

Overdue Process: Why Denial of Physician-Prescribed Marijuana to Terminally Ill Patients Violates the United States Constitution[†]

Matthew Segal*

[The] sluggishness of government, the multitude of matters that clamor for attention, and the relative ease with which men are persuaded to postpone troublesome decisions, all make inertia one of the most decisive powers in determining the course of our affairs and frequently gives to the established order of things a longevity and vitality much beyond its merits.¹

I. INTRODUCTION

Father Earle Rowell once called marijuana the “weed of madness.”² Given the nature of the current debate over medicinal marijuana use in the United States, his statement seems prophetic. Patients seriously ill with cancer, multiple sclerosis, and AIDS are being denied access to pain relief recommended by licensed physicians.³ The federal government is threatening to imprison these physicians and their patients if marijuana is prescribed to them. This is so even in states where marijuana has been legalized for medical use

† In memory of Ralph Seely.

* J.D. Candidate 1999, Seattle University School of Law; Clerk, Supreme Court of Washington, the Hon. Charles W. Johnson, 1999-2000; Clerk, Supreme Court of Washington, the Hon. Gerry Alexander, 2000-2001. Thanks to Karen Jensen, Kerry Everett, Professor David Skover and, of course, the carpool (Tana, Nicole, and John). Special thanks to Corrie Greene and my family.

1. *Duckworth v. Arkansas*, 314 U.S. 390, 400 (1941) (Jackson, J., concurring).

2. RUFUS KING, *THE DRUG HANG-UP: AMERICA'S FIFTY YEAR FOLLY 75-76* (1972). Father Rowell preached against the dangers of marijuana during the Great Depression. *Id.*

3. *See, e.g., Seeley v. State*, 132 Wash. 2d 776, 940 P.2d 604 (1997). The plaintiff was suffering from chordoma, a form of terminal bone cancer. One of his physicians recommended that he inhale marijuana to ease the pain and nausea from chemotherapy. Seeley then sought and received a declaratory judgment that the legal classification of marijuana, which prevented him from using it for this purpose, violated the Washington Constitution. The Supreme Court of Washington reversed the decision. *See* Brief of Respondent at 2-6, *Seeley*, 132 Wash. 2d at 776, 940 P.2d at 604 (No. 63534-0).

by popular initiative.⁴ One state legislature has overturned a popular initiative on marijuana use that was adopted by a more than 2-1 margin.⁵ Whatever one's position on the prospect of legalized medicinal marijuana use, one can hardly support the current state of affairs. Change, one way or another, is a legitimate objective. The question is how this change can and should be implemented, and for what reasons. To examine this issue, consider the following hypothetical.

William Cohen is an attorney.⁶ Before law school, he was a newspaper columnist and reporter, as well as the managing editor of a small aviation magazine. He was also an avid backpacker, fly fisherman, and horseback rider. Once, when he was covering a news story about a woman accused of sexual molestation, he was so sure that she was innocent and did not get a fair trial that he decided to become an attorney. After graduating from law school, he became heavily involved in civil rights work and won a nine million dollar verdict in an employment discrimination case. Through it all, Cohen also carried with him the knowledge that he had a terminal disease.

While still a reporter, Cohen was diagnosed with bone cancer. It started when he developed a sore tailbone from horseback riding. Eventually, surgeons discovered and removed a tumor from the base of his spine. For awhile, it looked as if he had beaten the cancer, but it returned while he was in law school. The result was eight additional

4. See Federal News Service, White House Briefing News Conference, December 30, 1996 [hereinafter White House Briefing]. In particular, U.S. Attorney Janet Reno said "U.S. Attorneys in [California and Arizona] will continue to review cases for prosecution and DEA officials will review cases as they have to determine whether to revoke the registration of any physician who recommends or prescribes so-called Schedule I controlled substances. We will not turn a blind eye toward our responsibility to enforce federal law and to preserve the integrity of medical and scientific process to determine if drugs have medical value before allowing them to be used." See also John Ritter, *Medical Marijuana: Legal, but for how long?*, USA TODAY, February 15, 1998, at 10A, in which Chuck Thomas, a spokesman for the Marijuana Policy Project in Washington, warned that "[t]he bottom line has been reinforced once more: Medical users can be sent to prison."

5. The Arizona legislature substantially revised Proposition 200, approved by the voters in 1996. The original proposition had legalized, with certain restrictions, the medical use of marijuana, but the new enactment made legalization dependent on federal legalization either by Congress or by approval of the Drug Enforcement Administration. See ARIZ. REV. STAT. ANN. § 13-3412.01 (West 1997), and the accompanying historical and statutory notes. See also 1997 Ariz. Sess. Laws 124 § 3-5; 246 § 3.

6. This hypothetical is based on the life of Ralph Seeley. The hypothetical was constructed from the following sources: *Seeley v. State*, 132 Wash. 2d 776, 940 P.2d 604 (1997); Brief of Respondent at 2-6, *Seeley* (No. 63534-0); Interviews with Ralph Seeley, in Tacoma, Wash. (October 29, 1997), (December 23, 1997); Jean M. Hilde, *Seeley Wages Battle with Cancer and Violators of Civil Rights*, TRIAL NEWS, March 1996, at 25; Rachel Zimmerman, *Marijuana Mercy Campaigner Lies in Coma*, SEATTLE POST-INTELLIGENCER, January 20, 1998, at B1.

surgeries and ongoing chemotherapy. The cancer caused intense pain, while the chemotherapy led to violent bouts of nausea. Extreme weight loss also followed. Sometimes, Cohen was so debilitated that he ended up on the floor in his own excrement and vomit.

Due to these symptoms, Cohen's oncologist, Dr. Allen, who is well respected in his field, prescribed him Marinol, a synthetic form of THC, the active ingredient in marijuana. No other drugs were working to kill the pain or give Cohen an appetite. The Marinol did help control his nausea, but William usually could not swallow the pills to begin with. Additionally, the effects of the pills were so strong that they knocked him out for fourteen hours or more. Cohen asked his oncologist if he could smoke marijuana instead of ingesting the synthetic THC pills. His oncologist agreed that this was the best option, but it was also illegal. While he wanted to write Cohen a prescription for leaf marijuana, to do so would make both men criminals and could lead to the loss of rights to practice law or medicine as well as a term in prison. This is because federal law does not recognize the right to prescribe marijuana for medical purposes.

Under the Federal Drug Abuse Prevention and Control Act of 1970, marijuana is a Schedule I substance.⁷ This means that it has a high potential for abuse, that there is a lack of accepted safety for the use of the drug under medical supervision, that the drug has no currently accepted medical use in the United States, and that it is not available by medical prescription. Along with marijuana, Schedule I contains heroin and LSD.⁸

This Comment is based on the premise that, were William Cohen to attack the constitutionality of marijuana's classification as a Schedule I substance, the appropriate result under the current substantive due process jurisprudence of the United States Supreme Court would conclude that this classification violates the Due Process Clauses of the Fifth and Fourteenth Amendments.⁹ Since marijuana's placement in Schedule I prevents any form of medical marijuana use, it denies a limited class of seriously ill individuals the right to effective pain relief and proper consultation with a physician. This impinges on funda-

7. See 21 U.S.C. § 801 (1997); 21 C.F.R. § 1308.11 (1997).

8. See 21 C.F.R. § 1308.11 (1997).

9. Almost as important as what this Comment will address is what it will not. This Comment will not suggest that there is a constitutional basis for a blanket legalization of drugs. It will not argue that there is a constitutional basis for private recreational use of drugs, including marijuana. And it will not argue that all individuals should have a constitutional right to the medical use of marijuana. This Comment's sole focus will be the right to the medical use of marijuana by the narrow class of people including William Cohen.

mental rights held by William Cohen and others without a compelling state interest to justify such an intrusion.¹⁰

Section II of the Comment will begin with a brief history of the medical use of marijuana in western culture and the United States. It will then examine the existing federal statutory scheme governing the use of marijuana and conclude with a look at current beliefs about the medical value of marijuana. Section III will analyze previous attempts to collaterally attack the scheduling of marijuana through the courts and show why those efforts have generally failed. Section IV will perform a substantive due process analysis of William Cohen's case and submit that Mr. Cohen has a fundamental right to consult with his physician to ease severe pain. It will then balance this right against the relevant state interests, which it will suggest are illusory. Finally, Section V will examine the policies supporting judicial, as opposed to legislative, solutions to the medicinal marijuana problem and will conclude that judicial action is the only method likely to bring about necessary change.

II. THE HISTORY OF MEDICINAL MARIJUANA USE AND REGULATION IN WESTERN CULTURE AND THE UNITED STATES

This section will discuss the history of marijuana's medicinal use and legal regulation. It will demonstrate that there is an historical basis for marijuana as medicine, and that the current status of marijuana as a Schedule I substance is a politically-based, and not a medically-based, decision.

