No. 00-151

IN TIIE SUPREME COURT OF THE UNITED STATES

UNITED STATES OF AMERICA

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE

BRIEF OF EDWARD NEIL BRUNDRIDGE

Filed February 20th, 2001

This is a replacement cover page for the above referenced brief filed at the U.S. Supreme Court. Original cover could not be legibly photocopied

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INTEREST OF *AMICI CURIAE*

Amici curiae, Edward Neil Brundridge, Ima Carter, Rebecca Nikkel and Lucia Y. Vier (collectively, the "Members"), are parties-in-intervention in the underlying actions from which the writ of *certiorari* arises.[1] They are members of the cannabis cooperatives, including respondent cooperative, against which the government sought injunctive relief. The Members intervened below as defendants. They answered, invoking the common law defense of necessity, and filed counterclaims-in-intervention seeking a declaration of their fundamental right to be free from governmental interdiction of their personal, self-funded medical decisions, in consultation with their physicians, to alleviate their suffering through the only effective treatment available to them: cannabis.

The Members suffer from chronic pain that seriously diminishes their quality of life. To obtain the only effective medical treatment available to alleviate their pain and allow them to function, the Members joined the cooperative associations that were formed after the passage in California of the Compassionate Use Act of 1996 (Calif. Health & Safety Code § 11362.5). The state statute sought to ensure that seriously ill Californians would have the right to obtain and use cannabis for medicinal purposes. The cooperatives are the only available legal source of safe and affordable cannabis to the Members.

As members of California cannabis cooperatives, the Members have an interest in the affirmance of the court of appeals' decision upholding the availability of the medical necessity defense in any action by the government to enforce

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[1] The parties have consented to the filing of this brief, and the written consents of each of their counsel of record are filed with this brief. Counsel for a party did not author this brief in whole or in part, and no person or entity, other than the *amici curiae* or their counsel, made a monetary contribution to the preparation or submission of the brief.

the Controlled Substances Act (21 U.S.C. § 801 *et seq.*) against respondents or themselves. In response to the government's enforcement action, the Members intervened and have invoked the defense of necessity in their answer. Like respondents, the Members argued below that distribution of cannabis to members of California cooperatives under circumstances that meet the common law standard of necessity articulated in *United States v. Aguilar*, 883 F.2d 662, 692 (9th Cir. 1989), may not be enjoined under the Controlled Substances Act. The Members urge the Court to affirm the court of appeals' judgment.

Although their constitutional claim is not before the Court, the Members also have an interest in ensuring that they have an adequate opportunity to present that claim below if necessary.[2] The question presented by the petition for *certiorari* is whether a medical necessity defense is available to respondents under the Controlled Substances Act. Should the Court reverse the court of appeals' ruling that the defense is available, resolution of this question of statutory interpretation would not prevent the Members from presenting their constitutional claim in light of a fully developed record. *See Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997).

To establish their constitutional claim, the Members intend to present evidence that the fundamental right they assert is deeply rooted in this Nation's history and tradition. In a related appeal, the court of appeals has ordered that the Members be allowed to do so.[3] The government has not

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[2] In this regard, the government has argued in the past and may argue again below—although it does not do so here—that respondents do not have standing to assert the Members' fundamental constitutional right as set forth in their counterclaims below.

[3] Pursuant to Federal Rule of Evidence 201, the Members request that the Court take judicial notice of the court of appeals' decision on May 10, 2000 in appeal nos. 99-15838, 99-15844 and 99-15879, reversing the district court's dismissal of the Members' counterclaim.

(footnote continued)

sought review of that ruling and thus the outcome of its challenge here to the appellate court's construction of the Controlled Substances Act cannot avert district court consideration of the constitutional issue presented by the Members' counterclaim.

SUMMARY OF ARGUMENT

The Court is being asked to decide whether a common law necessity defense is available in a civil enforcement action under the Controlled Substances Act. This brief describes the constitutional right to be free from governmental intervention in their medical treatment that the Members have asserted in the underlying actions. The existence of this right is an additional and compelling reason for this Court to rule that in enacting the Controlled Substances Act, Congress did not intend to preclude respondents' invocation of the necessity defense in this context.[4] The Members also ask the Court to ensure that its disposition of the present appeal not restrict the Members' ability to present their constitutional claim for a hearing in the district court on a fully developed record.

