



TOURO UNIVERSITY
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Touro Law Review

Volume 27 | Number 2

Article 7

October 2011

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Recommended Citation

Pfeifer, Daniel J. (2011) "Smoking Gun: The Moral and Legal Struggle for Medical Marijuana," *Touro Law Review*. Vol. 27: No. 2, Article 7.

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SMOKING GUN: THE MORAL AND LEGAL STRUGGLE FOR MEDICAL MARIJUANA

Daniel J. Pfeifer *

I. INTRODUCTION

In the debate over medical marijuana, the primary justification advanced by its supporters is that marijuana use, especially by terminally ill patients, mitigates their “suffering from [unnecessary] chronic and unbearable pain that persists until death.”¹ Currently, Washington D.C. and fourteen states have approved and finalized medical marijuana statutes: Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington.² Maryland and Arizona have approved legislation favorable to the use of medical marijuana, but have not legalized its use.³ Additionally, “New York,

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¹ Jay M. Zitter, Annotation, *Construction and Application of Medical Marijuana Laws and Medical Necessity Defense to Marijuana Laws*, 50 A.L.R.6th 353 (2009).

² 14 Legal Medical Marijuana States and DC: Laws, Fees, and Possession Limits, PROCON.ORG, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> (last updated Aug. 24, 2010).

³ *Id.* See Maryland Darrell Putman Compassionate Use Act, MD. CODE ANN., CRIM. LAW § 5-601(c)(3)(ii) (West 2010) (mitigating consequences if an individual possesses marijuana for medical use). With an overwhelming bipartisan support, Maryland’s Senate approved the bill by a 35-12 margin without any objections or discussion. Ryan Grim, *Medical Marijuana Bill Moves Through Maryland Senate in Landslide*, HUFFINGTON POST (Apr. 10, 2010, 4:20 PM), http://www.huffingtonpost.com/2010/04/10/medical-marijuana-bill-mo_n_532962.html. Senator David Brinkley (R-Frederick), the bill’s sponsor and a two-time cancer survivor, stated “Anyone who has watched a loved one suffer from a debilitating illness would agree that we should not stand between doctors and patients, or deprive seriously ill people safe access to a legitimate medicine if it can help them cope with their illness.” *Id.*

Illinois, Delaware, South Dakota, . . . and Kansas” are in the process of considering medical marijuana laws.⁴

Although all patients should have the right to treatment, rights, generally, must be considered within the context of national policy. Currently, the federal government has remained hesitant to support detailed medical research and advocacy for medical marijuana.⁵ Under the Uniform Controlled Substances Act, marijuana remains a Schedule I drug, meaning possession of it is still illegal and may only be utilized for research purposes.⁶ As “the sole Federal agency that approves drug products as safe and effective for intended” purposes, the Federal Drug Administration (“FDA”) firmly maintains that marijuana has no medicinal value.⁷ Consequently, the federal government has been in continuous conflict with states that have legalized medical marijuana.⁸

According to the American Medical Association, when a physician believes a law is unjust, he or she should work to change the

⁴ Grim, *supra* note 3. As of 2009, The Medical Society of the State of New York adopted an affirmative policy that:

[T]he use of marijuana may be appropriate when prescribed by a licensed physician solely for use in alleviating pain and nausea in patients who have been diagnosed as chronically ill with life threatening disease, when all other treatments have failed, that the physicians who prescribe marijuana for patient use, subject to the conditions set forth above, shall not be held criminally, civilly or professionally liable and that it supports continued clinical trials [sic] on the use of marijuana for medical purposes.

MSSNY Position Statements, 75.987 Medical Marijuana, MED. SOC’Y OF THE STATE OF N.Y., http://www.mssny.org/mssnyip.cfm?c=i&nm=Drugs_%7C_Medications (last visited Oct. 11, 2010).

⁵ See Paul Armentano, *Why Isn’t There More Medical Marijuana Research? Because The Feds Won’t Allow It, That’s Why!*, NORML BLOG (Jan. 27, 2010), <http://blog.norml.org/2010/01/27/why-isn%E2%80%99t-there-more-medical-marijuana-research-because-the-feds-won%E2%80%99t-allow-it-that%E2%80%99s-why/>.

⁶ 21 U.S.C.A. § 812(b)(1) (West 2010).

⁷ Press Release, FDA, Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine (Apr. 20, 2006), *available at* <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108643.htm>.

⁸ See ALASKA STAT. § 17.37.010 (2010); HAW. REV. STAT. § 329-123(b) (2010); ME. REV. STAT. tit. 22, § 2425 (2010); MICH. COMP. LAWS § 333.26424 (2010); MONT. CODE ANN. § 50-46-103 (2010); NEV. REV. STAT. § 453A.050 (2010); N.J. STAT. ANN. § 24:6I-4 (West 2010); N.M. STAT. ANN. § 26-2B-4(D) (2010); ORE. REV. STAT. § 475.309(2)(a) (2010); R.I. GEN. LAWS § 21-28.6-4 (2010); VT. STAT. ANN. tit. 18, § 4473 (2010); WASH. REV. CODE § 69.51A.005 (2010).

law.⁹ If medical marijuana is one treatment a physician can prescribe to alleviate a patient's pain and suffering, then the physician must promote the best interests of the patient by maintaining his or her well being and health.¹⁰ Ultimately, the federal government's prohibition on access to and use of medical marijuana to alleviate pain in terminally ill patients infringes upon their autonomy, which includes their rights to live and avoid severe physical suffering, the right to receive medical treatment, and the right to die with the dignity that comes from one's own choices.¹¹ If these patients truly find comfort by using medical marijuana, the federal government should not deliberately deny prolonged pain relieving treatments that improve a terminally ill patient's quality of life.

Part I will discuss the concept of patient autonomy and its legal corollary, the doctrine of informed consent, as it applies in the physician-patient relationship. By exploring the philosophy of Immanuel Kant and John Stuart Mill, Part I will discuss how the denial of access to medical marijuana infringes upon a patient's ability to practice his or her autonomy and pursue adequate healthcare decisions and treatment. Part II will discuss the therapeutic uses and risks associated with medical marijuana, as well as issues in prescribing medical marijuana. By tracing the legislative history surrounding the medical marijuana controversy, Part III will discuss the Uniform Controlled Substances Act and marijuana's subsequent placement into Schedule I and state legislation legalizing medical marijuana. Finally, Part IV will discuss patient autonomy and the terminally ill patients' access to medical marijuana by examining the conflict between federal and state legislation.

II. PATIENT'S CHOICE: THE PURSUIT OF AUTONOMY

Perhaps no greater principle exists in society than autonomy, the right to self-determination or self-governance.¹² An individual

⁹ *AMA Code of Medical Ethics: Principles of Medical Ethics*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml> (last visited Mar. 12, 2010) [hereinafter *Principles of Medical Ethics*].

¹⁰ *Id.*

¹¹ Note, *Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana*, 118 HARV. L. REV. 985, 990 (2005) [hereinafter *Last Resorts*].

¹² BIOMEDICAL ETHICS 38-39 (Thomas A. Mappes & David DeGrazia eds., 5th ed. 2001).

makes an autonomous decision when he or she “make[s] the decisions that affect [his or her life] and act[s] on the basis of these decisions.”¹³ In order to be truly autonomous, an “individual must act in a rational manner.”¹⁴ Although autonomy requires a degree of independence, an individual must avoid self-deception and irrationality to reach an informed decision.¹⁵ Choices must be natural inclinations, not random decisions.¹⁶ If an individual follows purely bodily desires, autonomy will be completely lost.¹⁷

Through a patient’s autonomy, a patient should exercise his or her rational capacity to self-govern and choose a course of action among different alternatives. For Immanuel Kant, one of the world’s most learned philosophers, the fundamental principle of morality is respect for persons as moral agents, which includes respect for personal autonomy.¹⁸ Humans should be respected as self-determining subjects, or rather, persons, as rational agents, should be treated as ends in themselves and never mere objects.¹⁹ For Kant, the individual has the freedom to pursue the principles of a self-legislated ethical system.²⁰ While an individual is free to follow his or her personal beliefs of what is right, Kant’s view of autonomy requires that “rational self-determination [be made] in accordance with universal moral laws.”²¹

Similarly, John Stuart Mill views autonomy in terms of individuality, which includes individual liberty and personal self-

¹³ *Id.* at 39. When a patient provides informed consent, the patient performs a truly autonomous action that is “(1) intentional, (2) based on sufficient understanding, (3) sufficiently free of external constraints, and (4) sufficiently free of internal constraints.” *Id.*

¹⁴ Andrew J. Boyd, *Medical Marijuana and Personal Autonomy*, 37 J. MARSHALL L. REV. 1253, 1280 (2004).

¹⁵ *Id.*

¹⁶ *Id.* at 1281.

¹⁷ *Id.*

¹⁸ See M. Hayry, *Prescribing Cannabis: Freedom, Autonomy, and Values*, 30 J. MED. ETHICS 333, 334-35 (2004). Kant believed individuals should celebrate their autonomy because “it is the only thing that can distinguish [rational beings] from the rest of the world, and [therefore] make us moral.” *Id.* at 335.

¹⁹ *Id.*

²⁰ See JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 22 (2d ed. 2001).

²¹ See Hayry, *supra* note 18, at 335. Kant believed that all of mankind, as rational beings, possesses “morally-practical reason,” enabling mankind to be “free to make its own laws, and to act in accordance with them, without paying unnecessary attention to the demands of the body.” *Id.* at 334.

determination.²² People possessing individuality reach their “decisions without manipulation by others, and exercising firmness and self-control in acting on their decisions.”²³ However, Mill followed the principle of utility, which holds that “ ‘actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure.’ ”²⁴ For Mill, utility was happiness that would be maximized as long as the individual knew what produced personal happiness and was allowed to act on that knowledge.²⁵

Individuality, as an expression of reason and will through one’s choices, is extremely valuable to one’s sense of self, but both Kant and Mill would agree that an individual cannot pursue his or her own happiness at the expense of others.²⁶ For Kant, “[t]he morality of an action . . . must be assessed in terms of the motivation behind it.”²⁷ But Kant did not mean that an action is morally good based on its outcome; rational beings should act according to the categorical imperative, that is, “ ‘[a]ct only according to that maxim by which you can at the same time will that it should become a universal law.’ ”²⁸ Even if a person intends to bring about a beneficial outcome or effect, an action is morally good only if it is guided by rea-

²² BIOMEDICAL ETHICS, *supra* note 12, at 43 (describing that pursuant to Mill, individuals “choos[e] their own plans of life, mak[e] their own decisions without manipulation by others, and exercis[e] firmness and self-control in acting on their decisions”). In Mill’s work *On Liberty*, he stressed the importance of autonomy, stating: “The only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it.” BERG ET AL., *supra* note 20, at 23.

²³ BIOMEDICAL ETHICS, *supra* note 12, at 43.

²⁴ Colin Heydt, *John Stuart Mill*, INTERNET ENCYCLOPEDIA PHIL., <http://www.iep.utm.edu/milljs/#SH2d> (last updated Oct. 24, 2006). As a consequentialist, Mill believed that the correctness of an act is dependent on the consequences of the act. *See id.* Also, Mill followed utilitarianism, a form of consequentialist ethics, which states the maximization of utility is the goal of human action, and identifying utility with pleasure, Mill believed that utility was happiness. *See* BERG ET AL., *supra* note 20, at 22-23.

²⁵ *See* BERG ET AL., *supra* note 20, at 22-24.

²⁶ *See* Heydt, *supra* note 24 (noting that it is imperative “that we aren’t violating the rights of others”); *see also* Matt McCormick, *Immanuel Kant: Metaphysics*, INTERNET ENCYCLOPEDIA PHIL., <http://www.iep.utm.edu/kantmeta/#H8> (last updated June 30, 2005). Since duty comprises the core of deontological ethics, Kant stressed that ethical obligations must be fulfilled regardless of the consequences, and thereby, a duty exists independent from its practical outcome. *Id.*

²⁷ McCormick, *supra* note 26.

