

**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF NEBRASKA**

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|---------------------------|---|-------------------|
| UNITED STATES OF AMERICA, | ) |                   |
| Plaintiff,                | ) |                   |
| v.                        | ) | No. 8:08-cr-00388 |
|                           | ) |                   |
| DEJAY MONSON,             | ) |                   |
| Defendant.                | ) |                   |

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**MEMORANDUM OF LAW IN SUPPORT OF  
DEFENDANT’S MOTION TO DISMISS  
FOR FAILURE TO STATE A VALID CAUSE OF ACTION**

**INTRODUCTION**

The question presented here is whether the federal Controlled Substances Act (“**CSA**” hereafter), 21 U.S.C. §§ 801-904, gives the United States Drug Enforcement Administration (“**DEA**” hereafter) the authority to decide whether a drug or substance has currently accepted medical use in treatment in the United States or whether the **CSA** gives the States the authority to determine whether a drug or substance has currently accepted medical use in treatment in the United States. Both statutory and case law on this issue conclusively show that Congress gave the States the authority to determine accepted medical use and the **DEA** only has the limited authority to regulate it. The findings required by 21 U.S.C. § 812(b) for Schedule I are as follows: “(A) The drug or other substance has a high potential for abuse. (B) The drug or other substance has no currently accepted medical use in treatment in the United States. (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.”

**GONZLES V. RAICH IS NOT CONTROLLING  
BECAUSE RAICH DID NOT CONTEST  
THE UNLAWFUL SCHEDULING OF MARIJUANA**

The question decided in *Gonzales v. Raich*, 545 U.S. 1 (2005) (“*Raich*” hereafter) was “whether the power vested in Congress by Article I, § 8, of the Constitution ‘[t]o make all Laws which shall be necessary and proper for carrying into Execution’ its authority to ‘regulate Commerce with foreign Nations, and among the several States’ includes the power to prohibit the local cultivation and use of marijuana in compliance with California law.” *Raich*, 545 U.S., at 5.

*Raich* did not contest the Constitutional Due Process violation resulting from the unlawful scheduling of marijuana in Schedule I of the CSA:

Respondents in this case do not dispute that passage of the CSA, as part of the Comprehensive Drug Abuse Prevention and Control Act, was well within Congress’ commerce power. Brief for Respondents 22, 38. Nor do they contend that any provision or section of the CSA amounts to an unconstitutional exercise of congressional authority. Rather, respondents’ challenge is actually quite limited; they argue that the CSA’s categorical prohibition of the manufacture and possession of marijuana as applied to the intrastate manufacture and possession of marijuana for medical purposes pursuant to California law exceeds Congress’ authority under the Commerce Clause.

*Raich*, 545 U.S., at 15.

We acknowledge that evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I. See, e.g., Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base* 179 (J. Joy, S. Watson, & J. Benson eds. 1999) (recognizing that “[s]cientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC [Tetrahydrocannabinol] for pain relief, control of nausea and vomiting, and appetite stimulation”); see also *Conant v. Walters*, 309 F.3d 629, 640-643 (CA9 2002) (Kozinski, J., concurring) (chronicling medical studies recognizing valid medical uses for marijuana and its derivatives). But the possibility that the drug may

be reclassified in the future has no relevance to the question whether Congress now has the power to regulate its production and distribution. Respondents' submission, if accepted, would place all homegrown medical substances beyond the reach of Congress' regulatory jurisdiction.

*Raich*, 545 U.S., at 28 n.37.

*Raich* challenged the power of Congress to regulate marijuana under the Commerce Clause. Defendant challenges the jurisdiction of the Court based on the Fifth Amendment Due Process violation resulting from the unlawful scheduling of marijuana by the **DEA**. In *Raich* the U.S. Supreme Court simply held that Congress has the power to regulate marijuana. In *Raich*, the U.S. Supreme Court did not rule on the challenge Defendant raises. Defendant submits that the **DEA's** failure to remove marijuana from Schedule I once marijuana had been accepted for medical use in treatment in the United States made enforcement of Schedule I sanctions a legal nullity.

