QUESTION PRESENTED

Whether the Drug Enforcement Agency ("DEA") may lawfully conclude that marijuana has "no currently accepted medical use in treatment in the United States" under the federal Controlled Substances Act, 21 U.S.C §§ 801-904 ("CSA"), when marijuana's medical use is currently accepted by 20 states and the District of Columbia?

PARTIES TO THE PROCEEDINGS BELOW

Carl Olsen intervened in a petition to reschedule marijuana filed with the Respondent DEA by Petitioners Americans for Safe Access William Britt, the Coalition to Reschedule Cannabis, Cathy Jordan, Michael Krawitz, Rick Steeb and Patients Out of Time.

CORPORATE DISCLOSURE STATEMENT

Olsen reports that he is an individual who does not have a parent corporation.

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PETITION FOR WRIT OF CERTIORARI

Intervenor respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit.

OPINIONS BELOW

The District of Columbia Circuit's opinion of January 22, 2013, is published at *Americans for Safe Access v. Drug Enforcement Administration*, 706 F.3d 438 (D.C. Cir. 2013). App. 1-52. The District of Columbia Circuit's order denying Intervenor's rehearing *en banc* is reported. App. 118-119.

JURISDICTION

The District of Columbia Circuit had original jurisdiction over the Petition for review of the decision of a federal agency pursuant to 21 U.S.C. § 877. It denied Intervenor's petition for rehearing *en banc* on March 11, 2013. App. 118. It further denied Petitioner Americans for Safe Access's panel rehearing and rehearing *en banc* on April 15, 2013. App. 120-121, 122-123. Pursuant to Rule 13(3) of the Rules of this Court, the time for filing a Petition for Writ of Certiorari in this Court elapses ninety days

later, which is July 14, 2013. Intervenor was granted additional time until September 12, 2013 to file the Petition. App. 124. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The appendix reproduces the relevant provisions of the Controlled Substances Act (CSA)[1], which consist of 21 U.S.C. §§ 801, 811, 812, and 877.

INTRODUCTION

The question of who makes the decision whether to accept the medical use of controlled substances in treatment in the United States was answered definitively by this Court in *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006):

> The Attorney General has rulemaking power to fulfill his duties under the CSA. The specific respects in which he is authorized to make rules, however, instruct us that he is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.

When Congress enacted the federal CSA in 1970, Congress recognized that some substances had currently accepted medical use in treatment in the United States, 21 U.S.C. §§ 812(b)(2), 812(b)(3),

[1] Pub.L. 91–513, 84 Stat. 1236, enacted October 27, 1970, codified at 21 U.S.C. §§ 801-904.

812(b)(4),and 812(b)(5), and other substances did not have currently accepted medical use in treatment in the United States, 21 U.S.C. § 812(b)(1). Because Congress recognized that underlying circumstances may change based on new scientific and medical evidence, Congress created a process by which changes in the classifications could be made, 21 U.S.C. §§ 811 and 812.

Congress instructed the Attorney General, with the advice of the Secretary of Health and Human Services, to consider 8 factors in determining the correct classification of controlled substances, 21 U.S.C. §§ 811(c)(1)-(8). The Secretary makes a scientific and medical evaluation and then makes a recommendation to the Attorney General, 21 U.S.C. § 811(b). The Attorney General is bound by the scientific and medical evaluation of the Secretary.

However, the ultimate decision on classification of controlled substances is a question of law. For example, if an international treaty is involved, placement in a classification recommended by the Secretary is not binding on the Attorney General, 21 U.S.C. § 811(d). This pattern is important, because it shows a two-step process: (1) the Secretary evaluates scientific and medical information in the first step; and (2) the Attorney General applies law in the second, final step.

