No. 20-148

IN THE
Supreme Court of the United States

MARVIN WASHINGTON, ET AL.,
Petitioners,

v.

WILLIAM P. BARR, ATTORNEY GENERAL, ET AL.,
Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

BRIEF OF AMERICANS FOR SAFE ACCESS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICUS CURIAE[1]

Americans for Safe Access ("ASA") is the nation's largest member-based organization of patients, medical professionals, scientists, and concerned citizens working to promote safe and legal access to cannabis for therapeutic use and research. ASA fulfills its mission through legislative advocacy, education, grassroots activism, services provided to patients and their providers, and litigation. ASA has more than 100,000 active members with chapters and affiliates in all 50 states and the District of Columbia.

The Second Circuit's decision evaded an important constitutional question: whether there is a substantive due process right to use cannabis for medical purposes, given that there is a consensus of at least 33 States (and the District of Columbia) legally permitting such use, and given the federal government's increasing deference to state laws? Because the Drug Enforcement Administration (DEA) is charged with the administration of the Controlled Substances Act (CSA), which places cannabis in the most restricted category (Schedule I), the court of appeals determined that the agency should have the first opportunity to resolve petitioners' claims. Worse still, the Second Circuit justified its exhaustion requirement by confusing constitutional claims (which petitioners raised) with a statutory re-scheduling claim (which petitioners did

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[1] All parties have consented to the filing of this brief. *Amicus curiae* timely provided notice of intent to file this brief to all parties. No counsel for a party authored any part of this brief, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to the brief's preparation or submission.

not). The latter is within DEA's competence to adjudicate, the former is not.

As one of the nation's leading advocacy groups for the right to access medical cannabis, ASA has an interest in ensuring that petitioners' constitutional claims are not lost to the abyss of agency adjudication. DEA has taken *decades* to resolve statutory issues relating to the scheduling of cannabis, and it has every incentive here to prolong its adjudication of constitutional claims that it should not be considering in the first place. And, in its most recent denial of a rescheduling request, in 2016, DEA justified that denial partly on the ground that its hands were tied on the issue because of treaty obligations. DEA has all but made clear that it has no interest in granting petitioners relief—however that relief is framed. It was wrong to require exhaustion of petitioners under those circumstances, and it was particularly wrong to do so by taking the unprecedented approach of *rewriting* claims.

ASA submits this amicus brief to highlight the existing circuit split that has only been worsened by the Second Circuit's decision, and to urge this Court to take up the pressing and long-overdue question of whether the right to medical cannabis, supported by a national consensus, is protected by the Due Process Clause.

SUMMARY OF ARGUMENT

A. This Court should grant certiorari to resolve a circuit split over whether a plaintiff must exhaust constitutional claims through the administrative process (for which agencies possess no expertise) before bringing those claims to a court. The Second Circuit adopted a radical new approach to that question: it

concluded that, if there is overlap between the constitutional claim and the statutory issues that the agency is charged with resolving, then the constitutional claim must be exhausted. That position upends the party presentation principle, which this Court recently reaffirmed, as it invites courts to reinvent a plaintiff's claims without his or her input.

B. This case also presents an opportunity for this Court to acknowledge under the Due Process Clause what much of the country has already recognized: there is a right to use cannabis for medical treatment. Cannabis has been used for medical treatment purposes for thousands of years. In the United States, there were no prohibitions on the use of medical cannabis from the nation's founding until 1970, when the Controlled Substances Act (CSA) became law. Today, at least 33 states and the District of Columbia—covering 76.5% of the American population—have returned to what had long been the status quo, having enacted laws allowing for the use of medical cannabis.[2] And while the CSA's designation of cannabis as a Schedule I substance remains on the books, both the Executive Branch and Congress have made clear that the CSA's criminal prohibitions will not be enforced against those engaged in the authorized use of medical cannabis.

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[2] The 76.5% figure does not include Texas and 13 other states that have authorized a more limited medical marijuana program. If these states are included in the count, the numbers are even more compelling: 47 states, the District of Columbia, and four territories have authorized some form of medical marijuana. *See* Ams. for Safe Access, *2019 State of the States*, https://www.safeaccessnow.org/sos.

