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MEDICAL MARIJUANA AND PERSONAL AUTONOMY

ANDREW J. BOYD*

I. INTRODUCTION

A. *A Clash between Federal and State Law*

Diane Monson was in pain. She suffered from a “degenerative disease of the spine” that caused frequent severe back spasms and chronic back pain.¹ Her doctor had recommended that she smoke marijuana to relieve her pain, and to that end she had cultivated six small marijuana plants in the backyard of her Butte County, California home.² Law enforcement, however, was hot on her trail.

Monson and her husband were the previous owners of another house on which Butte County sheriff’s deputies had found a large amount of growing marijuana.³ Their interest in Monson sparked, sheriff’s deputies flew over Monson’s house and spotted marijuana growing in her backyard, but these deputies were unable to immediately determine how much marijuana was present.⁴ To further their investigation, the sheriff’s deputies, along with several federal agents, raided the Monson home on August 15, 2002.⁵ The officers found only six small marijuana plants, and the local sheriff’s deputies determined that Monson’s possession of the plants was legal under California statutory law.⁶ California law allows individuals, on the recommendation of a doctor, to possess and consume marijuana for valid medical

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1. *Raich v. Ashcroft*, 248 F. Supp. 2d 918, 921 (N.D. Cal. 2003) [hereinafter *Raich I*].

2. Laura Smith, *Up in Smoke: Federal Government Clashes with County over Small Medical Marijuana Garden*, CHICO NEWS & REV., Aug 22, 2002, at News & Features, available at <http://www.newsreview.com/issues/chico/2002-08-22/news.asp?Print=1>.

3. *Id.* The Monsons also retained a security interest in the house. *Id.*

4. Terry Vau Dell, *Oroville Woman at Center of Medical Pot Ruling*, at <http://www.cannabisnews.com/news/thread17997.shtml> (Dec. 18, 2003).

5. *Id.* See also *Raich I*, 248 F. Supp. 2d at 921 (describing the raid).

6. *Raich*, 248 F. Supp. 2d at 921.

reasons.⁷ These local deputies were fully aware of this statute, and were ready to leave. “If the [feds] weren’t there, we’d have left the plants,” said Sheriff’s Lt. Jerry Smith. “We’re not out to bother with small medicinal grows like that.”⁸

The federal officers present, however, had other ideas. They determined that Monson’s cultivation of medicinal marijuana plants violated federal law. Federal law classifies marijuana as a Schedule I controlled substance.⁹ As a Schedule I controlled substance, the manufacture¹⁰ and possession¹¹ of marijuana is unlawful. The federal officers determined that it was therefore their duty under federal law to destroy Monson’s plants.¹² Appalled, the local sheriff’s deputies contacted the Butte County District Attorney Mike Ramsey, and informed Ramsey of the federal officers’ intentions.¹³ Ramsey ordered the local “deputies to ‘take whatever means necessary’ to stop the [federal] agents from uprooting the plants until he conferred with their superiors.”¹⁴ A three-hour standoff then ensued, involving Ramsey and “the United States Attorney for the Eastern District of California.”¹⁵ In the end, the federal officers destroyed Monson’s plants.¹⁶

Monson was flabbergasted by the actions of the federal officers. “I couldn’t believe they were taking my plants. I mean, this is just so against what the will of the people of the State of California is. I wasn’t doing anything against the law.”¹⁷ Monson was not, in fact, violating California law.¹⁸ She was, however, in violation of the federal law.¹⁹

As the Monson case demonstrates, state and federal laws are

7. CAL. HEALTH & SAFETY CODE § 11362.5 (Deering 2004). The statute reads in part:

Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient’s primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

Id.

8. Smith, *supra* note 2.

9. 21 U.S.C. § 812(b) (2000).

10. *Id.* § 841(a)(1).

11. *Id.* § 844(a).

12. Dell, *supra* note 4.

13. *Id.*

14. *Id.*

15. *Raich I*, 248 F. Supp. 2d at 921.

16. *Id.* See also Smith, *supra* note 2, and Dell *supra* note 4 (providing a fuller account of the factual background to the Monson case).

17. Smith, *supra* note 2.

18. See CAL. HEALTH & SAFETY CODE § 11362.5 (allowing the cultivation and use of medical marijuana).

19. Monson was in possession of a controlled substance, which violated 21 U.S.C. § 844(a). Monson had also been growing marijuana, which violated 21 U.S.C. § 841(a)(1).

in conflict on the matter of medical marijuana. Ten states have legalized the possession and use of marijuana for medical purposes.²⁰ The federal government, however, persists in classifying marijuana as a Schedule I controlled substance,²¹ which means that its possession is unlawful, even for valid medical reasons.²² This article will focus on this clash between state and federal law and will propose that marijuana be reclassified as a Schedule II substance. Schedule II substances are recognized as having “a currently accepted medical use in treatment in the United States.”²³ This article will also propose that Congress specifically recognize the medical value of marijuana and amend federal statutes to allow the possession and use of medical marijuana in the United States.

B. Organization

Part II of this article will explore the present legal status of medical marijuana in the United States. Part II will first examine the state statutes in question. These statutes are far from identical. The structure of each statute will be examined, and the requirements patients must follow to lawfully obtain medical marijuana will be explained. Part II will then examine the federal Controlled Substance Act and its contrast with state law will be highlighted.

Part II will also examine important state and federal medical marijuana case law. The most important of these cases, at least at the federal level, may be *United States v. Oakland Cannabis Buyer's Cooperative*, in which the United States Supreme Court held that marijuana has no valid medical use, and that the defense of medical necessity is not available to individuals prosecuted for the possession of marijuana.²⁴ However, there may be some positive case law for supporters of medical marijuana. Diane Monson, along with three other plaintiffs, sued the Attorney General of the United States following the incident described above.²⁵ An appeal from that case may have given supporters of medical marijuana a ray of hope.²⁶ In that appeal, the Ninth

20. These states are Alaska, Arizona, California, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington. The medical marijuana statutes of each of these states will be examined. *See infra* Part II. In addition, a Maryland statute specifically allows the use of the defense of medical necessity against a criminal charge of possession of marijuana, and sanctions only a small fine for the use of marijuana for medical purposes. That statute will also be examined. *See infra*, Part II.

21. 21 U.S.C. § 812.

22. *Id.* § 844(a).

23. *Id.* § 812 (b)(2).

24. 532 U.S. 483, 491 (2001).

25. *Raich I*, 248 F. Supp. 2d at 918.

26. *Raich v. Ashcroft*, 352 F.3d 1222 (9th Cir. 2003), *cert. granted*, 124 S.

Circuit Court of Appeals held that applying the Controlled Substances Act to Monson was most likely unconstitutional.²⁷ The United States Supreme Court recently granted a petition for writ of certiorari for this case.²⁸

Part III will examine the case for medical marijuana from the point of view of the medical profession.²⁹ Many medical journals and books have addressed the issue of medical marijuana. *Marihuana, the Forbidden Medicine* is perhaps the most notable book written on this topic.³⁰ Its authors, Lester Grinspoon and James B. Bakalar, survey numerous issues surrounding medical marijuana, and ultimately argue in favor of the use of marijuana as medicine.

Numerous medical journal articles also attest to the medicinal value of marijuana. For instance, Jerome P. Kassirer, M.D., in a *New England Journal of Medicine* editorial, writes: "The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana."³¹ Kassirer and others argue that marijuana has legitimate medical uses, and that federal policy that prohibits doctors from prescribing their patients the medicine they need is misguided at best.³² Other physicians are more cautious on this issue, admitting that marijuana can effectively treat pain and nausea in some patients, but are reluctant to wholeheartedly recommend its use as medicine

Ct. 2909 (2004) [hereinafter *Raich II*].

27. *Id.* at 1227. This case came before the Court of Appeals for the Ninth Circuit after the district court had "denied the appellants' motion for a preliminary injunction because the appellants had not established a sufficient likelihood of success on the merits." *Id.* at 1224. The circuit court held that the plaintiffs had in fact established a "strong likelihood" that the Controlled Substances Act had been unconstitutionally applied to them. *Id.* at 1227. The case was remanded to the district court for an "entry of a preliminary injunction." *Id.* at 1235.

28. *Ashcroft v. Raich*, 124 S. Ct. 2909 (2004).

29. Part III of this article is written, of course, by a medical layperson. This Part, however, strives to present the medical profession's viewpoint on medical marijuana as clearly and fairly as possible.

30. LESTER GRINSPOON & JAMES B. BAKALAR, *MARIHUANA, THE FORBIDDEN MEDICINE* (rev. ed. 1997).

31. Jerome P. Kassirer, M.D., *Federal Foolishness and Marijuana*, 336 *NEW ENG. J. MED.* 366, 366 (1997). Kassirer argues that the federal prohibition against the medical use of marijuana is irrational, as such prohibition either forces sick people to suffer needlessly, or to break the law by consuming marijuana. *Id.*

32. *Id.* at 366-67. "I believe that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane." *Id.* at 366.

because of either “adverse side effects,”³³ or the need for further study.³⁴ Part III of this article will conclude by arguing that, while some doctors are cautious on this issue, there is a significant body of medical literature that indicates that marijuana can be effective and safe medicine for some patients.

Part IV of this article will focus on the concept of personal autonomy. In short, personal autonomy can be understood as the ability of individuals to decide for themselves what their lives will be like.³⁵ “Individual autonomy is an idea that is generally understood to refer to the capacity to be one’s own person, to live one’s life according to reasons and motives that are taken as one’s own and not the product of manipulating or distorting external forces.”³⁶ The autonomous individual is essentially an individual who makes choices based not on external controls imposed on her, but rather one who makes choices as an individual, as an “authentic self.”³⁷ In this Part of the article, personal autonomy will be discussed as a laudable goal to be obtained.³⁸ This goal will be contrasted with a lack of autonomy, a state in which individuals suffer from “debilitating pathologies or are under oppressive and constricting conditions.”³⁹ In other words, a contrast will be drawn between the desirable state of autonomy⁴⁰ and the undesirable state of being less than autonomous.⁴¹

33. Martin R. Tramer et al., *Cannabinoids for Control of Chemotherapy Induced Nausea and Vomiting: Quantitative Systematic Review*, 323 BRIT. MED. J. 16 (2001), <http://bmj.bmjournals.com/cgi/content/full/323/7303/16>.

34. Fiona A. Campbell et al., *Are Cannaboids an Effective and Safe Treatment Option in the Management of Pain? A Qualitative Systematic Review*, 323 BRIT. MED. J. 13 (2001), <http://bmj.bmjournals.com/cgi/content/full/323/7303/13>.

35. For two good overviews of the notion of autonomy, see Sarah Buss, *Personal Autonomy*, in STAN. ENCYCLOPEDIA OF PHIL. (Edward N. Zalta ed, 2002), <http://plato.stanford.edu/archives/win2002/entries/personal-autonomy> (last visited Aug. 9, 2004) (outlining basic issues surrounding the concept of persons as “self-governing agents”), and John Christman, *Autonomy in Moral and Political Philosophy*, in STAN. ENCYCLOPEDIA OF PHIL. (Edward N. Zalta ed. 2003), [hereinafter Christman, *autonomy*] <http://plato.stanford.edu/archives/fall2003/entries/autonomy-moral> (last visited Aug. 9, 2004) (offering an “examination of the concept of autonomy” in moral, social, and political philosophy).