The Members' constitutional claim satisfies the two-pronged test adopted by the Court in *Washington v. Glucksberg*, 521 U.S. at 720-21. The first step focuses on consideration of the nature of the interests that the Due Process Clause protects: namely, fundamental rights and liberties that are "'deeply rooted in this Nation's history and tradition.'" *Id.* (quoting *Moore v. East Cleveland*, 431 U.S.

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[4] Under well-settled rules, Congress is presumed to have enacted legislation in accordance, rather than in conflict, with constitutional guarantees (*United States v. X-Citement Video, Inc.*, 513 U.S. 64, 73 (1994)), and the preferred construction of a federal statute is therefore one that avoids potential constitutional infirmity. *Id.* at 78.

494, 503 (1977) (plurality opinion)). This brief previews the types of evidence that the Members intend to offer below if necessary, to establish the deep and important historical roots for their fundamental right.[5] The second step in the substantive due process inquiry involves a formal prerequisite: that the asserted fundamental liberty interest be "careful[ly]" and narrowly described. *Id.* at 721. The right asserted in the Members' counterclaim satisfies this requirement. The Members assert the right to be free from governmental interdiction of their personal, self-funded medical decision, in consultation with their physicians, to alleviate their suffering through the only effective treatment available to them.

Finally, this brief addresses the government's argument—relegated to a footnote (*Brief for the Petitioner* ("Brf.") at p. 25, fn. 14) —that such a fundamental right does not exist. The government argues that the recognition of such a right is foreclosed by cases holding that individuals have no right to require a federal agency to reclassify a drug (*Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980)) or to have a particular type of treatment. *Rutherford v. United States*, 616 F.2d 455 (10th Cir. 1980). The government's authorities confirm, however, that the right to decide whether or not to have effective medical treatment at all is in fact fundamental. *Id.* at 457. Moreover, the relief the Members seek does not require the government to take any positive action. Instead, the Members ask that the government "leave them alone" and that they be permitted to act on their doctors' recommendations regarding the only available treatment that has proven effective for them.

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[5] This brief discusses the Nation's history and traditions supporting the right to bodily integrity and to be free from pain (pp. 9-14 *infra*) and the sanctity of the physician-patient privilege (pp. 14-17 *infra*). As part of the proof to be adduced in the district court, the Members also intend to show the long-accepted practice until the 1940s of using cannabis as a medicine. *See* Joint Appendix, Declaration of Lester Grinspoon, M.D., etc., at 122-125 (detailing history and tradition of therapeutic uses of cannabis).

STATEMENT OF FACTS

The Members are seriously ill individuals, and cannabis is the only effective medical treatment available to alleviate their pain. The Counterclaim[6] seeks (1) a declaration of the Members' fundamental right 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 (2) a declaration that the government cannot seek enforcement of the Controlled Substances Act against the Members or the cooperatives because it would violate the Members' fundamental right.[7]

As alleged in the Counterclaim, Lucy Vier, Becky Nikkel, Ed Brundridge and Ima Carter suffer from serious medical conditions, will suffer imminent harm if denied cannabis, need cannabis for the treatment of a medical condition or to alleviate the medical condition or symptoms

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[6] Pursuant to Federal Rule of Evidence 201, the Members request that the Court take judicial notice of each Counterclaim-in-Intervention (the "Counterclaim") (filed October 2, 1998), each Answer-in-Intervention (filed October 2, 1998), and the Members' motion for leave to intervene and the memorandum of points and authorities and the Members' declarations in support thereof (filed August 14, 1998), which were filed in the United States District Court for the Northern District of California in action nos. 98-00085, 98-00086, 98-00087, 98-00088 and 98-0245.

