Medical Marijuana, American Federalism, and the Supreme Court

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IN *GONZALEZ V RAICH*, THE US SUPREME COURT HELD THAT federal law enforcement authorities could criminally prosecute patients for possessing marijuana prescribed by a physician in accordance with state law.[1] The Court did not overturn state medical marijuana laws but did open the door to criminal prosecution under federal drug statutes. The Court also did not foreclose future challenges to federal enforcement on other constitutional grounds (eg, an unwarranted invasion of patient-physician privacy).

Explaining the significance of *Raich* requires examination of 2 issues. The first concerns American federalism and raises an important constitutional principle about the appropriate scope of federal public health powers. The second issue concerns the use of marijuana as a medical treatment and raises intriguing questions about the practice of medicine and the patient-physician relationship. In *Raich*, the Supreme Court pointedly questioned the wisdom of prosecuting patients: "The case is made difficult by respondents' strong arguments that they will suffer irreparable harm because . . . marijuana does have valid therapeutic purposes. The question before us, however, is not whether [the policy] is wise, [but] whether Congress has the power to regulate . . . medicinal substances . . . produced and consumed locally."

Gonzalez v Raich

California's Compassionate Use Act of 1996 (enacted by Proposition 215) was designed to ensure that "seriously ill" residents have access to marijuana for medical purposes to relieve suffering. The act exempts physicians, patients, and primary caregivers from criminal prosecution for possessing or cultivating marijuana for medicinal purposes with a physician's approval. Notably, the act states that physicians shall not be "punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."[2] Ten additional states—Alaska, Arizona, Colorado, Hawaii, Maine, Montana, Nevada, Oregon, Washington, and Vermont—allow use of marijuana for medical purposes.

Angel Raich and Diane Monson (respondents) use marijuana prescribed by board-certified family physicians who concluded that it is the only drug that provides effective treatment. Ms Raich has an inoperable brain tumor and wasting syndrome, and Ms Monson has a degenerative spine condition with chronic back pain. On August 15, 2002, county sheriffs and Drug Enforcement Administration (DEA) agents went to Ms Monson's home: the sheriffs found her use of marijuana to be entirely lawful, but the federal agents seized and destroyed all 6 of her cannabis plants. The respondents sued to prohibit the enforcement of the federal Controlled Substances Act (CSA).[3]

The CSA, enacted in 1970 as part of President Nixon's "war on drugs," regulates controlled substances. Marijuana, together with heroin and LSD (lysergic acid diethylamide), are classified as schedule I drugs based on the following findings: the high potential for abuse, no accepted medical use, and no accepted safety for use in medically supervised treatment. Marijuana, therefore, is strictly criminally prohibited except as part of a research study preapproved by the US Food and Drug Administration (FDA).[4] The US attorney general has routinely denied petitions to reclassify marijuana,[5,6] despite a ruling from Administrative Law Judge Francis Young that "it is unreasonable, arbitrary, and capricious for DEA to continue to stand between sufferers and the benefits of this substance in light of the evidence."[7,8]

In *Raich*, the Supreme Court held that Congress' authority to regulate interstate commerce includes the power to prohibit local cultivation and use of marijuana approved by a physician and in compliance with California law. Congress' power to regulate purely local activities that are part of an economic "class of activities" that have a substantial effect on interstate commerce is firmly established, Justice Stevens wrote. The Court found "striking similarities" between this case and a 1942 case that upheld a federal prohibition on a farmer growing wheat for his own consumption[9]: "Like the farmer, respondents are cultivating, for home consumption, a fungible commodity for which there is an established, albeit illegal, interstate market." The Court said that its prior decisions, striking down the federal Gun-Free School Zones Act[10] and the federal Violence Against Women

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Act[11] on the ground that those laws exceeded congressional authority, were read "far too broadly." The 6-3 decision in *Raich* revealed a fissure within the coalition on the Rehnquist Court that over the past decade has curtailed federal power and safeguarded state sovereignty.

American Federalism: Protection of Health, Safety, and Welfare

American federalism, the most basic constitutional arrangement, has become a hallmark of the Rehnquist Court.[12] Federalism is a form of governance in which states cede certain powers (eg, foreign affairs and interstate commerce) to a national government while retaining most other aspects of sovereignty. Ever since the nation's founding, the political community has differed on whether the powers delegated to the federal government are, as James Madison said, "few and defined" or, as Alexander Hamilton argued, more expansive.[13] In this debate, the Rehnquist Court usually has taken a "states rights" position, protecting spheres of state sovereignty from federal encroachment.

Medical marijuana exemplifies the role of states as laboratories for innovative solutions to the most intractable problems, where "a single courageous State may . . . try novel social and economic experiments without risk to the rest of the country."[14] Justice O'Connor, dissenting in *Raich*, lamented that the Court had extinguished an experiment on the difficult and sensitive question of whether marijuana should be available to relieve severe pain and suffering. The Supreme Court will soon decide the fate of another social experiment—whether the state of Oregon may legalize physician-assisted suicide.[15]

Although states should be free to be inventive in the face of difficult social problems, this ought not negate federal authority to set national standards for health protection. The Rehnquist Court's federalism jurisprudence rarely has protected innovative state experiments but rather has simply repudiated federal health and safety regulation. Not only has the Court thwarted federal regulation of firearms[10] and violence against women,[11] but it has also struck down environmental regulation[16] and antidiscrimination legislation.[17] Barely a week after *Raich* was decided, the Court refused to hear federalism cases involving such key public health issues as federal authority over endangered species and homemade machine guns, suggesting perhaps that the Rehnquist Court's federalism revolution is on the wane.