36. Christman, *autonomy*, *supra* note 35.

37. *Id.*

38. *See id.* (explaining that “ideal autonomy” is not the normal status of most individuals; rather, “ideal autonomy” is “an achievement that serves as a goal to which we might aspire and according to which a person is maximally authentic and free of manipulative, self-distorting influences”).

39. *Id.*

40. *Id.* “To be autonomous means deserving respect for one’s own ability to decide for oneself, control one’s life, and absorb the costs and benefits of one’s choices.” *Id.*

41. *Id.* “Lacking autonomy, as children do, is a condition which allows or invites sympathy, pity, or invasive paternalism.” *Id.*

Finally, Part V of this article will argue that, given the evidence of the efficacy and safety of marijuana as medicine and given that personal autonomy is a desirable state, the federal government ought not be in the business of preventing doctors from recommending that their patients use marijuana as medicine, nor should the federal government be in the business of preventing patients from access to medicine that, in consultation with their doctors, they have chosen to use. To that end, this article will offer the following proposals. Congress should reclassify marijuana as a Schedule II or lower substance. Congress should then amend the Federal Controlled Substances Act to provide that licensed physicians may recommend that their patients use marijuana for legitimate medical purposes, and that patients may possess and use marijuana for legitimate medical reasons. Alternatively, Congress should pass legislation that specifically grants immunity from federal arrest or prosecution to those doctors who recommend medical marijuana and patients who use medical marijuana, in those states that have passed laws allowing the use of medical marijuana.

II. THE PRESENT LEGAL STATUS OF MEDICAL MARIJUANA

A. Introduction

Part II of this article will describe ten state statutes that allow the use of medical marijuana, as well as one state statute that provides some relief for users of medical marijuana. Part II will also briefly explain the current state of medical marijuana in Illinois. Part II will then analyze the Federal Controlled Substances Act, which prohibits the possession or use of marijuana, and two cases that have interpreted that Act.

B. State Statutes

1. Alaska

Alaska voters approved this state's medical marijuana statute in 1998.⁴² A patient who wishes to use medical marijuana under this statute must first undergo examination by a doctor "in the

42. *Rollins v. Ulmer*, 15 P.3d 749, 750 (Alaska 2001). Although "nearly 60 percent of Alaska voters" approved of this measure, the law was not without its opponents. Yereth Rosen, *Alaska Legislature Tightens Medical-Marijuana Law*, at <http://www.alolaw.com/CurrentDevelopments/cdmedmari.htm> (May 19, 1999). Some argued that the measure was simply a "veiled attempt" to allow the recreational use of marijuana. *Id.* State Representative Ramona Barnes argued, "[a]nyone that believes that [the] medical-marijuana initiative didn't put us back to where we were in the mid-'80s, when marijuana was wide open in this state and (caused) the destruction of the minds and bodies of young people, think again." *Id.*

context of a bona fide physician-patient relationship.⁴³ If the doctor finds that the patient has “a debilitating medical condition,”⁴⁴ that treatment other than the use of marijuana has been considered, and that the patient would likely “benefit from the medical use of marijuana,”⁴⁵ the patient may apply “to be placed on the state’s confidential registry for the medical use of marijuana.”⁴⁶ If the state determines that the patient meets the statutory requirements (i.e., that a physician has examined the patient, determined that the patient suffers from a “debilitating medical condition,” and that the patient would benefit from marijuana),⁴⁷ a “registry identification card” will be issued to the patient and, if there is one, the patient’s “primary caregiver.”⁴⁸ Holders of these registry cards are then “privileged” to possess and use marijuana for medical reasons.⁴⁹ There are some “restrictions” on this privileged use of marijuana. Marijuana may not be used “in a way that endangers the health or well-being of any person.”⁵⁰ Marijuana may not be used in public.⁵¹ Registry cardholders may not possess more than one ounce of “useable” marijuana, and six

43. ALASKA STAT. § 17.37.010(c)(1)(A) (Michie 2003).

44. *Id.* § 17.37.010(c)(1)(B).

45. *Id.* § 17.37.010(c)(1)(C).

46. *Id.* § 17.37.010(c). See also *Rollins*, 15 P.3d at 749. In *Rollins*, the plaintiff challenged the constitutionality of these registration requirements. *Id.* at 750. It is interesting to note that the requirement to register with the state prior to obtaining medical marijuana was not a part of the original measure approved of by the Alaskan voters. Rosen, *supra* note 42. Six months after Alaskan voters endorsed the original medical marijuana statute, the Alaskan legislature passed a measure amending that statute to include the registration requirement. *Id.* Rollins argued that the requirement that users of medical marijuana register with the state violated a “constitutional right to privacy.” *Rollins*, 15 P.3d at 750. The Alaskan Constitution recognizes a fundamental right to privacy, stating “[t]he right of the people to privacy is recognized and shall not be infringed.” *Id.* at 751; ALASKA CONST. art. I, § 22. Rollins argued, among other things, that the “mere existence” of the registry would infringe on the patient’s ability to freely choose whether to use medical marijuana, as patients would fear the “stigmatization” that accompanies the very act of registering one’s medical condition and marijuana use with the state. *Rollins*, 15 P.3d at 753. The Supreme Court of Alaska, however, rejected Rollins’s challenge, reasoning that since the law barred the general public from access to the registry, and since the registry was limited to “legitimate purposes,” the registration requirement was not unconstitutional. *Id.* at 750. The court noted that even with the registration requirement, “Alaska’s medical marijuana law leaves patients and their physicians broad freedom to choose marijuana for treatment of debilitating conditions.” *Id.* at 754.

47. ALASKA STAT. § 17.37.010(c).

48. *Id.* § 17.37.010(f).

49. *Id.* § 17.37.030.

50. *Id.* § 17.37.040(a)(1).

51. *Id.* § 17.37.040(a)(2). The legislature is careful to note that this does not prohibit the possession of marijuana in public by qualified registry cardholders. *Id.* § 17.37.040(a)(2)(A)-(C).

marijuana plants.⁵²

2. Arizona

The status of medical marijuana in Arizona, while at first glance appearing favorable to medical marijuana patients, is in reality an effective prohibition on the use of medical marijuana.⁵³ Arizona does allow patients to use marijuana as medicine “pursuant to the *prescription* of a doctor.”⁵⁴ Most other state statutes allowing the use of medical marijuana require only that a doctor “recommend” marijuana to a patient.⁵⁵ However, Arizona’s insistence that patients hold an actual prescription in order to lawfully possess and use medical marijuana places doctors in an awkward situation.⁵⁶

Federal law prohibits the dispensing of controlled substances.⁵⁷ Federal courts have interpreted the term “dispense” broadly, to include the writing of prescriptions for controlled substances.⁵⁸ Since doctors generally do not wish to be prosecuted

52. *Id.* § 17.37.040(a)(4)(A)-(B).

53. The story of Russell “Sarge” Lintecum illustrates the status of medical marijuana in Arizona. Lintecum is a Vietnam War veteran suffering from post-traumatic stress disorder. Richard Ruelas, *Legal or Not, Pot Eases Decorated Vet’s Pains*, at <http://mapinc.org/newsnorm/v03/n1619/a07.html> (Oct. 20, 2003). Lintecum has been prescribed various medications to treat his symptoms, but these medications “left him feeling like a zombie.” *Id.* Desperate for relief, Lintecum turned to smoking small amounts of marijuana, and found some respite from his emotional pain. *Id.* However, even though Arizona voters have approved of the use of medical marijuana, Lintecum is in violation of the law every time he medicates himself with marijuana. *Id.* The problem is that, in short, the medical marijuana statute in Arizona requires that a doctor prescribe marijuana to a patient. *Id.*; ARIZ. REV. STAT. § 13-3412(A)(8) (2003). However, Arizona doctors have refused to write prescriptions for marijuana, fearing prosecution under federal law. Ruelas, *supra*. See also 21 U.S.C. § 812 (designating marijuana as a Schedule I drug, having “no currently accepted medical use in treatment in the United States”). So, without a prescription, Lintecum’s possession and use of marijuana remains unlawful, and Lintecum remains a criminal. Ruelas, *supra*.

54. ARIZ. REV. STAT. § 13-3412(A)(8) (emphasis added.)

55. For example, Section 11362.5 of the California Health and Safety Code requires that a patient have a doctor’s “recommendation” in order to take marijuana, rather than a doctor’s prescription.

56. Nat’l Org. for the Reform of Marijuana Laws, *Arizona*, at http://www.norml.org/index.cfm?Group_ID=4523&wtm_view=medical (last visited July 31, 2004) [hereinafter NORML Arizona]. Doctors face federal prosecution if they prescribe marijuana to patients. *Id.*

57. 21 U.S.C. § 841(a)(1).

58. *United States v. Davis*, 564 F.2d 840, 844 (9th Cir. 1977). “It is clear that, when a doctor steps out of the usual course of his professional duties and writes a prescription for someone for a controlled substance not pursuant to a legitimate medical purpose, he has initiated a transfer of that controlled substance.” *Id.* The Tenth circuit has also held that physicians who offer prescriptions without a “legitimate medical purpose” have violated the federal law against dispensing a controlled substance. *United States v. Jobe*, 487

by the federal government for prescribing medication, Arizona physicians seem to be uniformly declining to prescribe marijuana for their patients.⁵⁹ Arizona law does exempt doctors who prescribe marijuana from state prosecution,⁶⁰ but Arizona law does not shield doctors from federal prosecution.

3. California

The California statute designed to allow the use of medical marijuana, The Compassionate Use Act of 1996,⁶¹ was passed by voter approval at the ballot box.⁶² The Act itself provides a clear indication of the intent of the people of the State of California in passing it.

The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows: 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 in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.⁶³

The Act then goes on to expressly provide that, with the

F.2d 268, 268 (10th Cir. 1973). Since the federal government has classified marijuana as having no accepted medical value, prescribing marijuana can have no "legitimate medical purpose." *Cf.* 21 U.S.C. § 812(c).

59. NORML Arizona, *supra* note 56. "Not surprisingly, the attorney general's office reports that state physicians are not advocating medical marijuana therapy to their patients under the law." *Id.*

60. ARIZ. REV. STAT. § 13-3412.01(A). "[A]ny medical doctor licensed to practice in this state may prescribe a controlled substance included in schedule I . . . to treat a disease, or to relieve the pain and suffering or a seriously ill patient or terminally ill patient." *Id.*

61. CAL. HEALTH & SAFETY CODE § 11362.5.

62. *See* *People v. Trippet*, 66 Cal. Rptr. 2d 559 (Cal. Ct. App. 1997) (noting the arguments made by proponents of the Act). The Court indicates that the Act was "presented to California's voters as an act of compassion to those in severe pain." *Id.* at 567. The "ballot pamphlet" given to California voters considering this issue contained arguments by proponents and opponents of the Act. *Id.* In that pamphlet, San Francisco District Attorney Terence Hallinan stated, "I support [Proposition 215] because I don't want to send cancer patients to jail for using marijuana." *Id.* Moreover, the pamphlet explained, this Act was not intended to free recreational users of marijuana from California's statutory prohibition against possession of marijuana. *Id.* at 568. The Act was intended to "give those arrested a defense in court, if they can prove they used marijuana with a doctor's approval." *Id.*

63. CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(a). *See also* *People v. Bianco*, 113 Cal. Rptr. 2d 392 (Cal. Ct. App. 2001) (noting that this Act includes "precatory language" which shows that the intent of the people was to approve of medical marijuana, and to "exempt" those who use medical marijuana from criminal liability).