To the contrary, the U.S. Supreme Court acknowledged that the evidence suggested marijuana was not correctly scheduled. "We acknowledge that evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I." *Raich*, 545 U.S. at 28 n.37.

There is no question that the federal Controlled Substances Act ("**CSA**" hereafter) applies in and to the state of California. *Raich's* injury was not the result of Congress' regulation of marijuana, but the failure of the **DEA** to remove

marijuana from Schedule I of the **CSA** in 1996 when marijuana no longer met the statutory requirement for inclusion in Schedule I.

The original placement of marijuana in Schedule I by Congress was only preliminary:

In enacting the **CSA**, Congress classified marijuana as a Schedule I drug. 21 U.S.C. § 812(c). This preliminary classification was based, in part, on the recommendation of the Assistant Secretary of HEW "that marihuana be retained within schedule I at least until the completion of certain studies now underway."<sup>22</sup> Schedule I drugs are categorized as such because of their high potential for abuse, lack of any accepted medical use, and absence of any accepted safety for use in medically supervised treatment. § 812(b)(1). These three factors, in varying gradations, are also used to categorize drugs in the other four schedules. For example, Schedule II substances also have a high potential for abuse which may lead to severe psychological or physical dependence, but unlike Schedule I drugs, they have a currently accepted medical use. § 812(b)(2). By classifying marijuana as a Schedule I drug, as opposed to listing it on a lesser schedule, the manufacture, distribution, or possession of marijuana became a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration pre-approved research study. §§ 823(f), 841(a)(1), 844(a); see also *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 490, 149 L. Ed. 2d 722, 121 S. Ct. 1711 (2001).

<sup>22</sup> H. R. Rep., at 61 (quoting letter from Roger E. Egeberg, M. D. to Hon. Harley O. Staggers (Aug. 14, 1970)).

***Raich***, 545 U.S., at 14.

Not only was the placement of marijuana in Schedule I a preliminary classification, the legislative history shows that Congress actually expressed serious doubt about including marijuana in the **CSA** at all. "The House Report recommending that marihuana be listed in Schedule I notes that this was the recommendation of HEW 'at least until the completion of certain studies now under way,' and projects that the Presidential Commission's recommendations 'will be of

aid in determining the appropriate disposition of this question in the future.’ H.R. Rep. No. 91-1444 (Part 1), 91st Cong., 2d Sess. (1970) at p. 13.” *NORML v. Ingersoll*, 497 F.2d 654, 657 (D.C. Cir. 1974).

The Report of the Presidential Commission clearly shows that marijuana is not qualified for criminal sanctions:

New studies have indicated that the dangers of marijuana use are not as great as once believed. A recent report of a federal panel representing, inter alia, HEW, DEA, the State Department, and the White House, concluded that marijuana use entails a “relatively low social cost,” and suggested that decriminalization be considered. *Washington Post*, Dec. 12, 1976, at A1, col. 1; *Washington Star*, Dec. 12, 1976, at A7, col. 1. See *United States v. Randall*, supra note 61, at 2254 (characterizing marijuana as “a drug with no demonstrably harmful effects”). Indeed, in NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, SECOND REPORT, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE, Vol. I, at 235 (1973), the Commission recommended that “the United States take the necessary steps to remove cannabis from the Single Convention on Narcotic Drugs (1961), since this drug does not pose the same social and public health problems associated with the opiates and coca leaf products.”

*NORML v. DEA*, 559 F.2d 735, 751 n.70 (D.C. Cir. 1977)

In *Raich*, the U.S. Supreme Court noted that efforts to reschedule marijuana through administrative procedures established by the CSA had been unsuccessful, but all of those efforts to reschedule marijuana were prior to the enactment of the first state medical marijuana law in 1996:

The CSA provides for the periodic updating of schedules and delegates authority to the Attorney General, after consultation with the Secretary of Health and Human Services, to add, remove, or transfer substances to, from, or between schedules. § 811. Despite considerable efforts to reschedule marijuana, it remains a Schedule I drug.<sup>23</sup>

<sup>23</sup> Starting in 1972, the National Organization for the Reform of Marijuana Laws (NORML) began its campaign to reclassify marijuana. Grinspoon &

