No. 03-15481

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ANGEL MCCLARY RAICH, et al.,
Plaintiffs-Appellants,

v.

JOHN ASHCROFT, Attorney General; et al.,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
Case No. C 02-4872 MJJ
entered on March 5, 2003, by Judge Marvin J. Jenkins

Amicus Brief of the California Medical Association In Support of Plaintiffs-Appellants Angel McClary Raich, Diane Monson, John Doe No. One, John Doe No. 2

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INTEREST OF *AMICUS CURIAE*

The California Medical Association (CMA) is a nonprofit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are "... to promote 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."

The District Court's failure to grant a preliminary injunction to protect seriously ill patients whose doctors have recommended cannabis as a last-resort medical treatment seriously infringes upon the constitutional rights of the patients whose well-being the CMA is committed to preserve. This case threatens these (and other) patients' constitutional rights to make autonomous decisions regarding their bodies, and to seek medical treatment for alleviation of pain and suffering and preservation of life. Because the CMA strongly believes that the district court's refusal to grant injunctive relief has dire consequences for the care and well-being of patients, and the integrity of the caregiver-patient relationship, the CMA submits this brief as *amicus curiae.*

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

SUMMARY OF ARGUMENT

The federal Constitution protects against governmental interference with the narrow but fundamental right to seek medical treatment. The right to seek to alleviate pain and suffering when all conventional treatments have failed is a paradigmatic example of that right. In this case, seriously ill persons, who have unsuccessfully tried all other conventional treatments to alleviate their pain or symptoms, have demonstrated that they reasonably fear that the federal government will prevent them from growing or possessing the medical cannabis their competent doctors have recommended. This federal attempt to interfere with individual patient treatment violates those patients' fundamental rights, and the Court should therefore reverse the district court's denial of the preliminary injunction.

ARGUMENT

THE FEDERAL GOVERNMENT'S POLICY OF PROSECUTING PATIENTS AND SEIZING THEIR MEDICAL CANNABIS INFRINGES UPON PATIENTS' FUNDAMENTAL RIGHTS.

"[T]he Due Process Clause specially protects those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 703, 720-

21 (1997) (internal citations and quotation marks omitted); *see also Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (describing rights "so rooted in the traditions and conscience of our people as to be ranked as fundamental"). Such rights are identified by reference to "[o]ur Nation's history, legal traditions, and practices." *Glucksberg*, 521 U.S. at 721. If a plaintiff articulates such a right with specificity, and demonstrates historical recognition and protection of that right, government action that infringes upon the right will be deemed unlawful unless it is narrowly tailored to serve a compelling state interest. *Id.*

This case implicates a narrow, yet fundamental, right—the right, upon a physician's advice, to seek medical treatment to treat medical conditions, to alleviate pain and suffering, and to preserve one's life, when conventional treatments have failed. That right originates in our Nation's long history of protecting an individual's right to bodily integrity, and the longstanding sovereignty accorded to decisions regarding what will be done with one's body—rights that are at the core of the liberty interests that the Constitution protects. Indeed, when the Constitution was written, there were no federal restrictions on medications or patient care.[1]

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[1] The passage of the Pure Food & Drug Act of 1906 marked the first direct federal regulation of drugs. *See United States v. Articles of Drug*, 585 F.2d 575, 577 (3d Cir. 1978); Pub L. No. 59-384, § 8 (1906). Although that Act required the

Neither federal prosecutors nor the courts should impede a desperate patient who has tried all conventional treatments without success and, acting with the advice and approval of his or her physician, seeks to alleviate his or her serious suffering by using a non-conventional treatment that has been reasonably shown to be effective in his or her case. Allowing the federal government to seize the medical cannabis of seriously ill patients whose physicians have informed them that cannabis is the only available last-resort treatment to alleviate their pain and suffering, and to prosecute them for possessing it, impedes patients' rights in precisely that manner, and presents grave constitutional concerns. Accordingly, the government's threatened actions here must be carefully scrutinized by this Court.

A. Individuals Have A Fundamental Right To Seek Medical Treatment To Alleviate Pain And Suffering And Prolong Life.

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producers of foods and over-the counter medicines to provide labels clearly indicating the content and amount of substances such as cannabis that appeared in the products, *see Articles of Drug*, 585 F.2d at 577, it did not prohibit the medical use of cannabis. *See* Lauryn P. Gouldin, *Cannabis, Compassionate Use and the Commerce Clause: Why Developments in California May Limit the Constitutional Reach of the Federal Drug Laws*, 1999 Annual Survey of Am. Law 471, 475 & nn.18-19 (describing history of regulation of drugs and cannabis). The United States did not make the medical use of cannabis unlawful as a matter of federal law until 1970, when it passed the Controlled Substances Act. *See* Note, *Urgent Compassion: Medical Marijuana, Prosecutorial Discretion, and the Medical Necessity Defense*, 41 Boston Coll. L. Rev. 699, 701-05 (2000) (discussing history of medical use of cannabis and laws regulating that use).

