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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DR. MARCUS CONANT, et al.,

No. C 97-00139 WHA

Plaintiffs,

v.

BARRY R. MCCAFFREY, et al.,

Defendants.

**ORDER GRANTING IN PART  
AND DENYING IN PART  
CROSS-MOTIONS FOR  
SUMMARY JUDGMENT; DISSOLVING  
PRELIMINARY INJUNCTION;  
ENTERING PERMANENT  
INJUNCTION**

**INTRODUCTION**

This class action challenges the lawfulness of the federal government’s policy to punish physicians who “recommend” marijuana to patients. The parties have filed cross-motions for summary judgment both as to justiciability and the merits. This order holds that the relevant federal statute does not authorize the government to revoke a physician’s license to dispense controlled substances merely because a physician “recommends” marijuana as a therapy to a patient. Any contrary holding would raise severe First Amendment doubts.

**STATEMENT**

**1. The Compassionate Use Act**

On November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, also known as the Medical Marijuana Initiative, adding Section 11362.5 to California’s Health and Safety Code. The law took effect at 12:01 a.m., on

1 Wednesday, November 6, 1996. The Compassionate Use Act provides, in relevant part, that:

2 seriously ill Californians have the right to obtain and use marijuana for  
3 medical purposes where that medical use is deemed appropriate and  
4 has been recommended by a physician who has determined that the  
5 person’s health would benefit from the use of marijuana in the  
6 treatment of cancer, anorexia, AIDS, chronic pain, spasticity,  
7 glaucoma, arthritis, migraine, or any other illness for which marijuana  
8 provides relief.

9 Cal. Health & Safety Code § 11362.5(a) (West 2000). The Compassionate Use Act specifically  
10 protects physicians who recommend medical marijuana: “[No] physician in this state shall be  
11 punished, or denied any right or privilege, for having recommended marijuana to a patient for medical  
12 purposes.”

13 **2. Federal Regulation of Controlled Substances**

14 The Controlled Substances Act, 21 U.S.C. 801, et seq., established a comprehensive  
15 regulatory scheme governing the manufacture and distribution of dangerous drugs. The Controlled  
16 Substances Act classifies these drugs in one of five “Schedules,” depending upon such factors as  
17 potential for abuse, the extent to which they lead to psychological or physical dependence, whether  
18 there is an accepted level of safety for their use under medical supervision, and whether they have a  
19 currently accepted medical use in the United States.

20 Schedule I controlled substances are subject to the most strict regulation because the federal  
21 government has determined that they have a “high potential for abuse,” “no currently accepted medical  
22 use in treatment in the United States,” and a “lack of accepted safety” for “use under medical  
23 supervision.” 21 U.S.C. 812(b)(1). The Controlled Substances Act prohibits physicians from  
24 prescribing Schedule I drugs. Schedule I drugs may be dispensed in the United States only through  
25 strictly-controlled, federally-approved research programs. Marijuana is classified as a Schedule I  
26 drug.

27 Drugs in Schedules II through V may be prescribed. The federal government has determined  
28 both that they have some currently accepted medical uses in treatment in the United States and that  
29 they are safe for use under medical supervision. *Id.*, §§ 812(b)(2)-(5). A Schedule I drug may be  
30 reclassified only if the Food and Drug Administration approves a new drug application. The FDA has  
31 not done so for marijuana (Joint Stmt. Undisputed Facts ¶ 21).

1 In order to prescribe any controlled substances, a physician first must obtain a registration  
2 from the Attorney General (hereinafter “DEA registration”). The Controlled Substances Act confers  
3 authority on the Attorney General not only to grant registrations, but also to deny or revoke a  
4 physician’s DEA registration if the physician “has committed such acts as would render his registration  
5 under section 823 of this title inconsistent with the public interest . . . .” 21 U.S.C. 824(a)(4). The  
6 Attorney General has delegated this authority to the Administrator of the Drug Enforcement Agency.  
7 28 C.F.R. 0.100(b).

8 **3. The Federal Government’s Response to the Compassionate Use Act**

9 On December 30, 1996, less than two months after the Compassionate Use Act took effect,  
10 the Director of the Office of National Drug Control Policy<sup>1</sup> issued “The Administration’s Response to  
11 the Passage of California Proposition 215 and Arizona Proposition 200” (hereinafter the  
12 “Administration’s Response”) (Joint Stmt. Undisputed Facts ¶ 3). The Administration’s Response  
13 stated “that a practitioner’s action of recommending or prescribing Schedule I controlled substances is  
14 not consistent with the ‘public interest’ (as that phrase is used in the federal Controlled Substances  
15 Act), and will lead to administrative action by the Drug Enforcement Administration to revoke the  
16 practitioner’s registration” (*id.* at ¶ 4). The Administration’s Response focused on the term  
17 “recommend” in response to that term’s inclusion in the Compassionate Use Act (*id.* at ¶ 8).

18 The Administration’s Response stated that the Department of Justice and the Department of  
19 Health and Human Services would send a letter to national, state, and local practitioner associations  
20 and licensing boards, stating unequivocally that the DEA would seek to revoke the registrations of  
21 physicians who recommended or prescribed Schedule I controlled substances. The letter, according  
22 to the Administration’s Response, would also outline the authority of the Inspector General for HHS to  
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26 <sup>1</sup> The Office of National Drug Control Policy and the Drug Enforcement Agency are related but distinct  
27 federal entities. The ONDCP establishes policies, priorities, and objectives for the nation’s drug control  
28 program, the goals of which are to reduce illicit drug use, manufacturing and trafficking; drug-related crime and  
violence; and drug-related health consequences. To achieve these goals, the Director produces the National  
Drug Control Strategy, which directs the nation’s anti-drug efforts and establishes a program, a budget, and  
guidelines for cooperation among federal, state, and local entities. 21 U.S.C. § 1701, et seq. The Drug  
Enforcement Agency, on the other hand, is charged with enforcing federal drug laws. Among its other powers,  
the DEA may grant, deny, or revoke registrations under the Controlled Substances Act.

1 exclude specified individuals or entities from participation in the Medicare and Medicaid programs (*id.*  
2 at ¶ 5).

3 The Administration’s Response stated that the Department of Justice would “continue existing  
4 enforcement programs,” and specified the criteria that would be used by the five United States  
5 Attorneys in Arizona and California to “review cases for prosecution,” the Administration’s Response  
6 stated. Those criteria were described as follows:

- 7 (a) the absence of a bona fide doctor-patient relationship; (b) a high  
8 volume of prescriptions or recommendations of Schedule I controlled  
9 substances; (c) the accumulation of significant profits or assets from  
10 the prescription or recommendation of Schedule I controlled  
11 substances; (d) Schedule I controlled substances being provided to  
12 minors; and/or (e) special circumstances, such as when death or  
13 serious bodily injury results from drugged driving.