Of particular note: the international treaties covering control of substances are subject to constitutional limitations. Single Convention on

Narcotic Drugs, 1961 (UN 1961), Article 35(preamble), Article 36(1), Article 36(2), Article 38.[2] Convention on Psychotropic Substances, 1971 (UN 1971), Article 10(2), Article 21, Article 22(1), Article 22(2).[3] United Nations Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 (UN 1988), Article 3(1)(c), Article 3(2), Article 3(10).[4]

When Congress enacted the federal CSA in 1970, Congress accurately observed there were no states that currently accepted the medical use of marijuana in treatment in the United States. Since the initial placement of marijuana in Schedule I of the federal CSA in 1970, twenty states and the District of

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[2] Single Convention on Narcotic Drugs, opened for signature March 30, 1961, 18 U.S.T. 1407, 30 T.I.A.S. No. 6298, 520 U.N.T.S. 151 (Single Convention). The United States ratified the Single Convention in 1967
http://www.incb.org/pdf/e/conv/convention_1961_en.pdf

[3] Convention on Psychotropic Substances, opened for signature February 21, 1971, 32 U.S.T. 543, 1019 U.N.T.S. 175 (1971 Convention). The United States ratified the 1971 Convention in 1980, with the following exception: "In accord with paragraph 4 of article 32 of the Convention, peyote harvested and distributed for use by the Native American Church in its religious rites is excepted from the provisions of article 7 of the Convention on Psychotropic Substances."
http://www.incb.org/pdf/e/conv/convention_1971_en.pdf

[4] United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, opened for signature December 20, 1988, 28 I.L.M. 493. The United States ratified the 1988 Convention in 1990, with the following exception: Understandings: "(1) Nothing in this Treaty requires or authorizes legislation or other action by the United States of America prohibited by the Constitution of the United States."
http://www.incb.org/pdf/e/conv/1988_convention_en.pdf

Columbia have currently accepted the medical use of marijuana in treatment.[5] All of them are "in the United States."

The requirement that a substance be removed from Schedule I of the federal CSA, in 21 U.S.C. § 812(b)(1)(B), if a substance in Schedule I has "currently accepted medical use in treatment in the United States" is being unlawfully withheld by the Respondent, 5 U.S.C. § 706(1) ("agency action unlawfully withheld"), contrary to constitutional right, privilege, or immunity, and in excess of statutory jurisdiction, authority, or limitation or short of statutory right. 5 U.S.C. §§ 706(2)(B) and (C).

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[5] Alaska Statutes § 17.37 (1998); California Health & Safety Code § 11362.5 (1996); Colorado Constitution Article XVIII, Section 14 (2000); Hawaii Revised Statutes § 329-121 (2000); 22 Maine Revised Statutes § 2383-B (1999); Montana Code Annotated § 50-46-101 (2004); Nevada Constitution Article 4 § 38 - Nevada Revised Statutes Annotated § 453A.010 (2000); New Mexico Statutes Annotated § 30-31C-1 (2007); Oregon Revised Statutes § 475.300 (1998); Rhode Island General Laws § 21-28.6-1 (2006); 18 Vermont Statutes Annotated § 4471 (2004); Revised Code Washington (ARCW) § 69.51A.005 (1998). Arizona Revised Statutes, Title 36, Chapter 28.1, §§ 36-2801 through 36-2819 (2010); Connecticut Public Act No. 12-55 (2012) (not yet codified); Delaware Code, Title 16, Chapter 49A, §§ 4901A through 4926A (2011); D.C. Law 18-210; D.C. Official Code, Title 7, Chapter 16B, §§ 7-1671.01 through 7-1671.13 (2010); Michigan Compiled Laws, Chapter 333, §§ 333.26421 through 333.26430 (2008); New Jersey Public Laws 2009, Chapter 307, New Jersey Statutes, Chapter 24:6I, §§ 24:6I-1 through 24:6I-16 (2010). Massachusetts, November 6, 2012 (effective January 1, 2013), and New Hampshire, July 23, 2013 (effective July 23, 2013).

