No. 00-17222

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DR. MARCUS CONANT, *et al.*,

Plaintiffs-Appellees,

v.

EDWARD H. JURITH, *et al.*,

Defendants-Appellants.

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

Amicus Brief of California Medical Association, Global Lawyers and Physicians, American Academy of Pain Medicine, Society of General Internal Medicine, DKT Liberty Project, Leonard H. Glantz, Mary Faith Marshall, Steven Miles, Lawrence J. Nelson, and Linda Farber Post in support of Plaintiffs-Appellees Dr. Marcus Conant, *et al.*

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INTEREST OF *AMICI CURIAE*[1]

In response to California's decision to allow particular seriously ill patients for whom other treatments have failed, to use marijuana for medical purposes, the federal government has threatened to revoke the DEA licenses of physicians for "recommending" that treatment to their patients. This policy threatens vital First Amendment speech critical to the ethical and effective practice of medicine. *Amici* are non-profit associations of health care professionals, scholars of medical ethics, and a non-profit organization dedicated to the protection of civil liberties. These diverse organizations and individuals strongly believe that physician-patient discourse is at the core of speech protected by the First Amendment, and that the federal government may not prohibit physicians from fully and frankly counseling and recommending to their patients treatments that the physician reasonably believes may alleviate a patient's condition.

Amici submit this brief to: (1) address the First Amendment's protection of physician-patient speech; and (2) explain the adverse ramifications that the government's policy will have on patient care.

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[1]Pursuant to Fed. R. App. Proc. 29(a), the parties have consented to the filing of this brief.

The California Medical Association ("CMA") is a non-profit professional association of more than 30,000 physicians engaged in the practice of medicine in all specialties in California. CMA's primary purpose is the promotion of the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession.

Global Lawyers and Physicians is a non-governmental organization working at the local, national, and international levels through collaboration and partnerships with individuals, NGOs, IGOs, and governments on issues concerning the global implementation of the health-related provisions of the Universal Declaration of Human Rights and the Covenants on Civil and Political Rights and Economic, Social, and Cultural Rights, with a focus on health and human rights, patients rights, and human experimentation.

The American Academy of Pain Medicine is the only Medical Specialty Society representing physicians specializing in Pain Medicine. Its mission is to provide quality care to patients suffering with pain, through the education and training of all physicians, through research, and through the advancement of the specialty of Pain Medicine. It is a not-for-profit organization with 1,200 physician members.

The Society of General Internal Medicine ("SGIM") is an international organization of 3,000 physicians and others, who combine teaching, research, and

patient care in general internal medicine, in academic and related settings such as university hospitals, government agencies, and community health facilities. The SGIM is dedicated to improving patient care, education, and research in primary care and general internal medicine.

The DKT Liberty Project was founded in 1997 to defend individual liberties against encroachment of all kinds. This not-for-profit organization advocates vigilance over regulation of all kinds, especially restrictions of individual liberties that threaten the reservation of power to the citizenry that underlies our constitutional system. The DKT Liberty Project is particularly involved in defending the right to freedom of speech and has filed numerous briefs *amicus curiae* in both the United States Supreme Court as well as the federal and state courts of appeals.

Leonard H. Glantz, J.D., is Associate Dean and Professor of Health Law at the Boston University School of Public Health. He has advocated for the rights of seriously ill patients for over twenty years to receive appropriate end-of-life care, and to have the right to make decisions about the type and extent of medical care they wish to receive.

Mary Faith Marshall, Ph.D., is a Professor of Medicine and Bioethics at Kansas University Medical Center. She believes the issues raised by this case are important because the fiduciary relationship between physician and patient, which

is based on the ethical principles of respect for persons, nonmaleficience and beneficience, requires that physicians disclose all salient information to their patients.

Steven Miles, M.D., is Professor of Medicine and Bioethics at the Center for Bioethics at the University of Minnesota. He is past president of the American Association of Bioethics, past editor of Law, Medicine and Ethics, and is a recipient of the Distinguished Service Award of the American Association of Bioethics and Humanities.

Lawrence J. Nelson, Ph.D, J.D., is Adjunct Associate Professor of Philosophy and Women and Gender Studies at Santa Clara University. He has published on the ethical dimension of the physician-patient relationship and on the ethics of drug law and policy.

Linda Farber Post, J.D., B.S.N., M.A., is a Bioethics Consultant in the Division of Bioethics at Montefiore Medical Center and an Assistant Professor of Bioethics at Albert Einstein College of Medicine. She is also an Adjunct Assistant Professor in the New York University School of Education, Division of Nursing. She consults and teaches about the difficult ethical issues that arise in the practice of medicine, and has written and edited medical articles and chapters.

SUMMARY OF ARGUMENT

This case "is not about physicians prescribing, growing, or distributing marijuana." ER 52. Nor does it require the Court to pass judgment on marijuana's medical efficacy for those suffering from AIDS, cancer, glaucoma, and other serious illnesses. Rather, this case is about whether the federal government can penalize physicians who, on the basis of their best medical judgment, recommend such treatment to their patients.