C. Millions of Americans, including some of the petitioners here, depend on ready access to cannabis for lifesaving treatment. Despite the fact that the majority of states have authorized the medical use of cannabis, the CSA imposes a number of burdens that force those who depend on cannabis to choose between their quality of life or their livelihood. A person using cannabis for medical treatment can lose, among other things, her federal employment, her right to travel across state lines, and her federally funded housing. The Second Circuit's prescription for those seeking to remove such burdens on their right to medical treatment is to go to the DEA and seek statutory re-scheduling. History has shown that the re-scheduling process will result in nothing but futility and frustration, as even the court of appeals recognized when it retained jurisdiction to guard against agency delay. One re-scheduling petition for cannabis took 22 years to resolve, with the petitioners bouncing back and forth between agency and judicial fora. Petitioners here risk the same fate of agency dilatoriness; despite raising claims outside of the agency's expertise, the Second Circuit forced them back to the agency anyway. Now petitioners face the real possibility that they, too, may have to wait years, if not decades, to have their claims heard by the only forum that should hear them—an Article III court.

For these reasons, the Court should grant the petition for a writ of certiorari.

ARGUMENT

A. This Court should grant certiorari to address the growing split over whether a plaintiff must exhaust a constitutional challenge to the enforcement of a statute before the very agency responsible for enforcing that statute.

"The doctrine of exhaustion of administrative remedies . . . is, like most judicial doctrines, subject to numerous exceptions." *McKart v. United States*, 395 U.S. 185, 193 (1969). One such exception arises when "an agency may be competent to adjudicate the issue presented, but still lack[s] the authority to grant the type of relief requested." *McCarthy v. Madigan*, 503 U.S. 140, 148 (1992).

1. For over 200 years, this Court has recognized that it is the federal judiciary, and not any other branch of government, that is "supreme in the exposition of the law of the Constitution." *Cooper v. Aaron*, 358 U.S. 1, 18 (1958). Following this principle, it should be plainly obvious that, however competent an agency may be on matters of policy, statutory implementation, and regulatory enforcement, an agency in the executive branch is not "competent to adjudicate" constitutional claims.

But the courts of appeals have demonstrated that this corollary has been anything but plainly obvious. In particular, they have been split on whether to require agency exhaustion for constitutional claims, even though agencies are not charged in their enabling statutes with the task of resolving such claims.

Some courts have correctly recognized that there is no point in requiring an agency to resolve a constitutional claim because (1) agencies are not accustomed to adjudicating constitutional issues; and (2) agencies have little interest in invalidating the statutory and regulatory schemes they are charged with administering. *See, e.g.*, *United States v. Dohou*, 948 F.3d 621, 628-29 (3d Cir. 2020) ("We also excuse prudential exhaustion when the challenged agency action presents a clear and unambiguous violation of statutory or constitutional rights." (citation omitted)); *Gallegos-Hernandez v. United States*, 688 F.3d 190, 194 (5th Cir. 2012) (holding that it is "futile" to make a constitutional challenge before "those who are charged to enforce the regulation" being challenged).

But other circuits require plaintiffs to raise constitutional challenges before agencies, even if the agencies are powerless to do anything about the challenges. *See, e.g.*, *Marine Mammal Conservancy, Inc. v. Dep't of Agric.*, 134 F.3d 409, 414 (D.C. Cir. 1998) ("Exhaustion even of constitutional claims may promote many of the policies underlying the exhaustion doctrine."); *Colon-Calderon v. DEA*, 218 F. App'x 1 (D.C. Cir. 2007); *Home Care Providers, Inc. v. Hemmelgarn*, 861 F.3d 615, 624 (7th Cir. 2017) (requiring exhaustion for constitutional claims unless the constitutional challenge is "entirely collateral to [the] claim of entitlement, and the claimant's interest in having the issue resolved promptly is so great that deference to the agency's judgment is inappropriate" (citation omitted)); *Volvo GM Heavy Truck Corp. v. U.S. Dep't of Labor*, 118 F.3d 205, 215 (4th Cir. 1997) ("[E]xhaustion can be useful even where a constitutional issue is presented."). And some courts require exhaustion only if the agency has something meaning-

ful to add to the constitutional analysis, *i.e.*, it can moot the constitutional claim by resolving in the plaintiff's favor a separate statutory claim that is within its ambit, or develop a further record that would be useful for adjudicating the constitutional claim. *E.g.*, *S. Ohio Coal Co. v. Donovan*, 774 F.2d 693, 702 (6th Cir. 1985) (noting that exhaustion is unnecessary unless "agency expertise is needed to decide the legal issue involved," or an "adequate factual record" needs to be "compiled").

