

# CONANT V. MCCAFFREY: PHYSICIANS, MARIJUANA, AND THE FIRST AMENDMENT

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## INTRODUCTION

Imagine that a middle-aged woman—a life-long friend—is dying of a malignant brain tumor. Throughout her battle with cancer, this friend undergoes regular chemotherapy treatment, during which her body is inundated with toxic chemicals that destroy all of the rapidly dividing cells in her body. Each time she returns home from the hospital following her treatment, she becomes violently ill. Her eyes burn and her hair falls out. She vomits until there is nothing left in her stomach. Her persistent nausea and lack of appetite make it nearly impossible for her to replenish her body and maintain her strength.

In order to withstand the side effects of the chemotherapy, your friend smokes marijuana regularly. It is, she says, the only way to suppress her nausea and vomiting and stimulate her appetite. She is unable to get a prescription for “medical marijuana” from her physician and is forced to purchase the drug illegally. For her physician, the inability to prescribe medical marijuana legally presents a medical and ethical dilemma: a choice between following the law and providing effective medical care.<sup>1</sup>

The history of the medical use of marijuana dates back nearly 5,000 years, when it was used to treat a variety of illnesses like rheumatism and menstrual cramps.<sup>2</sup> In the

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1. This hypothetical scenario is drawn from a friend of the author's who passed away recently after an unsuccessful battle with cancer.

2. See Abbie Crites-Leoni, Commentary, *Medical Use of Marijuana, Is the Debate a Smoke Screen for Movement Toward Legalization?*, 19 J. LEGAL MED. 273, 274 (1998); Matthew W. Grey, Comment, *Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship*, 30 U. RICH. L. REV. 249, 251 (1996). For a broad and thorough discussion of the therapeutic effects of medical marijuana, see LESTER GRINSPOON, M.D. & JAMES B. BAKALAR, *MARIJUANA, THE FORBIDDEN MEDICINE* (rev. ed. 1997); Stephen Sidney et al., *Marijuana Use and Mortality*, 87 AM. J. PUB. HEALTH 585 (1997). See also *Hearing on Medical Marijuana Referenda Movement in America Before the Subcomm. on Crime of the House Comm. on the Judiciary*, 105th Cong. (Oct. 1,

United States, physicians recognized medical uses of marijuana as early as 1840.<sup>3</sup> Until 1942, the drug was included in the United States Pharmacopoeia, the official list of recognized medicinal drugs, as a recommended treatment for lack of appetite.<sup>4</sup> Currently, medical marijuana is used by AIDS patients whose bodies are slowly wasting away, cancer patients undergoing chemotherapy, glaucoma patients experiencing inter-ocular pressure, and other people suffering from painful and debilitating diseases like multiple sclerosis.<sup>5</sup> In the context of AIDS and cancer patients, marijuana stimulates appetite and calms the effects of nausea.<sup>6</sup>

The active ingredient in marijuana that produces these therapeutic results is delta-9-tetrahydrocannabinol ("THC"), which has been successfully extracted from marijuana plants and legally provided to patients in a form of pill called Marinol.<sup>7</sup> The advantage of medical marijuana, as compared with most painkillers and sedatives based on opiates, is that it reduces pain and is not physically addictive, "nor does it appear to carry the risk that patients may develop tolerance for it and require increasing doses."<sup>8</sup> Despite the availability of Marinol,

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1997), available in 1997 WL 14151530 [hereinafter *Marijuana Referenda Hearing*] (testimony of Dr. Lester Grinspoon, Associate Professor of Psychiatry, Harvard Medical School).

3. See Grey, *supra* note 2, at 251.

4. See *id.* at 251-52.

5. See *id.* at 252.

6. See *id.*

7. See *id.* In 1974, the average THC content of marijuana was less than 1%, whereas today the content ranges from 5% to 17%. See Drug Enforcement Admin., U.S. Dep't of Justice, *Marijuana* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/pubs/abuse/chap6/marijuan.htm>>. In addition to THC, marijuana generally contains more than 400 chemicals, many of which are toxic and can cause diseases like lung cancer. See Crites-Leoni, *supra* note 2, at 282; Drug Enforcement Admin., U.S. Dep't of Justice, *Say It Straight: The Medical Myths of Marijuana* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/pubs/sayit/myths.htm>>.

8. Robert Lee Hotz, *Animal Tests Confirm that Chemicals Found in Marijuana Help Control Pain*, NEWS TRIB. (Tacoma, Wash.), Oct. 27, 1997, at A1. But see 21 C.F.R. § 329.1 (1998) (listing cannabis extracts and derivatives as habit-forming). The government, however, contends that marijuana is psychologically addictive. See, e.g., Drug Enforcement Admin., U.S. Dep't of Justice, *Say It Straight: The Medical Myths of Marijuana* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/pubs/sayit/myths.htm>> (stating that there are "over 10,000 scientific studies that prove marijuana is a harmful addictive drug"). For a general discussion of addiction and marijuana, see GRINSPOON & BAKALAR, *supra* note 2, at 234-52 (discussing the acute and chronic effects of medical marijuana).

however, many terminally ill patients prefer to smoke marijuana or mix it with food, both of which are illegal in the United States, rather than take THC pills, which may be prescribed legally by physicians.<sup>9</sup> These patients often prefer to smoke or ingest marijuana because the pill lacks two advantages of smoking or ingesting: quick onset of effect and the ability to regulate the dosage so that the patient gets relief but avoids becoming too sedated and incoherent.<sup>10</sup> The cost of Marinol is also prohibitive for many patients who might benefit from its use.<sup>11</sup> Hence, for physicians whose terminally ill patients would prefer to smoke or ingest marijuana illegally rather than legally take THC pills, there arises a conflict of interest between an obligation to follow the letter of the law and a medical ethical obligation to disclose to their patients the risks of and alternatives to any proposed treatment.<sup>12</sup>

In making decisions for the treatment of the terminally ill, the American Medical Association indicates that a physician's primary consideration should be the best interest of the individual patient, not the avoidance of a burden to society.<sup>13</sup> Indeed, such has been the ethical duty of physicians "since the time of Hippocrates."<sup>14</sup> Quality of life, as defined by the patient's interests and values, is a factor to be considered in determining what is best for the individual.<sup>15</sup> However, physicians often are faced with dilemmas when treating the terminally ill and are forced to choose between rendering pure medical advice and complying with the law. If a physician believes that the medical use of marijuana is the best method of treatment but elects not to recommend marijuana, he effectively decides not to provide the best treatment for his

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9. See Sally Satel, *Medical Marijuana: Research, Don't Legalize*, WALL ST. J., Oct. 30, 1997, at A22; cf. Grey, *supra* note 2, at 252, 254.

10. See Satel, *supra* note 9, at A22.

11. See Allison L. Bergstrom, *Medical Use of Marijuana: A Look at Federal & State Responses to California's Compassionate Use Act*, 2 DEPAUL J. HEALTH CARE L. 155, 164 (1997).

12. See Michael S. Victoroff, M.D., *How to Inform Patients that They Cannot Be Informed*, 326 NEW ENG. J. MED. 896 (1992).

13. See AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS § 2.17 (1994), summarized in Grey, *supra* note 2, at 268-69.

14. Paula E. Berg, *Lost in a Doctrinal Wasteland: The Exceptionalism of Doctor-Patient Speech Within the Rehnquist Court's First Amendment Jurisprudence*, 8 HEALTH MATRIX 153, 173 (1998).