The government's attempt to silence physicians strikes at speech at the core of the First Amendment. The physician's right to speak fully and frankly to her patient, and the patient's right to receive all the information that the physician believes relevant, is fully protected by the First Amendment. The states' power to impose reasonable regulations on the practice of medicine does not diminish this constitutional protection. Nor can the government prohibit speech simply because it concerns illegal conduct. Accordingly, penalizing physicians precisely *because* they have recommended medical marijuana -- or any other treatment -- to alleviate a patient's suffering is utterly anathema to the First Amendment.

Moreover, this censorship of physician speech jeopardizes patient care. The government's disagreement about what is *generally* safe and effective treatment cannot control a physician's assessment based on knowledge and experience of an *individual* patient's needs. It is contrary to established

principles of medical ethics, under which a physician must counsel, advise, and recommend optimal treatment options that the physician, in the reasonable exercise of his medical judgment, believes may alleviate a patient's condition. The government's policy thus puts the physician in the untenable and constitutionally unacceptable position of having to choose between the discussion and recommendation required by the physician-patient relationship and the self-censorship required by federal law.

ARGUMENT

I. THE FIRST AMENDMENT PROTECTS PHYSICIAN-PATIENT DIALOGUE.

A. Physician-Patient Discourse Is At The Core Of First Amendment Speech.

By its terms, the First Amendment protects all speech, apart from certain judicially-crafted exceptions, such as obscenity, which are not at issue here. *See R.A.V. v. St. Paul*, 505 U.S. 377, 382 (1992). Physician-patient communications are thus fully protected by the First Amendment, and, as the district court properly concluded, "sound policy reasons justify *special* protection of open and honest communication between" physicians and patients. *Conant v. McCaffrey*, 172 F.R.D. 681, 695 (N.D. Cal. 1997) (emphasis added). Because speech between physicians and patients is "highly valued by society," *United States v. Byrd*, 750 F.2d 585, 589 (7th Cir. 1984), like other categories of particularly

important speech, it lies at the heart of First Amendment expression. "The First Amendment protects scientific expression and debate just as it protects political and artistic expression." *Board of Trustees of Leland Stanford Junior Univ. v. Sullivan*, 773 F. Supp. 472, 474 (D.D.C. 1991); *Keyishian v. Board of Regents*, 385 U.S. 589, 603 (1967) (scientific speech at core of First Amendment); *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 835 (1995).

Because this principle is so self-evident, it has rarely been challenged. "The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion." *Poe v. Ullman*, 367 U.S. 497, 513 (1961) (Douglas, J.) (dissenting from a ruling on standing). Indeed, in *Griswold v. Connecticut*, 381 U.S. 479 (1965), even dissenting Justices Black and Stewart acknowledged that advising or recommending a medical treatment -- even an illegal one -- is protected by the First Amendment. As Justice Stewart explained:

> If all the [physicians] had done was to advise people that they thought the use of contraceptives was desirable, *or even to counsel their use*, the [physicians] would, of course, have a substantial First Amendment claim. But their activities went far beyond mere advocacy. They prescribed specific contraceptive devices and furnished patients with the prescribed contraceptive materials.

Id. at 529 n.3 (Stewart, J., dissenting) (emphasis added). Justice Black similarly reasoned that:

> Had the doctor defendant here, or even the non-doctor defendant, been convicted for doing nothing more than *expressing opinions to persons coming to the clinic that certain contraceptive devices, medicines or practices would do them good and would be desirable, or for telling people how devices could be used,* I can think of no reasons at this time why their expressions of views would not be protected by the First and Fourteenth Amendments, which guarantee freedom of speech.

Id., at 507-08 (Black, J., dissenting) (emphasis added).

The Supreme Court has recognized a private physician's First Amendment right to freely discuss any issue with his or her patient, even while upholding restrictions on government-funded physician speech. *See Rust v. Sullivan*, 500 U.S. 173, 200 (1991). *See also Charles v. Carey*, 627 F.2d 772, 789 (7th Cir. 1980). And other courts have regularly upheld First Amendment rights of physicians. *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 776 F. Supp. 1422, 1428-29 (D. Guam 1990) (statute prohibiting physicians from soliciting patients for abortion violated First Amendment), *aff'd on other grounds*, 962 F.2d 1366 (9th Cir.); *Planned Parenthood v. Wichita*, 729 F. Supp. 1282, 1288 (D. Kan. 1990) ("The physician counseling a pregnant woman enjoys a constitutional [First Amendment] right to dispense medical information on the basis of her individual circumstances"); *Meyer v. Massachusetts Eye & Ear Infirmary*, 330 F. Supp. 1328, 1330 (D. Mass. 1971) (physician's allegation that hospital policy

prevented disclosure of dangers of certain medical procedures stated claim under First Amendment).