A. *Pre-1970: Free Use, Prohibition, and Narcotics Taxes*

Marijuana has a history of medicinal use arguably dating back thousands of years. In ancient China, for example, Han Dynasty writers included it in a medical treatise dating back to the fourth century B.C.¹¹ A noted early Chinese physician, Hua T'o, used hemp as an anesthetic.¹²

10. The Fifth Amendment reads in relevant part "No person shall be . . . deprived of life, liberty, or property, without due process of law. . . ." U.S. CONST. amend. V. The Fifth Amendment applies to federal controlled substance legislation. Similar legislation passed by the states would be subject to the Fourteenth Amendment: "No state shall . . . deprive any person of life, liberty, or property, without due process of law. . . ." U.S. CONST. amend. XIV, § 1. This Comment will focus on the constitutionality of the relevant federal laws under the Fifth Amendment.

11. See P. HUARD & M. WONG, CHINESE MEDICINE 10 (1968).

12. See *id.* at 16.

During the nineteenth century, marijuana was also used for medicinal purposes in Great Britain, with Queen Victoria apparently among the patients who utilized it.¹³ In 1893, in response to questions in the House of Commons about marijuana usage in India, the Indian Hemp Drugs Commission convened to study marijuana usage and its effects. After a year's worth of extensive hearings, the commission concluded, among other things, that while extensive use of marijuana could be harmful, small doses could be beneficial.¹⁴

In the United States, the medical qualities of marijuana began to be recognized around 1840.¹⁵ Throughout the nineteenth century, it was used as an anticonvulsant and an analgesic as well as to treat rheumatism, epilepsy, and tetanus.¹⁶ In 1850, marijuana was added to the United States Pharmacopoeia.¹⁷ Perhaps it should come as no surprise then that when America passed its first major drug laws of the twentieth century, marijuana was not among the items taxed or regulated.¹⁸ This changed with the arrival of Harry Anslinger as the head of the U.S. Narcotics Bureau in 1930, the same year that the Bureau became an independent unit of the Treasury Department. Anslinger was instrumental in the passage of the Marijuana Tax Act of 1937.¹⁹

Playing upon the marijuana frenzy, fueled in the late '20s and early '30s by Father Rowell, who traveled across the country destroy-

13. *Seeley*, 132 Wash. 2d at 800, 940 P.2d at 628, n.10 (Sanders, J., dissenting).

14. *Marijuana: Report of the Indian Hemp Drugs Commission 1893-94*, Vol. I. 264, 287, 359 (Silver Spring, Md., Thomas Jefferson Publishing Company) (1969). The Commission noted that, given its findings, "[t]otal prohibition of the cultivation of the hemp plant for narcotics, and of the manufacture, sale, or use of the drugs derived from it, is neither necessary nor expedient in consideration of their ascertained effects. . . ." *Id.*

15. Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 *HAMLIN J. PUB. L. & POL'Y* 117 (1992). For summaries of the early medicinal use of marijuana in the United States, see generally Bilz, *supra* this note at 117-21; *Seeley*, 132 Wash. 2d at 800, 940 P.2d at 628, n.10 (Sanders, J., dissenting); LESTER GRINSPOON M.D., *MARIJUANA RECONSIDERED* 5-13 (2d ed. 1977).

16. *Seeley*, 132 Wash. 2d at 800, 940 P.2d at 628, n.10 (Sanders, J., dissenting).

17. Bilz, *supra* note 15, at 118.

18. See generally Act of February 9, 1909, Pub. L. No. 60-100, 35 Stat. 614 (prohibiting importing of opium for nonmedicinal use); Harrison Narcotics Act of 1914, Pub. L. No. 63-223, 38 Stat. 785, (amended February 24, 1919, Pub. L. No. 65-254, 40 Stat. 1057, 1130). The Harrison Act imposed an excise tax on opium, coca leaves, and their various extracts and placed limits on the distribution and sale of opium and cocaine. The Act did not apply to the medical dispensing of drugs as part of a professional medical or dental practice. For a more detailed analysis of the Harrison Act and the climate in which it was passed, see KING, *supra* note 2, at 15-22, 33-39.

19. Pub. L. No. 75-238, 50 Stat. 551. For details of Harry Anslinger's rise through the ranks, his appointment to the Bureau of Narcotics, and his political campaign against marijuana, see KING, *supra* note 2, at 69-77.

ing hemp fields and preaching against marijuana use,²⁰ Anslinger threw his support behind several marijuana bills introduced to the 75th Congress. Congressional committees were told how marijuana and hashish had ravaged the ancient Muslim world, how studies in Tunisia showed that marijuana caused violent crimes, addiction, sterility, and insanity, and how high school students used marijuana with “deadly” effects.²¹

Significantly, the American Medical Association (AMA) opposed the passage of the Tax Act.²² AMA spokesman Dr. William C. Woodward told the House of Representatives that marijuana did in fact have valid medical uses. He demanded to know why hard evidence of the sensational allegations of crime and addiction had not been produced. Dr. Woodward’s testimony was largely disregarded, however, and the Tax Act became law.²³ Its ultimate impact was to impose registration duties and record-keeping requirements that made marijuana more expensive and more difficult for physicians to prescribe.²⁴ In 1942, marijuana was removed from the United States Pharmacopoeia.²⁵

Another result of the Tax Act was the near impossibility of further research on the medicinal effects of marijuana. Doctors or scientists had to obtain permits in order to conduct such research, and these permits were consistently denied by the Bureau of Narcotics.²⁶ One noteworthy study that was conducted shortly after the Tax Act was commissioned by New York Mayor Fiorello H. La Guardia. The study examined the physical and psychological effects of marijuana, as well as some of the specific allegations made at the Tax Act hearings. Its conclusions included the pronouncement that the horror stories told about marijuana were generally unwarranted.²⁷

Initially, the American Medical Association praised the study and continued to remind people of various medical uses of marijuana.²⁸ Shortly thereafter, however, arguably due to intense political pressure, the AMA reversed course and attacked the final La Guardia findings as unscientific.²⁹ Following the backlash from the La Guardia study,

20. See KING, *supra* note 2, at 75-76.

21. KING, *supra* note 2, at 75-76.

22. See *id.* at 76.

23. See *id.* at 77.

24. Bilz, *supra* note 15, at 118.

25. *Id.*

26. See KING, *supra* note 2, at 82.

27. See *id.* at 83.

28. Bilz, *supra* note 15, at 121.

29. See KING, *supra* note 2, at 84-85.

marijuana became a political hot potato in the scientific community, with doctors and scientists either unwilling to risk their reputations or unable to get the necessary permits to pursue further studies. While eighty-seven marijuana research projects had been licensed by the government in 1948, by 1958 the number was down to six.³⁰

The political climate was also felt in the federal judicial system. In 1949, Federal District Judge William T. McCarthy, in considering a marijuana case, distinguished between marijuana and opium:

After all, opium, or any of its derivatives—and this is not one—have a therapeutic value. They bring consolation to the sick and dying; they make their last days on this earth comfortable. But marijuana has no therapeutic value whatsoever. It has been responsible for the commission of crimes of violence, of murder and of rape. Those are two major tributaries that flow from this use of marijuana. I don't say misuse of it. It has no value of any kind.³¹

The 1950s and 1960s saw an increase in the penalties for use and possession of marijuana and other narcotics, as well as the advent of state laws criminalizing marijuana.³² Indeed, by 1965, possession of marijuana was a crime in all 50 states. Yet even then, almost all the laws at least nominally had exceptions for “(1) state-licensed manufacturers and wholesalers; (2) apothecaries; (3) researchers; (4) physicians, dentists, veterinarians, and certain other medical personnel; (5) agents or employees of the foregoing persons or common carriers; (6) persons for whom the drug had been prescribed or to whom it had been given by an authorized medical person; and (7) certain public officials.”³³ These exceptions would not to be found, however, in the next stage of federal drug regulation, the Comprehensive Drug Abuse Prevention and Control Act of 1970.

30. *See id.* at 85.

31. *Id.* at 88. This passage was included in the Bureau of Narcotics Annual Report for 1949, and hailed as “The Sound Policy of a United States District Judge.” *See also* Caudillo v. United States, 253 F.2d 513, 517 (9th Cir. 1958), where the court held:

There exists the possibility of lawful possession of opium derivatives, or other narcotics, for they have definite therapeutic medical values and a scientific need exists for their possession by many doctors and almost every hospital in the United States. But this Court knows of no medical or scientific use to be made of marihuana, save perhaps for occasional testing, in order to make scientific comparisons with other narcotics, barbiturates and amphetamines.

32. *See generally* KING, *supra* note 2, at 89-92; *Leary v. United States*, 395 U.S. 6, 16 (1969).

33. *Leary*, 395 U.S. at 17 (citing Uniform Narcotic Drug Act § 3-11, 9B Unif. L.A. 472-496 (1966); N.Y. Pub. Health Law §§ 3310, 3320-25, 3330-33 (1954 and Supp. 1968-1969); Tex. Pen. Code, Art. 725b, §§ 5-12 (1961)).