STATEMENT OF THE CASE

In October 2002, the Coalition to Reschedule Cannabis and others petitioned the DEA to remove marijuana from Schedule I of the federal CSA. *See Denial of Petition to Initiate Proceedings to Reschedule Marijuana*, 76 Fed. Reg. 40,552, 40,552 (July 8, 2011). The DEA denied the petition on July 8, 2011, finding among other things that "[t]here is no currently accepted medical use for marijuana in the United States." *Ibid.* at 40,552, 40,567. Intervenor was granted leave to intervene in this matter on September 1, 2011.

On January 22, 2013 the District of Columbia Circuit affirmed the denial of the petition to reschedule marijuana. App. 1-52. Intervenor timely requested rehearing *en banc*, which was denied on March 11, 2013. Intervenor was granted additional time to petition for certiorari until September 12, 2013. App. 124-125.

Accordingly, Intervenor now seeks review of the District of Columbia Circuit's opinion denying the petition to remove marijuana from Schedule I.

REASON FOR GRANTING THE WRIT

1. MARIJUANA HAD ACCEPTED MEDICAL USE IN TREATMENT IN THE UNITED STATES BEFORE THE CSA WAS ENACTED

Prior to the enactment of the federal CSA in 1970, marijuana had been accepted for medical use in treatment almost all 50 states in the United States. *James v. City of Costa Mesa*, 700 F.3d 394, 409 (9th Cir. 2012) (Berzon, J., dissenting):

> First, while California in 1996 became the first of the sixteen states that currently legalize medical marijuana, the history of medical marijuana goes back much further, so that use for medical purposes was not unthinkable in 1990. At one time, "almost all States ... had exceptions making lawful, under specified conditions, possession of marihuana by ... persons for whom the drug had been prescribed or to whom it had been given by an authorized medical person." *Leary v. United States*, 395 U.S. 6, 17, 89 S. Ct. 1532, 23 L. Ed. 2d 57 (1969).

The Marihuana Tax Act of 1937, Pub. 238, 75th Congress, 50 Stat. 551 (Aug. 2, 1937)[6], included an

[6] This act was overturned in 1969 in *Leary v. United States*, and was repealed by Congress the next year. For repeal, see section 1101(b)(3), Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236, 1292 (Oct. 27,

exemption for medical use. *Leary v. United States*, 395 U.S. 6, 15 n.10, 16-18 (1969). As noted by this Court in *Gonzales v. Raich*, 545 U.S. 1, 11 (2005):

> [D]octors wishing to prescribe marijuana for medical purposes were required to comply with rather burdensome administrative requirements.
>
> * * *
>
> Thus, while the Marihuana Tax Act did not declare the drug illegal per se, the onerous administrative requirements, the prohibitively expensive taxes, and the risks attendant on compliance practically curtailed the marijuana trade.

Marijuana is the only substance in Schedule I which the National Commission on Marihuana and Drug Abuse, Act of October 27, 1970, Pub. L. No. 91-513, § 601, 1970 U.S. Code Cong. & Admin. News (84 Stat.) 1280-1281, recommended be decriminalized.[7]

1970) (repealing the Marihuana Tax Act which had been codified in Subchapter A of Chapter 39 of the Internal Revenue Code of 1954).

[7] *Marihuana: a Signal of Misunderstanding*, First Report of the National Commission on Marihuana and Drug Abuse. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock Number 5266-0001, at page 152.

2. MARIJUANA HAS CURRENTLY ACCEPTED MEDICAL USE IN TREATMENT IN THE UNITED STATES

Twenty states "in the United States" have accepted the medical use of marijuana over the past 17 years.[8] The recent acceptance of the medical use of marijuana in treatment in the United States is understandable, given its acceptance for medical use in almost all 50 states in the United States prior to the enactment of the federal CSA.

3. STATES RETAIN THE RIGHT TO LEGISLATE ON BEHALF OF THE HEALTH AND WELFARE OF THEIR CITIZENS

It was settled by this Court in *Gonzales v. Raich*, 545 U.S. 1 (2005), that Congress acted within its constitutional commerce clause powers, U.S. CONST. art. IV, § 8, cl. 3, in enacting the federal CSA and that medical necessity provides no individual exception to the federal CSA.