14 On February 27, 1997, the Department of Justice and the Department of Health and Human  
15 Services sent a letter to national, state and local practitioner associations to clarify the government’s  
16 position (*id.* at ¶ 7). That letter, the so-called Medical Leader Letter, assured, among other things,  
17 that “nothing in federal law prevents a physician, in the context of a legitimate physician-patient  
18 relationship, from merely discussing with a patient the risks and alleged benefits of the use of marijuana  
19 to relieve pain or alleviate symptoms.” At the same time, the letter stated that physicians “may not  
20 intentionally provide their patients with oral or written statements in order to enable them to obtain  
21 controlled substances in violation of federal law” (*ibid.*).

22 Dr. Robert Mastroianni, a physician in Pollock Pines, California, was interviewed on or about  
23 January 27, 1997, by a DEA agent (*id.* at ¶ 20). The agent presented Dr. Mastroianni with a copy of  
24 a written marijuana recommendation which allegedly had been created by Dr. Mastroianni. The agent  
25 asked questions about Dr. Mastroianni’s medical practices, his recommendations of marijuana, and his  
26 familiarity with research on the medical efficacy of marijuana. The agent also requested to review Dr.  
27 Mastroianni’s prescription records at a local pharmacy (*ibid.*).

#### 28 **4. The Plaintiffs**

The plaintiff class is defined by stipulation and order as follows:

- (1) All licensed physicians practicing in the State of California who  
treat patients suffering from severe nausea (commonly associated with  
HIV/AIDS and cancer), wasting syndrome or anorexia (commonly  
associated with HIV/AIDS), increased intraocular pressure

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(commonly associated with glaucoma), seizures or muscle spasms associated with a chronic, debilitating condition (commonly associated with epilepsy, multiple sclerosis, and paraplegia/quadriplegia/hemiplegia), and/or severe, chronic pain (commonly associated with paraplegia/quadriplegia/hemiplegia, HIV/AIDS, metastasized cancers, and cervical disk disease), and who, in the context of a bona fide physician-patient relationship, discuss, approve, or recommend the medical use of marijuana for these patients based on the physician’s best medical judgment; and

(2) All patients in the State of California suffering from severe nausea (commonly associated with HIV/AIDS and cancer), wasting syndrome or anorexia (commonly associated with HIV/AIDS), increased intraocular pressure (commonly associated with glaucoma), seizures or muscle spasms associated with a chronic, debilitating condition (commonly associated with epilepsy, multiple sclerosis, and paraplegia/quadriplegia/hemiplegia), and/or severe, chronic pain (commonly associated with paraplegia/quadriplegia/hemiplegia, HIV/AIDS, metastasized cancers, and cervical disk disease), who, in the context of a bona fide physician-patient relationship, communicate with their physicians about the medical use of marijuana.

The named plaintiffs in this action include ten physicians, a physicians’ organization, six patients with terminal illnesses, and an organization comprised of people with AIDS. They are Dr. Marcus Conant, Dr. Donald Northfelt, Dr. Arnold Leff, Dr. Debasish Tripathy, Dr. Neil Flynn, Dr. Stephen Follansbee, Dr. Robert Scott, III, Dr. Stephen O’Brien, Dr. Milton Estes, Dr. Howard Maccabee, Dr. Allan Joseph Flach, Bay Area Physicians for Human Rights, Keith Vines, Judith Cushner, Valerie Corral, Dan Kane, Michael Ferrucci, and Being Alive: People with HIV/AIDS Action Coalition, Inc. Plaintiff Jo Daily, a victim of cancer, died after this suit was filed. In a declaration she submitted in support of plaintiffs’ request for a preliminary injunction, she requested that her name be left on the complaint should she not outlive this case.

Dr. Marcus Conant, to take an example of the physician plaintiffs, has practiced medicine in San Francisco for over thirty years (Conant Decl. ¶ 1). Dr. Conant is the Medical Director of the Conant Medical Group, a large private AIDS practice. He is a Professor at the University of California medical center in San Francisco and is the author or co-author of over seventy publications on treatment of AIDS (*id.* at ¶ 5). He and his colleagues provide primary care for over 5,000 HIV infected patients, including approximately 2,000 patients with active AIDS (*id.* at ¶ 1).

1 In his AIDS practice, Dr. Conant prescribes aggressive treatments combining several different  
2 drugs that are recently emerging as the first effective treatment for AIDS (*id.* at ¶ 10). Dr. Conant has  
3 found, however, that these drugs often cause severe nausea and vomiting, a particular worry when the  
4 patient is suffering from AIDS wasting syndrome, which causes a steady, uncontrolled weight loss.  
5 For many patients, traditional anti-nausea drugs and appetite stimulants are effective. Dr. Conant  
6 believes, however, that for some patients medical marijuana proves to be the best if not the only  
7 viable, treatment option. Prior to the Administration’s Response, he recommended marijuana to some  
8 patients (*ibid.*). In reaction to the Administration’s Response, Dr. Conant limited his conversations  
9 with patients, curtailing information regarding the risks and benefits of medical marijuana (*id.* at ¶¶ 16  
10 17). He directed his staff likewise to curtail their discussions with patients (*ibid.*).

11 Keith Vines is an AIDS patient who credits medical marijuana with helping to save his life  
12 (Vines Decl. ¶ 4). He has been HIV positive since 1983, and by 1990 his health began to deteriorate  
13 (*id.* at ¶ 7). In 1993, he was diagnosed with AIDS wasting syndrome. He lost more than forty  
14 pounds of lean body mass. His bones became brittle and his joints, for lack of nourishment, ached  
15 (*ibid.*). Mr. Vines was prescribed a series of medications to help fight his disease, including ddI, AZT,  
16 d4T, 3TC, Saquinavir, Crixavan, Septra and Acyclovir. Many of these medications suppressed his  
17 appetite (*id.* at ¶ 8).

18 Not only did Mr. Vines need food to stave off AIDS wasting syndrome, but his experimental  
19 growth-hormone therapy required that he eat regularly (*id.* at ¶ 9). His doctors told him it was  
20 essential that he eat three full meals a day for this treatment to be effective (*id.* at ¶ 11). To stimulate  
21 his appetite, one of his physicians prescribed Marinol, a synthetic derivative of THC, which is one of  
22 the primary active ingredients of marijuana (*id.* at ¶ 12). He found that he could not tolerate the side  
23 effects, though he tried to endure them despite only a small gain in appetite. A single Marinol capsule  
24 could make him feel “stoned” for several hours such that he could not function competently. Other  
25 times the Marinol put him to sleep. The side effects affected his performance as an assistant district  
26 attorney (*ibid.*).

