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Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship

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COMMENTS

MEDICAL USE OF MARIJUANA: LEGAL AND ETHICAL CONFLICTS IN THE PATIENT/PHYSICIAN RELATIONSHIP

I. INTRODUCTION

Kenneth Jenks was born a hemophiliac, inheriting the condition from his mother.[1] He contracted the HIV virus from a blood transfusion in 1980 and unknowingly passed the virus to his wife, Barbara Jenks. Mrs. Jenks was the first to suffer the effects of the illness. Her weight dropped by nearly forty pounds in three weeks due to constant debilitating nausea, and she was repeatedly hospitalized for two- to three-week stretches. Mrs. Jenks tried a half-dozen different oral medications for nausea to no avail, and could not function after shots for nausea left her in a stupor. Mr. Jenks experienced similar nausea and weight loss when he began AZT treatment.[2]

Mr. and Mrs. Jenks joined an AIDS support group sponsored by their local health department, where a group member told them about his positive experiences with marijuana. When Mr. and Mrs. Jenks tried marijuana, they found that the nausea they had experienced subsided enough to allow them to eat, gain weight, maintain their health, and retain prescribed AIDS medications. They attempted to get a prescription for marijuana from their treating physician, but could not obtain one legally. To supply their needs, the couple decided to grow two plants to

1. Jenks v. State, 582 So. 2d 676, 677 (Fla. Dist. Ct. App. 1991).

2. *Id.* The details of the case enumerated in this section are taken from the court's opinion.

keep the drug available and at the same time reduce the risk and expense of purchasing marijuana on the street. Mr. and Mrs. Jenks were arrested for cultivating marijuana and possession of drug paraphernalia in 1990. At the time of their arrest, they informed the police that they both had AIDS, and that they used marijuana to relieve the symptoms.

The couple's bench trial focused on the defense of medical necessity, and the parties stipulated to Mr. and Mrs. Jenks's attending physician's testimony that marijuana was the only drug that controlled their potentially fatal nausea. The trial judge rejected the defense and found the couple guilty, placing Mr. and Mrs. Jenks on unsupervised probation.[3] On appeal, however, the court found that the couple had established the medical necessity of their marijuana use.[4] The court held that the Jenks's had proved the three elements necessary to sustain the defense:

> 1. That the defendant[s] did not intentionally bring about the circumstance that precipitated the unlawful act;
> 2. That the defendant[s] could not accomplish the same objectives using a less offensive alternative available to the defendant[s]; and
> 3. That the evil sought to be avoided was more heinous than the unlawful act perpetrated to avoid it.[5]

The Jenkses had not intended to contract AIDS. The treating physician supported their assertion that no other drug available would control the nausea as effectively. Finally, the Jenkses established that failure to control the nausea would put their lives in jeopardy.

The Jenks case presents a scenario in which both a physician and patients choose an illegal but apparently effective treatment for an ailment that will ultimately cause a painful and

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3. *Id.*
4. *Id.* at 680.
5. *Id.* at 679. The elements of this defense as noted were set out in United States v. Randall, 104 Daily Wash. L. Rep. 2249 (D.C. Super. Ct. 1976), and State v. Mussika, 14 Fla. L. Weekly 1 (Fla. Cir. Ct. 1988), (involving patients asserting the medical necessity defense for the use of marijuana to alleviate the symptoms of glaucoma).

hastened death. The fact that the means of treatment is marijuana raises a number of issues for both physicians and patients in regard to health, applicable law, and the sometimes conflicting mandates of medical ethics and the law. The purpose of this Note is to explore those issues in the context of a particular ethical system, to uncover the conflict between the law and that system which may prevent consideration of controlled substances like marijuana for legitimate medical use, and to explore the dilemmas faced by both patients and physicians in seeking the treatment. The medical value and health risks associated with the substance will be discussed first, followed by a consideration of the ethical principles of autonomy, beneficence and non-maleficence that permeate the patient/physician relationship. The laws applied to controlled substances and the professional standards adopted by the medical community will then be viewed in light of the aforementioned principles. This analysis will lead to the conclusion that the controlled medical use of marijuana can be rationalized with the goals set by society in regulating the drug's abuse, and that such medical availability could enable the physician to fulfill his obligations and the patient to gain more complete autonomy.

II. MEDICAL CONTEXT

A. *Marijuana as Medicine*

Cannabis, more commonly referred to as marijuana, has a long history of medical use in this country and worldwide. Accounts dating back as far as 2700 B.C. describe the Chinese using marijuana for maladies ranging from rheumatism to constipation. There are similar reports of Indians, Africans, ancient Greeks and medieval Europeans using the substance to treat fevers, dysentery and malaria.[6] In the United States, physicians documented the therapeutic properties of the drug as early as 1840, and the drug was included in the United States Pharmacopoeia, the official list of recognized medicinal drugs, from 1850 through 1942.[7] During this period, lack of appetite

6. Kenton Robinson, *Medicinal Marijuana: An Organized Call to End the Ban*, HART. COURANT, Nov. 15, 1994, at E1.

7. Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13

was one of the indications for marijuana prescription.[8] The drug is currently being used to alleviate nausea and loss of appetite by AIDS patients and cancer patients undergoing chemotherapy, inter-ocular pressure among glaucoma sufferers, and cramping and spasticity among those stricken with multiple sclerosis or paralysis.[9]

One important reported effect of marijuana in the context of this case study is the stimulation of appetite. When the effects of ingested marijuana begin to wane, the body's blood sugar level drops, stimulating hunger. Marijuana also reportedly has a calming effect on nausea that would otherwise interfere with a normal appetite. The active ingredient in marijuana that causes these results is delta-9-tetrahydrocannabinol, known more commonly as THC. THC has been successfully extracted from the plant, purified, and provided in various forms, including pills and suppositories.[10] The pills have met with mixed reviews from especially those patients who have used the pills specifically for nausea, who note that the nausea is so extreme that anything which is ingested, including the medicine, will not stay down. The pill form of THC has also been found to lose its effectiveness quickly, as the active ingredient is altered before it enters the bloodstream.[11] Advocates say that smoking marijuana or mixing it into food and eating it are the most effective ways to combat nausea.