²⁸ *Id.*

son.²⁹

Likewise, under the harm principle, Mill stressed that the State may only interfere with a competent adult's individual liberty to prevent direct harm to others.³⁰ Mill believed that the utility of an action is determined by its tendency to produce or promote happiness, but while "happiness [is] the only intrinsically desirable end," Mill warned against pursuing only individual happiness.³¹ However, an action does not have to be motivated by seeking the general happiness for all of society to be considered morally right.³² When an individual seeks his own happiness, he or she must also consider the general public's well being, but only to the extent of ensuring that his or her actions do not "violate[] the rights of others."³³

A. Patient-Physician Relationship

While the healthcare industry must abide by the law, a physician and patient must continue to work towards the promotion of a patient's autonomy at all costs.³⁴ At the heart of the patient-physician relationship, autonomy exists in "the patient's right to re-

²⁹ BIOMEDICAL ETHICS, *supra* note 12, at 43. (explaining that an individual's actions must be based upon effective deliberation, guided by reason, and neither motivated by personal emotions nor manipulated by others).

³⁰ Heydt, *supra* note 24.

³¹ *See id.* (indicating that although many actions may create both positive and negative conditions, Mill followed the utilitarian calculation where the right action is one that upon balancing its positive and negative utility, promotes the most happiness rather than pain).

³² *Id.* By focusing on the notion of self-determination, Mill believed that three types of liberty exist: "inward domain of consciousness," in which an individual has the freedom to have his or her own thoughts and feelings; "liberty of tastes and pursuits," where an individual has the freedom to define his own existence and live as he or she sees fit; and the "freedom to unite with others" in which an individual has the freedom to coexist and combine with others. *See id.* Under the harm principle, Mill believed that the State could only interfere with these three individual liberties to protect society from harm caused by an individual's practice of these liberties. *Id.*

³³ *See* Heydt, *supra* note 24 (describing that as a utilitarian, Mill focused on the value of equality in which each individual counts as one, and every individual included in the utilitarian calculation counts equally when determining the true right action).

³⁴ *See* AM. COLL. OF LEGAL MED., LEGAL MEDICINE 223 (Shafeek S. Sanbar ed., 6th ed. 2004) [hereinafter LEGAL MEDICINE] (noting that although autonomy remains a vital aspect of medicine, it is important to remember that a patient's autonomous decision-making is limited because the "[l]aw is mostly about limits on autonomy"). The importance placed on a patient's autonomy has resulted from the attitudes of western society, which "put[s] a high value on free choice and liberty, and thus respect for even foolish or eccentric decisions is ultimately required because of the perception that the sort of society that does not require respect for autonomy is profoundly unacceptable." *Id.*

ceive information sufficient to . . . make an intelligent,” reasonable decision, as well as the patient’s right “to accept or refuse the recommended medical treatment.”³⁵ As a relationship based on trust, the physician has an “ethical obligation[] to place [the] patient[’s] welfare above [his or her] own self-interest and above obligations to other groups.”³⁶ The physician should serve as an advocate to promote the patient’s welfare above all.³⁷

While both patient and physician must take an active role in the medical decision-making process, both actors have essentially different roles.³⁸ A competent patient should exert some control over healthcare decisions, but do so in accordance with certain responsibilities. When choosing medical treatment, a patient should “be truthful and . . . express [his or her] concerns . . . to [his or her] physician[,],” provide all necessary medical information, and cooperate and comply with the chosen treatment.³⁹ Adhering to Mill’s harm principle, a patient may practice his or her autonomy, but should refrain from behavior that unreasonably risks the health of others.⁴⁰

While the physician must always rely on sound medical judgment, he or she must keep the patient’s best interests as paramount.⁴¹ “The physician must support the [patient’s] dignity . . . and

³⁵ See *id.*; see also GEORGE D. POZGAR, LEGAL AND ETHICAL ISSUES FOR HEALTH PROFESSIONALS 275 (2005).

Where there are two or more medically acceptable treatment approaches to a particular medical problem, the informed consent doctrine, medical ethics, and the standard of care all provide that a competent patient has the absolute right to select from among these treatment options after being informed of the relative risks and benefits of each approach.

Id.

³⁶ *Opinion 10.015: The Patient-Physician Relationship*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.shtml> (last visited Mar. 12, 2010) [hereinafter *Patient-Physician Relationship*].

³⁷ *Id.*

³⁸ *Opinion 10.02: Patient Responsibilities*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1002.shtml> (last visited Oct. 14, 2010) [hereinafter *Patient Responsibilities*].

³⁹ *Id.*

⁴⁰ *Id.* (adding that when considering the risks to others and a patient’s own well-being, a patient should assume personal responsibility to practice a healthy lifestyle, avoid the development of disease and potential transfer of disease to others).

⁴¹ See *id.*; see also *Definition of Hippocratic Oath*, MEDTERMS.COM, <http://www.medterms.com/script/main/art.asp?articlekey=20909> (last visited Oct. 16, 2010). Under the modern version of the Hippocratic Oath, a physician agrees to “apply, for the ben-

respect [his or her] uniqueness.”⁴² In order to provide competent medical care, the physician should maintain the patient’s “right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.”⁴³ Accordingly, a physician’s first duty is to maintain the patient’s health, a duty that should not be sacrificed to avoid prosecution by the federal government.⁴⁴ Since “[a] physician [must] . . . regard [his or her] responsibility to the patient as paramount,” “[a] physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.”⁴⁵ By guiding the patient towards the optimal course of action, a physician has the obligation to serve as the patient’s advocate and to foster the “patient[’s right to] accept or refuse any recommended medical treatment.”⁴⁶

B. Informed Consent

Under the doctrine of informed consent, the physician, acting as a rational agent, is directed to respect the patient’s freedom and right to make self-determinations concerning the best course of action for himself or herself.⁴⁷ Informed consent “applies only when [a] patient[] possess[es the necessary competence or] decision-making capacity.”⁴⁸ “When securing a [competent] patient’s permission to administer treatment,” a physician must disclose all necessary information regarding treatment, including “the nature and duration of the treatment, the likelihood of success, the likely risks and benefits associated with the recommended treatment, the alternatives (if any) available to the recommended treatment, and the likely consequences if treatment is refused.”⁴⁹ After the information has been

efit of the sick, all measures which are required . . . [and] prevent disease whenever [he or she] can . . . with special obligations to all [his or her] fellow human beings.” *Id.*

⁴² POZGAR, *supra* note 35, at 286.

⁴³ *Opinion 10.01: Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.shtml> (last visited Oct. 14, 2010) [hereinafter *Fundamental Elements*].

⁴⁴ *Principles of Medical Ethics*, *supra* note 9.

⁴⁵ *Id.*

⁴⁶ *Fundamental Elements*, *supra* note 43.

⁴⁷ POZGAR, *supra* note 35, at 14.

⁴⁸ TERRANCE C. MCCONNELL, *INALIENABLE RIGHTS: THE LIMITS OF CONSENT IN MEDICINE AND THE LAW* 65 (2000).

⁴⁹ *Id.*

disclosed, it is necessary that the patient possess an understanding of the disclosed material.⁵⁰ Lastly, the physician must receive authorization from the patient to carry out the treatment, “such as [his or her] signature on a consent form.”⁵¹

Additionally, the doctrine of informed consent is based on the physician’s “legal, ethical, and moral duty to respect patient autonomy and to provide only authorized medical treatment.”⁵² Consequently, the physician has two correlative duties associated with informed consent. First, the physician has a “duty to disclose . . . appropriate information about risks and alternatives.”⁵³ Although patients have the right to make their own decisions, they can only practice their autonomy and reach a reasonable decision if they know the risks, benefits, and alternatives to recommended procedures.⁵⁴ Secondly, “[t]he duty to obtain consent requires [that the physician] secur[e] proper patient authorization.”⁵⁵ Accordingly, the physician should respect the patient as a fellow rational agent by maintaining the patient’s dignity and well being.⁵⁶ By allowing the patient to voluntarily reach a decision, free from pressure or coercion, the physician ensures that a patient’s right of self-determination is maintained in the pursuit of adequate medical care.⁵⁷

C. Restraints on Patient Autonomy

Under the doctrine of informed consent and the patient-physician relationship, a patient has the right to effectively choose medical treatment according to a physician’s recommendation in order to preserve an individual’s liberty and autonomy.⁵⁸ When a patient receives necessary medical treatment, the physician, the patient, and the healthcare industry have collectively upheld the patient’s “dignity, autonomy, and avoidance of pain.”⁵⁹ When a patient’s mental, emotional, and physical integrity is respected, the patient is

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² POZGAR, *supra* note 35, at 275.

⁵³ MCCONNELL, *supra* note 48, at 65.

⁵⁴ POZGAR, *supra* note 35, at 275.

⁵⁵ MCCONNELL, *supra* note 48, at 65-66.

⁵⁶ *See Fundamental Elements, supra* note 43.

⁵⁷ *See* MCCONNELL, *supra* note 48, at 65.

⁵⁸ *See Last Resorts, supra* note 11, at 1995.

⁵⁹ *Id.* at 1996.

viewed as a free and equal moral person before others.⁶⁰ However, this freedom and respect is denied to patients when the federal government deprives terminally ill patients and other deserving unwell people from obtaining and using medical marijuana, or even being able to consider it as an option. When all other treatments have proven to be ineffective, both patient and physician can continue to work to treat the patient's illness and lessen pain and suffering.⁶¹ Medical marijuana, however, is eliminated from this equation.

Although informed consent safeguards the right to determine one's own destiny, current marijuana regulations only deteriorate the physician-patient relationship and narrow the importance of informed consent.⁶² By exercising its *parens patriae* power, the federal government attempts to protect the individual and act for the individual's benefit; however, under the principle of patient autonomy, an individual has a right against interference with the ability to control his or her life.⁶³ In order to choose freely among a variety of options, an individual must not be constrained by excessive pressure that results in undue influence or coercion.⁶⁴ If medical marijuana effectively alleviates pain for a patient, or if the patient believes medical marijuana is the only effective treatment when all others have failed, the federal government unduly burdens the patient and coerces him or her to accept undesirable, perhaps ineffective, treatments. As a result, the federal government effectively strips individuals of a potentially effective treatment option.

⁶⁰ See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972). *Canterbury* established the fundamental principle of informed consent "that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.'" *Id.* (alteration in original) (quoting *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

⁶¹ See *Fundamental Elements*, *supra* note 43. Consequently, a patient's freedom and autonomy can be respected and promoted by physicians working with the general public to remove economic and social constraints impeding a patient's access to medical treatment. Hayry, *supra* note 18, at 334.

⁶² See BERG ET AL., *supra* note 20, at 24 ("Autonomy is the freedom from external constraints . . . and the capacity for self-determination."). Informed consent considers medical decision-making a combination between the physician's technical expertise and the patient's subjective considerations. *Id.* at 30. Medical decisions cannot belong solely to a physician because only the patient has access to highly relevant personal information necessary to the decision. See *id.*

⁶³ Hayry, *supra* note 18, at 334. As rational agents, Kant believed that individuals followed a "morally-practical reason" in which an individual "is free to make its own laws, and to act in accordance with them." *Id.*

⁶⁴ BERG ET AL., *supra* note 20, at 25 (indicating that such decisions "severely compromise the capacity for autonomy").

If society seeks to promote autonomy, it must minimize governmental regulation over the individual's ability to freely choose in the healthcare context.⁶⁵ By recognizing the benefits of medical marijuana, the federal government can promote the patient's autonomy by allowing physicians to prescribe medical marijuana "to relieve suffering, produce beneficial outcomes . . . and enhance the patient's quality of life."⁶⁶

II. MARIJUANA AS MEDICINE: FACT OR ILLUSION?

Marijuana has been used medicinally for over five thousand years, with the earliest accounts dating back to China in the third millennium, B.C., where it was used to treat malaria and rheumatic pain.⁶⁷ "In India, marijuana [was] used in Ayurvedic medicine," as early as the Tenth Century, to treat various ailments, including "diarrhea, diabetes, tuberculosis, asthma, elephantiasis, anemia, and rabies."⁶⁸ In the Middle East, marijuana's medicinal value was recognized as early as the Seventh Century, B.C., and "during . . . the Roman Empire, marijuana was used as an analgesic and anesthetic."⁶⁹ In Europe, marijuana was recommended as medicine around 65 A.D. and was used well into the Nineteenth Century.⁷⁰ In the United States, physicians recognized marijuana's medicinal value as early as 1850 by listing it in the United States Pharmacopoeia "as a

⁶⁵ See Hayry, *supra* note 18, at 334 ("Legislation obviously plays an important role in what health professionals can and cannot do.").