Bakalar 13-17. After some fleeting success in 1988 when an Administrative Law Judge (ALJ) declared that the DEA would be acting in an "unreasonable, arbitrary, and capricious" manner if it continued to deny marijuana access to seriously ill patients, and concluded that it should be reclassified as a Schedule III substance, *Grinspoon v. DEA*, 828 F.2d 881, 883-884 (CA1 1987), the campaign has proved unsuccessful. The DEA Administrator did not endorse the ALJ's findings, 54 Fed. Reg. 53767 (1989), and since that time has routinely denied petitions to reschedule the drug, most recently in 2001. 66 Fed. Reg. 20038 (2001). The Court of Appeals for the District of Columbia Circuit has reviewed the petition to reschedule marijuana on five separate occasions over the course of 30 years, ultimately upholding the Administrator's final order. See *Alliance for Cannabis Therapeutics v. DEA*, 304 U.S. App. D.C. 400, 15 F.3d 1131, 1133 (1994).

*Raich*, 545 U.S., at 14-15.

The Defendant draws this Court's attention to several errors in footnote 23 to the *Raich* decision.

The drug in question in *Grinspoon v. DEA*, 828 F.2d 881 (1<sup>st</sup> Cir. 1987) ("*Grinspoon*" hereafter), was MDMA, not marijuana. *Grinspoon* ordered the DEA to place MDMA, not marijuana, in Schedule III. *Grinspoon* was decided prior to the ruling of the Administrative Law Judge ("*ALJ*" hereafter) in 1988.

The *ALJ* recommended that marijuana be placed in Schedule II, not Schedule III. *Raich* was not about marijuana's unlawful scheduling and is not controlling on the issue.

*Grinspoon* acknowledged the statutory obligation of the administrative agency to follow the statutory requirements for including a substance in a particular schedule:

The statutory findings required for agency scheduling decisions clearly state that the agency may not, in the absence of Congressional action, subject drugs with a currently accepted medical use in the United States to Schedule I controls.

*Grinspoon*, 828 F.2d, at 890.

Under the **CSA**, the **DEA** does not have the discretion to ignore the statutory requirements for inclusion of a substance in schedule I. Therefore, the **DEA**'s failure to reschedule marijuana in 1996 when the first state enacted a medical marijuana law renders marijuana's current scheduling a legal nullity.

*Alliance for Cannabis Therapeutics*, 15 F.3d 1131 (D.C. Cir. 1994), was decided by the U.S. Court of Appeals for the District of Columbia Circuit in 1994, two years before the enactment of the first state medical marijuana law in 1996, the California Compassionate Use Act. Therefore, *Alliance for Cannabis Therapeutics*, 15 F.3d 1131 (D.C. Cir. 1994), is not controlling on the issue of marijuana's unlawful scheduling.

Particularly instructive is the response from the **DEA** to Mr. Gettman's petition to reschedule marijuana (which was filed in 1995, a year before California enacted the first medical marijuana law in the United States): "You do not assert in your petition that marijuana has a currently accepted medical use in treatment in the United States or that marijuana has an accepted safety for use under medical supervision." 66 Fed. Reg. 20038 (April 18, 2001). Obviously, Mr. Gettman could not assert a fact that had not yet come into existence. Therefore, the **DEA** ruling of 2001 is not controlling on the issue of marijuana's unlawful scheduling.

In May of 2001, the U.S. Supreme Court acknowledged the criteria for inclusion in Schedule I are mandatory: "Under the statute, the Attorney General could not put marijuana into schedule I if marijuana had any accepted medical use."

*United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 492 (2001) (“*Oakland*” hereafter).

