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OAKLAND CANNABIS BUYERS'
COOPERATIVE AND JEFFREY JONES

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

CANNABIS CULTIVATOR'S CLUB, et al.,

Defendants.

AND RELATED ACTIONS.

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0089 CRB
C 98-0245 CRB

DEFENDANTS' REQUEST FOR JUDICIAL NOTICE
[FED. R. EVID. 201]

Date: September 28, 1998
Time: 2:30 p.m.
Courtroom: 8
Hon. Charles R. Breyer

Defendants Oakland Cannabis Buyers' Cooperative and Jeffrey Jones hereby request the Court to take judicial notice pursuant to Federal Rule of Evidence 201 of the following:

1. Declaration of Marcus A. Conant, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit A. It is appropriate for a court to take judicial notice of a court file in a related case in the same district. Fed. R. Evid. 201; *Cagan v. Intervest Midwest Real Estate Corp.*, 774 F. Supp. 1089, 1091 n. 1 (N.D. Ill. 1991).

2. Declaration of Neil M. Flynn, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit B. *Id.*

3. Declaration of Milton N. Estes, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit C. *Id.*

4. Declaration of Arnold S. Leff, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit D. *Id.*

5. Declaration of Howard D. Maccabee, Ph.D., M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit E. *Id.*

6. Declaration of Debasish Tripathy, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit F. *Id.*

7. Declaration of Stephen Eliot Follansbee, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit G. *Id.*

8. Declaration of Stephen O'Brien, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit H. *Id.*

9. Declaration of Donald W. Northfelt, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit I. *Id.*

10. Declaration of Virginia I. Cafaro, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit J. *Id.*

11. Declaration of Robert C. Scott, III, M.D. filed in case No. C 97-0139 FMS, a true and correct copy of which from the Northern District of California court file is attached hereto as Exhibit K. *Id.*

12. Declaration of Rebecca Nikkel previously filed in case No. C 98-00086 CRB, a true and correct copy of which is attached hereto as Exhibit L. A court must take judicial notice of a previous filing in the same case. Fed. R. Evid. 201; *United States v. Gariano*, 1993 U.S. Dist. LEXIS 11515, *13.

8. Declaration of Lucia Y. Vier previously filed in case No. C 98-00087 CRB, a true and correct copy of which is attached hereto as Exhibit M. *Id.*

9. Declaration of Edward Neil Brundridge previously filed in case No. C 98-00088 CRB, a true and correct copy of which is attached hereto as Exhibit N. *Id.*

10. Declaration of Ima Carter previously filed in case No. C 98-00088 CRB, a true and correct copy of which is attached hereto as Exhibit O. *Id.*

Dated: September 12, 1998

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EXHIBIT A

ED PAPER

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ORIGINAL
FILED

FEB 14 1997

RICHARD W. WIEKING
CLERK, U.S. DISTRICT COURT,
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF MARCUS A. CONANT, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF MARCUS A. CONANT, M.D.

I, Dr. Marcus A. Conant, declare as follows:

1. I am a physician licensed to practice in the State of California and a clinical professor of dermatology at the University of California Medical Center in San Francisco ["UCSF"], where I have taught for more than 30 years. I am also Medical Director of the largest private HIV/AIDS practice in the San Francisco Bay Area. Since establishing that practice, my colleagues and I have treated some 5,000 HIV-infected men and women, and we currently provide care for approximately 3,000 AIDS patients in both our clinic and our research facility.

2. I received a bachelor's degree in 1957 and a doctorate in 1961, both from Duke University. I subsequently completed an internship in internal medicine at the Duke University Medical Center (1961-1962), and a residency in dermatology at UCSF in San Francisco (1964-1967). I received further training at the School of Aerospace Medicine in San Antonio, Texas, and served in the United States Air Force from 1962 to 1964, as both a Medical Officer and a Flight Surgeon. I continued to serve as an Air Force Reserve Officer until 1967.

3. Since joining the UCSF faculty as a Clinical Instructor in 1967, I have held numerous positions, including Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor of Dermatology, a post I have held since 1984. I was Chief of both the Dermatology Clinic and the Dermatology Inpatient Service from 1967 through 1970, Co-Director of the Medical Center's Kaposi's Sarcoma Clinic (1981-1985), and Director of its AIDS Clinical Research Center (1983-1985). I am currently an Adjunct Professor at its Mount Zion Medical Center as well.

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4. Throughout my career, I have also been a consultant to numerous agencies and service providers, both public and private, including San Francisco General Hospital, the U.S. Public Health Service Hospital, UC Medical Center's Director of Hospitals and Clinics, and the California State Assembly Ways and Means Committee's AIDS Task Force. I have been appointed to similar task forces and committees of the Fifth Congressional District, the California State Department of Health Services, the California Medical Association, the San Francisco Medical Society, the American Academy of Dermatology, and the City of San Francisco. In 1983, I represented the United States at the World Health Organization meeting on AIDS. I served as Medical Director of the National Public Health Project Against AIDS for several years. I am currently a member of United States Senator Dianne Feinstein's AIDS Committee.

5. I have authored and co-authored some 70 articles in scholarly and professional journals, most of which deal with the diagnosis and treatment of AIDS and AIDS-related conditions. My work has been published in the Journal of the American Medical Association, New England Journal of Medicine, Western Journal of Medicine, Journal of the American Academy of Dermatology, Journal of Infectious Disease, American Journal of Clinical Pathology, Journal of Clinical Immunology, Journal of Osteopathic Medicine, American Journal of Oral Medicine, Public Health Reports, Clinical Research, American Journal of Pathology, and The Lancet. My colleagues and I have contributed chapters to medical textbooks, research publications, clinical protocols and conference reports. I am a frequent presenter at national and international conferences and congresses.

6. Many of the therapies used in the treatment of AIDS-related conditions can cause symptoms and medical complications which themselves are physically painful and medically dangerous. The most frequently cited example is chemotherapy, which is often a

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first-line treatment in the aggressive treatment of cancer. Chemotherapy has also been used in the treatment of several common AIDS-related conditions, including lymphoma and Kaposi's sarcoma. Chemotherapy -- administering medications such as adriamycin, fluorouracil, cytotoxin and methotrexate, usually in combination -- has proven to be highly effective in the treatment of many cancers, extending lives and relieving the symptoms of many individuals whose conditions were once considered hopeless. These medications have been approved by the FDA. Nonetheless, chemotherapy protocols used in the treatment of cancer often cause nausea and retching which is sometimes thoroughly disabling. They can result in severe weight loss, which itself has troubling implications not only for the efficacy of the treatment, but for a patient's health generally. The medications are indeed toxic. Administration of these drugs always includes considering potential adverse effects, advising the patient of the risks and providing information and treatment to reduce harmful or undesirable side effects. Acknowledgment and clinical treatment of those effects are standard and necessary parts of the chemotherapy protocols.

7. Other drugs frequently prescribed in the treatment of AIDS-related conditions have the potential to cause adverse medical conditions. Among them are AZT, ddI, ddC and d4T, all of which are approved by the FDA. More recently, physicians have prescribed a class of drugs known as "protease inhibitors," often in combination with other medications. The results have been very promising. Physicians are seeing positive clinical results, and laboratory findings (blood tests) show remarkable improvements. Many patients report great relief from physical suffering. These drugs are now approved by the FDA. One common AIDS-related condition is wasting syndrome, which undermines both the immune system generally and a patient's ability to withstand the effects of other therapies. The FDA has

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approved the use of Somatropin (human growth syndrome), as well as Megace and Marinol, to reverse the disabling effects of wasting syndrome.

8. As with all medications, further research is essential to our understanding of these medications. As research continues, the use of these medications (*e.g.*, dosages, means of ingestion, combination therapies) will be refined to maximize the potential for treatment and minimize adverse reactions. That is the very nature of research. There are always risks. As scientists, we identify those risks and provide information to reduce and ultimately eliminate those risks. As healers, we advise our patients accordingly and work with them to address their individual medical needs. Caution and candor are essential to maintaining scientific integrity and providing effective treatment.

9. Medical marijuana has been used extensively by physicians throughout the United States in the treatment of cancer and AIDS patients. It stimulates the appetite and promotes weight gain, in turn strengthening the body, combating chronic fatigue, and providing the stamina and physical well-being necessary to endure or withstand both adverse side effects of ongoing treatment and other opportunistic infections. It has been shown effective in reducing nausea, neurological pain and anxiety, and in stimulating appetite. When these symptoms are associated with (or caused by) other therapies, marijuana has been useful in facilitating compliance with more traditional therapies. It may also allow individual patients to engage in normal social interactions and avoid the despair and isolation which frequently accompanies long-term discomfort and illness. In glaucoma patients, marijuana has been effective in decreasing inter-ocular pressure. The evidence behind these findings is both scientific and anecdotal. The research in this area has been documented and published in the leading scientific journals, including the New England Journal of Medicine and Annals of Internal Medicine.

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10. In my practice, marijuana has been of greatest benefit to patients with wasting syndrome. I do not routinely recommend marijuana to my patients, nor do I consider it the first line of defense against AIDS-related symptoms. However, for some patients, marijuana proves to be the only effective medicine for stimulating appetite and suppressing nausea, thus allowing the AIDS patient to recover lost body mass and become healthier. Likewise, for some of my patients undergoing chemotherapy, when conventional drugs fail to relieve the severe nausea and vomiting, I often find that marijuana provides the patient with the ability to eat and to tolerate aggressive cancer treatments. As with any medication, I am aware of the potential for abuse and I am cautious in the information I provide. Some of my patients are using marijuana, which I learn in the course of my treatment. I advise those patients of the risks that marijuana may pose. In some instances, I have counseled patients to discontinue or decrease their use of marijuana. In patients with a history of substance abuse, I am especially vigilant in recommending caution. Physicians have always been held to that standard, whether the medication is Valium, morphine, Xanax, or marijuana. Safeguards to decrease the incidence and effects of substance abuse are already in effect. Medical practices in prescribing and recommending all treatments are monitored and subject to professional and legal guidelines.

11. It is the sanctity of the doctor-patient relationship that enables this counseling and guidance to take place. The unique nature of that relationship has been recognized throughout history. Legally, ethically and clinically, a physician has unique duties to a patient in his or her care. When I treat a patient with a potentially terminal condition, I provide the information and treatment that can literally determine whether my patient lives or dies. My duty is to provide accurate and complete information and treat each patient according to his or her individual symptoms, medical history and clinical responses. Each

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patient's medical needs are unique, as are his/her responses to specific therapies. Confidential communication is essential to this process.

12. As a physician responsible for the care and well-being of my patients, I cannot ignore information which might affect my assessment of a patient's condition or assist me in providing the best care possible. If I have knowledge that a patient is smoking marijuana, I would be seriously remiss if I failed to address the medical consequences with that patient. If I have information that limited use of marijuana may provide relief from disabling symptoms, I feel duty-bound to provide that information. If I believe, in my clinical judgment, that the risks to that patient may be reduced if the marijuana is ingested by means other than smoking (*e.g.*, by eating baked goods or drinking a tea with marijuana infusion), I have a duty to provide that information as well. That knowledge is based on my scientific knowledge, clinical judgment, and common sense.

13. My knowledge and clinical judgment are informed by all credible sources, including the federal Food and Drug Administration. I was one of the principal investigators of an FDA-supervised trial conducted by Unimed, Inc. on the safety and efficacy of Marinol as an appetite stimulant in HIV/AIDS patients suffering from wasting syndrome. Marinol is a form of THC, one of the key active components of marijuana; it is essentially a marijuana extract. It was approved by the FDA five years ago, and has been widely prescribed by physicians treating both AIDS and cancer patients.