However, the question presented here, the "manner" in which the administrative agencies regulate controlled substances under the federal CSA was not asked or answered in *Raich*, as specifically noted by this Court the following year in *Gonzales v. Oregon*, 546 U.S. 243, 271 (2006) (the only national standard the Attorney General has the authority to

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[8] *See* state statutes cited *supra* note 5.

make under the federal CSA is to "determine the appropriate methods of professional practice in the medical treatment of the narcotic addiction of various classes of narcotic addicts"):

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

In this case, the Respondent claims it has the authority to decide that marijuana has no accepted medical use in treatment in the United States, in blatant disregard of the Tenth Amendment. U.S. CONST. amend. X. *See*, *Bond v. United States*, 564 U.S. ___, ___, 131 S. Ct. 2355, 2366, 180 L. Ed. 2d 269, 282 (2011):

> The principles of limited national powers and state sovereignty are intertwined. While neither originates in the Tenth Amendment, both are expressed by it.

And see, *New York v. United States*, 505 U.S. 144, 156 (1992):

> If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States; if a power is an attribute of state sovereignty reserved by the Tenth Amendment, it is necessarily a power the Constitution has not conferred on Congress.

Here, the Respondent, rather than Congress, violates the Tenth Amendment, because Congress did not set a national standard on the accepted medical use of marijuana. This situation is unique, because marijuana is the only controlled substance in Schedule I of the federal CSA that has ever been accepted for medical use in treatment by any state, or that had accepted medical use in treatment in almost all 50 states prior to the enactment of the federal CSA.

The U.S. Court of Appeals failed to address the constitutional balance between the states and the national government, known as federalism, in its final ruling, even though the Intervenor brought it to the court's attention. A court cannot disregard its duty under 5 U.S.C. §§ 706(1) and (2) to address plain error of law. The dissenting opinion simply says, "[the Intervenor] invokes 'federalism'". App. 50. The majority opinion never mentions the Intervenor's argument at all.

What is most peculiar about the U.S. Court of Appeal's failure to address the issue of federalism is the appeal court's ruling on standing. After the petitioners failed to adequately establish standing in

their opening and reply briefs, the appeal court requested supplemental briefing on the issue of Michael Krawitz's standing. *Americans for Safe Access v. DEA*, 706 F.3d 438, 442 (D.C. Cir. 2013), App. 9-10. Krawitz had originally argued that the Veterans Administration was denying him pain medication because he lived in Virginia, a state that does not accept the medical use of marijuana in treatment. The Veterans Administration has a policy of non-discrimination against veterans using marijuana for medical purposes in states that do allow the medical use of marijuana in treatment. In their supplemental brief on standing, the Petitioners advanced a new theory on Michael Krawitz's standing:

> Rather, the Government merely noted that Petitioners' supplemental filings stated, "for the first time, that [Krawitz] participates in the 'Oregon Medical Marijuana Program.' "

Id., 706 F.3d at 444, App. 13. Oregon is one of the 20 states that accepts the medical use of marijuana in treatment, and Virginia is not one of those 20 states.[9] The appeal court simply acknowledged that state law makes a difference and then ignored the violation of state sovereignty and autonomy created by the Respondent's invalid interpretation of the statute.

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[9] *See* state statutes accepting the medical use of marijuana in treatment *supra* note 5

The Respondent relies on *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131, 1135 (D.C. Cir. 1994) (approving a five part test based on scientific and medical factors) as authority to override state sovereignty and autonomy. App. 82, 87-88, 98-100, 109. But the decision in 1994 did not take into account the enactment of 20 state medical marijuana laws beginning in 1996. How can the Respondent rely on a 1994 court decision to invalidate the decisions of 20 states after 1996? There was no conflict with state laws in 1994, because no state had accepted the medical use of marijuana in treatment in 1994 (prior to 1996). *See, e.g.*, *Grinspoon v. DEA*, 828 F.2d 881, 886 (1st Cir. 1987):

> We add, moreover, that the Administrator's clever argument conveniently omits any reference to the fact that the pertinent phrase in section 812(b)(1)(B) reads "in the United States," (emphasis supplied). We find this language to be further evidence that the Congress did not intend "accepted medical use in treatment in the United States" to require a finding of recognized medical use in every state or, as the Administrator contends, approval for interstate marketing of the substance.

