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IN THE UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

SAFEWAY INC.,

Plaintiff,

v.

CITY AND COUNTY OF SAN FRANCISCO, *et al.*,

Defendants.

Case No. CV-11-0761 (CW)

APPLICATION OF THE CALIFORNIA MEDICAL ASSOCIATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF; *AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

Date: June 2, 2011
Time: 2:00 p.m.
Judge: Hon. Claudia Wilken
Court: Courtroom 2 – 4th Floor

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

The California Medical Association ("CMA") hereby requests permission to file the attached a*micus curiae* brief in support of the City and County of San Francisco's ("San Francisco") motion to dismiss the complaint in this action, filed by Safeway Inc. ("Safeway"). Counsel for CMA has reviewed Safeway's complaint in this action to challenge the constitutionality and legality of San Francisco's ordinance prohibiting the sale of tobacco in retail stores with pharmacies, S.F. Ordinance Nos. 194-08 and 245-10 (the "Ordinance"). CMA believes it can assist the Court in resolving a key issue raised by Safeway's complaint: whether San Francisco treats similarly situated entities differently under the Ordinance and whether any such distinction is rationally related to a legitimate public health interest.

CMA is a not-for-profit professional association for physicians with approximately 35,000 members throughout California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of the public health and the betterment of the medical profession. CMA's physician members practice medicine in all specialties and settings. CMA carries out this mission through advocacy on behalf of organized medicine in the courts and before legislatures and regulators.

CMA strongly supports the San Francisco Ordinance because it is squarely in line with decades of official CMA policy, including recent policy specifically supporting a prohibition on the sale of tobacco products in stores that provide pharmacy services. Such policy mirrors that of the American Medical Association and is based upon sound medical and public health research. In short, the Ordinance is consistent with the conclusions of the medical and public health community that an integral component of the overall campaign against smoking and tobacco addiction must include efforts to address the social norms and messages associated with smoking and to limit the availability, visibility and accessibility of tobacco.

Unlike other retail outlets that sell cigarettes, stores that provide pharmacy services pose a unique problem if they also sell tobacco products. Stores such as Safeway that contain a pharmacy are an integral part of the health care delivery system. Selling tobacco products in such institutions creates a conflict of interest and sends a mixed message that can undermine the

campaign against smoking. Furthermore, as a practical matter, making cigarettes available where patients go to fill drug prescriptions can frustrate the treatment protocols of physicians.

CMA's *amicus* brief elaborates on these medical and public health reasons why banning the sale of tobacco products in retail stores with pharmacies is crucial in the public health fight against smoking. In so doing, the *amicus* brief presents organized medicine's perspective in supporting San Francisco's Ordinance and directly refutes Safeway's contention that the Ordinance is unconstitutional. The *amicus* brief could supplement the parties' briefs and aid the Court in reaching its decision on San Francisco's motion to dismiss.

Accordingly, CMA requests leave to file the attached *amicus* brief.

DATED: April 15, 2011

Respectfully,

FRANCISCO J. SILVA
LONG X. DO
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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION

INTRODUCTION

Cigarettes are the only consumable product that, when used as intended, will contribute to the death of at least one half of all users.[1] For this reason, physicians and public health organizations have sought for decades to reduce, and ultimately to eliminate, tobacco consumption. Furthering this critical public health goal, San Francisco's Ordinance states that "[n]o person shall sell tobacco products in a pharmacy." San Francisco Health Code §1009.92. A "pharmacy" under this Ordinance means "a retail establishment in which the profession of pharmacy . . . is practiced and where prescriptions are offered for sale." *Id.* at §1009.91. The Ordinance recognizes that "[a] pharmacy may also offer other retail goods in addition to prescription pharmaceuticals." *Id.* Thus, grocery stores, big box stores and drugstores that contain pharmacies fall within the reach of the Ordinance.

CMA disputes the principal premise underlying Safeway's lawsuit challenging the Ordinance – that the Ordinance treats similarly situated stores differently and that there is no rational basis for prohibiting the sale of tobacco products in stores with pharmacies but not other stores that sell tobacco products. This *amicus* brief explains why.