14. The current edition of the Physician's Desk Reference, the most widely-used and comprehensive authority on prescription medications, states that:

> Marinol (dronabinol) is indicated for the treatment of:
> 1. anorexia associated with weight loss in patients with AIDS; and
> 2. nausea and vomiting associated with cancer chemotherapy in patients who

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have failed to respond adequately to conventional antiemetic treatments.[1] Stedman's Medical Dictionary, another highly respected and widely-used reference work, as part of its definition of "cannabis," includes the following:

> C[annabis] was formerly used as a sedative and analgesic; now available for restricted use in management of iatrogenic[2] anorexia, especially that associated with oncologic chemotherapy and radiation therapy.[3]

I am aware of no medical report that would indicate serious adverse effects arising from the clinical use of Marinol.

15. I am aware, however, that Marinol (like any medication) is not effective in treating all patients. In some cases, the reason is simple: Marinol is taken orally, in pill form. Patients suffering from severe nausea and retching cannot tolerate the pills and thus do not benefit from the drug. There are likely other reasons why smoked marijuana is sometimes more effective than Marinol. The body's absorption of the chemical may be faster or more complete when inhaled. Means of ingestion is often critical in understanding treatment efficacy. Research has revealed, for example, that insulin, which is critical in the treatment of diabetes, is rendered ineffective when taken orally. Medications commonly used to treat asthma and lung infections are routinely administered through inhalers. Marinol is not currently available in any form other than pills. These are scientific facts which inform my clinical practice. I cannot ignore them or deprive my patients of that knowledge.

16. I am aware that federal government officials have issued threats of criminal, civil and administrative sanctions against physicians who recommend the use of marijuana or

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[1] *Physicians' Desk Reference*, 50th Edition (1996: Medical Economics), p. 2232.

[2] "Iatrogenic" conditions are those which result from medical treatments or procedures, such as chemotherapy-related nausea or weight loss.

[3] Spraycar, M. (ed.), *Stedman's Medical Dictionary*, 26th edition (1995: Williams & Wilkins), p. 269.

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counsel and advise patients regarding the clinical risks and benefits of marijuana. They have repeatedly stated that providing counsel and advice regarding the clinical use of marijuana is a violation of federal law. I see these public pronouncements as a threat to the integrity of my medical practice. While there are certainly limitations on my ability to obtain or prescribe medications, I cannot ethically withhold information or scientific data which may be of benefit to my patients. If I am prohibited from advising my patients on any matter affecting their health, I am unable to exercise clinical judgment and provide effective treatment.

17. Such interference in my communications with individual patients can do immeasurable damage to my relationship with specific patients, thereby undermining my ability to provide effective treatment generally. Without the element of mutual trust and protected confidentiality, many of my patients will be unable or unwilling to provide me with information essential to my medical assessment. As a result, I am disarmed in my struggle against illness and suffering. They are deprived of basic medical information which could inform their behavior and relieve their disabilities. In light of the recent government threats, I have already limited my discussions with patients and directed my staff (including other physicians) to use extreme caution when obtaining medical histories or answering patient inquiries about marijuana. Even this degree of wariness and apprehension has a chilling effect on my rapport with patients. They see me as part of their fight for life. Government threats disarm me in that struggle, and it is my patients who will ultimately suffer.

18. I have already stated that marijuana has proven effective in addressing many symptoms caused by medically prescribed treatments. The adverse affects of these therapies are particularly troubling to both the patient and the physician. In my practice, I frequently recommend treatments which, in the short term, may result in increased discomfort and visible suffering. They may also have adverse implications for the patient's long-term health.

I cannot, in good faith, recommend these procedures and medications without a professional commitment to decrease, prevent or reduce the effects of these conditions.

19. Failure to consider every possible means of alleviating adverse side effects has very serious implications. When a patient can no longer tolerate the adverse consequences, she or he will cease treatment. I have seen it many times in my own practice and my colleagues report it consistently. It is a tragic fact which we monitor and assess constantly. In the case of chemotherapy and many AIDS medications, terminating treatment can mean an early and often painful death. It results in hopelessness where there should be, or could be, hope. As a scientist and a healer, preventable suffering and unnecessary despair are unacceptable.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed this 14 day of February, 1997 in San Diego, California.

MARCUS A. CONANT, M.D.

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EXHIBIT B

16

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF NEIL M. FLYNN, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF NEIL M. FLYNN, M.D.

I, Dr. Neil M. Flynn, declare as follows:

1. I am a Professor of Clinical Medicine in the Division of Infectious Diseases of the Department of Internal Medicine at the University of California at Davis School of Medicine. I also serve as attending physician in the University Medical Center's AIDS and Related Disorders Clinic. I received my B.A. in bacteriology from the University of California at Los Angeles in 1970, graduated from the Ohio State University Medical School in 1973, and did my internship and residency in internal medicine at Loma Linda University Hospital from 1973-76. I completed a fellowship in infectious diseases at the University of California at Davis from 1976-78 and was awarded my Master of Public Health from the University of California, Berkeley, in 1994. I am licensed to practice medicine in the State of California.

2. I am a member in good standing of several professional societies including the American Public Health Association; Infectious Diseases Society of America; American College of Physicians; and the American Society for Microbiology. I am board certified in Internal Medicine and in Infectious Diseases.

3. In addition, I have served on numerous hospital and medical school committees at the University of California, Davis (UCD). Currently, I am the Chairperson for the UCD Human Subjects Review Committee, and a member of the Chancellor's Committee on AIDS. Previously, I have served as a member of the Department of Internal Medicine Quality Assurance Committee, the Medical Director of the AIDS & Related Disorders Clinic, and Chair of the Infection Control Committee.

4. Among the awards I have received are the ACP Humanitarian Award (1995), Sacramento Regional Pride Award (1991), Lambda Community Award (1988), Kaiser

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Foundation Hospitals Award for Excellence in Teaching Clinical Sciences (1986), Outstanding Staff Award at UCD Medical Center (1982-83), and the Roessler Foundation Research Scholarship Award (1972-73). I have successfully sought hundreds of thousands of dollars in grant money to pursue research on HIV and AIDS since establishing the UCD Clinic in 1983.

5. The continuation of this research depends upon my ability to obtain future grants from both private and public sources. I am the principal author or co-author of numerous articles and book chapters in the area of infectious diseases. My writings have appeared in such journals as *The New England Journal of Medicine*, *Journal of the American Medical Association*, *Western Journal of Medicine*, *Life Sciences*, *Annals of the New York Academy of Sciences*, and *Journal of Acquired Immune Deficiency Syndromes*. I have also delivered numerous lectures at professional symposia, in this and other countries, including the Third through Tenth International Conferences on AIDS.

6. Through the University's AIDS Clinic and the Center for AIDS Research, Education and Services (CARES), a private, non-profit clinic for treatment of HIV infection and disease, I participate in the care of approximately 1,500 AIDS patients. I am the primary physician for 200 AIDS patients.

7. Intractable nausea and wasting syndrome are frequent symptoms associated with AIDS and the treatment of AIDS. The nausea, which can last for days, weeks or months, is one of the most severe forms of discomfort or pain that the human being can experience. It destroys the quality of life of the patient, whose sole objective is to make it through the next hour, the next day. Racked by intense vomiting and queasiness, time for the patient seems to stand still. Wasting can take a similar psychological and physical toll.

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8. . For patients suffering intractable nausea and/or wasting, my first concern is to relieve these symptoms. If I fail to do so, the patient is increasingly likely to decide that life is simply intolerable. I have had patients whose nausea and/or wasting were so disabling that they preferred death. As a physician, I try my utmost to avoid this end result.

9. Fortunately, I often can relieve the patient's acute suffering and, thereby, restore her quality of life to an acceptable level. My first line of therapy for acute nausea involves the use of Compazine or Reglan. Sometimes these traditional anti-emetics do not work, either because they fail to reduce the nausea and/or the patient does not tolerate them well. The drugs themselves have side effects, and can cause impairments in a patient's fine and gross motor skills. As a result, patients sometimes move in a slow, stiffened manner. Their faces may appear frozen. And they can develop severe muscle contractions. Many of these side effects are similar to those experienced by patients treated with Thorazine and Haldol. I have also tried prescribing a newer drug called ondansetron which was developed specifically for the treatment of chemotherapy-induced nausea. The success of ondansetron varies greatly among patients. Lastly, benzodiazepines can be tried.

10. If I am unable to relieve the patient's nausea with the above remedies, I next prescribe Marinol, a synthetic version of THC, one of the main active compounds found in marijuana. Marinol is also helpful in stimulating appetite in patients suffering from AIDS wasting, as are other drugs, Megace, anabolic steroids, and human growth hormone.

11. If Marinol does not provide adequate relief from nausea and/or wasting, I may suggest that the patient try a related remedy, marijuana. I firmly believe that medical marijuana is medically appropriate as a drug of last resort for a small number of seriously ill patients. Over 20 years of clinical experience persuade me of this fact. The anecdotal evidence is overwhelming. Almost every patient I have known to have tried marijuana

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achieved relief from symptoms with it. That success rate far surpasses that for Compazine. Accordingly, as with any other medication that I consider potentially beneficial to my patients, I must discuss the option of medical marijuana in detail when appropriate. Anything less is malpractice.

12. For those patients for whom I believe marijuana is an appropriate remedy, I discuss the various ways in which marijuana can be ingested. Smoking marijuana is the most direct, rapid, and accurate delivery of the drug. But smoking has the drawback of putting particulate matter in the patient's lungs. This is of concern to me because studies show that AIDS patients who are heavy cigarette smokers shorten their life spans by about 2 years. It is not unreasonable to surmise that heavy marijuana smoking could lead to similar results. Nevertheless, smoking may be the most accurate way to deliver a number of drugs, including nicotine or marijuana. Furthermore, there are ways of reducing particulate intake, for example through the use of water pipes which tend to filter the smoke, and consumption of unadulterated marijuana.

13. I inform my patients that they may try eating marijuana. But this, too, is not without difficulties similar to those experienced by many patients who try Marinol. Eating marijuana (or ingesting a Marinol capsule) can cause unpredictable results because the absorption of the THC can either be rapid or delayed, depending on whether the patient ingests the marijuana on a full stomach. The same is true for drinking marijuana tea.

14. In my experience, the unpleasant side effects that some patients experience from marijuana, however it is ingested, are far less severe than the side effects experienced from Compazine and Reglan and similar drugs. Nor do I have to worry about harmful drug interactions with patients who use therapeutic doses of marijuana: to my knowledge, there are none. If a patient presents with both nausea and anxiety, I can prescribe Compazine and

Valium. However, marijuana can effectively treat both conditions simultaneously. It is not at all clear to me that the combination of Compazine and Valium, both of which are toxic, the latter of which is addictive, is better than marijuana alone.

15. As the above approach illustrates, I begin treating my AIDS patients by listening to their complaints and concerns. For symptoms such as intractable nausea and wasting syndrome, I first prescribe those medications that are legal. If these medications do not work, or prove intolerable, I then discuss the option of medical marijuana, which appears near the bottom of my cascade of options. But because I consider marijuana a legitimate medical option at all, I stand squarely in the cross-hairs of the federal government's official policy against medical marijuana and the doctors who recommend it. The government's threats to sanction physicians who, in their best medical judgment, recommend marijuana to treat a seriously ill patient are threats against me.

16. AIDS medicine is my profession and my passion. I have dedicated myself to this disease since 1983 when I opened the Clinic at U.C. Davis. Thus, I am deeply concerned about civil and criminal sanctions that loom over me. I do not want my job to be taken away by some government official who has a different medical paradigm than I, many of my colleagues, or for that matter, the majority of California voters. If I lost my Schedule II license, my ability to provide care for people with AIDS -- 80% of my patients -- would be severely compromised. I write 30-50 narcotic prescriptions per month for my seriously ill patients. I would no longer be able to do so if my DEA license were revoked.

17. I feel compelled and coerced by the government threats to withhold information, recommendations, and advice to patients regarding the use of medical marijuana. This state of affairs is unacceptable in medicine. My patients come to me seeking relief from pain or suffering or the threat of death or disability. Their complex and severe

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illnesses are often complicated by difficult personal situations. The government's threats inject yet another complication into the mix.