Here, the Respondent conveniently omits the phrase "in the United States" in its final ruling, truncating the criterion in 21 U.S.C. § 812(b)(1)(B) to "currently accepted medical use" as if "in the United States" was just superfluous language.

The U.S. Court of Appeals acknowledged that the phrase "currently accepted medical use" as used in the federal CSA is an ambiguous phrase. *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 939 (D.C. Cir. 1991).

> The difficulty we find in petitioners' argument is that neither the statute nor its legislative history precisely defines the term "currently accepted medical use"; therefore, we are obliged to defer to the Administrator's interpretation of that phrase if reasonable.

And yet, the Respondent interprets that ambiguous phrase in the federal CSA as a delegation of constitutional authority to interfere with the right of a state to regulate marijuana in the interest of the health and welfare of its own citizens.

Interference with state authority to regulate in the interest of the health and welfare of its citizens is a question of constitutional law, not a scientific and medical inquiry. *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006):

> [C]ongress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally. The silence is understandable given the

> structure and limitations of federalism, which allow the States " 'great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.' " *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475, 116 S. Ct. 2240, 135 L. Ed. 2d 700 (1996) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985)).

The Respondent's interpretation of "medical use in treatment in the United States" is not entitled to deference when it creates a clear violation of state sovereignty where no such conflict was intended by Congress. *Texas v. United States*, 497 F.3d 491, 500-505 (5th Cir. 2007):

> The authority of administrative agencies is constrained by the language of the statute they administer. See *Massachusetts v. EPA*, 549 U.S. 497, 127 S. Ct. 1438, 1462, 167 L. Ed. 2d 248 (2007). Under the *Chevron* doctrine, courts assess the validity of challenged administrative regulations by determining whether (1) a statute is ambiguous or silent concerning the scope of secretarial authority and (2) the regulations reasonably flow from the statute when viewed in context of the overall legislative framework and the policies that animated Congress's design. *See Chevron U.S.A. Inc. v. NRDC*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 2781-82 (1984).

* * *

Chevron deference "comes into play, of course, only as a consequence of statutory ambiguity, and then only if the reviewing court finds an implicit delegation of authority to the agency." (citation omitted)

* * *

Thus, even if there were an ambiguity . . ., an equally salient fact is that "[m]ere ambiguity in a statute is not evidence of congressional delegation of authority." (citation omitted)

* * *

Citing *Seminole Tribe*, Appellees further contend that a judicial decision can, ex post facto, create a *Chevron*-type "gap" that introduces ambiguity into the operation of a statutory scheme and thereby authorizes an administrative agency to step in and remedy the ambiguity. This claim ignores *Chevron's* well-established requirement that any delegation-engendering gap contained in a statute, whether implicit or explicit, must have been "left open by Congress," not created after the fact by a court. *Chevron*, 467 U.S. at 866, 104 S. Ct. at 2793 (emphasis added). (footnote omitted)

* * *

> However, the fact that later-arising circumstances cause a statute not to function as Congress intended does not expand the congressionally-mandated, narrow scope of the agency's power.
>
> * * *
>
> Thus, if Congress did not originally intend to confer rulemaking authority, the Secretary cannot synthesize that authority from a judicial opinion. (footnote omitted)

The federal CSA must be interpreted as a whole, not piecemeal. *United Savings Ass'n v. Timbers of Inwood Forest Associates*, 484 U.S. 365, 371 (1988):

> Statutory construction, however, is a holistic endeavor. A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme -- because the same terminology is used elsewhere in a context that makes its meaning clear, *see, e. g.*, *Sorenson v. Secretary of Treasury*, 475 U.S. 851, 860 (1986), or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law, *see, e. g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987); *Weinberger v. Hynson, Westcott & Dunning, Inc.*, 412 U.S. 609, 631-632 (1973); *Jarecki v. G. D. Searle & Co.*, 367 U.S. 303, 307-308 (1961).