But the right of physicians to speak is only half the story. Perhaps more significantly, *patients* have the constitutional right to receive *all* information and advice that the physician sincerely and reasonably believes is relevant to the patient's condition and which she wishes to convey. Thus, in the medical context, as in other areas, the *listener's* right to receive information from a willing speaker is paramount. *See, e.g., First Nat'l Bank v. Bellotti*, 435 U.S. 765, 783 (1978) (the First Amendment "prohibit[s] government from limiting the stock of information from which members of the public may draw"); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 756 (1976) (First Amendment "protection afforded is to the communication, to its source and to its recipients both"); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (it is "now well established that the Constitution protects the right to receive information and ideas"). There could hardly be an area of life in which that right is more significant than in physician-patient discourse.

The doctrine of informed consent, which is premised on the principle that "'[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body,'" reflects judicial recognition of the critical importance of this right. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C.

Cir. 1972), (quoting *Schloendorff v. Soc'y of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.)). *See generally* Ruth R. Faden & Tom L. Beauchamp, A HISTORY AND THEORY OF INFORMED CONSENT (1986). *See also Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (doctrine of informed consent is "firmly entrenched in American tort law"). To ensure that patients can exercise this right, the informed consent doctrine requires physicians to provide patients sufficient information and advice necessary to "evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury*, 464 F.2d 772, 271. Physicians must offer enough medical information and advice to give a patient "familiarity with the therapeutic alternatives and their hazards." *Cobbs v. Grant*, 8 Cal. 3d 229, 243 (Cal. 1972); *see also American Medical Association, Code of Medical Ethics* 120 (1996-1997) ("*AMA Code of Medical Ethics*"). This is information and advice which patients do not have and cannot easily obtain.

If physicians cannot share the recommendations and advice they reasonably believe are relevant to their patient's condition, those patients' First Amendment rights are infringed, as are the rights of physicians to inform, recommend, and counsel their patients according to their best medical judgment.

B. The Government Cannot Suppress Physician-Patient Communication, Even Where it Concerns Illegal Activity.

Although physicians may not aid or abet violations of state or federal law, the government may not suppress medical advice simply because the recommended treatment may be illegal under federal law. The Supreme Court has repeatedly held that the government's power to ban *conduct* does not include the power to suppress *speech* about that unlawful activity:

> We think it quite clear that banning speech may sometimes prove far more intrusive than banning conduct. As the venerable proverb teaches, it may prove more injurious to prevent people from teaching others how to fish than to prevent fish from being sold. Similarly, a local ordinance banning bicycle lessons may well curtail freedom far more than one that prohibits bicycle riding within city limits. In short, we reject the assumption that words are necessarily less vital to freedom than actions . . . .
>
> The text of the First Amendment makes clear that the Constitution presumes that attempts to regulate speech are more dangerous than attempts to regulate conduct. That presumption accords with the essential role that the free flow of information plays in a democratic society.

44 Liquormart, Inc. v. Rhode Island, 517 U.S. 484, 511-12 (1996). More recently, in rejecting the argument that advertisements could be restricted because they propose the illegal sale of tobacco to minors, Justices Kennedy and Scalia explained that government may not regulate the direct or indirect solicitation of

conduct because it is unlawful. *Lorillard v. Reilly*, 121 S. Ct. 2404, 2434-35 (2001) (Kennedy, J., concurring). "'Every idea is an incitement,' *and if speech may be suppressed whenever it might inspire someone to act unlawfully, then there is no limit to the State's censorial power.*" *Id.* (emphasis added) (citation omitted). Indeed, that is exactly why the Supreme Court has held that the government may not suppress even direct advocacy of illegal conduct, unless it is "directed to inciting or producing imminent lawless action and is likely to incite or produce such action." *Brandenberg v. Ohio*, 395 U.S. 444 (1969). The government makes no such claim here.

Moreover, it is beyond the pale for the government to argue that "recommending" marijuana to a seriously ill patient is aiding or abetting a violation of federal law. Where a physician reasonably and conscientiously recommends a treatment, based on his or her medical expertise in light of the individual patient's needs, that recommendation cannot constitute aiding and abetting a felony, particularly when, as the district court noted, there are many perfectly legal responses to the recommendation. ER 279-80. The patient is entitled to the physician's good faith recommendations. But patients' actions, informed as they may be by the judgment of their physician, are their own.

C. The Federal Government Cannot Suppress Speech On The Ground That The Medical Profession is a Regulated Profession.

The federal government argues that because the practice of medicine is a state-regulated and licensed profession, the First Amendment does not bar federal regulation of physician-patient dialogue, or that at most it must satisfy minimal constitutional scrutiny. Appellant Opening Br. at 33-34. The Court should readily reject this argument.