18. The threats erect a barrier between me and the patient. Yet the patient's trust is essential if I am to provide the best medical care possible. If, in an attempt to protect me from government sanctions, patients refrain from discussing the fact that they find relief from marijuana, I lose an opportunity to suggest that they try Marinol (if they have not done so already). Marinol, which is legal and covered by health insurance, can save the patient considerable money and anxiety, if it works. Similarly, if patients do not inform me that they can only control their nausea with marijuana, I remain ignorant of the full extent of the side effects of their illness or medications and miss the chance to change patients' bothersome medications in order to lessen or eliminate the nausea for which they have resorted to marijuana.

19. More fundamentally, I need to know how much pain my patients suffer. If I don't know this, I cannot perform my job effectively. If a patient, because of the government's threats, fails to inform me that s/he uses marijuana for nausea or wasting, but the marijuana is not very effective (although perhaps more effective and less deleterious than prescription medications), perhaps the patient is not using potent enough marijuana. As a physician, it is my duty to inquire into this possibility, and, where appropriate, suggest trying a different type of marijuana.

20. Protease inhibitors, the newest and perhaps most effective drugs in the battle against AIDS, are beginning to lose their efficacy in some AIDS patients. When this happens, wasting syndrome, a potentially deadly process, begins. Body mass lost to wasting is difficult to regain. Therefore, it is preferable to stop wasting as early in the process as possible. To effectively treat wasting, I must know when wasting starts and at what pace it occurs. Thus, it

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is important to know if a patient is combating wasting with marijuana. Such behavior signals that I should consider prescribing other drugs, such as Megace or anabolic steroids. The government's threats, however, hamper the free exchange of information and advice necessary to an accurate and comprehensive diagnosis of the patient's condition.

21. The government's threats have been the subject of discussion among my colleagues who provide care to AIDS patients in the greater Sacramento area. As a general policy, a group of physicians who treat approximately 1,200 AIDS patients decided to speak with their seriously ill patients about the benefits and drawbacks of medical marijuana, but not to record this information to protect the patient from government recrimination which could cause them far greater harm than the use of the drug itself. The policy also aimed to protect physicians and the institutions with which they are affiliated from government sanctions or liability. Such a policy -- don't chart, just tell -- flies in the face of how doctors are trained, and is not necessarily in the patient's best interest. If salient facts regarding the patient's medical condition and treatment do not appear in the patient's chart, a consulting physician or the patient's next physician may be deprived of critical facts necessary to provide adequate care. Doctors need every bit of information available to treat their seriously ill patients.

22. The absence of information in a patient's chart also robs doctors of the ability to scientifically study the efficacy of marijuana in the treatment of various symptoms. If only every fifth patient chart accurately reflects the fact that Compazine failed as an anti-nauseant and the patient successfully resorted to medical marijuana, while, in reality every third patient presented with this history, the medical landscape which scientists analyze is deeply distorted. What we cannot see we conclude to be nonexistent. Thus, the government's calls for further research of marijuana are undermined by its concurrent threats against physicians which

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result in the suppression of the data on which such research depends. The failure to record medical history in patient charts risks perverting scientific attempts to assess the use and efficacy of marijuana.

23. Doctors neither want to overdramatize nor obfuscate what they learn from their patients. Doctors should be free to record the information they learn and their ideas as they arise. We frequently do not understand everything we see or hear the first time we see or hear it. In my patient charts I sometimes write "Puzzling" or "not clear" if I am unsure of the significance of what I am observing or being told. I then can follow up and try to discover its true significance.

24. Physicians often consult with one another and discuss our various options of treatment and talk anecdotally about our patients' therapies, including their use of marijuana. We try to find the most effective, least toxic medications for our patients. When faced with a choice of equivalency, we opt for the least toxic treatment. When one medication is more toxic than another, but is also more effective, we discuss this fact with patients, and they pick the preferred course of action. Medicine is a constant process of adjustment. When advising a patient, I do not simply have my next move in mind, I have my next three or four moves in mind. I develop a sequence of options, in case my next move doesn't work. "If this hasn't worked in 2-3 days," I tell the patient, "we'll try something else."

25. Two of my colleagues have told me that they feel so constrained by the government threats that they will not talk with their seriously ill patients about marijuana until the issue is resolved legally.

26. The government's policy and threats make criminals out of people who are suffering from life-threatening illnesses. This stigmatization is unnecessary. The government permits doctors to prescribe narcotics, such as morphine, for the relief of pain.

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To single out doctors who recommend or patients who use medical marijuana -- a substance almost certainly less addictive than many narcotics, not to mention alcohol and nicotine -- is irrational. Benzodiazapines and barbiturates are more addictive, and far more dangerous than marijuana with respect to their ability to induce death due from overdose.

27. The federal government and the public have little to fear from physicians abusing their recommendations or prescriptions of marijuana. The vast majority of physicians dispense morphine or Valium, much more powerful drugs, without incident. It has traditionally been the province of state governments to curb abusive practices of physicians. In California, the Board of Medical Quality Assurance polices the state's medical practitioners. If a physician administers drugs in an irresponsible manner, an investigation will ensue. If the abuse is egregious, the doctor's license to practice will be revoked. There is no reason to believe that these same policing mechanisms would not be effective for marijuana.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Sacramento, California, this 13 day of February, 1997.

Neil Flynn MD

NEIL M. FLYNN, M.D.

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DECLARATION OF MILTON N. ESTES, M.D.

I, Dr. Milton N. Estes, declare as follows:

1. I am a physician licensed to practice in the State of California. I received both my undergraduate and medical degrees from the University of Chicago and completed my post-graduate medical training at St. Luke's Hospital, San Francisco. I am board certified by the American Board of Family Practice, and licensed to practice in the State of California. I am a member of the American Academy of Family Physicians, the California Academy of Family Physicians, the California Medical Association, and the Marin Medical Society.

2. From 1971 through 1974, I was Medical Director of the Orange Cove Family Health Center, a federally funded health clinic serving rural farm workers. Since 1974, I have maintained a private family practice in Mill Valley, California. In recent years, I have become the largest private provider of HIV care in Marin County. Since 1995, I have been Medical Director and Senior Physician for the Forensic AIDS Project. The Forensic AIDS Project, operated by the Department of Public Health of the City and County of San Francisco, provides early intervention, education, and medical care for inmates who are HIV-positive or who have AIDS.

3. I am presently an Attending Physician with active duties at Marin General Hospital. My previous hospital experience includes being Chair of the Department of Family Practice at Marin General Hospital, and Attending Physician at both Ross General and Mt. Zion Hospitals, and the California Pacific Medical Center (San Francisco).

4. My academic appointments include Clinical Instructor in Family Practice and Assistant Clinical Professor of Family Medicine at the University of California-Davis (1972-84), and Associate Clinical Professor in the Department of Obstetrics, Gynecology & Reproductive Medicine at the University of California-San Francisco (1983-present).

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5. I serve on several professional and community boards, include many years as a member of the Oncology Committee (1990-present), Bioethics Committee (1993-present), and AIDS Task Force (1986-present) at Marin General Hospital, as well as the Medical Advisory Board of the Coalition for the Medical Rights of Women (1984-1987). I currently serve as both the chair of Marin General Hospital's AIDS Task Force and the Marin Medical Society's AIDS Committee. I have been a member of the Marin AIDS Advisory Commission since its inception in 1987. For the past twenty years, I have lectured widely on issues of medical ethics, HIV and AIDS. In 1989, I was named Physician of the Year by the Marin Medical Society. In 1990, I received the Benjamin Dreyfus Award from the Marin Chapter of the American Civil Liberties Union; and in 1992, I received the Martin Luther King Humanitarian Award by the Marin County Human Rights Commission.

6. Last month, one of the most prestigious medical journals in the world, *The New England Journal of Medicine*, published an editorial that confirmed what practicing clinicians have long known: that relatively small amounts of marijuana can provide striking relief from intractable nausea, vomiting, pain, and anorexia that frequently plague persons suffering from cancer, AIDS, and other serious illnesses.

7. Shortly before that editorial, the nation's top law enforcement officials, joined remarkably by the Secretary of Health and Human Services, announced before cameras that they would bring the full force of government authority to bear on physicians who in their best medical judgment recommend medical marijuana to their seriously ill patients.

8. As a result of the government's public threats, I do not feel comfortable even discussing the subject of medical marijuana with my patients. I feel vulnerable to federal sanctions that could strip me of my license to prescribe the treatments my patients depend upon, or even land me behind bars. I am worried that a government agent, posing as a patient,

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will try to infiltrate my office in order to provoke a statement that the federal government considers dangerous but which I, as well as thousands of my colleagues, the *New England Journal of Medicine* and the voters of California, regard as sound medicine. As a result, I am somewhat less trusting of new patients. I am also concerned that a former patient who may himself feel vulnerable, or one who suffers an emotional disturbance (perhaps caused by the stress, anguish or dementia of late-stage AIDS) might make out-of-context reports to federal authorities that dovetail with the government's official policy regarding medical marijuana. Because of these fears, the discourse about medical marijuana has all but ceased at my medical office. If perchance the issue of medical marijuana does arise, I make no notes of the substance of the conversation for fear of government reprisal. My patients bear the brunt of this loss in communication.

9. Restrictions on the flow of relevant information between doctor and patient are, by definition, counter-therapeutic. It is critical for physicians to know what their seriously ill patients ingest. But this knowledge is generally provided by the patients themselves. That will occur only if patients trust their physician to maintain professional confidences and to use that information not to judge, but to treat. The dialogue that ensues from this atmosphere of trust continues throughout the course of treatment. I do not treat the patient as an anonymous subject; rather, the patient and I work together. We discuss together the symptoms and possible treatments. It is a critical collaborative effort.

10. Physician-colleagues work collaboratively as well. As doctors, we share and assess our observations, experiences, ideas, and knowledge. Government threats inhibit the discourse among physicians which is critical to advance our understanding of disease and the efficacy of certain treatments. Physicians are naturally reluctant to discuss any subject which

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implies or is associated with potentially illegal practices. Thus, the current threats stifle the free flow of ideas that medicine has traditionally depended upon to improve health care.

11. My fear of discussing medical marijuana precludes the climate of trust that must be established between doctor and patient. Imposed silence on any relevant issue, including the use of marijuana, leaves both patient and doctor with unspoken (and thus unanswered) questions: "What else is *not* being disclosed or addressed?" "Are we overlooking information which could be critical to medical treatment?"

12. I care for an increasing number of patients with HIV in various stages of illness. Over the years, through cautious trial and error, close observation, ongoing consultation and persistent research, AIDS researchers and front-line physicians (like myself) have developed an increasingly effective arsenal of drugs and protocols to combat HIV and AIDS. Only a few years ago, a positive test for HIV was perceived as the first step toward inevitable death. Today, our years of research have resulted in significant advances in drug therapies; there appear to be treatments which have brought us, as healers and as a community, within sight of the day when we eliminate the HIV virus and thus substantially improve the quality of life and extend the lives of persons inflicted with this epidemic.

13. However, the treatments of today, like those of previous years, are not without unknown or unintended effects. Some of my patients routinely take almost a dozen different medications each day to combat the virus and the opportunistic infections which prey on the body's compromised immune system. This daily regimen of medication poses serious problems for a significant number of my seriously ill patients. First, by definition, these pills must be swallowed. One of the frequent symptoms of HIV-related illness is severe and chronic nausea, such that swallowing pills on a regular basis can be difficult, if not impossible. To make matters worse, nausea is a common side effect of the medications

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themselves. Thus, a debilitating and demoralizing cycle sets in: the patient must repeatedly swallow pills which induce nausea, which is addressed, in turn, by yet another round of pills.