There is a long and ongoing campaign by health care professionals and public health officials to reduce, and ultimately to eliminate, tobacco use and addiction. Most recently, organized medicine has called for a ban on the sale of tobacco products in stores with pharmacies. Public health and medical researchers have established that social norms and perceptions about smoking, as well as the ubiquity of smokers and tobacco products, have an impact on the rates at which people start or quit smoking. Unlike stores that do not offer pharmacy services, stores that contain pharmacies pose a unique problem in the context of the anti-smoking campaign when they also sell cigarettes. Stores that offer pharmacy services, such as Safeway stores, are health

[1] *See, e.g.*, R. Doll, *et al.*, *Mortality in Relation to Smoking: 50 Years' Observations on Male British Doctors*, 328 BRIT. MED. J. 1519 (2004).

care delivery outlets where patients go to receive health care services and prescription drugs. The sale of cigarettes in such health care delivery outlets creates a conflict of interest and sends a mixed message about the harmful effects of smoking. It also could frustrate the ability of physicians to treat patients who may have access to cigarettes in the same location that fills their drug prescriptions and offers medical advice.

By focusing on stores that contain a pharmacy, San Francisco does not treat similarly situated stores differently and, in any event, has made a sound policy decision that is based on medical and public health research. The Ordinance is consistent with the official policy of organized medicine at the state and federal levels. Accordingly, CMA urges the Court to grant San Francisco's motion to dismiss Safeway's complaint.

BACKGROUND

The public health community has waged a long campaign against smoking and tobacco products. Smoking is the leading preventable cause of death. An average of 36,687 Californians died each year between 2000 and 2004 due to smoking.[2] Between 2004 and 2006 the rate of smoking among California high school students increased by 17 percent.[3]

In 1988 California voters passed Proposition 99, a health protection act that created the nation's first statewide tobacco control program.[4] Proposition 99 promotes the health of Californians by employing comprehensive public health strategies that work "1) to protect nonsmokers by reducing exposure to environmental tobacco smoke…; and 2) to reduce smoking prevalence by discouraging adolescents from taking up smoking and encouraging smokers to

[2] *State Specific Smoking Attributable Mortality and Years of Potential Life Lost – United States 2000-2004*, Centers for Disease Control and Prevention, CDC Pub. No. 58(02), at 29-33 (January 2009) [online at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5802a2.htm>].

[3] *Youth Smoking*, California Dep't of Public Health, California Tobacco Control Program (July 2008).

[4] *See Toward a Tobacco-Free California 2006-2008: Confronting A Relentless Adversary: A Plan for Success (Executive Summary)*, Tobacco Education and Research Oversight Committee for California (March 2006) [online at http://www.cdph.ca.gov/services/boards/teroc/Documents/TEROCMasterPlan06-08ExecSum.pdf].

quit."[5]

Part of California's response to Proposition 99 is the promulgation of regulations and restrictions on the use and sale of tobacco products. These sorts of governmental interventions are central because they serve the twin purposes of decreasing harmful exposure to secondhand smoke[6] and potentially reducing future addiction rates of current non-smokers.[7]

In 1976, the Legislature enacted the Indoor Clean Air Act, Health & Safety Code §§118885 *et seq.*, which requires that publicly-owned buildings, health facilities and retail food establishments dedicate significant portions of indoor space open to the general public as non-smoking areas. In 1995, California's comprehensive smoke-free workplace law took effect to prohibit smoking in virtually all enclosed workplaces, including offices, restaurants and shops. *See* Labor Code §6404.5. In 1998, bars in California became smoke-free. *See id.* at §6404.5(f). In 2003, California prohibited smoking within 20 feet of a main entrance, exit or operable window of a public building owned or leased by the state, a county, city, city and county, or a California community college district. *See* Gov. Code §§7596-98. The sale of tobacco products to minors is prohibited. *See* Penal Code §308; Bus. & Prof. Code §22952. Over twenty campuses of the University of California, California State University and California Community College system have prohibited the sale of tobacco products.[8]

Evidence-based studies by medical and public health researchers have shown that these sorts of governmental tobacco control policies work. As noted in *R.J. Reynolds Tobacco Co. v. Shewry*, 423 F.3d 906, 913 (9th Cir. 2005), "[t]here is substantial evidence, including published

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[5]Novotny & Siegel, *California's Tobacco Control Saga*, 15 HEALTH AFFAIRS 59, 59 (1996).