“recommendation or approval” of a physician, patients and their primary caregivers are free to possess marijuana for medical use.⁶⁴

The question of exactly what constitutes a “recommendation or approval” of the use of medical marijuana thus becomes quite important.⁶⁵ The court in *People v. Trippet* was faced with this issue under the following circumstances. A doctor, during a trial in which his patient had been charged with the possession of marijuana, “flatly denied” recommending to that patient that she should smoke marijuana.⁶⁶ However, that same doctor’s later testimony seemed to indicate he may have informally communicated to this patient that he “approved” of her marijuana use to mitigate the effects of migraine headaches.⁶⁷ The court concluded that even though the doctor made no formal recommendation regarding the use of marijuana, the physician’s informal approval of marijuana could satisfy the statutory requirement of “recommendation or approval.”⁶⁸

The court in *People v. Jones* approved of this reasoning. Defendant Jones, suffering from migraine headaches, had asked his doctor whether marijuana might alleviate his pain.⁶⁹ During Jones’s trial for “cultivating marijuana,” Jones testified that the doctor replied, “[i]t might help, go ahead.”⁷⁰ On appeal, the court considered whether such words could satisfy the statutory requirement that a physician “recommend or approve” of Jones’s use of marijuana.⁷¹ Following *Trippet*, the court explained that the

64. CAL. HEALTH & SAFETY CODE § 11362.5(b)(2)(d). It is important to note that the Act does not require a prescription from a physician; the Act requires only a physician’s “recommendation or approval,” and such “recommendation or approval” may be “written or oral.” *Id.* California doctors are thus not in the awkward position of having to violate federal law in order to afford their patients the medical benefits of marijuana. *See supra* notes 54 - 58 and accompanying text (explaining that Arizona law requires physicians to formally prescribe marijuana for their patients, which federal law forbids).

65. *See People v. Jones*, 4 Cal. Rptr. 3d 916, 920 (Cal. Ct. App. 2003), and *Trippet*, 66 Cal. Rptr. 2d at 559 (both reasoning that the act of approval is a materially different and more formal act than the act of recommendation).

66. *Trippet*, 66 Cal. Rptr. 2d at 569.

67. *Id.*

68. *Id.* The court also indicated that the physician’s approval of a patient’s marijuana use need not be prior to the patient’s possession of marijuana. *Id.* In other words, the court reasoned that the statutory requirement of “recommendation or approval” could be met if a patient first obtained marijuana for medical treatment, and the doctor later approved of this. *Id.* “[W]e can readily conceive of exigent circumstances in which the physician’s approval might well be contemporaneous with the possession, or even subsequent to the possession although prior to actual usage.” *Id.*

69. *Jones*, 4 Cal. Rptr. 3d at 917.

70. *Id.* The trial court refused to allow Jones to assert a “defense under the Compassionate Use Act,” as that testimony did not establish that the doctor approved of Jones’ use of marijuana. *Id.* at 917-18.

71. *Id.* at 920.

act of “recommending” something and the act of “approving” something are two very different things.⁷² The essential point, according to the court, was that a physician could “approve” of a patient’s use of medical marijuana without ever having formally “recommended” such use, and that either act would satisfy the statutory requirement in question.⁷³

The California statute also provides for an “identification card” program.⁷⁴ These cards are available to patients who satisfy the statutory requirements of the Act, but obtaining a card is purely voluntary.⁷⁵ There is no requirement that anyone using medical marijuana hold an identification card.⁷⁶ Finally, legitimate users of medical marijuana in California are allowed to possess up to “eight ounces of dried marijuana,” and up to “six mature or 12 immature marijuana plants.”⁷⁷

4. Colorado

The state of Colorado has amended its constitution to allow the medical use of marijuana.⁷⁸ The statute begins by defining the types of conditions marijuana may lawfully be used to treat. These conditions include cancer, glaucoma, HIV, and AIDS.⁷⁹ Colorado also provides that the “state health agency” is free to determine that marijuana is appropriate medication for other diseases or medical conditions.⁸⁰ Patients seeking to use medical marijuana must obtain a registry card from the state, “which identifies . . . [the] patient authorized to engage in the medical use of marijuana.”⁸¹ A patient can obtain this card by submitting an application to the state health agency, including “written

72. *Id.* The court reasoned that the word “recommend” indicates that a physician has initiated a conversation about marijuana, and has “presented it to the patient as a treatment that would benefit the patient’s health.” *Id.* However, the word “approve” indicates that it was the patient who initiated the conversation, and the physician only “expressed a favorable opinion of marijuana use as a treatment for the patient.” *Id.*

73. *Id.*

74. CAL. HEALTH & SAFETY CODE § 11362.71.

75. *Id.* § 11362.71(a)(1).

76. *Id.* § 11362.71(f). “It shall not be necessary for a person to obtain an identification card in order to claim the protections of Section 113.62.5.” *Id.*

77. *Id.* § 11362.77(a).

78. COLO. CONST. art. XVIII, § 14.

79. *Id.* art. XVIII, § 14(1)(a)(I). Colorado expressly states that, in addition to cancer, glaucoma, and AIDS, a number of diseases or medical conditions may be treated by marijuana. *Id.* art. XVIII, § 14(1)(a)(II). These conditions are “cachexia; severe pain; severe nausea; seizures; . . . or persistent muscle spasms.” *Id.*

80. *Id.*, art. XVIII, § 14(1)(a)(III). For now, however, only the expressly listed diseases or conditions may lawfully be treated with marijuana. *Id.*, art. XVIII, § 14(1)(a)(2-3).

81. *Id.*, art. XVIII, § 14(1)(g).

documentation stating that the patient has been diagnosed with a debilitating medical condition and the physician's conclusion that the patient might benefit from the medical use of marijuana.⁸² Patients may possess up to two ounces of marijuana, or six marijuana plants under this law.⁸³ Finally, patients are not allowed to use marijuana "in a way that endangers the health or well-being of any person," or to use marijuana in public.⁸⁴

5. *Hawaii*

Hawaii was the first state to legislatively (rather than through ballot initiative) allow medical marijuana use.⁸⁵ The Hawaii statute requires that a patient seeking to use medical marijuana be qualified by a physician as "having a debilitating medical condition" that medical marijuana would likely mitigate.⁸⁶

82. *Id.*, art. XVIII, § 14(3)(b)(I). The Governor of Colorado was less than enthusiastic towards this new legislation, and made an attempt to discourage doctors from approving of the use of medical marijuana. See Drug Reform Coordination Network, *Colorado Medical Marijuana Law Now in Effect: Governor and Attorney General Urge Feds to Bust Patients, Feds Say No Thanks*, at <http://stopthedrugwar.org/chronicle/189/colorado.shtml> (June 8, 2001). In a joint statement prepared by Governor Bill Owens and Attorney General Ken Salazar, they declared,

We remind anyone intending to register for the program—as well as physicians considering prescribing marijuana to their patients—that it remains a federal crime to possess, manufacture, distribute or dispense marijuana. To fulfill our duties under federal law, we are today contacting the Colorado Medical Association to remind the physicians of Colorado that doctors who dispense marijuana for any purpose risk federal criminal prosecution. We are also writing the acting United States Attorney for the District of Colorado to encourage the criminal prosecution of anyone who attempts to use this state program to circumvent federal anti-drug laws.

Id. United States Attorney Richard Spriggs declined Colorado's invitation to prosecute the use of medical marijuana.

We in the US Attorney's Office are truly grateful to Gov. Owens and Attorney General Salazar for sharing their problems with us We, however, are not the solution to their problem Neither the governor nor the attorney general should engage in unfounded speculation about who might be prosecuted in federal court.

Id.

83. COLO. CONST. art XVIII, § 14(4)(a)(I-II).

84. *Id.* art XVIII, § 14(5)(a)(I-II).

85. THE DRUG POLICY REFORM OF HAWAII, THE MEDICAL USE OF MARIJUANA: A GUIDE TO HAWAII'S LAW FOR PHYSICIANS, PATIENTS AND CAREGIVERS 1 (2001), available at <http://dpfhi.org/docs/mmjbooklet.pdf>. This booklet is a layperson's guide to the medical marijuana law in Hawaii. The complete statutory scheme is contained in sections 329-121 to 329-127 of the Hawaii Revised Statutes.

86. HAW. REV. STAT. § 329-122(a)(1-2) (2003). The physician must certify in writing that "the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient." *Id.* § 329-122(a)(2).

Patients in Hawaii who qualify under this standard must register with the state's department of public safety.⁸⁷ Physicians are expressly protected from arrest or prosecution for certifying a patient's medical marijuana use.⁸⁸ Finally, qualified patients who suffer the seizure of medical marijuana or marijuana paraphernalia have a statutory remedy that allows them to recover that property.⁸⁹

6. *Maine*

The statutory exemption in Maine for the use of medical marijuana requires that the patient be diagnosed by a physician as having one of a specific list of conditions.⁹⁰ While in possession of medical marijuana, the patient must carry "an authenticated copy of a medical record or other written documentation from a physician" attesting that the patient has been diagnosed with one of the listed conditions.⁹¹ The physician must have thoroughly discussed with the patient the possible benefits and risks of medical marijuana, offered his or her own professional opinion as to the usefulness of medical marijuana in the patient's "particular case," and "advised the person . . . that the person might benefit from the medical use of marijuana to relieve pain or alleviate symptoms of the person's condition."⁹² The patient is limited to the possession of a "useable amount marijuana for medical use."⁹³ The statute, however, does not provide any lawful means for patients to obtain marijuana.⁹⁴

87. *Id.* § 329-123(b).

88. *Id.* § 329-126. The physician must, however, explain "the potential risks and benefits of the medical use of marijuana" to the patient, and offer such certification only after having examined the patient in conformity with accepted professional standards, and within the context of a normal doctor-patient relationship. *Id.* § 329-126(2)-(3).

89. *Id.* § 329-127.

90. ME. REV. STAT. ANN. tit. 22 § 2383-B(5)(A)(1) (West 2003). A patient may use medical marijuana for the following conditions in Maine: vomiting, nausea, or loss of appetite resulting from AIDS or the treatment of cancer, glaucoma, seizures, or muscle spasms. *Id.* The statute does not indicate that marijuana may lawfully be used to treat any condition other than the ones specifically listed. *Id.*

91. *Id.* § 2383-B(5)(A).

92. *Id.* § 2383-B(5)(A)(2).

93. *Id.* § 2383-B(5)(A).