1. States, Not the Federal Government, Regulate the Practice of Medicine.

It has long been recognized that the federal government cannot regulate the practice of medicine. "Obviously, direct control of medical practice in the states is beyond the power of the federal government." *Linder v. United States*, 268 U.S. 5, 18 (1925). Rather, the authority to regulate the public health and welfare is reserved to the states. *James Everard's Breweries v. Day*, 265 U.S. 545 (1924); *see also* 21 U.S.C. § 396 (Federal Food, Drug, and Cosmetic Act may not be construed to regulate the practice of medicine); 42 U.S.C. § 1395 (same provision in Medicare and Medicaid statute). For this reason, *state* boards, not federal ones, determine the standards physicians must meet for licensure and for continuing practice. *State* laws, not federal ones, regulate what physicians are obligated to disclose to their patients to comply with informed consent provisions, and *state*

laws bind physicians to ethical obligations regarding full disclosure to a patient about potentially-beneficial treatments.

Nor can the government claim authority to regulate physician speech under the Controlled Substances Act, 8 U.S.C. § 801 *et seq.* ("CSA"). Although the CSA expressly gives the federal government authority over the action of "prescribing" controlled substances, that is clearly the limit of its power over any expressive conduct. 21 U.S.C. § 829. And the policy at issue here -- sanctioning physicians for "recommending" medical marijuana in their best medical judgment -- is certainly not limited to "prescribing" medical marijuana.[2] Given the long-standing recognition that states, not the federal government, regulate the practice of medicine, there is no evidence that Congress intended the CSA to authorize federal *law enforcement* authorities to regulate what physicians recommend to patients.

The government's argument that the CSA allows it to sanction physician-patient speech also raises substantial Tenth Amendment issues. States retain the reserved power to regulate health and welfare. *See United States v. Lopez*, 514

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[2]Federal regulations require that prescriptions be "dated as of, and signed on, the day issued, and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name, address and registration number of the practitioner." 21 C.F.R. § 1306.05(a). The government's policy goes far beyond such writings.

U.S. 549, 566 (1995) (Constitution limits federal government's enumerated powers and "withhold[s] from Congress a plenary police power that would authorize enactment of every type of legislation"). California exercised its reserved power to regulate health and welfare by permitting people with specified medical conditions to use marijuana for medical purposes. To implement that power, it has required physicians to make judgments and to communicate them. Thus, inherent in the structure of California's exercise of its reserved powers is the very speech that the federal government now seeks to sanction. Federal suppression of such speech interferes with California's reserved power to regulate the practice of medicine.

Indeed, the federal government has elsewhere recognized this limitation on federal authority. For example, although the FDA regulates testing and labeling for prescription drugs, it specifically does not regulate how or why physicians direct the use of those drugs. 21 U.S.C. § 396. Indeed, the use of medications for "off-label" or unapproved purposes, is "an established aspect of the modern practice of medicine," *Washington Legal Found. v. Friedman*, 13 F. Supp. 2d 51, 56 (D.D.C. 1998), which is entirely ethical. AMA, Policy 120.988, AMA Policy Compendium 1996. As the California Attorney General has opined, state and federal drug approval laws were not intended to interfere with the physician's

judgment regarding individual patient treatment. *See* 61 Ops. Cal. Atty. Gen. 192 (1978). Moreover, where the government has attempted to limit *communication* about such off-label uses, even without attempting to limit the uses themselves, those attempts violate the First Amendment. *Washington Legal Found.*, 13 F. Supp. 2d at 51 ("the open dissemination of scientific and medical information regarding these treatments is of great import").

2. There Is No Professional Speech Exemption to the First Amendment.

Even if the federal government could regulate the practice of medicine, there is no First Amendment exception for professional speech. Just as professional activity is not automatically insulated from regulation simply because it entails communications (Appellant Opening Br. at 34), neither are communications between physician and patient stripped of constitutional protection by virtue of the state's general authority to regulate the practice of medicine. *See Snell v. Dept. of Prof'l Regulation*, 742 N.E.2d 1282 (Ill. App. 4th Dist. 2001) (regulation barring chiropractor from using booklet with patient testimonials violated First Amendment); *Borgner v. American Acad. of Implant Dentistry*, 1998 U.S. Dist. LEXIS 15432 (N.D. Fla. 1998) (invalidating regulation barring dentists from advertising membership in accrediting organization). To the contrary, as the Supreme Court recently acknowledged, the relationship

between professional and client is a "medium of expression" that the government may not control. *Legal Servs. Corp. v. Velazquez*, 121 S. Ct. 1043, 1049 (2001).

Governmental regulation of professional speech that is not purely commercial in nature receives rigorous scrutiny. Thus, a lawyer's public criticism of the government, *Gentile v. State Bar of Nevada*, 501 U.S. 1030, 1049 (1991), and an attorney's solicitation of litigants to advance a civil rights agenda, *In re Primus*, 436 U.S. 412, 426-32 (1978), were fully protected -- indeed, they received "the strongest protection our Constitution has to offer." *Florida Bar v. Went-for-It, Inc.*, 515 U.S. 618, 634 (1995). And the Supreme Court recently struck down a federal statute barring federally-subsidized attorneys from challenging welfare laws because it interfered with their ability to perform their traditional professional functions, including dispensing legal advice. *Legal Serv. Corp.*, 121 S. Ct. at 1049.[3]