27 When Mr. Vines informed his doctors that he could no longer tolerate the Marinol, two of  
28 them suggested that he try marijuana (*id.* at ¶ 13). They told him that they had observed that for many

1 AIDS patients, smoking marijuana stimulated appetite better than Marinol, and did so without many of  
2 the side effects (*ibid.*). Mindful of his career in law enforcement, Mr. Vines was reluctant to use  
3 marijuana because it was illegal (*id.* at ¶ 14). Nevertheless, he obtained a small amount from a  
4 cannabis buyers' club and tried it (*ibid.*). He found that he needed very little for his appetite to return  
5 (*id.* at ¶ 15). The beneficial effect took place within minutes rather than the hours he sometimes  
6 waited after swallowing a Marinol capsule. Because he needed so little marijuana, he did not need to  
7 get stoned in order to eat (*ibid.*).

8 Mr. Vines believes that the government's threats jeopardize his relationships with his doctors  
9 (*id.* at ¶ 18). He believes the policy hinders him from receiving the best and most reliable medical  
10 advice (*ibid.*). Like Mr. Vines, many patients depend upon discussions with their physicians as their  
11 primary or only source of sound medical advice and information (Joint Stmt. Undisputed Facts ¶ 17).

## 12 5. The Reaction to the Government's Statements

13 All of the physician plaintiffs believe that their discussion and recommendation of medical use  
14 of marijuana is appropriate or potentially appropriate for some of their patients (*id.* at ¶ 1). Prior to  
15 the Administration's Response, Drs. Tripathy, Maccabee, Conant, Estes, Flynn, Leff, Scott, O'Brien,  
16 Follansbee, Brody, and Stalcup had discussed with and recommended to certain of their patients the  
17 medical use of marijuana (*id.* at ¶ 10).

18 After the Administration's Response, numerous California physicians contacted their  
19 professional organizations seeking guidance and clarification regarding its meaning (*id.* at ¶ 6). Drs.  
20 Estes, Follansbee, Scott, O'Brien, Maccabee, Tripathy, Conant, and Flynn self-censored their  
21 conversations with patients by withholding information, recommendations or advice regarding use of  
22 medical marijuana (*id.* at ¶ 11). Drs. Flynn, Conant and O'Brien omitted medically relevant  
23 information from some patient medical records (*id.* at ¶ 12).<sup>2</sup>

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26 <sup>2</sup> As a normal part of medical practice, physicians record their diagnoses and recommendations, and  
27 their patients' reactions to such diagnoses and recommendations, on patients' individual medical charts, as is  
28 required by California Business & Professions Code Sections 2234, 2266 (*id.* at ¶ 18). The parties agree that  
accurate charts are necessary to provide sound medical care to the patient in the future, either by the same  
physician or by a different physician, and the failure to accurately chart a patient's care could jeopardize the  
patient's life and health (*id.* at ¶ 19).

1 Drs. Estes, Follansbee, Scott, O'Brien, Maccabee, Tripathy, Conant, and Flynn subjectively  
2 fear that they will be prosecuted or lose their DEA registrations to dispense controlled substances if  
3 they engage in any discussion of medical marijuana, and/or that they will be prosecuted if they  
4 recommend a patient's medical use of marijuana (*id.* at ¶ 14). Drs. Estes, Follansbee, Scott, O'Brien,  
5 Maccabee, Tripathy, Conant, and Flynn continue to fear prosecution and loss of their DEA  
6 registrations, even after this Court entered a preliminary injunction in April 1997, the scope of which  
7 described below (*id.* at ¶ 15).

8 Significantly, the government concedes that in reaction to the Administration's Response, a  
9 reasonable physician would have a genuine fear of losing his or her DEA registration to dispense  
10 controlled substances if that physician were to recommend marijuana to his or her patients (*id.* at ¶  
11 13).

## 12 6. The Procedural History

13 The named plaintiffs filed this suit on January 14, 1997, against the following federal officials  
14 their official capacities: Barry McCaffrey as the Director of the United States Office of National Drug  
15 Control Policy; Thomas Constantine as the Administrator of the United States Drug Enforcement  
16 Administration; Janet Reno as the Attorney General of the United States; and Donna Shalala as the  
17 Secretary of Health and Human Services. Plaintiffs sought a preliminary and permanent injunction  
18 enjoining the government from enforcing or threatening to enforce any federal statute, regulation or  
19 other provision of law in a manner that would punish or penalize California physicians for  
20 communicating with their patients in the context of a bona fide physician-patient relationship regarding  
21 potential risks and benefits of medical use of marijuana. Plaintiffs further sought a declaration that the  
22 government's threats to enforce federal provisions of law in a manner that would punish or penalize  
23 physicians for communicating with their patients, using their best medical judgment in the context of a  
24 bona fide physician-patient relationship, regarding potential risks and benefits of medical use of  
25 marijuana violate the First Amendment on their face. Their initial complaint only leveled a facial  
26 challenge, not an as-applied challenge.

27 The case was first assigned to the Honorable Fern M. Smith, who issued a preliminary  
28 injunction and denied the government's motion to dismiss on April 30, 1997. *Conant v. McCaffrey*,

1 172 F.R.D. 681 (N.D. Cal. 1997). The preliminary injunction provided that the government could  
2 “only prosecute physicians who recommend medical marijuana to their patients if the physicians are  
3 liable for aiding and abetting or conspiracy” under 18 U.S.C. 2 or 21 U.S.C. 846. *Id.* at 700. The  
4 preliminary injunction also prohibited the government from taking administrative action against  
5 physicians “for recommending marijuana unless the government in good faith believes that it has  
6 substantial evidence” of aiding and abetting or conspiracy under 18 U.S.C. 2 or 21 U.S.C. 846. *Id.* at  
7 701. Finding the controversy ripe for review, Judge Smith denied the government’s motion to dismiss.  
8 The government did not appeal the preliminary injunction.

9 Along with issuing the preliminary injunction, Judge Smith certified a class of physicians,  
10 patients and organizations. On August 6, 1997, plaintiffs amended their complaint to include an as-  
11 applied challenge to the Administration’s Response. Two years later, in August 1999, this case was  
12 reassigned to the undersigned. On May 25, 2000, the Court granted plaintiffs’ motion to modify the  
13 class. The current class definition is stated above. Now before the Court are cross-motions for  
14 summary judgment.