94. Maine's Medical Marijuana Task Force proposed, in September of 2000, that the Maine Legislature create a state-run medical marijuana distribution center. Press Release, Marijuana Policy Project, Maine Task Force Approves Medical Marijuana Distribution Plan: Project Would Be First of Its Kind in the U.S. (Sept. 27, 2000), *available at* <http://www.mpp.org/releases/nr092700.html>. The task force had hoped that the State of Maine would be the first state to officially establish a medical marijuana distribution center. *Id.*

"If the state authorizes a medical marijuana distribution center, it

7. Nevada

In 1998, and again in 2000, the citizens of Nevada voted to amend the state constitution to allow the use of medical marijuana.⁹⁵ The amendment provides that the state legislature will allow the medical use of marijuana for the treatment of any one of a number of listed diseases or conditions, but leaves open the possibility that other conditions could be approved at a later date as lawfully treatable by marijuana.⁹⁶ The amendment also provides that the state will create a registry of patients authorized to use medical marijuana.⁹⁷

The resulting statutes indicate that the user of medical marijuana in Nevada is protected in two separate ways. First, holders of registry cards are “*exempt* from state prosecution for” possession, delivery, or the production of marijuana or marijuana paraphernalia.⁹⁸ The statute explains that only valid holders of registry cards are exempt from prosecution.⁹⁹ Second, however, those who do not hold valid registry cards, but have been diagnosed as having a “chronic or debilitating condition,” and who

would be a win-win situation,” said Chuck Thomas, director of communications for the Washington, D.C. - based Marijuana Policy Project. “The federal government will probably ignore it - - which would help countless patients in Maine and inspire other states to adopt similar laws.”

Id. However, the proposal died in 2001. Lisa Chmelecki, *Medical Marijuana*, at <http://www.cannabisnews.com/news/13/thread13951.shtml> (Sept. 1, 2002).

95. Scott McKenna, *Medical Marijuana Laws in the Silver State*, 10 NEV. LAW. 6, 6 (2002). See the resulting amendment to the Nevada Constitution at NEV. CONST. art. 4, § 38.

96. *Id.* art. 4, § 38(1)(a). The list of conditions is similar to the list found in section 2383-B of the Maine Revised Statutes Annotated. The listed conditions are cancer, glaucoma, AIDS, seizures, and muscle spasms. *Id.* However, this provision expressly provides that marijuana could be used for “other conditions approved pursuant to law for such treatment.” *Id.*

97. *Id.* art. 4, § 38(1)(d). The Nevada Legislature, in its 2001 session, dutifully created legislation that allowed the use of medical marijuana in Nevada. McKenna, *supra* note 95, at 6. The resulting statute is § 453A.200 of the Nevada Revised Statutes. This statute “functions as an exception to Nevada’s law on controlled substances (chapter 453 of NRS).” *Id.* at 36.

98. NEV. REV. STAT. 453A.200 (2003) (emphasis added).

99. *Id.* 453A.200(3). “The exemption from state prosecution . . . applies only to the extent that a person . . . holds a registry identification card.” *Id.* Individuals may obtain registry cards by submitting “written documentation” from their physician that they have “been diagnosed with a chronic or debilitating medical condition,” that medical marijuana may assist in the care of that condition, and the doctor has described the “possible risks and benefits of the medical use of marijuana.” *Id.* 453A.210(2)(a). This registry program was designed in order to assure that “only people who are legitimately ill may participate in the program.” McKenna, *supra* note 95, at 37. The registry system seems to be working, as recreational marijuana users tend to “give up” in their efforts to obtain marijuana under the program, after discovering the requirements necessary to obtain a registry card. *Id.*

have been informed by their doctor that marijuana may be an effective treatment for that condition, have an affirmative defense against any charge “in which possession, delivery or production of marijuana is an element.”¹⁰⁰ In either case, however, the patient may not possess more than one ounce of marijuana and seven marijuana plants.¹⁰¹

8. Oregon

The Oregon Medical Marijuana Act, also approved by voter initiative, first explains that the people of Oregon have found that marijuana is an effective treatment for certain medical conditions, that Oregonians should be allowed to use marijuana to treat “debilitating medical conditions,” and that Oregonians should be allowed to discuss, without fear of criminal liability, the efficacy of medical marijuana.¹⁰² To that end, Oregon has provided that those individuals who suffer from a “debilitating medical condition” may apply to the Oregon Department of Human Services for a registry card.¹⁰³

Like Nevada, Oregon offers users of medical marijuana two separate protections. Holders of these cards in Oregon are “excepted from the criminal laws of the state for possession, delivery or production of marijuana.”¹⁰⁴ Users of medical marijuana who do not possess a valid registry card may assert an affirmative defense to criminal charges of possession or production of marijuana.¹⁰⁵ Finally, if marijuana or marijuana paraphernalia is seized from a user of medical marijuana, should the state determine that the user is legitimately entitled to possess the marijuana under this law, the state must give the user back her marijuana.¹⁰⁶

100. NEV. REV. STAT. 453A.310.

101. *Id.* 453A.200(3)(b).

102. OR. REV. STAT. § 475.300 (2001). The entire text of the Oregon Medical Marijuana Act can be found at Section 475.300-346.

103. *Id.* § 475.309. The requirements for obtaining a registry card are similar to those in states already discussed. The patient must provide written documentation from her physician that she has been properly diagnosed with a “debilitating medical condition,” and that her condition might be helped by marijuana. *Id.* § 475.309(2)(a). This statute does not provide a list of conditions that would qualify a patient for a registry card. *Contra* ME. REV. STAT. ANN. tit. 22 § 2383-B(5)(A)(1) (providing a list of conditions that, when properly diagnosed and documented by a physician, allow a patient the lawful access to medical marijuana).

104. OR. REV. STAT. § 475.309(1). *Cf.* NEV. REV. STAT. 453A.200 (exempting registry cardholders from prosecution for possession or manufacture of marijuana).

105. OR. REV. STAT. § 475.319(2). *Cf.* NEV. REV. STAT. 453A.310 (offering those without registry cards an affirmative defense to prosecution).

106. OR. REV. STAT. § 475.323(2). This statute was tested in *Oregon v. Kama*. There, the City of Portland seized Kama’s medical marijuana, but was

9. Vermont

The state of Vermont recently passed a bill allowing the use of medical marijuana for “debilitating medical conditions.”¹⁰⁷ Under this statute, patients using marijuana for legitimate medical reasons, with a valid registration card, are exempt from “arrest or prosecution” for possession of marijuana.¹⁰⁸

10. Washington

On November 3, 1998, voters in the state of Washington passed an initiative that allowed the use of medical marijuana.¹⁰⁹ Patients may possess and use medical marijuana with “valid documentation” from a physician attesting that in the physician’s professional opinion, “the potential benefits of the medical use of marijuana would likely outweigh the health risks” for that patient.¹¹⁰ Patients may not “use or display medical marijuana” in public,¹¹¹ and may possess no more than a sixty-day supply of marijuana.¹¹²

later ordered to return it to him, as he was determined to be a valid medical marijuana user. *Oregon v. Kama*, 39 P.3d 866, 867 (Or. Ct. App. 2002). The City refused to return his medicine, arguing that such action would violate federal laws against the delivery of a controlled substance. *Id.* Both the trial and appellate courts rejected the State’s arguments, holding that federal law exempted police officers from criminal liability when those officers were acting pursuant to law. *Id.* at 867-68.

107. VT. STAT. ANN. tit. 18 § 4473(a), available at: <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2004/bills/passed/S-076.HTM>.

108. *Id.*

109. *Washington v. Shepherd*, 41 P.3d 1235, 1236 (Wash. Ct. App. 2002). The initiative was codified as the Washington State Medical Use of Marijuana Act. WASH. REV. CODE § 69.51A (2003). A sense of compassion for the sick was the driving force behind this legislation.

The people find that humanitarian compassion necessitates that the decision to authorize the medical use of marijuana by patients with terminal or debilitating illnesses is a personal, individual decision, based upon their physician’s professional medical judgment and discretion.

Id. § 69.51A.005.

110. WASH. REV. CODE § 69.51A.030. This statute does not require a registry card, but rather only a signed statement from a doctor. See *Shepherd*, 41 P.3d at 1238 (explaining exactly what this statement must include). The statement must indicate that the physician is convinced, “to a level of medical certainty required of experts in courts,” that marijuana will benefit a certain patient, and will “outweigh the health risks” for that patient. *Id.* A statement indicating that marijuana may “outweigh the risks” is insufficient. *Id.*

111. WASH. REV. CODE § 69.51A.060(1).

112. *Id.* § 69.51A.040(4)(b). The patient apparently has the burden of proving that the amount of marijuana he possesses falls within this limit. See *Shepherd*, 41 P.3d at 1239 (indicating that where the patient could not establish how much marijuana he needs to mitigate his condition, his showing was “insufficient to meet the requirements of the Act”).

11. Maryland

Maryland has not legalized the use of medical marijuana. This state has, however, enacted legislation that gives users of medical marijuana some statutory relief. First, if an individual is prosecuted for the “use or possession of marijuana, the defendant may introduce and the court shall consider as a mitigating factor any evidence of medical necessity.”¹¹³ In addition, should a court find a defendant in possession of marijuana “because of medical necessity . . . the maximum penalty that the court may impose on the person is a fine not exceeding \$100.”¹¹⁴

12. Illinois

Illinois has also not legalized the use of medical marijuana. The Medical Cannabis Act, which would have made Illinois the eleventh state to legalize the medical use of marijuana, was recently presented to the Illinois state legislature.¹¹⁵ This bill was sent to a subcommittee, which is “equivalent to a legislative wasteland,” in early March of 2004.¹¹⁶ The prospects for legalized medical marijuana in Illinois in the near future look grim.

C. The Federal Controlled Substances Act

Congress enacted The Controlled Substances Act in 1970.¹¹⁷ Under this Act, five “schedules” of drugs and chemicals were established.¹¹⁸ Marijuana was classified as a Schedule I controlled substance, which means that marijuana “has no currently accepted medical use in treatment in the United States.”¹¹⁹ Most important, it is illegal to knowingly or intentionally “manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance,” unless otherwise

113. MD. CODE ANN., [Criminal] § 5-601(c)(3)(i) (2002).

114. *Id.* § 5-601(c)(3)(ii).

115. H.B. 4868, 93rd Gen. Assem. (Ill. 2004) This legislation would have allowed any person “who has been diagnosed by a physician as having a debilitating medical condition,” and who has received a valid registry card from the state, to possess and use up to one ounce of cannabis and six marijuana plants. *Id.* This legislation was introduced by Angelo Saviano, Larry McKeon, and Susana Mendoza on February 4, 2004. *Id.*

116. Leslie Griffey, *Marijuana Bill Set Aside Before It Gets a Hearing*, CHI. SUN TIMES, March 3, 2004, at 18.

117. 21 U.S.C. §§ 801-904 (2003). See *Raich II*, 352 F.2d at 1222, and *National Organization for the Reform of Marijuana Laws (NORML) v. Drug Enforcement Admin.*, 559 F.2d 735, 737-740 (D.C. Cir. 1977) (offering brief overviews of the Controlled Substances Act).

118. 21 U.S.C. § 812 (2003).

