	HIV	042.
5/21/98	697	AIDS	728.85
5/21/98	735	Muscle Spasm, Gastritis	728.85
5/21/98	735	Muscle Spasm, Gastritis	042.
5/21/98	746	AIDS	042.
5/21/98	756	AIDS	042.
5/21/98	759	HIV	365.11
5/21/98	763	Glaucoma	250.0
5/21/98	788	Diabetic Neuropathy	729.81
5/21/98	801	Musculoskeletal Hip Pain	042.
5/21/98	803	AIDS	042.
5/21/98	816	AIDS	042.
5/21/98	826	AIDS	

Combined Summary

Entry Date	Member #	Specification	Code
5/21/98	832	HIV	042.
5/21/98	839	HIV	042.
5/21/98	848	Depression	300.4
5/21/98	866	AIDS	042.
5/21/98	871	AIDS	042.
5/21/98	888	AIDS	042.
5/21/98	892	HIV	042.
5/21/98	898	HIV	042.
5/21/98	900	AIDS	042.
5/21/98	901	Multiple Sclerosis	340.
5/21/98	902	AIDS	042.
5/21/98	908	AIDS	042.
5/21/98	940	HIV	042.
5/21/98	966	AIDS	042.
5/21/98	968	AIDS	042.
5/21/98	969	AIDS	042.
5/21/98	972	AIDS	042.
5/21/98	994	AIDS	042.
5/21/98	998	HIV	042.
5/21/98	998	HIV	042.
5/21/98	1003	HIV	042.
5/21/98	1003	HIV	042.
5/21/98	1007	AIDS	042.
5/21/98	1027	AIDS	042.
5/21/98	1028	HIV	042.
5/21/98	1031	AIDS	042.
5/21/98	1031	AIDS	042.
5/21/98	1033	AIDS	042.
5/21/98	1035	HIV	042.
5/21/98	1035	HIV	042.
5/21/98	1056	Anxiety Disorder	300.5
5/21/98	1089	Spondylosis Cervical Severe	720.9
5/21/98	1103	Depression	
5/21/98	1123	HIV	042.
5/21/98	1126	AIDS	042.
5/21/98	1128	HIV	042.
5/21/98	1135	Paranoid Schizoophrenio	295.4
5/21/98	1175	AIDS	042.
5/21/98	1195	Arthritis	716.5
5/21/98	1195	Arthritis	716.5
5/21/98	1214	HIV	042.
5/21/98	1215	AIDS	042.
5/21/98	1220	AIDS	042.
5/21/98	1223	AIDS	042.
5/21/98	1233	AIDS	042.
5/21/98	1244	Migrane	365.9
5/21/98	1247	Macular Degeneration	362.50

5/21/98	1252	Severe Spinal Strain	729.9
5/21/98	1252	Severe Spinal Strain	729.9
5/21/98	1255	Cancer	
5/21/98	1285	Fibromyalia/Depression	
5/21/98	1286	AIDS	042.
5/21/98	1289	AIDS	042.
5/21/98	1301	AIDS	042.
5/21/98	1305	AIDS	042.
5/21/98	1307	AIDS	042.
5/21/98	1315	AIDS	042.
5/21/98	1317	General Anxiety Disorder	304.0
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5/21/98	1324	Rotator Cuff Syndrome	
5/21/98	1341	Disabling HIV	042.
5/21/98	1352	Cervical Cancer	233.1
5/21/98	1359	Nausia	787.02
5/21/98	1392	PGW Syndrome, Fibromalgia	729.1
5/21/98	1392	PGW Syndrome, Fibromalgia	729.1
5/21/98	1421	Dysthimic Disorder	300.4
5/21/98	1422	AIDS	042.
5/21/98	1423	Chronic Pain from Degenerative Joi	
5/21/98	1429	AIDS	042.
5/21/98	1433	AIDS	042.
5/21/98	1433	AIDS	042.
5/21/98	1444	AIDS	042.
5/21/98	1444	AIDS	042.
5/21/98	1452	AIDS	042.
5/21/98	1455	Chronic Pain	
5/21/98	1472	AIDS	042.
5/21/98	1474	AIDS	042.
5/21/98	1493	AIDS	042.
5/21/98	1498	AIDS	042.
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5/21/98	1517	Post Traumatic Arthiritis	716.
5/21/98	1519	AIDS	042.
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5/21/98	1534	Stress/ Depression	300.4
5/21/98	1538	AIDS	042.
5/21/98	1541	HIV	042.
5/21/98	1567	HIV	042.
5/21/98	1598	Chronic Pain - Arthiritis- Depression	716
5/21/98	1599	Generalized Anxiety Disorder	300.0
5/21/98	1602	Arthiritis	716
5/21/98	1607	Chronic Pain	724.0
5/21/98	1612	HIV Disabling	042.
5/21/98	1613	Arthiritis	716.94
5/21/98	1620	Arthritic- Lim Pain	721.90

[illegible]	[illegible]	[illegible]	[illegible]
5/21/98	1621	H.I.V.	042.
5/21/98	1628	AIDS	042.
5/21/98	1633	AIDS	042.0
5/21/98	1635	H.I.V.	042.0
5/21/98	1657	H.I.V.	042.
5/21/98	1658	Dysthmia	
5/21/98	1660	Arthiritis	716.5
5/21/98	1662	H.I.V.	042.
5/21/98	1663	AIDS	042.
5/21/98	1663	AIDS	042.
5/21/98	1665	Pain and Headaches	
5/21/98	1670	Back Pain, T-Spine	724.1
5/21/98	1675	Scholiosis	754.2
5/21/98	1676	AML Leukemia	204.0
5/21/98	1701	AIDS	042.
5/21/98	1705	Endometriosis, Chronic Pelvic Pain	

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
✓C 98-0088 CRB
C 98-0245 CRB

NOTICE OF MOTION AND MOTION FOR PROTECTIVE ORDER RE CONFIDENTIAL INFORMATION; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

TO ALL PARTIES HEREIN AND THEIR ATTORNEYS OF RECORD:

Defendants Jeffrey Jones and the Oakland Cannabis Buyers' Cooperative ("Oakland Defendants") bring this motion for a protective order to protect from disclosure and from use for purposes other than those related to this case confidential information arising from the physician-patient relationship. This motion for a protective order is based on the ground that this Court has the inherent power to enter a protective order to protect from disclosure confidential and proprietary information. Moreover, this motion for a protective order is made on the further ground that confidential physician-patient information was inadvertently disclosed in the previously filed Declaration of Michael M. Alcalay, M.D., M.P.H., without the patients' consent.

STATEMENT OF FACTS

On September 14, 1998, the defendants filed their Response To Show Cause Order In Case No. C 98-0088 CRB, which included the declaration of Michael M. Alcalay, M.D., M.P.H. This declaration set forth some confidential information the Cooperative obtained from its patient-members. Declaration of Michael M. Alcalay, M.D., M.P.H., in Support of Defendants' Motion For Protective Order ("Alcalay Protective Order Decl."), filed herewith, at ¶ 2. This information included the names of many of these patients' treating physicians, and it included other confidential information arising from the physician-patient relationship. *Id.* The disclosure of this information was inadvertent. *Id.*

No patient of the Cooperative consented to the disclosure of this confidential information. Alcalay Protective Order Decl. at ¶ 3. The information inadvertently disclosed raises serious issues of confidentiality and privacy. *Id.* at ¶ 4. These issues concern the sanctity of the physician-patient relationship, which may be adversely impacted as a result of this disclosure. *Id.*

Defendants have submitted herewith a Supplemental Declaration of Michael M. Alcalay, M.D., M.P.H., which omits the confidential information. The only paragraphs affected by the revised submission are paragraphs 9, 25, and 28, and the only change to Exhibit A to the Alcalay Declaration is the omission of reference to referring physician names.

ARGUMENT

I. DEFENDANTS REQUEST THAT THIS COURT ENTER THEIR PROPOSED PROTECTIVE ORDER SO THAT CONFIDENTIAL INFORMATION MAY NOT BE USED FOR PURPOSES OTHER THAN THOSE RELATED TO THIS CASE.

The Oakland Defendants have filed herewith their proposed protective order that mirrors in many respects the protective order currently in place in *Conant v. McCaffrey*, Case No. C 97-0139 FMS, currently pending in the Northern District of California.[1] The *Conant* case involves a First Amendment claim brought by physicians against the federal government, and it raises issues of potential disclosure of confidential patient-physician information beyond the litigation of the case itself. There Judge Smith entered a very comprehensive protective order upon request of the plaintiff physicians who were concerned that confidential information obtained during discovery might be used beyond the litigation of the *Conant* case. The Court, at least implicitly, recognized the sanctity of the confidentiality of the physician-patient relationship in that case.

There is similarly the danger here of potential disclosure of confidential physician-patient information beyond the litigation of this case. This Court should enter the proposed protective order here where there is the potential for disclosure of very sensitive confidential information. The Ninth Circuit has recognized a privacy right in certain medical information. *See, e.g., Doe v. Attorney General of the U.S.*, 941 F.2d 780, 795 (9th Cir. 1991). Moreover, as the Court stated in *Norman-Bloodshaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1269 (9th Cir. 1998), "The constitutionally protected privacy interest in avoiding disclosure of personal matters clearly encompasses medical information and its confidentiality."

This Court has the authority to enter this protective order to protect the patients' and physicians' privacy rights and to prevent the disclosure of the confidential information beyond this case. *See, e.g. In re The Knoxville News-Sentinel Co., Inc.*, 723 F.2d 470, 476 (6th Cir. 1983)

---

[1] The only effective difference is that defendants' proposed protective order adds paragraph 5 specifically to address the disclosures made by the Alcalay Declaration of September 12, 1998. The other difference is that the defendants' proposed order omits paragraphs unrelated to this case.

(approving district court's protecting third party privacy interests by ordering nondisclosure). As the Court recognized in *Knoxville*, "trial courts have always been afforded the power to seal their records when interests of privacy outweigh the public's right to know." *Id.* at 474.

Therefore, this Court should enter the proposed protective order to protect the significant privacy rights involved. Disclosure of confidential information is likely to chill the relationship between patients and their doctors. This disclosure may also result in annoyance, embarrassment, and harassment of physicians whose names have been inadvertently released.[2]

This Court should enter the proposed protective order especially in light of the inadvertence of the disclosure that has already been made. *See KL Group v. Case, Kay & Lynch*, 829 F.2d 909, 919 (9th Cir. 1987) (district court's grant of protective order affirmed where third party confidential information was inadvertently disclosed without consent). Moreover, a protective order is particularly appropriate here because confidential information implicating third parties is involved. *See, e.g., Dart Indus. Co. v. Westwood Chem. Co.*, 649 F.2d 646 (9th Cir. 1980).

For the foregoing reasons, this Court should enter the proposed protective order to ensure that confidential information, which may have serious consequences chilling physician-patient relationships, is not used for any purpose beyond the current proceedings in this case.