2. The Second Circuit further complicated the split by taking a new approach to agency exhaustion: it *rewrote* petitioners' claims and changed them from constitutional claims outside of DEA's expertise to a statutory one within the agency's ambit. *See* Pet. App. 16a (summing up all claims as "marijuana should not be classified as a Schedule I substance under the CSA"). But, as this Court recently recognized in *United States v. Sineneng-Smith*, 140 S. Ct. 1575 (2020), a court must take issues as the parties have framed them. *Id.* at 1579 ("[O]ur system is designed around the premise that parties represented by competent counsel know what is best for them, and are responsible for advancing the facts and argument entitling them to relief." (citation, internal quotation marks, and modifications omitted)). Petitioners presented constitutional claims to the district court—in assessing exhaustion, the Second Circuit should have examined those claims as-is, and not reformulate them into something else solely for the purpose of triggering exhaustion requirements.

Moreover, requiring these petitioners' claims to undergo agency exhaustion makes little sense for at least three reasons. First, agencies are generally not in the business of declaring unconstitutional the very statutes they are charged with enforcing (here, the CSA's

Schedule I designation). *See Gallegos-Hernandez*, 688 F.3d at 194 (noting that it would be "futile" to challenge the constitutionality of an agency's regulations and to seek relief "from those who are charged to enforce the regulation").

Second, the constitutional challenges do not require agency expertise or factfinding. To be sure, there are commonalities in the respective analyses to determine whether there is a substantive due process right to use cannabis for medical purposes, and the CSA's statutory factors in determining whether a drug should be placed on Schedule I. But petitioners' claim is not that cannabis should be decriminalized. Rather, it is that the majority of States have *already made* policy determinations that Americans should have access to the safe and effective medical use of cannabis, and that those determinations now give rise to a substantive due process right to the use of cannabis for medical treatment. Courts, and not DEA, have expertise in recognizing such constitutional rights. *E.g.*, *Cruzan ex rel. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 295 (1990); *see also Lawrence v. Texas*, 539 U.S. 558, 573-74 (2003).

Third, DEA's position is ossified. Four decades of petitions to re-schedule cannabis have resulted in nothing but futility—time and time again, DEA has denied petitions (including by *amicus* ASA) despite significant evidence of the medical merits of cannabis. *See, e.g., NORML v. DEA*, 559 F.2d 735, 751 (D.C. Cir. 1977); *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994); Notice of Denial of Petition, 66 Fed. Reg. 20,038 (April 18, 2001); Denial of Petition To Initiate Proceedings To Reschedule Marijuana, 76 Fed. Reg. 40,552 (July 8, 2011); *Ams. for Safe Access v. DEA*,

706 F.3d 438 (D.C. Cir. 2013). DEA has looked for every excuse in the book to avoid re-scheduling. Most recently, in August 2016, DEA denied a petition to reschedule partly by invoking the United States' treaty obligations under the 1961 Single Convention on Narcotic Drugs. It concluded:

> Marijuana is a drug listed in the Single Convention. The Single Convention uses the term "cannabis" to refer to marijuana. Thus, the DEA Administrator is obligated under section 811(d) to control marijuana in the schedule that he deems most appropriate to carry out the U.S. obligations under the Single Convention. It has been established in prior marijuana rescheduling proceedings that placement of marijuana in either schedule I or schedule II of the CSA is "necessary as well as sufficient to satisfy our international obligations" under the Single Convention. *NORML v. DEA*, 559 F.2d 735, 751 (D.C. Cir. 1977). As the United States Court of Appeals for the D.C. Circuit has stated, "several requirements imposed by the Single Convention would not be met if cannabis and cannabis resin were placed in CSA schedule III, IV, or V." *Id.* Therefore, in accordance with section 811(d)(1), DEA must place marijuana in either schedule I or schedule II.

Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 53,688, 53,688-689 (Aug. 12, 2016). There is no reason to think that DEA's recalcitrance will not extend to constitutional claims as well.

3. The treaty issue illustrates another problem with exhaustion: if the Single Convention butts up against constitutional claims, DEA is in no position to untangle itself out of the treaty to honor the Constitution. Generally speaking, federal agencies are not in the business of interpreting or violating treaty obligations, which may be implicated if DEA were to remove cannabis from Schedule I. Courts, not agencies, are equipped to handle conflicts between an agency's organic statute and the treaty obligations that are carried out by the statute. *Cf. Sanchez-Llamas v. Oregon*, 548 U.S. 331, 334 (2006) ("If treaties are to be given effect as federal law, determining their meaning as a matter of federal law is emphatically the province and duty of the judicial department. . . ." (citation and internal quotation marks omitted)). The CSA fulfills the U.S.'s commitments under the Single Convention; if there is a conflict between petitioners' due process arguments and the U.S.'s treaty obligations, as DEA has said there would be, only a court is equipped to resolve that conflict.

4. This Court should intervene now to address the split in the circuits regarding the judicially created exhaustion doctrine, as it applies to constitutional challenges—made all the more confusing by the Second Circuit's decision below. Litigants that appear before agencies prophylactically raise constitutional issues all the time, and several courts have properly recognized that agencies are ill-equipped to resolve those issues. Here, the court of appeals went in the opposite direction, blessing an approach to exhaustion that rewrites a constitutional claim so that it sounds like a claim that the agency is equipped to handle. The Second Circuit turned petitioners' constitutional claim—*i.e.*,

whether there is a substantive due process right to use cannabis for medical purposes—into a question of statutory authority, *i.e.*, whether DEA may reschedule medical cannabis under the CSA, so that the court could sweep petitioners' claims back to DEA using the broom of exhaustion.

B. This Court should grant certiorari to reaffirm the fundamental liberty interest in the choice of medical treatment, and the right to use cannabis as part of that treatment.

The Due Process Clause "specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition,' . . . and 'implicit in the concept of ordered liberty.'" *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (quoting *Moore v. City of E. Cleveland, Ohio,* 431 U.S. 494, 504 (1977); *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)). "Our Nation's history, legal traditions, and practices thus provide the crucial 'guideposts for responsible decisionmaking' that direct and restrain [this Court's] exposition of the Due Process Clause." *Id.* at 721 (citation omitted).

1. The history of cannabis in the United States unambiguously supports the existence of a right to use cannabis for medical treatment. Cannabis has been used for therapeutic purposes for thousands of years around the world. Lewis A. Grossman, *Life, Liberty, [and the Pursuit of Happiness]: Medical Marijuana Regulation in Historical Context*, 74 Food & Drug L.J. 280, 287-88 (2019). In the United States, cannabis was recognized as a form of medical treatment for the first time in the mid-to-late 1800s, used for pain manage-

ment, muscle disorders, and a whole host of other conditions. *Id.* at 288.

In the early 1900s, several states had quietly prohibited the use of cannabis without undertaking "any empirical or scientific study of the effects of the drug," relying instead on "lurid and often unfounded accounts of marijuana's dangers." Richard J. Bonnie & Charles H. Whitebread, *The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition*, 56 Va. L. Rev. 971, 1021-22 (1970). But even in these states, cannabis use was allowed for "medical channels." *Id.* at 1027; *see also Raich v. Gonzales*, 500 F.3d 850, 865 (9th Cir. 2007) ("There is considerable evidence that efforts to regulate marijuana use in the early-twentieth century targeted recreational use, but permitted medical use."). Still, the medical use of cannabis waned in the first half of the 20th century; no state law prohibited it, but cannabis-as-medicine fell out of popularity due to efforts to "tax and regulate marijuana out of existence." Grossman, *supra*, at p. 290. By 1965, all states had criminalized the possession of cannabis, but almost every state had an exception for "persons for whom the d[rug] had been prescribed or to whom it had been given by an authorized medical person." *Leary v. United States*, 395 U.S. 6, 16-17 (1969).