[6]*Toward A Tobacco-Free California 2006-2008*, *supra* n.4, at 4.

[7]*See* Siegel, Michael, *et al.*, *Local Restaurant Smoking Regulations and the Adolescent Smoking Initiation Process*, 162 ARCH. PEDIATR. ADOLESC. MED. 477, 477 (2008); Alamar, Benjamin and Glantz, Stanton, *Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption*, 96 AMER. J. PUB. HEALTH: HEALTH POLICY & ETHICS 1359 (2006).

[8]These prohibitions in California's universities and colleges are documented online at http://www.cyanonline.org/College/CollegePolicies/CaliforniaPolicies.

medical studies indicating that the [state's tobacco control] programs, and the media campaign in particular have been successful in achieving their goals of 'preventing tobacco use by children and young adults.'" (quoting *R.J Reynolds v. Bonta*, 272 F. Supp. 2d 1085, 1088 n.5 (E.D. Cal. 2003)). *See also* Hamilton, W., *et al.*, *Do Local Tobacco Regulations Influence Perceived Smoking Norms? Evidence from Adult and Youth Surveys in Massachusetts*, 23 HEALTH EDUC. RES. 709 (2008) ("There is good evidence that tobacco control policies are associated with reductions in smoking prevalence among both youth and adults").

Given the successes of these anti-tobacco campaigns, public health officials and health professionals have begun to focus on new arenas and institutions where the harms of smoking and tobacco addiction can be implicated. Their trajectory has landed on health promoting businesses, such as pharmacies. Indeed, organized medicine has recently adopted formal positions to extend tobacco control efforts to these types of businesses. Pharmacy associations have long been opposed to the sale of tobacco products in pharmacies. In 1970, the American Pharmaceutical Association ("APhA") stated, "[m]ass display of cigarettes is in direct contradiction to the role of the pharmacy as a public health facility."[9] The next year, the APhA House of Delegates recommended that tobacco products not be sold in pharmacies.[10] In 1973 and 1977, the California Pharmacists Association recommended that pharmacists discourage the sale of tobacco products in the pharmacies in which they practice "in the interest of raising the standards for public health and social welfare in the community."[11] A study published in 2006 found that 81.7 percent of licensed pharmacists are opposed to the sale of tobacco products in pharmacies and only 1.6% of licensed pharmacists favored such sales.[12]

[9] *See* Hudmon, Karen S., *et al.*, *Pharmacy Students' Perceptions of Tobacco Sales in Pharmacies and Suggested Strategies for Promoting Tobacco-Free Experiential Sites*, 70 AM. J. PHARM. EDUC. 75 (2006).

[10] *See id.*

[11] *Id.*

[12] *Id.*

DISCUSSION

A. San Francisco's Ordinance Is Squarely in Line with Official Policies of the California Medical Association and the American Medical Association.

Organized medicine has long advanced policies and efforts to reduce the prevalence of smoking and tobacco. Each year CMA delegates — representing the approximately 35,000 CMA members and county and specialty medical societies — convene to debate and pass resolutions dictating official positions and policies of California's House of Medicine. There are more than fifty CMA resolutions since 1984 that broadly support prohibitions or strict restrictions on tobacco advertising, sales and use in public places. A sample of these policies includes:

- Res. 717a-06 (2006), to advance prohibitions on the sale of tobacco use and sale in state hospitals;
- Res. 105-98 (1998), to develop and implement an anti-tobacco program for young women;
- Res. 113-96 (1996), to study and implement better protection of children from tobacco products;
- Res. 121-95 (1995), to advocate for strong restrictions on tobacco advertising to teenagers;
- Res. 108a-93 (1993), to encourage education of the harmful effects of smoking in automobiles;
- Res. 102-92 (1992), to support broad licensing of businesses that wish to sell tobacco products;
- Res. 101a-92 (1992), to advocate for a ban on smoking on airlines;
- Res. 103-87 (1987), to advocate for the prohibition of smoking in the workplace; and
- Res. 101a-85 (1985), to encourage public and private school authorities to incorporate health maintenance with a heavy emphasis on non-smoking in junior high and high school curricula.