---

[2] Good cause exists for entering a protective order pursuant to Rule 26(c) because the information disclosed involved private and confidential medical information and the disclosure was made without patients' consent. Moreover, it is a basic principle of discovery that "[a] party generally cannot use discovery for purposes unrelated to the lawsuit," and that a "common 'unrelated' purpose is to gain information for use in a different action against the same party." 6 Moore's Federal Practice, § 26.101[1][b], at 26-241 (1998). The Supreme Court has made clear, therefore, that "[l]iberal discovery is provided for the *sole purpose* of assisting in the preparation and trial, or the settlement, of litigated disputes." *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 34 (1984) (emphasis added). The Ninth Circuit has stated that protective orders are designed "as a safeguard for the protection of parties and witnesses in view of the broad discovery rights authorized in Rule 26(b)"). *United States v. CBS*, 666 F.2d 364, 368-69 (9th Cir.), *cert. denied* 457 U.S. 1118 (1982). While the confidential and private information at issue here was not obtained through discovery, the Oakland Defendants did, however, file the Alcalay Declaration of September 12, 1998, in response to the Court's Order To Show Cause. The disclosure was made as part of a filing necessary in this case. Therefore, the same rationale employed by courts to safeguard the use of information obtained during discovery applies with equal force here.

II. DEFENDANTS REQUEST THAT THIS COURT ORDER THE RETURN OF INADVERTENTLY DISCLOSED CONFIDENTIAL INFORMATION, AND ACCEPT THE AMENDED DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H. OMITTING THE CONFIDENTIAL INFORMATION.

The disclosure of confidential information in the previously filed Declaration of Michael M. Alcalay, M.D., M.P.H., was inadvertent. Alcalay Protective Order Decl. at ¶ 2. None of the patients whose confidential information was disclosed consented to this disclosure. *Id.* at ¶ 3. Therefore, this Court should order the return of this inadvertently disclosed information to the Oakland Defendants.

The Ninth Circuit has held that a privilege is not waived when there was an inadvertent disclosure of privileged, confidential communications without the privilege-holder's consent. *KL Group*, 829 F.2d at 919. *See also Transamerica Computer Co., Inc. v. IBM Corp.*, 573 F.2d 646, 647 (9th Cir. 1978) (no waiver when privileged documents inadvertently produced). California state cases have similarly held that, under California law, inadvertent disclosure of confidential information subject to a privilege does not necessarily waive the privilege. *See, e.g., People v. Gardner*, 151 Cal. App. 3d 134, 141 (1984) ("As in other privileges for confidential communications, the physician-patient privilege precludes a court disclosure of a communication, even though there has been an accidental or unauthorized out-of-court disclosure of such communication").

Similarly, here confidential information was inadvertently disclosed. This disclosure may have serious consequences for the doctors and for the patients themselves to the extent their privileged and confidential relationships with their doctors may be adversely affected. Therefore, the Oakland Defendants request this Court to permit them to withdraw their previously submitted Declaration of Michael M. Alcalay, M.D., M.P.H., dated September 12, 1998, and to permit them to resubmit the Amended Declaration of Michael M. Alcalay, M.D., M.P.H., dated September 30, 1998. The only difference between these two declarations is that the declaration of September 30, 1998, omits the disclosure of the confidential information.

CONCLUSION

For the foregoing reasons, the Oakland Defendants respectfully request that this Court enter their proposed protective order so that neither the government nor anyone else may use the inadvertently disclosed confidential information for purposes other than those related to this case.

Furthermore, the Oakland Defendants respectfully request this Court to grant their request for an order to return inadvertently disclosed confidential information, and to accept the Amended Declaration of Michael M. Alcalay, M.D., M.P.H., omitting the confidential information.

Dated: September 30, 1998

JAMES J. BROSNAHAN
ANNETTE P. CARNEGIE
ANDREW A. STECKLER
CHRISTINA KIRK-KAZHE
MORRISON & FOERSTER LLP

By: _____
Andrew A. Steckler

Attorneys for Defendants
OAKLAND CANNABIS BUYERS' COOPERATIVE AND JEFFREY JONES

PROOF OF SERVICE BY OVERNIGHT DELIVERY
(N.D. Local Rule 5-3)

I declare that I am employed with the law firm of Morrison & Foerster LLP, whose address is 425 Market Street, San Francisco, California, 94105; I am not a party to the within cause; I am over the age of eighteen years and I am readily familiar with Morrison & Foerster's practice for collection and processing of correspondence for overnight delivery and know that in the ordinary course of Morrison & Foerster's business practice the document described below will be deposited in a box or other facility regularly maintained by United Parcel Service or delivered to an authorized courier or driver authorized by United Parcel Service to receive documents on the same date that it is placed at Morrison & Foerster for collection.

I further declare that on the date hereof I served a copy of:

NOTICE OF MOTION AND MOTION FOR PROTECTIVE ORDER CONFIDENTIAL INFORMATION; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

DEFENDANTS' [PROPOSED] PROTECTIVE ORDER

[PROPOSED] ORDER

DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H., IN SUPPORT OF DEFENDANTS' MOTION FOR PROTECTIVE ORDER

AMENDED DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H.

***EX PARTE* APPLICATION FOR ORDER SHORTENING TIME FOR HEARING ON DEFENDANTS' MOTION FOR PROTECTIVE ORDER RE CONFIDENTIAL INFORMATION IN CASE NO. C 98-0088 CRB**

DECLARATION OF ANDREW A. STECKLER IN SUPPORT OF DEFENDANTS' *EX PARTE* APPLICATION FOR ORDER SHORTENING TIME FOR HEARING ON DEFENDANTS' MOTION FOR PROTECTIVE ORDER RE CONFIDENTIAL INFORMATION IN CASE NO. C 98-0088 CRB

on the following by placing a true copy thereof enclosed in a sealed envelope with delivery fees provided for, addressed as follows for collection by United Parcel Service at Morrison & Foerster LLP, 425 Market Street, San Francisco, California, 94105, in accordance with Morrison & Foerster's ordinary business practices:

SEE ATTACHED SERVICE LIST

SERVICE LIST FOR
SEPTEMBER 30, 1998 COURT FILING

Opposing Counsel:

Mark T. Quinlivan
U.S. Department of Justice
901 E Street, N.W., Room 1048
Washington, D.C. 20530

Intevenor-Patients Thomas V. Loran III, Esq. Pillsbury Madison & Sutro LLP 235 Montgomery Street San Francisco, CA 94104	Cannabis Cultivator's Club, et al. J. Tony Serra/Brendan R. Cummings Serra, Lichter, Daar, Bustamante, Michael & Wilson Pier 5 North, The Embarcadero San Francisco, CA 94111
Marin Alliance for Medical Marijuana, et al. William G. Panzer 370 Grand Avenue, Suite 3 Oakland, CA 94610	Flower Therapy Medical Marijuana Club, et al. Helen Shapiro Carl Shapiro 404 San Anselmo Avenue San Anselmo, CA 94960
Ukiah Cannabis Buyer's Club, et al. Susan B. Jordan 515 South School Street Ukiah, CA 95482 David Nelson 106 North School Street Ukiah, CA 95482	Oakland Cannabis Buyers Cooperative, et al. Gerald F. Uelmen Santa Clara University School of Law Santa Clara, CA 95053 Robert A. Raich A Professional Law Corporation 1970 Broadway, Suite 1200 Oakland, CA 94612

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed at San Francisco, California, this 30th day of September, 1998.

Susan Romo
(typed)

(signature)

PROOF OF SERVICE BY FACSIMILE TRANSMISSION
(N.D. Local Rule 5-3)

I declare that I am employed with the law firm of Morrison & Foerster LLP, whose address is 425 Market Street, San Francisco, California, 94105; I am not a party to the within cause; I am over the age of eighteen years; and that the document described below was transmitted by facsimile transmission to a facsimile machine maintained by the person on whom it is served at the facsimile machine telephone number as last given by that person on any document which he or she has filed in the cause.

I further declare that on the date hereof I served a copy of:

NOTICE OF MOTION AND MOTION FOR PROTECTIVE ORDER CONFIDENTIAL INFORMATION; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

DEFENDANTS' [PROPOSED] PROTECTIVE ORDER

[PROPOSED] ORDER

DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H., IN SUPPORT OF DEFENDANTS' MOTION FOR PROTECTIVE ORDER

AMENDED DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H.

***EX PARTE* APPLICATION FOR ORDER SHORTENING TIME FOR HEARING ON DEFENDANTS' MOTION FOR PROTECTIVE ORDER RE CONFIDENTIAL INFORMATION IN CASE NO. C 98-0088 CRB**

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on the following by sending a true copy from Morrison & Foerster's facsimile transmission telephone number (415) 268-7520 and that the transmission was reported as complete and without error. The transmission report, which is attached to this proof of service, was properly issued by the transmitting facsimile machine.

Opposing Counsel:

Mark T. Quinlivan
U.S. Department of Justice
901 E Street, N.W., Room 1048
Washington, D.C. 20530
(202) 616-8470

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed at San Francisco, California, this 30th day of September, 1998

Susan Romo
(typed)

(signature)

COPY

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. CANNABIS CULTIVATOR'S CLUB, et al., Defendants. AND RELATED ACTIONS.	No. C 98-0085 CRB C 98-0086 CRB C 98-0087 CRB C 98-0088 CRB C 98-0245 CRB **DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H., IN SUPPORT OF DEFENDANTS' MOTION FOR PROTECTIVE ORDER**

ER1662

I, MICHAEL M. ALCALAY, declare:

1. I am Medical Director of the Oakland Cannabis Buyers' Cooperative (the "Cooperative" or "OCBC"). I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. On September 12, 1998, I inadvertently signed a declaration which I understand was filed in court on September 14, 1998. This declaration set forth confidential information the Cooperative had obtained from its patient-members. This information included the names of many of these patients' treating physicians. This disclosure was inadvertent.

3. No patient of the Cooperative consented to my disclosure of this confidential information.

4. The information inadvertently disclosed raises serious issues of confidentiality and privacy. These issues concern the sanctity of the physician-patient relationship, which may be adversely impacted as a result of this disclosure.

5. This confidential information should not have been disclosed. Any disclosure of this confidential information should have been made under seal with the Court so that the information could not be used in relation to any matter beyond the current contempt proceedings in this case.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 30th day of September at San Francisco, California.

Michael M. Alcalay

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Attorneys for Defendants
OAKLAND CANNABIS BUYERS'
COOPERATIVE and JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
✓C 98-0088 CRB
C 98-0245 CRB

DEFENDANTS' [PROPOSED] PROTECTIVE ORDER

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

For good cause, the Court hereby orders that a protective order be entered in this action as follows:

1. This Protective Order shall govern all documents, writings and testimony in this action designated as "COVERED BY PROTECTIVE ORDER" together with all information contained therein or derived therefrom, and all copies, portions, excerpts, abstracts or summaries thereof (hereinafter collectively referred to as "Information") arising from individual patient medical care (including but not limited to patients' physician's names or other identifying information; information concerning physician referrals to dispensaries and/or their authorizing or assenting to cannabis treatment; patient medical records or charts; physician status reports; notes made by physicians, nurses, physician assistants or other medical staff, letters or reports from physicians, nurses, physician assistants or other medical staff, reports of physical exams; and reports of medical tests).

2. Information "COVERED BY PROTECTIVE ORDER" shall be used solely for conduct of this litigation, and not for any other purpose. Information "COVERED BY PROTECTIVE ORDER" shall not be disclosed to anyone except as provided in this Protective Order. In particular, Information "COVERED BY PROTECTIVE ORDER" shall not be disclosed to any employee or agent of the Drug Enforcement Administration, the Federal Bureau of Investigation, or any federal, state or local law enforcement agency unless specifically provided for in this Protective Order.