Critics of medical uses for the drug note the limited research that has been done on the ingestion of marijuana in its unadulterated form. Marijuana is made up of some 400 different chemicals, and, when smoked, it produces hundreds more. It is unknown as to which of the compounds produced, if any, are actually beneficial to the therapeutic user.[12] Researchers have identified a number of harmful compounds produced when the substance is burned, including carbon monoxide, acetaldehyde,

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HAMLINE J. PUB. L. & POL'Y 117, 118 (1992) (citing JEROME L. HIMMELSTEIN, THE STRANGE CAREER OF MARIJUANA 22 (1983)).

8. *Id.*

9. *Id.*; *see also* Mark Sauer, *The Push to Legalize*, SAN DIEGO UNION TRIB., Nov. 2, 1993, at E1.

10. Roger Signor, *Marijuana in Medicine Research Draws Potshots from Politicians*, ST. LOUIS POST-DISPATCH, June 6, 1992, at 1D.

11. *Id.*

12. *Id.*

vinyl chloride, phenol, creosol and naphthalene. Smoked marijuana also contains twice as many carcinogens as tobacco.[13] Furthermore, marijuana in its crude form may be contaminated with diarrhea-causing salmonella bacteria and with aspergillus fungi, which can cause pneumonia. Prolonged exposure to marijuana smoking has been linked to emphysema-like symptoms, cancer of the lung, mouth and tongue, impairment of memory and motor skills, and an increase in the incidence of schizophrenia.[14]

Physicians and researchers have also questioned the effectiveness of smoked marijuana as a treatment for nausea, loss of appetite, and the ocular pressure associated with glaucoma. Cancer specialists have concluded that smoked marijuana has limited effectiveness in treating nausea accompanying chemotherapy. The American Cancer Society likewise has found no evidence that would warrant it to recommend reclassification of marijuana for medical use.[15] In spite of the reported shortcomings of the synthetic derivatives of cannabis given in pill form, researchers still maintain that they are effective and safer than smoked marijuana. These opinions run contrary to the anecdotal evidence and evidence supplied by practicing physicians that find a number of positive aspects to using marijuana in its crude form.

B. *AIDS and Marijuana*

The AIDS virus manifests itself in a number of ways in the human body, including asymptomatic disease, acute retroviral syndrome, chronic lymphadenopathy, opportunistic infections like thrush and pneumonia, Kaposi's sarcoma, and neuropsychiatric disorders.[16] Evidence gathered in recent years suggests that many of the conditions associated with the AIDS virus, including arthritis, pneumonitis, nephritis, diarrheal syndromes, wasting syndromes, and neuropsychiatric manifestations, may

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13. Gabriel G. Nahas & Nicholas A. Pace, *Marijuana as Chemotherapy Aid Poses Hazards*, N.Y. TIMES, Dec. 4, 1993, at 20.

14. *Id.*

15. *Id.*

16. *Report of the Second Public Health Service Aids Prevention Conference*, 103 PUBLIC HEALTH REP. 28-40 (1988).

be direct effects of the virus itself, rather than consequences of the immune system dysfunction that accompanies AIDS and may open the body to other infections.[17]

Anecdotal evidence supports the use of marijuana, generally smoked marijuana, to combat the nausea and wasting associated with AIDS. Samuel Skipper, a California man suffering from AIDS, witnessed his companion die despite aggressive treatment with AZT, a well known AIDS-controlling medication. Skipper grew and used marijuana to control nausea and stimulate his appetite. Since he started using the drug, he has kept his weight up, maintained a T-cell count in the normal range, and has shown few symptoms associated with AIDS.[18] Ric Gilberg, a former mountain guide with AIDS, smokes marijuana each day to control nausea that is so severe he often cannot tolerate even a small amount of food.[19] While formal clinical research has not conclusively shown that marijuana is effective or that close-up crude-form marijuana is more effective than drugs synthesized from its active ingredients, it appears that a number of patients who have tried the drug in its raw form have found relief.

C. *The Physician Perspective*

A consideration of the physician's role in the control and treatment of AIDS, or other similar diseases, brings to light some significant conflicts. Marijuana, unlike other forms of treatment, is likely to be a "last resort" among possible treatments, particularly from the physician's point of view. The dilemma arises when the physician is faced with this "last resort." The patient has AIDS, a fatal disease for which there is currently no cure. The patient is suffering from AIDS-related wasting, and his weight loss and malnutrition will inevitably rob him of the ability to ward off other AIDS-related conditions. The physician has unsuccessfully treated the patient with the accepted nausea-controlling drugs. As in the Jenks case, the

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17. *Id.*

18. Mark Sauer, *Marijuana as Medical Necessity Goes on Trial*, SAN DIEGO UNION-TRI., Oct. 8, 1993, at E1.

19. Mike McKee, *Caught in the Drug War Cross Fire*, THE RECORDER, Apr. 30, 1992, at 1.

patient has heard from others who have suffered the same wasting syndrome that marijuana has enabled them to eat, thereby reversing the wasting and helping the body to ward off the infections that typically accompany the disease. Finally, the patient comes to his physician to ask whether marijuana is a viable means of controlling the wasting symptoms.