1. The Right To Seek Medical Treatment Is A Core Liberty Interest Recognized In This Nation's History And Legal Traditions.

At bottom, the uniquely American right of self-determination is at issue here. "[T]he right of every individual to the possession and control of his own person, free from all restraint or interference of others, is so rooted in the traditions and conscience of our people, as to be ranked as one of the fundamental liberties protected by the substantive component of the Due Process Clause." *Newman v. Sathyavaglswaran*, 287 F.3d 786, 789 (9th Cir. 2002) (internal citations and quotation marks omitted), *cert. denied*, 71 U.S.L.W. 3191 (U.S. Nov. 18, 2002) (No. 02-423). The protection of this interest predates the establishment of this nation's laws, and is a touchstone of the Anglo-American legal tradition. *See, e.g.*, 1 William Blackstone, *Commentaries* *129 (1765) (discussing right to personal security "which consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation."). Indeed, over a century ago, the Supreme Court recognized that, "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of

others, unless by clear and unquestionable authority of law." *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

The courts have reaffirmed this principle, and have repeatedly protected individuals against government interference with the "right to determine what shall be done with [one's] own body." *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). For example, in *Rochin v. California*, the Supreme Court ruled that the police unconstitutionally violated a defendant's bodily integrity by administering an emetic to recover a pill swallowed upon arrest. 342 U.S. 165, 172 (1952). In *Cruzan*, the Court recognized that its precedent supported the inference that competent individuals possess a constitutionally protected liberty interest in refusing life-sustaining medical treatment. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278-79 (1990); *see also id.* at 287-88 (O'Connor, J., concurring) (explaining that liberty interest in refusing medical treatment "flows from decisions involving the State's invasion into the body" and noting that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination"). The overwhelming majority of states, in turn, have protected that right by allowing individuals to sign "living wills" or similar documents to direct the course of their medical treatment in the event that they become incapacitated, and to formally establish their desire to receive or refuse life-

sustaining procedures. *See* Note, *The Right to Choose How to Die: A Constitutional Assessment of State Laws Prohibiting Physician-Assisted Suicide*, 48 Stan. L. Rev. 937, 945-46 & nn. 49-50 (1996) (citing state laws). Similarly, courts have recognized a mentally ill prisoner's "significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." *Washington v. Harper*, 494 U.S. 210, 221-22 (1990). And in the Fourth Amendment context of search and seizure, the Court has also protected a person's bodily integrity. *See, e.g.*, *Winston v. Lee*, 470 U.S. 753, 766 (1985) (involuntary surgery was an unreasonable invasion of a defendant's body); *Schmerber v. California*, 384 U.S. 757, 773 (1966) (subjecting involuntary blood test administered upon drunken driving suspect to exacting constitutional scrutiny because "[t]he integrity of an individual's person is a cherished value of our society"). *See generally Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (describing "right to be let alone").

"Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony" is an equally fundamental liberty interest that is derivative of the right to bodily integrity and sovereignty. *Glucksberg*, 521 U.S. at 745 (Stevens, J., concurring). State action that prevents a person from taking measures to amelioriate such suffering is therefore as offensive to principles of

liberty and personal sovereignty as the government infliction of severe pain and suffering.[2] *See, e.g.*, *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1992) (noting that laws prohibiting abortion force women to endure anxiety and pain and thereby infringe upon women's liberty interests); *see also Glucksberg*, 502 U.S. at 790 (Breyer, J., concurring) (describing "right to death with dignity" as combination of "personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering"). Indeed, it is difficult to conceive of a right more "central to personal dignity and autonomy." *Casey*, 505 U.S. at 851.