14. The inability to swallow can have devastating consequences for both treatment compliance and the patient's general health. Not only must patients be able to ingest medications, they must be able to eat and hold down food in order to obtain the nutrition essential to anyone's health. The need for regular and adequate nutrition is even more critical in patients whose compromised immune systems render them vulnerable, especially when accompanied by late-stage wasting syndrome. Moreover, some of the medications prescribed for HIV/AIDS patients must be taken on a full stomach to allow full absorption and maximum efficacy. Thus, a premium is placed on the patient's ability to swallow both medications and food. Chronic and severe nausea and loss of appetite caused by the illness and/or clinical therapies pose severe obstacles to a patient's well-being.

15. In my experience as an HIV/AIDS physician, a significant number of patients use marijuana as both an anti-emetic (anti-nauseant) or appetite stimulant. For persistent nausea, I often prescribe Compazine or Marinol, a synthetic form of THC (the active compound found in marijuana), both of which are FDA-approved. But some patients do not tolerate these medications well. Many have complained of feeling dysphoric using Marinol or find the duration of effect unduly long. These adverse effects are of concern to me, not only because of the immediate effects on patient comfort and functioning, but also because they may signal greater difficulties in patients' inability to comply with medical protocols, now and in the future. Especially with the new generation of AIDS drugs, strict compliance with daily protocols is absolutely crucial. Missing even a small number of doses can allow a drug-resistant strain of HIV to resurge, thus undermining or eliminating the effectiveness of the treatment. In circumstances where a patient is unable to comply with medical protocols, it

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18. Protease inhibitors, currently the most promising drugs in the fight against AIDS, fall within this category. Historically, the FDA has made provisions for physicians to prescribe drugs for conditions other than those for which they were initially approved. The FDA also has a compassionate use protocol which makes available to seriously and terminally ill patients those medications whose efficacy has not yet been scientifically demonstrated. Even if the FDA chooses to ignore medical experience and continue its prohibition against marijuana, it is remarkable that marijuana has not been made available under these provisions.

19. Marinol, which is essentially a marijuana derivative, has been approved for several years. Therefore, common sense tells us that there is a presumptive medical benefit to be derived from cautious use. Moreover, despite clinical studies (admittedly limited, yet far more extensive than those conducted on other FDA-approved substances), no credible research has revealed serious health risks which would justify the restrictions currently in place.

20. I have practiced medicine for almost 30 years. In that time, I have never been subjected to intimidation on the level of General McCaffrey's recent threats. I have worked hard to establish relationships with my patients that facilitate effective treatment and safeguard their privacy and integrity. The proscription against recommending the private use of marijuana, or even providing clinical information about the known risks and benefits, compromises my ability to provide sound medical treatment and relief from human suffering.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed in San Francisco, California, this 13 day of February, 1997.

MILTON N. ESTES, M.D.

EXHIBIT D

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DECLARATION OF ARNOLD S. LEFF, M.D.

I, DR. ARNOLD S. LEFF, declare as follows:

1. I am a physician licensed to practice in the State of California and have been practicing medicine for 11 years in Santa Cruz, California.

2. I received a B.S. in zoology from the University of Cincinnati in 1963. I received an M.D. from the University of Cincinnati Medical School in 1967. I completed an Internship in internal medicine at the University of Cincinnati Medical Center Hospitals in 1968. In 1969, I completed an internal medicine Fellowship in clinical pharmacology, also at the Medical Center Hospitals.

3. From 1971-72 I was Deputy Associate Director for the White House Drug Abuse Office under President Richard Nixon. In that position, I worked on a number of different areas of drug policy including: developing drug abuse programs for the Department of Defense and State Department; establishing drug treatment programs in foreign countries; implementing drug testing and treatment programs for U.S. military troops; and consulting with local law enforcement officials on implementing drug treatment programs. From 1972-75 I was a consultant to the White House Drug Abuse Office on these and other issues. During the late 1970s, I advised President Jimmy Carter's Administration on national drug policy.

4. I have had experience in drug control policy and public health in other positions as well, including as Director of Health Services for Contra Costa County, California from 1979-83.

5. Throughout those years, I also held teaching positions on medical school faculties. I was an Assistant Clinical Professor at the University of Cincinnati College of

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Medicine from 1971-79, and an Associate Clinical Professor at the University of California from 1979-84.

6. I am currently a family practitioner with an emphasis on caring for geriatric and AIDS patients. My practice includes approximately 4,000 patients overall. I have been an AIDS specialist since 1985, and currently treat approximately 110 patients for AIDS and AIDS-related conditions.

7. For many of my AIDS patients, I prescribe Marinol, a synthetic version of a primary active ingredient of marijuana, to combat severe nausea and to stimulate appetite. In some cases, however, Marinol is inappropriate because patients cannot tolerate or effectively absorb it. A significant number of my patients find that Marinol is too strong and makes them dysphoric ("high"). Many of these patients find that by smoking medical marijuana they are able to limit the dose, thereby avoiding an unwelcome dysphoric feeling.

8. I currently treat at least 20 patients for whom I believe marijuana is medically appropriate in responding to treatment-induced nausea or for appetite stimulation. In my medical judgment, in some cases medical marijuana may be the only effective medicine.

9. I am aware of threats by federal government officials against physicians who provide their patients with information regarding the potential risks or benefits of the medical use of marijuana. Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana. I have postponed discussions about the use of medical marijuana and approach such discussions with trepidation. I am fearful and reluctant to engage in even limited communications regarding medical marijuana, yet I feel a duty to provide my patients with complete medical advice.

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10. Despite my extensive experience in drug policy and medicine, I am at a loss to justify the federal government's policy of denying sick and terminal patients a medicine that can be helpful.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Santa Cruz, California, this 13 day of February, 1997.

Arnold S. Leff, M.D.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF HOWARD D. MACCABEE, Ph.D., M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF HOWARD D. MACCABEE, Ph.D., M.D.

I, DR. HOWARD D. MACCABEE, declare as follows:

1. I am a physician licensed to practice in the State of California. I have been Medical Director of the Radiation Oncology Center in Walnut Creek, California, for 17 years. I am also an Assistant Clinical Professor of Medicine at the University of California at San Francisco ("UCSF").

2. I received a B.S. from Purdue University in Lafayette, Indiana in 1961. I received a Ph.D. from the University of California at Berkeley in 1966. My dissertation research was on radiation biophysics. After extensive research in the areas of physics and medicine, I attended the University of Miami School of Medicine, where I earned an M.D. in 1975. I then completed my Internship at UCSF in 1976, followed by a three-year Residency in radiation oncology, also at UCSF.

3. I am board certified in therapeutic radiology and am a member of several professional societies. I have published 25 articles on diverse scientific and medical topics.

4. I have also studied the ethical aspects of the doctor-patient relationship and am on the bioethics committees of John Muir Medical Center and the Alameda-Contra Costa County Medical Association. I have chaired symposia on this issue between 1988 and 1994 in Contra Costa County.

5. In my practice, I commonly use radiation therapy to treat the whole spectrum of solid malignant tumors. Radiation therapy is often used after surgery or chemotherapy, as a second stage in treatment. Sometimes, however, radiation therapy is used concurrently with chemotherapy, or even as the first or only modality of treatment.

6. I treat approximately 20 patients each day and provide follow-up care and/or consultation with another 5 or so patients a day. I currently have approximately 2,000

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patients in various stages of follow-up to their initial treatment. Most of these are long-term survivors.

7. Because of the nature of some cancers, I must sometimes irradiate large portions of my patients' abdomens. Such patients often experience nausea, vomiting, and other side effects. Because of the severity of these side effects, some of my patients choose to discontinue treatment altogether, even when they know that ceasing treatment could lead to death.

8. During the 1980s, I participated in a state-sponsored study of the effects of marijuana and THC (an active ingredient in marijuana) on nausea. It was my observation during this time that some patients smoked marijuana while hospitalized, often with the tacit approval of physicians. I also observed that medical marijuana was clinically effective in treating the nausea of some patients.

9. During my career as a physician, I have witnessed cases where patients suffered from nausea or vomiting that could not be controlled by prescription anti-emetics. I frequently hear similar reports from colleagues treating cancer and AIDS patients. As a practical matter, some patients are unable to swallow pills because of the side effects of radiation therapy or chemotherapy, or because of the nature of the cancer (for instance, throat cancer). For these patients, medical marijuana can be an effective form of treatment.

10. I occasionally have patients who inquire about the use of medical marijuana. I have always considered it my ethical duty as a physician to provide every patient with the full truth as I know it. This duty includes informing patients about treatment options that I personally do not provide. For example, although I do not prescribe chemotherapy, it is my ethical obligation to discuss this treatment option with patients who are also considering undergoing radiation treatment. Because of the threats by federal officials against physicians

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who provide information to patients regarding the potential risks or benefits of the medical use of marijuana, I have had to reexamine this basic ethical principle for the first time in my professional career.

11. Due to fear caused by the threats of federal officials, I feel compelled and coerced to withhold information, refuse to make recommendations, and modify for non-clinical reasons my advice to patients regarding use of medical marijuana. Since the threats, I have not had any patients ask about medical marijuana. When I do receive such an inquiry, however, I will temper what I say to avoid the risk of government sanction. Based on my years of practice, I am concerned that my reticence in providing information will adversely affect the doctor-patient relationship, a result which is both regrettable and ethically substandard.

12. I understand that one of the reasons behind the threats is to deter physicians who may inappropriately recommend the use of medical marijuana. The threat of abuse in this context is no greater than the threat posed by doctors who misprescribe or otherwise act irresponsibly with regard to any drug. There will always be a small number of doctors who behave irresponsibly; those individual doctors should certainly be sanctioned, but not at the expense of the ability of responsible doctors to provide important medical information to their patients.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Walnut Creek, California, this 14th day of February, 1997.

Howard D. Maccabee

EXHIBIT F

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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. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF DEBASISH TRIPATHY, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF DEBASISH TRIPATHY, M.D.

I, DR. DEBASISH TRIPATHY, declare as follows:

1. I am a physician licensed to practice in the State of California. I received a B.S. degree in chemical engineering from the Massachusetts Institute of Technology in Cambridge, Massachusetts in 1981, and earned my medical degree at Duke University School of Medicine in Durham, North Carolina in 1985. I subsequently completed an internship and residency in internal medical at Duke University Medical Center, followed by a clinical fellowship in hematology and oncology, and then a post-doctoral fellowship in cancer research, both at the University of California-San Francisco ["UCSF"].

2. I have been a member of the UCSF faculty since 1991, first as a Clinical Instructor, and then (since 1993) as Assistant Clinical Professor of Medicine. I am certified by the American Board of Internal Medicine in the areas of Internal Medicine, Clinical Hematology, and Medical Oncology. I am an active member in good standing of the American Society of Clinical Oncology. I serve on the Board of Directors of Cancer Support Community, a nonprofit agency which has provided free support and advice to cancer patients and their families for the past 20 years. I am a Contributing Editor of *Breast Diseases: A Year Book Quarterly.*

3. My clinical research and publications have focused on the diagnosis and treatment of breast cancer. I am currently involved in several major research studies assessing the efficacy of specific therapies in several patient groups, including those with metastatic breast cancer. I am the Principle Investigator on fifteen of those studies. I am the author and co-author of several chapters appearing in standard medical texts. I have also published widely in scholarly and professional journals, including Annals of Internal Medicine, Journal of Clinical Oncology, Breast Cancer Research Treatment, Journal of

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Clinical Outcomes Management, and Clinical Research.

4. Since 1993, I have been a physician at the UCSF Mount Zion Breast Care Center in San Francisco. My practice is devoted exclusively to breast cancer patients. I treat more than 1,000 patients. Approximately 100 of these patients are currently undergoing chemotherapy, a treatment utilizing various combinations of powerful medications. In some cases, the therapeutic dose of the medication we use is not far from the potentially lethal dose. Although chemotherapy is a widely used treatment in the treatment of many cancers, it can also cause severe adverse affects which some patients are simply unable to tolerate. The most common adverse effects of chemotherapy are nausea and retching.