⁶⁶ LEGAL MEDICINE, *supra* note 34, at 227.

⁶⁷ RICHARD GLEN BOIRE & KEVIN FEENEY, MEDICAL MARIJUANA LAW 13-14 (2006).

⁶⁸ *Id.* at 14. "Marijuana is listed as an ingredient in numerous [medicinal] preparations in the *Anandakanda*, a [Tenth] Century Indian Medical treatise, [and] is still used by some Ayurvedic doctors today." *Id.*

⁶⁹ *Id.* Medical marijuana was mentioned in a Middle Eastern religious text called the *Venidad*, which many believe Zoroaster wrote. *Id.* The Romans later "used [marijuana] to treat migraines, syphilis[,] and other medical problems." BOIRE & FEENEY, *supra* note 66, at 14.

⁷⁰ See *id.* at 14-15. The medicinal use of marijuana in Europe was recommended in several texts: in 65 A.D., in Dioscoride's *Materia Medica*, which was considered a fundamental medical text through the Seventeenth Century; in 1538, in William Turner's *New Herbal* which listed marijuana as a therapeutic agent; in 1649, in Nicholas Culpeper's *The Complete Herbal* which "recommended marijuana [to] treat[] . . . coughs, jaundice, joint pain, inflammation[,] and indigestion"; "in the 1840s . . . a French doctor[,] . . . Jacques-Joseph Moreau[,] found that marijuana suppressed headaches, increased appetites, and aided in sleep"; and in the British medical journal, *The Lancet*, which discussed how marijuana was used to treat opiate withdrawal. *Id.*

treatment for . . . neuralgia, tetanus, typhus, . . . leprosy, . . . gout, . . . insanity, . . . among others.”⁷¹

Originating from the leaves of the hemp plant, *Cannabis Sativa*, or marijuana, contains over 460 known compounds of which sixty are unique to marijuana, and are commonly referred to as cannabinoids.⁷² “Delta-9-tetrahydrocannabinol [(“THC”)], one of the most psychoactive ingredients in marijuana,” eliminates “[l]oss of appetite, nausea, and vomiting” in cancer patients undergoing chemotherapy.⁷³ Moreover, while THC may increase feelings of depression, these symptoms depend largely on the dose, as well as the psychological and physiological makeup of the patient.⁷⁴ Most importantly, THC serves as an analgesic that decreases sensitivity to pain.⁷⁵

A. Medicinal Value

Through a study conducted by the National Institutes of Health (“NIH”) in February 1997, five areas in which medical marijuana may provide therapeutic value were identified, though further research is still required.⁷⁶

1. *Wasting Syndrome: Aids and Cancer*

Many patients with AIDS (acquired immunodeficiency syndrome) or cancer are affected with significant weight loss and decreased caloric intake.⁷⁷ “Symptoms of AIDS wasting syndrome include an involuntary weight loss of at least ten percent with chronic diarrhea, weakness, or fever for thirty days or more”⁷⁸ In order

⁷¹ *Id.* at 16. Although a few marijuana distributors existed at this time, such as Parke Davis and E.R. Squibb & Sons, these distributors had problems determining the appropriate dosage and potency from different plants and processing, a major difficulty that still exists today. *Id.*

⁷² *Pharmacodynamics*, CREIGHTON UNIV. MED. CTR., <http://altmed.creighton.edu/medical/marijuana/Pharmacology.htm> (last visited March 12, 2010).

⁷³ Therese Andrysiak et al., *Marijuana for the Oncology Patient*, 79 AM. J. NURSING 1396, 1396 (1979).

⁷⁴ *See id.* (suggesting that the patient’s personality influences the effects of marijuana).

⁷⁵ *Id.* (“Until the 1930s . . . marijuana was listed in the pharmacopoeia as an analgesic.”).

⁷⁶ *See* Jane B. Marmor, Commentary, *Medical Marijuana*, 168 W. J. MED. 540, 541 (1998).

⁷⁷ *Id.*

⁷⁸ Annaliese Smith, Comment, *Marijuana as a Schedule I Substance: Political Ploy or Accepted Science?*, 40 SANTA CLARA L. REV. 1137, 1162 (2000).

to achieve weight gain, some of these patients have smoked medical marijuana to stimulate their appetite and food intake.⁷⁹ Additionally, “inhaled marijuana increases appetite and food intake in healthy persons.”⁸⁰ Since “there are no current cost-effective treatments for the wasting of AIDS or cancer,” medical marijuana may be an appropriate treatment upon further research to determine its safety and effectiveness.⁸¹

2. *Nausea and Vomiting*

For many cancer patients undergoing chemotherapy, the various treatments and drugs, such as pharmacologic agents (5-HT₃ receptor antagonists), often produce side effects of emesis (vomiting and nausea).⁸² Although antiemetic drugs are often prescribed to cancer patients, these medications often fail to work once emesis develops.⁸³ Since early treatment is the only way to truly deter emesis, many cancer patients inevitably suffer from such intense side effects that they forego treatment all together.⁸⁴ Searching for an alternative treatment, many cancer patients have smoked medical marijuana to deter emesis.⁸⁵ Research shows that “THC reduces the number of retching and vomiting episodes, the degree and duration of nausea, and the volume of emesis in cancer patients undergoing chemotherapy.”⁸⁶

⁷⁹ See Marmor, *supra* note 76, at 541.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Anticipatory Nausea and Vomiting (Emesis)*, NAT'L CANCER INST., <http://www.cancer.gov/cancertopics/pdq/supportivecare/nausea/HealthProfessional/page4> (last visited Mar. 18, 2010) [hereinafter NAT'L CANCER INST.]. “[A]nticipatory nausea appears to occur in approximately 29% of patients receiving chemotherapy (about one of three patients), while anticipatory vomiting appears to occur in 11% of patients (about one of ten patients.”). *Id.*

⁸³ *Id.*

⁸⁴ *See id.*

⁸⁵ See Marmor, *supra* note 76, at 541; *see also* NAT'L CANCER INST., *supra* note 82 (indicating that many medication treatments fail; thus, behavioral interventions have been investigated and suggested for cancer patients suffering from emesis, including: “progressive muscle relaxation with guided imagery, hypnosis, systematic desensitization, electromyography and thermal biofeedback and distraction via the use of video games”).

⁸⁶ Smith, *supra* note 78, at 1162.

3. *Glaucoma*

“Glaucoma is a group of diseases that can damage the eye’s optic nerve and result in vision loss and blindness.”⁸⁷ “Glaucoma occurs when the normal fluid pressure inside the eyes slowly rises,” wherein intraocular pressure causes intolerable levels of discomfort.⁸⁸ Although patients can protect their eyes against serious vision loss with early treatment, many glaucoma patients have resorted to smoking medical marijuana in order to relieve the pressure on their eyes.⁸⁹ Although marijuana only provides temporary relief for short durations, marijuana effectively reduces “intraocular pressure, pupil constriction, and conjunctival hyperemia.”⁹⁰

4. *Pain and Suffering*

Scientists have discovered two cannabinoid receptors, properly identified as CB1 and CB2, that “are present widely in the brain” as part of the human body’s natural pain control system.⁹¹ Consequently, marijuana performs a therapeutic function that has enabled cancer patients and patients in general to relieve pain, even if temporarily.⁹² Since many current analgesics are only marginally effective, cannabinoids may become a superior treatment in pain therapy, but only after further research is conducted.⁹³

5. *Neurologic and Movement Disorders*

Lastly, the NIH has found evidence of marijuana relieving neurologic and movement disorders.⁹⁴ As an unpredictable disease with no known cause, “[m]ultiple sclerosis [(“MS”)] affects the cen-

⁸⁷ *Facts About Glaucoma*, NAT’L EYE INST., http://www.nei.nih.gov/health/glaucoma/glaucoma_facts.asp (last visited Nov. 8, 2010) [hereinafter NAT’L EYE INST.].

⁸⁸ *Id.*

⁸⁹ See Marmor, *supra* note 76, at 542 (finding “dramatic decreases in intraocular pressure with smoked marijuana in patients with glaucoma”).

⁹⁰ Smith, *supra* note 78, at 1162.

⁹¹ Marmor, *supra* note 76, at 542.

⁹² See *id.* at 540 (alleging that marijuana is used to relieve pain for conditions such as “AIDS . . . arthritis . . . mood disorders . . . neurologic symptoms . . . cancer . . . [and] glaucoma”).

⁹³ *Id.* at 542-43 (indicating that several conditions have been identified “for which there may be a therapeutic benefit from marijuana use and that merit further research”).

⁹⁴ *Id.* at 542.

tral nervous system by damaging nerve fibers,” which often results in muscle spasticity where the muscles become “stiff, inflexible, and prone to spasms and cramping.”⁹⁵ While “[m]ost MS patients experience muscle weakness in their extremities and difficulty with coordination and balance[,]” some patients experience symptoms “severe enough to impair walking or even standing.”⁹⁶ “MS can [even] produce partial or complete paralysis.”⁹⁷ Since no cure or effective medication for MS exists, initial research has revealed that smoking marijuana has relieved, “spasticity and nocturnal spasms [associated with] multiple sclerosis and partial spinal cord injury.”⁹⁸

Furthermore, the Institute of Medicine (“IOM”), in a March 1999 study, concluded that marijuana’s benefits are limited to symptom relief, such as pain relief, appetite stimulation for AIDS wasting syndrome, and control of chemotherapy related nausea and vomiting.⁹⁹ Despite popular belief, the IOM reported that marijuana was only marginally useful in relieving eye pressure from glaucoma because the effects were only “short-term, and did not outweigh the long-term” risks.”¹⁰⁰ Moreover, the report reaffirmed that marijuana effectively treated “muscle spasms associated with multiple sclerosis.”¹⁰¹ However, despite these findings, “the IOM advised that marijuana [should] be considered . . . only when patients [did not receive]

⁹⁵ Boyd, *supra* note 14, at 1276.

⁹⁶ *NINDS Multiple Sclerosis Information Page*, NAT’L INST. OF NEUROLOGICAL DISORDERS & STROKE, http://www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm (last visited Mar. 15, 2010) [hereinafter *Multiple Sclerosis*]. “Most people with MS [experience] . . . abnormal sensory feelings such as numbness, prickling, or ‘pins and needles’ sensations” and may even suffer from pain. *Id.* Other common complaints include “[s]peech impediments, tremors, and dizziness,” and some MS patients even experience hearing loss. *Id.*

⁹⁷ *Id.* (“Approximately half of all people with MS experience cognitive impairments such as difficulties with concentration, attention, memory, and poor judgment, but such symptoms are usually mild and are frequently overlooked. Depression is another common feature of MS.”).

⁹⁸ Marmor, *supra* note 76, at 542 (referring to a study of ten patients with multiple sclerosis who smoked marijuana, which indicated that smoking marijuana “further impairs posture and balance in [such] patients,” but “no large-scale controlled clinical studies have been reported” as of yet).

⁹⁹ Peter A. Clark, *The Ethics of Medical Marijuana: Government Restrictions vs. Medical Necessity*, 21 J. PUB. HEALTH POL’Y 40, 40-41 (2000).

¹⁰⁰ *Id.* at 46.

¹⁰¹ *Id.* at 41.

enough relief from currently available drugs.”¹⁰² While the IOM cautioned “that ‘the benefits of smoking marijuana were limited by the toxic effects of the smoke, [the study] nonetheless recommended’ ” that patients be permitted to smoke marijuana when other therapies failed “on a short-term basis under close supervision.”¹⁰³

B. Common Misconceptions: Gateway Drug Theory and Addiction

Despite popular belief, the IOM suppressed marijuana critics’ argument that marijuana is a gateway drug and that legalization would result in increased use among the general population.¹⁰⁴ Although “marijuana use often precedes the use of hard drugs among abusers,” the IOM found there was insufficient evidence to support the proposition that marijuana use necessarily led the progression to experimentation with harder drugs.¹⁰⁵ Also, the *New England Journal of Medicine* added that marijuana is not a gateway drug, and “there is no evidence that use of [marijuana] would increase . . . if marijuana was legalized for medicinal purposes and regulated like other medications.”¹⁰⁶

Additionally, a major consideration must be placed on the social environment and behavioral context in which marijuana may be used. Peer pressure, in addition to a permissive environment, may lead marijuana users to abuse harder drugs.¹⁰⁷ Additionally, the me-

¹⁰² See *Medical Marijuana and the Mind*, HARV. MENTAL HEALTH LETTER, Apr. 1, 2010, available at 2010 WLNR 7099085 [hereinafter HARV. MENTAL HEALTH LETTER]; see also Clark, *supra* note 99, at 46.