Underscoring the depth of this fundamental right to seek and obtain medical treatment is the long-settled law recognizing the special nature of the physician-patient relationship. Because that relationship furthers these important rights, the courts have even allowed doctors to raise the privacy and liberty rights of their patients in court. *E.g., Roe v. Wade*, 410 U.S. 113, 153, 156 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965). Similarly, because courts have recognized the critical nature of communication between doctor and patient, and that to pursue one's best health interests, any communication with a physician must be

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[2] The Supreme Court has recognized that the Constitution prevents the government from inflicting pain and suffering. *See, e.g.*, *Ingraham v. Wright*, 430 U.S. 651, 674 (1977); *Hudson v. McMillian,* 503 U.S. 1, 9-10 (1992).

unfettered, such communications are, and have long been as a matter of common law, privileged communications. *See Conant v. Walters*, 309 F.3d 629, 636 (9th Cir. 2002). Finally, as noted recently by this Court, patients have the right to their physicians' full and frank discussion of all possible treatments, even those that may be proscribed by federal law, such as the use of medical cannabis. *See id.* at 636-37. Because the patients' rights are so significant, the government cannot punish or threaten doctors for discussing possible treatments, including even those that federal law prohibits. *See id.*

It is significant that the government does not dispute the facts that the plaintiffs here suffer painful, debilitating diseases that have not responded to conventional medicines, and that *have* responded to medical cannabis. Thus, the factual record is clear that for these patients, the use of medical cannabis ameliorates their suffering and pain, and affirmatively improves their condition. To hold that despite these undisputed facts, plaintiffs have no fundamental right to use the medical cannabis that provides the *only* relief their doctors have been able to find substitutes political machinations for individualized competent medical practice, denies the patients' liberty interests and supplants the patient-physician relationship.

2. The Ninth And Tenth Circuit Cases Rejecting Efforts To Change The Laetrile Laws Do Not Undermine The Right Asserted Here.

The District Court held that *Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980) (per curiam), and *Rutherford v. United States*, 616 F.2d 455 (10th Cir. 1980) preclude judicial recognition of the liberty interest articulated here. That view is incorrect.

In *Carnohan*, the plaintiff affirmatively sought a declaratory ruling that he had a right to use and procure laetrile in connection with a nutritional program for the prevention of cancer, without following the procedures that would ordinarily govern efforts to obtain FDA approval of a "new drug." 616 F.2d at 1121-22. This Court concluded he could not seek judicial review without first exhausting his administrative remedies by filing a new drug application with the FDA. Rejecting Carnohan's assertion that the regulatory procedures were so burdensome as to infringe upon his constitutional rights of privacy and personal liberty, the Court determined that it "need not decide whether Carnohan has a constitutional right to treat himself with home remedies of his own confection." *Id.*

Carnohan differs from this case in two critical respects. First, the liberty interest here is far narrower. Unlike the seriously ill patients here, who have no other alternatives to treat or alleviate current conditions, Carnohan sought to access

laetrile as a potential *preventive* measure. He did not allege that his physician had advised that laetrile was the only remaining option for alleviation of extreme pain and suffering or the preservation of his life, or even the only useful drug for a nutritional program for cancer prevention. Thus, his case simply did not implicate the narrow right asserted here, where the treatment at issue is the only treatment shown or reasonably likely to have any effect. In these circumstances, denying this "type of treatment" denies treatment altogether.

Second, Carnohan sought to *compel* government action—reclassifying laetrile—that would apply generally to the public. In contrast, the parties here have not requested that the government reclassify marijuana for medical use, or otherwise alter the federal laws regulating drugs. Instead, they are defending against federal government interference with their state right to use and obtain marijuana as a last-resort medical treatment, consistent with their physician's advice and California law. The difference between requiring the government to enable a person's exercise of a fundamental right, and preventing the government from affirmatively proscribing the exercise of that right, is more than semantic. *See, e.g.*, *Harris v. McRae*, 448 U.S. 297, 313-16 (1980) (Congress may decline to fund medically necessary abortions even though the government cannot deprive a woman of her constitutional right to obtain an abortion). The latter is a direct

attack upon the sovereignty and freedom to make decisions concerning one's body and a classic example of government interference with the right to be let alone.

Nor does *Rutherford* determine this case. There, the Tenth Circuit rejected cancer patients' challenge to the FDA's decision to not approve laetrile. *See* 616 F.2d at 456-57. The court concluded that "[i]t is apparent in the context with which we are here concerned that the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health." 616 F.2d at 457.

Unlike *Rutherford*, this case turns on the fundamental right whose existence the Tenth Circuit deemed "apparent"—"the decision *whether to have a treatment or not*." *Id.* (emphasis added). The *Rutherford* plaintiffs never alleged that the drug was the only effective treatment available to them, and thus the issue was between a choice of treatments. But the plaintiffs here have alleged exactly that, and the government has not disputed those allegations. **[MORE DETAILS FROM THE AFFIDAVITS TO COME HERE]**

In sum, neither *Carnohan* nor *Rutherford* prevent this Court from recognizing the narrow fundamental right that has been claimed here. Whether or not an individual can require the government regulators to reclassify cannabis, the

Constitution *does* protect seriously ill individuals from the government's use of its prosecutorial powers to foreclose their ability to obtain the only treatment their physicians deem effective for the treatment of their pain or the preservation of their life.