These resolutions have had a real impact on public health campaigns and legislation. Carrying out the 1987 resolution to prohibit smoking in the workplace, in 1994 CMA led a

coalition of health, labor and business interests to sponsor A.B. 13, known as the California Smoke-Free Workplace Law and signed by the Governor on July 21, 1994. The law is the first in the nation to establish a statewide prohibition of smoking in places of employment, including virtually all bars and restaurants. Similar laws have been passed throughout the nation. It is notable that the effort was started at the local level in San Francisco. The San Francisco Medical Society (a CMA affiliate) was prominent among anti-tobacco advocates who successfully instituted a ban on smoking in restaurants in San Francisco in the early 1990s, years ahead the rest of the state.

CMA's House of Delegates recently passed a resolution that has direct bearing on this case. In 2008 CMA delegates passed Resolution No. 719-08 to resolve "[t]hat CMA support prohibitions on the sale of tobacco products in pharmacies." The resolution also called for CMA to bring a similar measure before the American Medical Association ("AMA"), which has a similar policymaking process. Consequently, AMA Resolution 419 was passed at the 2009 annual meeting of AMA delegates, which commands the AMA to "[s]pecifically and publicly oppose the sale and marketing of tobacco products, including cigarettes, in a pharmacy" and "[c]ommunicate with appropriate federal agencies, including the Bureau of Alcohol, Tobacco, and Firearms, public health groups, various pharmacy trade groups, and media outlets to seek their help in removing tobacco products from pharmacy shelves."

These resolutions apply not only to stand-alone pharmacies but also to any business that provides pharmacy services to the public. This is because stand-alone pharmacies are rare and most, if not all, pharmacies are located within stores or businesses that offer other merchandise or services. Given this, a ban of tobacco sales just from the pharmacy units within stores would be too narrow and ineffective. As explained in the next section, the sale of tobacco products in stores with pharmacies could undermine efforts to control social norms and perceptions about smoking and a healthy lifestyle as well as interfere with the treatment protocols of physicians whose patients may go to stores with pharmacies to fill drug prescriptions.

B. The Experience and Research of Physicians and Public Health Officials Support San Francisco's Ordinance.

Organized medicine's call for a ban of the sale of tobacco products in stores with pharmacies reflects decades of research finding that altering social norms about smoking and lessening the ubiquity of smoking and tobacco products are vital in the public health campaign against smoking. San Francisco's Ordinance does just that.

1. The Research Behind the Campaign to Eliminate Smoking.

Empirical research has repeatedly confirmed the public health community's view that negative social perceptions about smoking, as well as reduced access to and visibility of smoking and cigarettes, can lower the rate at which current non-smokers experiment with and ultimately become addicted to smoking. Public health professionals identify "the key to a successful tobacco control effort is the contiguous delivery of anti-tobacco messages by many different sources, consistently and over an extended period of time."[13]

Studies have found that strong governmental regulation of smoking corresponds and may contribute to anti-smoking community norms.[14] Social norms about smoking influences smoking rates, particularly among those not yet addicted.[15] Surveys of adolescent smoking behavior

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[13]Novotny & Siegel, *California's Tobacco Control Saga*, *supra* n.5, at 68.

[14]*See* Hamilton, W., *et al.*, *Do Local Tobacco Regulations Influence Perceived Smoking Norms? Evidence from Adult and Youth Surveys in Massachusetts*, 23 HEALTH EDUC. RES. 709 (2008) at 709 ("[L]ocal communities can influence adults and youths' perceptions of community smoking norms by adopting a broad array of strong tobacco control regulations"); Macy, Jonathan T., *et al.*, *Smoke-Free Air Laws and Perceived Norms About Smoking in Four Texas Cities*, 136th American Public Health Association Annual Meeting and Exposition (Oct. 27, 2008); Albers, A.B., *et al.*, *Relation Between Restaurant Smoking Regulations and Attitudes Towards the Prevalence and Social Acceptability of Smoking*, 13 TOBACCO CONTROL 347 (2004).