15. See Grey, *supra* note 2, at 269.

patient.<sup>16</sup> On the other hand, if he does recommend the medical use of marijuana, he risks criminal prosecution and the loss of his medical licenses, including his license to prescribe drugs.<sup>17</sup> From an ethical standpoint, the physician's choice is whether to fulfill his obligation to provide beneficial health care or risk personal security and freedom.<sup>18</sup> From the patient's perspective, the choice is one between chronic pain and discomfort and the risk of prosecution and incarceration.<sup>19</sup>

On November 5, 1996, in response to the growing public recognition of the benefits of medical marijuana use and in an effort to relieve the burdens of such decisions on physicians and their patients, voters in California passed the Compassionate Use Act of 1996.<sup>20</sup> This act, better known as Proposition 215, decriminalized the possession of small amounts of marijuana for patients suffering from serious, debilitating diseases. The statute provided, in relevant part, that its purpose was:

To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

....

Notwithstanding any other provision of law, no physician in [California] shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.<sup>21</sup>

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16. *See id.* at 255. This is not to say, of course, that the physician who chooses not to recommend medical marijuana can perform no useful service for the patient. The physician may assist the patient in ways that do not violate the law—for example, by providing palliative care. If, however, the physician believes medical marijuana is the best treatment for the patient, he violates a professional ethical duty when he chooses not to prescribe or recommend it.

17. *See id.*

18. *See id.* at 255-57.

19. *See id.*

20. CAL. HEALTH & SAFETY CODE § 11362.5 (West Supp. 1999). The act further has been interpreted to provide an affirmative defense to charges of criminal possession of marijuana and to protect transportation of marijuana for medical purposes, but not to provide a right to an unlimited quantity of marijuana for medicinal purposes. *See Bergstrom, supra* note 11, at 170 (discussing *People v. Trippet*, 66 Cal. Rptr. 2d 559 (Ct. App. 1997)).

21. § 11362.5; *see also* Tim Golden, *Medical Use of Marijuana to Stay Illegal in Arizona*, N.Y. TIMES, Apr. 17, 1997, at A5.

By the plain terms of the statute, physicians may legally discuss the medical use of marijuana and recommend it to their patients. They may not, however, prescribe medical marijuana under Proposition 215. This distinction is discussed at greater length in Part I.A. Moreover, Proposition 215 does not provide an avenue for patients to acquire marijuana legally. Rather, patients must grow marijuana themselves or buy it from marijuana buyers' clubs.<sup>22</sup>

Shortly following the passage of Proposition 215, the Clinton Administration issued a response that indicated that Proposition 215, and medical marijuana measures passed in other states like Arizona,<sup>23</sup> would not affect the enforcement of federal drug laws. The Administration, through the President's "drug czar," Barry McCaffrey, the Department of Justice, the Department of Health and Human Services, and the Drug Enforcement Administration, threatened to prosecute physicians who recommend the medical use of marijuana to their patients as well as those patients caught using marijuana as medicine.<sup>24</sup>

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22. See *infra* note 208 and accompanying text.

23. See ARIZ. REV. STAT. § 13-3412.01 (1997). Commonly referred to as Proposition 200, this statute would decriminalize all Schedule I drugs, including LSD and heroin. See *id.* However, Proposition 200 has since been effectively repealed by the Arizona legislature. See George J. Annas, *Reefer Madness—The Federal Response to California's Medical-Marijuana Law (Legal Issues in Medicine)*, 337 NEW ENG. J. MED. 435, 436 (1997).

24. See *Administration Response to Arizona Proposition 200 and California Proposition 215*, 62 Fed. Reg. 6164, 6164-66 (1997) (notice signed Jan. 15, 1997 by General Barry R. McCaffrey, Director, Office of National Drug Control Policy); *Hearing on Examining the Newly Adopted Initiatives that Modify Arizona and California Law by Decriminalizing Drug Use in Some Circumstances Before the Senate Comm. on the Judiciary*, 104th Cong. 35 (1997) (prepared statement of Thomas A. Constantine, Administrator of the Drug Enforcement Administration); *White House Briefing News Conference*, FED. NEWS SERV., Dec. 30, 1996; see also David G. Savage & Jenifer Warren, *U.S. Threatens Penalties If Doctors Prescribe Pot Drugs: Criminal Charges, Other Sanctions Are Possible, Officials Warn California and Arizona Physicians*, L.A. TIMES, Dec. 31, 1996, at A3; Drug Enforcement Admin., U.S. Dep't of Justice, *Arizona Proposition 200 & California Proposition 215* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/pubs/pressrel/pr961106.htm>>. Presumably, the government threatened to prosecute physicians in order to deter them from recommending the medical use of marijuana. Similarly, the government threatened to prosecute patients in order to deter them from using marijuana. See Annas, *supra* note 23, at 436-37. More recently, Senator Lauch Faircloth of North Carolina introduced a bill proposing to provide federal sanctions for practitioners who administer, dispense, or recommend medical marijuana. See S. 40, 105th Cong. (1997). Although the bill was referred to the Senate Judiciary Committee, it was not carried over after the

The federal government's response to the state legislation, in turn, elicited strong criticism from people who advocate the medical use of marijuana, as well as from many in the general medical community.<sup>25</sup> The Administration's response to Proposition 215 was seen largely as an attempt to target physicians unfairly and impracticably in an effort to make a political statement concerning the Administration's "war on drugs" and bolster an established Administration policy against the general legalization of marijuana.<sup>26</sup> In short, the Administration's response appeared to be based not on rational medical discourse, but instead on a desire to achieve a rhetorical political advantage over those people who might criticize the Administration for being "soft on drugs."

Consequently, there arose public debate in California concerning the Clinton Administration's response to Proposition 215 and its threatened impact on the practice of medicine and treatment of terminally ill patients.<sup>27</sup> Several groups advocating the passage of Proposition 215 proposed a legal challenge to the government's marijuana policy.<sup>28</sup> One such challenge was *Conant v. McCaffrey*.<sup>29</sup>

This casenote discusses the court's decision in *Conant* and the potential implications of threats to prosecute physicians who discuss medical marijuana and recommend it to their patients. Notably, in *Conant*, the court entered a preliminary injunction prohibiting the government's policy of prosecuting or sanctioning physicians who recommend the medical use of marijuana.<sup>30</sup> Regardless, however, of the *Conant* court's decision not to permit the government to prosecute physicians who recommend the medical use of marijuana, or whether the

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1998 regular congressional session adjourned. *See id.* The House of Representatives also recently expressed its belief that marijuana is a dangerous and addictive drug and should not be legalized for medicinal use. *See* H.R. Res. 372, 105th Cong. (1998); H.R. REP. NO. 105-451(I) (1998). These recent developments illustrate the continuing federal opposition to medical marijuana.

25. For example, the 6,100-member California Academy of Family Physicians called the Administration's response "draconian" and said that it presented physicians with a "moral dilemma." *See* Savage & Warren, *supra* note 24, at A3.

26. *See infra* Part IV.A.

27. *See* Dan Baum, *California's Separate Peace*, ROLLING STONE, Oct. 30, 1997, at 43.

28. *See* *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997).

29. *Id.*

30. *See id.* at 701.

court's injunction is ever lifted or modified to allow these prosecutions,<sup>31</sup> government attempts to control the content of physician-patient communications will threaten physician-patient relationships in general and hinder the delivery of effective medical care.