¹⁰³ Clark, *supra* note 99, at 41, 46. While the report urged that alternative delivery methods such as “capsules, patches and bronchial inhalers [be] developed,” the IOM realized such methods may take time to develop, and stated that smoking marijuana could be permitted in the mean time, despite the potential harmful effects of marijuana smoke. *Id.* at 46.

¹⁰⁴ See J. Ryan Conboy, *Smoke Screen: America’s Drug Policy and Medical Marijuana*, 55 FOOD & DRUG L.J. 601, 614-15 (2000).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 615. See George J. Annas, *Reefer Madness: The Federal Response to California’s Medical-Marijuana Law*, 337 NEW ENG. J. MED. 435, 438 (1997) (referring to a 1994 study that found 83% of then current marijuana users never tried cocaine, and only “17[%] of current marijuana users [reported that] they had tried cocaine”).

¹⁰⁷ Peter J. Cohen, *Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology*, 2009 UTAH L. REV. 35, 67 (2009). An Australian study of 311 young adult identical and non-identical, same-sex twin pairs who began smoking marijuana in their early teens concluded:

The association [between early marijuana use and later drug use and

thod of acquiring marijuana plays a significant role in the use of harder drugs. Unlike heroin or cocaine, marijuana is “more easily available and less socially stigmatized.”¹⁰⁸ However, since “marijuana remains illegal, the only way to acquire [marijuana] for recreational use is [buying] it from [a dealer who may easily] . . . provide access to harder drugs.”¹⁰⁹ It may be “possible that a person who is psychologically disposed to seek the recreational enjoyment of marijuana is also [psychologically] disposed to seek . . . heroin” or cocaine for recreational enjoyment.¹¹⁰ Consequently, there is a weak causal connection between the use of marijuana and the subsequent use of harder drugs.

Also, while tolerance to marijuana often occurs, dependency on THC does not occur. Although marijuana has a slight addictive quality, only a mild withdrawal syndrome occurs.¹¹¹ “[T]he risk of becoming dependent on [marijuana] . . . is more like the risk [associated with] alcohol than for [either nicotine or] opioids.”¹¹² Only “about [ten] percent of regular marijuana users become addicted”; whereas, addiction arises fifteen percent in alcohol users, thirty-two percent for nicotine users, and twenty-three percent for opiate users.¹¹³ Despite their addictive qualities, opiates, such as morphine, are used significantly in pain therapy; physicians prescribing mor-

abuse or dependence] may arise from the effects of the peer and social context within which cannabis is used and obtained. In particular, early access to and use of cannabis may reduce perceived barriers against the use of other illegal drugs and provide access to these drugs.

Id. at 68 (alteration in original).

¹⁰⁸ See DOUGLAS HUSAK & PETER DE MARNEFFE, *THE LEGALIZATION OF DRUGS: FOR AND AGAINST* 178-79 (2005) (“The most widely used illegal drug [in America] is marijuana. Studies indicate . . . a third of Americans older than [twelve] years old have tried this drug; that about [one] in [ten] has used it within the past year; and that [one] in [seventeen] has used it in the past month.”).

¹⁰⁹ Cynthia S. Duncan, Note, *The Need for Change: An Economic Analysis of Marijuana Policy*, 41 CONN. L. REV. 1701, 1707-08 (2009).

¹¹⁰ HUSAK & DE MARNEFFE, *supra* note 108, at 178-79 (suggesting that evidence indicates a strong correlation between marijuana use and subsequent use of cocaine and heroin; only a minority of heroin or cocaine users did not try marijuana first).

¹¹¹ See Smith, *supra* note 78, at 1165. Marijuana produces a very limited possibility of physical addiction and symptoms of “withdrawal syndrome consisting of irritability, restlessness, nervousness, decreased appetite, weight loss, insomnia, rebound increase in REM sleep, tremor chills, and increased body temperature.” *Id.* However, “[i]f this [marijuana] withdrawal syndrome occurs, it only lasts four to five days.” *Id.*

¹¹² Cohen, *supra* note 107, at 56.

¹¹³ *Id.*

phine must carefully consider the possibility of addiction.¹¹⁴ However, when the risks and benefits are balanced, even morphine remains a legalized, yet addictive drug, while marijuana remains sidelined for prescriptive use.

C. Medical Risks and Prescription Issues

In assessing the medicinal value of any drug for therapeutic purposes, the benefits must outweigh the risks. The “‘therapeutic ratio,’ the difference between the size of dose needed for the desired effect and the size that produces poisoning,” of marijuana has not been found, however “it has been estimated [to be] in the thousands” due to the safety of the drug.¹¹⁵ In fact, a lethal dose of marijuana has yet to be calculated.¹¹⁶

Whether marijuana is smoked or taken orally, many patients encounter “a dose-related ‘high’ usually consisting of a pleasant, euphoric, relaxed feeling of well-being.”¹¹⁷ A patient may encounter rapid heartbeat, become anxious or even paranoid, and suffer occasional acute panic.¹¹⁸ However, “hallucinations are rare, even at high[er] doses.”¹¹⁹ Recreational use may also affect cognitive function, or the thought process, including “‘impairment of the ability to learn[,] . . . the formation of new memories[,] . . . [d]epersonalization, and other . . . effects’ ” on social behavior.¹²⁰ While marijuana may cause temporary impairment of short-term memory, thinking, and concentration, the symptoms experienced by the user depend on the

¹¹⁴ *Id.* at 56. It is interesting that the Controlled Substances Act permits the use of morphine, an “indispensable [drug] to modern medical practice [which is also] potentially lethal ‘Morphine is a primary and continuous depressant of respiration . . . [that] is discernible even with doses too small to disturb consciousness.’ ” *Id.* at 54-55.

¹¹⁵ RICHARD LAWRENCE MILLER, *THE CASE FOR LEGALIZING DRUGS* 19 (1991).

¹¹⁶ *Id.* Since “[m]arijuana does not create physical resonance, . . . no withdrawal syndrome occurs” within the user. *Id.* Consequently, aspirin likely produces more deaths from overdose than marijuana. *Id.*

¹¹⁷ Andrysiak et al., *supra* note 73, at 1397.

¹¹⁸ See HARV. MENTAL HEALTH LETTER, *supra* note 102. Although intense anxiety and panic attacks are the most common side effects of smoking marijuana, “[s]tudies report that about 20% to 30% of recreational users experience such problems after smoking marijuana,” and first time users are even more vulnerable to such side effects. *Id.*

¹¹⁹ Andrysiak et al., *supra* note 73, at 1397.

¹²⁰ Cohen, *supra* note 107, at 58. A recent study found “long-term marijuana users were impaired [seventy] percent of the time on a decision-making test, compared to [fifty-five] percent for short-term users and [eight] percent for nonusers.” *Id.* However, there has been no consensus as to marijuana’s long-term cognitive effects. *Id.* at 58-59.

dosage consumed or inhaled.¹²¹

Additionally, while a patient may have difficulty communicating due to short-term memory loss, “[c]oordination and reflex [skills remain] relatively unaffected.”¹²² In particular, marijuana impairs a patient’s critical skills “such as judgment of distances and reaction time” necessary to operate a motor vehicle safely.¹²³ Additionally, there has been no evidence of long-term memory impairment.¹²⁴ “Studies suggest that although overall cognitive ability remains intact, long-term use of marijuana may cause subtle but [potentially] lasting impairments in executive function. There is no consensus, however, about whether this affects real-world functioning.”¹²⁵

Although marijuana contains some beneficial cannabinoids, marijuana smoke may also contain gases and other particles harmful to the human body.¹²⁶ Even though “[i]nhalation is the fastest way to deliver THC to the bloodstream, . . . smoking marijuana exposes the lungs to multiple chemicals and poses many of the same respiratory health risks as smoking cigarettes.”¹²⁷ Like tobacco, smoking marijuana causes a “mild airway obstruction, chronic cough, bronchitis and decreased [exercise tolerance and] pulmonary function.”¹²⁸ Although marijuana and tobacco smoke contain many of the same carcinogenic components, a 1996 study examining the relationship between marijuana use and cancer incidence did not show any

¹²¹ See HARV. MENTAL HEALTH LETTER, *supra* note 102.

¹²² Andrysiak et al., *supra* note 73, at 1397.

¹²³ Clark, *supra* note 99, at 42.

¹²⁴ See Andrysiak et al., *supra* note 73, at 1397.

¹²⁵ HARV. MENTAL HEALTH LETTER, *supra* note 102; see Joyce Cooper-Kahn & Laurie Dietzel, *What is Executive Functioning*, LD ONLINE (2008), http://www.ldonline.org/article/What_Is_Executive_Functioning%3F (“The executive functions are a set of processes that all have to do with managing oneself and one’s resources in order to achieve a goal. It is an umbrella term for the neurologically-based skills involving mental control and self-regulation.”).

¹²⁶ See HARV. MENTAL HEALTH LETTER, *supra* note 102.

¹²⁷ *Id.* (“Limited research suggests that vaporizers may reduce the amount of harmful chemicals delivered to the lungs during inhalation.”).

¹²⁸ Cohen, *supra* note 107, at 64-65. Although tobacco and marijuana produce similar pulmonary ailments, a 1990 survey of members of the American Society of Oncology showed that of more than one thousand respondents, “44% [of the oncologists] reported that they had recommended marijuana to at least one patient.” Clark, *supra* note 99, at 43. Also, these oncologists believed smoked marijuana was more effective than Marinol, a pill form of synthetic THC. *Id.*

significant association between marijuana use and cancer.¹²⁹

Moreover, non-conclusive studies theorize that THC may affect the immune system and could seriously injure AIDS patients using marijuana.¹³⁰ Another study even suggested that “people who used medical marijuana were more likely to develop pneumonia and other respiratory problems, and experience vomiting, and diarrhea.”¹³¹ However, since marijuana is illegally cultivated, it may “also be contaminated by microorganisms and fungi, which can [eventually] cause possible infections by pathogenic organisms.”¹³² Unless marijuana growth and production is regulated, the potential side effects will continue to remain unknown and may pose further health risks to patients who use medical marijuana.

In addition to all of marijuana’s potential side effects, a key issue associated with prescribing medical marijuana is the difficulty of determining the appropriate dosage.¹³³ In order to effectively alleviate pain and the side effects associated with marijuana, the concen-

¹²⁹ See Stephen Sidney et al., *Marijuana Use and Cancer Incidence (California, United States)*, 8 *CANCER CAUSES & CONTROL* 722, 727 (1997). The study examined 64,855 people between 1979 and 1985, with ages ranging from fifteen to forty-nine years old. *Id.* at 722. By examining nonsmokers of cigarettes who smoked marijuana and cigarette smokers who smoked marijuana, the study showed associations between marijuana use and increased risk of prostate cancer in males and cervical cancer in females who were marijuana users and nonsmokers of cigarettes. *Id.* at 727. Although the incidence of lung cancer caused from marijuana smoke remains largely unknown, a similar study found marijuana smoke, like tobacco smoke, contained ammonia at levels twenty times greater than in tobacco, as well as concentrations of hydrogen cyanide. Cohen, *supra* note 107, at 65. However, in another study comparing tobacco and marijuana smokers, both groups of “smokers reported coughing and wheezing’ . . . [but] only tobacco smokers demonstrated signs of emphysema, a chronic pulmonary disease.” *Id.* at 66.

¹³⁰ See Clark, *supra* note 99, at 44 (stating that these “nonconclusive studies have shown that THC both suppresses macrophages and human T-lymphocytes and enhances macrophage secretion of interleukin-I (19)”).