5. The nausea and retching associated with chemotherapy are often disabling and intractable. The severity of the symptoms and their medical consequences vary from patient to patient. In many cases, the immediate results are weight loss, fatigue, and chronic discomfort. The consequences can be far graver in patients whose health and functioning is already compromised. For example, the dangers associated with weight loss and malnutrition are greater in patients whose cancer has metastasized and attacked other parts of the body.

6. For most chemotherapy patients, relief from nausea is obtained through one of several medications, including Compazine or Ondansetron, a recently developed medication specifically used for relieving chemotherapy-induced nausea. In my practice, I often rely on these medications as first-line treatment for my chemotherapy patients. They are legally available and clinically effective in many patients. For those who cannot tolerate them in pill form (*e.g.*, certain patients with cancer of the colon, stomach, throat or esophagus), these and some of the other anti-nauseants are available in other forms. Compazine, for example, can be administered intravenously, intramuscularly or in suppository form. Nonetheless, these FDA-approved medications are not effective in some patients. There is no singular formula

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for treating illness -- *I. e.*, no "best medicine" which is appropriate or advisable for all patients. Indeed, the phrase "best medicine" belies the concept of individualized treatment.

7. Another medication often used to combat nausea is Marinol, a synthetic form of THC, which is one of the key active ingredients in marijuana. In my opinion, Marinol is often the third or fourth line treatment for chemotherapy-induced nausea. I generally prescribe Marinol only after Compazine or Ondansetron have proven unsuccessful in "refractory" patients -- *i.e.*, those who are resistant to traditional treatments. It is often in that patient group (those who do not respond to commonly effective treatments) that clinicians see the greatest variation. Individual responses to medication may be idiosyncratic, unexpected or otherwise unique. In those patients, cautious trial and error is essential to effective treatment. Therapies must be modified or "customized' to the unique needs and responses on the individual. Some degree of experimentation, closely monitored, is clinically appropriate.

8. Marinol is FDA-approved as an appetite stimulant and for relief from nausea associated with chemotherapy. I have prescribed Marinol to some of my patients and it has proven effective in some cases. However, scientific and anecdotal reports consistently indicate that smoking marijuana is a therapeutically preferable means of ingestion. Marinol is available in pill form only. Moreover, Marinol contains only one of the many ingredients found in marijuana (THC). It may be that the beneficial effects of THC are increased by the cumulative effect of additional substances found in cannabis. That is an area for future research. For whatever reason, smoking appears to result in faster, more effective relief, and dosage levels are more easily titrated and controlled in some patients.

9. Still, patient preferences between Marinol and marijuana are not uniform. I have had patients who stopped smoking marijuana and returned to Marinol to address their nausea. Some report bothersome side effects, including the grogginess reported by some

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Marinol users. Still others, whose fellow patients have endorsed marijuana, have been reluctant to try it for legal, social or philosophical reasons. They cite the moral stigma attached to marijuana as an illegal "drug," their concern that others will learn of their "drug" use, and practical concerns about violating the law.

10. Means of ingestion is often critical to the efficacy of specific treatments. For example, insulin is far more effective when injected. Many medications are inhaled, while others are administrated intravenously or intramuscularly. DDAVP, a synthetic pituitary hormone, is administered through a rhinal tube, through which the patient sniffs the substance.

11. Like many substances, the efficacy of Marinol is particularly variable in refractory patients. Clinicians report a range of factors which appear to increase the difficulty of identifying effective treatment. For example, younger cancer patients seem to have more difficulty with the adverse effects of chemotherapy, possibly because they generally have more acute sensory reflexes. Adverse reactions are also more common among patients with co-existing conditions. They may present with more complicated symptom pictures, and their bodies may already be weakened by the effects of pre-existing illness. Emotional and psychiatric disorders, not uncommon in seriously or terminally ill patients, may also render traditional side-effect medications less effective.

12. In my practice, the most common treatment-induced symptom reported is nausea, which is fairly subjective. and therefore difficult to measure. Because there has been relatively little research conducted on this subject, I believe that physicians have a duty to provide their suffering patients with all clinical information available. From a moral and humane point of view, my duty increases when the suffering is caused by treatments which I have recommended and administered. When I consider chemotherapy for my patients, I

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factor in the possibility of disabling adverse reactions, as well as my ability to reduce or eradicate unwanted effects. In some instances, the balance between the risks and benefits of a proposed treatment is very close. If the information I provide does not include all possible means of reducing adverse effects, my patients must make decisions with incomplete information. In other words, the balance between the pros and cons of chemotherapy (or any treatment) may be thrown off. The patient's decisions regarding treatment may therefore be ill-informed and medically regrettable. When the treatment (*e.g.*, chemotherapy) is intended to prolong life and cure cancer, the choice to forego potentially life-saving treatment can literally be fatal.

13. The balance of risks and benefits is a process which continues throughout treatment. There are patients whose adverse reactions are seemingly intolerable. It is not unusual for those patients to consider terminating therapy; some of them discontinue treatments midway through the therapeutic protocol. For them, the suffering caused by the chemotherapy outweighs the potential long-term benefits of completing the full cycle. In many cases, incomplete therapy is of little use in fighting cancer. The decision to stop treatment can shorten lives. If I believe that marijuana might reduce their suffering and allow them to complete treatment, I must provide that information.

14. I do not generally initiate discussions about marijuana, but I am ethically bound to answer questions posed by my patients. When asked, I advise my patients about the benefits and risks (both scientific and legal) inherent in the use of marijuana for medicinal purposes. Were it clearly legal, I would include marijuana as one of the medical options available in treating persistent treatment-induced nausea. I have not provided written recommendations for marijuana to my patients, but that decision is not based upon independent clinical judgment. It is colored by political and legal implications, as well as

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threats of criminal sanctions.

15. There is one additional consideration which must be addressed in this discourse. The medical benefits of marijuana are generally limited to its use in treating cancer patients and late-stage AIDS patients suffering from wasting syndrome. I am aware of no clinical or scientific reports indicating short-term risks posed by marijuana when used in small amounts. Any discussion of adverse consequences appears to focus on the effects of long-term use (*e.g.*, adverse effects on the lungs), and even those concerns are speculative. That fact must be a factor in balancing the risks and benefits. In populations with short life expectancies, the risks become less imminent and the benefits more paramount.

16. Many medications administered to combat cancer and other serious (potentially fatal) illnesses are far more toxic than marijuana. That is a consideration which I, as a healer, must acknowledge in caring for every patient in my practice. It defies common sense and sound medical practice to withhold any information which might minimize the effects of those treatments. The recent government threats to prosecute physicians for recommending, or even advising, their patients regarding marijuana place me in an unacceptable and unethical position: to fulfill my duties as a healer, I make myself vulnerable to legal sanctions which are not grounded in science or the healing arts. The government's recently announced policies jeopardize both the integrity of my practice and the quality of care received by the many patients who depend on me.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct and this declaration was executed this 13th day of February, 1997, in San Francisco, California.

2/13/97
DEBASISH TRIPATHY, M.D.

EXHIBIT G

LED PAPER

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DECLARATION OF STEPHEN ELIOT FOLLANSBEE, M.D.

I, Dr. Stephen E. Follansbee, declare as follows:

1. I am a physician licensed to practice in the State of California. I graduated *cum laude* from Pomona College in 1970, and earned a Master's degree from Harvard University in 1972. In 1977, I was awarded a doctorate *magna cum laude* from the University of Colorado School of Medicine. I subsequently completed an Internship at San Francisco General Hospital (1977-1978), a Residency at the University of California-San Francisco ["UCSF"] (1978-1980), and a Fellowship at UCSF's Division of Infectious Diseases (1980-1982). I am board-certified in both Internal Medicine and Infectious Diseases by the American College of Physicians.

2. I am currently Chief of Staff at Davies Medical Center in San Francisco. I am also Medical Director of the Institute for HIV Treatment and Research at Davies Medical Center, a position I have held for the past nine years. In 1982 I entered the private practice of infectious diseases in San Francisco. That practice has become Infectious Diseases Associates Medical Group, Inc., and I am a full-time employee of that medical corporation at this time. One year later, in 1983, I became an Attending Physician on Ward 86 (Division of AIDS) at San Francisco General Hospital and in that capacity, a part-time (hourly) employee of the University of California, San Francisco. I am currently on staff at Davies Medical Center, California Pacific Medical Center, St. Luke's Hospital, and San Francisco General Hospital Medical Center. I am also an Associate Clinical Professor of Medicine at UCSF's School of Medicine.

3. My work as both a researcher and a physician extends into the larger community, as well. Since 1990, I have been the Assistant Director of the Bay Area Community Consortium, whose primary purpose has been to promote AIDS-education and

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research. For more than 10 years, I have served as Medical Adviser to FOCUS: A Guide to AIDS Research and Counseling, a publication of the AIDS Health Project in San Francisco. I am currently a member of the Institutional Review Board of Project Inform.

4. I am a member of several professional societies, including the Infectious Diseases Society of America, the Bay Area Infectious Diseases Society, and Bay Area Physicians for Human Rights. I am the author, principle author or co-author of approximately 40 articles and research studies on the subjects of respiratory illnesses, opportunistic infections, epidemiology, and the study and treatment of AIDS-related conditions with a range of clinical therapies. These studies have been published in scholarly and professional peer review journals, including the New England Journal of Medicine, Annals of Internal Medicine, Journal of Infectious Diseases, Clinical Infectious Diseases, Annals of Neurology, Annals of Plastic Surgery, Journal of Experimental Medicine, Western Journal of Medicine, Virology, and the Journal of Reconstructive Microsurgery. My colleagues and I have also authored book chapters, research reports, and educational publications. Several additional manuscripts are currently in print.

5. For a long time, I resisted going to medical school, largely because I naively regarded doctors as glorified auto-mechanics. I assumed that the practice of medicine involved the rote following of established procedures to fix broken or ailing parts, and that creativity and nuance were neither valued nor necessary. I could not have been more wrong. Medicine, particularly the treatment of the seriously ill, is an art that places a premium on the physician's ability to recognize and respond to each patient as a unique individual. It requires the application of general scientific knowledge to the specific needs and conditions presented in an individual with a unique and complex medical history. I cannot know in advance what will constitute the best treatment for any patient. Rather, I must make educated guesses about

what may work best, then observe the patient closely and, when necessary or appropriate, refine and modify the treatment plan in order to strike or maintain optimal conditions for improvement. Certain treatment options work well in some patients but not others; or the treatment works well, but only for a limited period, after which it loses it efficacy. Some patients tolerate various options equally well, in which case I must assess (and likely re-assess) which among them will provide the greatest benefits to my patient.

6. When a patient suffers from nausea, retching, or persistent weight loss ("wasting syndrome"), I do not consider medical marijuana as my first treatment option. It has always been my practice to first attempt to identify the cause of the problem, and prescribe the necessary therapy for treatable causes. If there are no directly treatable causes, symptomatic therapy may be necessary. For nausea or retching, I start with anti-nausea medications, of which there are several available by the oral, rectal, or on occasion the intravenous route. For wasting syndrome due to poor appetite, after altering the medications that may be contributing to this problem, I have prescribed Marinol since it was USA-FDA approved for this indication. I begin with Marinol because it is legally available and it is often an effective treatment in relieving these symptoms. However, in my clinical experience, a significant number of patients find that Marinol is not as effective as marijuana; it does not provide the same relief. Because the Marinol capsule is not as quickly or efficiently absorbed, it can be less effective than marijuana. My patients frequently report that Marinol can create a dysphoria that they dislike. As a practical matter, the very symptoms which Marinol is intended to address (*e.g.*, nausea and retching) often make oral ingestion of any medication intolerable or ineffective. Marinol is currently available in capsule form only. Marijuana, on the other hand, can be ingested by inhaling it, eating it in baked goods, or drinking marijuana tincture in a tea.

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7. The federal government's threats against physicians who discuss or recommend medical marijuana can have, and are indeed having, several negative repercussions on the quality of care that physicians can provide their seriously ill patients.