In this instance, the basic dilemma for the physician is whether to condone an illegal and potentially harmful drug that he himself cannot supply to the patient. The consequences of the physician's decision, whether to approve or recommend against using marijuana, will have a number of effects on the patient. If the physician recommends against using marijuana, and the anecdotal evidence of the drug's effectiveness is indeed correct, he or she is effectively shutting off the patient's last potential hope for overcoming nausea and wasting. In so doing, the physician is, in effect, choosing not to treat the patient. His decision to recommend against marijuana may be a signal to the patient that there is no further hope, that the patient is now out of options unless a new treatment emerges while he or she is still living. If, on the other hand, the physician does "prescribe" marijuana to the patient, he encounters a different set of problems. The first is that marijuana remains an illicit drug, and a patient who procures the drug risks criminal prosecution, regardless of whether the drug was obtained on the advice of a physician. Marijuana is also known to produce carcinogens when smoked, and smoking it may cause other respiratory ailments. The physician would be prescribing a drug that would control one set of symptoms, while potentially enabling other conditions to develop. The physician would also be prescribing a substance that has not benefitted from the same type of exhaustive research and experimentation that goes into the development of new medicine, relying purely on anecdotal evidence and discounting the means with which he has been taught to choose a proper and acceptable treatment.

D. *The Patient Perspective*

The dilemmas facing the AIDS patient, when considering marijuana, overlap those facing the physician who considers prescribing the drug. If the patient has tried all available methods of treatment to no avail, or if some methods of treatment

that might be effective are cost prohibitive,[20] he may view marijuana as the only alternative to wasting away towards a painful death. If the patient does choose to treat himself with marijuana, he is breaking the law. In committing a crime, the patient may encounter both an external and an internal dilemma. First, if the patient grows, purchases, or possesses marijuana, he risks prosecution and incarceration. Second, because society has chosen to make marijuana illegal, the patient who uses marijuana is making a choice to break the law. That choice may not affect all people the same way; if the patient is one who places a great deal of value on laws and social norms, he must then decide which he values more, adhering to the law or prolonging his life by breaking the law. The patient wary of breaking the law may also need to decide how long he should wait before resorting to marijuana. Since there are legal treatments, it is conceivable that the individual would feel an obligation to try all legal routes before breaking the law. This dilemma prompted one patient's lawyer to ask, "how many ineffective, blind-alley lethal medicines do you have to take and see someone die from before you can choose what you know works?"[21]

E. *Conflicts*

In order to better understand the ethical contours and the accompanying conflicts of the use of marijuana as medicine, it may be helpful to summarize those conflicts before turning to a consideration of the applicable ethical principles. The physician's dilemma is whether to bypass a treatment because it is illegal, or to recommend it to a patient and put the patient at legal and medical risk. The patient's dilemma centers on the choice between following what the law mandates and breaking

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20. Signor, *supra* note 10 (noting that one anti-nausea treatment costs $600 per dose).

21. Anne Krueger, *Jury Clears La Mesa Man Who Grew Pot as Rx for his HIV*, SAN DIEGO UNION TRI., Oct. 16, 1993, at A1 (quoting Juliana Humphrey). Ms. Humphrey, a Deputy Public Defender, argued that her client's marijuana use was out of medical necessity. Samuel Skipper was acquitted on the basis of that necessity. Sauer, *supra* note 9. Skipper had not, in fact, tried any legal treatments prior to his choice to grow and use marijuana, although he did witness another patient die after AZT failed to control the disease. *Id.*

the law with the potential of preserving personal health. There are other issues that should be kept in mind. One issue worth considering is whether the means by which the patient contracted the AIDS virus impacts on the ethical choices to be made by the physician or the patient. The difference between an "involuntary" contractor of the AIDS virus and one who may not be considered by all to have contracted AIDS involuntarily is an important distinction to bear in mind when considering both the ethics and applicable law that govern this situation. The means by which a patient contracted the disease should not change a physician's obligation to treat the patient, but it may have some effect over the patient's ability to legally use the drug.[22]

III. ETHICAL CONTEXT

A. *Principles Considered*

In considering the conflicts created by the prescription and use of marijuana as medicine, several important ethical principles are implicated. The concept of beneficence, requiring positive acts that contribute to human welfare, is primary among these principles. Related to, and more accurately a part of, the concept of beneficence is the theory of utility, which in this case requires a weighing of the benefits of the medical use of marijuana against its burdens on both the individual level and on a broader, society-wide scale. The principle of non-maleficence also must be considered in light of the known and suspected negative health effects of marijuana use. While the physician may be prescribing marijuana to alleviate one set of symptoms, his obligation to "do no harm" may be compromised by suggesting the use of a drug that may cause a different type of harm. Finally, the principle of patient autonomy must be considered, both in terms of the patient's choice of a particular treatment and the physician's obligation to respect the autonomy of the individual patient. Analysis of the ways in which these principles affect both physician and patient, and of the ways in which these principles conflict with and compliment one another, may

22. *See supra* note 5 and accompanying text for the elements of the "medical necessity" defense.

help illuminate the conflicts between the law governing marijuana use for medical treatment, the role of, and limitations placed on, the physician, and the needs of the patient.