¹³¹ HARV. MENTAL HEALTH LETTER, *supra* note 102 (claiming that, nonetheless, these side effects caused by medical marijuana were found to be relatively mild).

¹³² Clark, *supra* note 99, at 44.

¹³³ See Cohen, *supra* note 107, at 53.

[W]hen used as medical therapy, marijuana is administered only in doses sufficient to produce the desired clinical effect and only for as long as medically necessary. The effects of any pharmaceutical agent, whether beneficial or pathologic, depend on [several factors, including:] the route of administration (e.g., oral, intravenous, intramuscular, or smoked), the dose administered, the pharmacologically active fraction of the administered dose that reaches the desired site of action, the rate at which the drug is metabolically inactivated, and the frequency and duration of use.

Id.

tration of THC, the most active component, must be determined because it “varies according to the particular plant and [the method in which] it is grown.”¹³⁴ For instance, “THC may intensify phantom pain” in patients with physiological conditions.¹³⁵ Also, ingesting food after taking “an oral dose of [marijuana] can increase the effects of [THC] because fatty food may stimulate THC absorption” throughout the patient’s body.¹³⁶ In order to secure effective treatment for a patient, it is important to have knowledge of what treatments work for particular symptoms and issues, and most importantly, for which patients.¹³⁷

D. Current Use and the Need for Further Research

Although THC is listed separately as a Schedule I controlled substance and hallucinogen, the Controlled Substances Act supports the production of synthetic THC.¹³⁸ For example, Dronabinol (marketed as Marinol) exists in pill form to treat nausea and vomiting in cancer patients receiving chemotherapy “who have not responded to [other] conventional . . . therapy.”¹³⁹ However, unlike smoked mari-

¹³⁴ Clark, *supra* note 99, at 44. At low doses, THC can be sedating; whereas, at higher doses, THC may induce episodes of anxiety. See HARV. MENTAL HEALTH LETTER, *supra* note 102. “In the United States, THC concentrations in marijuana sold on the street used to range from 1% to 4% of the total product; [yet] by 2003, the average THC concentration had risen to 7%.” *Id.* In addition to the quantity of THC absorbed, other factors that affect the potency and subsequent euphoric effects of marijuana include the smoker’s habitual use and the amount of time that smoke is held in the lungs. See Cohen, *supra* note 107, at 62-63.

¹³⁵ Andrysiak et al., *supra* note 73, at 1398.

¹³⁶ *Id.*

¹³⁷ See HARV. MENTAL HEALTH LETTER, *supra* note 102. The use of marijuana and the type of patient are closely linked. For instance, marijuana may contribute to psychiatric problems, and although “[l]ittle controlled research has been done,” patients with bipolar disorder often use marijuana and suffer induced “manic episodes and increase[d] rapid cycling between manic and depressive moods.” *Id.* Also, marijuana may increase psychotic symptoms in patients diagnosed with schizophrenia, and studies suggest individuals who smoked marijuana “in the[ir] early teen[s] may have an] increase[d] risk of developing psychosis.” *Id.*

¹³⁸ See ALEXANDER T. SHULGIN, CONTROLLED SUBSTANCES: A CHEMICAL AND LEGAL GUIDE TO THE FEDERAL DRUG LAWS 86 (2d ed. 1992) (illustrating that the Controlled Substances Act designates THC as a Schedule II substance when the delta-9-(trans)-isomer of THC is specifically “mixed with sesame oil and encased in a soft gelatin capsule,” and thereby administered orally rather than inhaled).

¹³⁹ Clark, *supra* note 99, at 43; see SHULGIN, *supra*, note 138, at 86. Under the Controlled Substances Act, Dronabinol is listed under Schedule II meaning it “has a high potential for abuse” and “may lead to severe psychological or physical dependence,” but also “has a cur-

juana, Marinol produces inconsistent effects because it is absorbed slowly and the amount of medication that reaches the bloodstream varies between patients.¹⁴⁰ Furthermore, Marinol does not contain cannabidiol ("CBD"), a chemical found in the plant extract of marijuana, resulting in "intense and unpleasant psychoactive reactions."¹⁴¹ The NIH has identified CBD as a potential drug to "protect[] against brain damage caused by [a] stroke," and may even help treat arthritis.¹⁴²

According to Mill, the freedom of choice of behavior should be restricted to adults of sound mind and should not interfere with the rights of others, but the federal government is restricting a patient's individuality and pursuit of happiness before medical marijuana's true harms are known.¹⁴³ Until further controlled government research can be performed on medical marijuana, the potential therapeutic purposes and risks will continue to remain unknown. Patients

rently accepted medical use in treatment in the United States or a currently accepted medical use . . . with severe restrictions." 21 U.S.C.A. § 812(b)(2)(A)-(C).

¹⁴⁰ HARV. MENTAL HEALTH LETTER, *supra* note 102. Since "[m]ost of the [THC in Marinol] is metabolized during digestion, . . . only 10% to 20% of the original dose reaches the bloodstream." *Id.* Currently, the United States is investigating Sativex, a combination of THC and Cannabidiol, used in Canada that is "referred to as 'liquid cannabis' because it is sprayed under the tongue or elsewhere in the mouth, using a small handheld device." *Id.* However, since Sativex must "be absorbed through tissues lining the mouth before it can reach the bloodstream," it takes some time before any effects may be noticed. *Id.* "When Marijuana is smoked, THC in the form of an aerosol . . . is absorbed within seconds and delivered to the brain rapidly and [more] efficiently" than orally ingested THC. Marmor, *supra* note 76, at 541 ("Maximum blood concentrations are reached about the time smoking is finished and then rapidly dissipate. Psychopharmacologic effects peak at [thirty] to [sixty] minutes."). Conversely, oral ingestion of THC results in "subjective effects [that] last for [five] to [twelve] hours without a clear peak" in psychopharmacologic effects. *Id.*

¹⁴¹ BOIRE & FEENEY, *supra* note 67, at 83. CBD helps curb the intense intoxicating effect of THC and "has properties that include: anti-convulsive, anti-anxiety, anti-psychotic, anti-emetic, anti-inflammatory, anti-oxidant and sedative properties." *Id.*

¹⁴² Conboy, *supra* note 104, at 613. Unlike THC, "[l]ess is known about cannabidiol, although the research suggests that it interacts with THC to produce sedation." HARV. MENTAL HEALTH LETTER, *supra* note 102. Also, cannabidiol "may independently have anti-inflammatory, neuroprotective or antipsychotic effects, although the research [remains] too preliminary to be applied clinically." *Id.* Although the research has yet to be tested on human subjects, NIH's study has indicated that smoking marijuana instead of ingesting it "will [probably] not provide an effective dose of the compound." Conboy, *supra* note 104 at 613. Removing the euphoric effects caused by smoking marijuana, CBD works as a strong "anti-oxidant that has successfully protected rat brain cells from a toxic chemical produced during a stroke." *Id.*

¹⁴³ See BERG ET AL., *supra* note 20, at 23-24. This seems to mean that a patient's right to make medical decisions should be promoted in some circumstances, but should not grant the patient freedom to use any and all medical care they desire. *Id.* at 24.

suffering from AIDS, cancer, chronic pain, glaucoma, and arthritis would greatly benefit from federally regulated medical marijuana to alleviate the pain associated with their chronic and terminal illnesses.¹⁴⁴ Thus, the federal government is restricting the freedom of behavior and choice of sound adults who have rationally chosen medical marijuana for therapeutic use.

Furthermore, because there is no control of the purity or strength of marijuana, the benefits and harms remain skewed.¹⁴⁵ Unregulated marijuana may be contaminated with substances that may harm AIDS and cancer patients, and make them more susceptible to disease due to weakened immune systems.¹⁴⁶ As long as marijuana remains a Schedule I drug under the Controlled Substances Act, patients relying on medical marijuana will be subject to criminal liability and inevitably forced to seek out illegally grown and unregulated sources of marijuana.¹⁴⁷ Therefore, until the federal government begins to engage in meaningful research and regulation of medical marijuana, the majority of patients will be denied an effective treatment, as well as their right to make an informed choice.

III. LEGAL STATUS OF MEDICAL MARIJUANA

A. Early Legislation: Historical Use of Marijuana

In the United States, Europeans “introduced marijuana (hemp) into Massachusetts [in 1629] to be cultivated and used as a fiber for rope and other products.”¹⁴⁸ Through the establishment of the early colonies, “[h]emp eventually became a major crop in America.”¹⁴⁹ By 1762, Virginia required its citizens to grow marijuana and even imposed penalties on those who refused to grow it.¹⁵⁰ Additionally, marijuana was included in the United States Pharmacopoeia in 1850 as a treatment for numerous ailments, “including: neuralgia, tetanus, typhus, cholera, rabies, dysentery, alcoholism, opiate addiction, anth-

¹⁴⁴ See *Medical Marijuana for Pain and Depression*, DISABLEDWORLD.COM <http://www.disabledworld.com/medical/pharmaceutical/marijuana/> (last visited Nov. 4, 2010).

¹⁴⁵ See Marmor, *supra* note 76, at 542.

¹⁴⁶ See *id.*

¹⁴⁷ See *id.*; see also 21 U.S.C.A. § 812(c); 21 U.S.C.A. § 841(b)(1)(C) (West 2010).

¹⁴⁸ RICHARD JAY MOLLER, MARIJUANA: YOUR LEGAL RIGHTS 8 (1981).

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

rax, leprosy, incontinence, gout, convulsive disorders, tonsillitis, insanity, excessive menstrual bleeding and uterine bleeding.”¹⁵¹ Since marijuana was considered a valuable medication, marijuana was not subject to federal or state regulation until California and Utah first prohibited its possession or sale in 1915.¹⁵² In that same year, “The U.S. Treasury Department [initially] prohibited the importation of marijuana for nonmedical purposes.”¹⁵³

As the federal government abandoned its moral crusade against alcohol in the 1930s, the U.S. Treasury Department established the Federal Narcotics Bureau which, under the supervision of Henry Anslinger, began the fight to prohibit marijuana use.¹⁵⁴ Although opposed by the American Medical Association, the federal government attempted to “‘tax [marijuana] out of existence’” by passing the Marijuana Tax Act of 1937, which in effect was really a *de facto* prohibition on the use of marijuana, including medicinal uses.¹⁵⁵ Furthermore, Anslinger successfully removed marijuana from the United States Pharmacopoeia in 1941.¹⁵⁶ By “1951, the Boggs Act [implemented] mandatory prison sentences and . . . monetary fines” for possession of marijuana, which were only reinforced

¹⁵¹ BOIRE & FEENEY, *supra* note 67, at 16.

¹⁵² See MOLLER, *supra* note 148, at 11. Following California and Utah, “and before alcohol was again legalized in 1933, thirty-two additional states” regulated the use of marijuana based on the establishment of two fears. *Id.* “The first was a racially motivated hostility toward the 500,000 Mexicans who immigrated to America between 1915 and 1930, many of whom smoked marijuana.” *Id.* Secondly, there was “a fear that the underworld—prostitutes, pimps, and gamblers—who were ‘notorious’ drug users—would entice *good citizens* . . . to become ‘*dope fiends*.’” *Id.* (emphasis added).

¹⁵³ MOLLER, *supra* note 148, at 11.

¹⁵⁴ *Id.* (noting that in 1932, the Bureau recommended that all states should adopt the Uniform Narcotic Drug Act). Interestingly, the Act did not prohibit marijuana, but only “classified [it] as an optional drug that could be . . . added to the list of ‘narcotic drugs’ by any state” that chose to do so. *Id.* However, “by 1937, forty-six of the forty-eight [existing] states, plus the District of Columbia, had [enacted] laws prohibiting marijuana.” *Id.*

¹⁵⁵ Conboy, *supra* note 104, at 601-02 (alteration in original). See also BOIRE & FEENEY, *supra* note 67, at 18-19 (“The Marihuana Tax Act . . . required all manufacturers, importers, dealers and medical practitioners dealing with marijuana to register with the federal government and to pay a special occupational tax.”). In fact, Dr. William C. Woodward spoke on behalf of the AMA stating: “The obvious purpose and effect of this bill is to impose so many restrictions on the medicinal use as to prevent such use altogether . . . it may serve to deprive the public of the benefits of a drug on further research may prove to be of substantial value.” *Id.* at 19.