### 15 ANALYSIS

16 Federal Rule of Civil Procedure 56(c) provides that a party shall be entitled to summary  
17 judgment “if the pleadings, depositions, answers to interrogatories, and admissions on file, together  
18 with the affidavits, if any, show that there is no genuine issue as to any material fact and that the movi  
19 party is entitled to a judgment as a matter of law.” In this case, the parties have stipulated to the  
20 material facts; what remains for the Court is to resolve the issues of law.

21 This case presents three central legal issues: (1) whether the case is justiciable; (2) whether  
22 the government’s policy exceeds the authority of the Controlled Substances Act; and (3) whether the  
23 government’s policy violates plaintiffs’ First Amendment rights. As discussed below, the Court holds  
24 that plaintiffs’ challenges to the government’s DEA de-registration policy is justiciable but their  
25 challenges to the government’s policies on criminal prosecutions and Medicare/Medicaid participation  
26 are not. The DEA de-registration policy exceeds the scope of the Controlled Substances Act because  
27 it raises grave constitutional doubts. Although the Court engages in a First Amendment analysis to  
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1 show serious constitutional doubts, the Court need not hold that the policy in fact violates the  
2 First Amendment. It is sufficient to hold that the policy lacks statutory authority.

3 **1. Justiciability**

4 Judge Smith examined justiciability at the preliminary injunction stage. At the summary  
5 judgment stage, however, Judge Smith’s findings are not strictly law of the case. Also, the  
6 circumstances have changed. Specifically, plaintiffs added an as-applied challenge to their complaint,  
7 the government has not criminally prosecuted any physician in the interim years, and the Ninth Circuit  
8 issued an *en banc* opinion on the justiciability of pre-enforcement challenges to statutes based on First  
9 Amendment grounds. *See Thomas v. Anchorage Equal Rights Comm’n*, Nos. 97-35220, 97-  
10 35221, 2000 WL 1069977 (9th Cir. Aug. 4, 2000). Guided by Judge Smith’s analysis, but taking  
11 into account these changes, the Court holds that plaintiffs’ challenge to the government’s interpretation  
12 of the Controlled Substances Act regarding revocation of DEA registrations is justiciable but that the  
13 criminal-prosecution and Medicare/Medicaid policies are not. The constitutional and prudential  
14 components of the justiciability inquiry are addressed in turn below.

15 **A. Constitutional Component**

16 To satisfy the case-or-controversy requirement of Article III of the United States Constitution,  
17 plaintiffs must demonstrate that they have suffered an actual or threatened injury as a result of the  
18 challenged conduct, and that the injury will be redressed by favorable decision. *See Valley Forge*  
19 *Christian College v. Americans United for Separation of Church and State, Inc.*, 454 U.S. 464,  
20 472 (1982). This inquiry, often treated under the rubric of standing, holds for both facial and as-  
21 applied challenges. *Flast v. Cohen*, 392 U.S. 83, 94-101 (1968).

22 The Court first turns to the question of actual or threatened injury. Standing to bring a pre-  
23 enforcement challenge exists when a plaintiff “faces a realistic danger of sustaining a direct injury as a  
24 result of the statute’s operation or enforcement.” *Babbitt v. United Farm Workers Nat’l Union*,  
25 442 U.S. 289, 298 (1979). The Ninth Circuit very recently addressed what constitutes a credible  
26 threat of prosecution in the context of a pre-enforcement challenge based on the First Amendment. In  
27 *Thomas v. Anchorage Equal Rights Commission*, Nos. 97-35220, 97-35221, 2000 WL 1069977  
28 (9th Cir. Aug. 4, 2000), the court held that landlords failed to meet the constitutional component of the

1 justiciability because any threat of enforcement or prosecution against them for refusing to rent to  
2 unmarried couples, although theoretically possible, was not “reasonable or imminent.” *Id.* at \*5. In  
3 evaluating the genuineness of the claimed threat, the court looked to the following three factors:  
4 “whether the plaintiffs had articulated a ‘concrete plan’ to violate the law in question, whether the  
5 prosecuting authorities have communicated a specific warning or threat to initiate proceedings, and the  
6 history of past prosecution or enforcement under the challenged statute.” *Id.* at \*4 (quoting *San*  
7 *Diego County*, 98 F.3d at 1126-27). Applying these factors to this case, the Court finds that  
8 plaintiffs face a credible threat of DEA registration revocation, though not of criminal prosecution or  
9 exclusion from Medicare and Medicaid programs.

10 The “concrete plan” factor plays out differently in this case than in *Thomas*. There, the  
11 landlords could not articulate to whom, when, where, or under what circumstances they had refused to  
12 rent to unmarried couples in the past, and although they pledged to violate the law in the future, they  
13 could not articulate when, to whom, where, or under what circumstances. 2000 WL 1069977, at \*4.  
14 Here, while plaintiffs have not pointed to a specific “plan” to violate the Administration’s Response,  
15 they have shown that they are at immediate risk of violating it because the government’s distinction  
16 between “discussions” (permissible, according to the government) and “recommendations”  
17 (impermissible, according to the government) is vague and unclear. Physicians have a very concrete  
18 and ever-present professional obligation to treat their patients. In a very palpable way, physicians will  
19 inevitably confront the government’s ban on marijuana recommendations.

20 Moving to the next factor, “the prosecuting authorities” in this case “have communicated a  
21 specific warning or threat.” DEA de-registrations will attend any physician who recommends  
22 marijuana. The government reaffirmed this position at the recent hearing on these cross motions. The  
23 warning appears serious. In January 1997, during the short period between the issuances of the  
24 Administration’s Response and the preliminary injunction, a DEA agent interviewed Dr. Mastroianni.  
25 The agent presented a copy of a written marijuana recommendation allegedly created by  
26 Dr. Mastroianni, asked questions regarding Dr. Mastroianni’s medical practices, recommendations of  
27 marijuana and familiarity with research on the medical efficacy of marijuana, and requested to review  
28 Dr. Mastroianni’s prescription records at a local pharmacy. In light of the preliminary injunction,

1 which issued just months after the Administration’s Response, the absence of any *subsequent* threats  
2 is immaterial. The Court finds in favor of a threatened injury based on the government’s DEA  
3 de-registration policy.