3. Notwithstanding paragraph 2, Information "COVERED BY PROTECTIVE ORDER" may be disclosed to the following persons who are participating in the conduct of this action on behalf of the plaintiff after they have signed and sent to defendants' counsel the form attached hereto stating their agreement to be bound and abide by the provisions of this Protective Order:

United States Department of Justice

Frank W. Hunger, Assistant Attorney General
Robert S. Mueller III, United States Attorney
David J. Anderson
Arthur R. Goldberg
Mark T. Quinlivan

Defendants' Counsel

James J. Brosnahan
Annette P. Carnegie
Andrew A. Steckler
Christina Kirk-Kazhe
Robert A. Raich
Gerald F. Uelmen

Information "COVERED BY PROTECTIVE ORDER" may also be disclosed, to the extent reasonably necessary in conducting this litigation, to the secretaries, paralegal assistants, and legal assistants of the above-named persons after they have signed and sent to defendants' counsel the form attached hereto stating their agreement to be bound and abide by the provisions of this Protective Order; and to Court officials involved in this litigation (including court reporters, persons operating video recording equipment at depositions, and any special master appointed by the Court). Provided that the individual to whom disclosure is made has signed and sent to defendants' counsel the form attached hereto stating his or her agreement to be bound and abide by the provisions of the Protective Order, such Information may also be disclosed to persons noticed for depositions or designated as trial or deposition witnesses to the extent reasonably necessary in preparing to testify; to such other persons agreed to by defendants' counsel in writing in advance of disclosure (such agreement shall not be unreasonably withheld); and to such other persons designated by the Court in the interest of justice.

4. The inadvertent or unintentional disclosure to plaintiff or their counsel by defendants or their counsel of Information "COVERED BY PROTECTIVE ORDER," regardless of whether the Information was so designated at the time of disclosure, shall not be deemed a waiver in whole or in part of defendants' claim that such Information is covered by this Protective Order. In the event of inadvertent or unintentional disclosure of Information "COVERED BY PROTECTIVE ORDER," defendants shall give prompt notification to plaintiff after learning of an inadvertent or unintentional disclosure, and shall provide plaintiff with new copies of the inadvertently or unintentionally produced documents, re-marked as "COVERED BY PROTECTIVE ORDER." The documents inadvertently or unintentionally produced without such designation shall then be returned promptly to defendants.

5. The Declaration of Michael M. Alcalay, M.D., M.P.H., along with the Exhibit A attached thereto, filed September 14, 1998, is hereby deemed by the Court to be an inadvertent or unintentional disclosure of Information "COVERED BY PROTECTIVE ORDER," as described in paragraph 8. As such, this Information shall be returned promptly to the defendants. Plaintiff is hereby ordered to return to defendants the Declaration of Michael M. Alcalay, M.D., M.P.H. along with the Exhibit A attached thereto, and it is ordered to return to defendants all copies made of this same Information. Plaintiff is hereby further ordered to prepare and provide to the Court within seven days a log of all copies made of this same Information, and to prepare and maintain a log of all copies that may be made of this same Information in the future. This same Information shall be deemed "COVERED BY PROTECTIVE ORDER" from and including September 14, 1998, and into the future. The Court will receive, and orders served on plaintiff and all parties, the Amended Declaration of Michael M. Alcalay, M.D., M.P.H., dated September 30, 1998.

IT IS SO ORDERED.

Dated: _____

_____
UNITED STATES DISTRICT COURT JUDGE

APPENDIX TO PROTECTIVE O

AGREEMENT TO ABIDE BY TERMS OF

I have received and read a copy of the foregoing P
and abide by the terms of the Protective Order and will
"COVERED BY PROTECTIVE ORDER" as defined in the
the parties to any other person, except under the terms specified in

Dated:

_____

10.1.98

FRANK W. HUNGER
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ROBERT S. MUELLER, III (Cal. BN 59775)
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DAVID J. ANDERSON
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Attorneys for Plaintiff

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

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB; and DENNIS PERON,

Defendants.

AND RELATED ACTIONS

Nos. C 98-0085 CRB RELATED
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0245 CRB

REPLY IN SUPPORT OF PLAINTIFF'S MOTIONS IN LIMINE TO EXCLUDE AFFIRMATIVE DEFENSES, AND OPPOSITION TO APPLICATION FOR USE IMMUNITY

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom of the Hon. Charles R. Breyer

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OTHER AUTHORITIES

PRELIMINARY STATEMENT

In our opening memorandum, the United States demonstrated that defendants Oakland Cannabis Buyers' Cooperative ("OCBC") and Jeffrey Jones in Case No. C 98-0088 CRB (collectively the "OCBC defendants"); and defendants Marin Alliance for Medical Marijuana ("Marin Alliance") and Lynnette Shaw in Case No. C 98-0086 CRB (collectively the "Marin Alliance defendants"), have failed to present any competent evidence regarding their affirmative defenses of medical necessity, substantive due process, and joint users sufficient to present to a jury and that, in any event, each of these defenses fails as a matter of law. In their Opposition to Government's Motion in Limine to Exclude Defendants' Affirmative Defenses in Case No. C 98-0088 CRB ("OCBC Opp."), the OCBC defendants have now essentially foresworn any effort to establish that each and every person distribution of marijuana in which they engaged on May 21, 1998, was justified by one or more of their affirmative defenses. Instead, the OCBC defendants contend that they are in substantial compliance with the Court's May 19, 1998 Preliminary Injunction Order and, moreover, that their meager evidentiary showing is sufficient to warrant a trial on their affirmative defenses.

Similarly, in the Opposition of Defendants Marin Alliance for Medical Marijuana and Lynnette Shaw to Plaintiff's Motion in Limine to Exclude Defendants' Affirmative Defenses in Case No. C 98-0086 CRB ("Marin Opp."), the Marin Alliance defendants contend that they are not obligated to provide any information regarding the fourteen or more persons to whom they distributed marijuana on May 27, 1998, because the government has allegedly "failed to present the Court or [the Marin Alliance defendants] with any allegation of a specific transaction under a specific set of facts." Marin Opp. at 4.

As we demonstrate below, neither of these arguments has any merit. The OCBC and Marin Alliance defendants, having repeatedly promised the Court that they would produce evidence supporting their asserted affirmative defenses when given the opportunity, have now been exposed. Neither group of defendants, in response to the Court's Show Cause Orders, has

offered competent evidence contesting that they engaged in the distribution of marijuana on May 21 and 27, 1998, respectively, nor have they provided the Court with competent evidence sufficient to present to a jury that each of the distribution of marijuana in which they engaged on these dates was justified by one or more affirmative defenses. Under these circumstances, the Court should vindicate its authority, reject the affirmative defenses put forward by the OCBC and Marin Alliance defendants, and grant the relief sought by the United States.

ARGUMENT

I. STANDARDS

We begin by responding to several of the OCBC and Marin Alliance defendants' misunderstandings regarding the standards which govern these civil contempt proceedings.

1. Although the OCBC defendants assert that they have disputed engaging in the distribution of marijuana, see OCBC Opp. at 4, and the Marin Alliance defendants state that they are not "admitting that any distribution has taken place," Marin Alliance Opp. at 3, neither group of defendants is, in reality, contesting the fact that they distributed marijuana on May 21 and 27, 1998, respectively. Instead of submitting declarations denying that they distributed marijuana to their clientele -- which, of course, would contradict the very legal defenses they assert as well as the evidence they *have* placed before the Court -- the OCBC and Marin Alliance defendants continue to play at word games. For example, the OCBC defendants assert that, in their response to the Court's Show Cause Order, "defendants made it abundantly clear that they deny any distributions of marijuana *in violation of the Court's Preliminary Injunction Order*." OCBC Opp. at 4 (emphasis supplied). Such a tautology, that defendants' distributions of marijuana are not in violation of the Preliminary Injunction Order because they have raised affirmative defenses, cannot suffice as a factual denial. See generally British Airways Bd. v. The Boeing Co., 585 F.2d 946, 952 (9th Cir. 1978) ("[L]egal memoranda and oral argument are not evidence, and they cannot by themselves create a factual dispute sufficient to defeat a summary judgment motion where no dispute otherwise exists."), cert. denied, 440 U.S. 981 (1979).

Accordingly, under well-settled principles of law, the defendants' failure to specifically contest that they distributed marijuana and used their respective premises for this purpose should be "considered evidence of acquiescence." Baxter v. Palmigiano, 425 U.S. 308, 319 (1976). Accord United States v. Hale, 422 U.S. 171, 176 (1975); United States ex rel. Bilokumsky v. Tod, 263 U.S. 149, 153-54 (1923) (Brandeis, J.); Watson v. Perry, 918 F. Supp. 1403, 1415-16 (W.D. Wash. 1996), aff'd, 124 F.2d 1126 (9th Cir. 1997).

2. The OCBC defendants' assertion that they need only show that they are in "substantial compliance" with this Court's May 19, 1998 Preliminary Injunction Order, also is wrong in the context of this case. The Ninth Circuit's rule regarding contempt "has long been whether defendants have performed 'all reasonable steps within their power to insure compliance' with the court's orders." Stone v. City and County of San Francisco, 968 F.2d 850, 856 (9th Cir.1992) (quoting Sekaquaptewa v. MacDonald, 544 F.2d 396, 404 (9th Cir.1976), cert. denied, 430 U.S. 931 (1977)), cert. denied, 506 U.S. 1081 (1993). Thus, although substantial compliance with a court order is a defense to an action for civil contempt, and "technical or inadvertent violation of the order will not support a finding of civil contempt," a violating party will be found to have substantially complied with a court order ***only*** if it has "taken 'all reasonable steps' to comply with the court order * * * *." General Signal Corp. v. Donnallco, Inc., 787 F.2d 1376, 1379 (9th Cir. 1986) (emphasis supplied) (quoting Vertex Distr. v. Falcon Foam Plastics, Inc., 689 F.2d 885, 891-92 (9th Cir. 1982)).

In these cases, the OCBC and Marin Alliance defendants have taken ***no*** steps to comply with the Court's Preliminary Injunction Orders. Instead, they have essentially continued business as usual, distributing marijuana to their members under the assumption (or hope) that they can ultimately persuade a jury that their affirmative defenses are valid. OCBC Opp. at 1-2; Marin Alliance Opp. at 3. This is not the "substantial compliance" or "technical or inadvertent violation" envisioned by the courts. In Robin Woods Inc. v. Woods, 28 F.3d 396 (3d Cir. 1994), for example, the Third Circuit held that a violation of a court order could not be deemed "technical"

or "inadvertent" when the alleged contemnor "consciously chose" to violate injunction, even though the alleged contemnor had acted in good faith and on the advice of counsel. Id. at 399. Indeed, to hold otherwise would be to allow the defendants to continue to violate the Preliminary Injunction Orders by distributing marijuana on a widespread basis and, so long as they can justify some of these distributions under one or more of their affirmative defenses, escape any form of sanction. This Court has previously rejected substantially similar arguments advanced by the defendants. United States v. Cannabis Cultivators Club, 5 F. Supp.2d 1086, 1102 (N.D. Cal. 1998) ("[T]he defense of necessity has never been allowed to exempt a defendant from the criminal laws on a blanket basis."); id. at 1103 (defense based on substantive due process "is not available, however, to exempt generally the distribution of marijuana from the federal drug laws."). The Court therefore was quite right in determining that, in order for the defendants to properly invoke these affirmative defenses, they must demonstrate that "each and every" distribution of marijuana was justified by one or more of them.[1]

3. The OCBC defendants' related argument, that they acted in good faith in interpreting and relying on the Court's May 13, 1998 Memorandum and Order, see OCBC Opp. at 7, also is unavailing to them. As the Ninth Circuit explained in Stone, "[i]ntent is irrelevant to a finding of civil contempt and, therefore, good faith is not a defense." 968 F.2d at 856. Accord In re Crystal Palace Gambling Hall, Inc., 817 F.2d 1361, 1365 (9th Cir. 1987); Donovan v. Mazzola, 716 F.2d 1226, 1240 (9th Cir. 1983), cert. denied, 464 U.S. 1040 (1984). The sole question is whether a party complied with the district court's order. See, e.g., McComb v. Jacksonville Paper Co., 336 U.S. 187, 191 (1949).