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[3]The Supreme Court's decisions in *Pennsylvania v. Casey*, 505 U.S. 833 (1992), and *Rust v. Sullivan*, 500 U.S. 173 (1991), are not to the contrary. In *Casey*, a state informed consent statute, "aimed at ensuring" that patients would be able to make "mature and informed" decisions about abortion, resulted in patients receiving *more* information from their physicians, not less. *Id.* at 883. And in *Rust*, the regulation barring federally-funded physicians from speaking about abortion in the context of that federally-funded program was permissible because the government was not required to *fund* speech about subjects "outside the scope" of its program. 500 U.S. at 197. But the Court explicitly acknowledged the First Amendment right of physicians to discuss abortion and other topics outside the context of this federally-funded program. *Id.* at 198-200, 203. Further, it noted

(continued...)

Indeed, even when professional speech is purely commercial, it falls within the ambit of the First Amendment. *See, e.g.*, *Florida Bar*, 515 U.S. at 635. Such speech, which proposes a commercial transaction, is constitutionally protected, although to a lesser degree than non-commercial speech. But the government does not argue that a physician's medical recommendations are commercial speech. Nor could it, as the Supreme Court has squarely rejected that view. *See Board of Trustees of State Univ. of N.Y. v. Fox*, 492 U.S. 469, 482 (1989) (noting that "tutoring, legal advice, and medical consultation provided (for a fee) . . . . do not consist of speech that *proposes* a commercial transaction, which is what defines commercial speech") (citation omitted).

In sum, physician-patient speech is fully protected by the First Amendment.

II. THE GOVERNMENT POLICY VIOLATES THE FIRST AMENDMENT.

A. The Government Policy Cannot Satisfy Strict Scrutiny.

The government's policy is based solely and specifically on the *content* of the speech the government dislikes. Only recommendations favoring the medical

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[3](...continued)
that the physician-patient relationships established by the program were limited and did not justify "an expectation on the part of the patient of comprehensive medical advice." *Id.* at 200. In contrast, patients of the private physician plaintiff class here have every reason to expect comprehensive medical advice.

use of marijuana raise the threat of sanctions. Such content-based suppression of medical advice is "presumptively invalid." *R.A.V.*, 505 U.S. at 382. Unless the government satisfies the rigorous judicial review of strict scrutiny, this policy cannot stand. *See Rosenberger*, 515 U.S. at 828; *United States v. Playboy Entm't Group, Inc.*, 529 U.S. 803, 812 (2000); *Turner v. FCC*, 512 U.S. 622, 677 (1994). Thus, the government must demonstrate both that it has a compelling interest, and that its restriction is narrowly tailored to burden the least possible speech. *See Playboy*, 529 U.S. at 816.

The clear governmental interest that emerges from the record is the government's interest in preventing physicians from sending the "wrong" message to the public about drug use. *See, e.g.*, SER 373:14-375:6, 380:9-19, 689, 766, 767, 700, 707, 737. However, forbidding a particular message is *never* a compelling or important government interest; to the contrary, it is by definition an entirely illegitimate objective. *Turner*, 512 U.S. at 641.

Moreover, even crediting the government's assertion that its interest is enforcing the CSA, and even assuming *arguendo* that interest is compelling, it has failed to satisfy its burden of establishing that its policy is narrowly tailored to effect that goal. Rather, the most the government can muster is its claim that physician recommendations of marijuana "*may* constitute" aiding or abetting or

conspiracy, or "*may* promote illegal drug activity." Appellant Opening Br. at 30 (emphasis added).

These assertions are woefully inadequate. As the district court correctly concluded, there are many possible responses to a physician's recommendation of marijuana as a medical treatment that are perfectly lawful. ER 279. First, there is always a significant chance that the patient will not, for any number of reasons, follow the physician's advice. *See* Jay Katz, M.D., THE SILENT WORLD OF DOCTOR AND PATIENT xiv 4 n. 2 (1984) (citing studies). This probability is exponentially increased here because of the obstacles and disincentives resulting from marijuana's illegal status under federal law. For example, many patients will not act on a physician's recommendation because they (i) do not want to violate federal law, (ii) cannot practically obtain marijuana, or (iii) have moral reservations about using marijuana. Second, even under federal law a patient may legally obtain marijuana through participation in a federally-approved clinical study concerning medical marijuana. This is hardly an unreasonable possibility given the high proportion of AIDS and cancer patients enrolled in clinical research programs. Third, a patient may obtain and use medical marijuana in a country where it is legal, such as Canada. And fourth, a patient may decide to become active in seeking federal legalization of marijuana. Thus, the

government's policy will inevitably suppress speech that would not result in any violation.

Moreover, even if a patient were to decide that the potential benefit to his medical condition justified the risk of federal prosecution, recognizing that he may pay a penalty for that decision, the federal government may prosecute that patient to enforce federal law. But the mere *possibility* of that violation cannot justify sanctioning a physician for advising the patient of the physician's best medical judgment. As a mechanism to enforce the CSA, forbidding physicians to "recommend" marijuana is, at best, entirely hit-or-miss, and thus cannot survive strict scrutiny.