Part I of this casenote examines the California case of *Conant v. McCaffrey* and its holding. Next, Part II analyzes the current state of First Amendment law as it relates to physician-patient communications. Part III explores the resolution of *Conant* and its potential impact on the practice of medicine. This casenote then discusses the policy implications of restricting the practice of medicine by removing medical decisions from the discretion of physicians in Part IV. Part V relates the implications of the *Conant* debate to a recent Colorado ballot initiative. Finally, Part VI offers the conclusion that the federal government should rescind its prohibition of the medical use of marijuana and its threat to prosecute physicians who recommend the medical use of marijuana to their patients.

## I. CONANT V. MCCAFFREY

Litigated in the United States District Court for the Northern District of California, *Conant v. McCaffrey* promises to have important consequences for the practice of medicine throughout the United States. Ultimately, this case will prove to be a useful tool in analyzing future challenges by the federal government to other state laws or initiatives that allow physicians to recommend the medical use of marijuana to terminally ill patients. Before considering the implications of *Conant*, however, this casenote first examines the facts and procedural history of the case, as well as Judge Fern Smith's holding and reasoning.

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31. Although "[t]he government chose not to appeal Judge Smith's preliminary injunction[,] which will now remain in effect while the parties submit further briefings and arguments[,] . . . [a] final court ruling [on the government's ability to prosecute physicians who recommend medical marijuana was] expected by summer 1998." The Lindesmith Center, *Conant v. McCaffrey: Federal Class Action Lawsuit on Behalf of Physicians Who Recommend and Seriously Ill Patients Who Need Medical Marijuana* (visited Feb. 10, 1999) <<http://www.lindesmith.org/mmjsuit/conant.html>>.

### A. *Facts and Procedural History*

*Conant v. McCaffrey* was brought as a direct challenge to the constitutionality of the Clinton Administration's unequivocal threat to prosecute physicians who, in accordance with the California measure, recommend the medical use of marijuana as treatment for their seriously ill patients.<sup>32</sup> It is important to note, however, as the court in *Conant* pointed out, that this case was not about doctors prescribing, growing, or distributing marijuana, nor was it about giving patients free reign to make large purchases of marijuana for distribution to the general public.<sup>33</sup> Instead, the case was about the ability of physicians, on an individualized basis, to give medical advice and recommendations to patients suffering from debilitating illnesses concerning the possible benefits of the medical use of small amounts of marijuana.<sup>34</sup> At this point, it is also important to note that prescribing marijuana is not the same as recommending it for medical use.<sup>35</sup> Prescribing marijuana generally involves procurement of the drug through legal means, while recommending the medical use of marijuana arguably only involves a discussion between a physician and the patient concerning the benefits and risks associated with the drug, and, possibly, acknowledgment that possession and use of the drug is illegal. Proposition 215 only allows physicians to recommend the medical use of marijuana; it does not allow physicians to prescribe the medical use of marijuana.<sup>36</sup>

There are three types of physicians who typically could recommend the medical use of marijuana legally under Proposition 215: physicians who treat serious illnesses like cancer and AIDS, physicians who believe that marijuana use can ease a myriad of symptoms, and physicians who are wary of marijuana's effects but are willing to defer to their patients' wishes for the drug.<sup>37</sup> In *Conant*, the plaintiffs included eight

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32. 172 F.R.D. 681 (N.D. Cal. 1997).

33. *See id.* at 686.

34. *See id.*

35. For one distinction between approval and recommendation of medical marijuana by a physician, see Bergstrom, *supra* note 11, at 176-79.

36. *See supra* notes 20-22 and accompanying text.

37. *See* Hanna Rosin, *The Return of Pot*, NEW REPUBLIC, Feb. 17, 1997, at 22-23.

physicians specializing in the treatment of HIV and AIDS, two oncologists, two patients dying from HIV or AIDS, two cancer patients, and one person suffering from seizures.<sup>38</sup>

Among the patient-plaintiffs, Jo Daly served as police commissioner of San Francisco for six years before being diagnosed in 1988 with cancer of the colon, ovaries, and lymph nodes.<sup>39</sup> To fight her cancer, Daly's oncologists prescribed "an aggressive regimen of chemotherapy."<sup>40</sup> In her sworn declaration to the *Conant* court, Daly recalled the effects of her treatment:

Each day, when I returned home from the hospital following treatment[,] . . . my whole body turned quite warm, as if a fever were coursing through me. My fingernails even burned with heat. Invariably, I was overcome by a sudden wave of intense nausea—like a nuclear implosion in my solar plexus—and I rushed desperately for the bathroom where I would remain for hours, clutching the toilet and retching my guts out. I had no appetite. I could not hold down what little food that I managed to swallow. And I could not sleep at night.

. . . .  
My second session of chemotherapy was even more brutal than the first. My hair fell out. My gums swelled up and bled. My body was racked with pain. I suffered extreme bouts of nausea and retching. And I found myself in a terrible state of despair. . . . I was experiencing "cellular suicide." . . .

To calm my stomach, I ingested marijuana . . . during my stay in the hospital. . . . Were it not for the marijuana I could not have eaten. And if I had not eaten, I would have become even weaker and very likely would have died. . . .

. . . .  
. . . The marijuana saved my life. But the illegal status of my medicine greatly exacerbated the stress of suffering a terrifying illness and undergoing a painful treatment.<sup>41</sup>

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38. See *Conant*, 172 F.R.D. at 692.

39. See Declaration of Jo Daly, *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (No. C 97-0139 FMS), available at The Lindesmith Center, *Conant v. McCaffrey: Federal Class Action Lawsuit on Behalf of Physicians Who Recommend and Seriously Ill Patients Who Need Medical Marijuana* (visited Feb. 10, 1999) <<http://www.lindesmith.org/mmjsuit/conant.html>>.

40. *Id.*

41. *Id.*

Notable among the physician-plaintiffs was Dr. Marcus Conant, a professor at the University of California Medical Center in San Francisco.<sup>42</sup> At the time of the litigation, he had practiced medicine for about thirty-three years in San Francisco, specializing in dermatology, and was the author or co-author of over seventy publications addressing the treatment of AIDS and HIV.<sup>43</sup> In addition, "Dr. Conant [was] the Medical Director of the Conant Medical Group, the largest private AIDS practice in the United States."<sup>44</sup> He and his colleagues "provide[d] primary care for over 5,000 HIV infected patients, including approximately 2,000 patients with AIDS."<sup>45</sup> In his practice, Dr. Conant prescribed several drugs to treat AIDS, many of which caused his patients severe nausea and vomiting, for which he prescribed "traditional anti-nausea drugs and appetite stimulants."<sup>46</sup> For many of his patients, Dr. Conant prescribed Marinol.<sup>47</sup> However, he believed that medical marijuana is the "best, if not the only viable, treatment option" for approximately 100 of his patients.<sup>48</sup>

By contrast, the *Conant* defendants were several federal government officials, including retired military general and Director of the United States Office of National Drug Control Policy Barry McCaffrey, former state prosecutor and Attorney General Janet Reno, and former university administrator and Secretary of Health and Human Services Donna Shalala.<sup>49</sup>

According to the plaintiffs' complaint in *Conant*, the federal government had neither punished nor threatened physicians for recommending the medical use of marijuana to treat terminally ill patients prior to the passage of Proposition 215.<sup>50</sup> Apparently, prior to Proposition 215, physician-patient discussions concerning the medical use of marijuana were

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42. See Class Action Complaint for Declaratory and Injunctive Relief, *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (No. C 97-0139 FMS), available at The Lindesmith Center, *Conant v. McCaffrey: Federal Class Action Lawsuit on Behalf of Physicians Who Recommend and Seriously Ill Patients Who Need Medical Marijuana* (visited Feb. 10, 1999) <<http://www.lindesmith.org/mmjsuit/conant.html>>.