B. 1970-1994: *Drug Schedules and the Attempts to Reschedule Marijuana*

The Comprehensive Drug Abuse Prevention and Control Act of 1970 ("the Act") had several goals, among them: the unification of the various drug enforcement and policy efforts in the United States, the application of the norms and practices agreed upon at the 1961 International Single Convention on Narcotic Drugs, and an inherent flexibility to account for changes in the drug scene and in society as a whole.³⁴

To assure the desired flexibility, the Act created a series of drug schedules, dividing substances into various categories and leaving open the possibility that drugs could be rescheduled in the future.³⁵

Schedule I contains substances with a high potential for abuse, no currently accepted medical use in the United States, and a lack of accepted safety for use of the substance under medical supervision.³⁶ Among the items in Schedule I are heroin, LSD, and marijuana.³⁷ No medical prescriptions are available for Schedule I substances.³⁸ Schedule II also contains drugs with a high potential for abuse.³⁹ Unlike Schedule I, however, Schedule II drugs do have a currently accepted medical use in treatment in the United States, and thus even though they may lead to severe psychological or physical dependence, they are available upon a written nonrefillable prescription.⁴⁰ Schedule II includes various opiates, morphine, cocaine, amphetamines, barbiturates, and PCP.⁴¹ Schedules II through V slowly relax the restrictions on the remaining listed drugs in proportion to the dangers associated with the drugs and their societal value.⁴²

34. See generally 21 U.S.C. § 801 (Congressional findings); ROBERT L. BOGOMOLNY ET AL., A HANDBOOK ON THE 1970 FEDERAL DRUG ACT: SHIFTING THE PERSPECTIVE 5, 63-65 (Springfield, Ill., Charles C. Thomas 1975).

35. See 21 U.S.C. §§ 811, 812.

36. See 21 U.S.C. § 812.

37. See 21 C.F.R. § 1308.11. Foreshadowing the current dilemma, Bogomolny, Sonnenreich, and Roccograndi noted in their 1975 commentary to the Act that "[d]espite any moral bias with regard to marihuana, if it proves successful in treatment, such as in reducing intraocular eye pressure glaucoma, then it *must be* rescheduled to a lower schedule because of its medical use." BOGOMOLNY, *supra* note 34, at 74 (emphasis added).

38. 21 U.S.C. § 812.

39. See 21 C.F.R. § 1308.12.

40. 21 U.S.C. § 812.

41. 21 C.F.R. § 1308.12.

42. See 21 U.S.C. § 812; 21 C.F.R. §§ 1308.12-1308.15.

The authority to examine substances and move them between schedules was given to the Attorney General.⁴³ Before initiating control proceedings, the Attorney General must also seek medical and scientific evaluations from the Secretary of Health, Education, and Welfare.⁴⁴ The Secretary, in turn, is to make a recommendation as to the proper disposition of the substance in question, including which schedule it should be placed in.⁴⁵ The authority to reschedule substances was delegated by the Attorney General to the Director of the Bureau of Narcotics and Dangerous Drugs (now the Drug Enforcement Administration).⁴⁶

The Act had been in effect for scarcely more than a year when the first petition to reschedule marijuana was filed in 1972. The petition asked that marijuana be moved from Schedule I to Schedule V.⁴⁷ The Bureau of Narcotics and Dangerous Drugs (BNDD) quickly declined to file the petition, indicating that the 1961 Single Convention requirements prevented such action. The petitioners appealed to the D.C. Circuit, which remanded the case. The court found the BNDD's decision to be inconsistent with the administrative process, which called for a finding on the merits.⁴⁸

On remand, hearings were held before Administrative Law Judge Lewis Parker in 1975. Judge Parker found that the 1961 treaty did allow for a placement of cannabis or cannabis resin in Schedule II, and cannabis leaves in Schedule V, and further suggested that the proper course of action was to hold rescheduling hearings as called for in the Act.⁴⁹ Nevertheless, the Acting Administrator of the Drug Enforcement Administration (DEA) entered a final order denying the petition "in all respects."⁵⁰ Again, petitioners appealed, and again the D.C. Circuit remanded the case. This time, the court of appeals ordered the DEA to refer the petition to the Secretary of Health, Education and

43. 21 U.S.C. § 811(a).

44. 21 U.S.C. § 811(b).

45. *Id.*

46. See 28 C.F.R. § 0.100, *et. seq.* The DEA became the successor to the BNDD in 1973. See 38 Fed. Reg. 15932 (1973).

47. The petition was filed by the National Organization for the Reform of Marijuana Laws (NORML) and several other groups. See *NORML v. Ingersoll*, 497 F.2d 654, 655 (D.C. Cir. 1974); *NORML v. DEA*, 559 F.2d 735, 740 (D.C. Cir. 1977). Since 1987, the efforts of the major proponents of rescheduling have focused only on a transfer of marijuana to Schedule II. See *In the Matter of Marijuana Rescheduling Petition* [Drug Enforcement Administration], No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of A.L.J. Francis L. Young at 4 [hereinafter *Young Opinion*].

48. *NORML v. Ingersoll*, 497 F.2d at 659, 660.

49. *NORML v. DEA*, 559 F.2d at 742.

50. 40 Fed. Reg. 44,164, 44,168 (1975) (citing *NORML v. DEA*, 559 F.2d at 742).

Welfare (HEW) for an independent scientific evaluation, and to generally comply with the "rulemaking procedures" of the Act.⁵¹

In 1979, when the HEW issued a recommendation that marijuana remain in Schedule I, the DEA issued a final order denying the rescheduling petition, again failing to hold hearings on the matter.⁵² For the third time, the petitioners appealed to the D.C. Circuit, and for the third time the case was remanded, this time for a full reconsideration of the issues. The court of appeals instructed the DEA to refer the substances at issue to the Department of Health and Human Services, successor to the HEW, for a full scientific evaluation and scheduling recommendation.⁵³ The parties complied, and in 1986 the DEA announced that rescheduling hearings would be held before Administrative Law Judge Francis Young.⁵⁴ During the preliminary stages of the hearings, the rescheduling petition was amended to restrict the hearings to consideration of placement of marijuana in Schedule II.⁵⁵ The issues before Judge Young were whether marijuana had a currently accepted medical use, or currently accepted medical use with severe restrictions, and whether there was a lack of accepted safety for use of the marijuana plant under medical supervision.⁵⁶

Extensive evidentiary hearings were held in San Francisco, New Orleans, and Washington, D.C., with final oral arguments before Judge Young in Washington, D.C. in June of 1988.⁵⁷ Based on the evidence before him, Judge Young found that marijuana did not have an accepted medical use to treat glaucoma, but did have accepted medical uses for the treatment of multiple sclerosis, spasticity, hyperarathyroidism, and cancer during chemotherapy. With respect to cancer treatment, Judge Young concluded the following:

[I]t is clear beyond any question that many people find marijuana to have, in the words of the Act, an "accepted medical use in treatment in the United States" in effecting relief for cancer patients. Oncologists, physicians treating cancer patients, accept this. Other medical practitioners and researchers accept this. Medical faculty professors accept it. Nurses performing hands-on patient care accept it. Patients accept it.⁵⁸

51. *NORML v. DEA*, 559 F.2d at 757. Those "rulemaking procedures" are contained in 21 U.S.C. §§ 811 & 812.

52. See Young Opinion at 3. For the final order, see 44 Fed. Reg. 36,123 (1979).

53. See Young Opinion at 3.

54. See *id.* at 4.

55. See *id.*

56. See *id.* at 6.

57. See *id.*

58. *Id.* at 26.

Judge Young also found that there was an accepted safety for use of marijuana under medical supervision.⁵⁹ Overall, Judge Young recommended that the DEA move marijuana to Schedule II.⁶⁰

The DEA, however, rejected Judge Young's recommendation, finding that the phrase "currently accepted medical use" required that more than a minority, "even a respectable minority," of physicians accept the usefulness of marijuana. The DEA Administrator developed and employed an eight-factor test to determine the meaning of "currently accepted medical use" and found that marijuana did not meet the criteria.⁶¹ In particular, he concluded that "[t]he vast majority of physicians do not accept marijuana as having a medical use" and that marijuana was "not recognized as medicine in generally accepted pharmacopoeia, medical references, journals, or textbooks."⁶²

For a fourth time, petitioners appealed to the D.C. Circuit, and for the fourth time the case was remanded. This time, the court found that although the eight-factor test used by the DEA was "in the main acceptable," it contained several factors that could never be met. In particular, the test required general use and acceptance of a drug before it could be removed from Schedule I, even though Schedule I expressly prevented such use and acceptance.⁶³

On remand, the DEA discarded the eight-factor test, removed the elements generally considered impossible to meet, and formulated a new five-factor test.⁶⁴ In addition, the new DEA Administrator

59. See Young Opinion at 66.

60. See *id.* at 67, 68.

61. *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 938 (D.C. Cir. 1991) (citing 53 Fed. Reg. 5,156 (1988)). The eight factors used by the DEA were (1) scientifically determined and accepted knowledge of its chemistry, (2) toxicology and pharmacology of the substance in animals, (3) establishment of its effectiveness in humans through scientifically designed clinical trials, (4) general availability of the substance and information regarding the substance and its use, (5) recognition of its clinical use in generally accepted pharmacopoeia, medical references, journals, or textbooks, (6) specific indications for the treatment of recognized disorders, (7) recognition of the use of the substance by organizations or associations of physicians, and (8) recognition and use of the substance by a substantial segment of the medical practitioners in the United States. *Id.* Under the Act, "currently accepted medical use" is not defined, but the administrator is obliged to consider "scientific evidence of [the drug's] pharmacological effect" and the "state of current scientific knowledge regarding the drug." 21 U.S.C. § 811(c)(2), (3).