4 The analysis differs, however, with respect to the government’s criminal-prosecution and  
5 Medicare/Medicaid policies. As to criminal prosecutions, the Administration’s Response stated only  
6 “that the DOJ will continue existing enforcement programs regarding criminal possession or conspirac  
7 to possess marijuana.” This threat, while troubling to the plaintiff physicians, was not as clear or  
8 specific as the government’s threat to revoke DEA registrations. A mere recommendation alone was  
9 *not* enough to initiate prosecution. A list of factors was relevant, such as the absence of bona-fide  
10 doctor-patient relationships and the accumulation of profits from the prescription or recommendation  
11 of marijuana (see full list of factors above). The Administration’s Response said that the Department  
12 of Justice would merely “continue existing enforcement programs.”

13 In the case of the Medicare and Medicaid programs, the Administration’s Response stated  
14 only that the government “will send a letter” that “will outline the authority of the Inspector General fr  
15 HHS to exclude specified individuals or entities from participation in the Medicare and Medicaid  
16 programs.” Such a letter has never been prepared or released. The parties can only speculate as to  
17 what such a letter would contain, and what effect it would have on plaintiffs. The Administration’s  
18 Response alone does not amount to a specific threat. This factor is fatal to plaintiffs’ challenge of the  
19 Medicare/Medicaid policy. “Unadorned speculation” is “insufficient to invoke federal judicial power.”  
20 *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990).

21 Finally, the history of enforcement also weighs in favor of justiciability of the DEA  
22 de-registration policy but against justiciability of the criminal-prosecution policy. Unlike *Thomas*, this  
23 case does not present a situation in which a policy has languished on the books, unenforced or very  
24 rarely enforced, for a period of years or decades. The Administration’s Response was issued in  
25 December 1996, the case was filed in January 1997, and the preliminary injunction was issued in April  
26 1997. Given this four-month time frame and the existence of the preliminary injunction, it is not  
27 significant that there have been no DEA registration revocation proceedings. On balance, this factor  
28 weighs in favor of plaintiffs regarding the credible threat of DEA registration revocation for

1 recommendations of marijuana, given the investigation of Dr. Mastroianni noted above, although it is  
2 clear that an investigation is not tantamount to an enforcement proceeding. In light of the three  
3 *Thomas* factors, the record supports that there is a credible threat of DEA registration revocation.

4 As for the criminal-prosecution policy, however, there have been no signs of enforcement.  
5 The government has not pursued any criminal prosecutions in the years since the Administration's  
6 Response, despite the clear authority under Judge Smith's preliminary injunction allowing prosecution  
7 for conspiracy and aiding and abetting. Nor had the government pursued any prosecutions before the  
8 preliminary injunction. The *Thomas* factors counsel against adjudicating plaintiffs' challenge to this  
9 policy, given the general, rather than specific, threat of criminal prosecution, and the lack of actual  
10 prosecutions.

11 There still remains the question of whether plaintiffs have suffered a *actual* injury. A chilling  
12 effect on protected speech is an adequate actual injury to establish standing for facial overbreadth  
13 challenges because the "alleged danger . . . is, in large measure, one of self-censorship; a harm that can  
14 be realized even without an actual prosecution." *San Diego County Gun Rights Comm. v. Reno*, 98  
15 F.3d 1121, 1129 (1996) (quoting *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 393  
16 (1988)). The chilling effect caused by the government's DEA de-registration policy is alone a  
17 sufficient injury for the purposes of an overbreadth challenge. This conclusion flows inexorably from  
18 the stipulated facts. Plaintiff physicians believe that recommendation of marijuana is appropriate for  
19 some patients; before the Administration's Response plaintiff physicians discussed marijuana with and  
20 recommended for some patients; the Administration's Response threatens that merely recommending  
21 marijuana will lead to revocation of DEA registrations; plaintiff physicians responded to the  
22 Administration's Response by withholding discussions and advice regarding medical use of marijuana.  
23 *Even the government concedes that a reasonable physician would have a genuine fear of losing*  
24 *his or her DEA registration to dispense controlled substances if that physician were to*  
25 *recommend marijuana to his or her patients* (Joint Stmt. Undisputed Facts ¶ 13).<sup>3</sup> As discussed

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27 <sup>3</sup> There is no inconsistency in the Court's holding that physicians are both chilled from speaking  
28 about marijuana *and* at immediate risk of violating the government's DEA de-registration policy. As noted  
above, the vague nature of "recommend" puts plaintiffs in danger of violating the Administration's Response  
even while they are engaging in self-censorship.

1 above, however, the same is not true for criminal prosecution and exclusion from Medicare/Medicaid  
2 Just as there is no credible threat that the government will criminally prosecute physicians or exclude  
3 them from Medicare or Medicaid programs, so too is there no reasonable chill from the  
4 Administration's Response on these points.

5 The second prong of the constitutional component of justiciability is redressability. It seems  
6 clear that a favorable ruling would redress the injury caused by the government's DEA de-registration  
7 policy. A declaration that the government has exceeded its statutory authority or has violated the First  
8 Amendment, along with a tailored injunction, can prevent unauthorized sanctions or unconstitutional  
9 limitations of protected speech. *Conant*, 172 F.R.D. at 686. In summary, plaintiffs may challenge the  
10 government's stated intent to initiate DEA registration revocation proceedings for doctors who  
11 recommend medical marijuana.

### 12

### 13 **B. Prudential Component**

14 The evaluation of the prudential component of justiciability is guided by two primary  
15 considerations: "the fitness of the issues for judicial decision and the hardship to the parties of  
16 withholding court consideration." *Thomas*, 2000 WL 1069977, at \*5 (quoting *Abbott Labs. v.*  
17 *Gardner*, 387 U.S. 136, 149 (1967)). A case is fit for review if there is a sufficient factual record and  
18 the challenged administrative action is final. *See Trustees for Alaska v. Hodel*, 806 F.2d 1378, 1381  
19 (9th Cir. 1986) (citing *Abbott Labs.*, 387 U.S. at 149). In order to demonstrate hardship, plaintiffs  
20 must demonstrate a realistic possibility of sustaining an injury as a result of enforcement. *See O'Shea*  
21 *v. Littleton*, 414 U.S. 488, 494 (1974).

22 The finality of the administrative action and the factual record, both previously evaluated by  
23 Judge Smith, render this case fit for review. Moreover, as detailed by Judge Smith, the plaintiffs  
24 would suffer significant hardship were this Court to withhold review. The Court adopts the analysis of  
25 these points set forth in *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997). Plaintiffs'  
26 challenge to the DEA de-registration policy is justiciable.