43. See *id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. See *id.*

48. *Id.*

49. See *Conant*, 172 F.R.D. at 688.

50. See *id.* at 686.

illegal but did not attract any real interest on the part of the government to prosecute or sanction physicians. However, as the California election approached and it became more certain that Proposition 215 would pass, McCaffrey first suggested that the federal government would act against physicians for conduct explicitly protected by the state measure.<sup>51</sup> After Proposition 215 passed<sup>52</sup> and was enacted on November 5, 1996, McCaffrey confirmed that the federal government, in accordance with federal drug laws,<sup>53</sup> would prosecute physicians, revoke their licenses, and deny them participation in Medicare and Medicaid programs for recommending the medical use of marijuana in accordance with Proposition 215.<sup>54</sup>

On February 14, 1997, the plaintiffs, through their private attorneys and attorneys for the American Civil Liberties Union and The Lindesmith Center,<sup>55</sup> filed suit in federal district court in California against McCaffrey, in his capacity as Director of the United States Office of National Drug Control Policy, and the other defendants in their official capacities.<sup>56</sup> The plaintiffs sued to enjoin the federal government from prosecuting physicians who recommend the medical use of marijuana in accordance with Proposition 215.<sup>57</sup> They claimed that the federal government's medical marijuana policy, as outlined by McCaffrey following passage of Proposition 215, infringed their First Amendment rights to free speech.<sup>58</sup> In support of their claim, the plaintiffs offered declarations indicating that some physicians were "sufficiently worried by the government's

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51. *See id.*

52. *See supra* notes 20-21 and accompanying text. Proposition 215 passed by a vote of 56% to 44%. *See* Rebecca Voelker, *New Marijuana Laws in 2 States Prompt Caution*, 276 JAMA 1786, 1787 (1996).

53. The government presumably would undertake to prosecute physicians who recommend medical marijuana in accordance with Proposition 215 for attempting or conspiring to violate federal drug laws like the Controlled Substances Act, 21 U.S.C. §§ 801-971 (1994 & Supp. III 1997), for aiding and abetting such violations, or for obstruction of justice.

54. *See Conant*, 172 F.R.D. at 686. The federal government is able to challenge Proposition 215 because, under the Supremacy Clause, federal law supersedes all conflicting state laws.

55. The Lindesmith Center is a private drug policy research institute established in 1994. *See* The Lindesmith Center, *Broadening the Debate on Drugs and Drug Policy* (visited Jan. 19, 1999) <<http://www.lindesmith.org>>.

56. *See Conant*, 172 F.R.D. at 686.

57. *See id.* at 685.

58. *See id.* at 686.

threats that they [were] afraid to offer patients their best medical judgment regarding the use of marijuana to treat disease, and [had] begun to censor their communications with patients."<sup>59</sup> The plaintiffs further alleged that the physicians' self-censoring "threaten[ed] the integrity of the physician-patient relationship and prevent[ed] proper patient care," and that this "chilling" effect on doctor-patient communications violated the physicians' and patients' First Amendment rights to free speech.<sup>60</sup> Accordingly, the plaintiffs requested a preliminary injunction, asking the court to declare that, because physician-patient communications are protected under the First Amendment, the government may not prosecute or otherwise sanction physicians for recommending the medical use of marijuana.<sup>61</sup>

On February 28, 1997, the government defendants responded to the plaintiffs' request for an injunction and moved to dismiss the suit on the basis of a letter written on February 27, 1997 by Dr. Jo Ivey Boufford, Assistant Secretary for Health and Human Services, which attempted to clarify the federal government's response to the passage of Proposition 215.<sup>62</sup> The letter stated that physicians may discuss the medical use of marijuana with their patients but may not "intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of the law."<sup>63</sup> Specifically, the letter stated that no "gag rule" prohibits physicians from engaging in discussions about medical marijuana, and encouraged doctors to talk about any procedure, treatment, substance, or device that may affect a patient's health.<sup>64</sup> Nevertheless, the letter also indicated that these discussions have limits.<sup>65</sup> The government contended that this letter of clarification satisfied

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59. *Id.*

60. *Id.*

61. *See id.*

62. *See id.* at 687.

63. Reynolds Holding, *U.S. Letting Doctors Discuss Marijuana*, S.F. CHRON., Mar. 1, 1997, at A3 (quoting the letter from Assistant Secretary of Health and Human Services Dr. Jo Ivey Boufford); *see also Marijuana: Doctors Can Discuss Uses with Patients*, STAR-TRIB. NEWSPAPER OF THE TWIN CITIES, Mar. 1, 1997, at 7A.

64. *See Marijuana: Doctors Can Discuss Uses with Patients*, *supra* note 63, at 7A.

65. *See id.*

First Amendment requirements by delineating the limits of permissible behavior for physicians, thereby eliminating any Article III case or controversy and, thus, mooting the plaintiffs' suit.<sup>66</sup> However, no effort was made by the government to clarify what constituted a "recommendation" of the medical use of marijuana, and the Administration openly continued to threaten physicians who discussed the medical use of marijuana with criminal and administrative sanctions.<sup>67</sup> Rather than try to explain its contradictory responses, the government continued to insist that its approach to the medical use of marijuana was both clear and uniform.<sup>68</sup>

After hearing motions concerning the injunction on April 11, 1997, the court issued a temporary restraining order preventing the government from taking action against physicians who recommend the medical use of marijuana.<sup>69</sup> However, the court also ordered the parties to attend a settlement conference.<sup>70</sup> After the parties failed to resolve their differences in the settlement conference, the issues were litigated before the court.<sup>71</sup>

### B. *Holding and Reasoning*

Judge Fern Smith, who presided over the case, initially determined that, because the government persisted in issuing ambiguous and conflicting interpretations of its medical marijuana policy,<sup>72</sup> and because government attorneys were unable to articulate the "contours of federal policy on the subject" clearly, the harms demonstrated by the plaintiffs were significant and their constitutional vagueness and overbreadth challenges were ripe for review.<sup>73</sup> The judge then proceeded to

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66. See *Conant*, 172 F.R.D. at 687; see also U.S. CONST. art. III, § 2.