[7] The Counterclaim also seeks a preliminary and permanent injunction restraining the government from interfering with the Members' exercise of their fundamental right and from attempting to enjoin the cooperatives from providing the Members or their primary caregivers with safe and affordable cannabis for personal medicinal use by the Members upon a physician's recommendation as permitted by the Compassionate Use Act of 1996.

associated with it and have no legal alternative to cannabis for the effective treatment of their condition. Each has tried other legal alternatives to cannabis but has found that they are ineffective in treating their condition or result in intolerable side effects.

The Members' doctors have determined that cannabis would be beneficial to their health and have recommended its use. In each case, the physician's recommendation conforms to California's Compassionate Use Act.

Lucy Vier has been diagnosed with terminal squamous cell cancer. She has undergone radiation and chemotherapy treatments, but they have caused her to experience nausea and made it almost impossible for her to taste food. Ms. Vier's doctor accordingly recommended that she use cannabis to stimulate her appetite. Because of her small physique (she is approximately four feet eleven inches tall and weighs eighty-seven pounds), it is crucial that Ms. Vier maintain her weight. She has found that cannabis is effective to stimulate her appetite. Without cannabis, Ms. Vier is unable to eat enough food to maintain her health.

For these reasons, in the opinion of Ms. Vier's treating physician (as well as herself), the use of cannabis is a medical necessity. No known traditional medicines stimulate her appetite effectively. If she were unable to use cannabis, she will lose weight rapidly, and her day-to-day pain will increase. She also believes that without cannabis, she would not be able to survive as long as her doctor's prognosis.

Becky Nikkel has fibromyalgia and multiple sclerosis. These conditions cause her to experience severe, painful muscle spasms. She experiences pain on a daily basis, and at times, it can be continuous. Ms. Nikkel has tried many conventional treatments and medicines, but they have been ineffective or caused allergic reactions. For example, upon the recommendation of her doctor, Ms. Nikkel tried baclofen, but that caused her legs to become so weak that she could not walk. Another conventional medication caused a

severe allergic reaction that progressed to anaphylactic shock and was nearly fatal.

Ms. Nikkel's doctor recommended cannabis as the only medicine that effectively and safely alleviates the pain caused by her muscle spasms. The absence of other medical alternatives ,for relief of her pain makes using cannabis a medical necessity for Ms. Nikkel.

Ed Brundridge suffers from severe arthritis in the right knee, which causes him extreme pain and inability to walk unaided by a cane. He also suffers from loss of appetite due to anxiety and depression. To alleviate pain, Mr. Brundridge has tried many traditional medicines, such as ibuprofen. All of them, however, either were ineffective or caused him to experience an allergic reaction. Moreover, he is unable to take many traditional pain relievers due to liver damage as a result of Hepatitis C and peculiar addiction risks he faces as a recovering alcoholic and drug abuser.

Mr. Brundridge's doctor recommended cannabis as a legal medical alternative to relieve his pain caused by the swelling in his knee and to stimulate his appetite. Cannabis is the only medicine that he has used that effectively alleviates the pain of his arthritis and counteracts the dietary effects of his anxiety and depression. Obviously, aware of his patient's background of addiction, Mr. Brundridge's doctor recommended cannabis based on his knowledge that it is not addictive. Without cannabis, Mr. Brundridge believes he would not be alive today.

Ima Carter has congenital scoliosis, fibromyalgia and cervical nerve damage. These conditions cause her severe back and head pain. Ms. Carter has tried numerous traditional medicines for these conditions, none of which has been effective. Cannabis is the only drug that she has used that has dulled or stopped the pain. She was once forced to go without cannabis temporarily. During that time, Ms. Carter was completely disabled by pain and unable to leave her bedroom. She now uses cannabis on the recommendation of her doctor. Cannabis is the only effective treatment available to alleviate her pain. If there

were anything Ms. Carter could do to relieve her pain other than using cannabis, she would do it.