Based on the fact that marijuana’s unlawful scheduling has never been addressed by the **DEA** or any federal court since California enacted the first state medical marijuana law in the United States in 1996, this raises a question of first impression that was not decided or foreclosed by *Gonzales v. Raich*, 545 U.S. 1 (2005), or *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

**THE CSA DOES NOT PREEMPT  
STATE MEDICAL MARIJUANA LAWS**

When the federal government regulates in an area traditionally regulated by the states, the presumption is that Congress does not intend to preempt state law unless it specifically says so. “Consideration of issues arising under the Supremacy Clause ‘starts with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress.’” *Cipollone v. Liggett Group*, 505 U.S. 504, 516 (1992) (citing, *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

The **CSA** does not contain any language stating that it was the intent of Congress to preempt state laws establishing accepted standards of medical practice. On the contrary, the **CSA** actually contains language that says Congress did not intend to occupy the field of medicine traditionally regulated by the states. That field, traditionally regulated by the states, includes setting standards for use of

drugs in that state. 21 U.S.C. § 903. See *Gonzales v. Oregon*, 546 U.S. 243 (2006).

In rejecting any attempt by the **DEA** to define accepted state medical practice, the U.S. Supreme Court held: “The Government, in the end, maintains that the prescription requirement delegates to a single Executive officer the power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality. The text and structure of the CSA show that Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it.” *Gonzales v. Oregon*, 546 U.S. 243, 275 (2006) (“*Oregon*” hereafter).

The issue in *Oregon* was whether the **DEA** could issue an interpretive rule conflicting with the **CSA**. Just as the **DEA** cannot issue an interpretive rule conflicting with the **CSA**, the **DEA** cannot interpret an existing rule to have continued validity when that rule comes into conflict with the **CSA** because of a federally authorized change in State law. A change in state law accepting the medical use of a drug or substance initially placed in Schedule I of the **CSA** requires that substance to be removed from Schedule I.

#### **PREVIOUS CASES DEFINING THE DEA’S AUTHORITY**

Previous case law on the question of marijuana’s scheduling has all been decided in the context of the absence of any State law accepting the medical use of marijuana. The enactment of 13 state laws accepting marijuana’s medical use is a substantial change that automatically triggers statutorily required rescheduling.

In the absence of any State law accepting the medical use of marijuana, the **DEA** has the authority under the **CSA** to make an independent determination of whether marijuana has any accepted medical use. However, once a State accepts the medical use of marijuana, the **DEA** no longer has the role of determining accepted medical use. Judge Young pointed this out in his September 6, 1988 recommended ruling, *In the Matter of Marijuana Rescheduling*, DEA Docket No. 86-22.

At page 32, Judge Young wrote: “The DEA, on the other hand, is charged by 21 U.S.C. § 812(b)(1)(B) and (2)(B) with ascertaining what it is that other people have done with respect to a drug or substance: ‘Have they accepted it?;’ not ‘Should they accept it?’”

At page 33, Judge Young (referring to *Grinspoon*) continued: “In the MDMA third final order DEA is actually making the decision that doctors have to make, rather than trying to ascertain the decision which doctors have made. Consciously or not, the Agency is undertaking to tell doctors what they should or should not accept. In so doing the Agency is acting beyond the authority granted in the Act.”

This was affirmed in the final decision on the marijuana rescheduling petition, *In the Matter of Marijuana Rescheduling*, DEA Docket No. 86-22, issued by the DEA Administrator in 1992:

Clearly, the Controlled Substances Act does not authorize the Attorney General, nor by delegation the DEA Administrator, to make the ultimate medical and policy decision as to whether a drug should be used as medicine. Instead, he is limited to determining whether others accept a drug for medical use. Any other construction would have the effect of reading the word "accepted" out of the statutory standard.

57 Fed. Reg. 10499, 10505 (March 26, 1992).

The U.S. Supreme Court referred to five previous controlled substance scheduling cases, *Raich*, 545 U.S., at 15 n.23, which are summarized below:

The National Organization for the Reform of Marijuana Laws (“NORML” hereafter) filed a petition to reschedule marijuana with the Department of Justice in May 1972. It was filed within two months after the release of *Marihuana: A Signal of Misunderstanding*, the title given to the First Report by the National Commission on Marihuana and Drug Abuse, chaired by Governor Shafer. The Bureau of Narcotics and Dangerous Drugs (“BNDD” hereafter) responded by saying that international treaties precluded the rescheduling of marijuana. The U.S. Court of Appeals rejected the interpretation of the BNDD: “The respondent seems to be saying that even though the treaty does not require more control than schedule V provides, he can on his own say-so and without any reason insist on Schedule I. We doubt that this was the intent of Congress.”