Beneficence entails taking positive action in order to contribute to another's welfare. By definition, the term beneficence includes acts of mercy, kindness, charity and humanity.[23] Beneficence, as will be explained, is one building block of the theory of utility. The primacy of positive acts for the good of others that defines beneficence gives rise to disagreement as to whether beneficence is an ideal or an obligation.[24] Acts of charity, one aspect of beneficence, are universally thought to be voluntary, and individuals who choose not to act charitably are not deemed to be morally deficient.[25] The obligation to act for the good of another may be tempered by competing obligations, like the obligation to honor the personal choices of that other person. The obligation may also be lessened by the situation of the actor himself: one is certainly not required to put one's own life at peril to help another. Rather, it might be considered an ideal, one that all might not necessarily embrace, to value another person's life or health over one's own personal welfare.

The concept of utility helps create this obligation/ideal dichotomy. This concept focuses on the consequences of a particular act, and asserts that we should attempt to produce the greatest possible balance of positive results over negative results.[26] While this basic concept of utility seems to be a truism, there are a number of individual ideas on which values should be promoted.[27] Proponents of utility can be broken down into two categories: act utilitarians and rule utilitarians. Act utilitarians focus on the good and bad consequences that result from a particular act in particular sets of circumstances.[28] Rule utilitari-

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23. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS, 260 (1994).

24. *Id.* at 261.

25. *Id.*

26. *Id.* at 47.

27. *Id.* at 48. Some utilitarian thinkers have sought "intrinsic" goods, goods that every rational person values, which would negate the need to consider the consequences of the acts producing these goods. The complexity of most decisions that deal with human health and medical treatment, however, may prevent any significant consensus being reached that would create such intrinsic goods. *Id.*

28. *Id.* at 50.

ans support the development of a set of moral rules that will govern actions. The rules as developed and an act's conformity to those rules determine what is good. Act utilitarians, by contrast, are willing to forego rules on an individual case basis if they determine that the rules will not maximize the general good.[29] Utility in either form helps to create the concept of beneficence by requiring the actor to weigh the consequences of possible courses of action to determine what would result in the most good and whether to act at all.

B. *Physician: Beneficence as Obligation or Ideal*

The physician's "duty" of beneficence is evident in the Hippocratic oath, which provides that physicians will "come for the benefit of the sick," will apply treatment "for the benefit of the sick according to [their] ability and judgment," and "will keep patients from harm and injustice."[30] The positive duty that is described in this oath leads to the conclusion that a physician, by accepting the role as a health care provider, has assumed an obligation to provide beneficent care. Beneficence cannot be considered an ideal for which a physician may strive or an optional act of charity. When this physician chooses not to act, he is violating a codified duty. While the requirement of the oath certainly give that appearance, there is room to argue that the duty to act has limits.

The *Jenks* case brings to light the conflict faced by an AIDS patient's treating physician when marijuana is proposed as treatment. If the Jenkses approached their physician and inquired about obtaining marijuana or asked for his approval of their use of marijuana, the physician then would need to determine his proper course of action. If followed to the letter, the principle of beneficence that permeates the Hippocratic oath would impose on the physician a duty to treat the patient according to the patient's needs, but would allow the physician to exercise his judgment. If the physician determines that the health risk of using marijuana combined with its status as an

29. *Id.* at 51.

30. *Id.* at 269 (citing LUDWIG EDELSTEIN, ANCIENT MEDICINE (Oswei Temkin & Lillian C. Temkin eds., 1967)).

illicit drug creates a more negative than positive outcome, he has the discretion not to suggest or prescribe it. Since the drug is in fact illegal, the physician could even choose not to consider the health risks associated with the drug and base his decision not to act solely on the drug's illegality. The beneficence that may result from approving or prescribing the use of marijuana has then become an ideal rather than an obligation.

The special facts that surround the case of an AIDS patient may change the equation to some extent. As has been mentioned,[31] at the present time there is no cure for AIDS, and the drugs that have been developed to control the disease may have adverse side-effects or be generally ineffective on a case-by-case basis. If a patient with full-blown AIDS approaches a physician and asks for marijuana, a substance whose effectiveness in treating the nausea complained of has been supported by anecdotal evidence, then the physician's role in "dispensing" beneficence may change. Though it may be an extreme example, the physician is given the task of weighing the life expectancy of a terminal patient with a treatment's potential health risks to determine whether there is any sense in withholding a treatment that poses some risks. If potential health risks are to a great extent taken out of the equation, then the only real downside remaining for the physician to consider is the illegality of marijuana and the legal risk that the patient takes in using the drug. At that point, the physician's decision to recommend against marijuana would be grounded more in paternalism than in a valid cost-benefit analysis.

Another somewhat more speculative issue that might influence a physician's decision is the signal that he would send out if he were to prescribe marijuana based on anecdotal evidence of its benefits. Marijuana is certainly not a cure for AIDS, but only a means by which to control some of its more debilitating symptoms. If use of the drug is condoned, approved and even recommended by physicians, it seems possible that progress toward a true cure through further development of experimental drugs might be compromised. Reliance on purely anecdotal evidence also runs contrary to what physicians have been

31. *See supra* part II.B.

taught, that scientifically controlled research is the most effective and safest way to make progress.