¹⁵⁶ BOIRE & FEENEY, *supra* note 67, at 19 (adding that Anslinger was also one of the chief architects of the Marihuana Tax Act of 1937).

by the Narcotic Control Act of 1956.¹⁵⁷

B. Federal Legal Status

1. *The Final Straw: Controlled Substances Act*

By 1970, it was only too clear that marijuana would no longer be granted the freedom it was once afforded in American society. With the implementation of the Controlled Substances Act, Congress established five schedules into which a drug may be placed.¹⁵⁸ Marijuana is classified as a Schedule I controlled substance, the most restrictive schedule out of five.¹⁵⁹ By its Schedule I classification, the Attorney General has determined that marijuana “has no currently accepted medical use in treatment in the United States,” “has a high potential for abuse,” and “[t]here is a lack of accepted safety for use . . . under medical supervision.”¹⁶⁰ Consequently, the Controlled Substances Act makes it unlawful for any person to “knowingly or intentionally . . . manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance.”¹⁶¹

¹⁵⁷ Conboy, *supra* note 104, at 602. See BOIRE & FEENEY, *supra* note 67, at 20 (“Following World War II, a perceived increase in the use of narcotics along with a growing culture of paranoia, fueled by McCarthyism, led to a new drug hysteria and . . . [t]he passage of the Boggs Act.”). Although the Act “focused predominantly on the use of narcotics, the debate leading to its passage cemented the notion that use of marijuana leads to the use of harder drugs.” *Id.* Consequently, marijuana was listed along side narcotics, which created the “‘gateway [drug] theory’ ” underlying marijuana prohibition even today. *Id.*

¹⁵⁸ See 21 U.S.C.A. § 812.

¹⁵⁹ See *id.* § 812(c); see also SHULGIN, *supra* note 138, at 128-29. Marijuana is listed as a Schedule I substance, particularly as a Hallucinogen; this includes marijuana in the forms of marijuana (granulated, powdered, etc.), marijuana plant, marijuana seeds, marijuana resin (hashish), marijuana oil (hash oil, liquid oil), and cannabis in three forms: extract, fluid extract, and tincture. *Id.* at 128. Also, THC is listed separately as a Schedule I and Hallucinogen. *Id.* However, additional compounds present in the plant extract are known and not included as a scheduled drugs including, Cannabidiol, Cannabinol, Cannabichromene, Cannabinol Acetate, Cannabicycol, and Cannabigerol. *Id.* at 129.

¹⁶⁰ 21 U.S.C.A. § 812(b)(1)(A)-(C).

¹⁶¹ 21 U.S.C.A. § 841(a)(1). See also BOIRE & FEENEY, *supra* note 67, at 21. During the formation and passing of the Controlled Substances Act in 1970, many congressmen, including Senator Ted Kennedy, opposed marijuana’s classification as a Schedule I substance. *Id.* Consequently, marijuana was temporarily placed in Schedule I pending a federal investigation by a presidential commission called the Shafer Commission, which was composed of thirteen members, largely congressmen opposed to rescheduling marijuana, appointed by President Nixon and Congress. *Id.* In the report, the Commission rejected the legalization of marijuana, but “urged the withdrawal of criminal sanctions for personal use of marijuana.”

Since marijuana remains a Schedule I drug, possession of marijuana is illegal unless the federal government has made it available for an approved research project under the Controlled Substances Act.¹⁶² The Attorney General may register applicants to manufacture and distribute Schedule I or II substances if he determines such registration is consistent with the public interest, and in doing so, the following factors considered include, but are not limited to:

(1) maintenance of effective controls against diversion of particular controlled substances . . . in schedule I or II compounded therefrom into other than legitimate medical, scientific, research, or industrial channels . . . ; (2) compliance with applicable State and local law; [and] (3) promotion of technical advances in the art of manufacturing these substances and the development of new substances.¹⁶³

However, since the federal government is hesitant to distribute marijuana for research, it is increasingly difficult to obtain research approval and access to marijuana.¹⁶⁴ The National Institute on Drug Abuse (“NIDA”) possesses “[t]he only legal and controlled source of marijuana” on a farm in Mississippi.¹⁶⁵ Although the federal government has an approved source of legalized marijuana, researchers can only obtain this federal marijuana after the NIH has completed a peer review of the research project and the NIDA has granted approval.¹⁶⁶

2. *Wishful Thinking: Controlled Substances Act Rescheduling*

Although a drug has been placed into a particular schedule,

Id. at 22. Although the Commission recommended marijuana as a treatment for “‘glaucoma, migraine, alcoholism and terminal cancer,” President Nixon ignored the Commission’s findings. *Id.*

¹⁶² See 21 U.S.C.A. § 823(f) (West 2010).

¹⁶³ *Id.* § 823(a)(1)-(3).

¹⁶⁴ See *id.* § 823(f) (specifying that the Attorney General has the authority to register or deny applicants for research only on controlled substances in schedules II, III, IV, or V and therefore, research on marijuana as a schedule I controlled substance is effectively denied).

¹⁶⁵ Marmor, *supra* note 76, at 542.

¹⁶⁶ See *id.* (illustrating that even the NIH recognized “that the current regulatory system should be modified to remove barriers to clinical research with controlled substances”).

the Attorney General may “remove any drug or other substance from the schedules if he finds that the drug or other substance does not meet the requirements for inclusion in any schedule.”¹⁶⁷ However, before a drug can be removed, the Attorney General must examine the Secretary of Health and Human Services’ medical and scientific evaluation of the substance and consider the following criteria:

- (1) Its actual or relative potential for abuse. (2) Scientific evidence of its pharmacological effect, if known. (3) The state of current scientific knowledge regarding the drug or other substance. (4) Its history and current pattern of abuse. (5) The scope, duration, and significance of abuse. (6) What, if any, risk there is to the public health. (7) Its psychic or physiological dependence liability. (8) Whether the substance is an immediate precursor of a substance already controlled under this subchapter.¹⁶⁸

Following the enactment of the Controlled Substances Act, the National Organization for the Reform of Marijuana Laws (“NORML”) petitioned the Drug Enforcement Agency (“DEA”) to reschedule marijuana to Schedule V in 1972.¹⁶⁹ If marijuana was removed to Schedule V, it would be considered both a socially and medically accepted drug with “a low potential for abuse,” “a currently accepted medical use in treatment in the United States,” and “abuse of the drug . . . may lead to a limited physical . . . or psychological dependence.”¹⁷⁰ However, the DEA Administrator denied the motion to transfer marijuana from Schedule I to V.¹⁷¹

Although rescheduling marijuana into Schedule V would have

¹⁶⁷ 21 U.S.C.A. § 811(a)(2) (West 2010). Although the Attorney General has the authority to conduct the investigation into the drug’s scheduling, the proceedings “may be initiated by the Attorney General . . . on his own motion, . . . at the request of the Secretary [of Health and Human Services], or . . . on the petition of any interested party.” *Id.*

¹⁶⁸ *Id.* § 811(b)-(c). The Attorney General essentially shares his decision-making authority with the Secretary of Health and Human Services. *See id.* § 811(b). The Attorney General is bound by the Secretary’s medical and scientific evaluation, so “if the Secretary recommends that a drug or other substance not be controlled, the Attorney General shall not control the drug or other substance.” *Id.*

¹⁶⁹ *See Nat’l Org. for the Reform of Marijuana Laws v. DEA (NORML)*, 559 F.2d 735, 741 (D.C. Cir. 1977).

¹⁷⁰ *See* 21 U.S.C.A. § 812(b)(5)(A)-(C).

¹⁷¹ *NORML*, 559 F.2d at 753.

been a huge stretch, NORML argued that marijuana should at least be rescheduled into Schedule II.¹⁷² Accordingly, like other Schedule II substances, including opium and methadone, marijuana would be considered to have “a high potential for abuse” and “may lead to severe psychological or physical dependence,” but more importantly, marijuana would have an “accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.”¹⁷³

In *National Organization for the Reform of Marijuana Laws (NORML) v. DEA*,¹⁷⁴ the court held that the Attorney General was bound by the Secretary of Health, Education, and Welfare’s medical and scientific evaluations when rescheduling a controlled substance.¹⁷⁵ By seeking rescheduling of marijuana from Schedule I, NORML argued that the Attorney General could override the Secretary of Health, Education, and Welfare’s medical and scientific evaluations “to the extent those recommendations conflict with” the United States’ commitments under the United Nation’s Single Convention on Narcotics Drugs (1967).¹⁷⁶ The court reasoned that the Attorney General could make legal judgments as to controls on drugs according to international commitments and then establish a minimum schedule or control for the drug.¹⁷⁷ After reviewing the Secretary’s medical and scientific evaluations, the Attorney General would determine if more restrictive controls needed to be imposed.¹⁷⁸

More importantly, the court directed the acting Administrator to refer NORML’s petition to the Secretary of Health, Education, and Welfare for medical and scientific findings and recommendations for rescheduling marijuana.¹⁷⁹ Although Francis L. Young, the Chief Administrative Judge for the DEA, determined marijuana belonged in

¹⁷² See *id.* at 751.

¹⁷³ 21 U.S.C.A. § 812(b)(2)(A)-(C).

¹⁷⁴ 559 F.2d 735.

¹⁷⁵ See *NORML*, 559 F.2d at 746-47.

¹⁷⁶ *Id.* at 738-40. The Controlled Substances Act and the Single Convention provided different definitions of marijuana as “cannabis” and “cannabis resin,” listing marijuana as a Schedule I and Schedules I and IV respectively. *Id.* at 739-40. Under the Single Convention, cannabis has a relatively high abuse liability under Schedule I, and as a Schedule IV substance, cannabis resin has an abuse liability not offset by substantial therapeutic advantages. *Id.*

¹⁷⁷ See *id.* at 746.

¹⁷⁸ See *NORML*, 559 F.2d at 746-47.

¹⁷⁹ *Id.* at 757 (concluding that the acting DEA Administrator believed cannabis and cannabis resin should be rescheduled to Schedule II consistent with the Single Convention).

Schedule II, Congress and the DEA have firmly stood by their position that marijuana has no currently accepted medical use in treatment.¹⁸⁰ Accordingly, state laws, such as California's Compassionate Use Act of 1996, are in direct conflict with federal law.¹⁸¹

C. State Legal Status

1. *The California Standard*

Under the Compassionate Use Act of 1996, California set the standard for patient autonomy by approving the medical use of marijuana.¹⁸² Through voter approval, California sought "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana."¹⁸³ While exempting patients and physicians from criminal prosecution or sanction, California sought a collaborative effort between the federal and state governments "to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana."¹⁸⁴

Although California established an identification card program, patients may register on a voluntary basis, but once validly registered, a patient will not face criminal prosecution "for possession, transportation, delivery, or cultivation of medical marijuana."¹⁸⁵ In order to receive an identification card, a patient must provide written documentation that his or her physician diagnosed him or her with a "serious medical condition" and determined that the use of medical

¹⁸⁰ See *BOIRE & FEENEY*, *supra* note 67, at 25-26. On September 6, 1988, Young stated that "one must reasonably conclude that there is accepted safety for use of marijuana under medical supervision. To conclude otherwise, on this record, would be unreasonable, arbitrary and capricious." *Id.* However, "federal agencies are not bound by the recommendations of their own administrative law judges." *Id.* at 26. Ultimately, then DEA Administrator John Lawn rejected Judge Young's recommendation on December 29, 1989. *Id.*

¹⁸¹ See CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 2010).

¹⁸² *Id.*

¹⁸³ *Id.* § 11362.5(b)(1)(A). Under section 11362.5(b)(1)(A), marijuana may be used only for serious medical conditions, including "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other [chronic or persistent] illness for which marijuana provides relief." *Id.*

¹⁸⁴ *Id.* § 11362.5(b)(1)(B)-(C).