8. Medical students are taught that proper diagnosis and treatment require a detailed and accurate patient history. That chart will follow the patient wherever he or she goes. If properly maintained, it provides critical information to all future health providers. Each treating physician necessarily relies on the information contained in that chart in diagnosing and devising a safe course of treatment for that patient.

9. The government's gag on physicians discourages doctors from maintaining a comprehensive written record of the patient and the care she or he receives. I am personally very nervous about creating a detailed record of my patient histories with respect to the use of marijuana, medically or otherwise, for fear of government reprisal against me, my medical practice, or the hospital of which I am Chief of Staff. The government's threats expose me to criminal and civil sanctions, including the loss of my DEA license to prescribe schedule II drugs, without which I could not practice infectious disease medicine. I fear the loss of government research grants, both to myself and to my colleagues and the facilities I am associated with. I also fear that, on the basis of my record-keeping, my patients might be denied coverage under Medicare or MediCal, which is so often the only means for them to receive continued medical treatment for any illness or ailment.

10. Information about a patient's drug use -- licit and illicit -- is an important part of that patient's history (medical, psychiatric and social) that a physician must consider to provide safe, appropriate and effective medical care. It is common practice to learn about a patient's use of tobacco and alcohol, as well his/her history of substance abuse or dependence. That information, which may be embarrassing or shameful or involve illegal behavior, can

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only be fully disclosed in an atmosphere of trust and safety. That is one very important reason that I spend a great deal of time making my office a safe and confidential place for my patients. I make sure they understand that our discussions are confidential and their files are secure.

11. There are many instances in which a conversation about medical marijuana with a seriously ill patient is medically warranted. First, there are possible health risks of ingesting marijuana. The physician must be able to provide that information to a seriously ill patient; s/he must also advise that patient on how s/he might reduce or eliminate those risks. For example, patients with HIV or AIDS may suffer from respiratory problems that may be exacerbated by smoking any substance, whether tobacco or marijuana. I have these concerns with patients suffering from pulmonary aspergillosis, an infection of the lungs seen often among AIDS patients. In such circumstances, the physician might wish to dissuade the patient from smoking marijuana, encouraging the patient to try alternative treatments, including ingesting marijuana as a tincture or in baked form. Providing that advice is part of my duty to treat and prevent unnecessary illness and suffering.

12. There may be other risks associated with marijuana. Marijuana sold on the street may contain fungaspores and other impurities that pose little danger to healthy users but can compromise the health of a seriously ill patient, particularly a patient whose immune system is weakened. A physician might wish (quite properly) to dissuade the patient from using marijuana and encourage the patient to try alternative treatments. Failing that, the doctor might encourage the patient to avoid marijuana from unknown street sources; or to bake the marijuana to kill fungaspores before ingesting; or to smoke the marijuana through a water pipe to decrease exposure to impurities.

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13. Finally, a patient who is not accustomed to marijuana, or a patient who habitually ingests more than is medically indicated, may experience adverse effects from THC. The obvious concern is that the over-medicated patient may forget to take his or her other medications. This is true with every drug which causes drowsiness, including many medications used to relieve pain or to treat anxiety, trauma, seizure disorders, allergies, and a range of psychiatric conditions. To assess the risks to a particular patient, the atmosphere of candor and confidentiality must be unquestioned by either doctor or patient. Only then can a physician feel free to ask, and the patient feel comfortable in answering, questions regarding marijuana use. As with any medication, the physician must consider that information in her/his individualized assessment regarding that medication, its dosage, the route of administration, and the possible interactions with other medications. Ultimately, my decision must be explained to the patient -- that, too, is a necessary part of the doctor-patient relationship.

14. After candid and thorough discussions with my patients, I have refused to write letters recommending medical marijuana for several patients, generally because I believe that those patients are not proper candidates for this medicine. There are also patients I have counseled not to *smoke* marijuana when their particular circumstances or conditions pose risks which, in my clinical opinion, outweigh the potential medical benefits. In those situations, I often counsel the patients to try a different means of ingesting the marijuana -- for example, by baking it or using a water pipe.

15. Since the government's initial threats in December, my conversations have been curtailed. Because of these threats, I have been reluctant to raise the issue of marijuana, or even use the word, with my seriously ill patients. I feel extremely vulnerable to intrusive actions by the government which will undermine my clinical judgment and the integrity of my

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practice. I am, frankly, fearful that a government agent will masquerade as a patient in an attempt to monitor my practices and, if possible, develop evidence to imply wrongdoing or unethical practice. I am concerned that overzealous officials might seek to prosecute or sanction me as an example to individual physicians and the medical profession. I believe that my concerns are well-founded. Reports of DEA agents appearing in physicians' offices are already spreading through the medical community.

16. If I discuss marijuana with a patient (upon the patient's initiative or my own), s/he may well report that marijuana has helped reduce nausea or combat wasting syndrome. Having learned that, I am cast between the Scylla of legal sanctions and the Charybdis of medical care. To acknowledge that the patient's report is not uncommon -- supported by medical research and echoed by the *New England Journal of Medicine* -- may lead the patient to request that I recommend marijuana as a part of treatment. If I respond honestly, based on my medical knowledge and clinical experience, I may be inclined to recommend marijuana. In doing so, though, I risk sanction by the federal government.

17. If I decline to answer the patient's question, I risk losing that patient's trust and confidence, sending the message that there are issues regarding that patient's health that are off-limits; that, at some level, I hold the patient's well-being subordinate to issues of politics. This result stands at odds with my dedication to the art of healing; it results in my refusal to relieve that patient -- already seriously ill and struggling to remain alive -- from additional, unnecessary pain, suffering, and hopelessness.

18. It might be suggested that I parrot the views of General Barry McCaffrey and Attorney General Janet Reno, that "smoke is not medicine," and "marijuana has no known medical use but is a highly dangerous drug." To adopt such an obviously ill-informed position would undoubtedly alienate the patient, who through personal experience (and

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perhaps some background research) knows otherwise. Many of my patients use aerosolized medicines and would be right to question why one form of inhalation is efficacious while another is not. If the patient senses that his/her physician has been dishonest or disingenuous or is withholding critical information, s/he may well terminate the relationship and discontinue treatment. Alternatively, patients may try to read my mind and discern my true opinion. No patient should be forced to read a doctor's mind. Alternatively, patients may simply consider me sorely misinformed, and so, with good reason, may question or reject my medical advice on other serious issues. Either way, sound medicine suffers. More importantly, the patient's health is jeopardized. I cannot practice medicine in an ethical and honest manner if ill-informed government policies mandate that I be dishonest with those who seek my help.

19. A core tenet of medical practice is to "do no harm." In that spirit, I believe that acts of omission are often as profound (and as potentially damaging) as acts of commission. If a seriously ill patient is suffering severe nausea or chronic loss of appetite as a result of his/her illness or treatment, and such symptoms or side effects compromise his/her ability to tolerate other, traditional therapies, or to withstand a second or third cycle of chemotherapy for lymphoma, or simply to maintain the physical or psychological strength to fight for life, I do significant and inexcusable harm if I fail to counsel and treat that patient in accordance with my best medical judgment.

20. My increased reluctance to discuss medical marijuana with seriously ill patients recently led a patient's wife, who was with him in my office, to raise the issue herself. This placed me in an extremely difficult situation. I felt gagged by the government, yet ethically obligated to act as a physician. The patient and his wife, in turn, expressed terrible guilt at having placed me in a moral dilemma. That should never occur in a proper

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clinical setting. No simple question about medical treatment should place a physician in a conflict of that sort; and no patient should ever be dissuaded from requesting reasonable (indeed appropriate) medical information. That is the chilling affect of government interference in clinical practice.

21. Adjusting treatment options to best serve a patient's individual needs is what sound medical practice requires. Government officials evince a stunning disregard for the healing arts when they attack medical marijuana with the assertion that patients deserve "the *best* available medicine." We all want and deserve the *best* treatment. But in medicine, the best is always a personal best; it is not determined by a simple formula. The government's contention -- that marijuana can never be the best, or even an appropriate medicine -- is simply wrong. This contention fails to recognize that physicians typically value and depend upon a range of medical treatments, that no one medicine is best for all patients. To speak of the *best* medicine makes little sense unless viewed in the context of treatment options. For some seriously ill patients suffering extreme nausea, Marinol may be the best treatment available for them. But that does not make Marinol the "best" medicine for anyone else. The government's references to the "best" medicine are facile and without any clinical or practical meaning. In my experience, Marinol does not work well for all patients. The same applies to virtually any medication, aspirin and penicillin included. For certain seriously ill patients, marijuana may in fact be the best medicine, or the only medicine. The federal government now prohibits me from informing those patients of this fact.

22. Even if it were true, as the government contends, that marijuana is not the "best" medicine, the government itself acknowledges that an important role is served by second-, third-, and even fourth-line drugs. Federal regulations require that manufacturers of certain drugs state that they are considered a secondary or tertiary treatment option for certain

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conditions. The treatment of pneumocystis pneumonia with Mepron is one such example. Nonetheless, these medications are not proscribed or criminalized because they are not generally (or even usually) the "best" medications available. The government instead relies on the informed judgment of physicians to determine whether, when, and how to dispense these drugs.

23. Marijuana, by history and for clinically sound reasons, is one of these so-called second or third-line medications. To proscribe any potentially-effective treatment, including marijuana, as a treatment option, flies in the face of longstanding government policy and medical practice. It also deprives the healer of the full clinical armamentarium -- *i.e.*, the entire range of treatment options available in the practice of medicine. The federal government has in place detailed procedures for authorizing the use of experimental drugs. Many experimental drugs, including retrovirals and growth hormone, have been licensed by the Food and Drug Administration having had much less information than the medical profession has about marijuana.

24. A large percentage of my patients are infected by the HIV virus; a significant number suffer from conditions and opportunistic infections which have come to define AIDS. I have provided care for a population that, until very recently, was considered hopeless. They were perceived as suffering from a terminal illness that progressively and painfully destroyed the immune system, rendering them thoroughly disabled -- blind, demented, incontinent, and unable to attend to their most basic needs. The physical agony and mental anguish that often accompanies AIDS results in some patients' desire to die. I know of no physician who relishes the thought of a patient dying. Indeed, as a doctor, I work daily to stave off death and to provide my patients with the means to control their pain and maintain their autonomy and

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dignity. As our knowledge and treatments become refined and more plentiful, the certain death we saw only a few years ago is no longer an accepted fate for my patients.

25. Patients who seek my advice regarding the benefits of medical marijuana are evidence that there is hope. They have a very strong desire to survive their illness and to function as normally and productively as possible. Some of the medications that have led to this renewed optimism and have recently been licensed by the USA-FDA produce side effects (nausea and vomiting) that can be alleviated by the medical use of marijuana, and may not respond to other first-line or second-line agents. These patients ask me about marijuana not because they want to get high, but because they are fighting for their lives, which includes an honest search for the best available means to do so. Government threats against the physicians who struggle with these patients will inevitably thwart the patients' efforts. They may, in fact, remove their doctors from the healing process when vulnerable individuals are most in need of their counsel. Denying information and treatment advice to a seriously ill patient, when that medicine could promote and facilitate critical medical treatment, may needlessly hasten the patient's death.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed this 13 day of February, 1997 in San Francisco, California.

STEPHEN ELIOT FOLLANSBEE, M.D.

EXHIBIT H

23

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FOR THE NORTHERN DISTRICT OF CALIFORNIA

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. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, on behalf of themselves and all others similarly situated; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; and BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., Plaintiffs, v. BARRY R. McCAFFREY, as Director, United States Office of National Drug Control Policy; THOMAS A. CONSTANTINE, as Administrator, United States Drug Enforcement Administration; JANET RENO, as Attorney General of the United States; and DONNA SHALALA, as Secretary of Health and Human Services, Defendants.	CASE NO. C 97-0139 FMS DECLARATION OF STEPHEN O'BRIEN, M.D. Date: March 21, 1997 Time: 10:00 a.m.

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DECLARATION OF STEPHEN O'BRIEN, M.D.