62. *Alliance for Cannabis Therapeutics*, 930 F.2d at 938 (citing 54 Fed. Reg. 53,784).

63. See *id.* at 937, 941.

64. See *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131, 1135 (D.C. Cir. 1994) (citing 57 Fed. Reg. 10,506, 10,507 (1992)). The five factor test to determine "currently accepted medical use" is as follows: (1) the drug's chemistry must be known and reproducible, (2) there must be adequate safety studies, (3) there must be adequate and well-controlled studies proving efficacy, (4) the drug must be accepted by qualified experts, and (5) the scientific evidence must be widely available. *Id.*

indicated that his predecessor had not relied on the "impossible" factors in his earlier analysis. Under the new test, the Administrator issued a final order denying the rescheduling petition.⁶⁵ For a fifth and final time the petitioners appealed, objecting to the variations in the evidentiary standard and the alleged bias of the DEA. The court of appeals found, however, that the petitioners had not been prejudiced by the evidentiary standard, and that the Administrator's findings were supported by "substantial evidence."⁶⁶ On February 18, 1994, the petition for review was denied, bringing to an end twenty-two years of marijuana rescheduling litigation in the federal courts.⁶⁷

C. Medical Use of Marijuana Today

At least a "respectable minority" of the modern medical community believes that marijuana has legitimate medicinal value for cancer patients suffering nausea from chemotherapy. In fact, when a random sample of the American Society of Clinical Oncology was questioned about the value of marijuana, more than 1,000 oncologists responded, and forty-four percent reported they had suggested marijuana use to at least one of their patients.⁶⁸ More recently, the editor of the *New England Journal of Medicine* attacked the federal policy on marijuana, arguing that "[t]he 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."⁶⁹ Similarly, after a meeting in February of 1997, a National Institute of Health panel recommended further research on marijuana relating to chemotherapy nausea, wasting due to AIDS, glaucoma, and neuropathic pain.⁷⁰

On the other hand, significant members of the medical community are opposed to the medical use of marijuana. One objection is that leaf marijuana contains over four hundred chemicals, increasing to over two thousand when smoked, and many of these chemicals cannot be identified. This prevents a "precise chemical quantification" of

65. See *Alliance for Cannabis Therapeutics*, 15 F.3d at 1134 (citing 57 Fed. Reg. 10,499).

66. *Id.* at 1137.

67. See *id.* at 1136, 1137.

68. Doblin RE and Kleiman MA, *Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes*, J. CLIN. ONCOLOGY (1991).

69. Jerome P. Kassirer, M.D., *Federal Foolishness and Marijuana*, 5 NEW ENG. J. MED. 366 (1997) [hereinafter *Federal Foolishness*].

70. W.E. Leary, *U.S. Panel Urges Study of Medical Marijuana*, NEW YORK TIMES, February 21, 1997, at A27.

marijuana, and causes problems when attempting to isolate a standardized dosage.⁷¹ Additionally, physicians opposed to marijuana use cite to the availability of alternative remedies such as Ondansetron and Marinol, or synthetic THC.⁷² The American Medical Association, the American Cancer Society, the National Multiple Sclerosis Society, and the American Glaucoma Society also oppose medicinal use of marijuana.⁷³

This division is also reflected politically: voters in some states have approved medicinal marijuana initiatives, while some have not.⁷⁴ Even so, the viability of the state initiative process as a conduit for reform of medicinal marijuana restrictions is in question at this time. After successful initiatives in California and Arizona, the federal government has reminded doctors that federal law still applies and that physicians who prescribe marijuana may lose their licenses and their right to federal funds, as well as face criminal prosecution.⁷⁵

Thus the question is, given this current climate, the history of rescheduling efforts under the Controlled Substances Act, and the history of medicinal marijuana use in the United States, can the federal government constitutionally keep marijuana in Schedule I? Given the circumstances of people like William Cohen, the answer is no.

III. THE CONSTITUTIONALITY OF MARIJUANA IN SCHEDULE I: THE WRONG RIGHTS

The success of a constitutional argument against the placement of marijuana in Schedule I is premised on what is defined as the relevant right. Numerous attempts have been made to attack the constitutionality of this statutory provision. They have included religious rights under the First Amendment, cruel and unusual punishment attacks under the Eighth Amendment, and due process or equal protection

71. Seeley, 132 Wash. 2d at 788, 940 P.2d at 616.

72. See Seeley, 132 Wash. 2d at 789, 940 P.2d at 617. In 1984, a study published in the Proceedings of the American Society of Clinical Oncology suggested that smoked marijuana provided no more relief from nausea than synthetic THC, the active ingredient in marijuana. 132 Wash. 2d at 790, 940 P.2d at 618, n.14. See also Gabriel G. Nahas et al., *Marijuana Is the Wrong Medicine*, WALL ST. J., March 11, 1997, at A22 (denouncing the New England Journal of Medicine's stance on the issue).

73. Seeley, 132 Wash. 2d at 788, 940 P.2d at 616.

74. See generally Cal. Health & Safety Code § 11362.5 (West 1997) (codifying California's Prop. 215, approved by the voters November 5, 1996); 1997 Ariz. Sess. Laws 124 §§ 3-5; 246 § 3 (codifying Arizona's Prop. 200, approved by the voters November 5, 1996); ARIZ. REV. STAT. ANN. § 13-3412.01 (West 1997) (version as modified by Arizona legislature); Hunter T. George, *Voters Reject Broad Drug Initiative*, Associated Press Pol. Serv., Nov. 5, 1997, available in 1997 WL 2560691 (describing rejection of Proposition 685 by Washington voters).

75. See White House Briefing, *supra* note 4.

challenges based on the right to possess marijuana in one's own home. All of these attacks, with some narrow exceptions, have been unsuccessful. This section will summarize these various attempts and explain why they have been rejected. It will demonstrate that these challenges ask courts to address issues that are too broad and would have results that cannot be justified without legislative action. It will conclude that these types of challenges are not necessary when the issue is medical use of marijuana by seriously ill individuals. In other words, when the constitutional issue at stake is medicinal use of marijuana, the protections claimed below are the wrong rights.

A. Cruel and Unusual Punishment

At the time the Comprehensive Drug Abuse Prevention and Control Act of 1970 was passed by Congress, many states had legislation on the books that treated marijuana as a narcotic or hallucinogen and provided for exceptional sentences upon conviction for possession, sale, or distribution.⁷⁶ Thus, in Missouri, one could be sentenced to death for selling marijuana to a minor, and simple possession in Colorado could lead to a sentence of fifteen years.⁷⁷ These sentences lead to attacks on the statutes based on the Eighth Amendment guarantee against cruel and unusual punishment.

The most famous of these cases reached the Supreme Court of Michigan in 1972. Radical poet John Sinclair had been arrested for possession of two marijuana cigarettes, and he faced a minimum sentence under Michigan law of over nine years in prison.⁷⁸ The conviction was overturned for a variety of reasons, with four judges submitting extensive opinions. Justice Brennan, writing to vacate the sentence, held that the minimum term imposed by the statute was "demonstrably and grossly excessive" given the nature of the offense and the disposition of other similar offenses.⁷⁹ The *Sinclair* opinion reflected an attitude in the early 1970s that when marijuana was not distinguished from narcotics or other harder drugs, the resulting sentences were inappropriate and unconstitutional.⁸⁰

76. See Hyman M. Greenstein and Paul E. Dibianco, *Marijuana Laws—A Crime Against Humanity*, 48 NOTRE DAME LAWYER 314 (1972).

77. See *id.*

78. See *Michigan v. Sinclair*, 194 N.W.2d 878, 879 (Mich. 1972). Sinclair was arrested in 1967, and charged with unlawful possession under Michigan law.

79. *Id.* at 906. Justice Adams concurred in that opinion.

80. Some of these decisions viewed the sentence schemes as an equal protection problem. See, e.g., *Sinclair*, 194 N.W.2d at 887 (Swainson, J.); *People v. McCabe*, 275 N.W.2d 497 (Ill. 1971).

Nevertheless, the attack on marijuana scheduling through the sentencing provisions has essentially been foreclosed because marijuana is no longer classified as a narcotic, possession sentences have been greatly reduced, and most simple possession charges result in misdemeanor and not felony dispositions.⁸¹ States have generally eliminated marijuana sentences that truly shock the conscience.⁸² In addition, federal sentencing provisions are generally lenient. They allow for civil dispositions and limited, if any, jail time, especially for first offenders.⁸³ Therefore, whatever one's view of the effectiveness of current marijuana sentences, it is doubtful they would be considered "extreme examples that no rational person, in no time or place, could accept."⁸⁴

B. *Freedom of Speech, Expression, and Religion*

Another avenue of constitutional attack on marijuana scheduling laws has been the First Amendment, and in particular the claim that marijuana use is part of a religious exercise. The federal courts, however, have been relatively clear that no broad religious exception from marijuana laws is constitutionally required.⁸⁵ The passage of the Religious Freedom Restoration Act could have provided some constitutional protection to Rastafarians or others who use marijuana as part of an established religious practice.⁸⁶ Since the Act has been found unconstitutional, however, the issue has been rendered moot.⁸⁷ Even had the Act survived, it would have provided little consolation to those who do not smoke marijuana as part of a religious practice. Since William Cohen wishes to use marijuana for medical, and not

81. See, e.g., *Marcoux v. Attorney General*, 375 N.E.2d 688, 693 (Mass. 1978) (upholding marijuana statute and noting reduction of marijuana possession sentences); *Illinois NORML, Inc. v. Scott*, 383 N.E.2d 1330, 1335 (Ill. 1978). For a summary of cruel and unusual punishment challenges, see 96 A.L.R.3d 225 § 8 (1980).