B. The Government's Policy Cannot Satisfy Intermediate Review.

Although the physician-patient communication at issue here is plainly entitled to more protection than purely commercial speech, it is telling that the government's policy could not even satisfy the intermediate scrutiny accorded to restrictions on commercial expression. The government may regulate commercial speech -- such as advertising -- "only in the service of a substantial governmental interest, and only through means that directly advance that interest." *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 638 (1985) (citations omitted). However, even in commercial speech, the government may not suppress messages

simply because it disagrees with them. *See Lorillard*, 121 S. Ct. at 2433 (Thomas, J., concurring) ("Whatever power the State may have to regulate commercial speech, it may not use that power to limit the content of commercial speech . . . . Such content-discriminatory regulation--like all other content-based regulation of speech--must be subjected to strict scrutiny.").

As noted above, preventing physicians from sending the "wrong" message about drug policy is never an important government interest. However, again, even if the court were to credit the government's ostensible objective of enforcing the CSA as an important interest, the government's policy does not pass muster because it does not directly advance that purpose.

Under intermediate scrutiny, a speech regulation "may not be sustained if it provides only ineffective or remote support for the government's purpose." *44 Liquormart, Inc.*, 517 U.S. at 505 (citation omitted). To the contrary, the government must prove that the prohibition will "*significantly*" advance its ostensible goal of enforcing the CSA. *Id.* at 506. A mere "common sense" connection between the regulation is not enough. *Id.* at 505. But here the government has not and cannot show that its policy *directly* prevents violations of the CSA. Worse, as noted above, the policy will suppress valuable speech that

would not result in a violation. Consequently, even under the standard applied to commercial speech, the government's policy cannot be sustained.[4]

III. THE GOVERNMENT'S POLICY IS CONTRARY TO ESTABLISHED PRINCIPLES OF MEDICAL ETHICS AND OTHER GOVERNMENT REGULATION.

Requiring physicians to withhold information and recommendations from seriously ill patients about a medical treatment they reasonably and sincerely believe may be beneficial is antithetical to centuries-old principles governing the ethical practice of medicine. By eroding the trust between physician and patient, the government's policy also threatens the efficacy of their therapeutic alliance. Indeed, despite its reluctance to take a position on the therapeutic value of marijuana without further study, the American Medical Association has taken the position with regard to marijuana that "effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either

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[4]In addition to the failure to satisfy strict scrutiny, the government's policy is also impermissibly vague. Physicians are understandably confused about where a discussion about marijuana crosses over to what the government deems an impermissible "recommendation." The inevitable result of this justifiable uncertainty is self-censorship by physicians of constitutionally-protected discourse, in an effort to avoid federal sanctions. To avoid redundancy, *amici* adopt plaintiff's well-argued position that the government's policy is unconstitutionally vague.

party to criminal sanctions." AMA Policy H-95.952 (available at www.ama-assn.org/ama/pub/article/2036-4971.htm.).

A. The Government's Policy Would Erode the Physician-Patient Relationship and Would Jeopardize Patient Care.

Forbidding physicians to recommend to their patients treatments such as marijuana -- or any other alternative treatment, such as massage, vitamins, or acupuncture that the government may disagree with -- also jeopardizes the "collaborative effort" between physicians and patients that is critical to "the health and well-being of patients." *AMA Code of Medical Ethics* at xli.

The physician-patient relationship rests upon the "imperative need for confidence and trust" between physician and patient. *Trammel v. United States*, 445 U.S. 40, at 51. For the patient, this means "[t]rust that the treatment [the] physician thought best is indeed the best one...trust that [the] physician can and will take the time to explain matters...trust [that the] physician be well-informed about *all available* treatment modalities..." Katz, *supra* at 95-96 (emphasis added). For the physician, this means trust that the patient will be forthright in providing the information necessary for medical diagnosis and treatment, including full information about medical history, symptoms, reactions to medication, fears, and desired treatment methods. *Trammel*, 445 U.S. at 51 (the

"physician must know all that a patient can articulate in order to identify and to treat disease"). Although much of this information may be sensitive, "[a] patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage and sexual experiences, and to allow the physician to examine intimate parts of his or her anatomy." Robert Arnold *et al.*, *Medical Ethics and Doctor/Patient Communication*, in THE MEDICAL INTERVIEW 345, 365 (Mack Lipkin Jr., et al. eds. 1995).