If respondents and the other defendant cooperatives below are prevented from distributing cannabis to persons such as the Members, who satisfy the criteria for medical necessity, these seriously ill individuals will be unable to obtain cannabis legally or safely. The Members thus would suffer a special harm to their privacy interests and doctor relationships as a result of the attempted governmental intrusion. If the government's challenge to the modification of the preliminary injunction is upheld, the Members will be unable not only to speak freely with their doctors about their conditions and medical needs, but also to act on their doctors' recommendations as to the only medication that effectively alleviates their pain or stimulates their appetite: cannabis.

ARGUMENT

I. The Members Have a Constitutional Right to Be Free from Governmental Interdiction of Their Personal, Self-Funded Medical Choices, in Consultation with Their Personal Physicians, to Alleviate Their Suffering through the Only Effective Treatment Available for Them.

The Members advocate a narrow substantive due process right: the right to treat themselves and to be free from pain by using the only effective medical treatment available to them pursuant to their physicians' recommendations. To achieve a constitutional dimension, a claimed "fundamental" right must be "implicit in the concept of ordered liberty." *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). The interest asserted must be, "'deeply rooted in this Nation's history and tradition,' [*Moore*, 431 U.S. at 503] . . . and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [it] were sacrificed,' [*Palko*, 302 U.S. at 325]." *Washington v. Glucksberg*, 521 U.S. at 720-21. [8] An analysis of the history and tradition of a right "tends to rein in the subjective elements that are necessarily present in due-process judicial review." *Id.* at 722. As outlined below, this Nation's history and tradition of protecting the individual's right to privacy and bodily integrity and of safeguarding the integrity of the physician-patient relationship demonstrate that the right claimed by the Members is "fundamental" within the meaning of the Due Process Clause.

A. The right to bodily integrity and to be free of pain.

The Members' asserted fundamental right has deep roots in our Nation's history and legal tradition of permitting decisions about one's body to be made free from governmental intervention. The right articulated by the Members is concomitant with the established rights to bodily integrity and to be free of pain.

The right to be free of government intrusion with respect to one's body has roots in natural law principles and the philosophy of individual autonomy. *See* Mill, *On Liberty*, 60-69 (Penguin Books 1985) (1859) (concluding that "[o]ver himself, over his own body and mind, the individual is sovereign"). United States legal precedent in the past century has consistently upheld legal protection for this individual right.[9] In fact, the origin of this precedent in the

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[8] In *Washington v. Glucksberg*, the Court considered whether the State of Washington's prohibition against physician-assisted suicide violated substantive due process guarantees. In concluding that it did not, the Court reviewed the 700-year history of suicide and assisted suicide under the Anglo-American common law tradition. 521 U.S. at 711. In addition, the Court considered that, "[t]hough deeply rooted, the States' assisted-suicide bans ha[d] in recent years been reexamined and, generally, affirmed." *Id.* at 716.

[9] *See, e.g., Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 281 (1990) (finding that the Due Process Clause

(footnote continued)

Anglo-American legal tradition pre-dates our own decisions by at least two hundred years.[10] The legal tradition traces its ultimate roots at least to the early thirteenth century: under the 39th Article of the Magna Carta, a citizen could not be deprived of the right of personal security "except by the legal judgment of his peers or by the law of the land." Perry & Cooper, *Sources of Our Liberties*, 17 (1959).

The right to be free of pain likewise finds its source in both legal precedent and important traditions of this Nation. Outside of the legal context, this right is embedded in the professional and ethical standards of physicians and other

protects an interest in life as well as an interest in refusing life-sustaining medical treatment); *Winston v. Lee*, 470 U.S. 753, 766 (1985) (finding involuntary surgery to remove bullets from defendant's shoulder unreasonable invasion of his body); *Ingraham v. Wright*, 430 U.S. 651, 673-74 (1977) ("The liberty preserved from deprivation without due process include[s] . . . a right to be free from and to obtain judicial relief, for unjustified intrusions on personal security. . . . [This] encompass[es] freedom from bodily restraint and punishment"); *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (stating in the context of prisoners' rights that "denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. . . . The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation."); *Rochin v. California*, 342 U.S. 165, 172 (1952) (finding an unconstitutional violation of bodily integrity when police took defendant to hospital and administered an emetic to recover pill swallowed upon arrest); *Schloendorff v. Soc'y of N.Y. Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (stating in a case involving the patient's claim that her doctor had removed a tumor without her consent, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.").