119. *Id.* § 812(b)(1)(B). As a Schedule I substance, marijuana is also classified as having “a high potential for abuse.” *Id.* § 812(b)(1)(A). It is classified as unsafe to consume, even “under medical supervision.” *Id.* § 812(b)(1)(C).

provided by the Controlled Substances Act.¹²⁰ It is also illegal to possess a controlled substance, again unless otherwise provided for by this Act.¹²¹ It is interesting to note that Congress has expressly found that a number of the drugs classified within this Act do have “a useful and legitimate medical purpose.”¹²² Marijuana, as a Schedule I substance, is not one of those substances,¹²³ although unsuccessful legislative efforts have been made to reschedule marijuana as a Schedule II substance.¹²⁴

The United States Supreme Court was asked to interpret the status of medical marijuana under this statute in *United States v. Oakland Cannabis Buyers' Cooperative*.¹²⁵ After California passed its Compassionate Use Act, which allowed the use of medical marijuana in that state,¹²⁶ a number of organizations created “medical cannabis dispensaries,” that would provide marijuana to patients.¹²⁷ The Oakland Cannabis Buyer's Cooperative (“Co-op”) was sued by the federal government, which sought to halt the Co-op's distribution of marijuana to its patients.¹²⁸ The federal district court granted the injunction, but the Co-op continued to distribute marijuana, and eventually appealed the case to the Ninth Circuit Court of Appeals.¹²⁹ The Co-op asserted a defense of medical necessity, which the Ninth Circuit, in reversing and remanding, found was a “legally cognizable defense.”¹³⁰

120. *Id.* § 841(a)(1).

121. *Id.* § 844(a).

122. *Id.* § 801(1). While marijuana is classified as having no legitimate medical purpose, opium and cocaine are classified as Schedule II substances. *Id.* § 812(b). Schedule II substances are classified as having “a currently accepted medical use in treatment in the United States.” *Id.*

123. See *Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 930 F.2d 936, 937 (D.C. Cir. 1991) (indicating that “[Schedule I substances] are deemed to be the most dangerous substances, possessing no redeeming value as medicines”). Following the classification of marijuana as a Schedule I substance, various groups made several unsuccessful attempts to have marijuana's classification changed. See, e.g., *id.* (remanding for further inquiry); *NORML*, 559 F.2d at 735 (noting the “ongoing controversy” surrounding marijuana's classification).

124. See H.R. 2233, 108th Cong. § 2(a) (1st Sess. 2003) (proposing to reschedule marijuana as a Schedule II substance).

125. 532 U.S. 483 (2001).

126. See *infra* Part II B 3 and accompanying notes (examining this statute and attending case law).

127. *Oakland*, 532 U.S. at 486. Patients were required to provide written documentation from their physician indicating that the physician approved of “marijuana therapy,” and to “submit to a screening interview.” *Id.*

128. *Id.* at 487. Despite the government's claim that the Co-op. was in violation of the Controlled Substances Act, which provides that violators may be subject to criminal penalties, the government sought only to enjoin the Co-op. from “distributing and manufacturing marijuana.” *Id.*

129. *Id.* at 487-89.

130. *Id.* at 488. The defense of necessity has four elements. Brief for the Respondents at 4, *United States v. Oakland Cannabis Buyer's Coop.*, 532 U.S.

The Supreme Court, however, held that given the express statutory language of the Controlled Substances Act, the medical necessity defense was not available to the Co-op.¹³¹ The Court noted that Congress has expressly indicated that marijuana has no medical value whatsoever.¹³² This determination, the Court reasoned, strictly foreclosed any further inquiry into a defense of necessity.¹³³

However, there may be one small ray of sunshine poking through these dark clouds for supporters of medical marijuana. The Ninth Circuit, in *Raich v. Ashcroft*, found that the Controlled Substances Act was likely unconstitutional under the commerce clause.¹³⁴ In this case, two California citizens, Diane Monson and Angel Raich, grew and used medical marijuana pursuant to California state law.¹³⁵ However, federal agents seized Monson's plants after a tense standoff with local law enforcement personnel.¹³⁶ Monson and Raich sued the federal government, seeking a declaration that the Controlled Substances Act was unconstitutional, and an injunction preventing federal agents from seizing their cannabis.¹³⁷

The Ninth Circuit Court of Appeals noted that the Controlled Substance Act was passed "under the *Commerce Clause of the Constitution*."¹³⁸ The court reasoned that the plaintiffs' marijuana growing activities did not constitute participation in interstate commerce, as the marijuana was grown and consumed locally.¹³⁹ A preliminary injunction in the plaintiffs favor was granted, and the

483 (2001) (No. 00-151). The elements are the following: the party asserting the defense chose the lesser of a number of evils; the choice was made in order "to prevent imminent harm"; the party reasonably expected that his or her action would prevent the harm; and "there were no other legal alternatives to violating the law." *Id.* Here, the Co-op. argued that its patients faced just such a choice. *Id.* at 5. These patients could either violate the federal law, or suffer "from debilitating pain, life-threatening illness, or loss of sight." *Id.*

131. *Oakland*, 532 U.S. at 491-95.

132. *Id.* at 491. "[T]he statute reflects a determination that marijuana has no medical benefits worthy of an exception." *Id.*

133. *Id.* When a legislature has made what the Court calls a "determination of values," (such as the value determination that marijuana has no legitimate medical use) there can be no necessity defense that would override that "determination." *Id.*

134. *Raich II*, 352 F.3d at 1227.

135. *Id.* at 1225-26.

136. *See supra* Introduction (explaining the factual background to this case).

137. *Raich II*, 352 F.3d at 1226. The case came to the Ninth circuit on interlocutory appeal after the district court found plaintiffs Raich and Monson had not established a minimum "likelihood of success." *Id.*

138. *Id.* at 1227.

139. *Id.* at 1233. "Medical marijuana, when grown locally for personal consumption, does not have any direct or obvious effect on interstate commerce." *Id.*

case was remanded back to the district court.¹⁴⁰ This case will ultimately be decided by the United States Supreme Court.¹⁴¹

D. Conclusion

The contrast between federal and state law on the issue of medical marijuana is clear. Ten states have legalized the use of medical marijuana, although Arizona's legalization of medical marijuana is admittedly illusory. The federal Controlled Substances Act, however, prohibits the possession or use of marijuana, and the United States Supreme Court, in *Oakland*, has strictly interpreted this statute. Advocates of medical marijuana therefore seem to face an uncertain future.

III. MEDICAL MARIJUANA FROM THE POINT OF VIEW OF THE MEDICAL PROFESSION: BENEFITS AND SIDE EFFECTS

A. Introduction

Part III of this article will examine medical marijuana from the point of view of the medical profession. Part III will first offer an introduction to physicians' arguments for and against medical marijuana. Then, Part III will examine medical arguments regarding the efficacy of marijuana in treating some specific conditions. Finally, Part III will describe the harmful side effects that often accompany the use of marijuana.

The simplest argument in favor of medical marijuana is that marijuana works. "The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana."¹⁴² Medical studies have shown marijuana to be an effective treatment for conditions such as pain, nausea, and loss of appetite.¹⁴³ There is also anecdotal evidence that marijuana is effective in treating conditions such as glaucoma, epilepsy, migraine headaches, and multiple sclerosis.¹⁴⁴ In addition, some argue that marijuana is a

140. *Id.* at 1235.

141. Ashcroft, 124 S. Ct. 2909.

142. Kassirer, *supra* note 31, at 366.

143. MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE viii (Janet E. Joy et al. eds. 1999) [hereinafter MARIJUANA AND MEDICINE]. The Institute of Medicine issued this report in response to a request from the White House Office of National Drug Control Policy. *Id.* at vii. The White House requested that the Institute of Medicine undertake this study following several state initiatives legalizing medical marijuana. *Id.* See also *supra* Part II (reviewing various state medical marijuana statutes).

144. GRINSPOON & BAKALAR, *supra* note 30, at chs. 2-3. Anecdotal evidence consists of reports of individual users who have had favorable experiences

safe medicine. "Marihuana in its natural form is possibly the safest therapeutically active substance known."¹⁴⁵ Although there are some side effects that accompany the use of marijuana, these effects are "within the range tolerated for other medications."¹⁴⁶

However, others argue that marijuana has not been proven, in valid controlled studies, to be anything more than moderately efficient in treating various conditions. "The effects of cannabinoids on the symptoms studied are generally modest, and in most cases there are more effective medications."¹⁴⁷ Some studies show that marijuana is not as efficient a treatment for pain or nausea as are currently available medications.¹⁴⁸ In addition, marijuana use does have significant harmful side effects. The use of marijuana has "acute" side effects, such as a "high,"¹⁴⁹ "diminished psychomotor performance," and "chronic" side effects, such as risk of lung damage and cancer (for smoked marijuana), and the possibility of patients developing dependence on marijuana.¹⁵⁰ The moderate efficiency of medical marijuana, combined with marijuana's harmful side effects, lead some physicians to suggest that marijuana, on balance, does not have positive medical value.¹⁵¹

B. Pain

There is evidence from controlled studies that marijuana is an effective analgesic (i.e., pain reliever).¹⁵² In one study, oral THC (the active chemical compound in marijuana) proved to relieve

with medical marijuana. *Id.* at 228-29. In contrast, "controlled studies" are scientifically valid experiments used to determine whether marijuana is more effective for a group of individuals than other medications. *Id.* at 226-27. These studies must be well designed, in order to assure that there is sufficient diversity between patients, and must discern between the actual effects of marijuana and effects attributable to a patient's subjective reaction to the marijuana, or effects otherwise independent of the marijuana itself. MARIJUANA AND MEDICINE, *supra* note 143, at 138-39.

145. GRINSPOON & BAKALAR, *supra* note 30, at 235.

146. MARIJUANA AND MEDICINE, *supra* note 143, at 126-27. The editors stress, however, that there are serious harms that accompany the smoking of marijuana. *Id.* at 126.

147. *Id.* at 3.

148. Eija Kalso, *Cannabinoids for Pain and Nausea: Some Evidence But Is There Any Need?*, 323 BRIT. MED. J. 2, 2 (2001), <http://bmj.bmjournals.com/cgi/reprint/323/7303/2>. Kalso concedes that marijuana has some positive effect on patients suffering from these conditions. *Id.*

149. MARIJUANA AND MEDICINE, *supra* note 143, at 83-84. A "high" is described as a "sense of well-being or euphoria and increased talkativeness and laughter alternating with periods of introspective dreaminess followed by lethargy and sleepiness." *Id.* at 83.

150. *Id.* at 126.