A patient's willingness to disclose such personal information depends on faith in the physician's commitment to the patient's best interests. A patient confides intimate medical information in exchange for an accurate diagnosis and appropriately tailored medical advice. A doctor's "withholding of crucial information compromises intimacy, and physicians and patients can only engage in arm's length transactions." Katz, *supra*, at 193. When patients do not disclose all pertinent information, including the full range of substances they ingest, their health can be seriously endangered.[5]

In addition to jeopardizing the accuracy of medical diagnosis and advice, interference with the physician-patient dialogue may diminish patients'

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[5]*See* Declaration of Plaintiff Milton N. Estes, M.S., ¶ 9 (Feb. 13, 1997), SER at 84; Declaration of Plaintiff Stephen E. Follansbee, M.D., ¶ 15 (Feb. 13, 1997), SER at 105-106; Declaration of Neil M. Finn, M.D., ¶ 18, SER at 95.

compliance with medical treatment. As studies have demonstrated, patient adherence to recommended medical treatment is often a significant obstacle to successful health care. *See* Katz, *supra*, at xiv & n.2 ("[s]ocial science studies on patient compliance have consistently supported the depressing conclusion that a great many patients do not comply with their physicians' prescriptions"). Such compliance requires a patient's willingness to make the requisite investment to begin medical treatment and to persevere when the benefits may be slow to appear, or the treatment may appear to be no longer needed. Such willingness to follow advice and adhere to treatment is dependent on a patient's level of confidence in the physician. Nancy E. Dye, et al., *Enhancing Cooperation with the Medical Regimen* in THE MEDICAL INTERVIEW 134, 142 (a "patient's ability to trust the physician influences his or her receptivity to information").

The erosion of the trust between physician and patient will not just jeopardize the health care of one or two patients. Rather, the entire relevant patient population is at risk. Once AIDs patients, for example, learn that physicians cannot or will not recommend potentially beneficial medical treatments due to fear of federal sanctions, those patients will increasingly seek care elsewhere, or not at all. Patients may increasingly resort to the Internet and other less reliable sources to educate themselves about medical treatments and as

a result may make choices inappropriate for their individual medical condition. For example, for patients who are immuno-compromised -- as in the case of AIDS patients and patients undergoing chemotherapy -- smoking marijuana may pose a heightened risk of respiratory infection. Follansbee Decl., ¶ 11, SER at 104. Such patients in reliance on information obtained on their own, may not know of the risk, much less have a sound basis to evaluate it.

B. The Government's Policy Is Contrary to Medical Ethics.

A patient's right to self-determination is the cornerstone of the ethical practice of medicine. *See Canterbury*, 464 F.2d at 729 (right to self-determination is "fundamental to American jurisprudence"); *Washington v. Glucksberg*, 521 U.S. 702, 777 (1997) (Souter, J., concurring). Consequently, a physician is ethically obliged to "provide[] his or her client with all information necessary for the patient to make an informed choice about treatment." Nancy S. Jecker, "Introduction to the Method of Medical Ethics," in BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE (Jecker et al. eds. 1997); *Accord AMA Code of Medical Ethics* at xli ("The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives."); Ruth R. Faden & Tom L. Beauchamp, A

HISTORY AND THEORY OF INFORMED CONSENT 123 (1986); Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 63 (5th ed. 2001).

The meaningful exercise of a patient's right to choose her medical treatment depends upon the physician's full disclosure of "adequate information to enable an intelligent choice." *Cobbs*, 8 Cal. 3d at 245. *Accord AMA Code of Medical Ethics* at 120. From this right to self-determination "springs the need, and in turn the requirement, of a reasonable divulgence by the physician to the patient to make such a decision possible." *Canterbury*, 464 F.2d at 779; *see also id.* ("True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."); *Murrey v. United States*, 73 F.3d 1448, 1453 (7th Cir. 1996); *Harbeson v. Parke Davis*, 746 F.2d 517, 522 (9th Cir. 1984); *AMA Code of Medical Ethics* xli.

But information is not enough. Professional standards also require physicians to offer advice and guidance that will "help the patient make choices from among the therapeutic alternatives." *AMA Code of Medical Ethics* at 120; *see also id.* ¶ 8.08; *Matthies v. Mastromonaco*, 709 A.2d 238, 253 (N.J. Sup. Ct. App. Div. 1998) ("To the extent the physician has a view as to which of the reasonably available alternative courses of treatment is the best in the

circumstances as a matter of medical judgment, the physician must also give the patient the benefit of a recommendation."), *aff'd*, 733 A.2d 456 (N.J. 1999). As prominent medical ethicists Tom Beauchamp and James Childress have noted, "the health professional's *recommendation* of one or more actions" is at least as important as "disclosure of information." Tom Beauchamp & James Childress, PRINCIPLES OF BIOMEDICAL ETHICS 81 (5th ed. 2001) (emphasis added). *See also id.* at 81 ("[p]rofessionals are generally obligated to disclose a core set of information, including . . . the professional's *recommendation*") (emphasis added); *AMA Code of Ethics* at 120 (physician is ethically obligated to "make *recommendations* for management" of the patient's care "in accordance with good medical practice") (emphasis added); *id.* at xli ("Patients should receive guidance from their physicians as to the optimal course of action."). Physicians cannot discharge this obligation through silence or "half truths." George J. Annas, STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS 19 (1993).