C. *Autonomy in the Patient/Physician Relationship*

The principle of autonomy stands for the idea of personal self-rule, free from both interference by others and from personal limitations that impede the individual's ability to act freely.[32] Liberty, defined generally as independence from controlling influences, and agency, defined as the capacity for intentional action, are the two basic elements of autonomy.[33] According to Beauchamp and Childress, autonomous action is analyzed in terms of "normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their actions."[34] The last two elements are matters of degree, and a decision may be called autonomous even if an individual is not acting with a complete understanding and is not fully free of controlling influences. To require full understanding and complete freedom from constraint in every set of circumstances would be entirely impracticable. While it may seem that individual autonomy is incompatible with the existence of overarching rules of society, it is clear that autonomy and authority are essentially compatible when one recognizes that individual autonomous choices are not made in a vacuum free from consideration of societal values.[35] Finally, autonomy is not defined solely by an individual's decisions, but also by the individual's functioning within certain interdependent relationships, such as the relationship between a physician and a patient. As in other situations, autonomy in the medical context assumes both a negative and a positive connotation. On one hand, autonomy is a moral and legal defense against paternalism and against the imposition of societal, religious and moral values. However, autonomy also creates an obligation to foster self-determination and independence.[36]

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32. BEAUCHAMP & CHILDRESS, *supra* note 23, at 121.
33. *Id.*
34. *Id.* at 123.
35. *Id.* at 124.
36. Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 51 (1993).

Compared with patient autonomy, physician autonomy has received little attention.[37] There is no disputing the importance of protecting a patient's right to understand and participate in decisions that will affect his or her life. Paternalism in medical treatment is seen as one means of subjugating patient autonomy.[38] If the physician's "paternalism" is aimed toward empowering the patient and ultimately fostering autonomous decisionmaking, then the physician assumes a vital role in bringing about true patient autonomy.[39] Because of the unique roles and obligations of each party in the patient/physician relationship, the autonomy of the physician should be recognized as well. Edmund D. Pellegrino recognizes three facets of physician autonomy (1) personal autonomy, giving moral status to the physician's personal values and conscience; (2) physician autonomy, giving moral status to the physician's knowledge and obligation to use it properly; and (3) professional autonomy, recognizing the physician's membership in the community with collective obligations to patient and society.[40]

In regard to personal autonomy, the physician cannot be expected to set aside personal values and beliefs any more readily than any other individual. While patient autonomy, according to Pellegrino, requires that the physician not impose his beliefs on the patient, it cannot demand that the physician ignore his or her own moral guidelines.[41] In addition, since the physician assumes the key role in the treatment of the patient and by law bears much of the responsibility for the outcome, the physician cannot avoid the obligation to refrain from harming the patient.[42] A physician's autonomy should not be compromised to the extent that his or her ability to assist the patient in making a beneficial choice is hampered.[43] The physician's autonomy also comes from possessing specialized knowledge to be used for the benefit of the sick, and a physi-

37. *Id.*
38. *Id.*
39. *Id.*
40. *Id.*
41. *Id.* at 52.
42. *Id.*
43. *Id.* at 52-53.

cian must be allowed the discretion to apply this knowledge in the most effective ways.[44]

In the context of treatment, the autonomy of the patient and that of the physician may conflict. Particularly in the case of the terminal patient suffering from a disease like AIDS, a patient's autonomy may be impeded to a great extent by anxiety, fear, social stigmatization, and the dependence and helplessness that the more severe symptoms of the disease may bring about.[45] A proper goal of the physician is to use his specialized knowledge to break down impediments to autonomy. The physician stands in a unique position of power over the patient in this regard, and the physician runs the risk of compromising the goal of autonomy if he lets his own value system interfere with complete disclosure of information to the patient.[46] Patient vulnerability must constantly be kept in mind, and the physician must work to avoid influencing the patient's choices with his own biases. Preserving patient autonomy does not, however, mean that a physician should pass all responsibility for a decision to the patient. To do so would be to ignore the obligation of the physician to use what he knows to give the patient back the autonomy that illness has taken away.

D. *Patient/Physician Relationship: Balancing Non-Maleficence and Autonomy*

Non-maleficence requires that a physician not inflict harm upon the patient, that is, that treatment never be used to injure the patient.[47] In the context of marijuana's use as a medical treatment, the physician is faced with clinical evidence of the carcinogenic properties of the drug, as well as a lack of conclusive clinical evidence that the drug is an effective treatment. As stated earlier,[48] the majority of the evidence support-

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44. *Id.*

45. *Id.* at 54. Pellegrino also cites the values to which the patient adhered before the incidence of disease as affecting autonomy. Personal relationships, moral beliefs, and characteristics like independence will impact upon the character of the patient/physician relationship that arises out of need and will likely impact the kind of autonomy that each party chooses. *Id.*

46. *Id.* at 50.

47. BEAUCHAMP & CHILDRESS, *supra* note 23, at 189.

48. *See supra* part II.

ing marijuana's use as a treatment for AIDS is anecdotal, while much of the information concerning the harmful nature of the drug in its raw form was collected in what may be considered an appropriate, accepted, scientific manner. If the physician were to weigh the evidence purely on the basis of scientific proof, the principle of non-maleficence would mandate that marijuana not be considered as a possible treatment.

If the physician considers other factors, however, non-maleficence may not be so readily compromised by prescribing a potentially harmful drug like marijuana. Patient autonomy, among other factors, may alter the equation so that the treatment will not interfere with the physician's obligation to the patient. There is a trade-off of sorts that must be made between the two principles if both are to be preserved to the fullest extent possible. If the physician compromises the accuracy of her explanation of the reported benefits of marijuana by emphasizing personal feelings about using the drug or skepticism over purely anecdotal evidence, she is not fulfilling her obligation of promoting patient autonomy. On the other hand, if the physician fails to consider her obligation to "do no harm," she may under emphasize the potentially harmful effects of the drug and may also shirk her duty to use her knowledge to assist and protect the patient.