### 27 **2. The Government's Construction of the Controlled Substances Act**

28

1 The Controlled Substances Act vests power in the Attorney General to deny or revoke a  
2 physician’s DEA registration to prescribe controlled substances. 21 U.S.C. 824. The  
3 Attorney General has delegated that authority to the Administrator of the Drug Enforcement Agency.  
4 28 C.F.R. 0.100(b). One of the permissible grounds for revocation is a finding that the physician “has  
5 committed such acts as would render his registration under section 823 of this title inconsistent with the  
6 public interest as determined under such section.” 21 U.S.C. 824(a)(4). In turn, Section 823 states  
7 that “public interest” should be determined by the following factors:

- 8 (1) The recommendation of the appropriate State licensing board  
9 or professional disciplinary authority.
- 10 (2) The applicant’s experience in dispensing or conducting  
11 research with respect to controlled substances.
- 12 (3) The applicant’s conviction record under Federal or State laws  
13 relating to the manufacture, distribution, or dispensing of  
14 controlled substances.
- 15 (4) Compliance with applicable State, Federal, or local laws  
16 relating to controlled substances.
- 17 (5) Such other conduct which may threaten the public health and  
18 safety.

16 Based on this statutory language, the government construes Factor Five to allow the Administrator of  
17 the Drug Enforcement Agency to revoke a physician’s registration if he or she merely recommends  
18 marijuana to a patient.

19 Significantly, the government admits that revocation is *not* authorized where a doctor discusses  
20 the pros and cons of marijuana use with a patient. Yet the government claims the doctor crosses a  
21 statutory line when the discussion melds into a recommendation. Also of significance, both sides  
22 acknowledge that a doctor may not, under the statute, actually prescribe or dispense marijuana.  
23 Plaintiffs do not seek to do so. The focus is on “recommend” and whether a statutory line can really  
24 be drawn between discussions of pros and cons versus recommendations.

25 Referring to Section 823 for the definition of “public interest” (as directed by Section 824), the  
26 government concludes that recommending marijuana falls within Factor Five — “[s]uch other conduct  
27 which may threaten the public health and safety.” Factor Five, according to the government’s  
28 construction, must be something beyond controlled-substance convictions and/or violations, since such

1 conduct already is covered by Factors Three and Four. There is no caselaw precedent. There is no  
2 legislative history on point. The issue is of first impression.

3 When a court reviews an agency’s construction of the statute which it administers, it must first  
4 look to see whether Congress addressed the precise question at issue. *Chevron U.S.A. v. Natural*  
5 *Resources Def. Council*, 467 U.S. 837, 842-43 (1984). If the intent of Congress is clear, the court  
6 must give effect to that intent, unless it is unconstitutional, even if it is inconsistent with the agency’s  
7 construction. If Congress is silent on the issue, on the other hand, the court normally defers to the  
8 agency’s interpretation if it is reasonable. *Ibid.* A court will reject an agency interpretation that would  
9 ordinarily receive deference under *Chevron*, however, if it believes the agency’s reading raises serious  
10 constitutional doubts. *Williams v. Babbitt*, 115 F.3d 657, 661-63 (9th Cir. 1997) *cert. denied sub*  
11 *nom. Kawerak Reindeer Herders Ass’n v. Williams*, 523 U.S. 1117 (1998) (citing *DeBartolo*  
12 *Corp. v. Florida Gulf Coast Trades Council*, 485 U.S. 568 (1988) and *Rust v. Sullivan*, 500 U.S.  
13 173 (1991)). “[I]f Congress meant to push the constitutional envelope, it must do so explicitly.”  
14 *Williams*, 115 F.3d at 662.

15 Congress did not address whether the government may revoke a physician’s registration  
16 based on the physician recommending a Schedule I drug to a patient. The term “recommend” does  
17 not appear in Section 824 of the statute. The legislative history is silent as to whether Congress  
18 intended that such conduct could constitute a ground for revocation. As stated, no caselaw addresses  
19 the point. No regulations have been issued. All that exist are statements by the government, including  
20 the Administration’s Response, giving its current view of the statute.

21 Were it not for First Amendment considerations, the government’s interpretation of the  
22 Controlled Substances Act might be permissible under *Chevron*. As the government notes, Factor  
23 Five’s “[s]uch other conduct which may threaten the public health and safety” presumably includes  
24 conduct apart from that already listed in the previous four factors. That previously listed conduct  
25 includes convictions relating to controlled substances and violations of the law relating to controlled  
26 substances. Recommending the medical use of a prohibited substance might arguably fall within such  
27 “other conduct.” As discussed below, however, the constitutional doubts raised by such an  
28 interpretation are most serious.

1           **3.       The First Amendment**

2           The practice of the learned professions such as medicine and law necessarily involve  
3 communications with patients, clients and others. While such communications implicate  
4 First Amendment concerns, no one would claim that the professions are immunized from regulation  
5 merely because speech is incident to the trade. For the professional, “[o]bedience to ethical precepts  
6 may require abstention from what in other circumstances might be constitutionally protected speech.”  
7 *In re Sawyer*, 360 U.S. 622, 646-47 (1959) (Stewart, J., concurring). A lawyer, for example, may  
8 not counsel a client to violate the law or to commit perjury. The First Amendment would not prohibit  
9 the lawyer’s disbarment for doing so. A doctor, to take another example, may not counsel a patient to  
10 rely on quack medicine. The First Amendment would not prohibit the doctor’s loss of license for  
11 doing so. *E.g.*, *Shea v. Board of Medical Examiners*, 81 Cal. App. 3d. 564, 577 (3rd Dist. 1978)  
12 (affirming revocation of license to practice medicine where physician “treated” patients by luridly and  
13 salaciously describing sexual foreplay and intercourse). As stated in *Shea*, “[the First Amendment]  
14 does not insulate the verbal charlatan from responsibility for his conduct.” *Ibid*. Speech protected on  
15 the street corner might not be protected in the professional’s venue.

16           Still, there is First Amendment protection in the practice of the learned professions. As the  
17 government itself recognizes, when a governmental regulation of professional practice “implicates First  
18 Amendment rights, the Court must balance those interests against the State’s legitimate interest in  
19 regulating the activity in question” (Br. 4, citing *Gentile v. State Bar of Nevada*, 501 U.S. 1030,  
20 1075 (1991)). In *Gentile*, the Supreme Court reviewed a First Amendment challenge to a state-bar  
21 sanction against a criminal defense attorney who had given a press conference on the particulars of his  
22 client’s defense while the case was pending. The rule under which the sanction issued prohibited a  
23 lawyer from making “an extrajudicial statement . . . if the lawyer knows or reasonably should know  
24 that it will have a substantial likelihood of materially prejudicing an adjudicative proceeding.” The  
25 Court held that the “substantial likelihood” standard was constitutional, rejecting the argument that the  
26 First Amendment required the state to demonstrate a “clear and present danger” of actual prejudice”  
27 or “an imminent threat” before any sanction could be imposed based on an attorney’s speech. *Id.* at  
28 1071-76. In reaching its decision, the Court weighed the state’s interest in protecting the integrity and

1 fairness of the state’s judicial system against the attorney’s interest in free speech, and found that the  
2 state’s regulation of speech was sufficiently limited to pass constitutional muster, particularly given th  
3 it was content neutral. *Id.* at 1076.