151. Kalso, *supra* note 148, at 3. "[T]he current information is that the adverse effects of cannabinoids outweigh their effectiveness." *Id.*

152. GRINSPOON & BAKALAR, *supra* note 30, at 110-11.

pain in cancer patients for several hours.¹⁵³ In another study, THC was shown to be as effective as codeine in relieving pain in advanced stage cancer patients.¹⁵⁴ In general, studies tend to show that cannabinoids are “mild to moderate analgesics.”¹⁵⁵

Studies of the effects of cannabinoids on pain focus on two types of pain: acute pain, and chronic pain.¹⁵⁶ Marijuana does not seem to be an effective analgesic for acute pain, such as post-operative pain.¹⁵⁷ However, there is considerable evidence, from both controlled studies and anecdotes, that marijuana is an effective pain reliever for those suffering from chronic (persistent) pain.¹⁵⁸ Researchers have found that cannabinoids are effective in relieving cancer pain, offer patients a sedative effect, and tend to improve the mood of patients, while lowering patients’ anxiety levels.¹⁵⁹ One patient, who suffered from painful bone cancer, indicated that “marihuana has effectively controlled my pain and allowed me to reduce my use of conventional (and far more dangerous) drugs like Sopor, Dilantin, and Dilaudid.”¹⁶⁰ Researchers indicate that marijuana warrants further study into its effectiveness for numerous types of chronic pain,¹⁶¹ but that as things stand, “the available evidence . . . indicates that cannabinoids can have a substantial analgesic effect.”¹⁶²

C. Nausea and Vomiting

A number of medical conditions can cause emesis (nausea and vomiting). Many patients undergoing cancer chemotherapy suffer from emesis as a side effect of the “chemotherapeutic drugs.”¹⁶³ The vomiting and nausea accompanying chemotherapy has proven

153. *Id.* at 110. THC demonstrated sedative effects as well. *Id.*

154. *Id.*

155. MARIJUANA AND MEDICINE, *supra* note 143, at 140. Joy notes that “opiates” (i.e., drugs like morphine and codeine) are most often prescribed for acute pain, but these drugs are not “consistently effective” in treating chronic pain, and are accompanied by undesirable side effects. *Id.*

156. *Id.* at 141-43.

157. *Id.* at 142. See also Campbell, *supra* note 34 (indicating that “cannabinoids [are] unlikely to be useful . . . for moderate or severe postoperative pain.”)

158. MARIJUANA AND MEDICINE, *supra* note 143, at 142-43.

159. *Id.*

160. GRINSPOON & BAKALAR, *supra* note 30, at 118. This patient does, however, acknowledge some adverse effects to his lungs due to smoking marijuana. *Id.*

161. MARIJUANA AND MEDICINE, *supra* note 143, at 144-45. The chronic pain conditions that warrant further study are chemotherapy, postoperative pain, spinal cord injuries, and AIDS. *Id.*

162. *Id.* at 145.

163. *Id.* at 146-47. Other conditions that can cause emesis are viral illness, cancer itself, “postoperative recovery, pregnancy, motion, and poisoning.” *Id.* at 145.

so devastating for some cancer patients that some have chosen to forego chemotherapy altogether.¹⁶⁴ There is evidence from controlled studies that THC is an effective treatment for “chemotherapy-induced emesis.”¹⁶⁵ In addition, marijuana, in controlled studies, was rated as “moderately or highly effective” by thirty-four percent of chemotherapy patients.¹⁶⁶

There is also anecdotal evidence as to marijuana’s effectiveness as an anti-emetic. The following is one of these anecdotes. Fourteen-year old “Danny,” who suffered from leukemia, experienced terrible spells of vomiting after his chemotherapy treatments.¹⁶⁷ His vomiting would continue unabated for up to eight hours after treatment, and he would understandably become quite anxious prior to these treatments.¹⁶⁸ His father reported what happened after Danny smoked marijuana prior to one treatment.

He did not protest as he was given the medicine, and we were all delighted when no nausea or vomiting followed. On the way home, he asked his mother if we could stop for a submarine sandwich, and when he got home he began his usual activities instead of going straight to bed. We could scarcely believe it.¹⁶⁹

Physicians acknowledge that there are patients like Danny, for whom standard anti-emetics simply do not work.¹⁷⁰ For these patients, the admittedly “harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana”¹⁷¹ In addition, patients experiencing

164. *Id.* at 147. Grinspoon and Bakalar write,

Retching (dry heaves) may last for hours or even days after each treatment, followed by days and even weeks of nausea. Patients may break bones or rupture the esophagus while vomiting. The sense of loss of control can be emotionally devastating. Furthermore, many patients eat almost nothing because they cannot stand the sight or smell of food. As they lose weight and strength, they find it more and more difficult to sustain the will to live.

GRINSPOON & BAKALAR, *supra* note 30, at 24.

165. MARIJUANA AND MEDICINE, *supra* note 143, at 148. See also D.A. Treffert and D.E. Joranson, *Delta 9-Tetrahydrocannabinol and Therapeutic Research Legislation for Cancer Patients*, 249 JAMA 1469 (1983) (concluding that THC “does relieve nausea and vomiting in some cancer chemotherapy patients, but adverse side effects are prevalent”).

166. MARIJUANA AND MEDICINE, *supra* note 143, at 149.

167. GRINSPOON & BAKALAR, *supra* note 30, at 26.

168. *Id.*

169. *Id.* Danny’s experience prompted doctors to undertake “the first clinical experiment on the use of cannabis in cancer chemotherapy.” *Id.* at 27.

170. MARIJUANA AND MEDICINE, *supra* note 143, at 154.

171. *Id.* These physicians, however, are wary of the negative side effects of smoking marijuana, and hope that someday a “rapid-onset antiemetic drug delivery system” can be developed that could introduce cannabinoids to the system without smoking. *Id.* Until that day comes, however, there is cautious approval by some physicians for the smoking of marijuana to relieve

emesis express a strong preference for marijuana treatment.¹⁷² Physicians acknowledge that the subjective preference of patients is "more important than the scientifically evaluated efficacy" of marijuana.¹⁷³

D. AIDS and Wasting Syndrome

Patients suffering from acquired immune deficiency syndrome (AIDS) may experience significant involuntary weight loss.¹⁷⁴ This weight loss can be exacerbated by a common anti-AIDS drug, AZT.¹⁷⁵ AIDS patients therefore "need to maintain their appetite and body weight because they may be in danger of wasting away."¹⁷⁶ There is ample anecdotal evidence that marijuana stimulates the appetite.¹⁷⁷ Controlled studies also show that marijuana is a very effective appetite stimulant.¹⁷⁸ Cannabinoids have also been shown to be effective in stimulating appetite, and promoting weight gain in cancer patients.¹⁷⁹

E. Other Conditions

There is anecdotal evidence that marijuana is an effective treatment for many other conditions.¹⁸⁰ This section will focus briefly on two conditions for which there is also some controlled study evidence of marijuana's effectiveness.

1. Multiple Sclerosis

Multiple sclerosis (MS) affects the central nervous system by damaging nerve fibers.¹⁸¹ Patients develop muscle "spasticity," in which muscles become stiff, inflexible, and prone to spasms and cramping.¹⁸² THC treatment has been shown, in controlled studies, to lessen this spasticity to some extent.¹⁸³ There is also

chemotherapy-induced nausea and vomiting. *Id.*

172. Tramer et al., *supra* note 33.

173. *Id.*

174. MARIJUANA AND MEDICINE, *supra* note 143, at 154. This weight loss often follows diarrhea or fever in AIDS patients. *Id.*

175. GRINSPOON & BAKALAR, *supra* note 30, at 101.

176. *Id.*

177. *Id.*

178. *Id.* at 101-02. See also MARIJUANA AND MEDICINE, *supra* note 143, at 156 (concluding that "[i]n controlled laboratory studies of healthy adults, smoked marijuana was shown to increase body weight, appetite, and food intake").

179. MARIJUANA AND MEDICINE, *supra* note 143, at 158.

180. GRINSPOON & BAKALAR, *supra* note 30, at chs. 2-3. Grinspoon and Bakalar list twelve "common" medical uses of marijuana, and twenty "less common" medical uses. *Id.*

181. MARIJUANA AND MEDICINE, *supra* note 143, at 160.

182. *Id.*

183. *Id.* This treatment was not always effective, and often caused "unpleasant side effects." *Id.*

anecdotal evidence of marijuana's effectiveness in treating MS. Greg Paufler succinctly explained the results of treating his MS with marijuana: "I can stand on one foot with my eyes closed. I walk completely unaided. I can actually run!"¹⁸⁴ It has been suggested that further controlled studies of marijuana's effect on MS would be useful.¹⁸⁵

2. Glaucoma

Glaucoma is a disorder of the eye in which "intraocular pressure" rises to an unacceptable level.¹⁸⁶ The result can be a gradual loss of vision; in some cases blindness results.¹⁸⁷ Controlled studies show that marijuana unquestionably reduces intraocular pressure.¹⁸⁸ However, the effect of marijuana on intraocular pressure lasts only three to four hours, making marijuana of dubious effect in treating this condition.¹⁸⁹

F. The Side Effects of Medical Marijuana

All medicines have side effects, and marijuana is no exception. Those who use medical marijuana may experience a variety of acute or chronic side effects.¹⁹⁰ Acute side effects include loss of psychomotor control, "impaired performance of complex tasks," dysphoria (depression), paranoia, and hallucinations.¹⁹¹ Chronic effects include increased risks of cancer and lung damage associated with smoking, and possible dependence on THC.¹⁹²

The extent of the severity of these side effects is an unsettled question among medical researchers. Some argue that the side effects of marijuana are no worse than those of other medications.¹⁹³ Others argue that the side effects of marijuana preclude its use as medicine.¹⁹⁴ Still others argue that marijuana may be the safest therapeutic substance in existence today.¹⁹⁵

184. GRINSPOON & BAKALAR, *supra* note 30, at 86.

185. MARIJUANA AND MEDICINE, *supra* note 143, at 161.

186. *Id.* at 173.

187. *Id.* In fact, "glaucoma is the second-leading cause of blindness in the world." *Id.*

188. *Id.* at 174. Marijuana works as well as any other available medicine in reducing intraocular pressure, reducing pressure up to twenty-five percent after a single treatment. *Id.*

189. *Id.*

190. MARIJUANA AND MEDICINE, *supra* note 143 at 125-27. An acute side effect is one that results from a single use of medical marijuana. *Id.* at 125-26. A chronic side effect is one that results from repeated uses. *Id.*

191. *Id.* at 126; Tramer et. al., *supra* note 33.

192. MARIJUANA AND MEDICINE, *supra* note 143, at 126.

193. *Id.* at 126-27. The editors conclude that although marijuana does have adverse side effects, "the safety issues associated with marijuana do not preclude some medical uses." *Id.* at 127.

194. Kalso, *supra* note 148, at 3.

195. GRINSPOON & BAKALAR, *supra* note 30, at 235.

G, Conclusion

The available medical research indicates that marijuana is an effective treatment for chronic pain, nausea and vomiting, and loss of appetite due to cancer chemotherapy.¹⁹⁶ Patients who have undergone medical marijuana treatment express a strong preference for marijuana as opposed to other medications.¹⁹⁷ Some argue that this preference is more important than what the medical research shows. "What really counts for a therapy . . . is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial 'proves' its efficacy."¹⁹⁸ Marijuana also presents many opportunities for future medical research projects, and researchers are optimistic that "medically useful cannabinoid-based drugs" can be developed.¹⁹⁹

However, marijuana treatment has side effects, particularly when the patient smokes marijuana. Some argue the side effects are minimal, and that marijuana is a "relatively benign" substance.²⁰⁰ Others, however, argue that the side effects of marijuana are significant enough to preclude its effect as medicine.²⁰¹

The current state of research on medical marijuana therefore indicates that marijuana is (1) an effective treatment for certain medical conditions, (2) preferred by patients, and (3) presents significant opportunities for future research projects, but (4) has side effects of arguable seriousness.