Congress's decision in 1970 to place cannabis on Schedule I—a classification for drugs that have "no currently accepted medical use in treatment," 21 U.S.C. § 812(b)(1)(B)—departed sharply from historical medical and legal practice. By the 1980s, in the wake of the CSA, states had abandoned their longstanding provisions allowing for the medical use of cannabis. Grossman, *supra*, p. 297 (noting that, by the end of the

1980s, states "revok[ed] their medical marijuana statutes or let[] them expire.").

But the states began to change course in 1996. That year, California enacted Proposition 215, otherwise known as the Compassionate Use Act of 1996, which ensured that "'seriously ill' residents of the State [of California] [had] access to marijuana for medical purposes." *Gonzales v. Raich*, 545 U.S. 1, 5-6 (2005). Two years later, five other states—Alaska, Arizona, Nevada, Oregon, and Washington—enacted medical cannabis laws. Grossman, *supra*, p. 308.

2. The current legal landscape with respect to medical cannabis is far different than what it was when the CSA was adopted in 1970 or even in the 1980s. In the two-and-a-half decades since Proposition 215, the majority of states have restored the legal right to use cannabis for medical purposes. Today, 33 states and the District of Columbia authorize the use of medical cannabis, and over 76% of Americans have state-legal access to it. The change in attitudes—and the growing acknowledgement that cannabis has therapeutic value—is part of a growing global trend. Canada, Mexico, Germany, France, Greece, Portugal, South Korea, Australia, South Africa, Argentina, Chile, and 29 other countries allow for medical access to cannabis. *See* The Cannigma Staff, *Cannabis Regulation Around the World* (Oct. 2, 2019), https://cannigma.com/regulation/cannabis-regulation-around-the-world/#central-south-america.

Although cannabis remains on Schedule I, the federal government has increasingly recognized and accommodated its sale and use for medical purposes in several ways.

Federal law enforcement, for example, has all but given up on enforcing the CSA's criminal prohibitions against those using or supplying cannabis for therapeutic purposes. In 2009, the Department of Justice issued a memorandum directed at U.S. attorneys indicating that the federal government would not devote its resources to prosecuting "individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana." Mem. from David W. Ogden, Deputy Att'y Gen., U.S. Dep't of Justice, to Selected U.S. Att'ys, 1-2 (Oct. 19, 2009), *available at* https://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf. In 2013, the Department of Justice reaffirmed that it was not "an efficient use of federal resources to focus enforcement efforts" on cannabis designated for "seriously ill individuals." Mem. from James M. Cole, Deputy Att'y Gen., U.S. Dep't of Justice, to All U.S. Att'ys, 3 (Aug. 29, 2013), *available at* https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf. The Department indicated that in states where the use of cannabis (particularly medical cannabis) was authorized and well-regulated, it would be appropriate to defer to the "enforcement of state law by state and local law enforcement and regulatory bodies." *See id.*

Despite a change in administration, the Department has made clear it will not prioritize enforcement of the CSA for individuals using cannabis for medical purposes authorized under state law. *See Confirmation Hearing on the Nomination of Hon. William Pelham Barr to be Attorney General of the United States: Hearing Before the S. Judiciary Comm.,* S. Hrg. 116-65, 116th Cong., at 70 (2019) (statement of William P.

Barr) ("My approach to this would be not to upset settled expectations and the reliance interests that have arisen as a result of the Cole Memoranda.").