Non-maleficence and autonomy must, however, be balanced to produce the best outcome. If some of the absolute nature of non-maleficence is tempered by considering the harm in withholding even a potentially dangerous treatment and by considering the nature of the illness itself, the prescription of a potentially harmful drug like marijuana can be more easily justified. By allowing anecdotal evidence from the patient to factor into the physician-patient decision, the physician is also promoting autonomy, and if the drug works for a particular patient in the way it has been said to work, autonomy is certainly served as well. Both patient and physician autonomy must be compromised to a degree. A physician may have to set aside his personal beliefs if he finds the use of illegal drugs for any purpose to be personally repugnant. The patient with the same value system would be forced to do the same—her autonomy is compromised by the fact that the best solution, the use of marijuana to control symptoms, is one that forces her to set aside her

values. Most patients suffering from serious illnesses or injuries are robbed of autonomy by the conditions, and then by the treatment, with the ultimate hope that more complete autonomy will result.

E. *The Dilemma of the Terminal Patient*

The AIDS patient faces a dilemma much like that of any other patient hampered by illness, but with heightened concerns about personal preservation. While a physician is operating under an oath to bring beneficial treatment to the patient, the voluntary nature of beneficence contrasts with the more personal urgency of self-preservation and autonomy that lies with the patient. When an AIDS patient seeks an effective treatment to control the disease, it follows that his decision is based on his belief in the fundamental rights of life and liberty, manifested in the liberty to have access to information about viable treatment, and to choose the treatment that will benefit him the most.

How important individual autonomy is in comparison to societal interests is a topic of much debate and disagreement. Some see individual rights as "trumps" that take precedence over social interests. Social interests, according to this view, prevent the individual from asserting rights only when the constraints of those rights has a high degree of social utility.[49] Others point out the need to balance conflicting rights, and draw a distinction between violating a right and justifiably infringing upon a right.[50] In the context of an AIDS patient seeking potentially effective marijuana treatment, the rights to be balanced are the individual's right to preserve his life through access to medical treatment and society's right to be free from the potentially damaging effects of the drug.

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49. Pellegrino, *supra* note 36, at 72; *see* R.M. DWORKIN, TAKING RIGHTS SERIOUSLY (1978).

50. Pellegrino, *supra* note 36, at 72.

F. *Fitting the Principles Together*

Despite apparent conflicts between the principles of beneficence, non-maleficence and autonomy, these concepts, can be reconciled within the context of the patient/physician relationship, specifically in regard to a physician's recommendation or support of the use of an illegal drug as treatment. Beneficence again calls for the physician to take positive action to assist and treat the patient. The point at which beneficence comes into conflict with autonomy is where paternalism emerges as the predominant physician response. Paternalism, even in the name of beneficence, ignores the patient's value system to the extent that the goal of autonomy is compromised. When beneficence is emphasized and properly used, it enhances and enables autonomy. Paternalism should only be exercised long enough to assist the patient in regaining autonomy. If the physician keeps in mind the patient's vulnerability and the physician's own power to affect the patient in both a positive and negative way, paternalism will be held in check.

Patient autonomy has been elevated a great deal in recent years, possibly not only in reaction to the paternalism of physicians, but also at the expense of the more positive principles under which physicians operate. If the parties on both sides of the relationship are made aware of the values that the other must keep in mind, that awareness may take some of the conflict out of the relationship. In the scenario explored here, the patient should respect the physician's hesitance to prescribe a potentially harmful and illegal drug like marijuana. Even if it is just a matter of allowing the physician to discuss other options, a patient can contribute to the relationship by giving the physician the opportunity to work through his or her own obligations to do good for the patient while refraining from harm.

At the same time, the physician can contribute to the relationship by fully disclosing all of the positive and negative factors associated with medical uses of marijuana. By fully disclosing all of the facts known about the treatment, whether clinical or purely anecdotal evidence, a physician is assisting the patient in making an autonomous choice without imposing personal values that would potentially mislead the patient. Beneficence and non-maleficence can be balanced in this situation as

well. The physician's duty to actively treat for the good of the patient and the duty to refrain from harm can be reconciled by a thorough fact-specific inquiry into the condition of a particular patient. For example, if the AIDS patient is given a prognosis of a limited period of survival, the risk of side effects from using marijuana should probably be subjugated somewhat to the benefits of increased comfort and the possibility of appetite stimulation and nausea control that may, in the end, prolong the life of the patient, or at least make suffering more bearable. For a patient in the beginning stages of AIDS with a longer survival timeline, the physician should balance the duty not to compromise the patient's immunity by treating with marijuana with the duty to positively treat the patient with a substance that may ward off the wasting effects that may compromise immunity at a later stage. The final impediment facing both the physician and the patient to finding common ground among these principles is the law as it currently deals with the medical uses for the drug.

IV. APPLICABLE LAW AND PROFESSIONAL STANDARDS

A. *Marijuana as a Controlled Substance*

In spite of marijuana's long history of medical use, it is and has been an illegal drug since 1937. The Marijuana Tax Act of 1937 imposed a registration tax on marijuana that made prescribing the drug particularly burdensome for physicians.[51] Marijuana may have become illegal as much as a result of politics as from legitimate public health concerns. Recreational use of the drug in immigrant populations and the jazz subculture may have helped to foster the notion that marijuana use inevitably resulted in violence and immorality.[52] Marijuana was in fact classified as a "narcotic" rather than grouped with alcohol and tobacco.[53] Early legislation that keeps marijuana illegal to this day focused more on political and socio-economic factors than on arguably more legitimate concerns, like the health risks associated with marijuana use. A commission es-

51. Bilz, *supra* note 7, at 118.
52. *Id.* at 119.
53. *Id.*

tablished by President Nixon in 1972 found the 1937 Act to be without rational basis, giving further credence to the possibility that the criminalization of the drug has no currently complete scientific foundation.[54]