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[1] In any event, the OCBC defendants' submission of declarations from eight individuals out of 191, or roughly 4% of the club's customers on May 21, 1998, could not establish "substantial compliance" with the Court's Preliminary Injunction Order even on the merits. Indeed, viewed in this light, the OCBC defendants' "mountain of evidence," OCBC Opp. at 14, is revealed as the proverbial molehill that it is.

4. The Marin Alliance defendants' contention that they cannot respond to the Court's Show Cause Order because the government has allegedly "failed to present * * * any allegation of a specific transaction under a specific set of facts," Marin Opp. at 4, also is meritless. The Court's September 3, 1998 Order to Show Cause specifically found that, based on the totality of circumstances, the United States had made a prima facie case that the Marin Alliance defendants had distributed marijuana and used their premises for this purpose on May 27, 1998, and required the Marin Alliance defendants "to show cause why they should not be held in civil contempt of the Court's May 19, 1998 Preliminary Injunction Order by distributing marijuana and by using the premises of 6 School Street Plaza, Fairfax, California, for the purpose of distributing marijuana, on May 27, 1998 * * * *." Hence, the burden of production has shifted to the Marin Alliance defendants to show "categorically and in detail" either substantial compliance or inability to comply. See Donovan, 716 F.2d at 1240. It therefore is no answer for the Marin Alliance defendants to continue to contest the evidentiary showing by the United States; the burden of production is now on their shoulders.

Furthermore, the Marin Alliance defendants suggestion that they are unable to determine which of the (apparently) numerous individuals to whom they distributed marijuana on May 27, 1998, are the subject of the Court's Show Cause Order cannot be taken seriously. The Show Cause Order did not limit itself to only fourteen individuals or distributions, but is inclusive of any and all distributions which occurred on May 27. Moreover, the Marin Alliance defendants' complaints in this regard ring hollow because, as they do not dispute, all the relevant information is in their possession and control.

II. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO ESTABLISH THE DEFENSE OF MEDICAL NECESSITY

In our opening memorandum, we showed: (1) that Congress made a determination of values when it passed the Controlled Substances Act and precluded any possibility of a medical necessity defense; (2) that, because the OCBC and Marin Alliance defendants did not seek redress

before this Court, they cannot establish, as a matter of law, the absence of reasonable, legal alternatives; (3) that, in any event, the medical necessity defense has only been allowed in cases involving possession, not distribution; and (4) that the OCBC and Marin Alliance defendants have failed to offer competent evidence demonstrating that each and every person to whom they distributed marijuana on May 21 and 27, 1998, respectively, could establish the elements of a necessity defense.

1. The OCBC defendants first contend that "[t]he government's claim that Congress has abrogated any possibility of a medical necessity defense here is simply wrong." OCBC Opp. at 12. On the contrary, the recent decision in United States v. Diana, Nos. CR-98-068-RHW; CR-98-069-RHW; CR-98-070-RHW; and CR-98-072-RHW (E.D. Wash. Sept. 21, 1998), squarely supports the conclusion that Congress precluded any possibility of a medical necessity defense. In Diana, the lead defendant, who suffered from multiple sclerosis, was arrested with three other individuals for the manufacture and possession of marijuana.[2] Three of the four defendants, including the lead defendant, raised the defense of medical necessity to the federal charges.

The district court held that the medical necessity defense was unavailable to the defendants as a matter of law. Noting that Congress had placed marijuana in Schedule I, see 21 U.S.C. § 812 Schedule I(c)(10), had delegated to the Attorney General the authority to reschedule drugs, id. § 811(a), and had provided for research programs to determine whether medical uses might develop for substances in Schedule I, id. § 823(f), the district court held that "Congress was aware of the competing interests in cases such as Defendants' and addressed them." Diana, Nos. CR-98-068-RHW; CR-98-069-RHW; CR-98-070-RHW; and CR-98-072-RHW, slip op. at 5. The district court further noted that, while no published federal decision had yet adopted this analysis, the four state courts which had reached an identical conclusion under state law "were correctly decided."

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[2] The lead defendant had previously been acquitted in Washington state court of state marijuana possession charges based on the medical necessity defense. See State v. Diana, 24 Wn. App. 908 (1979).

Id. (citing State v. Tate, 102 N.J. 64, 73, 505 A.2d 941, 946 (1986); State v. Hanson, 468 N.W.2d 77, 78 (Minn. App. 1991); State v. Cramer, 174 Ariz. 522, 524, 851 P.2d 147, 149 (1992); and Kaufman v. State, 620 So.2d 90, 92-93 (Ala. Crim. App. 1992)).

This Court should follow the Diana court's persuasive analysis. Congress's determination that marijuana has "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use * * * under medical supervision," 21 U.S.C. § 812(b)(1), as well as its creation of an administrative rescheduling and research process to take into account changes in scientific and medical knowledge, id. §§ 811(a), 823(f), reveals that the Legislative Branch considered and rejected any possible medical necessity defense for marijuana.

2. The OCBC defendants also fail to undermine our showing that, because they did not pursue available remedies in the judicial system, their invocation of the medical necessity defense must be rejected under United States v. Aguilar, 883 F.2d 662 (9th Cir. 1989), cert. denied, 498 U.S. 1046 (1991). In that case, the Ninth Circuit held that, because the defendants could have "appeal[ed] to the judiciary to correct any alleged improprieties by the INS and the immigration court," this available legal alternative "nullifies the existence of necessity for all the underlying crimes stated * * * *." Id. at 694. Similarly here, the OCBC and Marin Alliance defendants had the right to appeal from the Court's Preliminary Injunction Orders, see 28 U.S.C. § 1292(a)(1), and also could have moved the Court to modify the Preliminary Injunction Orders to allow for the distribution of marijuana in particular circumstances or cases, see Fed. R. Civ. P. 60(b), including seeking expedited relief, if necessary. See Local Rule 7-10 (expedited motions); Local Rule 7-11 (ex parte motions). Because the OCBC and Marin Alliance defendants failed to pursue available judicial remedies, Aguilar dictates rejection of their medical necessity defense.

The OCBC defendants argue, however, that they have met the fourth prong of the necessity test because "no other alternative effectively can prevent the serious and imminent *medical* harm they seek to avoid." OCBC Opp. at 13. But this argument misses the mark. As Aguilar establishes, the judicial process itself can be a reasonable, legal alternative, see 883 F.2d

at 693-94, and the OCBC and Marin Alliance defendants were obligated to avail themselves of this alternative.

Moreover, the OCBC defendants have failed to offer competent evidence demonstrating that each of the persons to whom they distributed marijuana had no other medical alternative. In Diana, for example, the district court determined that, because the lead defendant had not sought a prescription for Marinol, a Schedule II substance in pill form which contains the THC found in marijuana, or sought to participate in a controlled research project pursuant to section 823(f), the defendant failed the fourth prong of the necessity test. Diana, Nos. CR-98-068-RHW; CR-98-069-RHW; CR-98-070-RHW; and CR-98-072-RHW, slip op. at 6-7. Similarly here, with the exception of Dr. Alcalay, none of the declarations submitted by the OCBC defendants establish that those persons had tried Marinol, or sought to participate in a section 823(f) research project. Borrowing the Diana court's language, "there were legal alternatives which work for others, and may have worked for Defendant[s]. [They] did not try them. Failing this fourth prong [of the necessity test], there is no need to address the others." Id. See also Aguilar, 883 F.2d at 692-93 ("[I]f defendants' offer of proof is deficient with regard to any of the four elements, the district judge must grant the motion to preclude evidence of necessity.").

3. Although they cannot point to a single case in which a medical necessity defense was authorized outside the context of a possession charge, the OCBC defendants continue to argue that they may assert this defense even though these cases involve distribution, not possession. OCBC Opp. at 15. This argument, too, is without foundation. As one judge has observed:

> If the [medical necessity] defense prevails it serves not only to exculpate defendant of unlawfully using marihuana, but also as an invitation to him and to others to commit a wide range of possessory infractions without hindrance in the future. The amnesty granted is not only for possession immediately incidental to use, but for possession at all other times as well. This follows because the need for therapeutic administration cannot be forecast and defendant would have to have it available at all times for use when the need arises. Furthermore, it would be left to defendant's unsupervised judgment to decide when, under what circumstances and in what dosages it should be used. As the trial judge himself recognized, the substance may not be prescribed for use and it would therefore be impossible for defendant to obtain professional guidance when actually medicating.

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> [T]he defense of necessity * * * should not be available where the alleged necessity is regularly recurrent and the violation evidences a calculated intention to disregard the statutory prohibition. If there is to be a change in the legal status of his drug it should be made by the legislature and not by the courts.

State v. Tate, 198 N.J. Super. 285, 288-89, 486 A.2d 1281, 1283-84 (1984) (Antell, P.J.A.D., dissenting), rev'd, 102 N.J. 64, 505 A.2d 941 (1986). The Court should follow this reasoning.

4. Finally, apparently recognizing their inability to meet the Court's requirement that they produce evidence showing that each and every distribution of marijuana on May 21, 1998, was justified by medical necessity, the OCBC defendants instead point to the alleged "stringency of their admission criteria—both upon initial application to the Cooperative and at each subsequent visit," OCBC Opp. at 8, as proof of their compliance. Any such evidence, however, is legally insufficient, as the Ninth Circuit made clear in Aguilar. In that case, the defendants, who had been convicted of various provisions of the immigration laws for their participation smuggling, transporting, and harboring refugees from Central America, argued on appeal that they were entitled to an instruction on necessity at trial because the Immigration and Naturalization Service ("INS") had continually frustrated the ability of these individuals to obtain refugee status. Although the court rejected this claim on the ground that the defendants had failed to pursue available judicial remedies, the Ninth Circuit was careful to note that:

> We also doubt the sufficiency of the proffer to establish imminent harm. The offer fails to specify that the ***particular aliens assisted*** were in danger of imminent harm. Instead, it refers to general atrocities committed by Salvadoran, Guatemalan, and Mexican authorities. The only indication that appellants intended to show that the aliens involved in this action faced imminent harm was their proffer that they adopted a process to screen aliens in order to assure themselves that those helped actually were in danger. ***This allegation fails for lack of specificity***. Moreover, even a specific proffer would establish only appellants' deliberative assessment that certain aliens faced imminent harm, and not that these aliens in fact were in danger. In other contexts, perhaps this proffer would be sufficient. In the immigration area, however, allowing this showing to establish a necessity defense essentially would result in sanctioning the creation of religious boards of review to determine asylum status. The executive branch, not appellants, is assigned this task.