¹⁸⁵ CAL. HEALTH & SAFETY CODE § 11362.71(a)(1), (e) (West 2010).

marijuana was an appropriate treatment.¹⁸⁶ This ensures that a patient has a true medical necessity for medical marijuana and that medical marijuana is not an arbitrary treatment. While California limits the amount of marijuana that a patient may possess, a patient may essentially carry a quantity according to a physician's recommendations based on the patient's needs.¹⁸⁷

2. *States Falling in Line*

Following California's example to respect a patient's autonomy in choosing to utilize medical marijuana as treatment, several states, including Alaska, Vermont, Hawaii, Maine, Michigan, Montana, Oregon, New Mexico, Rhode Island, Nevada, New Jersey, and Washington have legalized medical marijuana.¹⁸⁸ However, unlike California, these states require that patients who have been prescribed medical marijuana by their physician must enter into a patient registry.¹⁸⁹ Before a patient can receive a registration identification card, a physician must diagnose the patient with a "debilitating medical condition" in the context of a bona fide patient-physician relationship and determine that such patient will benefit from the use of medical marijuana.¹⁹⁰ Also, the doctor must discuss alternative treatments

¹⁸⁶ CAL. HEALTH & SAFETY CODE § 11362.715(a)(2) (West 2010). Additionally, under section 11362.76(a)(2)(A), a patient must annually submit written documentation of his or her debilitating medical condition to ensure the patient still has a necessity for medical marijuana in the pursuit of effective treatment. CAL. HEALTH & SAFETY CODE § 11362.76(a)(2)(A) (West 2010).

¹⁸⁷ CAL. HEALTH & SAFETY CODE § 11362.77(a)-(b) (West 2010) (stating that "[a] qualified patient or primary caregiver may possess no more than eight ounces of dried marijuana . . . [and] no more than six mature or [twelve] immature marijuana plants per qualified patient"). However, this provision is considered invalid because it is preempted by federal law under the Controlled Substances Act. *Id.*

¹⁸⁸ See ALASKA STAT. § 17.37.010; HAW. REV. STAT. § 329-123(b); ME. REV. STAT. tit. 22, § 2425; MICH. COMP. LAWS § 333.26424; MONT. CODE ANN. § 50-46-103; NEV. REV. STAT. § 453A.050; N.J. STAT. ANN. § 24:61-4; N.M. STAT. ANN. § 26-2B-4(D); ORE. REV. STAT. § 475.309(2)(a); R.I. GEN. LAWS § 21-28.6-4; VT. STAT. ANN. tit. 18, § 4473; WASH. REV. CODE § 69.51A.005.

¹⁸⁹ *Id.* Currently, Maine, Rhode Island, Washington, and Hawaii's medical marijuana statutes are only proposed legislation and wait further approval. New Jersey passed its Compassionate Use Medical Marijuana Act in June 2009, which became effective on July 1, 2010. N.J. STAT. ANN. 24:61-1.

¹⁹⁰ See ALASKA STAT. § 17.37.010(c)(1)(A)-(C) (requiring patients to obtain registry identification card); *id.* § 17.37.070(2). Under both provisions, a *bona fide physician-patient relationship* means that the physician obtained a patient history, performed an in-person physical examination of the patient, and documented written findings, diagnoses,

with the patient before prescribing marijuana.¹⁹¹ By promoting the physician-patient relationship, these states have effectively respected the patient's autonomy as a rational being capable of making informed medical decisions and promoted the state interest in preserving life.

Additionally, these patient registry states will neither subject the patient to arrest, prosecution, or penalty for being listed in the registry, nor subject the physician to penalty, prosecution, arrest, or disciplinary action for prescribing marijuana.¹⁹² However, several restrictions have been placed on the privileged use of marijuana. Following Mill's harm principle, these states ensure that a patient or caregiver will not use marijuana in a way that directly harms or endangers the health or well being of any person, such as driving under the influence of marijuana or using marijuana in plain view of the general public unless it is in a closed container.¹⁹³

Unlike other states that have passed medical marijuana legislation through voter initiatives, Colorado and Nevada amended their state constitutions to allow the use of medical marijuana; under the Colorado and Nevada Amendments, marijuana may be prescribed to patients with debilitating medical conditions, such as cancer, AIDS, and symptoms associated with MS.¹⁹⁴ Additionally, Colorado's state

recommendations, and prescriptions in written patient medical records maintained by the physician. *Id.* See also HAW. REV. STAT. § 329-122(a) (West 2010); ME. REV. STAT. ANN. tit. 22, § 2427(1)(A) (West 2010); MICH. COMP. LAWS ANN. § 333.26428(a)(1) (West 2010); N.M. STAT. ANN. § 26-2B-3(B) (West 2010); ORE. REV. STAT. § 475.309(2)(a); R.I. GEN. LAWS § 21-28.6-3(3) (2010); VT. STAT. ANN. tit. 18, § 4473.

¹⁹¹ See ALASKA STAT. § 17.37.010(c)(1). By invoking the doctrine of informed consent, this provision ensures that the physician has discussed not only the preferred medical treatment, but also other alternatives and their associated risks and benefits. *Id.*

¹⁹² See ALASKA STAT. § 17.37.030(b)-(c) (2010) (listing the privileged uses of medical marijuana for patients and physicians). However, under subsection (d), both the patient and physician will be subject to prosecution, arrest, or penalty for the possession, use or sale of marijuana for nonmedical use. *Id.* See also MONT. CODE ANN. § 50-46-201 (2010); N.M. STAT. ANN. § 26-2B-4(D)-(E); R.I. GEN. LAWS § 21-28.6-8 (2010); VT. STAT. ANN. tit. 18, § 4474b(a)-(b) (2010).

¹⁹³ See ALASKA STAT. § 17.37.040(a) (2010) (listing restrictions on the use of medical marijuana). Under subsection (a)(4), a patient can only carry "one ounce [or less] of marijuana in usable form[, or] six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time." *Id.* § 17.37.040(a)(4). See also HAW. REV. STAT. § 329-122; MICH. COMP. LAWS ANN. § 333.26424; N.J. STAT. ANN. § 24:61-1 (West 2010); R.I. GEN. LAWS § 21-28.6-7 (2010); WASH. REV. CODE § 69.51A.060 (2010).

¹⁹⁴ See COLO. CONST. art. 18, § 14(1)(a)(I)-(II); NEV. CONST. art. 4, § 38(1)(a); see also NEV. REV. STAT. § 453A.050. Additionally, such debilitating medical conditions include, but are not limited to, glaucoma, HIV, relieving symptoms of cachexia, severe pain, severe nau-

health agency may further determine and approve the use of medical marijuana to treat other medical conditions pursuant to either its own authority or petition by a patient or physician.¹⁹⁵ In order to lawfully possess and use medical marijuana, a patient must be placed on the state's confidential registry after a physician diagnoses the patient "with a debilitating medical condition and . . . conclu[des] that the patient might benefit from the medical use of marijuana."¹⁹⁶ Although the patient may use an amount of marijuana medically necessary to treat the debilitating medical condition, the patient must not use marijuana "in a way that endangers the health or well-being of any person."¹⁹⁷

3. *States Moving Towards Legalization*

Lastly, several states either have not completely legalized the use of medical marijuana or are currently considering legislation.¹⁹⁸ Although marijuana is listed as a Schedule I substance, Arizona allows physicians to use marijuana "to treat a disease, or to relieve the pain and suffering of a seriously ill patient or terminally ill patient."¹⁹⁹ However, the Arizona statute strictly regulates and limits the physician's ability to prescribe medical marijuana as a potential treatment.²⁰⁰ The physician can prescribe medical marijuana only after he or she has documented scientific research supporting the use of marijuana for treatment, obtained a second opinion from another physician supporting marijuana as the appropriate treatment, and re-

sea, and seizures, including those that are characteristic of epilepsy. NEV. REV. STAT. § 453A.050.

¹⁹⁵ See COLO. CONST. art. 18, § 14(1)(a)(III); see also COLO. REV. STAT. § 25-1.5-106 (2010) (describing the powers and duties of the Colorado Department of Public Health).

¹⁹⁶ COLO. CONST. art. 18, § 14(3)(b)(I). See also NEV. CONST. art. 4, § 38(1)(a), (d); NEV. REV. STAT. § 453A.210 (2010). However, under section 453A.310(1)-(2) of the Nevada Revised Statutes, a person diagnosed with a debilitating medical condition by a physician who believes marijuana may be an effective treatment for that condition and does not possess a registry identification card may still assert an affirmative defense against any charge of possession, delivery, or production of marijuana. NEV. REV. STAT. § 453A.310(1)-(2) (2010).

¹⁹⁷ COLO. CONST. art. 18, § 14(5)(a)(I). The State has determined that a patient may not possess "more than two ounces of a usable form of marijuana[,] and [n]o more than six marijuana plants . . . [as] a usable form." *Id.* § 14(4)(a).

¹⁹⁸ See, e.g., ARIZ. REV. STAT. ANN. § 13-3412.01 (2010); MD. CODE ANN., CRIM. LAW § 5-601.

¹⁹⁹ ARIZ. REV. STAT. ANN. § 13-3412.01.

²⁰⁰ See *id.* (listing various requirements doctors must satisfy as condition precedents before prescribing marijuana to patients).

ceived the patient's written consent.²⁰¹ Lastly, while Maryland is the most recent state to approve marijuana legislation, "New York, Illinois, Delaware, South Dakota, . . . and Kansas are" moving towards proposed legislation.²⁰²

D. Federal and State Law: The Struggle for the Terminally Ill

Although most courts accept a right of personal autonomy, particularly as a crucial aspect of medical decision-making, an individual will inevitably be forced to "yield . . . to the greater good of society."²⁰³ In *United States v. Oakland Cannabis Buyers' Cooperative*,²⁰⁴ the Supreme Court held there is no defense of medical necessity to manufacturing and distributing marijuana.²⁰⁵ In *Oakland Cannabis Buyers' Cooperative*, the United States sought "to enjoin the Cooperative from distributing and manufacturing marijuana."²⁰⁶ As a not-for-profit organization that distributed marijuana to patients whose physicians prescribed marijuana therapy, the Cooperative operated under the supervision of "[a] physician serv[ing] as medical director, and registered nurses [as] staff."²⁰⁷ Under California's Compassionate Use Act of 1996, these patients legally sought medical marijuana to alleviate severe pain and other debilitating symptoms.²⁰⁸

However, by rejecting the Cooperative's stance that medical necessity should be read into the Controlled Substances Act, the Court reasoned that a legal necessity "defense cannot succeed when

²⁰¹ *Id.*

²⁰² Grim, *supra* note 3. See also Maryland Darrell Putman Compassionate Use Act, MD. CODE ANN., CRIM. LAW § 5-601(c)(3)(ii) (highlighting the court's consideration of medical necessity as a mitigating factor in possession of marijuana prosecutions).

²⁰³ See Elizabeth Weeks Leonard, *The Public's Right to Health: When Patient Rights Threaten the Commons*, 86 WASH. U. L. REV. 1335, 1336 (2009).

²⁰⁴ 532 U.S. 483 (2001).

²⁰⁵ *Id.* at 494.

²⁰⁶ *Id.* at 486-87.

²⁰⁷ *Id.* at 486.

²⁰⁸ CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A). A 1997 survey showed that out of the 900 members of the Oakland Cannabis Buyers' Cooperative, "62% ha[d] AIDS . . . , 10% used marijuana for pain or arthritis, 8% for mood disorders, 6% for neurologic symptoms, 4% for cancer, 4% for glaucoma, and 6% for 'other' conditions." Marmor, *supra* note 76, at 540.

the legislature . . . has made a ‘determination of values.’ ”²⁰⁹ Although the Cooperative argued that Congress, and not the Attorney General, classified marijuana as a Schedule I drug, the Court relied on the simple “determination that marijuana had no medical benefits [that would allow] an exception” for medical use.²¹⁰ By strictly enforcing Mill’s harm principle, the Court has apparently interfered with the Cooperative’s individual liberty to prevent direct harm to others.²¹¹ While the federal government nobly intends to protect society from widespread drug use, the government has ultimately ignored reason in order to reach this decision.