We do not argue that every physician has a *duty* to specifically recommend or discuss the use of medical marijuana any more than thousands of other alternative treatment options, which would impose an unreasonable standard of care. But the issue here is not the existence of such a duty, it is whether physicians, who believe in their best medical judgment that marijuana may

alleviate a patient's condition, have the *right* to so inform a patient, and to recommend such treatment. Governmental censorship of that recommendation is incompatible with the fundamental tenet of medical ethics, with roots as ancient as the Hippocratic Oath, that physicians must "follow that system of regimen," which according to their "ability and judgment," they believe may benefit their patients. Oath of Hippocrates (5th Century B.C.), *reprinted in* 1 Francis Adams (transl.) HIPPOCRATES, WORKS, 299-301.

This censorship sets a particularly dangerous precedent in light of today's "proliferation of treatment options." Katz, M.D., THE SILENT WORLD OF DOCTOR AND PATIENT 102 (1984). "No single right decision exists for how the life of health and illness should be lived. . . . Alleviation of suffering can be accomplished in a variety of ways and alternative choices must be explained." *Id.*

These core ethical precepts call upon a physician to convey his reasonable belief that a patient may benefit from a medical treatment. The government's policy places the physician in an untenable position of conflicted loyalties between the patient's interests in accurate information and clinical judgment, and the physician's interests in professional and personal security. According to medical ethicist Bernard Lo, conflicts of interest threaten the therapeutic interaction by (1) placing patients at risk of physical harm when clinical decisions

are based on considerations other than their best interest; (2) violating the integrity of medical judgments, thereby jeopardizing the well-being of future patients; and (3) rupturing the trust that is central to the physician-patient relationship. Bernard Lo, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS, SECOND EDITION, 232 (2000).

C. The Policy Sanctioning Physician Speech Is Contrary To Other Government Policies.

In addition to jeopardizing patient care, the government's policy regarding marijuana recommendations conflicts with other federal policies. For the same reasons that state tort law requires informed consent to medical procedures and treatments, the federal government's own guidelines for medical research mandate disclosure of, among other things, any "alternative procedures or course[s] of treatment" to prospective subjects of a medical study. 45 C.F.R. § 46.116(a)(4). In counseling patients suffering from debilitating illnesses like AIDs, cancer, and glaucoma, many of whom are enrolled in clinical research, physicians whose sincere medical judgment is that marijuana may be a beneficial alternative treatment for a patient are required by these federal regulations to so advise a patient.

Similarly, forbidding recommendation of an alternative treatment option is contrary to the federal government's opposition to gag orders imposed by

HMO's. The Department of Health & Human Services has noted that Medicare beneficiaries are entitled to "advice from their physicians on medically necessary treatment options that may be appropriate for their condition or disease. . . . Since a gag clause would have the practical effect of prohibiting a physician from giving a patient the full range of advice and counsel that is clinically appropriate," it would deny patients the rights to which they are entitled. Operational Policy Letter #46 dated Dec. 19, 1996, Dept. of Health and Human Services, Health Care Financing Administration (available at http://www.hcfa.gov/medicare/opL046.htm) (emphasis added). Thus, HHS has ruled: "Clauses in HMO contracts or similar restrictions that prevent physicians or other providers from fully discussing *all* diagnostic or treatment options with a patient are not allowed." *Id.* (emphasis added); *see also* Martin & Bjerknes, *The Legal and Ethical Implication of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433 (1996).

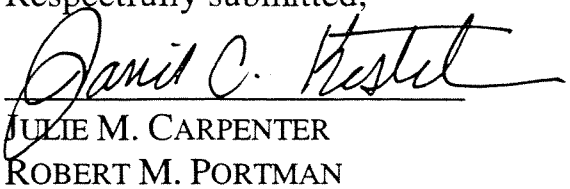
The CSA cannot be interpreted to conflict with these requirements.

CONCLUSION

Because reasonable, good-faith physician recommendations of medical marijuana to seriously ill patients for whom other treatments have failed is both protected by the First Amendment and required for sound patient care, the

government's policy of suppressing such speech is unconstitutional. The judgment of the district court should be affirmed.

Respectfully submitted,



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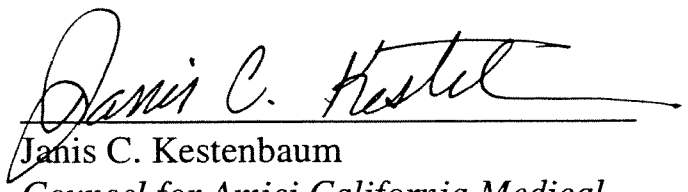
CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that the foregoing Amicus Brief of the California Medical Society, *et al.*, in Support of Plaintiffs-Appellees complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B), Fed. R. App. P. 29(d), and Ninth Circuit Rule 32-1. The text of the brief is proportionally spaced, has a typeface of 14 points, and contains 6,920 words as counted by WordPerfect 9.



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CERTIFICATE OF SERVICE

I hereby certify that on September 7, 2001 I served the foregoing amicus brief by U.S. Mail on the following:

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