I, DR. STEPHEN O'BRIEN, declare as follows:

1. I am a physician licensed to practice in the State of California and currently practicing medicine at the East Bay AIDS Center in Berkeley, California.

2. I received my B.A. and B.S. from the University of Washington at Seattle in 1986. I graduated from the University of Washington Medical School in 1990 and did a residency in internal medicine at the University of California at San Francisco ("UCSF") from 1990-93.

3. After completing my residency, I was employed at UCSF as a Clinical Instructor in Medicine from 1993-94 and an Assistant Clinical Professor of Medicine from 1994-95. From 1993-95 I was Co-Director for UCSF HIV Managed Care.

4. I am board certified in internal medicine. I currently maintain a private medical practice which is devoted almost solely to treating AIDS patients. I specialize in the treatment of patients in the advanced stages of AIDS. I have approximately 200 patients, about 70 percent of whom have T-Cell counts below 100. T-Cells are one measure of the strength of the immune system. A normal T-Cell count is 500-1,500. One measure of AIDS is having a T-Cell count below 200. A T-Cell count below 100 usually indicates an advanced stage of AIDS during which the patient is most at risk for opportunistic infections.

5. Many patients with advanced AIDS experience nausea, wasting syndrome, and severe pain. My usual protocol is to prescribe Compazine, Marinol, or Reglan for nausea; Megace or Marinol to stimulate appetite; and pain medication ranging from Tylenol and Tylenol with Codeine to Morphine. For most patients, these medications are at least partially effective.

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less rigorous scientific evidence than is the norm. Indeed, at least one drug, ddC, was released and subsequently withdrawn from its original indication after later studies cast doubt on its effectiveness. Because AIDS is a life-threatening illness, it is appropriate to allow the use of drugs that have not undergone traditional FDA approval.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Berkeley, California, this 13 day of February, 1997.

Stephen O'Brien, M.D.

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EXHIBIT I

LFD PAPER

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DECLARATION OF DONALD W. NORTHFELT, M.D.

I, DR. DONALD W. NORTHFELT, declare as follows:

1. I am a physician licensed to practice in the State of California, an Assistant Clinical Professor of Medicine at the University of California, San Diego, and an AIDS oncologist and AIDS primary care physician at the Pacific Oaks Medical Group in Palm Springs, California.

2. I received a B.S. in geology with high distinction from the University of Minnesota, Minneapolis in 1978. I then attended the California Institute of Technology in Pasadena, and received an M.S. in geochemistry in 1980. I received my medical degree from the University of Minnesota, Minneapolis in 1985. I completed an Internship and Residency at the University of California, Los Angeles in 1988. I then did a fellowship in hematology and oncology at the University of California, San Francisco from 1988 through 1991.

3. Among other positions I have held since receiving my M.D., I was an Assistant Clinical Professor of Medicine at the University of California, San Francisco, from 1991-95. During my eight years in San Francisco, I specialized in the treatment of AIDS.

4. I am the author or co-author of over 35 peer-reviewed publications, 16 book chapters, and 18 other publications on the treatment of AIDS. I also frequently lecture on specialized AIDS care. I am a member of a number of professional societies, including the American Society of Clinical Oncology, and a Fellow in the American College of Physicians.

5. My current practice focuses on care for AIDS patients and, in particular, AIDS patients suffering from cancer. I presently provide treatment for approximately 200 cancer patients and 300 AIDS patients.

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unnecessarily from pain, nausea, and poor appetite with subsequent weight loss and weakness if marijuana had the potential to alleviate these problems but this information was withheld.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at PALM SPRINGS, California, this 14 day of February, 1997.

2/14/97
Donald W. Northfelt, M.D.

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6. To properly treat a patient, a physician must obtain a reliable and complete medical history. Such information, which includes the patient's drug history, is essential to prompt and proper diagnoses and medical intervention. To obtain it, it is my duty to create an atmosphere of candor and absolute confidentiality. This atmosphere has generally enabled me to obtain frank information from my patients and to provide honest and complete medical advice. In my practice, I have never been prohibited, by the federal government or anyone else, from providing my clinical knowledge to patients who might benefit as a result. In the past months, that has changed. I am now aware of threats by federal officials to sanction and even criminally prosecute physicians who counsel their patients about the risks and benefits of medical marijuana.

7. Marijuana, when ingested in proper doses, has proven to be effective in the treatment of nausea and retching. It is also effective as an appetite stimulant, which is critical for patients suffering from wasting syndrome. One of the active ingredients in marijuana, THC, is legally available as a pill called Marinol. In some patients, Marinol provides relief from nausea and enables patients to eat, regain weight and muscle mass, and improve their general health. Other medications can also be prescribed for nausea and retching. Some patients, however, do not respond to any such prescription drugs, but have successfully treated their nausea and loss of appetite by ingesting marijuana. Although Marinol is related to marijuana and contains one of its key ingredients, it is not the same substance and is often less effective clinically than marijuana itself. The reasons for this are not fully understood, but one factor is likely the means of ingestion. Marinol is currently available in pill form only. Many patients cannot tolerate medications taken orally. Moreover, the absorption and efficacy of Marinol is unreliable and unpredictable. By contrast, inhaled marijuana is easier to control and absorption rates may be more consistent.

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8. These are just some of the factors to be considered in the discourse on medical marijuana. Prior to the government's recent threats, they were part of the ongoing dialogue between doctor and patient. That dialogue has now been effectively curbed. In treating and advising new patients, for example, I do not provide as broad a view of their treatment options as I used to. Since the threats by federal officials, I have avoided directly broaching the subject of medical marijuana even with patients who could, in my clinical judgment, obtain marked relief with the use of marijuana. When the discussion does take place, it is now limited to providing clinical and scientific data. Further, my patients are fearful of placing me at risk, which is not a concern any patient should have.

9. My patients' health is my paramount concern. The federal government has evidently chosen to subordinate health needs to political expediency. As a physician, if anything, this increases my duty to work with my patients to maintain trust and identify effective interventions. I also feel duty-bound to challenge the federal policy through the courts in the interests of my patients.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed at San Francisco, California, this 14 day of February, 1997.

Virginia I. Cafaro, M.D.

EXHIBIT K

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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DECLARATION OF ROBERT C. SCOTT, III, M.D.

I, DR. ROBERT C. SCOTT, III, declare as follows:

1. I am a physician licensed to practice in the State of California and have been practicing medicine for 20 years in Oakland, California.

2. I received a B.S. from Parsons College in Fairfield, Iowa, in 1963. I received an M.S. in 1965 and an M.Ed. in 1968, both from the University of Illinois at Urbana. I earned my medical degree from the University of California at San Francisco Medical School in 1974. I completed an Internship in medicine at Emory University in Atlanta, Georgia, the following year. I then did a Residency in internal medicine at Stanford University Hospitals from 1975-77.

3. I am on the medical staff of the Alta Bates Medical Center and the Summit Medical Center. I am a member of a number of local, state, and national organizations of physicians, including the American College of Physicians, American Association of Internal Medicine, National Medical Association, Alameda-Contra Costa Medical Association, and HIV Clinical Trials Researchers. I was a founding member of Bay Area Physicians for Human Rights.

4. I practice internal medicine and have over 2,000 patients. My practice is located in a poor city, and most of my patients are indigent, retired, and on fixed incomes.

5. Approximately 350 of my patients are infected with HIV. Many of them suffer from severe nausea, progressive anorexia, or chronic pain. I generally prescribe drugs such as Marinol, Compazine, or Tigan for nausea; Megace or Marinol for anorexia; and Vicadin, Demorol, or Duragesic for pain.

6. In my experience, one or more of these drugs is often effective in alleviating these symptoms in most patients. I have found, however, that in some patients these

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conventional prescription drugs are inappropriate either because patients cannot tolerate them or because the drugs are ineffective in reaching the central nervous system. Patients frequently complain that Marinol causes haziness or a sense of dizziness or vertigo, among other undesirable side effects. Some of these patients are able to titrate (adjust the quantity) marijuana to obtain relief without the potential negative side effects. I also have patients taking "protease inhibitors" who successfully use marijuana to alleviate the gastrointestinal side effects of these drugs, such as nausea, diarrhea, and bloating. I currently treat at least 75 patients for whom I believe medical marijuana is a medically appropriate form of treatment for nausea, anorexia, or pain. For some patients, I believe that medical marijuana may be the only effective medicine. I believe it is my duty as a doctor to provide information about potential medical benefits, as well as risks, of marijuana use for patients for whom it is medically appropriate.

7. Because of the nature of my patient population, the expense of drugs such as Marinol is also a relevant issue. Most of my patients are uninsured or underinsured. Medicare does not pay for drugs, and MediCal provides only limited payment.

8. Many of my patients used marijuana prior to consulting me. It is important to my evaluation of their conditions that I discuss their use of marijuana, or any other substances that potentially affect their medical history or current conditions. It is also important to patients' personal decisions about medical marijuana use that I discuss with them the risks and benefits of medical marijuana.

9. In all aspects of my practice, a secure physician-patient relationship is critical to providing high quality medical care. I depend on my patients to provide me with all information that might have an affect on their health. They depend on me to provide full information about treatment options so that they can make informed choices.

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10. I am aware of threats by federal officials against physicians who provide information to patients regarding the potential risks or benefits of the medical use of marijuana. Due to fear caused by these threats, I feel compelled and coerced to withhold information, recommendations, and advice to patients regarding use of medical marijuana. I am particularly fearful that the federal government might send in someone posing as a patient in an attempt to gather evidence against me, even though I always act in my best medical judgment. Because of this fear, I have instituted an application procedure for new patients. Any patient who desires to consult with me must fill out a form with relevant information. I then decide whether to treat this patient. Since instituting this application procedure, I have turned away a couple of prospective patients because I was suspicious of their motives. In general, I am much more careful in my discussions with new and longstanding patients, and am fearful and reluctant to engage in even limited communications regarding medical marijuana.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Oakland, California, this 14 day of February, 1997.

Robert C. Scott, III, M.D.

EXHIBIT L

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. MARIN ALLIANCE FOR MEDICAL MARIJUANA; and LYNETTE SHAW, Defendants. AND RELATED ACTIONS	No. C 98-00086 CRB DECLARATION OF REBECCA NIKKEL IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, REBECCA NIKKEL, declare as follows:

1. I am a member of the Marin Alliance for Medical Marijuana in Fairfax, California (the "Marin Alliance"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the matters set forth in this declaration and could and would

testify competently to them if called on by the Court to do so.

2. I am 44 years old. I have fibromyalgia and multiple sclerosis. I was diagnosed with multiple sclerosis in June 1998. Both of these conditions cause me to experience severe muscle spasms which are very painful.

3. The pain caused by these conditions changes, depending on other stressors in my environment. For example, warm weather causes me to experience more muscle spasms. For the last six months, I have experienced pain from muscle spasms on a daily basis. The pain can be continuous at times. Recently, I have been experiencing tingling in my arms and hands, and the pain has been very intense particularly in my right hand.

4. I have tried many traditional medicines to alleviate the pain caused by these severe muscle spasms, but none of them has worked effectively. For example, I have tried baclofen, which caused my legs to become very weak. While using baclofen, I was not able to walk. I have tried other conventional medicines, none of which has worked effectively to alleviate my pain. I have also had allergic reactions and developed over time a hypersensitivity to many traditional medicines. On one occasion, I went into anaphylactic shock and nearly died as a result of an allergic reaction to a conventional drug.

5. Because of these harmful, painful and life-threatening experiences, I do not want to continue risking my life by trying new conventional medicines. I am afraid to try

new medicines because of the violent allergic reactions and side effects I have experienced in the past.

6. My doctor gave me a written recommendation for the use of cannabis to alleviate the pain caused by the muscle spasms. I have used cannabis, and it helps me tremendously. The cannabis is the only medicine which effectively and safely alleviates the pain caused by the muscle spasms. The use of cannabis is a medical necessity for me. No other conventional medicine effectively manages the pain I experience from the muscle spasms.