[15]*See, e.g.*, Christakis, Nicholas and Fowler, James, *The Collective Dynamics of Smoking in a Large Social Network*, 358 NEW ENGL. J. MED. 2249 (2008); Katz, Mitchell, *Banning Tobacco Sales in Pharmacies: The Right Prescription*, 300 J. AM. MED. ASS'N 1451 (2008); Alesci, Nina, *et al.*, *Smoking Visibility, Perceived Acceptability, and Frequency in Various Locations Among Youth and Adults*, 36 PREV. MED. 272 (2003); Alamar & Glantz, *Effect of Increased Social Unacceptability of Cigarette Smoking*, *supra* n.7, at 1359 ("Social unacceptability has been repeatedly shown to be an important influence on both initiation and quitting.") (citing *Preventing Tobacco Use Among Young People: A Report of the Surgeon*

"suggest that smoke-free workplaces and homes are associated with significantly lower rates of adolescent smoking."[16] This demonstrates that the "adoption of a smoke-free home policy sends a message to family members that smoking is not condoned, while the lack of such a policy may send the opposite message."[17] Furthermore, empirical research connects lower densities of retail outlets with lower consumption, particularly among youth.[18]

A recent study analyzing Chinese and Korean immigrants in California (large ethnic populations in San Francisco) found that "immigrant smokers in California have stopped smoking at a dramatically higher rate than their counterparts in their native countries not because their personal propensity for success at quitting suddenly changes after moving to a new country, but because the social norm in California makes them more likely to try."[19] Thus, immigrants reacted to living in an environment promoting the social norm that smoking is unacceptable by trying to quit more than those who stay in their native countries where smoking is more acceptable. The more they try to quit the more they succeed.[20]

General, U.S. Dept. of Health & Hum. Servs. (1994); *Reducing Tobacco Use: A Report of the Surgeon General*, U.S. Dept. of Health & Hum. Servs. (2000)).

[16]Farkas *et al.*, *Association Between Household and Workplace Smoking Restrictions and Adolescent Smoking*, 284 J. AMER. MED. ASS'N 717, 720 (2000).

[17]*Id.* at 721.

[18]*See, e.g.*, Pearce, J., *et al.*, *The Neighbourhood Effects of Geographical Access to Tobacco Retailers on Individual Smoking Behavior*, 63 J. EPIDEMIOL. CMTY. HEALTH 69 (2009) (finding individuals living in neighborhoods with best access to supermarkets and convenience stores where tobacco sold higher odds of smoking); Leatherdale, S.T. and Strath, J.M., *Tobacco Retailer Density Surrounding Schools and Cigarette Access Behaviors Among Underage Smoking Students*, 33 ANN. BEHAV. MED. 105 (2007) (finding tobacco retailer density surrounding school is related to student access behaviors); Novak, Scott, *et al.*, *Retailer Tobacco Outlet Density and Youth Cigarette Smoking: A Propensity-Modeling Approach*, 96 AM. J. PUB. HEALTH 670 (2006) (reductions in retail tobacco outlet density may reduce rates of youth smoking).

[19]Zhu *et al.*, *High Quit Ratio Among Asian Immigrants in California: Implications for Population Tobacco Cessation*, 9 NICOTINE & TOBACCO RESEARCH, S505, S513 (2007).

[20]*Id.* at S512.

2. Applying the Lessons of the Public Health Campaign Against Smoking and Tobacco Products to Stores with Pharmacies.

Since studies have found that "increasing the social unacceptability of smoking is a highly effective policy tool in reducing consumption," restricting tobacco access by prohibiting its sale in stores with pharmacies would increase the perception of social unacceptability in the community, especially in places that also provide health care services. The experience of the anti-tobacco campaign is that such efforts are likely to result in reduced consumption of tobacco.[21]

By offering pharmacy services, a store becomes an access point within the health care delivery system. The store is perceived by the public to be, and in fact is, an institution where customers can receive trustworthy healthcare advice and receive prescription drugs as part of medical treatment for all sorts of diseases and ailments. Indeed, the public perceives community pharmacists as among the most trusted health care professionals, according to the drugstore industry's trade organization.[22] It is thus antithetical to the health promoting functions and perceptions associated with stores that offer pharmacy services to also offer tobacco products. Public health officials and researchers have concluded that "[s]elling tobacco products sends misleading messages that conflict with a pharmacy's purpose of promoting health."[23] Accordingly, organized medicine believes that providing access to tobacco in places that provide pharmacy services could undermine anti-tobacco efforts.