[10] Blackstone recognized a 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." 1 Blackstone, *Commentaries* *130 (1765). Blackstone extended prosecution to the "preservation of a man's health from such practices as may prejudice or annoy it." *Id.* at *134.

caregivers. Allowing a patient to experience unnecessary pain and suffering of any form is considered substandard medical practice, regardless of the nature of the patient's condition or the goals of medical intervention.[11] Likewise, physicians have a moral and ethical duty to provide relief from pain and suffering.[12] This standard has in fact been recognized since the inception of medical ethics in western

[11] *See, e.g.*, Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 Wm. Mitchell L.Rev. 1, 4 (2000).

[12] *See, e.g.*, Post et al., *Pain: Ethics, Culture, and Informed Consent to Relief*, 24 J. Law, Med. & Ethics 348 (1996) ("[O]ne 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's duty of care includes palliation. Moreover, the centrality of this obligation is both unquestioned and universal, transcending time and cultural boundaries."); Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New England J. Med. 844 (1989) (concluding that "[t]o allow a patient to experience unbearable pain or suffering is unethical medical practice. . . . The physician should follow these principles without exaggerated concern for legal consequences, doing whatever is necessary to relieve pain and bring comfort, . . . [and t]o withhold any necessary measure of pain relief in a hopelessly ill person out of fear of depressing respiration or of possible legal repercussions is unjustifiable.").

culture,[13] and its underpinnings in contemporary thought derive from many varied and different sources.[14]

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[13] *See, e.g.*, Amundsen, *Medicine, Society, and Faith in the Ancient and Medieval Worlds*, 33 (1996) ("The treatise entitled *The Art* in the Hippocratic Corpus defines medicine as having three roles: doing away with the sufferings of the sick, lessening the violence of their diseases, and refusing to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless"); Cassell, *The Nature of Suffering and the Goals of Medicine*, 306 New England J. Med. 639 (1982) ("[T]he obligation of physicians to relieve human suffering stretches back into antiquity.").

[14] Members of the American Society of Law, Medicine and Ethics, for example, argue that this standard is based on tenets of professionalism:

> Principled analyses of the doctor-patient relationship suggest that it is the dual obligation of physicians to respect and promote the autonomy of their patients and to protect and enhance their well-being . . . [which includes] relief of pain and suffering. . . . . [W]e submit that providing relief from pain is central to the very notion of healing and, for that reason alone, it requires no exceptions or intellectual artifice for its validity.

Post et al., *supra*, 24 J. Law, Med. & Ethics at 349, 358.

Others, such as the mid-1980s philosopher Rem Edwards, assert that the medical standard is dictated by ethics: "there is a broadly based humanistic ethics which applies to the domain of medical care which gives patients a strong *prima facie* right to freedom from unnecessary pain, . . . [and] there is the duty to do all that can be done within the limits of current medical knowledge and available resources to relieve all the pain and suffering which can be alleviated. . . . [T]hese rights and duties . . . can be derived in one way or another from almost every major philosophical theory of ethics available to us. In that sense they are broadly justified." Edwards, *Pain and the Ethics of Pain Management*, 18 Soc. Sci. Med. 515, 517 (1984) (emphasis added); *accord*, Morris, *The Culture of Pain*, 191 (1991) (observing that "*not* relieving pain brushes dangerously close to the act of willfully inflicting it" (original emphasis)).

(footnote continued)

The decisions of this Court and the arguments of the government itself in other, related contexts are in accord with the standards that inform medical practice. A majority of this Court in *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992); *Hudson v. McMillian*, 503 U.S. 1, 9-10 (1992); *Ingraham v. Wright*, 430 U.S. at 673-74, assumed the existence of a fundamental right of a seriously ill patient to be free from unnecessary pain and suffering.