82. The Missouri law that once allowed for the death penalty for sale of marijuana to a minor now makes the same crime a class B felony, punishable by a maximum of fifteen years in prison. See MO. ANN. STAT. §§ 195.212, 558.011 (West 1997).

83. See, e.g., 21 U.S.C. § 844 (1997). This provision provides relatively lenient sentencing options for simple possession of marijuana and other substances, especially in the case of first offenders, who may receive a maximum of one year's imprisonment and a \$1,000 fine. The sentencing guidelines also distinguish between marijuana and other substances such as cocaine, where a minimum five-year prison term is imposed. See *id.* Finally, a 1988 addition to the Act allows for a civil penalty not to exceed \$10,000 in cases where the amount possessed is deemed to be for "personal use" under regulations promulgated by the Attorney General. See *id.*

84. *Harmelin v. Michigan*, 501 U.S. 957, 1018 (1991) (rejecting Eighth Amendment proportionality review of drug sentence).

85. See, e.g., *United States v. Greene*, 892 F.2d 453, 456-457 (6th Cir. 1989) (citing numerous federal cases to support this conclusion).

86. See *United States v. Bauer*, 75 F.3d 1366, 1376 (9th Cir. 1995).

87. See *City of Boerne v. Flores*, 117 S. Ct. 2157 (1997).

religious purposes, neither the Act nor the First Amendment are applicable.⁸⁸

C. Equal Protection

Numerous equal protection challenges have been advanced on the theory that marijuana possession statutes impose penalties not imposed upon users of alcohol, tobacco, and other substances.⁸⁹ Almost unanimously, state and federal courts have rejected this argument on the grounds that legislatures may engage in so-called piecemeal lawmaking: "Whatever the harmful effects of alcohol and tobacco . . . , Congress is not required to attempt to eradicate all similar evils."⁹⁰ Federal courts, in particular, have applied rational basis review and have declined to act as a "superlegislature" in evaluating policy choices between the regulation of marijuana, alcohol, and tobacco, emphasizing that these issues do not invoke "fundamental rights."⁹¹ The same can be said of continuing attempts to invoke the Due Process Clause as a protection to possess and use marijuana in one's own home.

D. Due Process Privacy Right to Possess Marijuana in the Home

The concept that one's home is a castle, as related to the private use of controlled substances, dates back more than a century. The earliest cases addressing the issue dealt with the right to possess and consume liquor in the home.⁹² The cases that found statutes preventing private liquor possession unconstitutional relied on the philosophical underpinnings of William Blackstone, John Stuart Mill, and the common law maxim of *sic utere tuo ut alienum non laedas*.⁹³ The well-known Latin phrase, normally applied to property rights, reflected the idea that one who consumed liquor in his own home injured nobody but himself, and thus could not be subjected to the controls of

88. For other marijuana cases rejecting First Amendment claims, see 96 A.L.R.3d 225 § 7 (1980). Although there is no First Amendment right to use marijuana for medical purposes, there is almost certainly a right to publicly advocate its use for such purposes. See, e.g., *State v. Marsh*, 1997 WL 633000 (Wash. App. Div. 1) (1997) (unpublished opinion).

89. See generally *United States v. Fry*, 787 F.2d 903, 905 (4th Cir. 1986) (citing *Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955)); *Ravin v. State*, 537 P.2d 494, 512 (Alaska 1975); *State v. Kells*, 259 N.W.2d 19, 24 (Neb. 1977); *Illinois NORML*, 383 N.E.2d at 1336. Cf. *State v. Leigh*, 46 U.S.L.W. 2425 (CC Fla. 1978).

90. *Fry*, 787 F.2d at 905.

91. *Greene*, 892 F.2d at 455, 456.

92. See generally *State v. Gilman*, 10 S.E. 283 (W.Va. 1889); *Commonwealth v. Campbell*, 117 S.W. 383 (Ky. 1909).

93. See *Gilman*, 10 S.E. at 284; *Campbell*, 117 S.W. at 385-87. *Sic utere tuo ut alienum non laedas*: "one should use his own property in such a manner as not to injure that of another." BLACK'S LAW DICTIONARY 1380 (6th ed. 1990).

the state. Similarly, Mill's essay *On Liberty* suggested severe limitations on the exercise of a state's police power in the name of the natural rights of individuals.⁹⁴

Indeed, Mill's ideas have been influential enough to survive into modern case law. In *Sinclair*, for example, one of the justices voting to overturn the marijuana statute suggested that the Due Process Clause itself incorporated Mill's ideas and thus prohibited legislation against private marijuana possession.⁹⁵ While not going this far, the Supreme Court of Alaska recognized that the right to privacy protects the possession and use of marijuana in the home in *Ravin v. State*.⁹⁶ These cases, however, by far represent the minority opinion in current privacy jurisprudence.

For one, these cases are severely limited in their precedential value. The earliest cases hail from an era when the courts regularly invalidated statutes under now discredited substantive due process analysis.⁹⁷ The *Sinclair* opinion represents the writing of one judge on a fragmented court, and relies on no citation at all to legal authority.⁹⁸ And the *Ravin* case has not only been sharply restricted in its application, but arguably was based primarily on the Alaska Constitution, and not on federal rights.⁹⁹ Thus, when other plaintiffs have attempted to apply the reasoning of *Ravin*, they have consistently been denied relief.¹⁰⁰ The reason why is that the courts, under a modern substantive due process analysis, have determined that there is no fundamental right to smoke marijuana, even in the home.¹⁰¹

94. [T]he only purpose for which power can be rightfully exercised over any member of the community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others to do so would be wise, or even right.

Campbell, 117 S.W. at 386 (citing *On Liberty*, 22-23).

95. See *Sinclair*, 194 N.W.2d at 896 (Kavanagh, J.). Justice Kavanagh cites the same passage from Mill that the *Campbell* court relied upon. He then continues, "[a]lthough it is conceivable that some legitimate public interest might warrant state interference with what an individual consumes, 'Big Brother' cannot, in the name of Public health, dictate to anyone what he can eat or drink or smoke in the Privacy of his own home." *Id.*

96. See *Ravin*, 537 P.2d at 511.

97. See, e.g., *Lochner v. New York*, 198 U.S. 45 (1905).

98. See *Sinclair*, 194 N.W.2d at 896 (Kavanagh, J.).

99. See *Ravin*, 537 P.2d at 500 (conducting state constitutional analysis to reach conclusion on privacy right). See also *Marcoux*, 375 N.E.2d at 691 (rejecting *Ravin* in part because the decision rested on art. 1, § 22 of the Alaska constitution); *State v. Erickson*, 574 P.2d 1, 12 (Alaska 1978) (declining to apply *Ravin* to cocaine).

100. See, e.g., *Marcoux*, 375 N.E.2d at 691; *Kells*, 259 N.W.2d at 23.

101. See generally *Seeley*, 132 Wash. 2d at 784, 940 P.2d at 612; *Marcoux*, 375 N.E.2d at 690-91; *Kells*, 259 N.W.2d at 23; *Greene*, 892 F.2d at 456; *Fry*, 787 F.2d at 905.

This, in turn, subjects marijuana statutes challenged on this ground to rational basis review, a standard that is very easy to satisfy. Hardly anyone can argue that laws preventing the use of marijuana do not have at least some rational connection to some legitimate state interest, particularly relating to the protection of the public health, safety, and morals.¹⁰²

Of course, many of these cases are distinguishable from the case of William Cohen in the sense that most did not deal with medical use, but merely with the criminalization of simple possession. Notably though, the Supreme Court of Washington recently applied the "fundamental right to smoke marijuana" analysis as part of its premise to reject a claim made by a terminally ill cancer patient.¹⁰³ This suggests that the standard possession privacy approach will not be successful no matter whom the plaintiff is. Thus, in order to avoid rational basis review, a constitutional challenge to the placement of marijuana in Schedule I must be based on different rights: rights that the courts will, or already have, considered fundamental. Only these rights can justify the Court's engagement in a more heightened scrutiny of the legislation at issue.