883 F.2d 693 n.28 (emphasis supplied).

This language makes clear that the OCBC and Marin Alliance defendants are obligated to specify that each of their customers could establish a medical necessity defense, and that generalized statements as to admission criteria cannot substitute for such a showing. Because the OCBC and Marin Alliance defendants have failed to offer any evidence that each of the persons to whom they distributed marijuana was in danger of imminent harm, and had no alternative, legal remedies available, their invocation of the medical necessity defense cannot stand.

III. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO ESTABLISH THE DEFENSE OF SUBSTANTIVE DUE PROCESS

In our opening memorandum, we showed that, under binding Ninth Circuit precedent, the OCBC and Marin Alliance defendants do not have a substantive due process right to use marijuana. In Carnohan v. United States, 616 F.2d 1120 (9th Cir. 1980), the Ninth Circuit, consistent with every other court of appeals to have considered the issue,[3] held that the "[c]onstitutional rights of privacy and personal liberty do not give individuals the right to obtain laetrile free of the lawful exercise of the government's police power." Id. at 1122. We also showed that, in any event, the OCBC and Marin Alliance defendants had failed to offer any competent evidence establishing that each and every person to whom they distributed marijuana on May 21 and 27, 1998, respectively, could establish a violation of their substantive due process rights.

In their opposition, the OCBC defendants argue that Carnohan is distinguishable on three grounds. None of these purported distinctions is persuasive. First, the OCBC defendants contend that this case is distinguishable because "defendants do not assert the right to a particular treatment as [in Carnohan]." OCBC Opp. at 16. Rather, the OCBC defendants argue that they are

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[3] See Sammon v. New Jersey Bd. of Medical Examiners, 66 F.3d 639, 645 n.10 (3d Cir. 1995); Mitchell v. Clayton, 995 F.2d 772, 775-76 (7th Cir. 1993); Rutherford v. United States, 616 F.2d 455, 457 (10th Cir.), cert. denied, 449 U.S. 937 (1980). See also Smith v. Shalala, 954 F. Supp. 1, 3 (D.D.C. 1996) (quoting Carnohan for proposition that there was no substantive due process right "to obtain unapproved drugs free of the lawful exercise of government police power.").

"assert[ing] the fundamental liberty interest to be free from unnecessary pain, to receive palliative treatment for painful medical conditions, to care for oneself, and to preserve one's life." OCBC Opp. at 16.

There is no merit to this assertion. In Washington v. Glucksberg, 117 S. Ct. 2258 (1997), the Supreme Court made clear that, in substantive due process cases, "a 'careful description' of the asserted fundamental liberty interest" is a primary feature of substantive due process analysis. Id. at 2268. Here, the OCBC defendants are not merely asserting the right to be free from pain, to receive treatment, to care for oneself, and to preserve one's life in a vacuum. Necessarily, the OCBC defendants are also asserting that, in order to vindicate these rights, they must be allowed to use marijuana. Carnohan precludes any such argument. See 616 F.2d at 1122. As the Tenth Circuit explained in Rutherford, "the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health." 616 F.2d at 457. Accord Mitchell, 995 F.2d at 775-76 ("[A] patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider").

Second, the OCBC defendants argue that, in contrast to Carnohan, "the government has introduced no evidence concerning the harmfulness of cannabis." OCBC Opp. at 16. The Marin Alliance defendants also assert that "the government has glaringly failed to submit any scientific evidence to support its contention that a rational basis exists to ban medical marijuana." Marin Opp. at 6. These arguments fundamentally misapprehend the nature of rational basis review. Legislative classifications subject to rational basis review are accorded "a strong presumption of validity" and must be sustained if there is "any reasonably conceivable state of facts that could provide a rational basis for the classification." Heller v. Doe, 509 U.S. 312, 319-20 (1993). The Government "has no obligation to produce evidence to sustain the rationality" of the Act; "a legislative choice is not subject to courtroom factfinding and may be based on rational speculation

unsupported by evidence or empirical data." Id. at 320. Instead, "[t]he burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it * * * whether or not the basis has a foundation in the record." Id. at 320-21.

Here, as we described in our opening memorandum, by placing marijuana in Schedule I, Congress determined that the substance has a "high potential for abuse," "no currently accepted medical use in treatment in the United States," and a "lack of accepted safety for use under medical supervision." 21 U.S.C. § 812(b)(1). Moreover, when it passed the Controlled Substances Act, Congress provided for a statutory framework wherein controlled substances that have been placed in Schedule I (or any other schedule) may be rescheduled, or removed from the five schedules. Id. § 811(a). As the Second Circuit has held, "[t]he very existence of the statutory scheme indicates that, in dealing with the 'drug' problem, Congress intended flexibility and receptivity to the latest scientific information to be the hallmarks of its approach. This * * * is the very antithesis of the irrationality [defendants] attribute[] to Congress." United States v. Kiffer, 477 F.2d 349, 357 (2d Cir. 1972), cert. denied, 414 U.S. 831 (1973). Accord National Organization for the Reform of Marijuana Laws v. Bell, 488 F. Supp. 123, 142 (D.D.C. 1980) (three-judge panel) (same).

Third, the OCBC defendants argue that "medical cannabis has played a role in our '[n]ation's history, legal traditions and practices' * * * at least between 1840 and 1937." OCBC Opp. at 16 (quoting Glucksberg, 117 S. Ct. at 2262). Here again, there is no basis to this argument. In Glucksberg, the Supreme Court rejected the asserted right to physician assisted suicide because "[t]he history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause." 117 S. Ct. 2271. Similarly here, in addition to the prohibitions in the Controlled Substances Act, there can be no dispute that "the use, possession, and sale of marijuana remains illegal in almost every state." Cass R.

Sunstein, *Pornography and the First Amendment*, 1986 Duke L.J. 589, 627. See generally Leary v. United States, 395 U.S. 6, 17 (1969); United States v. Alkhafaji, 754 F.2d 641, 644 (6th Cir. 1985). Under these circumstances, the OCBC defendants cannot establish that their asserted right is so deeply rooted in the Nation's history and traditions as to be fundamental. Glucksberg, 117 S. Ct. at 2268.

Finally, the OCBC defendants contention that they are not required to show that each and every person to whom they distributed marijuana on May 21, 1998, could establish the defense of substantive due process, see OCBC Opp. at 17-18, fails for the reasons set forth above. See Part I-II.

IV. THE OCBC AND MARIN ALLIANCE DEFENDANTS HAVE FAILED TO ESTABLISH THE DEFENSE OF JOINT USERS

In our opening memorandum, we showed that, because the OCBC and Marin Alliance defendants failed to present any competent evidence demonstrating that they were "joint possessors who *simultaneously acquired possession* at the outset for their own use," United States v. Swiderski, 548 F.2d 445, 450-51 (2d Cir. 1977) (emphasis supplied), their invocation of the defense of joint users fails as a matter of law. See, e.g., United States v. Wright, 593 F.2d 105, 198 (9th Cir. 1979) (refusing to extend scope of the Swiderski ruling to cases which do not involve joint *and* simultaneous acquisition[4]). As this Court explained, "[a]pplying Swiderski to a medical marijuana cooperative would extend Swiderski to a situation in which the controlled substance is not literally purchased simultaneously for immediate consumption. In light of the fact that Swiderski has never been so extended, and in light of the fact that it has not been adopted by the Ninth Circuit, the Court concludes that it is reasonably likely that such a defense would not prevail at a trial addressing whether injunctive relief should be granted." Cannabis Cultivators Club, 5 F. Supp.2d at 1101. See also United States v. Washington, 41 F.3d 917, 920 (4th Cir.

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[4] Indeed, in Wright, the Ninth Circuit expressly declined to decide whether Swiderski was good law in the Ninth Circuit. 593 F.2d at 108.

1994) (affirming district court's denial of Swiderski instruction because "[a] defendant who purchases a drug and shares it with a friend has 'distributed' the drug even though the purchase was part of a joint venture to use drugs").

The OCBC defendants completely fail to respond to this showing in their opposition brief. Instead, in a transparent attempt to muddy the waters, they argue that the government's argument focused on the fact "that the Cooperative members are not two members, husband and wife." OCBC Opp. at 19. This, of course, was not the government's argument, as any cursory review of our opening memorandum demonstrates.[5] Again, because neither the OCBC or Marin Alliance defendants have offered a scintilla of evidence that they and their customers *simultaneously acquire* marijuana, as Swiderski and Wright require, their invocation of the joint user defense must be rejected..

IV. THE COURT SHOULD DENY THE OCBC DEFENDANTS' APPLICATION FOR USE IMMUNITY

The OCBC defendants also have filed an application for use immunity "[i]n anticipation of trial on the government's allegations that defendants are in contempt of this Court's Preliminary Injunction Order * * * *." Application for Use Immunity for Statement or Testimony of Defendant and Defense Witnesses in Case No. C 98-0088 CRB ("Immunity App.") at 1. Because this Court should exclude the OCBC and Marin Alliance defendants' affirmative defenses and find them in civil contempt, the Court need not consider this application as there is no need for a

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[5] The United States did argue that the sheer volume of customers at the OCBC on May 21, 1998 -- 191 -- dictates rejection of the joint user defense. And for good reason. The courts have been extremely reluctant to extend Swiderski beyond its narrow factual posture. See, e.g., United States v. Rush, 738 F.2d 497, 514 (1st Cir. 1984) (declining to extend Swiderski "to situations where more than a couple of defendants and a small quantity of drugs are involved."), cert. denied, 470 U.S. 1004 (1985); United States v. Taylor, 683 F.2d 18, 21 (1st Cir.) (finding Swiderski inapplicable to complex marijuana distribution organization), cert. denied, 459 U.S. 945 (1982). In contrast, the OCBC defendants have failed to cite to a single case in which Swiderski was applied to an alleged joint users numbering in the hundreds, if not thousands.

trial in this matter. Nonetheless, we briefly respond to the arguments advanced in the application for use immunity.

As a preliminary matter, the OCBC defendants do not dispute, as they cannot, the bedrock principle that "[i]mmunity is an executive, not a judicial function, and '[t]his court has emphatically rejected the argument that the sixth amendment provides a defendant with a right to demand use immunity for defense witnesses who invoke their privilege against self-incrimination.'" United States v. Baker, 10 F.3d 1374, 1414 (9th Cir. 1993) (quoting United States v. Brutzman, 731 F.2d 1449, 1451-52 (9th Cir. 1984)), cert. denied, 513 U.S. 934 (1994). Rather, the OCBC defendants contend they are entitled to use immunity under two narrow exceptions to this general rule. Neither exception is applicable here.

The OCBC defendants first contend the Court should provide use immunity to defendant Jeffrey Jones "in order to 'vindicate the most fundamental of all constitutional rights, [his] right of liberty from civil incarceration.'" Immunity App. at 5 (quoting United States v. Perry, 788 F.2d 100, 116 (3d Cir.), cert. denied, 479 U.S. 864 (1986)). The OCBC defendants argue that, because the United States is seeking civil contempt, and because defendant Jones "faces in civil contempt proceedings the risk of civil incarceration," use immunity is necessary to vindicate his right of liberty from civil incarceration. Id.