Congress, too, has repeatedly recognized and accommodated Americans' use of cannabis for medical purposes. In December 2014, Congress enacted the Rohrabacher-Farr Amendment as part of an omnibus appropriations bill. Pub. L. No. 113-235, § 538, 128 Stat. 2130, 2217 (2014). The Amendment has been renewed every year and has been in force without interruption. The Amendment, in its current form, states that the Department of Justice's appropriated funds may not be used "to prevent [47 states, the District of Columbia, and the territories of Puerto Rico, Guam, and the Northern Mariana Islands] from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." Pub. L. No. 116-6, § 537, 133 Stat. 13, 138 (2019). While the Amendment is an appropriations rider, courts have used it as an active restraint on the federal government's enforcement authority. In one case, the Ninth Circuit held that a defendant could rely on the Amendment to challenge an indictment for conduct that was lawful under state medical cannabis laws. *See United States v. McIntosh*, 833 F.3d 1163, 1179 (9th Cir. 2016); *see also United States v. Pisarski*, 965 F.3d 738, 741-42, 746 (9th Cir. 2020) (affirming the district court's decision to enjoin further prosecution of farmers who cultivated cannabis for medical marijuana purposes, on the grounds that the farmers had established that they complied strictly with California's medical marijuana laws). And in a Tenth Circuit case, the court of appeals concluded that the Bureau of Prisons was compelled to release a prisoner incarcerated

for distributing medical cannabis that was lawful under state law, as the Bureau's funds flowed from the Department of Justice. *Sandusky v. Goetz*, 944 F.3d 1240, 1247 (10th Cir. 2019).

It is no surprise that the medical use of cannabis is now accepted in 33 States and the District of Columbia: recent research on the therapeutic efficacy of cannabis has debunked Congress's initial conclusion in 1970 that "marijuana has 'no currently accepted medical use.'" *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 491 (2001).

The best known medical use of cannabis is for the treatment of chronic pain—well-controlled clinical trials have demonstrated that cannabis is effective for this purpose. Nat'l Academy of Sciences, Eng'g, & Med., *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research* 87 (2017). Studies also show that cannabis is demonstrably effective in treating chemotherapy-induced nausea, multiple sclerosis spasticity, and certain sleep disorders. *Id.* at 13. Cannabis is also showing promise as a treatment for Tourette's syndrome, anxiety, posttraumatic stress disorder, and intracranial hemorrhaging. *Id.* at 14.

In 2018, the Food and Drug Administration (FDA) approved a New Drug Application for Epidiolex (cannabidiol), which was to be used for the treatment of "two rare and severe forms of epilepsy, Lennon-Gastaut syndrome and Dravet syndrome." FDA New Release: *FDA Approves First Drug Comprised of an Active Ingredient Derived From Marijuana to Treat Rare, Severe Forms of Epilepsy* (June 25, 2018), https://www.fda.gov/news-events/press-announcements/fda-appr

oves-first-drug-comprised-active-ingredient-derived-marijuana-treat-rare-severe-forms. For most drugs, the approval process would end there; FDA's approval signals that the drug is safe and effective, and thus ready for commercial marketing in the United States. *See* 21 U.S.C. § 355(b). But because Epidiolex's active ingredient is derived from cannabis, a Schedule I controlled substance (for which there is purportedly "no currently accepted medical use"), the DEA had to reschedule the drug and approve controls for its use. *See id.* § 355(x).

Citing treaty obligations, FDA formally recommended that cannabidiol be listed on Schedule V—the CSA's least restrictive schedule—despite *also* concluding that cannabidiol "does not meet the criteria for placement in any of Schedules II, III, IV, or V under the CSA." Letter from Brett P. Giroir, M.D., Assistant Secretary for Health, to the Honorable Robert W. Patterson (May 16, 2018); *see also* U.S. Dep't of Health & Human Servs., Basis for the Recommendation to Place Cannabidiol in Schedule V of the Controlled Substances Act 22. After some hemming and hawing about whether to re-schedule cannabis more generally, DEA began its classification decision by reiterating its longstanding refusal to revisit cannabis's Schedule I classification. *See* Schedules of Controlled Substances: Placement in Schedule V of Certain FDA-Approved Drugs Containing Cannabidiol; Corresponding Change to Permit Requirements, 83 Fed. Reg. 48,950, 48,952 (Sept. 28, 2018). Rather, DEA implemented FDA's "recommendation" to place Epidiolex on Schedule V, *id.*, and later implemented FDA's *actual* recommendation by removing it from the CSA's listings altogether. GlobeNewswire, *GW Pharmaceuticals plc and Its U.S.*