IV. THE CONSTITUTIONALITY OF MARIJUANA IN SCHEDULE I: THE RIGHT RIGHT

A substantive due process claim under current doctrine, in order to succeed, all but requires that the right asserted implicate a fundamental liberty. Only then will the Court depart from rational basis analysis and engage in a careful balancing of liberty and authority.¹⁰⁴

How one determines whether a right is fundamental is unclear given the most recent decisions of the Court. One definition limits fundamental rights to those "deeply rooted in this Nation's history and tradition."¹⁰⁵ An alternate approach would find a fundamental right abridged when "a statute sets up one of those 'arbitrary impositions' or 'purposeless restraints' at odds with the Due Process Clause of the

102. A common rational basis argument, for example, is the state's interest in keeping the roadways safe from drivers under the influence of marijuana. See, e.g., *Ravin*, 537 P.2d at 511. Furthermore, under the deference that rational basis review affords to the legislature, as long as there are conflicting opinions about the medical value of marijuana, the legislature's judgment is likely to stand. See *Fry*, 787 F.2d at 905.

103. See *Seeley*, 132 Wash. 2d at 784, 940 P.2d at 612.

104. See, e.g., *Washington v. Glucksberg*, 117 S. Ct. 2258, 2281-83 (1997); *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990).

105. *Glucksberg*, 117 S. Ct. at 2268 (citing *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) ("so rooted in the traditions and conscience of our people as to be ranked as fundamental")).

Fourteenth Amendment.”¹⁰⁶ The second test, most recently advanced by Justice Souter in *Washington v. Glucksberg*, has the advantage of avoiding “the absolutist failing of many older cases without embracing the opposite pole of equating reasonableness with past practice described at a very specific level.”¹⁰⁷ Whichever test is employed, though, the right asserted by William Cohen should be considered fundamental if it is narrowly defined. The narrower the asserted liberty interest, the easier it will be for the Court to recognize it; the broader the interest, the more stark the implications will be.

For example, a broad right to smoke marijuana would mean that not only possession, but also sale and distribution of marijuana would be protected. Similarly, marijuana use could not be restricted to those with a medical need. Such a right would not qualify as fundamental under either of the above tests. If, however, the asserted interest is a narrow right of the seriously ill to consult with a physician in a manner necessary to control severe pain, the right should receive heightened protection under the Due Process Clauses of the Fifth and Fourteenth Amendments.¹⁰⁸ In fact, there is substantial authority to suggest that such a fundamental right already has been recognized, that it is rooted in this Nation’s history, and that to abridge it would indeed enact an arbitrary and purposeless restraint. This fundamental right should be applied to the medicinal use of marijuana and properly balanced against competing state interests.

A. *The Fundamental Liberty Interest*

There are longstanding fundamental rights to both bodily integrity and consultation with a physician. The genesis of these rights is generally traced back to the Common Law.¹⁰⁹ Blackstone recognized a right to “personal security” which included “a person’s legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation.”¹¹⁰ Protection extended to “[t]he preservation of a

106. *Glucksberg*, 117 S. Ct. at 2275 (Souter, J., concurring); see also *Planned Parenthood v. Casey*, 505 U.S. 833, 848 (1992). Presumably this test would apply to the Due Process Clause of the Fifth Amendment if the challenged legislation were federal, and not state.

107. *Glucksberg*, 117 S. Ct. at 2281.

108. This analysis, like much modern substantive due process analysis, could also apply to an equal protection challenge to the statute, “but that source of law does essentially nothing in a case like this that the Due Process Clause cannot do on its own.” *Id.* at 2277, n.3.

109. See, e.g., *Glucksberg*, 117 S. Ct. at 2288 (Souter, J., concurring) (linking right of bodily integrity to common law of battery).

110. William Blackstone, *Of the Rights of Persons*, COMMENTARIES ON THE LAWS OF ENGLAND 125 (Univ. of Chicago Press ed. 1979) (1765).

man's health from such practices as may prejudice or annoy it. . . ."111 An oft-quoted early modern statement of this right comes from Justice Cardozo who, while on the New York Court of Appeals, opined that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."112

The Supreme Court has applied variations of this right to many different factual situations, affording due process protection to procreation, contraception, child bearing, abortion, and most notably, the hastening of death by refusal of medical treatment.¹¹³ This last application, in *Cruzan v. Director, Missouri Dept. of Health*, has also been interpreted as a right of "freedom from state-inflicted pain."¹¹⁴

In *Washington v. Glucksberg*, the Supreme Court declined to extend a right of bodily integrity to allow terminally ill, mentally competent patients access to physician assisted suicide.¹¹⁵ Nevertheless, a majority of the Justices in that case based their opinions on the fact that the patients in question were not being denied relief from pain. Justice Stevens, for example, suggested that plaintiffs had a strong liberty interest in avoiding suffering:

[N]ot only were they terminally ill, they were suffering constant and severe pain. Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."¹¹⁶

Likewise, Justice Souter, in addressing one of the State's arguments against a right to die, noted that unlike the circumstances in cases of assisted suicide, "the importance of pain relief is so clear that there is less likelihood that relieving pain would run counter to what

111. *Id.* at 130. This portion of Blackstone's work has been recognized by American Courts and cited approvingly. See, e.g., *Ketterer v. Armour & Co.*, 247 F. 921, 923 (2d Cir. 1917).

112. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914). For an early recognition of the right by the Supreme Court, see *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891): "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference with others, unless by clear and unquestionable authority of law." *Botsford*, 141 U.S. at 251.

113. See generally *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (child rearing); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) (refusal of medical treatment to hasten death).

114. *Glucksberg*, 117 S. Ct. at 2311 (Stevens, J., concurring) (citing *Cruzan*, 497 U.S. 261).

115. See *id.* at 2259.

116. *Id.* at 2307 (Stevens, J., concurring) (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

a responsible patient would choose. . . ."¹¹⁷ Finally, Justices Breyer, Ginsburg and O'Connor did not even address the asserted due process right to avoid suffering, because they assumed that the patients had access to palliative care.¹¹⁸

In the case of William Cohen, the right asserted raises implications similar to the right in *Glucksberg*. Mr. Cohen is terminally ill and in grave pain. In the name of personal bodily integrity, he seeks protection of his right to the counsel of a physician to help him end that pain. But unlike the assisted suicide cases where the availability of palliative care is assumed, this case is about the denial of palliative care. In that sense, it is like *Cruzan*, in which the patient was found to have a right to be free of state inflicted pain.¹¹⁹ Because it involves state interference with medical judgment, it is also like *Roe*, where the Court determined that decisions on abortion in the first trimester of pregnancy were medical in nature and should be left to the mother's physician.¹²⁰

Under the preceding jurisprudence, Mr. Cohen's liberty interest in consulting with his physician and avoiding pain and suffering is fundamental and must therefore be balanced with the interests of the State.

B. *Balancing the State Interests*

After determining that a person has a valid fundamental liberty interest under the Due Process Clause, the next step is to balance that interest against the relevant state interests.¹²¹

Significantly, there are no state interests involved in this case reaching the magnitude of certain earlier substantive due process cases. For example, the State does not have an interest in protecting fetal life, as in the abortion cases.¹²² The State also does not have an interest in protecting people who may be mentally incompetent from making

117. *Id.* at 2291 n.16 (Souter, J., concurring).

118. *See id.* at 2303 (O'Connor, J., concurring), 2310 (Ginsburg, J., concurring for the reasons given by Justice O'Connor), 2312 (Breyer, J., concurring). Justice Breyer stated "were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law's impact upon serious and otherwise unavoidable physical pain would be more directly at issue." *Id.* at 2312.

119. *Glucksberg*, 117 S. Ct. at 2305 (Stevens, J., concurring) (citing *Cruzan*, 497 U.S. at 269).

120. *Roe*, 410 U.S. at 164.

121. *Cruzan*, 497 U.S. at 279.

122. *See Roe*, 410 U.S. at 162; *Casey*, 505 U.S. at 844. Note that the case of William Cohen, quite obviously, also does not implicate the other state interest laid out in the abortion cases: protecting the health of pregnant mothers.

significant decisions about life and death. This interest was at issue both in *Cruzan* and *Glucksberg*, which involved physician-assisted suicide and the termination of life support, and played an important role in the Court's decisions.¹²³ Without these interests, the State must rely on traditional interests in preventing the proliferation of dangerous drug usage and preserving the health and morals of society.

Since the nineteenth century, however, courts have been aware that these types of state interests may only reach so far. For example, in 1890, the Supreme Court of Washington, in a 3-2 decision, found that a territorial opium law did not violate the Constitution.¹²⁴ Justice Scott assailed the law as overbroad in his dissent, however, because it did not distinguish between recreational and medicinal usage of opium:

I make no question but that the habit of smoking opium may be repulsive and degrading. That its effect would be to shatter the nerves and destroy the intellect; and that it may tend to the increase of pauperism and crime. But there is a vast difference between the commission of a single act, and a confirmed habit. There is a distinction to be recognized between the use and abuse of any article or substance. It is also well known that opium, in its different forms, is frequently administered as a medicine with beneficial results; and while it may not be customary to administer it by way of inhalation, yet the legislature should not arbitrarily prevent its use in such a manner.¹²⁵

This opinion recognizes that while drug use may be insidious, the mere fact that a statute is designed to prevent abuse of controlled substances does not make it constitutional. Thus, in analyzing the State's asserted interests in the context of drug use prevention, two important points should be considered. First, those interests pertaining strictly to the recreational use of marijuana should be separated from those that potentially apply to medicinal use. And second, these interests should be examined in light of the possibility that they could be accomplished if marijuana were placed in Schedule II.¹²⁶

123. See *Cruzan*, 497 U.S. at 279; *Glucksberg*, 117 S. Ct. at 2272.

124. See *Territory v. Ah Lim*, 1 Wash. 156 (1890).

125. *Id.* at 174-75 (Scott, J., dissenting). Justice Stiles concurred with Justice Scott. See also *In re Ah Jow*, 29 F. 181 (C.C.D. Cal. 1886) (releasing convict on petition for habeus corpus due to overbreadth of opium statute).