IV. PERSONAL AUTONOMY

A. Introduction

The notion of autonomy may well have no single definition that satisfies all moral and political philosophers.²⁰² However, philosophers do agree that the concept of "self-government" is central to autonomy.²⁰³ "The autonomous man has a mind of his

196. MARIJUANA AND MEDICINE, *supra* note 143, at 177.

197. Tramer et al., *supra* note 33. Patients "overwhelmingly" preferred cannabinoids for treatment of chemotherapy-induced emesis. *Id.*

198. Kassirer, *supra* note 31.

199. MARIJUANA AND MEDICINE, *supra* note 143, at 177.

200. GRINSPOON & BAKALAR, *supra* note 30, at 234-35. Arguments that marijuana is a "gateway" drug that inevitably leads to the use of harder drugs are not supported by the current medical research. MARIJUANA AND MEDICINE, *supra* note 143, at 98-101.

201. Kalso, *supra* note 148, at 3.

202. John Christman, *Constructing the Inner Citadel: Recent Work on the Concept of Autonomy*, 99 ETHICS 109, 109 (1988) [hereinafter Christman, *Citadel*]. Christman notes that the concept of autonomy really has no "single meaning." *Id.*

203. *Id.* The origins of the word "autonomy" are the Greek words *autos* and *nomos*, which together mean "self-rule." Thomas May, *The Concept of*

own and a will of his own. He exercises independence in his thinking and his decisions about practical affairs.²⁰⁴ The autonomous individual is able to determine what she values in life, and also has the power to pursue those goals free from undue external influences.²⁰⁵ Autonomy is thus essentially the notion that humans are, or, more properly, ought to be, self-governed or self-directed in terms of their choices, their actions, and the direction of their lives.²⁰⁶

Autonomy is distinguishable from freedom. One is free if there are no external constraints on one's actions.²⁰⁷ An individual could, however, be free without being autonomous. Suppose X is acting under hypnosis, but faces no restraints on her actions from any external source.²⁰⁸ X would be acting freely, but since X's actions were not a product of her own desires and choices, X would not be acting autonomously.²⁰⁹ Freedom, or the lack of it, impacts one's ability to act; autonomy, or the lack of it, impacts one's ability to decide for one's self just how one will act.²¹⁰

This section will first explain what conditions must occur for a person to achieve true autonomy.²¹¹ These conditions are psychological²¹² and social²¹³ in nature. Next, this section will explain two different notions of what, exactly, it means for a person to be autonomous. Some thinkers argue that autonomy is a virtue, or a positive character trait.²¹⁴ Other thinkers argue that autonomy is a right individuals hold to have their choices and

Autonomy, 31 AM. PHIL. Q. 133, 139 (1994).

204. John Benson, *Who Is the Autonomous Man?*, 58 PHIL. 5, 6 (1983).

205. Marina A. L. Oshana, *Personal Autonomy and Society*, 29 J. SOC. PHIL. 81, 82 (1998).

206. *Id.* This does not preclude an autonomous individual from seeking the counsel or assistance of others. *Id.* The truly autonomous person makes her own choices, although those choices may to a certain extent reflect external influences. *Id.*

207. Christman, *Citadel*, *supra* note 202, at 111.

208. *Id.* at 111-12.

209. *Id.*

210. *Id.* at 112. "To be free . . . means there is an absence of restraints . . . standing between a person and the carrying out of that person's *autonomously formed* desires." *Id.*

211. Personal autonomy can be distinguished from group autonomy. Political groups of people may claim to be autonomous; these groups assert that "they ought to be allowed to govern themselves They are insisting . . . that . . . they, and they alone, have the *authority* to determine and enforce the rules and policies that govern their lives." Buss, *supra* note 35.

212. See John Christman, *Autonomy and Personal History*, 21 CANADIAN J. PHIL. 1 (1991) (explaining the psychological conditions necessary for true autonomy).

213. See Oshana, *supra* note 205 (explaining the social conditions necessary for autonomy) [hereinafter Christman, *Personal History*].

214. Benson, *supra* note 204, at 5.

desires given respect and protection.²¹⁵

B. *The Psychological and Social Conditions Necessary for True Autonomy*

1. *Psychological Conditions*

For an individual to be autonomous, two things must be true about the individual's psychological make-up. The individual must actively evaluate her desires and choices,²¹⁶ and the individual cannot "be self-deceived or irrational."²¹⁷

The autonomous individual will engage in an "active assessment" of her environment and the choices that are presented to her in that environment.²¹⁸ The individual will not "simply react" to her environment, but will take an active role in formulating a response to the challenges of that environment.²¹⁹ "Autonomy requires that the [individual] play a significant role in formulating the *content* of her behavior."²²⁰ While engaging in this "active assessment" of her environment and her choices, the individual must act in a rational manner.²²¹ While thinkers differ in precisely what it means to fulfill this rationality requirement, some argue that at a minimum, rationality entails consistency of "beliefs and desires."²²² In addition, the autonomous individual cannot engage in "self-deception."²²³ Self-deception is defined as a process where an individual insists on clinging to certain beliefs she knows are untrue.²²⁴

The psychological conditions that must occur for an individual to be autonomous, then, are that the individual actively assesses her environment and the choices available to her in that environment, and do so in a rational and non-self-deceptive manner.

2. *Social Conditions*

True autonomy only occurs, however, when, in addition to the

215. Christman, *Citadel*, *supra* note 202, at 119.

216. May, *supra* note 203, at 141; Christman, *Personal History*, *supra* note 212, at 11.

217. Christman, *Personal History*, *supra* note 212, at 11.

218. May, *supra* note 203, at 141.

219. *Id.*

220. *Id.*

221. Christman, *supra* note 212, at 14.

222. *Id.* This consistency test is not stringent. Few individuals have completely consistent beliefs and desires. *Id.* The autonomous individual, however, cannot hold "manifestly inconsistent" beliefs and desires, or beliefs and desires that are in "obvious conflict." *Id.* at 15.

223. *Id.* at 16-19.

224. *Id.* at 17. For example, "a person's belief . . . that she does not have cancer in the face of a competent doctor's diagnosis" is self-deception. *Id.*

psychological conditions explained above, certain social conditions exist. First, the autonomous individual must have available to her a legitimate range of alternative actions from which to choose.²²⁵ Secondly, the individual's choices must not be overly restricted by others.²²⁶

The autonomous individual exists within a social context in which she has the ability to make real choices. If an individual's choices are determined purely by her economic or bodily needs, in other words, she is not autonomous.²²⁷ "The social climate must be sensitive to the fact that humans are not brute creatures; they are individuals whose physical and emotional well-being depends on the ability to engage the body and mind variously and creatively."²²⁸

This need for alternatives may be a natural inclination. In experiments conducted on mice that have been trained to run through a maze for food, scientists have noticed that even the well-trained mouse will occasionally take a wrong turn.²²⁹ One hypothesis for these "wrong" turns is that the mice are not, in fact, making mistakes after all.²³⁰ The mouse is simply naturally seeking out alternative ways to find food; the mouse is keeping "its options open."²³¹ In that same way, some argue, autonomous humans constantly seek new and fresh options.

Our success – in gaining knowledge, pursuing science, working out problems – is deeply rooted in the pattern that also guides the foraging of the white-footed mouse. We pursue a path because it is particularly successful, but we do not stop exploring new ones. When the successful behavioral pattern loses its effectiveness we have another alternative ready.²³²

Autonomy thus requires that individuals have "access to genuine alternatives."²³³ The autonomous individual will be able to choose a new alternative if and when a new alternative presents

225. Oshana, *supra* note 205, at 94; Richard N. Waller, *Natural Autonomy and Alternative Possibilities*, 30 AM. PHIL. Q. 73, 74-77 (1993).

226. Oshana, *supra* note 205, at 97. For example, a slave cannot be truly autonomous, as her choices are so constrained by her social situation that she is "incapable of functioning in a self-governing way." *Id.*

227. *Id.* at 94.

228. *Id.*

229. Waller, *supra* note 225, at 74.

230. *Id.* The wrong turn only seems to be wrong from the perspective of the scientist. *Id.* The mouse "has a certain degree of variability built into many of its behavior patterns. This variability is adaptive to conditions in the wild, where there are many relationships that are not strictly prescribed." *Id.*

231. *Id.*

232. *Id.*

233. Waller, *supra* note 225, at 74. The strategy of constantly seeking new alternatives is important to survival. *Id.*

itself as a real possibility.²³⁴ These choices are not made randomly by the autonomous individual, however. To act in a truly autonomous manner, the individual will intelligently and rationally choose alternative actions that seem legitimately productive to her.²³⁵ For the individual to be truly autonomous, however, these alternatives must first actually exist within that individual's social situation.

For these alternatives to exist, the individual must "find herself within a set of relations with others that enable her to pursue her goals in a context of social and psychological security."²³⁶ True autonomy requires that the individual feel secure in her social context in two ways. The autonomous individual first feels secure from assault or deprivation of her rights.²³⁷ She also feels safe in holding values or preferences different from the values and preferences of those in authority.²³⁸ If the individual does not feel secure in holding these values or preferences, either because those in authority are actively interfering with her preferences, or because she feels that holding those preferences carries with it a significant "risk of reprisal," the individual does not exist within a social milieu that allows her full autonomy.²³⁹ A truly autonomous individual will therefore possess a feeling of security and control over the social context in which she finds herself.²⁴⁰

3. *Summary*

The autonomous individual, then, will be an individual for which certain psychological and social conditions are true. She will actively evaluate her desires and choices, and those choices will be rational and not self-deceptive. She will also, however, exist within a social context in which she has legitimate alternative choices for action, feels secure from harm, and free to hold values and preferences that are different from the values and preferences of those in authority.

C. Autonomy as a Virtue

Some thinkers envision autonomy as a positive character

234. *Id.* at 76.

235. *Id.*; Oshana, *supra* note 205, at 94.

236. Oshana, *supra* note 205, at 94.

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.* at 97. An individual in a very restrictive social environment, for example a slave, could well have preferences and desires that are autonomous in the psychological sense. *Id.* However, the slave's social situation is far too constraining for the slave to actually be a truly autonomous person. *Id.*

trait.²⁴¹ A positive character trait, or a virtue, is defined as a mean or moderate state between a deficiency and an excess of a particular characteristic.²⁴² For example, bravery is the mean state between rashness and cowardice.²⁴³ Bravery is therefore a virtue. Autonomy has been defined as the mean, or virtuous, state between the deficiency of passiveness and the excess of arrogance.²⁴⁴

The autonomous person, then, will not be overly dependent on the judgments and advice of others, nor will she rely only on her own judgment when it would be prudent to accept the counsel of other individuals.²⁴⁵ The virtue of autonomy does not require that one never accept the advice of others; to do so would be to exhibit the vice of arrogance.²⁴⁶ The autonomous individual can and will accept the advice of others, provided she has reason to think the advice is reliable,²⁴⁷ but she will rarely engage in the “unreflective acceptance of authority.”²⁴⁸ The autonomous individual thus exhibits the virtue, or the strength of character, in which she thinks for herself and makes independent judgments, but also is willing to accept the counsel of others when she has good reason to do so.²⁴⁹

D. Autonomy as a Right

Autonomy has also been described as a right individuals have to be treated in a certain manner.²⁵⁰ On this view, the autonomous individual has a right against actions of others that would “interfere with [her] ability to control a certain area of [her] own life that should be left strictly to [her].”²⁵¹ Autonomy is thus, in

241. Benson, *supra* note 204, at 5.

242. ARISTOTLE, *NICOMACHEAN ETHICS* 44 (Terence Irwin trans., Hackett Publishing Co. 1985). The mean state is relative to the individual in question. *Id.*

243. *Id.* at 73-74.