67. See Stephanie Stapleton, *Medical Pot: Feds Say Talk Is OK, Just Don't Recommend It*, AM. MED. NEWS, Mar. 17, 1997, at 1. Administrative liability would include the loss of medical licenses and physician participation in federal Medicare programs. See *id.*

68. See *id.*

69. See *Conant*, 172 F.R.D. at 687.

70. See *id.*

71. See *id.*

72. See *infra* notes 92-96 and accompanying text for examples of the government's conflicting positions.

73. *Conant*, 172 F.R.D. at 691. The court cited numerous declarations by the federal government regarding its position on the limits that federal drug laws place upon physician-patient communications concerning the medical use of

certify a plaintiff class.<sup>74</sup> She included the following individuals within the class: California physicians who discuss medical marijuana with their patients, and patients with serious, debilitating diseases who seek medical advice concerning treatment with marijuana.<sup>75</sup> Specifically, she defined the class as:

(1) All licensed physicians practicing in the State of California who treat patients diagnosed with HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with a chronic, debilitating condition, and who, in the context of a bona fide physician-patient relationship, discuss, approve, or recommend the medical use of marijuana for these patients based on the physician's best medical judgment; and

(2) All patients in the State of California diagnosed with HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with a chronic, debilitating condition, who, in the context of a bona fide physician-patient relationship, communicate with their physicians about the medical use of marijuana.<sup>76</sup>

Judge Smith then ordered preliminary injunctive relief with respect to the entire class.<sup>77</sup>

She then proceeded to analyze the merits of the plaintiffs' First Amendment claims. First, she determined that the "broad reaches of the government's policy" implicated speech that is protected by the First Amendment.<sup>78</sup> She reasoned that the government, in general, may not regulate speech based on its substantive content or the message it conveys, including

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marijuana, including some declarations that patently contradicted the letter of clarification issued by the Clinton Administration and insisted that physicians would be vigorously prosecuted for discussing medical marijuana with patients. The court determined that the plaintiffs had shown that the government continued to vacillate in its description of sanctionable conduct and thus that its policy was subject to varying interpretations that failed to delineate the limits of permissible conduct for physicians. Consequently, the court determined that the fear of prosecution and administrative sanction had censored the plaintiff-physicians' medical advice to patients by compelling them to refuse to provide guidance concerning the benefits and detriments of the medical use of marijuana. *See id.* at 687-89.

74. *See id.* at 691; *see also* FED. R. CIV. P. 23(c)(1).

75. *See Conant*, 172 F.R.D. at 693.

76. *Id.*

77. *See id.*; *see also* FED. R. CIV. P. 23(b)(2).

78. *Conant*, 172 F.R.D. at 695.

discussions of marijuana.<sup>79</sup> Moreover, Judge Smith reasoned that the government's statutory authority to regulate the distribution and possession of drugs does not authorize the government to prohibit protected speech about drugs,<sup>80</sup> as in the context of physician-patient communications concerning the medical use of marijuana. She also recognized that Supreme Court case law implicitly assumes that physician-patient communications receive heightened First Amendment protection.<sup>81</sup> Lastly, the judge cautioned that, although the First Amendment allows physicians to discuss and advocate the medical use of marijuana despite its illegality, physicians may not advocate medical marijuana where such advocacy is directed towards inciting or producing imminent lawless action and is likely to incite or produce such action.<sup>82</sup> Nevertheless,

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79. See *id.* at 694 (quoting *Rosenberger v. Rector of Univ. of Va.*, 515 U.S. 819 (1995); *NAACP v. Alabama*, 377 U.S. 288 (1964)). This reasoning refers to the well-established principle that, in a First Amendment free speech controversy, the government may not restrict speech based on its content. Rather, in order to suppress speech, the government must prove that "the words used . . . in such circumstances . . . are of such a nature as to create a clear and present danger that they will bring about the substantive evils that Congress has a right to prevent." *Schenck v. United States*, 249 U.S. 47, 52 (1919). In other words, "constitutional guarantees of free speech . . . do not permit [the government] to forbid or proscribe advocacy . . . except where such advocacy is directed to inciting or producing imminent lawless action and is likely to incite . . . such action." *Brandenburg v. Ohio*, 395 U.S. 444, 447 (1969).

80. See *Conant*, 172 F.R.D. at 694 (citing *NAACP v. Alabama*, 377 U.S. 288 (1964)).

81. See *id.* (citing, as examples, *Planned Parenthood v. Casey*, 505 U.S. 833, 884 (1992); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 445 (1983)). It is important at this point to note that many of the physician-patient cases cited by Judge Smith in *Conant* are fundamental rights (abortion) cases. Access to medical care, by contrast, including medical marijuana, is not a fundamental right. See *infra* note 130 and accompanying text. Given attempts to limit the holding of *Roe v. Wade*, 410 U.S. 113 (1973), one accordingly may argue that it is risky to infer heightened protection for physician-patient relations outside of the fundamental rights context, especially outside of the context of abortion and cases decided following *Roe*. See, e.g., *Casey*, 505 U.S. at 873 (rejecting *Roe's* "rigid trimester framework"). It is plausible to contend, however, as Judge Smith appears to do, that the abortion cases often assume heightened protection for physician-patient relations generally, and that the subject-matter limitations on fundamental rights only speak to the issue of which rights are constitutionally protected.

82. See *supra* note 79 and accompanying text. In addition, it is important to note that advocating the medical use of marijuana often will not rise to the level of imminent incitement to a clear and present danger, thereby warranting suppression of physician-patient speech. For example, in an instance where a physician merely discusses the benefits and risks associated with marijuana use,

Judge Smith noted that the government never alleged that the physicians who discussed or recommended the medical use of marijuana were inciting imminent lawless action, nor did the record demonstrate that the physicians' recommendations of medical marijuana could be characterized in this way.<sup>83</sup>

Because the plaintiffs in *Conant* alleged a First Amendment violation, and because the court determined that the government's policy concerning the medical use of marijuana implicated physicians' and patients' First Amendment rights to free speech, Judge Smith presumed irreparable injury to the plaintiffs.<sup>84</sup>

She then weighed the government's interests in regulating illicit drugs against the potential injury to the plaintiffs and concluded that the "balance of hardship" tipped in favor of the plaintiffs.<sup>85</sup> Specifically, she observed that, when faced with "the fickle iterations of the government's policy, physicians have been forced to suppress speech that would not rise to the level of that which the government constitutionally may prohibit."<sup>86</sup> The judge further commented that "it is hard to imagine that in every situation, a physician could easily determine whether a communication with a patient had crossed the line from protected speech to conduct the government has threatened to prosecute."<sup>87</sup>

Conversely, she discounted the government's interest in regulating drugs and in its ability to enforce federal drug laws, stating that "[t]his case involves no more than the ability of physicians to recommend personal use of marijuana to bona fide patients suffering from a narrow range of serious, debilitating diseases."<sup>88</sup> Judge Smith did not consider physicians' recommendations concerning the medical use of

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but does not urge or otherwise help the patient acquire marijuana, it is doubtful that such speech could be suppressed under the regime of *Brandenburg v. Ohio* and subject the physician to criminal liability. See *supra* note 79 and accompanying text.

83. See *Conant*, 172 F.R.D. at 694.

84. See *id.* at 697. The loss of First Amendment freedoms, even for a short period of time, always constitutes irreparable injury. See *id.* (citing *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); see also *City of Akron*, 462 U.S. at 445 (indicating that the state may not place obstacles in the path of a physician on whom a patient may rely for medical advice).

85. See *Conant*, 172 F.R.D. at 698.

86. *Id.* at 696.

87. *Id.* at 697.