Physicians have an additional, more practical reason to strongly oppose the sale of tobacco products in stores where pharmacists operate. Smoking and tobacco addiction are known to cause or be associated with innumerable medical ailments and maladies. Avoiding tobacco products is important, and often critical, in the treatment of these various medical issues. When

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[21] Alamar & Glantz, *Effect of Increased Social Unacceptability of Cigarette Smoking*, *supra* n.7, at 1362.

[22] *See* National Association of Chain Drug Stores, Chain Pharmacy Industry Profile at 61 (2008-09).

[23] *Toward A Tobacco-Free California 2009-2011*, Tobacco Education and Research Oversight Committee for California, at 21.

physicians prescribe drugs as part of their treatment protocol, they do not want their patients to have access to tobacco products in the same place where they go to get their prescription medications. In other words, selling tobacco in Safeway stores where patients go to fill drug prescriptions could undermine physicians' efforts to treat their patients.

San Francisco's Ordinance applies the research and experience of the public health community. It is in line with the trajectory of tobacco control efforts and is expected to yield benefits in the continuing public health campaign against smoking and tobacco products.

C. The San Francisco Ordinance Does Not Violate Equal Protection.

In spite of the public health benefits to be achieved by San Francisco's Ordinance, Safeway apparently wishes to see the whole Ordinance stricken because it distinguishes between retail stores that do or do not contain pharmacies. Safeway alleges that the Ordinance "differentiates arbitrarily and capriciously between similarly situated retailers solely on the ground that some have, and some do not have, somewhere on their premises, a lawful pharmacy." Complaint ¶66. Organized medicine disagrees.

First, as evident from the foregoing discussion, stores that contain pharmacies and also sell cigarettes, such as Safeway stores, are not similarly situated to stores that sell cigarettes but do not contain pharmacies. Unlike with the latter type of stores, the problems with a conflict of interest, mixed message about the harmful effects of smoking and frustration of physicians' efforts at treating their patients arise when a store that offers pharmacy services also sells cigarettes. These problems may not arise in general retail outlets that sell cigarettes but do not serve as an access point in the health care delivery system, like stores with pharmacies. Organized medicine's call for a prohibition on cigarette sales in stores with pharmacies is consistent with calls for such anti-tobacco controls in all other health care delivery institutions, such as hospitals.

Second, regardless whether San Francisco has made a distinction between similarly situated stores, there is a rational basis for banning the sale of tobacco products in stores with pharmacies. As explained, the official policy of CMA (as well as the AMA) calling for such a ban relies on the research and experience of physicians and public health officials. The

underlying clinical and scientific evidence that informs such policy also supports the distinction that San Francisco's Ordinance makes between stores that contain a pharmacy and stores that do not. Not only is the distinction rational, it is one that organized medicine has considered and fully endorses.

CONCLUSION

For the foregoing reasons, as well as the reasons stated in San Francisco's memorandum of points and authorities in support of its motion, Safeway's complaint should be dismissed.

DATED: April 15, 2011.

Respectfully,

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PROOF OF SERVICE

I, Long X. Do, certify that on this 15th day of April, 2011, a copy of the foregoing **Application of the California Medical Association for Leave to File *Amicus Curiae* Brief; *Amicus Curiae* Brief in Support of Defendants' Motion Dismiss** was served on all counsel of record by electronically filing it with the Clerk of the Court for the United States District Court, Northern District of California, Oakland Division, by using the official Electronic Case File (ECF) Internet Site of the Northern District of California system, which automatically provides electronic notification to the following persons:

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