244. Benson, *supra* note 204, at 5.

245. *Id.* at 5-6.

246. *Id.* “Autonomy, then, is compatible with the acceptance of testimony [of others].” *Id.* at 8.

247. *Id.* The autonomous individual, however, must not simply accept the advice or counsel of another when she is in a position to investigate matters herself. *Id.*

248. *Id.* at 10-11. The autonomous individual may, on occasion, accept without question the “competent authority” of others regarding matters of scientific fact, such as whether smoking damages one’s health. *Id.* at 11.

249. Benson, *supra* note 204, at 8.

250. Christman, *Citadel*, *supra* note 202, at 110.

251. *Id.* Groups can also claim a right to self-government. Christman, *Autonomy*, *supra* note 35.

When people living in some region of the world declare that their group has the right to live autonomously, they are saying that they ought to be allowed to govern themselves. In making this claim, they are, in essence, rejecting the political and legal authority of those not in their

addition to a positive character trait, a "right to be treated as a free and equal moral person, a fundamental human right."²⁵²

When an individual claims that she is autonomous, she is denying that others have the right to make decisions for her, or to decide for her what her life will be like.²⁵³ The individual who asserts her autonomy demands that others respect her "capacity for rational agency and [her] ability to formulate a plan of life."²⁵⁴ The autonomous individual rejects the paternalistic actions of others, and insists that she be treated as if she is fully capable of (1) analyzing the options presented to her in various situations, and (2) making rational choices from among those options.²⁵⁵

E. Conclusion

Autonomy is thought to be "a fundamental human value."²⁵⁶ Some thinkers argue that the value of autonomy, or self-governance, is grounded in its conduciveness to human happiness,²⁵⁷ or its conduciveness to self-esteem, while others argue that autonomy is intrinsically valuable (valuable in and of itself).²⁵⁸ Autonomy is also thought to be both a positive character trait,²⁵⁹ and a right.²⁶⁰ In essence, autonomy is a good thing. Individuals should strive to achieve true autonomy,²⁶¹ and society should seek to protect autonomy.²⁶²

V. THE AUTONOMOUS INDIVIDUAL AND MEDICAL MARIJUANA

A. Introduction

This article makes the following proposals. Congress should reclassify marijuana as a Schedule II or lower substance.²⁶³ Congress should then amend the Federal Controlled Substances Act to specifically indicate that licensed physicians may lawfully recommend that their patients use marijuana for legitimate

group.

Buss, *supra* note 35.

252. Christman, *Citadel*, *supra* note 202, at 119.

253. Christman, *Autonomy*, *supra* note 35.

254. Christman, *Citadel*, *supra* note 202, at 120.

255. *Id.* at 110.

256. *Id.* at 120.

257. *Id.* This view is attributable to John Stuart Mill. *Id.*

258. *Id.*

259. Benson, *supra* note 204, at 5.

260. Christman, *Citadel*, *supra* note 202, at 120-21

261. Benson, *supra* note 204.

262. Christman, *Citadel*, *supra* note 202, at 120. Society can protect autonomy by respecting individual rights. *Id.*

263. See 21 U.S.C. § 812(b) (classifying marijuana as a Schedule I substance, or a substance that "has no currently accepted medical use.").

medical purposes, and that patients who hold such a recommendation²⁶⁴ may possess and use marijuana for legitimate medical reasons. In the alternative, Congress should pass legislation that provides that doctors who lawfully recommend medical marijuana, and patients who lawfully use medical marijuana, in those states that have passed laws allowing the use of medical marijuana, are not subject to federal arrest or prosecution.²⁶⁵

Congress should pass this legislation, in essence, because the current legal climate surrounding medical marijuana makes it impossible for individuals to make truly autonomous decisions as to whether or not to use medical marijuana. The remainder of this article will make the following arguments. First, the present legal status of medical marijuana impinges upon the social conditions that must exist for individuals to be truly autonomous. Second, and perhaps most important, the present legal status of medical marijuana inflicts tremendous damage on the right of individuals to make autonomous decisions regarding their health care.

B. *Social Conditions and Alternative Choices*

In order for an individual to be truly autonomous, she must exist within a social context that offers her a sense of security as she pursues goals and makes choices.²⁶⁶ The autonomous individual also must not be "subject to the dictates of others, or . . . [be] severely constrained."²⁶⁷ Finally, the autonomous individual must have a legitimate range of alternative actions open to her as she seeks to solve problems.²⁶⁸ Due to the present legal status of medical marijuana, users of medical marijuana are under the constant threat of arrest, or, at a minimum, having their medicine confiscated, by federal authorities.²⁶⁹ These individuals cannot make truly autonomous choices regarding their medical care when

264. Congress could draft legislation that provides that patients must hold a registry card, indicating that a physician has formally recommended marijuana to the patient. *See, e.g.*, ALASKA STAT. § 17.37.010(f), and COLO. CONST. art. XVIII, § 14(1)(g) (requiring that patients using medical marijuana possess a valid registry card).

265. Federal prosecutors in the meantime ought to exercise their prosecutorial discretion, and refuse to prosecute cases in which medical marijuana is legitimately used under valid state law. *See* Andrew J. LeVay, *Urgent Compassion: Medical Marijuana, Prosecutorial Discretion and the Medical Necessity Defense*, 41 B.C. L. REV. 699 (2000) (recommending that federal prosecutors not prosecute individuals using marijuana for legitimate medical reasons).

266. Oshana, *supra* note 205, at 94.

267. *Id.* at 97.

268. Waller, *supra* note 225, at 74-77.

269. *See Raich I*, 248 F. Supp. 2d at 918 (outlining a situation in which federal officers confiscated the marijuana of two individuals who possessed the marijuana lawfully under California's Compassionate Use Act).

their freedom is threatened in this manner. These threats take away the sense of security an individual must have to make autonomous decisions, and unduly constrain the individual's range of alternative choices. In other words, an individual cannot really make legitimately autonomous decisions regarding her medical care when she is concerned that her choice will lead to her arrest, or the confiscation of her medicine.

C. *The Right to Make Autonomous Decisions Regarding Medical Care*

Those who argue that autonomy is a right argue that individuals ought to be left to themselves to make decisions and choices in their lives.²⁷⁰ Upholding this right requires that others refrain from acting in ways that would impinge upon the ability of the individual to "control a certain area of [her] own life that should be left to [her]."²⁷¹ One of the areas of life that ought to be left to the individual is the area of medical care.²⁷² Medical patients have "rights to make autonomous decisions regarding their bodies, and to seek medical treatment for alleviation of pain and suffering and preservation of life."²⁷³ These rights include the right to choose medical marijuana. "When a state has permitted the use of medical cannabis for [medical patients], after conventional medication has failed or forced them to suffer intolerable side effects, their very ability to define their life is at stake."²⁷⁴

Some thinkers argue that a truly autonomous choice must be a rational choice at some minimal level.²⁷⁵ Medical research has established that marijuana has legitimate medical uses, although, like any other medication, the use of marijuana does have side effects.²⁷⁶ These uses include "pain relief, control of nausea and vomiting, and appetite stimulation."²⁷⁷ The side effects are minimal, according to some. "Marihuana in its natural form is possibly the safest therapeutically active substance known."²⁷⁸

270. Christman, *Citadel*, *supra* note 202, at 119.

271. *Id.* at 110.

272. Amici Brief of the California Medical Association and the California Nurses Association in Support of Plaintiffs-Appellants Angel McClary Raich, Diane Monson, John Doe Number One, John Doe Number Two at 1-2, *Raich v. Ashcroft*, 352 F.3d 1222 (9th Cir. 2003) (No. 03-15481).

273. *Id.*

274. Brief of the National Organization for the Reform of Marijuana Laws and National Association of Criminal Defense Lawyers as Amici Curiae in Support of Respondents at 15, *United States v. Oakland Cannabis Buyer's Cooperative*, 532 U.S. 483 (2001) (No. 00-151).

275. Christman, *Personal History*, *supra* note 212, at 14.

276. See MARIJUANA AND MEDICINE, *supra* note 143, at 1-8.

277. *Id.* at 3.

278. GRINSPON & BAKALAR, *supra* note 30, at 235.

According to others, the side effects of marijuana are not insignificant, but are "within the range tolerated for other medications."²⁷⁹ Given the efficacy of medical marijuana, and the fact that for most researchers the side effects of marijuana are acceptable, the choice to use medical marijuana is a rational one for most patients.

The inevitable conclusion of the above two propositions, that the individual has a right to autonomy, and that the choice to use medical marijuana is a rational one, is that the right to autonomy includes the right to use medical marijuana. In other words, the right that individuals have to be treated as autonomous beings includes the right to use medical marijuana. As autonomous individuals, we have a right to make choices about our lives. That right includes the right to decide, in consultation with a physician, what medicines to use. The law should not "impede a desperate patient who has tried all conventional treatments without success and, acting with the advice and approval of his or her physician, seeks to alleviate his or her serious suffering by using a non-conventional treatment that has been reasonably shown to be effective in his or her case."²⁸⁰

VI. CONCLUSION

This article has examined the clash between federal and state law regarding the use of medical marijuana. Ten states presently allow their citizens to use marijuana for legitimate medical reasons,²⁸¹ but federal law prohibits the possession of marijuana.²⁸² Medical research has shown that marijuana is an effective medication for several conditions, including pain, nausea and vomiting, and loss of appetite due to AIDS.²⁸³ The use of marijuana has side effects, but research tends to show that these side effects are within medically acceptable levels.²⁸⁴

This article therefore proposes that Congress amend the Controlled Substances Act to allow the use of medical marijuana, or, in the alternative, that Congress immunize citizens in states that have legalized medical marijuana from federal arrest or prosecution for possession of marijuana. This proposal is grounded in the philosophical theory of autonomy, which holds

279. MARIJUANA AND MEDICINE, *supra* note 143, at 126-27. To be fair, however, some medical researchers do argue that the side effects of marijuana preclude its use as medicine. Kalso, *supra* note 148, at 3.

280. Amici Brief for the California Medical Association at 4, *Raich* (No. 03-15481).

281. *E.g.*, CAL. HEALTH & SAFETY CODE § 11362.5.

282. 21 U.S.C. § 844(a).

283. MARIJUANA AND MEDICINE, *supra* note 143, at 1-8.

284. *Id.* at 126-27. *But see* Kalso, *supra* note 148, at 3 (arguing that the side effects of marijuana outweigh its value as medicine).

that individuals have a right to freely decide for themselves what goals to pursue in life, and what choices to make regarding all facets of life. That right includes the “right, upon a physician’s advice, to seek medical treatment to treat medical conditions, to alleviate pain and suffering, and to preserve one’s life, when conventional treatments have failed.”²⁸⁵

285. Amici Brief for the California Medical Association at 3, *Raich* (No. 03-15481).