Subsidiary Greenwich Biosciences, Inc. Announce That EPIDIOLEX® (cannabidiol) Oral Solution Has Been Descheduled and is No Longer a Controlled Substance (Apr. 6, 2020, 9:00 ET), https://www.globenewswire.com/news-release/2020/04/06/2012160/0/en/GW-Pharmaceuticals-plc-and-Its-U-S-Subsidiary-Greenwich-Biosciences-Inc-Announce-That-EPIDIOLEX-cannabidiol-Oral-Solution-Has-Been-Descheduled-And-Is-No-Longer-A-Controlled-Substan.html.

C. The millions of Americans who depend on medical cannabis should not be forced to wait decades for DEA to mull over a due-process claim that it should not be adjudicating in the first place.

1. Millions of Americans now use cannabis for medical treatment. Am. for Safe Access, *State of the States Report* 4, https://www.safeaccessnow.org/sos; Marijuana Policy Project, *Medical Marijuana Patient Numbers* (July 6, 2020), https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/. Practitioners and patients alike agree that cannabis can be a medical necessity, to treat chronic conditions so that patients can go about their everyday lives. Christopher Ingraham, *92% of Patients Say Medical Marijuana Works*, Wash. Post (Oct. 1, 2014, 10:33 a.m.), https://www.washingtonpost.com/news/wonk/wp/2014/10/01/92-of-patients-say-medical-marijuana-works/.

Yet the outmoded federal Schedule I designation, combined with the statutory and regulatory outgrowth sprawling out of the CSA, has made it difficult for many patients who rely on medical cannabis to live their everyday lives. Non-enforcement of federal crim-

inal laws for users of medical cannabis is simply not enough; the patchwork of other federally imposed restrictions and prohibitions effectively cut off access to the essential treatment of cannabis. For example:

- A federal employee cannot use cannabis for any purpose, even if it is medically necessary. Exec. Order No. 12,564, 51 Fed. Reg. 32,889 (Sept. 15, 1986); *see also Hansen v. Dep't of Homeland Sec.*, 911 F.3d 1362, 1367 (Fed. Cir. 2018) (the government need not establish intent to remove a federal employee from service for using cannabis).
- A recipient of federal housing benefits may lose those benefits for using medical cannabis, even if that use is fully authorized by state law. *E.g.*, *Forest City Residential Mgmt. ex rel. Plymouth Square Ltd. Dividend Housing Ass'n v. Beasley*, 71 F. Supp. 3d 715, 727, 731 (E.D. Mich. 2014) (holding that Michigan's medical cannabis statute is preempted by the CSA, and that the resident who uses medical cannabis to treat her multiple sclerosis is not entitled to an accommodation under the Fair Housing Act).
- Federally funded health care providers cannot prescribe cannabis for medical purposes, no matter how effective it may be. This includes hospitals operated by the Department of Veterans Affairs, despite increased advocacy by veterans' groups to explore cannabis as a therapeutic treatment for service-connected injuries. *See* U.S. Dep't of Veterans Affairs, Veterans Health Administration, *VHA Directive 1315: Access to VHA Clinical Programs for Veterans Participat-*

ing in State-Approved Marijuana Programs (Dec. 8, 2017), *available at* https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5711 ("VHA providers are prohibited from completing forms or registering Veterans for participation in a State-approved marijuana program"); Disabled American Veterans, Resolution No. 076, *Support Department of Veterans Affairs Research Into the Medical Efficacy of Cannabis for Service-Connected Disabled Veterans* (2019-2020), *available at* https://www.dav.org/wp-content/uploads/ResolutionBook.pdf (expressing support for "more comprehensive and scientifically rigorous research by the VA into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans").