This contention is a non-starter. The United States is not seeking civil incarceration of defendant Jones, or any other defendant, as a potential remedy in this case. Indeed, the United States has made it abundantly clear that it is seeking an order authorizing the United States Marshal to enforce the Court's Preliminary Injunction Orders by padlocking the defendant clubs until such time as the OCBC and Marin Alliance defendants can "satisfy [the Court] that [they are] no longer in violation of the injunctive order and that [they] would in good faith thereafter comply with the terms of the order." Lance v. Plummer, 353 F.2d 585, 592 (5th Cir. 1965), cert. denied, 384 U.S. 929 (1966). Hence, there is no merit to the OCBC defendants' argument that defendant Jones is entitled to use immunity because he is in danger of civil incarceration.

The OCBC defendants also contend, relying on United States v. Lord, 711 F.2d 887 (9th Cir. 1983), and United States v. Westerdahl, 945 F.2d 1083 (9th Cir. 1991), that the Court should provide them and other defense witnesses with use immunity in order to protect their due process right to a fair trial based on the government's alleged "intentional distortion of the fact-finding process." Immunity App. at 8. This contention, too, is without foundation. As an initial matter, Lord and its progeny are inapplicable to civil proceedings, in which the Ninth Circuit has made clear that "[a] defendant has no absolute right not to be forced to choose between testifying in a civil matter and asserting his Fifth Amendment privilege." Keating v. Office of Thrift Supervision, 45 F.3d 322, 326 (9th Cir.), cert. denied, 516 U.S. 827 (1995). Indeed, the OCBC defendants do not point to a single case in which Lord-type immunity was provided in a civil case, and we are aware of none.

Moreover, none of the circumstances at issue in Lord or Westerdahl are present here. In Westerdahl, the Ninth Circuit explained that an evidentiary hearing regarding the government's refusal to provide a potential witness with use immunity is required either: (1) where the defendant makes a prima facie showing that "the government or its agents took *affirmative* actions to prevent defense witnesses from testifying," 945 F.2d at 1086 (emphasis supplied); or (2) where the government grants immunity to one witness while denying immunity to a defense witness who would directly contradict the testimony of the government witness. Id. at 1087. Neither of these situations is present here.

First, the United States has not taken any "affirmative action" to prevent defense witnesses at trial. Indeed, the government has had no contact whatsoever with the defendants, or the potential defense witnesses, regarding their testimony in this case. In Lord, by contrast, the Ninth Circuit found that "[t]he record can * * * be read to suggest that prosecutorial misconduct caused [the potential witness] to invoke his fifth amendment privilege against self-incrimination," insofar as the prosecutor had allegedly informed the witness "that whether he would be prosecuted depended on his testimony," and "that the government would not prosecute [him] if he submitted

to an interview and testified truthfully." 711 F.2d at 891. Therefore, because there is no evidence that the United States has taken "affirmative actions" to prevent defense witnesses from testifying in this matter, there is no basis for the OCBC defendants' request for use immunity on this basis. See, e.g., Jeffers v. Ricketts, 832 F.2d 476, 479 (9th Cir. 1987), rev'd on other grounds, 497 U.S. 764 (1990) (defendant failed to make a prima facie case of prosecutorial misconduct because "[t]here is no suggestion that the prosecutor made any threat to [the potential witness] that induced him to invoke the fifth amendment, as was prima facie shown to have occurred in Lord.").

Second, "[t]his is not a case where two eyewitnesses have conflicting stories to tell, and the government seeks and obtains immunity for its own eyewitness while refusing to request immunity for defendant's eyewitness." Brutzman, 731 F.2d at 1452. The government has not provided any witnesses with immunity in these actions, and the OCBC defendants do not point to any instance in which two (or more) eyewitnesses have conflicting stories to tell.

Accordingly, the OCBC defendants' application for use immunity should be denied.

CONCLUSION

For the reasons set forth above, and in our opening memorandum, the Court should grant the United States' motion in limine to exclude the affirmative defenses offered by the OCBC and Marin Alliance defendants, find defendants in civil contempt of the May 19, 1998 Preliminary Injunction Orders, and enter the relief proposed by the United States.

Respectfully submitted,

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UNITED STATES OF AMERICA

Dated: October 1, 1998

CERTIFICATE OF SERVICE

I, Mark T. Quinlivan, hereby certify that on this 1st day of October, 1998, I caused to be served a copy of the foregoing Reply in Support of Plaintiff's Motions in Limine to Exclude Affirmative Defenses, and Opposition to Application for Use Immunity, and the accompanying [Proposed] Order, upon counsel for the defendants and intervenors, by the following means:

By facsimile transmission and overnight delivery:

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. OAKLAND CANNABIS BUYERS' COOPERATIVE, and JEFFREY JONES, Defendants.	No. C 98-00088 CRB ANSWER TO COMPLAINT OF INTERVENOR-DEFENDANTS AND REQUEST FOR JURY TRIAL

Defendants in intervention EDWARD NEIL BRUNDRIDGE and IMA CARTER (the "Members") respond to plaintiff's Complaint for Declaratory Relief, and Preliminary and Permanent Injunctive Relief against defendants Oakland Cannabis Buyers' Cooperative, and Jeffrey Jones, (the "Complaint") as follows:

FIRST DEFENSE

The Complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Members answer the allegations of the numbered paragraphs of the Complaint using the same paragraph numbers:

1. The Members are without knowledge or information sufficient to enable them to form a belief as to the truth or falsity of plaintiff's averments concerning its intent and state of mind. Answering the remaining allegation of paragraph 1, the Members aver that the Complaint speaks for itself and that provisions of the Controlled Substances Act (the "Act"), 21 U.S.C. § 801 et seq., are conclusions of law, which speak for themselves. Except as so averred, the Members deny the allegations of paragraph 1.

2. The Members aver that section 512(a) of the Act, 21 U.S.C. § 882(a), is a matter of law that speaks for itself and further aver upon information and belief that this Court has jurisdiction over the claims alleged pursuant to 28 U.S.C. §§ 1331 and 1345 and that venue lies in this district. Except as so averred, the Members deny the allegations of paragraph 2.

3. The Members admit the allegations of paragraph 3 upon information and belief.

4. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. Except as so averred, the Members deny the allegations of paragraph 4.

5. The Members aver upon information and belief that Jeffrey Jones ("Jones") is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 5.

6. The Members aver that 21 U.S.C. § 801 et seq. is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 6.

7. The Members aver that section 501(a) of the Act, 21 U.S.C. § 871(a), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 7.

8. The Members aver that section 101 of the Act, 21 U.S.C. § 801, is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 8 to the extent the quoted language is taken out of context. The Members specifically deny that the findings excerpted in paragraph 8 represent all of the Congressional findings in 21 U.S.C. § 801 that are pertinent to this action.

9. The Members aver that section 102(6) of the Act, 21 U.S.C. § 802(6), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 9.

10. The Members aver that section 202(b) of the Act, 21 U.S.C. § 812(b), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 10.

11. The Members aver that section 202(c) of the Act, 21 U.S.C. § 812(c), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 11.

12. The Members aver that section 401(a) of the Act, 21 U.S.C. § 841(a)(1), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 12.

13. The Members aver that section 102(15) of the Act, 21 U.S.C. § 802(15), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 13.

14. The Members aver that section 416(a) of the Act, 21 U.S.C. § 856(a)(1), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 14.

15. The Members aver that section 406 of the Act, 21 U.S.C. § 846, is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 15.

16. The Members aver that section 512(a) of the Act, 21 U.S.C. § 882(a), is a matter of law that speaks for itself. Except as so averred, the Members deny the allegations of paragraph 16.

17. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members deny the allegations of paragraph 17.

18. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 18.

19. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine

for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 19.

20. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 20.

21. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 21.

22. The Members aver upon information and belief that the Oakland Coop is an unincorporated cooperative association located at 1755 Broadway Avenue in Oakland, California that operates as a not for profit organization pursuant to and in accordance with the statewide mandate of Proposition 215 to help provide medicine for members who need it. The Members further aver upon information and belief that Jones is the director of the Oakland Coop. Except as so averred, the Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 22.

23. The Members refer to and incorporate by reference herein as if fully set forth their answers to paragraphs 1 through 22 of the Complaint.

24. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 24.

25. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 25.

26. The Members refer to and incorporate by reference herein as if fully set forth their answers to paragraphs 1 through 25 of the Complaint.

27. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 27.

28. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 28.

29. The Members refer to and incorporate by reference herein as if fully set forth their answers to paragraphs 1 through 28 of the Complaint.

30. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 30.

31. The Members are without knowledge or information sufficient to form a belief as to the truth or falsity of the allegations of paragraph 31.

THIRD DEFENSE

Plaintiff's claims are barred by the doctrine of unclean hands.

FOURTH DEFENSE

The Members are informed and believe, and on that basis allege, that at all times relevant to the matters alleged in the Complaint, plaintiff was informed of any rights and claims which it may have had against the Members. Having such knowledge, plaintiff intentionally conducted itself in such a way as to lead the Members to believe plaintiff intentionally relinquished the rights and claims which it

may have had against the Members. Plaintiff is therefore estopped from seeking damages and any other relief based on the allegations of the Complaint.

FIFTH DEFENSE

The Members are informed and believe, and on that basis allege, that plaintiff knowingly and unreasonably delayed in asserting the claims contained in the Complaint, without good cause and under circumstances permitting and requiring diligence, and thereby prejudiced the Members. For that reason, the Complaint and each purported cause of action therein are barred by the doctrine of laches.

SIXTH DEFENSE

The Members are informed and believe, and on that basis allege, that at all times relevant to the matters alleged in the Complaint, plaintiff was fully informed of the alleged rights it now asserts in its Complaint. Having such knowledge, plaintiff intentionally conducted itself in a manner inconsistent with the assertion of those rights and caused the Members to believe that it had relinquished said rights. As a result, plaintiff has waived the rights it now claims to assert.

SEVENTH DEFENSE

The Members' actions are lawful under the doctrine of necessity.

EIGHTH DEFENSE

The statutes and regulations upon which plaintiff relies, as applied herein, violate the Commerce Clause of the United States Constitution.

NINTH DEFENSE

The statutes and regulations upon which plaintiff relies, as applied herein, violate the substantive due process rights of life, privacy, freedom from government

interference to use the most effective medication, bodily integrity and the doctor-patient relationship and privilege as recognized by the United States Constitution.

TENTH DEFENSE

The statutes and regulations upon which plaintiff relies, as applied herein, violate the Members' rights as recognized by the Fourth, Fifth and Sixth Amendments to the United States Constitution.

ELEVENTH DEFENSE

The Members' actions are not unlawful purchase, but rather constitute joint possession or joint use.

TWELFTH DEFENSE

The Members' actions are lawful as activities of ultimate users.

THIRTEENTH DEFENSE

The Members' actions about which plaintiff complains are the result of entrapment.

FOURTEENTH DEFENSE

The Members' actions have caused no irreparable injury.

FIFTEENTH DEFENSE

The balancing of hardships weighs in favor of the Members' actions.

SIXTEENTH DEFENSE

The Members' actions are lawful as consistent with the public interest.

SEVENTEENTH DEFENSE

The Members' actions lawfully constitute an exercise of power retained by the State of California, and by the people of the State of California, under the Tenth Amendment to the United States Constitution.