88. *Id.* at 698.

marijuana as serious, viable threats to the government's overall drug policies prohibiting the use of marijuana.<sup>89</sup>

Principally, however, the *Conant* court examined the government's response to Proposition 215 and concluded that, because the government persisted in issuing ambiguous and conflicting interpretations of its medical marijuana policy, its decision to sanction physicians was unconstitutionally vague.<sup>90</sup> The court commented that, in the First Amendment context, the government may only regulate with "narrow specificity."<sup>91</sup> But, in this case, the court found that the government had issued numerous broad and conflicting statements regarding its position on the use of medical marijuana.<sup>92</sup> For example, Judge Smith cited government statements appearing after its initial responses to Proposition 215 indicating that "the government [would] take action against physicians who simply recommend[ed] marijuana to treat disease[s]," as well as other statements which indicated that "physicians may discuss the risks and . . . benefits of medical [use of] marijuana [with patients] in the context of a bona fide physician-patient relationship."<sup>93</sup> "The government's statements range," Judge Smith said, "from suggesting that the government will use informers and surveillance to detect physicians who recommend medical marijuana to assuring that simple advice about [medical marijuana use] will not subject physicians to government sanctions."<sup>94</sup> "The distinction the government attempts to draw," the judge concluded, "between a permissible discussion [of marijuana between physician and patient] and

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89. *See id.*

90. The court determined that, because the plaintiffs met their burden of showing that serious questions existed as to whether the government's marijuana policy was vague, the court did not need to consider the plaintiffs' parallel contention that the government's policy was unconstitutionally overbroad. *See id.* at 695.

91. *Id.* (quoting *NAACP v. Button*, 371 U.S. 415, 433 (1963)).

92. *See id.* at 696. The Clinton Administration also continued to waffle in its response to Proposition 215, stating that it was "not going to focus on [prosecuting] any one profession," while also continuing to threaten doctors without saying exactly what penalties they would face for prescribing the medical use of marijuana. Louis Freedberg & Glen Martin, *U.S. Warns Pot Doctors: Attack on Medical Marijuana Aimed at Patients, Too*, S.F. CHRON., Dec. 31, 1996, at A1 (quoting Attorney General Janet Reno); *see also* Herbert A. Sample, *Drug Czar: Clinton Targets Medicinal Pot*, SACRAMENTO BEE, Dec. 30, 1996, at A3.

93. *Conant*, 172 F.R.D. at 696.

94. *Id.*

an impermissible recommendation may well break down in practical application.<sup>95</sup> The judge therefore found the government's policy to be unconstitutionally vague.<sup>96</sup>

Consequently, Judge Smith entered a preliminary injunction prohibiting the government's policy of prosecuting or sanctioning physicians who recommend the medical use of marijuana in the context of a bona fide physician-patient relationship.<sup>97</sup> Nevertheless, she also concluded that, "[i]f [the] physicians' conduct, which could include speech, [rose] to the level of aiding and abetting or conspiracy, in violation of valid federal [drug laws], such conduct [would be] punishable under federal law."<sup>98</sup> In essence, the judge indicated that the court could not and would not immunize physicians from sanctions by the federal government, but that it would draw the line for such sanctioning at criminal conduct for intentionally aiding and abetting or conspiring to violate federal drug laws.<sup>99</sup>

In addition, Judge Smith examined the Controlled Substances Act<sup>100</sup> and the Medicare statute<sup>101</sup> and determined that, by their plain language, neither law allows the government to impose administrative sanctions against physicians for recommending the medical use of marijuana, unless the physicians are otherwise liable for aiding, abetting, or conspiracy.<sup>102</sup> Specifically, she determined that each statute includes a finite list of circumstances under which the Drug Enforcement Administration could revoke physicians' licenses.<sup>103</sup> She indicated that none of these circumstances include the power to revoke licenses for underlying conduct, including mere discussion or recommendation of the medical use of marijuana, that does not violate federal, state, or local law, or state licensing guidelines.<sup>104</sup>

Ultimately, the California district court granted the plaintiffs' request for a preliminary injunction prohibiting the government from prosecuting physicians who recommend the

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95. *Id.*

96. *See id.*

97. *See id.* at 698.

98. *Id.*

99. *See id.*

100. 21 U.S.C. §§ 801-971 (1994 & Supp. III 1997).

101. 42 U.S.C. §§ 1301-1324 (1994 & Supp. II 1996).

102. *See Conant*, 172 F.R.D. at 699-700.

103. *See id.*

104. *See id.*

medical use of marijuana, unless the physicians are also liable for aiding and abetting in violation of federal drug laws, or conspiracy to violate those same laws. Similarly, the court prohibited the government from taking administrative action against physicians unless the physicians are likewise liable for aiding and abetting or conspiracy.

## II. THE PHYSICIAN-PATIENT RELATIONSHIP AND THE FIRST AMENDMENT

This part discusses and analyzes the current state of First Amendment law as it relates to physician-patient communications. As discussed, First Amendment case law influenced the court's decision in *Conant* to enjoin the government's policy regarding the medical use of marijuana as unconstitutionally vague.

As indicated by *Planned Parenthood v. Casey*,<sup>105</sup> while the Supreme Court has not explicitly determined that physician-patient relationships are afforded a higher degree of protection under the First Amendment, Supreme Court case law might be interpreted to assume such a heightened standard for such relationships.<sup>106</sup> In *Casey*, the Court held, *inter alia*, that the principle of *stare decisis* required a reaffirmance of *Roe v. Wade*'s<sup>107</sup> essential holding recognizing a woman's right to an abortion.<sup>108</sup> In its decision, the Court noted that the physician-patient relationship in the context of abortion is entitled to the same "solicitude" it receives in other medical contexts.<sup>109</sup>

Nevertheless, it is equally clear from Supreme Court decisions that physician-patient communications may be constitutionally limited under certain circumstances.<sup>110</sup>

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105. 505 U.S. 833 (1992).

106. *See id.* at 884. Again, it is important to note the possible distinction between physician-patient relations in the abortion-fundamental rights context and physician-patient relations in the medical marijuana context. *See supra* note 81. Many jurisdictions also recognize by statute an evidentiary privilege for physician-patient communications in order to foster these communications and encourage full disclosure of medical histories, ailments, and treatment options between physician and patient. *See* CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 5.36 (1995).

107. 410 U.S. 113 (1973).

108. *See Casey*, 505 U.S. at 846.

109. *See id.* at 884.

110. *See, e.g., Rust v. Sullivan*, 500 U.S. 173 (1991). *Cf. Casey*, 505 U.S. at 884 (determining that, where physicians' First Amendment rights not to speak

Perhaps most notable is the Supreme Court's decision in *Rust v. Sullivan*,<sup>111</sup> which restricted physician-patient communications in federally funded health clinics. In *Rust*, the Court upheld regulations promulgated by the Secretary of Health and Human Services regarding the distribution of federal funds to Title X family-planning facilities, which stated that a Title X project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning.<sup>112</sup> While again declining to determine the constitutional status of the physician-patient relationship, the Court in *Rust* indicated that, while the government may not erect a barrier to prevent citizens from exercising their constitutional rights, it may fund one constitutionally protected activity (childbirth) without funding another constitutionally protected activity (abortion).<sup>113</sup> Concurrently, the Court determined that, because other doctors were available who were not legally constrained in what they could tell their patients, and because Title X did not provide post-conception health care, the abortion "gag rules" did not significantly impinge on the physician-patient relationship and, therefore, satisfied First Amendment scrutiny.<sup>114</sup>

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are implicated, there is "no constitutional infirmity in the requirement that the physician provide the information mandated by the State").

111. 500 U.S. 173 (1991).

112. See George J. Annas, *Restricting Doctor-Patient Conversations in Federally Funded Clinics*, 325 NEW ENG. J. MED. 362 (1991) (summarizing *Rust v. Sullivan*, 500 U.S. 173 (1991)); see also Annas, *supra* note 23.