*NORML v. Ingersoll*, 497 F.2d 654, 660-661 (D.C. Cir. 1974).

In 1977, The U.S. Court of Appeals rejected the DEA’s argument that lack of accepted medical use automatically determines that a substance must be scheduled in Schedule I, but at the same time recognized that accepted medical use requires removal from Schedule I. “Admittedly, Section 202(b), 21 U.S.C. § 812(b), which sets forth the criteria for placement in each of the five CSA schedules, established medical use as the factor that distinguishes substances in Schedule II from those in Schedule I.” *NORML v. DEA*, 559 F.2d 735, 748 (D.C. Cir. 1977).

In the absence of any accepted medical use of marijuana, the DEA is authorized under the CSA to make an independent analysis using the factors set forth in 21 U.S.C. § 811(c). “Moreover, DEA’s own scheduling practices support the conclusion that substances lacking medical usefulness need not always be placed in Schedule I. At the hearing before ALJ Parker DEA’s Chief Counsel, Donald Miller, testified that several substances listed in CSA Schedule II, including poppy straw,

have no currently accepted medical use. Tr. at 473-474, 488. He further acknowledged that marihuana could be rescheduled to Schedule II without a currently accepted medical use. Tr. at 487-488. Neither party offered any contrary evidence.” *NORML v. DEA*, 559 F.2d 735, 749 (D.C. Cir. 1977).

*Grinspoon v. DEA*, 828 F.2d 881 (1st Cir. 1987), clarifies the limited role of the DEA in determining “accepted medical use in treatment in the United States.” *Grinspoon* is particularly instructive on the operation of the scheduling criteria. “[C]ongress did not intend ‘accepted medical use in treatment in the United States’ to require a finding of recognized medical use in every state . . .” *Grinspoon*, 828 F.2d at 886.

“As is apparent, one salient concept distinguishing the two schedules [Schedule I and Schedule II] is whether a drug has ‘no currently accepted medical use in treatment in the United States.’ *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 937-938 (D.C. Cir. 1991) (“*ACT I*” hereafter). “[N]either the statute nor its legislative history precisely defines the term ‘currently accepted medical use’; therefore, we are obliged to defer to the Administrator's interpretation of that phrase if reasonable.” *ACT I*, 930 F.2d at 939. Again, this decision was prior to the enactment of the first state medical marijuana law in 1996.

Medical use is not defined in 21 U.S.C. § 812 because it is defined in 21 U.S.C. § 903. If no state accepts the medical use of a drug or other substance, the DEA can make an independent determination of whether it has accepted medical use despite the lack of accepted medical use in any state. However, when a state

accepts the medical use of a drug or other substance, then the **DEA** is bound by that state's decision because of 21 U.S.C. § 903.

“A drug is placed in Schedule I if (1) it ‘has a high potential for abuse,’ (2) it has “no currently accepted medical use in treatment in the United States,’ and (3) ‘there is a lack of accepted safety for use of the drug ... under medical supervision.’ 21 U.S.C. § 812(b)(1) (1988) (emphasis added). The Schedule II criteria are somewhat different: (1) the drug ‘has a high potential for abuse,’ (2) it ‘has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions,’ and (3) ‘abuse of the drug ... may lead to severe psychological or physical dependence.’ 21 U.S.C. § 812(b)(2) (1988) (emphasis added).

***Alliance for Cannabis Therapeutics v. DEA***, 15 F.3d 1131, 1133 (D.C. Cir. 1994)

(“**ACT II**” hereafter). “[T]he Administrator found on December 29, 1989, that marijuana had no currently accepted medical use.” **ACT II**, 15 F.3d at 1134.

Again, 1989 was 7 years prior to the enactment of the first state medical marijuana law in 1996. The administrator had the statutory authority to determine whether marijuana had any accepted medical use in 1989. Now, and since 1996, the **DEA** no longer has any statutory authority to determine whether marijuana has accepted medical use, because the states have that authority under 21 U.S.C. § 903, and the states have made that determination.