Affirming federal constitutional power to safeguard the public's health and safety is vital to the population's well-being. It is important to remember that citizens have historically turned to federal authority in times of hardship to create equality before the law, protect workers from injury, safeguard the environment, provide social security, and finance health care for poor and elderly persons. The next time the Supreme Court hears a federal-powers case relating, for example, to pollution, occupational safety, or nondiscrimination, it ought to be guided by its decision in *Raich*. In this sense, the Court's possible retreat from strict federalism may ultimately advance protection for people and the environment.

Medical Marijuana: Evidence-Based Health Policy

The use of marijuana for medicinal purposes touches on ethical problems with significant implications for health care and public health. Sound policy requires regulatory oversight based on public health, a rigorous research agenda, a private patient-physician relationship, and relief of patient suffering.

Public Health Regulation. Medical marijuana ideally should be regulated by a specialized health agency using the best available scientific evidence and having a strong research agenda. "Medicine by regulation is better than by referendum," said Justice Breyer during oral arguments.[18] Marijuana need not necessarily be subject to the same kind of preapproval drug evaluation as other prescription medications because of the legal and cultural differences. However, a rational system based on science should be in place.

Current federal regulation of marijuana is flawed. The CSA is not an appropriate model for regulating drugs with potential medical benefits. It primarily addresses enforcement of drug laws, not clinical practice and research. The Supreme Court has unanimously ruled that there is no medical necessity exception to the CSA's prohibitions on marijuana. "The statute reflects a determination that marijuana has no medical benefits worthy of an exception," wrote Justice Thomas.[4] The agencies responsible for medical marijuana, moreover, have conflicting missions: law enforcement (DEA), prevention of drug abuse and addiction (National Institute of Drug Abuse [NIDA]), and public health (FDA).

Research. The Institute of Medicine found that "scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC [tetrahydrocannabinol], for pain relief, control of nausea and vomiting, and appetite stimulation."[19] Yet research has been sporadic, with the federal apparatus posing multiple hurdles to scientists. The FDA must approve research on scientific grounds and an institutional review board must approve on ethics grounds. The only legal source of marijuana is a farm in Mississippi run by NIDA. As gatekeeper of the supply, NIDA must also approve the research project. The marijuana supplied by the NIDA facility lacks purity and strength, depriving researchers of a stable source of raw material.[20] Once a study is approved, the DEA monitors distribution of marijuana to physicians and patients and requires tight security (eg, locked safes, adequate ventilation, secure transportation, and accurate scales to weigh the arriving and dispensed product). Since the mission of NIDA does not include development of marijuana as a prescription medicine, private funding sources are required. To objectively answer the questions about the efficacy and safety of marijuana, the federal government must be open to the results of scientific research.

Patient-Physician Relationship. Federal drug policy chills clinical judgment relating to marijuana. Agency officials have

sought to punish physicians who prescribe marijuana by excluding them from the Medicare program and suspending or revoking their registration to prescribe restricted drugs. They have threatened prosecution of physicians and their patients for supplying or possessing marijuana.[21] The Ninth Circuit Court of Appeals held that punishing physicians for recommending marijuana "strikes at core First Amendment interests" because "an integral component of the practice of medicine is the communication between a doctor and a patient."[22] Physicians must be able to speak frankly and openly with patients to gain their trust and to accurately diagnose and treat disease.

Relief of Suffering. The prime objective of medical marijuana is to relieve patient suffering. Seriously or terminally ill patients have an abiding interest in living with dignity by having the highest possible quality of life. Marijuana use may help relieve the symptoms of illness and lessen the adverse effects of conventional treatments such as chemotherapy.[19] Perhaps the greatest public concern with strict federal enforcement of drug restrictions is the perception that it denies patients needed relief.

Sound Regulation of Medical Marijuana

Sound regulation of medical marijuana requires government oversight based on public health, a rigorous research agenda, a private physician-patient relationship, and respect for patients who seek relief from suffering. A first step would be to reclassify marijuana as a schedule II drug because, like the schedule II substances cocaine and morphine, it fits well within the statutory definition of having "a high potential for abuse" but "a currently accepted medical use with severe restrictions."[23] This would allow for medical prescriptions subject to strict regulation without unduly interfering with federal drug policy. Allowing restricted access to marijuana for seriously ill patients would not necessarily send a "soft" or "wrong" message about drug abuse. The public can make a distinction between a drug of abuse and a drug prescribed by a physician for a compassionate purpose. The data suggest that marijuana may offer respite for some patients—a position supported by patient experiences and physician opinions. The "drug war" metaphor does not justify an ideology that removes hope from patients when they are most vulnerable and in need.

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