- If a child needs medical cannabis to live, a school receiving federal funding may not provide that child with accommodations under the Individuals with Disabilities Education Act (IDEA), forcing the parents to either find a private school willing to provide a medical accommodation, or risk their child's health. *See, e.g. Albuquerque Pub. Sch. v. Sledge*, No. CV 18-1029 KK/LF, 2019 WL 3755954, at *10 (D.N.M. Aug. 8, 2019) (finding that IDEA does not require the Albuquerque Public Schools to administer, or accommodate the administration of, medical cannabis to a student in order to satisfy its obligation to provide students with a free and public education, and noting "that [although] the CUA permits Mother to give Student [medical] can-

nabis[, that] does not change the fact that federal law prohibits it").

- Medical cannabis patients attending institutions of higher education that receive federal funding are generally prohibited from administering their medical cannabis on campus (including in the privacy of their on-campus residences). The Drug-Free Schools and Campuses Act requires schools to implement programs that "prohibit . . . unlawful possession, use, or distribution of illicit drugs." Failing to enforce the prohibition may mean losing federal funding. *See* 34 C.F.R. §§ 86.100, 86.300, 86.304.
- Most relevant to petitioners here, federal law still prevents a patient from traveling interstate with cannabis used for medical purposes. Medical marijuana patients are effectively prohibited from entering federal buildings, traveling interstate for work, or using methods of transportation funded by the federal government, while maintaining ready access to their life-saving treatment.

2. The Second Circuit's answer to the millions who may seek to exercise their substantive due process right to cannabis treatment is for those Americans to undergo the statutory re-scheduling mechanism and to seek relief from the agency. It is hard to see how DEA will treat the constitutional analysis as anything other than a re-scheduling request under the statutory factors prescribed by the CSA, even though the constitutional and statutory analyses are entirely different.

And that process will be long, frustrating, ill-fated, and futile. So notorious is DEA's reputation for delay

that the Second Circuit took the extraordinary step of *retaining jurisdiction*. Pet. App. 23a ("[I]n light of the unusual circumstances of this case, we hold the case in abeyance and retain jurisdiction . . . to take whatever further action might become appropriate should Plaintiffs initiate administrative review and the administrative process fail to operate with adequate dispatch."). With good cause. In 1972, shortly after the CSA's enactment, the National Organization for the Reform of Marijuana Laws (NORML) petitioned for cannabis to be rescheduled out of Schedule I. Grossman, *supra*, p. 291. It took 11 years for FDA to provide a recommendation on the rescheduling request, something that DEA was statutorily required to obtain before undertaking a rulemaking. *Id.* at 295. In 1988, an administrative law judge found that "[m]arijuana, in its natural form, is one of the safest therapeutically active substances known to man," and recommended that cannabis be transferred to Schedule II. *Id.* 296-97 (citation omitted). The DEA administrator rejected the ALJ's findings, and the D.C. Circuit reversed the administrator's decision as arbitrary and capricious. *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 940 (D.C. Cir. 1991). The administrator fixed his order rejecting the rescheduling request, which the D.C. Circuit upheld in 1994—22 years after NORML filed its rescheduling petition. *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994).

It is not difficult to see how a due-process claim before DEA might meet a similar fate. The Second Circuit's transmogrification of petitioners' substantive due process claim into a statutory re-scheduling claim will only encourage DEA to make policy judgments about medical necessity and engage in protracted navel-

gazing about the therapeutic merits of cannabis, as the CSA instructs it to do. But the 33 states that have authorized the medical use of cannabis have already made that policy judgment. Moreover, agencies do not recognize substantive due process rights—that responsibility falls squarely on the courts. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 849 (1992) ("The inescapable fact is that adjudication of substantive due process claims may call upon the Court in interpreting the Constitution to exercise that same capacity which by tradition courts always have exercised: reasoned judgment.").

The growing number of Americans who depend on medical cannabis to live their everyday lives cannot afford to wait decades to have their constitutional right to medical treatment recognized by the judiciary. This Court should grant certiorari to acknowledge as a matter of due process what the consensus in this country has already observed: there is a right to medical treatment in the form of cannabis, and Schedule I—with its outmoded *blanket* prohibition on the use of cannabis—cannot stand. *See Reno v. Flores*, 507 U.S. 292, 301-2 (1993) ("[T]he Fifth and Fourteenth Amendments' guarantee of 'due process of law' [] include a substantive component, which forbids the government to infringe certain 'fundamental' liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.").

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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