113. See *Rust*, 500 U.S. at 201; Annas, *supra* note 112; see also Annas, *supra* note 23, at 437.

114. See *Rust*, 500 U.S. at 198-200. When Congress neither invades a substantive constitutional right (such as abortion) nor enacts legislation that operates to the detriment of a suspect class, the legislation need only bear a rational relation to some legitimate state interest, such as the health, safety, or welfare of citizens. See *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977). A rational relation standard of review is, however, usually outcome determinative in favor of government legislation. Furthermore, it is important to note that, while the Rehnquist Court has been deeply divided on many legal issues, it has been nearly unanimous in "demanding strict viewpoint neutrality, and in . . . protecting speakers and listeners from government paternalism." Berg, *supra* note 14, at 159. Perhaps ironically, however, in looking at *Rust* and *Casey*, the Court has not interpreted the First Amendment to "prohibit the federal government from manipulating the content of physician-patient speech, in both publicly and privately financed settings, in order to promote a particular ideology or to accomplish a policy unrelated to patient health." *Id.* at 158. At least one commentator has interpreted this lack of protection for physician-patient communication as a viewpoint- and content-based

Another major example of a specific, constitutional limitation on physician-patient communications is the prosecution or sanction of speech that rises to the level of aiding and abetting criminal conduct or conspiring to violate federal laws.<sup>115</sup> The court in *Conant* explicitly referred to such a limitation on physicians' and patients' First Amendment speech rights.<sup>116</sup> The court indicated that "[t]he First Amendment does not protect speech that is itself criminal because [the speech is] too intertwined with illegal activity."<sup>117</sup> The court failed to mention that, in a case like *Conant*, for the government to prevail under an aiding and abetting theory of liability, it would have to prove more than simply that the physician recommended marijuana as part of the treatment for a medical condition.<sup>118</sup> Perhaps, as the Sixth Circuit Court of Appeals indicated in *Morei v. United States*,<sup>119</sup> in order to be prosecuted, a physician would have to "'associate himself with the venture' of illegally purchasing marijuana 'as something he wished to bring about and sought by his actions to make succeed.'"<sup>120</sup>

Of course, these formulations of the limitations on physician-patient communications still leave uncertain exactly how far physicians may go in recommending marijuana before the federal government can constitutionally prosecute them for criminal behavior.<sup>121</sup> In any event, only when a case like *Conant* is decided by the Supreme Court will the aiding and abetting standard for physicians recommending the medical use of marijuana be clearly established.

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restriction on speech equal to restrictions on "low value" speech, such as obscenity and fighting words, and more restrictive than regulation of commercial speech. See *id.* at 160-63.

115. See *Conant*, 172 F.R.D. at 698.

116. See *id.*

117. *Id.*

118. See Tim Golden, *Federal Judge Supports California Doctors on Marijuana Issue*, N.Y. TIMES, Apr. 12, 1997, at A1.

119. 127 F.2d 827 (6th Cir. 1942).

120. Annas, *supra* note 23, at 437 (quoting *Morei*, 127 F.2d at 831); cf. *State v. Gladstone*, 474 P.2d 274, 279 (Wash. 1970) (holding that the defendant could not be convicted for aiding and abetting another in the unlawful sale of marijuana where it was not shown that the defendant encouraged or induced or directed the sale of marijuana, or in any other way communicated the notion that he would aid in the sale).

121. See Annas, *supra* note 23, at 437.

III. POST-*CONANT* IMPACT ON THE PRACTICE OF MEDICINE

This part first discusses the likely chilling effect on physician-patient communications that would result if the federal government were permitted to prosecute physicians and patients for medical marijuana in states that have adopted medical marijuana laws. It then explores the denial of medical treatments that probably would result from the chilling effect on physician-patient communications.

The plaintiffs in *Conant* contended that, if the government were permitted to prosecute physicians' acts under Proposition 215, the government's medical marijuana policy would "chill" physician-patient communications.<sup>122</sup> The plaintiffs argued that some physicians were sufficiently worried by the government's threats that they had already begun to censor communications with their patients, and that patients no longer trusted their physicians' advice and could no longer comfortably communicate with their physicians about medical marijuana.<sup>123</sup> Specifically, the plaintiff-physicians' sworn declarations in *Conant* indicated that some physicians were refusing to provide guidance to their patients regarding the risks and benefits of the medical uses of marijuana, and that patients were less likely to relate complete medical histories and tell their physicians about personal marijuana use.<sup>124</sup> If this result were allowed to continue, this casenote contends, government attempts to control the content of physician-patient communications would further threaten the physician-patient relationship and hinder the delivery of effective medical care. This idea is developed more fully in Part IV.C.

Although the federal government continues to claim that the vast majority of American physicians are against the medical use of marijuana to withstand the side effects of conventional treatments like chemotherapy,<sup>125</sup> a recent survey of oncologists by researchers at the Kennedy School of Government at Harvard University revealed that nearly half of

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122. See *Conant*, 172 F.R.D. at 686.

123. See *id.*

124. See *id.* at 690-91.

125. See Golden, *supra* note 21; see also *In the Matter of Marijuana Rescheduling Petition*, Drug Enforcement Admin., Docket No. 86-22, Sept. 6, 1988 (Opinion, Recommended Ruling, Finding of Fact, Conclusions of Law and Decision of Administrative Law Judge Francis L. Young).

those who responded said that they would prescribe the drug to cancer patients if it were legal to do so.<sup>126</sup> Despite the traditional medical folklore<sup>127</sup> surrounding the therapeutic effects of smoking marijuana, recent studies indicate that the active biochemicals in marijuana have a direct mitigating effect on pain signals in the central nervous system and other related tissues.<sup>128</sup> These studies further conclude that marijuana, unlike opiate-based drugs that currently can be prescribed to patients, is not addictive and does not appear to carry the risk that patients will develop a tolerance for it and require increasing doses.<sup>129</sup> Consequently, allowing the government to prosecute physicians for recommending the medical use of marijuana would also result in the denial of a viable medical treatment—perhaps the best medical treatment—for patients suffering from serious, debilitating illnesses.

In addition, it is critical to note that some medical marijuana advocates argue access to the medical use of marijuana should be a fundamental right for patients suffering from serious, debilitating diseases like AIDS and cancer; however, such claims almost always fail.<sup>130</sup> Even though many health care providers, especially advocates of the medical use of marijuana, believe that treating terminally ill patients involves heightened concerns about reducing suffering and maintaining personal dignity at the end of life,<sup>131</sup> the Supreme Court recognizes only a very “weak constitutional right ‘not to suffer.’”<sup>132</sup> As an example, when an AIDS patient seeks an

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126. See Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 *HAMLIN J. PUB. L. & POL'Y* 117, 117 (1992) (citing Ronald J. Ostrow, *Forty-Eight Percent of Cancer Specialists in Study Would Prescribe Pot*, *L.A. TIMES*, May 1, 1991, at A12).

127. The folklore surrounding medical marijuana is simply that the drug is a panacea. See Rosin, *supra* note 37, at 22-23; see also Hotz, *supra* note 8, at A1.

128. See *supra* note 8 and accompanying text; see also Richard E. Doblin & Mark A.R. Kleiman, *Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes*, 9 *J. CLINICAL ONCOLOGY* 1314 (1991); Warren E. Leary, *U.S. Panel Urges Study of Medical Marijuana*, *N.Y. TIMES*, Feb. 21, 1997, at A27.

129. See *supra* note 8 and accompanying text.

130. Courts overwhelmingly have refused to recognize any fundamental right to medical marijuana. See Bergstrom, *supra* note 11, at 161; Crites-Leoni, *supra* note 2, at 297.