According to Kant, an action is morally good only if it is guided by reason, but the government has hastily taken misguided actions to protect the general public.²¹² Consequently, the federal government, through the regulation of medical marijuana, has denied terminally ill patients’ worth as rational beings. By restraining a patient’s freedom to practice his or her autonomy, the government has sought its own “happiness” to seemingly protect the rest of society from harm at the cost of denying a patient’s right to live, and ultimately die, with dignity.²¹³

Through the physician-patient relationship, both patient and physician work together to promote autonomy by finding a treatment method that will uphold the patient’s right to avoid pain. This is an inherent right belonging to every human being and it is even more fundamental to a terminally ill patient.²¹⁴ The federal government has imposed restraints on a patient’s individuality of choice by interfering with a terminally ill patient’s right to avoid pain. Simply put, the argument for medical marijuana is that no one should be forced to suffer severe physical pain, whether self-imposed or by the state or

²⁰⁹ *Oakland Cannabis Buyers’ Coop.*, 532 U.S. at 491.

²¹⁰ *Id.* (noting that the issue of whether federal courts have authority to recognize a necessity defense not provided by statute remains open).

²¹¹ See Heydt, *supra* note 24.

²¹² See McCormick, *supra* note 26 (“[T]he morality of our actions does not depend upon their outcome. . . . The morality of an action, therefore, must be assessed in terms of the motivation behind it.”).

²¹³ See Heydt, *supra* note 24 (“Yet the world’s good is made up of the good of the individuals that constitute it and unless we are in the position of, say, a legislator, we act properly by looking to private rather than to public good.”).

²¹⁴ See *Last Resorts*, *supra* note 11, at 1990, 1994 (“[P]rohibitions on the last-resort use of medical marijuana make it impossible to exercise an array of fundamental rights The pursuit of physician-assisted suicide and the choice to use medically necessary marijuana to avoid severe pain at the end of life implicate the same values.”).

federal government, where a safe and effective remedy is available.²¹⁵ By denying last resort methods of avoiding pain, a patient cannot maintain his or her self-dignity and self-definition.²¹⁶

For terminally ill patients, the ability to live life comfortably and enjoy their final days as they see fit is the ultimate expression of autonomy. Nothing is more vital to a terminally ill patient than self-definition, which “include[s] life, health, . . . minimiz[ing] unnecessary suffering, dignity, [and] autonomy.”²¹⁷ Yet in 2005, the Supreme Court dealt the final blow to medical marijuana laws conflicting with federal law. In *Gonzales v. Raich*,²¹⁸ the Court held that the Controlled Substances Act provisions criminalizing the manufacture, distribution, and possession of marijuana as applied to intrastate growers and users for medical purposes did not violate Congress’s Commerce Clause power.²¹⁹ Angel McClary Raich continued to suffer from serious medical conditions after other conventional treatments proved to be ineffective or resulted in intolerable side effects.²²⁰ After Raich’s physician concluded marijuana was the only drug available to provide effective treatment, she used medical marijuana and experienced immediate, but not total, relief from her nausea and constant pain.²²¹ Since marijuana is a Schedule I substance, Raich was forced to use marijuana that local growers personally cultivated.²²² Consequently, the DEA raided the home of Diane Monson, another respondent in this case, and seized and destroyed Monson’s homegrown marijuana plants.²²³

Although Raich’s physician had approved her use of marijuana, the Court refused to accept this argument because “[t]he [Controlled Substances Act] requires manufacturers, physicians, pharmacies, and other handlers of controlled substances to comply with

²¹⁵ See *id.* at 1994 (“[T]he Court’s substantive due process jurisprudence . . . support[s] a right against being forced by the state to suffer otherwise-avoidable physical pain. . . . [S]ubstantive due process cases suggest that the right also includes freedom from state-imposed restraints on last-resort methods of avoiding pain.”).

²¹⁶ See *id.* at 1995 (“The fact that severe physical suffering is, for some, an obstacle to dignity and to free self-definition places this right squarely within the autonomy approach to substantive due process.”).

²¹⁷ *Id.* at 1988.

²¹⁸ 545 U.S. 1 (2005).

²¹⁹ See *id.* at 22.

²²⁰ See *id.* at 7-8.

²²¹ See *id.* at 7.

²²² *Id.*

²²³ *Gonzales*, 545 U.S. at 7.

statutory and regulatory provisions.”²²⁴ Even after prescribing conventional medicines, Raich’s physician determined that medical marijuana was the only drug available to effectively treat her symptoms.²²⁵ In fact, Raich’s physician stated that denying the use of marijuana treatment would certainly “cause Raich excruciating pain and could very well prove fatal.”²²⁶ Yet the Court failed to realize that the right to life is one of preservation and one that government has no legitimate interest in impeding.²²⁷

Furthermore, although Raich was a terminally ill patient and used marijuana in compliance with California’s Compassionate Use Act, the Court upheld Congress’s power to regulate activities that substantially affect interstate commerce.²²⁸ Applying *Wickard v. Filburn*,²²⁹ the Court firmly upheld Congress’s Commerce Clause power “to regulate purely local activities that are part of an economic ‘class of activities’ that have a substantial effect on interstate commerce.”²³⁰ The Court reasoned that the homegrown consumption of marijuana for medical purposes by Raich had a substantial effect on interstate commerce “in both [the] lawful and unlawful drug markets.”²³¹ Since marijuana is classified as a Schedule I drug, Congress has the discretionary and explicit power to regulate it, even if used for medical purposes.²³² However, by focusing on the economic impact of prescribing and growing medical marijuana, rather than the intimate personal choice of a suffering patient, the Court ultimately ignored a

²²⁴ *Id.* at 27.

²²⁵ *See id.* at 7.

²²⁶ *Id.*

²²⁷ *See Last Resorts*, *supra* note 11, at 1991-92 (“For these patients, denial of lifesaving treatment surely implicates the fundamental interest in living. In this analysis, it is of little importance that the risk of death is caused not by direct state action, but rather by a preexisting health condition for which the state seeks to withhold treatment.”).

²²⁸ *See Gonzales*, 545 U.S. at 22.

²²⁹ 317 U.S. 111 (1942).

²³⁰ *Gonzales*, 545 U.S. at 17 (citing *Wickard*, 317 U.S. at 128-29).

²³¹ *Id.* at 19. The Supreme Court reasoned that it was “appropriate to include marijuana grown for home consumption in the [Controlled Substances Act because of] the likelihood that the high demand in the interstate market will [subsequently] draw . . . marijuana into [the black] market.” *Id.* The Court went on to state that “the diversion of homegrown marijuana tends to frustrate the federal interest in eliminating commercial transactions in the interstate market in their entirety.” *Id.*

²³² *See id.* at 14. Yet eight years earlier, by holding there was no fundamental right to physician-assisted suicide, the Supreme Court reasoned that “[p]ublic concern and democratic action are . . . focused on . . . protect[ing] a terminally ill patient’s] dignity and independence at the end of life.” *Washington v. Glucksberg*, 521 U.S. 702, 716 (1997).

terminally ill patient's autonomy to choose medical treatment that could have preserved his or her life and dignity before death.²³³

When medical marijuana solely provides relief for a patient, the government should not impose barriers on the only effective method of avoiding pain.²³⁴ These terminally ill patients consulted their physicians and after trying other conventional treatments, rationally concluded that medical marijuana was the only effective alternative treatment available to them. By following Kant's categorical imperative and Mill's principle of utility, these patients made informed decisions guided not only by reason, but also by the pursuit of individual happiness.²³⁵ It is true that "[t]he autonomous actions of [a patient] must not infringe upon the rights of another."²³⁶ While autonomy is not an absolute principle, these terminally ill patients were not threatening the health of others because they used medical marijuana in their own privacy to treat severely debilitating medical conditions. Although the Supreme Court and federal government follow Mill's harm principle, these patients should not be denied the right to die with bodily integrity, control their final moments of life, and avoid unnecessary physical suffering.²³⁷

IV. CONCLUSION

In the pursuit of autonomy, the patient and physician's primary focus is to protect the patient's independent process of self-definition. Regardless of the identity that a terminally ill patient

²³³ See *Last Resorts*, *supra* note 11, at 1996-97 ("[F]or a last-resort patient, medical marijuana is, by hypothesis, the only way to stay alive, die with dignity, or avoid pain.").

²³⁴ See *Glucksberg*, 521 U.S. at 729. Focusing on a patient's right to life, the Supreme Court further reasoned that both the federal and state governments have a strong interest in preserving the lives of patients who not only want to enjoy the remainder of their lives, but also want to be part of society. *Id.*

²³⁵ See McCormick, *supra* note 26 ("The categorical imperative is Kant's famous statement of this duty: 'Act only according to that maxim by which you can at the same time will that it should become a universal law.'"); see also Heydt, *supra* note 24 ("The utilitarian candidate is the principle of utility, which holds that 'actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain . . .'").

²³⁶ POZGAR, *supra* note 35, at 14.

²³⁷ See *Last Resorts*, *supra* note 11, at 1993 ("For patients who are chronically ill and facing an imminent risk of death, treatment that palliates severe pain serves the right to die with dignity . . ."); see also Heydt, *supra* note 24, ("That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.").

seeks to adopt or keep, autonomy requires an individual to be free from constraints including death, pain and suffering, and indignity at the end of life.²³⁸ As President Obama's administration continues to impact American culture, patients may finally gain the support they need to access legal medical marijuana.²³⁹ Through the collaborative efforts of President Obama and Attorney General Eric Holder, the U.S. Department of Justice will seek criminal charges against medical marijuana users only when both state and federal laws have been violated.²⁴⁰ Additionally, medical marijuana clinics will be free of federal investigations provided their operations are lawful.²⁴¹

As autonomous persons, patients have the right to make decisions regarding their bodies and to seek any and all medical treatment to alleviate pain and suffering and preserve life.²⁴² This right entitles a patient to non-interference from people who might attempt to infringe upon these rights and freedom of choice.²⁴³ Ultimately, a patient should be free to make medical decisions concerning treatment and medication that directly impacts his or her own body. In making decisions concerning a patient's health and well being, patients should be given the right to access medical marijuana for therapeutic purposes. By refusing to allow medical marijuana as an alternative pain treatment, the federal government has infringed upon a patient's fundamental right of autonomy.

While the federal government should not persecute patients using medical marijuana for treatment, medical marijuana should be

²³⁸ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.").

²³⁹ See *Guidelines Released on Medical Marijuana*, NATION'S HEALTH, Dec. 1, 2009, at 14, available at 2009 WLNR 26387525 (explaining that law enforcement officials have been advised "not to arrest or harass medical marijuana patients in states where the practice is legal").

²⁴⁰ See *id.*

²⁴¹ See *id.* ("These new guidelines effectively open the [sic] door to sensible collaboration between state governments and medical marijuana providers in ensuring that [sic] patients have safe and reliable access to their medicine . . .").

²⁴² See Hayry, *supra* note 18, at 335 ("It could be argued that universal reason . . . would not oppose the use of cannabis, especially if there are good medical grounds for this. Then autonomy as conformity to the moral law would not require restrictions of freedom as the non-restriction of options.").

²⁴³ See *id.* ("The most important of these are the right to life, the right to health . . . the right to bodily integrity These rights are, essentially, entitlements to non-interference. Other people should not actively attempt to . . . curtail our freedom of choice.").

carefully regulated and patients should be given access to medical marijuana in controlled doses under controlled conditions. Like any medication, marijuana presents its own set of benefits and risks.²⁴⁴ While smoking marijuana may not be the safest method to deliver THC through the body, other methods such as ingesting oral forms of synthetically government approved THC, for example Marinol, have their own drawbacks.²⁴⁵ Just like tobacco, smoking marijuana may require the use of filters to reduce the amount of harmful chemicals entering the body. Although marijuana should not necessarily be legalized across the board, it should be at least removed from Schedule I to Schedule II. However, the medical marijuana debate will only be resolved through further government funded, independent research.

²⁴⁴ See Clark, *supra* note 99, at 40 (explaining that a major criticism of medical marijuana as an alternative therapy is that it “ha[s] not been scientifically tested; therefore, [its] safety . . . has been called into question.”). However, medical marijuana “can be used to help patients withstand the effects of accepted treatments.” *Id.*

²⁴⁵ See *id.* at 43 (“First, some patients have complained that the effects of the pill were too strong at first, then wore off quickly. Second, Marinol is very expensive, costing about \$500 for one hundred 10-mg capsules. Third, it can be difficult for nauseous patients to consume.”).