126. For example, in a footnote in *Seeley*, the Supreme Court of Washington cites numerous cases in support of the premise that marijuana's classification does not violate due process. The cases cited involving marijuana, however, do not deal with medical use of marijuana, but use in general. See *Seeley*, 132 Wash. 2d at 791, 940 P.2d at 619 n.20 (citing *Fry*, 787 F.2d at 903; *Bell*, 488 F. Supp. at 134 n.29; *State v. Dickamore*, 22 Wash. App. 851, 592 P.2d 681 (1979)). Thus,

The State has advanced numerous interests in support of keeping marijuana in Schedule I. They include the lack of comprehensive knowledge about marijuana's effects, the conflict in the medical community about its viability as a medicine, the public health risk associated with high contents of carcinogens and other unknown substances, and the potential of marijuana to act as a "gateway" to other drugs and send the wrong message to society.¹²⁷

Since recreational use is not an issue in this case, certain of these interests are at best only marginally applicable. Quite obviously, for example, the presence of carcinogens and other harmful substances is not relevant to a plaintiff who is already dying of cancer, or in the advanced stages of multiple sclerosis.

Nor does the argument that marijuana is a "gateway" drug that will send the wrong message to society make any sense in the context of medicinal use. This position is completely debunked by a recent article in the *New England Journal of Medicine*.¹²⁸ Addressing the improper message argument, the Journal cites to Boston Globe columnist Ellen Goodman, who asked "What is the infamous signal being sent to [children]? . . . If you hurry up and get cancer, you, too, can get high?"¹²⁹ Responding to the "gateway" argument, the Journal cited a 1994 study finding that 83 percent of then current marijuana users never try cocaine.¹³⁰

And while the above study also tells us that 17 percent of marijuana users have tried harder drugs, this is at best an argument against blanket legalization. Like the other state interests noted above, the "gateway" problem will become no more severe if marijuana is placed in Schedule II. It is hard to imagine that the placement of cocaine, opiates, morphine, amphetamines, barbiturates, and PCP in Schedule II is also sending a message to children to use these drugs. Just as ridiculous is the suggestion that the placement of these drugs in Schedule II opens the door to experiment with them as a stepping stone to harder Schedule I substances such as LSD or heroin. Many Schedule II drugs are equally, if not more, dangerous than marijuana.

they are based on rational basis review of the wrong rights, and not applicable.

127. For advancements of these state interests, see generally *Seeley*, 132 Wash. 2d at 790, 940 P.2d at 618; *NORML v. Bell*, 488 F. Supp. 123, 136, 139 (D.D.C. 1980); *Kells*, 259 N.W.2d at 22-24.

128. See George J. Annas, *Reefer Madness—The Federal Response to California's Medical-Marijuana Law*, 6 NEW ENG. J. MED. 337 (1997).

129. *Id.*

130. *Id.*

The State may also assert that since THC, the active ingredient in marijuana, is available in synthetic form, this should allow more comprehensive regulation of smoked marijuana. There are several problems with this assertion. First, as noted before, synthetic THC, or Marinol, has several side-effects not associated with smaller doses of smoked marijuana. For example, one Marinol dose may render a patient virtually unconscious for extended periods of time. In addition, patients wishing to take smoked marijuana to avoid the nausea associated with chemotherapy may not be able to swallow doses of Marinol.¹³¹ Second, even if patients are able to take Marinol, and obtain the same results as smoked marijuana, Marinol may not be available to them.¹³²

Finally, unlike other controversial drugs such as laetrile, marijuana is not being advanced as a cure for any of the diseases in question, but merely as a painkiller.¹³³ Thus the question as to its effectiveness is best left to the patient in consultation with his physician.¹³⁴ If the State, as well as at least a respected minority of the medical community, can acknowledge that marijuana gives a dying man comfort, it is

131. See Brief of Respondent at 2-6, *Seeley* (No. 63534-0); *Federal Foolishness*, *supra* note 69 (discussing difficulty in properly titrating doses of synthetic THC).

132. Consider the case of Todd McCormick, a longtime bone cancer patient and marijuana user arrested in California for the cultivation of 4,000 marijuana plants at a Bel Air mansion. When U.S. Magistrate James McMahan thought that McCormick, who was awaiting trial, was using his Marinol treatments to mask the continued use of smoked marijuana, McMahan ordered McCormick to stop using Marinol as well. McCormick was eventually jailed after he continued to test positive for chemical marijuana. U.S. District Judge George H. King overruled McMahan's order jailing McCormick, but maintained the Marinol prohibition. At the time of this writing, McCormick's trial is pending in United States District Court in California. See Matt Krasnowski, 'Pot Prince' Jailed After Positive Tests: Tearful McCormick Insists He Has Obeyed the Judge, SAN DIEGO UNION TRIBUNE, April 4, 1998 at A18; Linda Deutsch, *Marijuana Activist Freed Pending Court Hearing*, Associated Press (April 15, 1998).

133. The *Seeley* court, for example, also relied on some of the laetrile cases of the 1970s to conclude that there is no due process right to ingest marijuana to relieve severe pain. See *Seeley*, 132 Wash. 2d at 791, 940 P.2d at 619, n.20. But laetrile was advanced by doctors as a cure for cancer and a substitute for other forms of treatment. Patients were even encouraged in some instances to discontinue more traditional treatment, even if such treatment might be effective for them, and to begin taking laetrile. See, e.g., *People v. Privitera*, 591 P.2d 919, 923-25 (Cal. 1979). Accordingly, the "legitimate state interest" advanced in the laetrile cases was "the effective diagnosis, care, treatment, or cure of persons suffering from cancer . . ." *Id.* at 923. No such interest can be advanced to prevent the use of marijuana as a painkiller, since such use in no way interferes with the diagnosis or treatment of illnesses. See also *United States v. Rutherford*, 442 U.S. 544 (1979).

134. See, e.g., *Seeley*, 132 Wash. 2d at 795, 940 P.2d at 623 (Sanders, J., dissenting) (noting that the State "cannot dispute Mr. Seeley's beliefs about marijuana and how it affects him . . ."); *Privitera*, 591 P.2d at 924 ("What can 'effective' mean if the person, by all prevailing standards . . . is going to die of cancer regardless of what may be done").

hard to see how the State can also assert that marijuana has “no currently accepted medical use.”¹³⁵

Ultimately, these arguments do not mean that the State must take the most sensible path simply because there is a conflict in authority. But recalling the substantive due process test as including a “freedom from all substantial arbitrary impositions and purposeless restraints,” the State must advance a more compelling interest to keep marijuana in Schedule I, rather than Schedule II, at the expense of suffering and seriously ill individuals.¹³⁶ While the legislature may seem to be the ideal place to come to this conclusion, there are significant reasons to believe that the responsibility must lie with the Court.

V. POLICIES SUPPORTING JUDICIAL REVIEW

If we balance the individual and state interests elaborated above, it becomes clear that the individual right is more compelling. The question then becomes whether the Court, as opposed to state or federal legislatures, is the best place for William Cohen to seek protection of this right. As will be shown below, however, both state and federal political systems are not effective forums to address this issue. First, federal enforcement of the Drug Abuse Prevention and Control Act places a chokehold on the states’ freedom to legislate their own solutions to the medicinal marijuana problem. Second, the plight of terminally ill patients seeking marijuana is unlikely to be addressed by the federal political process because of the continuing stigma attached to marijuana users and physicians willing to prescribe marijuana. This leaves the Court as the only viable option for William Cohen and those in similar circumstances.

A. *Stymieing the States*

Recently a headline in USA Today proclaimed: “Medical Marijuana: Legal, but how long?”¹³⁷ This accurately reflects the shadow hanging over state legislatures that would deal with the medical marijuana problem themselves, or even grassroots campaigners at a state level seeking to win the passage of a popular initiative.

Of course, under the principles of federalism, the states should be laboratories for “social and economic experiments.”¹³⁸ A corollary of this idea is that citizens opposed to certain controversial policy

135. 21 U.S.C. § 812(b)(1)(B).

136. *Casey*, 505 U.S. at 848 (citing *Poe v. Ullman*, 367 U.S. 497, 543 (1961)).