In the United States' *amicus* brief for the petitioners in *Washington v. Glucksberg*, 521 U.S. 702, the Solicitor General cited these decisions to assert that the infliction of severe pain or suffering on an individual implicates a fundamental liberty interest:

> A competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case. That liberty interest encompasses an interest in avoiding not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic

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In fact, the duty of physicians to help patients to be free from pain ultimately implicates the Judeo-Christian religious tradition and encompasses recognition of the role that narcotics may play in achieving this end. For example, at a convention of Catholic physicians in 1957, the Pope responded to a series of questions directed at an individual's right to be free of pain and acknowledged the role of narcotics in safeguarding this right. The Pope stated that "[t]he patient desiring to avoid or relieve pain can in good conscience use those means discovered by science which, in themselves, are not immoral" (Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia*, 129 (Human Sci. Press 1977) (1975)) and announced that "if . . . the administration of narcotics, itself lead [sic] to two distinct effects, one the relief of pain and the other the shortening of life, it is lawful." *Euthanasia: Recent Declarations of Popes and Bishops*, Life Ethics Centre, Christian Pamphlet No. 3, 8-9 (Alphonse de Valk, C.S.B., ed. 1983).

> bodily or mental functions in the terminal stage of an illness.

Brief for the United States as *Amici Curiae* Supporting Petitioners, *available in* 1996 WL 663185, at *8, 12-13 (1996), in *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).[15]

The right to be free from severe pain and suffering is thus a fundamental liberty interest that is central to the Nation's history and traditions.[16] For these reasons, the government cannot, consistent with the Due Process Clause, abridge the rights of seriously ill patients by preventing or deterring their physicians from recommending controlled substances in kind and quantity sufficient to relieve their pain.[17]

B. The sanctity of the physician-patient relationship.

The right to consult with one's doctor about one's medical condition also is recognized as a fundamental right deeply rooted in our history and legal tradition. The right asserted by the Members—to prevent governmental

[15] In its *amicus* brief, the United States also argued that a state cannot prevent a person in extreme pain from obtaining medication demonstrated to be safe and effective in relieving that pain (*see id.* 1996 WL 663185 at *13) and listed loss of appetite and nausea as conditions of a terminally ill person that would trigger this liberty interest. *See id.* at *15-16. Solicitor General Dellinger reiterated the existence of this fundamental liberty interest in oral argument. Transcript of Oral Argument, *Washington v. Glucksberg*, 521 U.S. 702 (No. 96-110), *available in* 1997 WL 13671, at *18, *20-21 (Jan. 8, 1997).

[16] *Cf. Vacco v. Quill*, 521 U.S. 793, 807 n.11 (1997) (stating that "[j]ust as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death").

[17] *See also* Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 Minn. L. Rev. 923, 936 (1998).

interference with their ability to act on their doctors' treatment recommendations—is based in significant part on imperatives established by the doctor-patient relationship. For this reason as well, the Members' claimed right must be accorded constitutional status.

The Court has acknowledged the sanctity of the physician-patient relationship in numerous substantive due process cases. It was first noted in *Griswold v. Connecticut*, 381 U.S. 479 (1965). There, doctors from Planned Parenthood violated a Connecticut law making it a crime to distribute contraceptives. *Id.* at 480. In finding that the criminalization of contraception violated a right guaranteed by due process, the Court relied on the fact that "[t]his law operates directly on an intimate relation of husband and wife and their physician's role in one aspect of that relation." *Id.* at 482.

The importance of the physician-patient relationship also has been stressed in the abortion cases. For example, in *Roe v. Wade*, 410 U.S. 113 (1973), the Court emphasized that myriad and fundamental privacy and personal liberty interests, such as medical, physical, social, and spiritual choice, were impugned by the criminalization of abortion. *Id* at 153. The *Roe* decision also stressed that such a violation of privacy interests, although personal to the woman, detrimentally affected the physician-patient relationship. *Id.* at 153, 156.[18]

More recently, in *Washington v. Glucksberg*, the Court observed that the State also has an interest in protecting the