B. The Practice Of Medicine Has Long Recognized And Protected The Fundamental Right Of Patients To Seek Relief From Pain And Suffering.

Protecting a patient's right to take measures to treat a medical condition, or to relieve or alleviate pain implicates one of the most historically profound functions of physicians, nurses, and other medical professionals. A patient should not endure unnecessary pain and suffering of any form, regardless of the nature of the patient's condition or the goals of medical intervention. *See, e.g.,* Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 Wm. Mitchell L. Rev. 1, 4 (2000). Thus, physicians must be free to try to provide relief from pain and suffering: "One caregiver mandate remains as constant and compelling as it was for the earliest shaman—the relief of pain. Even when cure is impossible, the physician seeks to provide effective palliation. Moreover, the centrality of this role is both unquestioned and universal, transcending time and cultural boundaries." Post et al., *Pain: Ethics, Culture, and Informed Consent to Relief*, 24 J. Law, Med. & Ethics 348 (1996).

Because a patient does have the right to seek treatment for medical conditions or therapies that will alleviate pain, physicians and nurses must be able to address patients' particular needs as they arise. And because individual response to various treatments may vary dramatically, treating severe or chronic pain often requires a patient and his or her physician to embark together on a difficult and frustrating process of exploration and discovery. When medical problems remain intractable, the patient and physician must be free to explore all therapeutic options, and the physician needs the latitude to offer the patient his or her opinion and advice on any and all potential courses of treatment. The collective effort to pursue and provide these remedies is a fundamental aspect of good patient care.

Good medicine does not involve just the application of cold data to "a case." Rather, it requires the application of intuition, sensitivity, and creativity to the circumstances of a specific patient. If the patient has an intractable problem, various measures may be tried and abandoned; consultation may be sought; research may be undertaken. To be sure, standard therapies, if available, will certainly be tried first, but if those fail, sound medical opinion supports the exploration of different options.[3] Sometimes an option will involve the use of

[3] It is incontrovertible that some patients with serious medical conditions *cannot be helped by standard therapies.* For example, in a recent report on

unconventional or unapproved substances. In rare instances, treatment options may require the use of a substance, like cannabis, whose medical purpose the federal government does not recognize (although many doctors and the state of California disagree).[4] But the substance may offer the only hope of effective treatment for a particular patient. The government should not and cannot deprive patients and physicians of the opportunity to discover the option that relieves the suffering of otherwise "untreatable" patients. In some cases, the only alternative may involve a drug that has been approved for marketing in other countries, but has not yet received approval for any indication by the Food and Drug Administration (FDA) in the U.S. For example, there are patients who suffer from debilitating seizures who can obtain relief only from drugs available in Europe, but not the U.S. In other cases, patients may seek relief from various types of alternative therapies, such as herbs, vitamins,[5] meditation, yoga, and acupuncture.

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medical cannabis, the prestigious Institute of Medicine noted that, despite new advances in antiemetic (anti-vomiting) medications, 20-30% of cancer patients who receive highly emetogenic chemotherapy will still experience acute emesis. Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base*, 151-52 (1999). Others will suffer from conditions for which there is no standard therapy or for whom the side effects of such therapy are intolerable.

[4] For a discussion of the research indicating that cannabis may have medical uses for certain patients who do not respond to conventional treatment, *see Conant v. Walters*, 309 F.3d at 640-43 (Kozinski, J., concurring).

[5] Herbs, vitamins, minerals, botanicals, and similar substances are regulated as "dietary supplements," rather than "new drugs," by the FDA, so long as they are

Physicians may assist patients in identifying whether any of such therapies are likely to be helpful. Although these therapies may not have been shown to be effective for a large percentage of people through controlled clinical trial, they may provide a particular patient's sole source of relief.

In sum, the exhaustion of treatment options, including those that are unconventional, is an accepted aspect of medicine. Indeed, the ability to pursue such options motivates and informs many patients' decision to seek the care of a physician and selection of a particular caregiver. Judicial recognition of the right of the desperately ill to seek unusual or even unapproved remedies, based on their physicians' advice, is consistent with these longstanding medical practices.

C. The Federal Government's Regulation Of Drugs Generally Cannot Justify Interfering With A Patient's Right To Seek And Obtain Specific Competent Medical Treatment.