7. I understand that the federal government has threatened to prosecute doctors who recommend the use of cannabis to patients. For this reason, I have been hesitant to discuss with my doctors the use of cannabis to treat my condition. I have only felt comfortable discussing the use of cannabis with two of my doctors. One of these two doctors told me that she believes that cannabis is the safest drug she could ever give to me. As a result of my experience with traditional medicines and cannabis, I agree with my doctor that cannabis is the safest drug she can give me to alleviate my pain.

8. I have been a member of the Marin Alliance since December 1997, and I visit it every ten (10) days. For this reason, I know that I visited the Marin Alliance several times during the period of May to June 1998. If the Marin Alliance and the other defendant clubs are closed, I will

suffer immediate harm because I will have nowhere legally to obtain cannabis.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of August, 1998 at Santa Rosa, California.

Rebecca Nikkel

EXHIBIT M

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. UKIAH CANNABIS BUYER'S CLUB; CHERRIE LOVETT; MARVIN LEHRMAN; and MILDRED LEHRMAN, Defendants. AND RELATED ACTIONS	No. C 98-00087 CRB DECLARATION OF LUCIA Y. VIER IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, LUCIA Y. VIER, declare as follows:

1. I am a member of the Ukiah Cannabis Buyer's Club in Ukiah, California (the "Ukiah Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the matters set forth in this declaration and could and would

testify competently to them if called on by the Court to do so.

2. I am 48 years old. In March 1998, I was diagnosed with squamous cell cancer. My doctor found a cancerous tumor in my pelvic area and cancerous spots in my lungs. I am in stage four of the cancer, and my doctors have told me that with treatment I may have a year to a year and a half to live. I underwent radiation treatments and am now being treated with chemotherapy.

3. In or about March 1998, my doctor gave me a written recommendation for cannabis. The chemotherapy caused me to experience nausea, and it has made it almost impossible for me to taste food. I use cannabis to stimulate my appetite. I am a small person, approximately four feet eleven inches tall, and I weigh approximately 87 pounds. It is therefore crucial that I maintain my weight. The cannabis is very effective at stimulating my appetite. Without cannabis, I would not want to and I would not be able to eat the amount of food that is necessary to maintain my health. For this reason, the use of cannabis is a medical necessity for me. I do not know of any traditional medicines that would stimulate my appetite effectively, and my doctor has not tried to prescribe any drug for this reason other than cannabis.

4. In addition, the cannabis helps me get through the day. Without cannabis, my days would drag on and be a lot harder and longer. The cannabis relaxes me and helps me be more productive.

5. If the Ukiah Club and the other defendant clubs are closed, I will suffer immediate harm. I cannot imagine how I would survive day to day without the use of cannabis. If I were forced to go without cannabis, I believe I would rapidly lose weight and my day to day pain would increase. I also believe that without cannabis, I would not be able to survive as long as my doctors' prognosis.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6 day of August, 1998 at Santa Rosa, California.

Lucia Y. Vier

Lucia Y. Vier

EXHIBIT N

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. OAKLAND CANNABIS BUYERS' COOPERATIVE, and JEFFREY JONES, Defendants. AND RELATED ACTIONS	No. C 98-00088 CRB DECLARATION OF EDWARD NEIL BRUNDRIDGE IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, EDWARD NEIL BRUNDRIDGE, declare as follows:

1. I am a member of the Oakland Cannabis Buyers' Cooperative in Oakland, California (the "Oakland Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the

matters set forth in this declaration and could and would testify competently to them if called on by the Court to do so.

2. I am 58 years old. I had Hepatitis C which caused damage to my liver. As a result, I am not able to take many traditional medications.

3. I have severe arthritis in my right knee. The arthritis is so extensive that I have had to use a cane for the past year. My doctor wanted to prescribe ibuprofen to relieve the swelling caused by the arthritis, but I am allergic to ibuprofen. I understand that ibuprofen is what my doctor generally recommends to alleviate the swelling associated with arthritis. To alleviate the pain caused by the arthritis, I have tried other traditional medicines. These medicines were not effective in relieving that pain. I was either allergic to the traditional medications or they did not alleviate my pain.

4. I have successfully used cannabis, however, to alleviate this pain. In addition, cannabis also allows me to be alert, which many of the traditional medicines do not. Cannabis is the only medicine I have used which effectively alleviates the pain caused by the arthritis.

5. The traditional medicines I have tried either do not work or are so strong that I cannot participate in the activities that I need to do every day. These necessary daily activities include driving, taking my dog out for walks, shopping, talking to other people, taking

care of my finances, riding public transportation, doing the dishes, cleaning my house, reading and answering the telephone. Cannabis, however, alleviates the pain without preventing me from functioning in my daily life.

6. I also suffer from insomnia. The cannabis helps me sleep and relieves my anxiety. Without cannabis, I would not be able to sleep. Conventional sleeping pills are highly addictive, and, for that reason, I am not able to take them. I cannot handle conventional sleeping medications and my doctor will not prescribe them for me.

7. My doctor told me that I will need to enter the liver institute very soon, which will put me in line for a liver transplant in the next several years. This news has caused me to suffer from anxiety and extreme depression. I am presently seeing a therapist for treatment for these conditions. As a result of my anxiety and depression, I no longer had an appetite. I use cannabis to relieve the stress of my depression and to give me an appetite. I once went without cannabis, and I lost 30 pounds in three weeks. I am presently taking Prozac, which helps alleviate my anxiety and depression, but it does nothing to stimulate my appetite.

8. Cannabis is the only drug that effectively gives me an appetite. Without using cannabis, I believe I would not be alive today. For this reason, the use of cannabis is a medical necessity for me. There is no drug other than cannabis that alleviates my pain and

depression and gives me the appetite I need to stay alive. I have tried many traditional drugs, none of which is effective in alleviating my pain and stimulating my appetite. Many of these traditional drugs were not effective because I was allergic to them.

9. There is another reason that I cannot take many traditional medicines. I am a recovering drug abuser and alcoholic. I cannot take many traditional pain relievers because of these addictions. I become easily addicted to traditional pain killers.

10. My doctor recommended that I use cannabis, but he was afraid to give me a written recommendation for fear of prosecution by the government and therefore would not give me a written recommendation for cannabis. Nevertheless, he telephoned the Oakland Club and gave it an oral recommendation for cannabis for me. I feel that my private relationship with my doctor has been damaged because of the government's threat of prosecution and the fear it has caused in my doctor to treat me with the only effective medicine for alleviating my pain and stimulating my appetite: cannabis. Because of this fear, I feel that my doctor has been reluctant to discuss cannabis as a possible treatment and he has been reluctant to prescribe it.

11. In addition, I feel that my privacy rights have been violated as a result of plaintiff's action to close the Oakland Club and the other defendant clubs to prevent the

medicinal use of cannabis. I live in constant fear that I will be prosecuted concerning my use of cannabis and that my doctor will be prosecuted for recommending that I use cannabis. I also fear that my private conversations with my physician and my medical records will be made public as a result of the relief sought by plaintiff. If the Oakland Club and the other defendant clubs are closed, I will suffer immediate harm since I will not be able legally to obtain cannabis, which is the only effective treatment available to alleviate my pain and stimulate my appetite.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 5th day of August, 1998 at San Francisco, California.

Edward Neil Brundridge

EXHIBIT O

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. OAKLAND CANNABIS BUYERS' COOPERATIVE, and JEFFREY JONES, Defendants. AND RELATED ACTIONS	No. C 98-00088 CRB DECLARATION OF IMA CARTER IN SUPPORT OF MOTION FOR LEAVE TO INTERVENE Date: Time: Courtroom of the Hon. Charles R. Breyer

I, IMA CARTER, declare as follows:

1. I am a member of the Oakland Cannabis Buyers' Cooperative in Oakland, California (the "Oakland Club"). I am submitting this declaration in support of the motion for leave to intervene in this action. Except where stated on information and belief, I have personal knowledge of the

matters set forth in this declaration and could and would testify competently to them if called on by the Court to do so.

2. I am 55 years old. I suffer from several different conditions and injuries which cause me significant and constant pain. I use cannabis for several of these conditions: congenital scoliosis, fibromyalgia and cervical nerve damage which I suffered as a result of being involved in several car accidents in which I was rear-ended. These conditions which include cervical nerve damage in C4 through C7 of my spine, cause me enormous pain in my back. This pain is marked by frequent muscle spasms, and a recurring shooting pain in my head. Cannabis is the only drug in my experience that has effectively treated this pain.

3. I have tried numerous traditional medicines for these conditions, none of which was effective. For example, I took steroids and anti-inflammatory drugs. These drugs have caused me to bleed internally.

4. I have also tried rhizotomy, which is a laser treatment. During this treatment, a laser beam was burned into the cervical nerves to create scar tissue. The treatment required that I be awake during it and it was excruciatingly painful. It is my understanding that physicians have now discontinued prescribing rhizotomy treatments because they are unbearably painful and useless. The rhizotomy treatments did not relieve my back pain. This pain feels like a hot burning pain going down my left arm into my hand.

5. In addition, I underwent breast reduction surgery to relieve the scoliosis pain in my back. I also tried many different forms of physical therapy, including various exercises, ultrasound, ice packs, jacuzzi treatments and others. None of these even touched the recurring shooting pain I experience in my head.

6. I also have a therapeutic electrical neuro-stimulator (a "TENS") unit that controls some of my pain from the cervical nerve damage and scoliosis. However, the TENS unit does not stop or dull in any way the shooting pain that occurs in my head at frequent intervals. I am presently taking morphine as prescribed by my doctor, but it--like the TENS unit--does not stop or dull in any way the frequent pain in my head.

7. I first tried cannabis on the recommendation of my nutritionist, and it is the only drug that I have used that has dulled or stopped the pain. I was once forced to go without cannabis. During this period of time, the pain was completely disabling and prevented me from being able to function. During this time, I could not leave my bedroom due to the pain that recurred every few minutes, and therefore I could not do any of my regular daily activities, such as answering the phone, doing the dishes, running errands, watching television, reading and taking care of my finances.

8. I was afraid to ask my doctor for a recommendation for cannabis. I was afraid of alienating him by asking him for a drug which I understood the government was threatening to prosecute doctors for prescribing. When I asked him, I

was nervous and upset. Nevertheless, I asked my doctor to give me a written recommendation for cannabis and he agreed. My doctor monitors my use of cannabis by seeing me frequently and discussing my treatment. In addition, he renews my letter of referral every few months. I feel that my private relationship with my doctor is endangered because of the government's threat of prosecution. The fear it has caused me makes me unable to speak freely with my doctor about my condition and my medical needs when a nurse or assistant is present. Because of this fear, I had been reluctant to discuss openly and extensively with my doctor the possibility of using cannabis to treat my condition.

9. In addition, I feel that my privacy rights have been violated as a result of plaintiff's action to close the Oakland Club and the other defendant clubs to prevent the medicinal use of cannabis. I live in constant fear that I will be prosecuted for my use of cannabis and that my doctor will be prosecuted for recommending that I use cannabis. I also fear that my private conversations with my physician and my medical records will be made public as a result of the relief sought by plaintiff. If the Oakland Club is closed, I will not be able legally to obtain cannabis, which is the only effective treatment available to alleviate my pain and frequent muscle spasms associated with congenital scoliosis, fibromyalgia and nerve damage.

10. As described above, I have previously gone without using cannabis. If the Oakland Club and other defendant

clubs are shut down or I am in some other way prohibited from obtaining cannabis, I will suffer immediate harm. Using cannabis is a medical necessity for me. When I am not using cannabis, I am completely incapacitated and cannot leave my room. Without cannabis, I experience intense intervals of pain in my head that occur every few minutes. There is no drug other than cannabis that alleviates these shooting pains. I have tried many traditional drugs, including morphine, steroids, rhizotomy treatments and breast reduction surgery, none of which has alleviated the shooting pains.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of August, 1998 at Oakland, California.

Ima Carter

Ima Carter