**THERE IS NO POSITIVE CONFLICT BETWEEN  
STATE MEDICAL MARIJUANA LAWS AND THE CSA**

“The CSA explicitly contemplates a role for the States in regulating controlled substances, as evidenced by its pre-emption provision.” ***Gonzales v. Oregon***, 546 U.S. 243, at 251.

The Attorney General has rulemaking power to fulfill his duties under the CSA. The specific respects in which he is authorized to make rules, however, instruct us that he is not authorized to make a rule declaring

illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.

***Gonzales v. Oregon***, 546 U.S. 243, at 258.

As for the federal law factor, though it does require the Attorney General to decide “[c]ompliance” with the law, it does not suggest that he may decide what the law says. Were it otherwise, the Attorney General could authoritatively interpret “State” and “local laws,” which are also included in 21 U.S.C. § 823(f), despite the obvious constitutional problems in his doing so.

***Gonzales v. Oregon***, 546 U.S. 243, at 264.

The statute and our case law amply support the conclusion that Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally. The silence is understandable given the structure and limitations of federalism, which allow the States “great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.” *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475, 116 S. Ct. 2240, 135 L. Ed. 2d 700 (1996) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985)).

The structure and operation of the CSA presume and rely upon a functioning medical profession regulated under the States’ police powers. The Attorney General can register a physician to dispense controlled substances “if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.” 21 U.S.C. § 823(f). When considering whether to revoke a physician’s registration, the Attorney General looks not just to violations of federal drug laws; but he “shall” also consider “[t]he recommendation of the appropriate State licensing board or professional disciplinary authority” and the registrant’s compliance with state and local drug laws. *Ibid.* The very definition of a “practitioner” eligible to prescribe includes physicians “licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices” to dispense controlled substances. § 802(21). Further cautioning against the conclusion that the CSA effectively displaces the States’ general regulation of medical practice is the Act’s pre-emption provision, which indicates that, absent a positive conflict, none of the Act’s provisions should be “construed as

indicating an intent on the part of the Congress to occupy the field in which that provision operates . . . to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State." § 903.

***Gonzales v. Oregon***, 546 U.S. 243, at 269-271. See ***San Diego v. NORML***, 165 Cal. App. 4th 798, 81 Cal. Rptr. 3d 461 (2008) (the court found that issuing identification cards to medical marijuana users in California does not create a “positive conflict” between California law and the federal CSA). “[T]he CSA’s preemption clause showed Congress ‘explicitly contemplates a role for the States in regulating controlled substances’ (*Gonzales v. Oregon*, at p. 251), including permitting the states latitude to continue their historic role of regulating medical practices.” ***Id.*** 165 Cal. App. 4th, at 821, 81 Cal. Rptr. 3d, at 477.

Even though regulation of health and safety is "primarily, and historically, a matter of local concern," *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719, 105 S. Ct. 2371, 85 L. Ed. 2d 714 (1985), there is no question that the Federal Government can set uniform national standards in these areas. See *Raich, supra*, at 9, 125 S. Ct. 2195, 162 L. Ed. 2d 1. In connection to the CSA, however, we find only one area in which Congress set general, uniform standards of medical practice. Title I of the Comprehensive Drug Abuse Prevention and Control Act of 1970, of which the CSA was Title II, provides that

“[The Secretary], after consultation with the Attorney General and with national organizations representative of persons with knowledge and experience in the treatment of narcotic addicts, shall determine the appropriate methods of professional practice in the medical treatment of the narcotic addiction of various classes of narcotic addicts, and shall report thereon from time to time to the Congress.” § 4, 84 Stat. 1241, codified at 42 U.S.C. § 290bb-2a.

This provision strengthens the understanding of the CSA as a statute combating recreational drug abuse, and also indicates that when Congress wants to regulate medical practice in the given scheme, it does so by explicit language in the statute.

*Gonzales v. Oregon*, 546 U.S. 243, at 271-272.