137. See Ritter, *supra* note 4, at 10A.

138. See *New State Ice Co. v. Liebman*, 285 U.S. 262, 311, (1932) (Brandeis, J., dissenting).

choices will “vote with their feet” by locating in a state providing the package they most prefer.¹³⁹ This state flexibility invariably reduces the need for the Court to engage in substantive due process.¹⁴⁰

This was readily apparent from Justice Souter’s opinion in *Glucksberg*. Recognizing the factual disagreement over the feasibility of governmental regulation of assisted suicide, Justice Souter noted that the best precedent available for comparison was the Dutch experience, which he found inadequate for judicial evaluation. Citing to the superior ability of the legislature to evaluate the wisdom of such social policies, Justice Souter then went on to suggest that “[t]here is, indeed, good reason to suppose that in the absence of a judgment for the respondents here, just such experimentation will be attempted in some of the States.”¹⁴¹

As shown above, however, there is no reason to believe that any such experimentation will be allowed in the context of medicinal marijuana use. The federal government has made it clear that despite the passage of popular initiatives in Arizona and California, federal marijuana laws will still be enforced against those who use or distribute marijuana for medical purposes.¹⁴² Several bills have also been introduced in Congress to allow for sanctions against physicians who prescribe medicinal marijuana.¹⁴³ In sum, this effectively prevents states such as California and Arizona from attempting to develop workable regulation schemes that would allow applicable patients to use marijuana while at the same time adequately protecting the legitimate State interests at stake.¹⁴⁴ The prospect of state solutions,

139. See, e.g., Prichard, *Securing the Canadian Economic Union: Federalism and Internal Barriers to Trade*, *Federalism and the Canadian Economic Union*, 6, 17-18 (1983).

140. See, e.g., *Glucksberg*, 117 S. Ct. at 2293 (Souter, J., concurring).

141. *Id.* (citing ORE. REV. STAT. ANN. § 127.800 (Supp. 1996)). Justice Souter was, of course, referring to the adoption of Oregon’s assisted suicide initiative.

142. See, e.g., White House Briefing, *supra* note 4.

143. See generally S. 3, 105th Cong. (1997); S. 40, 105th Cong. (1997).

144. In reality, the authority of the states to enact legislation that places marijuana in Schedule I may be even more limited than the authority of Congress. For more than a century, the courts have placed substantive restrictions on the exercise of state police power regulations. The police power extends generally to the health, safety, and morals of the public. The interests of society as a whole must justify the regulation, however, and the means must be reasonably necessary to accomplish the end “and not unduly oppressive on individuals.” *Lawton v. Steele*, 152 U.S. 133, 136, 137 (1894). This is considered the classic statement of the restraints on the police power, and is still frequently cited. See, e.g., *Goldblatt v. Hempstead*, 369 U.S. 590, 594 (1962). It has also been applied to the issue of laws preventing marijuana use. See generally *Seeley*, 132 Wash. 2d at 797, 940 P.2d at 625 (Sanders, J., dissenting); *State v. Baker*, 535 P.2d 1394, 1406 (Haw. 1975) (Kobayashi, J., dissenting); *State v. Mallan*, 950 P.2d 178, 192 (Haw. 1998) (Levinson, J., dissenting). Whether state marijuana laws satisfy this standard is beyond the scope of this Comment. Even if, however, the Court were to find current federal marijuana

through the legislature or by initiative, becomes nothing more than a paper tiger.

B. Failures of the Federal Political Process

When refusing to invalidate the placement of marijuana in Schedule I on constitutional grounds, courts have reminded litigants that the judiciary does not sit as a "superlegislature," and will not reconcile conflicting policy choices.¹⁴⁵ In essence, courts have deferred to the legislature's determinations on the placement of marijuana. This deference is improper in the context of the present case. First, as noted above, the Court should be engaging in heightened scrutiny. William Cohen asserts a right that is fundamental and must therefore be more carefully balanced against the State's interests. Courts deferring to the legislature have engaged in rational basis review of the right to smoke marijuana, and not the more searching analysis based on legislation implicating the right to palliative care and pain relief.¹⁴⁶ Second, judicial review is appropriate because the federal political mechanisms designed to address grievances of this nature are ineffective when medicinal marijuana is involved.

This premise has been borne out already by the manner in which petitions for the rescheduling of marijuana have been approached by the DEA. One major goal of the 1970 Act was to allow for flexibility in the drug schedules and modifications when they proved necessary.¹⁴⁷ Specific statutory criteria are designed to govern this process.¹⁴⁸ Yet these seven criteria were not cited when the DEA, under the authority of the Attorney General, repeatedly denied petitions to reschedule marijuana. In fact, DEA administrators twice created their own lists of factors to determine the meaning of the phrase "currently accepted medical use."¹⁴⁹ These factors were not found anywhere in the statute, and the D.C. Circuit Court of Appeals determined that at least one of the lists contained factors that were impossible to meet.¹⁵⁰ These factors were utilized by the DEA to reject the findings of its own administrative law judge, who conducted extensive evidentiary hearings and suggested that marijuana be moved to

restrictions unconstitutional, this would not stop the states from adopting their own variations.

145. See, e.g., *Fry*, 787 F.2d at 905; *Greene*, 892 F.2d at 455; *Bell*, 488 F. Supp. at 142.

146. See *Fry*, 787 F.2d at 905; *Greene*, 892 F.2d at 455-56; *Bell*, 488 F. Supp. at 138.

147. See 21 U.S.C. § 801.

148. 21 U.S.C. § 811(c).

149. *Alliance for Cannabis Therapeutics*, 930 F.2d at 938; 15 F.3d at 1135.

150. *Alliance for Cannabis Therapeutics*, 930 F.2d at 941.

Schedule II.¹⁵¹ Indeed, granting authority to the DEA to determine whether marijuana should be rescheduled is like letting the fox guard the henhouse.

In addition, the political process is inadequate to address the rights at issue in this case because of the stigma attached to the use of marijuana. As Justice Stone noted in his famous *Carolene Products* footnote, when legislation negatively impacts upon the political process that could be expected to bring about its repeal, it may be subject to "more exacting judicial scrutiny. . . ."¹⁵² The social consequences of promoting marijuana rescheduling are such that this prospect should be given serious consideration here.

For example, physicians groups might wield enough political influence to lobby for a change in federal marijuana policy. Faced, however, with threats of criminal prosecution, as well as threats to their licenses and reputations, they may decline to exercise this power.¹⁵³ Even grassroots campaigners will feel similar pressures.

For example, a Washington man recently convicted of marijuana possession was sentenced to a community placement program that prevented him from advocating the medicinal use of marijuana. The state court of appeals reversed the sentence as a violation of the First Amendment.¹⁵⁴ Nevertheless, the case demonstrates the strong connection between medicinal marijuana use and criminal conduct, and shows why many who would advocate medicinal use of marijuana may be unwilling, or even unable, to do so.

None of these arguments suggest that, under ideal circumstances, the Court is the superior branch of government to address these types of questions. But, "[s]ometimes a court may be bound to act regardless of the institutional preferability of the political branches as forums for addressing constitutional claims."¹⁵⁵ Given the political climate that has surrounded the use of marijuana since the early

151. See Young Opinion, *supra* note 47, at 67; *Alliance for Cannabis Therapeutics*, 930 F.2d at 938.

152. *United States v. Carolene Products*, 304 U.S. 144, 152 n.4 (1938).

153. See generally White House Briefing, *supra* note 4; *WHO's Marijuana Report Squelched, Magazine Says*, Boston Globe, February 19, 1998, at A2 (discussing possible suppression of report by the World Health Organization finding that cannabis is safer than alcohol or tobacco, for fear it would "give ammunition" to the campaign to legalize marijuana); 143 Cong. Rec. E629-02 (Thursday, April 10, 1997) (Statement of Representative Solomon) (announcing introduction of the Medical Marijuana Prevention Act, which would require the DEA to revoke the federal license of a physician who recommends smoked marijuana for medical treatment).

154. See *State v. Marsh*, 1997 WL 633000 (Wash. App. Div. 1) (1997) (unpublished opinion).

155. *Glucksberg*, 117 S. Ct. at 2293 (citing *Bolling v. Sharpe*, 347 U.S. 497 (1954)).

twentieth century, this is one of those instances where the Court is bound to act.

VI. CONCLUSION

There are times when the United States Supreme Court must assert its countermajoritarian role to protect the rights of individuals. The Court's recent reluctance to recognize new substantive due process rights is understandable, especially given the compelling state interests involved in such issues as physician-assisted suicide, abortion, and the removal of life support. None of these compelling interests, however, are present in the case of William Cohen. All of the valid state concerns regarding marijuana use could easily be satisfied by moving it to Schedule II.

Likewise, Mr. Cohen has a fundamental right to be free from severe pain during the final stages of a terminal illness, and has the right to follow the advice of a competent physician on how best to relieve that pain. Justice Sanders, the lone dissenter in the Supreme Court of Washington's recent medical marijuana decision, posed the proper question when he asked how long members of the legislature would bear the plaintiff's pain before recognizing the arbitrariness of the law.¹⁵⁶

Ultimately, the political process is the preferable forum to resolve this issue. But there is every reason to believe that, if left to the political process, there will be no change. Even if the states continue to pass initiatives allowing for medicinal marijuana use, the federal government has made it clear that it will not allow such laws to disrupt national policy. The Court is the only avenue of redress for William Cohen and others who are similarly situated. Their process is long overdue.

156. See *Seeley*, 132 Wash. 2d at 803, 940 P.2d at 631 (Sanders, J., dissenting).