4 Likewise, the Supreme Court has recognized the First Amendment interests in discussions  
5 between doctors and patients. In *Rust v. Sullivan*, 500 U.S. 173, 200 (1990), the Court suggested,  
6 but did not hold, that individual doctor-patient relationships, in contrast to family-planning clinics, mi  
7 enjoy First Amendment protection even when subsidized by the government. Although the Court did  
8 not decide whether the doctor-patient relationship is entitled to special First Amendment protection  
9 from the state’s purse strings, its discussion presupposed First Amendment interests in discussions  
10 between doctors and patients.

11 In *Planned Parenthood v. Casey*, 505 U.S. 833, 884 (1992), the Supreme Court again  
12 acknowledged the First Amendment interests in doctor-patient discussions, but suggested that a  
13 rational basis would justify regulation of speech as part of the practice of medicine. There, the  
14 petitioners challenged a provision that required doctors to inform abortion patients of the nature of the  
15 procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the  
16 unborn child. *Id.* at 881. A plurality rejected a First Amendment challenge to the informed-consent  
17 provision.<sup>4</sup> *Id.* at 884. The state may compel physicians to provide health-related information so long  
18 as it is true and reasonable.

19 The *Casey* regulation merely compelled disclosure of information about a medical procedure,  
20 much like warning labels disclose the side effects and risks of pharmaceuticals. In this case, by  
21 contrast, the government would punish physicians for voicing their professional opinions based on the  
22 best medical judgment. Like *Gentile*, this case involves punishment of affirmative professional speech

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23  
24 <sup>4</sup> The following paragraph comprises the full extent of the plurality’s First Amendment analysis:

25 All that is left of petitioners’ argument is an asserted First Amendment right of  
26 a physician not to provide information about the risks of abortion, and  
27 childbirth, in a manner mandated by the State. To be sure, the physician’s  
28 First Amendment rights not to speak are implicated, see *Wooley v. Maynard*,  
430 U.S. 705 (1977), but only as part of the practice of medicine, subject to  
reasonable licensing and regulation by the State, cf. *Whalen v. Roe*, 429 U.S.  
589, 603 (1977). We see no constitutional infirmity in the requirement that the  
physician provide the information mandated by the State here. *Id.* at 884.

1 Given the stark differences, the balancing framework of *Gentile* is more appropriate than the  
2 “reasonable regulation” framework of *Casey*.

3 In striking the appropriate balance in this case, the Court recognizes that the government has a  
4 legitimate interest in suppressing and controlling the flow of dangerous drugs and controlled substances  
5 within the United States. A recommendation by a doctor may (or may not) be used by a patient to  
6 obtain marijuana under the Compassionate Use Act. On the other side of the scale, physicians have a  
7 legitimate need to discuss with and to recommend to their patients all medically acceptable forms of  
8 treatment. In California and seven other states,<sup>5</sup> recommending marijuana to treat certain debilitating  
9 illnesses is recognized as legitimate in medically appropriate circumstances. The government itself  
10 would allow physicians to “discuss” the pros and cons of marijuana therapy with their patients. In  
11 some cases, however, it will be the professional opinion of doctors that marijuana is the best therapy  
12 or at least should be tried. If such recommendations could not be communicated, then the physician-  
13 patient relationship would be seriously impaired. Patients need to know their doctors’  
14 recommendations.

15 Contrary to the government’s argument, it is not true that a mere recommendation will  
16 necessarily lead to the commission of a federal offense. To the contrary, such recommendations can  
17 lead to lawful and legitimate responses. *First*, a cancer or AIDS victim so advised may choose to  
18 honor the federal law but, armed with the doctor’s recommendation, may urge the federal government  
19 to change that law. Petitioning Congress or federal agencies for redress of a grievance or a change in  
20 policy is a time-honored tradition. In the marketplace of ideas, few questions are more deserving of  
21 free-speech protection than whether regulations affecting health and welfare are sound public policy.  
22 In the debate, perhaps the status quo will (and should) endure. But patients and physicians are  
23 certainly entitled to urge their view. To hold that physicians are barred from communicating to patients  
24 sincere medical judgments would disable patients from understanding their own situations well enough  
25 to participate in the debate. As the government concedes, and as Mr. Vines exemplifies, many  
26 patients depend upon discussions with their physicians as their primary or only source of sound

27 \_\_\_\_\_  
28 <sup>5</sup> Alaska, Arizona, Hawaii, Maine, Nevada, Oregon and Washington have passed laws similar to California’s Compassionate Use Act.

1 medical information. Without open communication with their physicians, patients would fall silent and  
2 appear uninformed. The ability of patients to participate meaningfully in the public discourse would be  
3 compromised. This factor alone persuades the Court that the balance of considerations ought to be  
4 struck firmly on the side of protecting sincere medical recommendations.

5 *Second*, a cancer or AIDS victim may well be able to obtain medical marijuana without  
6 violating federal law. There are three possible ways. One is to enroll in a federally-approved  
7 experimental marijuana therapy program.<sup>6</sup> Another is to travel to a country where marijuana is legally  
8 dispensed. Finally, the Ninth Circuit has recently recognized the “medical necessity” defense for  
9 cannabis-club distribution of marijuana to patients requiring marijuana as a medical necessity.<sup>7</sup> The  
10 point is that a recommendation for marijuana therapy does not translate, as night follows day, into a  
11 violation of federal law. To the contrary, a recommendation for marijuana may lead to actions by  
12 patients all of which are lawful under federal law and some of which are themselves protected, such as  
13 petitioning the government for a change in the prohibition itself, by the First Amendment.

14 To be sure, some patients may use sincere medical recommendations to obtain marijuana from  
15 cannabis clubs in circumstances illegal under federal law. A doctor, for example, may sincerely believe  
16 that a cancer victim, having exhausted other medications without success, should try marijuana. Such  
17 a circumstance may or may not qualify as a medical necessity. Even though the doctor warns of the  
18 illegal status of marijuana, the patient may use the doctor’s recommendation to obtain marijuana under  
19 the Compassionate Use Act. If so, however, the acquisition of marijuana is committed by the patient,

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20  
21 <sup>6</sup> Schedule I substances may be dispensed in strictly-controlled research projects registered with the  
22 DEA, and approved by the Secretary of Health and Human Services, acting through the Food and Drug  
Administration. *See* 21 U.S.C. § 823(f). The government conceded at oral argument that some patients may seek  
to enroll in its experimental marijuana therapy programs.