In spite of continued pressure from decriminalization groups questioning the scientific basis for the prohibition, marijuana remains illegal. The states have varying sanctions for marijuana possession, generally based on the weight of the marijuana possessed. Marijuana is classified by the federal government as a "Schedule I" drug, meaning that it has a high potential for abuse and no recognized medical use.[55] Cocaine, generally considered a more lethal and addictive drug, is classified as "Schedule II", meaning that it has a high potential for abuse, but has legitimate medical uses and can in fact be prescribed.[56]

Of particular interest when considering marijuana's continued classification as a drug with no legitimate medical use is the Compassionate Investigational New Drug program, established by the federal government in 1982, and discussed below.[57] Although the program has been canceled, there remain eight people across the country who receive marijuana from the government to treat medical conditions, including AIDS. Kenneth and Barbara Jenks were part of this program before they died, receiving pre-rolled marijuana cigarettes, made with marijuana grown at a government-funded farm in Mississippi. The Government's allowance of those eight individuals to receive legal marijuana for medical treatment has in some minds compromised the credibility of continued prohibition against medical use for marijuana.

B. *AMA Code*

The physician is bound to a great extent by a separate set of ethical principles that supplement the law. The Code of Medical

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54. *Id.*
55. *Id.* at 123-24.
56. *Id.* at 124.
57. *See infra* part IV.C.

Ethics, adopted by the American Medical Association speaks to the subject of treatment of the terminally ill patient:

> In the making of decisions for the treatment of seriously disabled newborns or of other persons who are severely disabled by injury or illness, the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family *or to society*. Quality of life, *as defined by the patient's interests and values*, is a factor to be considered in determining what is best for the individual.[58]

This tenet requires that the physician make a fact-specific inquiry into the needs of the individual patient and to place the good of the patient above the potential burden to society. The good in the case of the AIDS patient may be to find a way to stem the effects of wasting to maintain health. The burden to society may be that the indicated treatment, marijuana in its crude form ingested by smoking, is a method that runs counter to the goals set by society in regard to controlling potentially harmful illicit drug use.

Additionally, the same Code section states that the patient's own interests and values help determine quality of life for that individual patient.[59] There does not appear to be much room for consideration of goals set by society that do not have built-in consideration for the needs of individuals. If an individual's condition, such as AIDS, indicates the usefulness of treatment with marijuana, and her own values do not preclude the use of that drug for therapy, then that indication should help to define the quality of life for that individual and should help to determine the appropriate treatment. That particular element of the physician's duty to the patient seems to exemplify the physician's responsibility to foster patient autonomy.

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58. AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS § 2.17 (1994) (emphasis added).

59. *Id.*

C. *Compassionate Investigational New Drug Program*

The United States government-regulated program known as the Compassionate Investigational New Drug Program was established to provide a means by which non-approved drugs could be made available on a limited basis to patients who qualified for the program. Whether intended or not, one result of the program may have been the creation of a means by which physicians could serve individual patients without the burden of widely applicable laws that might hamper treatment. Marijuana was one drug that became available in this protected pocket created by the program. The program was canceled in 1991, but as of 1992 there were fourteen individuals who were receiving legal marijuana from the government as a result of the program.[60] The cancellation of the program is seen more likely as a result of politics than a comment on marijuana's effectiveness as treatment.[61] The cancellation came at a time when the government's efforts against the illicit drug trade were at their height, and provided a means by which a consistent position on marijuana could be established. As discussed earlier, however, the individual patients who had qualified to receive the drug were, and some still are, receiving marijuana legally from a federally funded facility.[62]

The cancellation of the program puts the law at odds with both patient autonomy and the affirmative duty that physicians have adopted for themselves in the Code of Medical Ethics. Even if an individual patient has come to terms with the potentially hazardous effects of using marijuana as therapy and his own reluctance to use the drug, the cancellation of the program has taken away the only reasonable legal avenue for the patient to seek what he may see as the most effective treatment. The physician is told that despite the medical profession's goal of elevating patient need over the burden on society in individual cases, consideration of the burden on society has been ac-

60. Michael Isikoff, *HHS to Phase Out Marijuana Program*, WASH. POST, June 22, 1991, at A14.

61. *Id.*

62. *Id.*

corded a more substantial interest. The physician's hands are bound in fulfilling the goals set by the medical profession.

D. *Medical Necessity Defense*

The medical necessity defense is the remaining means by which a patient can support marijuana as treatment, although it does not actually give the patient a "free pass" to use the drug. The case described at the beginning of this text involving Kenneth and Barbara Jenks was decided on the assertion of this defense, and the couple was spared from criminal sanctions for using marijuana.[63] Successful use of the defense turns on three elements: first, that the defendant did not intentionally bring about the circumstances which precipitated the unlawful act; second, that the defendant could not accomplish the same objective using less offensive available alternatives; finally, that the evil sought to be avoided was more heinous than the unlawful act done to avoid it.[64] The Jenkses proved the elements of the defense by showing that they did not intentionally contract AIDS, that other treatments were ineffective for them, and that the inevitable result of foregoing the use of marijuana, in their case a hastened death, was a greater evil than the use of the illegal drug.[65] Several jurisdictions have recognized this defense when used in the context of marijuana use as treatment, although individual courts have modified elements of the defense and restricted its availability to some degree.[66]

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63. *See supra* notes 1-5 and accompanying text.

64. Jenks v. State, 582 So. 2d 676, 678 (Fla. Dist. Ct. App. 1991).

65. *Id.* at 679.