EIGHTEENTH DEFENSE

Any alleged act or omission giving rise to this action was committed or omitted without knowledge of the Members.

NINETEENTH DEFENSE

Any alleged act or omission giving rise to this action was committed or omitted without consent of the Members.

WHEREFORE, the Members pray for judgment on the Complaint in their favor and against plaintiff as follows:

(a) That plaintiff take nothing by reason of its Complaint;

(b) That the Complaint be dismissed with prejudice;

(c) That no declaration issue finding that the Members have violated the Controlled Substances Act;

(d) That no permanent injunction issue;

(e) That the Members be awarded their costs of suit and attorneys' fees incurred herein; and

(f) For such other relief as the Court may deem just and proper.

Dated: October 1, 1998.

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DEMAND FOR JURY TRIAL

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, the Members demand a trial by jury of all issues properly tried to a jury.

Dated: October 1, 1998.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. CANNABIS CULTIVATOR'S CLUB, et al., Defendants. AND RELATED ACTIONS	Nos. C 98-00085 CRB C 98-00086 CRB C 98-00087 CRB C 98-00088 CRB C 98-00245 CRB COUNTERCLAIM-IN-INTERVENTION FOR DECLARATORY AND INJUNCTIVE RELIEF DEMAND FOR JURY TRIAL

As and by way of a counterclaim against plaintiff United States of America, defendants and counterclaimants-in-intervention EDWARD NEIL BRUNDRIDGE, IMA CARTER, REBECCA NIKKEL and LUCIA Y. VIER (collectively, the "Members"), allege as follows:

BACKGROUND

1. By these related actions, plaintiff and counter-defendant United States of America seeks to preliminarily and permanently enjoin the Oakland Coop, the Marin Alliance, the Ukiah Coop (as those terms are hereinafter defined) and others from

allegedly using a facility for the purpose of manufacturing and distributing marijuana in violation of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (the "Controlled Substances Act") and from allegedly engaging in other violations of the Controlled Substances Act.

2. By their counterclaim-in-intervention, the Members seek to obtain a judicial declaration of their fundamental right guaranteed under the Fifth Amendment of the United States Constitution (the "Fifth Amendment") to be free from governmental interdiction of their personal, self-funded medical choice, in consultation with their personal physician, to alleviate their suffering through the only effective treatment available for them. The Members also seek to obtain a preliminary and permanent injunction restraining and enjoining the United States of America, and its agents and employees and all persons acting in concert with any of them, from interfering with the Members' exercise of this fundamental right and from hindering, obstructing, preventing or attempting to enjoin the Oakland Coop, the Marin Alliance, the Ukiah Coop or any of the other defendants from providing the Members, or their primary care givers, with safe and affordable cannabis for personal medicinal use by the Member upon a physician's recommendation as permitted by Proposition 215, the Compassionate Use Act of 1996 (codified at California Health and Safety Code § 11362.5).

JURISDICTION

3. The jurisdiction of this Court over the subject matter of this counterclaim is based on 28 U.S.C. §§1331, 1346(a)(2), 2201(a) and the principles of ancillary jurisdiction.

PARTIES

4. Defendant and counterclaimant-in-intervention Edward Neil Brundridge ("Brundridge") is a natural person, a resident of the City and County of San Francisco, State of California and a member of the Oakland Cannabis Buyers' Cooperative (the "Oakland Coop").

5. Defendant and counterclaimant-in-intervention Ima Carter ("Carter") is a natural person, a resident of the City of Richmond, County of Contra Costa, State of California and a member of the Oakland Coop.

6. Defendant and counterclaimant-in-intervention Rebecca Nikkel ("Nikkel") is a natural person, a resident of the City of Santa Rosa, County of Sonoma, State of California and a member of the Marin Alliance for Medical Marijuana (the "Marin Alliance").

7. Defendant and counterclaimant-in-intervention Lucia Y. Vier is a natural person, a resident of the City of Santa Rosa, County of Sonoma, State of California and a member of the Ukiah Cannabis Buyer's Club (the "Ukiah Coop").

8. The Members name plaintiff United States of America ("United States") as a counter-defendant.

FIRST CLAIM

(Violation of Substantive Due Process Rights)

9. The Members reallege and incorporate herein by reference as if fully set forth the allegations of paragraphs 1-8 hereof.

10. Each of the Members is a Californian in danger of imminent harm due to serious illness. Each uses cannabis for medical purposes. In each case, such use has been deemed appropriate and recommended by a physician who has determined it to be beneficial to the Member's health.

11. Edward Neil Brundridge suffers from severe arthritis in the right knee, which causes him extreme pain and difficulty in walking. In an effort to alleviate this

pain, Brundridge tried many traditional medicines, which were either ineffective or caused him to experience an allergic reaction. Brundridge's doctor recommended cannabis as a legal medical alternative to relieve his pain caused by the swelling in his knee. His doctor's recommendation conformed with the Compassionate Use Act (codified at California Health and Safety Code § 11362.5). Cannabis provides Brundridge relief unavailable from any other medical treatment.

12. Rebecca Nikkel has fibromyalgia and multiple sclerosis. Both of these conditions cause her to experience severe muscle spasms which are very painful. Nikkel has tried many traditional medicines to alleviate this pain, but the traditional medicines were either ineffective or caused her to experience an allergic reaction. For example, upon the recommendation of her doctor, Nikkel tried baclofen, which caused her legs to become so weak that she could not walk. Nikkel's doctor recommended cannabis as a legal medical alternative to relieve the pain caused by her muscle spasms. Nikkel's doctor's recommendation conformed with the Compassionate Use Act (codified at California Health and Safety Code § 11362.5). Cannabis provides Nikkel relief unavailable from any other medical treatment.

13. Ima Carter has congenital scoliosis, fibromyalgia and cervical nerve damage. These conditions cause her enormous pain in her back and her head. Carter has tried many traditional medicines to alleviate the pain caused by the muscle spasms, but none of these traditional medicines has worked effectively. For example, Carter tried steroids and anti-inflammatory drugs, but they caused her to bleed internally. She also tried rhizotomy treatments and breast reduction surgery, neither of which relieved all of her pain. Carter's doctor recommended cannabis as a legal medical alternative to relieve the pain caused by her muscle spasms. Carter's doctor's recommendation conformed with the Compassionate Use Act (codified at California Health and Safety Code § 11362.5). Cannabis provides Carter relief unavailable from any other medical treatment.

14. Lucia Y. Vier was diagnosed with squamous cell cancer in March 1998. Her doctors have indicated that with radiation and chemotherapy treatments she may live a year to a year and a half. Vier uses cannabis on the recommendation of her doctor to stimulate her appetite. Without cannabis, Vier would not want to or be able to eat a sufficient amount to stay alive. Vier's doctor recommended that she use cannabis as a legal medical drug to stimulate her appetite and calm her. Vier's doctor's recommendation conformed with the Compassionate Use Act (codified at California Health and Safety Code § 11362.5). Cannabis provides Vier relief unavailable from any other medical treatment.

15. The Members use cannabis as the only effective medical treatment for their medical conditions described above. Each of the Members consulted with his or her personal physician, who has recommended that the Member use cannabis based upon the physician's determination that it is beneficial to the Member's health. The Members have tried traditional, conventional medicines, none of which was effective in treating their conditions. Each of the Members has tried cannabis and found it to be the only effective treatment for his or her condition.

16. Each of the Members is a member of one of the cooperatives named as a defendant in each of these three actions. The defendant cooperatives have served as the Members' source of legal, safe and affordable cannabis upon the recommendation of each Member's physician. As such, the Members are able to obtain safe, affordable and legal cannabis from the defendant cooperatives during regular business hours pursuant to their doctors' recommendations. If the defendant cooperatives are closed, the Members will be irreparably harmed in that they will not be able to obtain cannabis when it is the only effective medical treatment for them.

17. The Members have a fundamental right and liberty interest under the Fifth Amendment to be free from governmental interdiction of their personal, self-funded medical choice, in consultation with their personal physician, to alleviate their suffering through the only effective treatment available for them.

18. The Members' fundamental right in this regard is deeply rooted in this nation's histories and traditions:

(a) The Members have a fundamental right to privacy for personal and intimate decisions. These privacy rights extend to the most personal and intimate decisions about life such that an individual has a right to use cannabis free of governmental interdiction when such use is the only effective treatment for his or her pain or disease, and no other effective alternatives are available;

(b) The Members have a fundamental right to bodily integrity. The right to maintain one's bodily integrity extends to an individual's right to control whether he or she receives medical care and the related tradition of preventing governmental interference with medical care that he or she needs to control his or her body, and specifically includes the right to be free from governmental interdiction of the self-funded medicinal use of cannabis when it is the only effective treatment for an individual's pain or disease, and no other effective alternatives are available for them;

(c) The Members have a fundamental right to maintain the integrity of their relationship with their doctors. The doctor-patient relationship historically is rooted in trust and confidence. The right to maintain the integrity of one's relationship with one's doctor without governmental interference includes the right to speak freely with one's doctor, including both the right to discuss the option of using cannabis as a medical treatment without fear of governmental prosecution and the related right to be treated with cannabis when it is the only effective treatment for an individual's pain or disease and no other effective alternatives are available.

19. The Controlled Substances Act, 21 U.S.C. § 801 *et seq.*, as it is sought to be enforced in these related actions, violates the Fifth Amendment, in that it would impermissibly burden the Members' fundamental rights to be free of governmental interdiction of their personal, self-funded medical decisions to take the only effective

legal medication available to relieve their own pain and suffering, to obtain their personal physicians' recommendations for appropriate medical care for serious illnesses and injuries, and to take advantage of available medications for such conditions recommended by their personal physicians. The federal government's interference with this right is not supported by sufficiently compelling state interests to justify such an intrusion on privacy, bodily integrity, and the traditional confidences and the sanctity of the doctor-patient relationship, nor is it narrowly tailored to effectuate any government interest which may exist. In the alternative, there is no rational relationship between any legitimate governmental purpose and the means chosen to achieve this purpose in these related actions.

20. The Controlled Substances Act and the injunction against defendants entered in these related actions on May 19, 1998 is overbroad in that it does not distinguish between citizens using cannabis for medical necessity when no other effective medication is available and citizens using cannabis for other purposes. As construed by the United States, the statute thus purports to reach self-financed life-saving medical treatment, in violation of the fundamental right of privacy and the fundamental right to bodily integrity. In failing to make the distinction between unprotected recreational acts and the government's forcing a patient involuntarily to forgo life-saving medical treatment, the statute and injunction are over-inclusive and therefore unconstitutional.

21. An actual controversy has arisen and now exists between the Members, on the one hand, and the United States, on the other hand, concerning their respective rights under the Controlled Substances Act and the Members' fundamental rights and liberty interests under the Fifth Amendment. In this regard, the Members contend that:

a. The Members have, and at all times have had, a fundamental right guaranteed under the Fifth Amendment to be free from governmental interdiction of their personal, self-funded medical decisions to take the only

effective legal medication available to relieve their own pain and suffering, to obtain their personal physicians' recommendations for appropriate medical care for serious illnesses and injuries, and to take advantage of available medications for such conditions as recommended by their personal physicians; and

b. The United States cannot seek enforcement or application of the Controlled Substances Act against the Members or the Oakland Coop, the Marin Alliance and/or the Ukiah Coop in these related actions without violating the Members' fundamental right guaranteed under the Fifth Amendment.