[18] The abortion cases also note the importance of medical consultation to the exercise of fundamental rights. *See Roe*, 410 U.S. at 164; *Casey*, 505 U.S. at 879, 883-84; *Stenberg v. Carhart*, 530 U.S. 914, ___, 120 S.Ct. 2597, 2618 (2000) (O'Connor J., concurring) (stating that, "As we held in *Casey*, . . . any such regulation or proscription [of abortion] must contain an exception for instances 'where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'").

integrity and ethics of the medical profession. 521 U.S. at 731. The Court found that, in this regard, "physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming." *Id.*

Likewise, in his concurrence in *Washington v. Glucksberg*, Justice Souter relied upon the view that medical assistance may fall within the penumbra of a cognizable liberty interest: "[w]ithout physician assistance in abortion, the woman's right would have too often amounted to nothing more than a right to self-mutilation." 521 U.S. at 778. Justice Souter also affirmed the strong tradition of comprehensive medical care in our society:

> [T]he Court recognized that the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more that treat symptoms, one who ministers to the patient.

Id. at 779.[19]

The importance of the physician-patient relationship is further demonstrated by the existence of state legislation granting a statutory physician-patient privilege. Currently, forty-one states recognize some form of a physician-patient

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[19] In his concurrence in *Washington v. Glucksberg*, 521 U.S. 702, Justice Stevens also emphasized the intimate nature of the doctor-patient relationship:

> For doctors who have longstanding relationships with their patients, who have given their patients advice on alternative treatments, who are attentive to their patient's individual needs, and who are knowledgeable about pain symptom management and palliative care options, [] heeding a patient's desire to assist in her suicide would not serve to harm the physician-patient relationship.

Id. at 748.

testimonial privilege. *See* Appendix A. Moreover, many of the statutory privileges are very old. New York was the first state to pass a physician-patient testimonial privilege in 1828, with Missouri following suit in 1835. *See* 8 Wigmore on Evidence, § 2380 (rev. ed. 1961). Though physician-patient communication is "subject to reasonable licensing and regulation by the State" (*Casey*, 505 U.S. at 884), when such regulation defeats the purpose of the physician-patient relationship by preventing the physician from fulfilling his or her duties, such regulation is impermissible. *See, e.g., Conant v. McCaffrey*, 172 F.R.D. 681, 694-95 (N.D. Cal. 1997) (holding that government's statutory authority to regulate distribution and possession of drugs did not allow government to quash protected speech between physician and patient).

In this case, the interests arising within the physician-patient relationships are of the highest order. Recognition of the medical necessity defense to prevent governmental interdiction of the Members' personal, self-funded decisions to use medicinal cannabis as recommended by their doctors will safeguard the physician-patient relationships. Moreover, unless unfettered communication and the freedom to act on one's physician's advice are guaranteed by the Due Process Clause in this context, the related fundamental rights of bodily integrity and freedom from pain and suffering will be rendered nugatory.

II. The Members' Fundamental Right Is Different From The Rights Asserted In *Carnohan* And *Rutherford*, Which Therefore Have No Application Here.

The government argues that the right the Members assert here cannot exist because courts have held that there is no fundamental right to use an unapproved drug for medical treatment. *See* Brf. at 25, fn.14 (*citing Carnohan v. United States*, 616 F.2d at 1122; *Rutherford v. United States*, 616 F.2d at 457; and other cases). The government's argument is incorrect.

The cases invoked by the government have no application here. None involved the fundamental right articulated by the Members. Moreover, in all of them, it was the proponents of the asserted constitutional rights, not the government, who sought affirmative, coercive relief. The decision in *Rutherford* in fact confirms that the right to decide whether or not to have effective medical treatment at all is in fact fundamental. *Id.*

In *Carnohan*, for example, the plaintiff brought a declaratory action "to secure the right to obtain and use laetrile in a nutritional program for the prevention of cancer." 616 F.2d at 1121. The relief sought (a declaration that laetrile was not a "new drug" within the meaning of the Federal Food, Drug and Cosmetic Act) fell squarely within the rule-making authority of the Food and Drug Administration (the "FDA"). *Id.* Specifically, the claim in *Carnohan* was that the "state and federal regulatory schemes that require [filing a new drug application] are so burdensome when applied to private individuals as to infringe upon constitutional rights." *Id.* at 1122.