Although the federal government has a significant role to play in ensuring that manufacturers who claim that their products will accomplish particular medical results are held to a high level of accountability of efficacy and safety, that consumer protection role has never justified interfering with a specific doctor's recommendation to a specific patient about how best to treat or help alleviate a

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not accompanied by claims of specific medical or health benefits. 21 U.S.C. § 343(r)(6). Therefore, they have not been rigorously tested for safety and efficacy by controlled clinical trials.

particular condition. Indeed, if anything is clear in the area of federal government interest in health care, it is that the "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); *see also Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (noting that "health care" is a "subject of traditional state regulation").

For this reason, federal law regulating drug labelling and testing does *not* limit the manner in which physicians can use prescription drugs. Although controlled clinical trials have contributed greatly to scientific knowledge, they are not the only means of obtaining useful information about a potential treatment modality. Anecdotal cases, particularly if they are meaningful in number, may offer critically important guidance to physicians and patients.

Consequently, it is well-accepted that patients may take, on prescription, an approved medication for an unapproved medical use, i.e. "off-label" prescriptions. The American Medical Association takes the position that "a physician may lawfully use an FDA approved drug product for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion." Policy 120.988, AMA Policy Compendium 1996.[6] The AMA Council on Scientific

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[6] This is also true of medical devices. In fact, the FDA Modernization Act (FDAMA) explicitly prohibits FDA intrusion into medical practice with regard to the off-label use of devices:

Affairs has reviewed the issue of off-label prescription and concluded that the prevalence and clinical importance of unapproved indications are substantial, especially in the areas of oncology, rare diseases, and pediatrics. Report of the Council on Scientific Affairs 3-A-97, *Unlabeled Indications of Food and Drug Administration-Approved Drugs*. Similarly, the California Attorney General has opined that the state and federal drug approval laws were intended to protect consumers from drug manufacturers, not to interfere with the physician's judgment regarding individual patient treatment. *See* 61 Ops. Cal. Atty. Gen. 192 (1978).

Further, although the Food, Drug, and Cosmetic Act prohibits *manufacturers* from promoting a drug for an unapproved use, it does not restrict other persons—if they derive no direct commercial interest from the sale or distribution of the product—from making such claims. The FDCA also does not prohibit a physician from prescribing or dispensing an unapproved drug outside the bounds of an approved investigational drug study. To the contrary, it explicitly permits a physician, or a pharmacist upon a physician's order, to compound—mix up on its

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> Nothing in this [Act] shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship.

21 U.S.C. § 396.

own—a drug product for an identified patient, without obtaining the approval the FDCA would otherwise require for a "new drug." 21 U.S.C. § 353a.

Finally, as this Court has recently made clear, the federal government lacks authority under the Controlled Substances Act to interfere with the patient's right to obtain information about possible treatment modalities from his or her doctor, even if the doctor advises the patient that some illegal substance might be helpful in treatment. In *Conant v. Walters*, this Court held that the CSA did *not* justify a federal government directive that physicians who "recommended" the use of medical cannabis could lose their DEA licenses to prescribe controlled substances, or be subjected to investigations that might lead to revocation of those licenses, *see* 309 F.3d at 632, because physician-patient communication regarding treatment options is "an integral component of the practice of medicine." *Id.* at 636. Indeed, as Judge Kozinski noted, the policy invalidated there was particularly offensive because it deprived patients of "information critical to their well-being." *Id.* at 640.

Thus, the federal government's role as market regulator has never been, and cannot now be, transmuted into medical expertise that overrides a particular physician's judgment as to a particular patient's needs.

D. This Case Should Be Resolved Narrowly.

This case raises complex issues regarding individuals' ability to make intimate decisions regarding their physical health, and their ability to try, outside of commerce, unconventional homegrown medical treatments when all others have failed. The constitutional protection accorded to those sensitive and innately personal decisions requires the injunction sought here, because the articulated governmental interests in applying the Controlled Substances Act do not survive the heightened scrutiny applicable to actions that infringe upon fundamental rights. *See* Appellants' Br. at 58-59 (explaining why the government's interests do not meet those heightened standards). The CMA therefore urges this Court to hold that the denial of the requested injunction is unconstitutional, and reverse the district court's decision. Because *amicus* writes primarily to underscore the significance of the rights at issue here, and to avoid repetition, we will rely on Appellant's brief, and not argue that point further here.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

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 Association, in Support of Plaintiffs-Appellants 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 ____ words as counted by Word Perfect 9.

_____
Julie M. Carpenter
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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of April, 2002, I caused true and accurate copies of the foregoing Amicus Brief of California Medical Association In Support of Plaintiffs-Appellants Angel McClary Raich, *et al.* to be served via first-class mail, postage prepaid, on the parties indicated below.

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Julie M. Carpenter