23 <sup>7</sup> In *United States v. Oakland Cannabis Buyers’ Cooperative*, 190 F.3d 1109, 1113-15 (9<sup>th</sup> Cir. 1999), the  
24 Ninth Circuit held that the district court had the equitable discretion to modify an injunction to allow continuing  
25 cannabis distribution to patients whose physicians certify that (1) the patient suffers from a serious medical  
26 condition; (2) if the patient does not have access to cannabis, the patient will suffer imminent harm; (3) cannabis  
27 is necessary for the treatment of the patient’s medical condition or that cannabis will alleviate the medical  
28 condition or symptoms associated with it; (4) there is no legal alternative to cannabis for the effective treatment  
of the patient’s medical condition because the patient has tried other legal alternatives to cannabis and has  
found them ineffective in treating his or her condition or has found that such alternatives result in intolerable  
side effects. The panel noted that these factors were modeled on the Ninth Circuit’s recognition of a necessity  
defense to violations of federal law in *United States v. Aguilar*, 883 F.2d 662, 692 (9<sup>th</sup> Cir.1989). The government  
is still in the process of seeking review in the Supreme Court of the United States. This Court’s judgment,  
however, does not depend upon *Oakland Cannabis Buyers’ Cooperative* for the reasons stated above.

1 not the doctor. A sincere recommendation alone is not a federal crime, even if the doctor foresees it  
2 could be used to facilitate a federal crime. The federal interest in enforcing the marijuana prohibition in  
3 the United States is a legitimate concern, but it pales by comparison to the free speech concerns.

4 What is more, the government’s position is weakened by the artificial line it would draw.  
5 “Discussions of pros and cons” with patients are proper, the government concedes, but  
6 “recommendations” drawn therefrom are not. The government’s test is wholly unworkable. The  
7 government would define “recommend” as “to present as worthy of confidence, acceptance, use, etc.”  
8 or “to suggest” (Reply Br. 13). It would be impossible to discuss even the pros and cons without, at  
9 least in some cases, the patient concluding that the doctor is suggesting marijuana or “presenting it as  
10 worthy of acceptance.” This would be so even if the doctor never used the term “recommend” or  
11 “suggest.” Accordingly, prudent doctors wishing to retain their DEA registrations would plainly be  
12 deterred from even discussing the pros and cons of marijuana. In other words, the vagueness of the  
13 government’s proposed test exacerbates the compromise of First Amendment interests. *See NAACP*  
14 *v. Button*, 371 U.S. 415, 433 (1963).

15 When a doctor recommends marijuana, a patient who is accepting of the idea may well ask  
16 how to obtain it. Here, doctors must be honest. The First Amendment is not a license to circumvent  
17 the federal drug laws. If the doctor addresses the subject, he or she must be truthful and advise on the  
18 unavailability of marijuana under the present federal drug laws and on the availability of the federal  
19 experimental programs and overseas laws (to the extent the doctor is knowledgeable).

20 Turning to written recommendations, the same balance of considerations controls — with one  
21 exception. Patients have a legitimate need to know that their doctors will back them up if and when  
22 federal authorities question their “medical necessity” defense or if and when they choose to urge  
23 publically a change in the law. A writing from a physician memorializing a recommendation serves  
24 those uses. Where those uses do not apply, however, physicians should proceed more cautiously. If  
25 (and only if) a physician concludes that the sole use and reason for the writing (as opposed to the  
26 recommendation itself) would be simply to obtain marijuana in violation of federal law, it would be  
27 hard to see how the extra step of a writing in and of itself serves any purpose other than to facilitate an  
28 illegal transaction, and hard to see why the writing itself deserves free-speech protection. The “public

1 interest” comprehends regulation of communication with no purpose other than to facilitate violations  
2 of the Controlled Substances Act. A doctor would be well advised to state in his or her own records  
3 the reason for each recommendation and the reason for each written certification.

4 The government is legitimately concerned that a physician might in bad faith issue  
5 recommendations that would then be used to enlarge the distribution of marijuana to those who really  
6 do not need it. From time to time, physicians registered under the Controlled Substances Act abuse  
7 their privileges, dispensing, for example, excessive controlled substances or otherwise circumventing  
8 the Act. *See, e.g., United States v. Moore*, 423 U.S. 122 (1975). Physicians who issue insincere  
9 recommendations without a medical basis and with knowledge that they would be used to illegally  
10 obtain marijuana would be subject to DEA revocation. On the other hand, doctors are entitled to be  
11 confident that their good-faith recommendations based on honest medical judgments will not be the  
12 basis for DEA revocations even when they foresee their recommendations might be used by the patients  
13 to obtain marijuana from sources illegal under federal law.

14 Given the doctrine of constitutional doubt, the government’s construction of the Controlled  
15 Substances Act cannot stand. The government should be permanently enjoined from (i) revoking any  
16 physician class member’s DEA registration merely because the doctor makes a recommendation for  
17 the use of medical marijuana based on a sincere medical judgment and (ii) from initiating any  
18 investigation solely on that ground. The injunction should apply whether or not the doctor anticipates  
19 that the patient will, in turn, use his or her recommendation to obtain marijuana in violation of federal  
20 law.

21 **CONCLUSION**

22 Plaintiffs’ motion for summary judgment is **GRANTED IN PART** and **DENIED IN PART**.  
23 Defendants’ motion for summary judgment is **GRANTED IN PART** and **DENIED IN PART**. The  
24 government’s interpretation of the registration-revocation provision of the Controlled Substances Act  
25 exceeds the statute’s authority. The government is permanently **ENJOINED** from (i) revoking a  
26 class-member physician’s DEA registration merely because the doctor recommends medical marijuana  
27 to a patient based on a sincere medical judgment and (ii) from initiating any investigation solely on that  
28 ground. This injunction applies whether or not the physician anticipates that the recommendation will

1 in turn, be used by the patient to obtain marijuana in violation of federal law. The Court finds that all  
2 other issues tendered are not justiciable. All claims having been resolved, the preliminary injunction is  
3 **DISSOLVED** and superceded by this permanent injunction. The Clerk shall close the file and enter  
4 judgment.

5  
6 **IT IS SO ORDERED.**

7  
8 Dated: September 7, 2000.

9 WILLIAM ALSUP  
10 UNITED STATES DISTRICT JUDGE