The court of appeals rejected this claim, finding that the plaintiff was required to exhaust his administrative remedies to seek reclassification of the drug laetrile by filing a new drug application with the FDA. *Id.* The appellate court, however, expressly declined to consider whether the plaintiff had "a constitutional right to treat himself with home remedies of his own confection." *Id.*

Unlike *Carnohan*, the Members here do not seek reclassification of any drug or seek to compel the government affirmatively to give them access to any medication. The Members simply assert the right to be free of governmental interference with their obtaining and using, upon their personal physicians' recommendations in accordance with California's Compassionate Use Act, the only medication that has been demonstrated to be effective in alleviating their pain and suffering. These key facts are absent in *Carnohan*.

The government also relies on *Rutherford v. United States*, 616 F.2d 455, another laetrile case. *Rutherford* held that "*the decision by the patient whether to have a treatment or not is a protected right* but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health." *Id.* at 457 (emphasis added). There is no indication that the plaintiffs in *Rutherford* attempted to establish that the drug at issue represented the *only* effective treatment for them. Instead, they simply sought to have a particular *type* of treatment declared to be a fundamental right.

This is a critical distinction. Here, the Members and their doctors have declared that cannabis is the only effective treatment for them. Hence, to permit the government to interfere with the Members' use of cannabis is to deny them the right recognized by *Rutherford*: the right to decide whether or not to have medical treatment. Because cannabis is the *only* effective treatment for the Members, to deny them the right to use cannabis is to deny them any medical treatment at all. Cannabis is not simply the "medication of choice," it is the only medication for the Members.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

APPENDIX A

United States Jurisdictions With a Statutory Physician-Patient Testimonial Privilege

State	Code #
Alaska	Alaska R. Evid. 504
Arizona	Ariz. Rev. Stat. § 12-2235
Arkansas	Ark. R. Evid. 503
California	Cal. Evid. Code §§ 990-1007
Colorado	Col. Rev. Stat. § 13-90-107
Delaware	Del. R. Evid. 503
District of Columbia	D.C. Code Ann. § 14 –307
Hawaii	Haw. Rev. Stat. § 504
Idaho	Idaho Code § 9-203
Illinois	735 Ill. Comp. Stat. 5/8-802
Indiana	Ind. Code § 34-46-3-1
Iowa	Iowa Code § 622.10
Kansas	Kan. Stat. Ann. § 60-427
Louisiana	La. Code. Evid. Art. 510
Maine	Me. R. Rev. 503
Michigan	Mich. Stat. Ann. § 600.2157
Minnesota	Minn. Stat. § 595.02
Mississippi	Miss. Code Ann. § 13-1-21
Missouri	Mo. Rev. Stat. § 491.060
Montana	Mont. Code. Ann. § 26-1-805
Nebraska	Neb. Rev. Stat. § 27-504

State	Code #
Nevada	Nev. Rev. Stat. Ann. § 49.225
New Hampshire	N.H. Rev. Stat. Ann. § 329:26
New Jersey	N.J. Stat. Ann. § 2A:84A-22.2
New Mexico	N.M. R. Evid. 11-504
New York	N.Y. Civ. Prac. L. & R. § 4504
North Carolina	N.C. Gen. Stat. § 8-53
North Dakota	N.D. R. Evid. 503
Ohio	Ohio Rev. Code. § 2317.02
Oklahoma	Okla Stat. § 2503
Oregon	Or. Rev. Stat. § 40.235
Pennsylvania	42 Pa. Code § 5929
Rhode Island	R.I. Gen. Laws §5-37.3-6.1
South Dakota	S.D. Codified Laws § 19-13-7
Texas	Tex. R. Evid. 509
Utah	Utah R. Evid. 506
Vermont	Vt. Stat. Ann. §1612
Virginia	Va. Code Ann. § 8.01-399
Washington	Wash. Rev. Code § 5.60.060
Wisconsin	Wis. Stat. § 905.04
Wyoming	Wyo. Stat. Ann. § 1-12-101