22. The Members are informed and believe and on that basis allege that the United States disputes and denies the foregoing contentions and contends that the Members do not have a fundamental right cognizable under the Fifth Amendment as alleged and that the United States is entitled to enforce the Controlled Substances Act against the Members or the Oakland Coop, the Marin Alliance and/or the Ukiah Coop in these related actions.

23. A judicial determination of the respective rights of the Members, and the Oakland Coop, the Marin Alliance and/or the Ukiah Coop, on the one hand, and the United States, on the other hand, under the Controlled Substances Act is necessary and proper at this time.

24. Pending issuance of a permanent injunction restraining enforcement of the Controlled Substances Act against the Members, the Oakland Coop, the Marin Alliance and/or the Ukiah Coop, there is a serious and palpable threat that the United States will obstruct or attempt to hinder, prevent or seek to enjoin the Members from exercising their fundamental right guaranteed under the Fifth Amendment to be free of governmental interdiction of their personal, self-funded medical decisions to take the only effective legal medication available to relieve their own pain and suffering, to obtain their personal physicians' recommendation for appropriate medical care for

serious illnesses and injuries, and to take advantage of available medications for such conditions as recommended by their personal physicians.

25. As a direct and proximate result of any such threatened interference in the Members' exercise of such fundamental rights guaranteed under the Fifth Amendment, the United States, unless restrained by this Court, will cause the Members irreparable injury.

26. Accordingly, the Members are entitled to a preliminary injunction, and a permanent injunction thereafter, restraining and enjoining the United States and its agents and employees and all persons acting in concert with any of them, from interfering with the Members' exercise of this fundament right and from hindering, obstructing, preventing or attempting to enjoin the Oakland Coop, the Marin Alliance, the Ukiah Coop or any of the other defendants from providing the Members, or their primary care givers, with safe and affordable cannabis for personal medicinal use by the Member upon a physician's recommendation as permitted by Proposition 215, the Compassionate Use Act of 1996 (codified at California Health and Safety Code § 11362.5).

WHEREFORE, the Members pray for judgment in their favor and against the United States as follows:

(a) For a declaration: (i) of the Members' fundamental right guaranteed under the Fifth Amendment to be free from governmental interdiction of their personal, self-funded medical decisions to take the only effective legal medication available to relieve their own pain and suffering, to obtain their personal physicians' recommendations for appropriate medical care for serious illnesses and injuries, and to take advantage of available medications for such conditions as recommended by their personal physicians; and (ii) that the United States cannot seek enforcement or application of the Controlled Substances Act against the Members or the Oakland Coop, the Marin Alliance and/or the Ukiah Coop in these related actions because it

would thereby violate the Members' fundamental right guaranteed under the Fifth Amendment;

(b) For a preliminary and permanent injunction restraining and enjoining the United States, and its agents and employees and all persons acting in concert with any of them, from: (i) interfering with the Members' exercise of their fundamental right guaranteed under the Fifth Amendment to be free from governmental interdiction of their personal, self-funded medical decisions to take the only effective legal medication available to relieve their own pain and suffering, to obtain their personal physicians' recommendations for appropriate medical care for serious illnesses and injuries, and to take advantage of available medications for such conditions as recommended by their personal physicians; and (ii) hindering, obstructing, preventing or attempting to enjoin the Oakland Coop, the Marin Alliance, the Ukiah Coop or any of the other defendants from providing the Members, or their primary care givers, with safe and affordable cannabis for personal medicinal use by the Member upon a physician's recommendation as permitted by Proposition 215, the Compassionate Use Act of 1996 (codified at California Health and Safety Code § 11362.5);

(c) For the Members' costs of suit incurred herein, including reasonable attorneys' fees; and

(d) For such other relief as the Court may deem just and proper.

Dated: October 1, 1998.

PILLSBURY MADISON & SUTRO LLP
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San Francisco, CA 94120-7880

By Margaret S. Schroeder

Attorneys for Defendants and Counterclaimants-in-Intervention Edward Neil Brundridge, Ima Carter, Rebecca Nikkel and Lucia Y. Vier

DEMAND FOR JURY TRIAL

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, the Member counterclaimants demand a trial by jury of all issues properly tried to a jury.

Dated: October 1, 1998.

PILLSBURY MADISON & SUTRO LLP
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By Margaret S. Schroeder

Attorneys for Defendants and Counterclaimants-in-Intervention Edward Neil Brundridge, Ima Carter, Rebecca Nikkel and Lucia Y. Vier

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Attorneys for Defendants
OAKLAND CANNABIS BUYERS'
COOPERATIVE and JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0245 CRB

DEFENDANTS' ~~[PROPOSED]~~ PROTECTIVE ORDER

Date: October 5, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

For good cause, the Court hereby orders that a protective order be entered in this action as follows:

1. This Protective Order shall govern all documents, writings and testimony in this action designated as "COVERED BY PROTECTIVE ORDER" together with all information contained therein or derived therefrom, and all copies, portions, excerpts, abstracts or summaries thereof (hereinafter collectively referred to as "Information") arising from individual patient medical care (including but not limited to patients' physician's names or other identifying information; information concerning physician communications, recommendations or approvals regarding medical cannabis ~~referrals to dispensaries and/or their authorizing or assenting to cannabis treatment~~; patient medical records or charts; physician status reports; notes made by physicians, nurses, physician assistants or other medical staff, letters or reports from physicians, nurses, physician assistants or other medical staff, reports of physical exams; and reports of medical tests).

2. Information "COVERED BY PROTECTIVE ORDER" shall be used solely for conduct of this litigation, and not for any other purpose. Information "COVERED BY PROTECTIVE ORDER" shall not be disclosed to anyone except as provided in this Protective Order. In particular, Information "COVERED BY PROTECTIVE ORDER" shall not be disclosed to any employee or agent of the Drug Enforcement Administration, the Federal Bureau of Investigation, or any federal, state or local law enforcement agency unless specifically provided for in this Protective Order.

3. Notwithstanding paragraph 2, Information "COVERED BY PROTECTIVE ORDER" may be disclosed to the following persons who are participating in the conduct of this action on behalf of the plaintiff after they have signed and sent to defendants' counsel the form attached hereto stating their agreement to be bound and abide by the provisions of this Protective Order:

United States Department of Justice

Frank W. Hunger, Assistant Attorney General
Robert S. Mueller III, United States Attorney
David J. Anderson
Arthur R. Goldberg
Mark T. Quinlivan

Defendants' Counsel

James J. Brosnahan
Annette P. Carnegie
Andrew A. Steckler
Christina Kirk-Kazhe
Robert A. Raich
Gerald F. Uelmen

Information "COVERED BY PROTECTIVE ORDER" may also be disclosed, to the extent reasonably necessary in conducting this litigation, to the secretaries, paralegal assistants, and legal assistants of the above-named persons after they have signed and sent to defendants' counsel the form attached hereto stating their agreement to be bound and abide by the provisions of this Protective Order; and to Court officials involved in this litigation (including court reporters, persons operating video recording equipment at depositions, and any special master appointed by the Court). Provided that the individual to whom disclosure is made has signed and sent to defendants' counsel the form attached hereto stating his or her agreement to be bound and abide by the provisions of the Protective Order, such Information may also be disclosed to persons noticed for depositions or designated as trial or deposition witnesses to the extent reasonably necessary in preparing to testify; to such other persons agreed to by defendants' counsel in writing in advance of disclosure (such agreement shall not be unreasonably withheld); and to such other persons designated by the Court in the interest of justice.

4. The inadvertent or unintentional disclosure to plaintiff or their counsel by defendants or their counsel of Information "COVERED BY PROTECTIVE ORDER," regardless of whether the Information was so designated at the time of disclosure, shall not be deemed a waiver in whole or in part of defendants' claim that such Information is covered by this Protective Order. In the event of inadvertent or unintentional disclosure of Information "COVERED BY PROTECTIVE ORDER," defendants shall give prompt notification to plaintiff after learning of an inadvertent or unintentional disclosure, and shall provide plaintiff with new copies of the inadvertently or unintentionally produced documents, re-marked as "COVERED BY PROTECTIVE ORDER." The documents inadvertently or unintentionally produced without such designation shall then be returned promptly to defendants.

5. The Declaration of Michael M. Alcalay, M.D., M.P.H., along with the Exhibit A attached thereto, filed September 14, 1998, is hereby deemed by the Court to be an inadvertent or unintentional disclosure of Information "COVERED BY PROTECTIVE ORDER," as described in paragraph 8. As such, this Information shall be returned promptly to the defendants. Plaintiff is hereby ordered to return to defendants the Declaration of Michael M. Alcalay, M.D., M.P.H. along with the Exhibit A attached thereto, and it is ordered to return to defendants all copies made of this same Information. Plaintiff is hereby further ordered to prepare and provide to the Court within seven days a log of all copies made of this same Information, and to prepare and maintain a log of all copies that may be made of this same Information in the future. This same Information shall be deemed "COVERED BY PROTECTIVE ORDER" from and including September 14, 1998, and into the future. The Court will receive, and orders served on plaintiff and all parties, the Amended Declaration of Michael M. Alcalay, M.D., M.P.H., dated September 30, 1998.

IT IS SO ORDERED.

Dated: 10-8-98

UNITED STATES DISTRICT COURT JUDGE

APPENDIX TO PROTECTIVE ORDER

AGREEMENT TO ABIDE BY TERMS OF PROTECTIVE ORDER

I have received and read a copy of the foregoing Protective Order. I hereby agree to be bound and abide by the terms of the Protective Order and will not disclose any Information designated as "COVERED BY PROTECTIVE ORDER" as defined in the Protective Order entered into between the parties to any other person, except under the terms specified in the Protective Order.

Dated:

_____

AO82 SWEDA
(Rev. 10/89)

ORIGINAL

RECEIPT FO' \YMENT
UNITED STATES L 'RICT COURT
for the
NORTHERN DISTRICT OF CALIFORNIA

49204

at SAN FRANCISCO, CALIFORNIA

Fund	
6855XX	Deposit Funds
604700	Registry Funds
	General and Special Funds
508800	Immigration Fees
085000	Attorney Admission Fees
086900	Filing Fees
322340	Sale of Publications
322350	Copy Fees
322360	Miscellaneous Fees
143500	Interest
322380	Recoveries of Court Costs
322386	Restitution to U.S. Government
121000	Conscience Fund
129900	Gifts
504100	Crime Victims Fund
613300	Unclaimed Monies
510000	Civil Filing Fee (½)

08/24/98

49204*#
085000 20.00
AA##
510000 30.00
AA##
6855XX 60.00
LF##
TOTAL 110.00
CHECK 110.00
5102021*#
CHANGE 0.00
3 ITM-CT
089416B000 11:44

CASE REFERENCE: Marcus Foster

RECEIVED FROM 425 Mkt St SF Ca 94105

DEPUTY CLERK

Checks and drafts are accepted subject to collection and full credit will only be given when the check or draft has been accepted by the financial institution on which it was drawn.

★ U.S. GPO: 1997-583-992

ORDERS

SUBMITTING COUNSEL ARE
DIRECTED TO SERVE THIS ORDER UPON
ALL OTHER PARTIES IN THIS ACTION