66. In Commonwealth v. Hutchins, 575 N.E.2d 741 (Mass. 1991), the Massachusetts Supreme Judicial Court denied the availability of the medical necessity defense to a glaucoma sufferer who was arrested for possession and cultivation of marijuana. Although Hutchins had satisfied the four elements associated with the defense, the court added an additional "competing harms" analysis that resulted in the court's denying Hutchins's assertion of the defense. In doing so, the court decided as a matter of law that the defendant's glaucoma and demonstrated need for alternative treatment "would not clearly and significantly outweigh the potential harm to the public were we to declare that the defendant's cultivation of marijuana and use for medicinal purposes may not be punishable." *Id.* at 745. This decision provides a clear example of the conflict between the established law and the ethical system that a physician adopts in treating a patient and ultimately enabling the patient to function autonomously. *See also* United States v. Burton, 894 F.2d 188 (6th Cir. 1990), in which the court held that a government program established to study the effects of

While on its surface this defense seems to remove an obstacle to patient autonomy, the individual elements of the defense do very little to promote appropriate functioning of the principle. Taken as a whole, the defense forces the patient to assume the risk of prosecution and litigation to use the drug, rather than giving the patient a means to establish some sort of immunity before resorting to the therapeutic use of the drug. The threat of prosecution will loom as the patient makes the decision, rather than there being some way to qualify for the treatment without running the risk of later prosecution and an indefinite interruption in treatment. The first element of the defense, that the individual not have intentionally brought about the circumstances, is vague and somewhat untested in cases of AIDS contracted through sexual contact. Mr. Jenks was a hemophiliac and unknowingly received the virus in a transfusion. This begs the question as to whether sexual transmission or intravenous drug use constitutes knowingly, willingly, or intentionally bringing about the circumstances, thereby foreclosing the use of the defense. The third element of the defense requires the patient to make a determination as to whether the evil avoided is greater than the evil that results from the unlawful act, and allows the finder of fact to reconsider the patient's analysis without necessarily relying on the same set of values that the patient used in making the decision. Finally, the defense does nothing to address the ability of the physician in assisting the patient to procure the treatment and to use it under some supervision, and therefore ignores the physician's role as care-provider.

Ideally, in a situation like that of the Jenkses, the defendant's ability to use marijuana legally would depend more on the immediacy of need and balancing of harms by the individual patient, rather than on the substituted judgment of the

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marijuana on glaucoma precluded the defendant from asserting the defense, as a "reasonable legal alternative to violating the law" existed. *Id.* at 191. Several states have precluded the use of the defense in similar circumstances where the legislature has spoken directly to the issue either through statutory preclusions or the establishment of research programs. For a comprehensive discussion of the medical necessity defense in prosecutions for possession and cultivation of marijuana, see generally Todd H. Whilton, Commonwealth v. Hutchins: *A Defendant is Denied the Right to Present a Medical Necessity Defense*, 27 NEW ENG. L. REV. 1101, 1108-10 nn.49-50 (1993).

factfinder. Likewise, the element requiring that the patient be unwillingly or unknowingly cast into the circumstances should be developed past the point at which it gives only a vague hint as to whether an AIDS patient contracting the disease through intravenous drug use or sexual contact would qualify to use the defense. If Mr. Jenks had been an intravenous drug user, the court may have found him to be unwillingly cast into the circumstances, but quite possibly not unknowingly, expecting him to have known the risks of that behavior.

V. CONCLUSION: RATIONALIZING THE ETHICS AND THE LAW

In light of the shortcomings of the current law in enabling both the patient and physician to achieve the goals established by the principles of autonomy, beneficence and non-maleficence, it appears that the laws should be changed in order to promote individual good without significantly interfering with the priorities adopted by society. Society's ostensible interest is to control abuse of marijuana and the results of that abuse, particularly health effects and criminal activity that is associated with illegal drugs. Keeping that in mind, there are means by which marijuana may be made available to deserving patients that would not disrupt accepted societal goals. In order to overcome the health-related drawbacks of the drug's use, the first step should be to increase research into the production a product that would maximize the benefits of marijuana while removing the impurities that compromise health. From what is known, it may be impossible to remove the elements of marijuana that produce carcinogens when the substance is smoked, but viral and fungal contaminants could be removed so as not to compromise the immunity of an already seriously ill patient. Increased research would potentially result in an end product that would alleviate both a patient's fears in using the drug that take away from patient autonomy and a physician's struggle in prescribing it while keeping in mind his duty of non-maleficence.

Second, the legal control of the drug must be reconsidered. While there is some justification for the politicization of marijuana and a uniform policy in dealing with the drug, making its potential benefits available through regulated access is a preferable means of administering the drug. Assuming that

more extensive research, coupled with the already existing anecdotal evidence on the drug's benefits, would show that marijuana can be an effective symptomatic treatment, especially for a disease with no known cure, availability of marijuana should be no more limited than that of other drugs with a potential for abuse. Drugs that have been shown to be both physically and psychologically addictive, like cocaine and morphine, sedatives and relaxants like valium and xanax, and amphetamines like ritalin, are all available by prescription, some quite readily, and all carry a substantial risk of misuse or abuse. Substances without treatment value, like alcohol and nicotine, are available in spite of potential for abuse and addictive effects. All of these substances are subject to regulations that control public access, with the goal of preserving their value but not at the expense of public safety. Marijuana could and should be similarly regulated in order to preserve its beneficial effects and to promote individual autonomy in choosing a viable treatment alternative without the legal and health-related risks that currently exist. Regulated availability would also help the physician better fulfill his obligation as care provider and enabler of patient autonomy.

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