### **SAFETY FOR USE UNDER MEDICAL SUPERVISION**

Marijuana's safety for use under medical supervision is controlled by the same factors that determine its "accepted" medical use (which is defined by the States pursuant to 21 U.S.C. § 903). Both the courts and the DEA acknowledge this. "Petitioners also quarrel with the Administrator's decision that marijuana lacks 'accepted safety for use.' Since the Administrator based this determination on his decision that no medical uses are possible (and thus any use lacks 'accepted safety'), we do not see that 'safety' issue as raising a separate analytical question." *Alliance for Cannabis Therapeutics v. Drug Enforcement Administration*, 930 F.2d 936, 940 n.4 (1991). The DEA Administrator agreed with the analysis of the U.S. Court of Appeals. "The scheduling criteria of the Controlled Substances Act appear to treat the lack of medical use and lack of safety as separate considerations. Prior rulings of this Agency purported to treat safety as a distinct factor. 53 FR 5156 (February 22, 1988). In retrospect, this is inconsistent with scientific reality. Safety cannot be treated as a separate analytical question." 57 Fed. Reg. 10499, 10504 (March 26, 1992).

### **POTENTIAL FOR ABUSE**

Although "potential for abuse" is identical in both Schedule I and Schedule II, and the only difference between Schedule I and Schedule II is whether a substance has accepted medical use in treatment in the United States, it is worth noting that marijuana has no potential for abuse at all.

Congress had doubts about placing marijuana in the **CSA** and established a Presidential Commission to resolve those doubts. Section 601 of the **CSA**, Public Law 91-513, October 27, 1970, 84 Stat. 1236, 1280-1281, established a Commission on Marihuana and Drug Abuse. The Report of the Commission recommended that marijuana be decriminalized and removed from international drug control. See *NORML v. DEA*, 559 F.2d 735, 751 n.70 (D.C. Cir. 1977) (“[T]he Commission recommended that ‘the United States take the necessary steps to remove cannabis from the Single Convention on Narcotic Drugs (1961)’ . . .”).

The only review of marijuana conducted under the process in the **CSA** for rescheduling of drugs resulted in a finding that: “Marijuana, in its natural form, is one of the safest therapeutically active substances known to man.” In the Matter of Marijuana Rescheduling, DEA Docket No. 86-22, September 6, 1988, at pages 58-59.

### **ONGOING LITIGATION**

Because the **DEA** has failed to remove marijuana from schedule I of the **CSA** after California legalized medical use in 1996, the **DEA** is clearly in violation of federal law. A civil action to enjoin the **DEA** from further illegal enforcement of its unlawful scheduling of marijuana in Schedule I of the **CSA** has been filed in the United States District Court for the Southern District of Iowa, *Carl Olsen v. Michael Mukasey, et al.*, No. 4:08-cv-370 (filed on September 16, 2008).

### **CONCLUSION**

It is clear from the legislative history, the language of the statute, and the case law, that the findings required by 21 U.S.C. § 811 can never justify the inclusion of drugs or substances which have accepted medical use in treatment in the United States in Schedule I of the **CSA**. Congress explicitly recognized the authority of the states to determine accepted medical use. Congress explicitly expressed its intent not to preempt state laws regarding accepted medical use of drugs or substances. 21 U.S.C. § 903. **Gonzales v. Oregon**, 546 U.S. 243 (2006).

Prior to 1996, in the absence of any state law accepting the medical use of marijuana, it was entirely acceptable for the **DEA** to apply the requirements of 21 U.S.C. § 811 to marijuana in determining whether it should remain in Schedule I or be transferred to a lower schedule. **Alliance for Cannabis Therapeutics v. DEA**, 930 F.2d 936 (D.C. Cir. 1991); **Alliance for Cannabis Therapeutics v. DEA**, 15 F.3d 1131 (D.C. Cir. 1994).

It is now entirely unlawful for the DEA to maintain marijuana in Schedule I because marijuana now has accepted medical use in treatment in the United States. If a substance has accepted medical use in treatment in the United States, it cannot be in Schedule I. **Grinspoon v. DEA**, 828 F.2d 881 (1st Cir. 1987); **United States v. Oakland Cannabis Buyers' Cooperative**, 532 U.S. 483 (2001).

Respectfully submitted:

*Filed Electronically*

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### **CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on November 12, 2008 I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

KIMBERLY C. BUNJER, Assistant U.S. Attorney

*Filed Electronically*

MICHAEL F. MALONEY