The intent of Congress was to create harmony between state and federal law, not discord. *Gonzales v. Oregon*, 546 U.S. 243, 264 (2006), specifically identifies 21 U.S.C. § 823:

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

The federal CSA further identifies the relationship between the states and the Attorney General in § 873. 21 U.S.C. § 873 provides:

> The Attorney General shall cooperate with local, State, and Federal agencies concerning traffic in controlled substances and in suppressing the abuse of controlled substances. To this end, he is authorized to assist State and local governments in suppressing the diversion of controlled substances from legitimate medical, scientific, and commercial channels by…

Particularly illustrative of state autonomy to decide if and when to use a particular controlled substance in medical treatment is the Revised Uniform Controlled Substances Act, 9 U.L.A. Part II

(1994) ("USCA")[10]. In the prefatory comments to the 1990 amendments, the Commission states, "Legitimate use of controlled substances is essential for public health and safety, and the availability of these substances must be assured." Prefatory Note for Uniform Controlled Substances Act (1990), at page 2, 9 U.L.A. Part II 5 (1994). Section 201 of the UCSA gives states the option of accepting the medical use of controlled substances regardless of their placement in Schedule I of the federal CSA. *Id.*, at pages 13-14, 9 U.L.A. Part II 42-43 (1994). *See also*, Comments on § 201 of the UCSA, *id.*, at page 16, 9 U.L.A. Part II 44 (1994) ("appropriate person or agency within the State … should have expertise in law enforcement, pharmacology, and chemistry"). Section 201 of the UCSA is essentially the same as it was in the 1970 version of the USCA. *Id.*, at page 18, 9 U.L.A. Part II 53 (1994) ("the requirements for placing substances in the various schedules are being retained in substantially the form contained in the 1970 Uniform Act"). The USCA makes it clear that states have not ceded any authority to the Respondent to decide if and when substances can or cannot have accepted medical use within their borders.

Finally, 21 U.S.C. § 903, as noted by this Court in *Gonzales v. Oregon*, 546 U.S. 243, 251 (2006), provides

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[10] Uniform Law Commission, The National Conference of Commissioners on Uniform State Laws.
http://uniformlaws.org/Act.aspx?title=Controlled%20Substances%20Act
http://www.uniformlaws.org/shared/docs/controlled%20substances/UCSA_final%20_94%20with%2095amends.pdf

evidence that Congress envisioned a significant role for the states in the federal CSA:

> The CSA explicitly contemplates a role for the States in regulating controlled substances, as evidenced by its pre-emption provision.

And see, *Conant v. Walters*, 309 F.3d 629, 639 (9th Cir. 2002), *cert. denied*, *Walters v. Conant*, 540 U.S. 946 (2003):

> Our decision is consistent with principles of federalism that have left states as the primary regulators of professional conduct. *See Whalen v. Roe*, 429 U.S. 589, 603 n. 30, 51 L. Ed. 2d 64, 97 S. Ct. 869 (1977) (recognizing states' broad police powers to regulate the administration of drugs by health professionals); *Linder v. United States*, 268 U.S. 5, 18, 69 L. Ed. 819, 45 S. Ct. 446 (1925) ("direct control of medical practice in the states is beyond the power of the federal government"). We must "show[] respect for the sovereign States that comprise our Federal Union. That respect imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to serve as a laboratory in the trial of novel social and economic experiments without risk to the rest of the country." *Oakland Cannabis*, 532 U.S.

at 501 (Stevens, J., concurring) (internal quotation marks omitted).

The federal CSA must be interpreted by the Respondent to create harmony between the states and the national government, not discord.

CONCLUSION

Accordingly, the petition for a writ of certiorari should be granted.

DATED: September 9, 2013

Respectfully submitted,

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