131. See Grey, *supra* note 2, at 262-65.

132. Annas, *supra* note 23, at 438 (paraphrasing the Clinton Administration's Solicitor General, Walter Dellinger); see also *Washington v. Glucksberg*, 117 S. Ct. 2258, 2303 (1997) (O'Connor, J., concurring) (upholding a

effective treatment to control the disease, "it follows that his decision is based on his belief in the fundamental rights of life and liberty, manifested in the liberty to have access to information about viable treatment, and to choose the treatment that will benefit him the most."<sup>133</sup> However, individual rights do not always "trump" social interests.<sup>134</sup>

Notably, in physician-assisted suicide cases, the Supreme Court has been reluctant to conclude that suffering patients have a constitutionally cognizable interest in obtaining relief from the pain they may experience toward the end of their lives.<sup>135</sup> Rather, the Court has clearly held that the fact that "many of the rights and liberties protected by the [Constitution] sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."<sup>136</sup> Therefore, if the fundamental rights cases are any indication of the direction in which the debate over medical marijuana is likely to gravitate, they suggest that the *Conant* injunction is likely to be lifted or limited at some point in the future. Any change in the injunction's status, however, would be subject to strictly prescribed limitations on the government's ability to interfere with physician-patient communications.

#### IV. POLICY IMPLICATIONS

The convergence of a chilling effect on physician-patient communications and the denial of medical treatment poses serious policy considerations concerning the practice of medicine in the United States. Before discussing these considerations, however, this part outlines the contextual backdrop to the current medical marijuana controversy. It then addresses current trends in medicine and the resulting impact on patient care. Finally, this part analyzes government arguments against the medical use of marijuana.

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Washington statute prohibiting physician-assisted suicide for the terminally ill).

133. Grey, *supra* note 2, at 266.

134. *See id.*

135. *See, e.g., Glucksberg*, 117 S. Ct. at 2302 (O'Connor, J., concurring). *See also Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (holding that a person does not have a right to refuse to be vaccinated).

136. *Glucksberg*, 117 S. Ct. at 2271.

### A. Context of the Marijuana Prohibition

The federal government's reluctance to accept a legitimate medical use for marijuana stems from the extensive and exhaustive efforts it has expended since the Nixon Administration to prohibit and discourage recreational marijuana use, especially by adolescents.<sup>137</sup> After a brief hiatus during the Carter Administration, the "war on drugs," as the political movement against drugs has come to be known, reemerged under President Ronald Reagan with increased vigor.<sup>138</sup> Reagan picked up Nixon's fight against drugs and added the power of the United States Armed Forces, the Federal Bureau of Investigation, and the Central Intelligence Agency to the campaign dedicated to eradicating drugs and drug use in America.<sup>139</sup> Because so many resources were devoted to fighting drugs, it seems inevitable that government spending on the drug war significantly increased the federal deficit.<sup>140</sup> In 1991, for example, one study estimated that the drug war in America generated more than \$30 billion a year in public expenditures, while the annual federal drug budget that year was only about \$10.5 billion.<sup>141</sup> Created by an executive order on July 1, 1973, the Drug Enforcement Administration alone has a current annual budget of \$1.2 billion.<sup>142</sup>

While it is beyond question that trafficking of some drugs poses serious health, safety, and economic threats to the United States, central to the war on drugs is the notion that "drugs are bad."<sup>143</sup> In part, this moralistic stance derived from a cultural conflict that had been raging since the 1960s between the "establishment" and the "counterculture" over the appropriate place of drugs in American life.<sup>144</sup> As support for their idea that, without exception, all illegal drugs are bad, many politicians point to addiction, drug-related violence, and

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137. See Bilz, *supra* note 126, at 131.

138. See Rosin, *supra* note 37, at 20.

139. See *id.*

140. *Cf. id.*

141. See Baum, *supra* note 27, at 44 (citing an unnamed RAND Corp. study).

142. See Drug Enforcement Admin., U.S. Dep't of Justice, *DEA at 25: Building on a Tradition of Excellence* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/agency/press.htm>>.

143. See Rosin, *supra* note 37, at 20.

144. See Baum, *supra* note 27, at 44-46.

the destruction of American families and cities by drugs, all of which increased rapidly in the 1980s largely as a result of the rise in crack cocaine use in America. McCaffrey and the United States Office of National Drug Control Policy estimate, for example, that the annual social costs of drugs in America, including the costs of crime, AIDS-related costs, and illness-related costs, is over \$65 billion.<sup>145</sup> The tactics of the war on drugs include harsh crime control policies that often focus on artificially increasing the number of arrests and incarcerations for drug offenses.<sup>146</sup>

More recently, under the Clinton Administration, the war on drugs continues at its highest level ever, in terms of dollars spent, arrests, numbers of incarcerations, and lengths of prison sentences.<sup>147</sup> However, the war on drugs continues to fail to bring about its intended results. While anti-drug efforts have reduced some drug use and drug trafficking, increases in arrests and incarceration for drug offenses have done almost nothing to curb widespread drug use, violence connected with drugs, or the deterioration of American families and cities.<sup>148</sup> Rather, all that remains of the drug war is the symbolic effort by politicians to prove to their constituents that they are "tough on crime" and responsive to the drug problems that plague America.<sup>149</sup>

Apparently, throughout the war on drugs, the potential medical benefits of drugs like marijuana rarely have been debated objectively, perhaps for fear that this would be seen as a step toward softening the stance on crime. With that

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145. See *Hearing on the 1998 National Drug Control Strategy Before the Subcomm. on National Security, International Affairs and Criminal Justice of the House Government Reform and Oversight Comm.*, 105th Cong. (Mar. 26, 1998), available in 1998 WL 8993743 (testimony of Barry R. McCaffrey, Director, Office of National Drug Control Policy).

146. See MICHAEL TONRY, *MALIGN NEGLECT: RACE, CRIME, AND PUNISHMENT IN AMERICA* 116-23 (1995).

147. See Baum, *supra* note 27, at 44; see also Eric Blumenson & Eva Nilsen, *Policing for Profit: The Drug War's Hidden Economic Agenda*, 65 U. CHI. L. REV. 35 (1998). "Today we annually spend \$15 billion in federal funds and \$33 billion in state and local funds to finance [the war on drugs]." *Id.* at 36-37 (footnotes omitted). In 1995, there were "almost 1.5 million drug arrests, of which 500,000 were for marijuana possession," and today nearly "[s]ixty percent of federal prisoners are incarcerated for drug offenses." *Id.* at 37 (footnotes omitted).

148. See TONRY, *supra* note 146, at 116-23; Blumenson & Nilsen, *supra* note 147, at 37-39.

149. See TONRY, *supra* note 146, at 123.

historical framework in mind, one is better able to understand the confusing rationale and apparent lack of logic behind recent governmental decisions to ignore research results, as well as state legislative initiatives, and to uphold the ban on the medical use of marijuana.<sup>150</sup>

Although physicians in the United States recognized the therapeutic potential of marijuana as early as 1840, the medical use of marijuana essentially has been banned by the federal government since the passage of the Marijuana Tax Act of 1937.<sup>151</sup> Currently, marijuana is classified by the Drug Enforcement Administration as a Schedule I drug, which is the classification reserved for drugs with a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use of the drug under medical supervision.<sup>152</sup> By way of comparison, heroin and crack cocaine are also classified as Schedule I drugs.<sup>153</sup>

Many parties advocating the outright legalization of marijuana have sought reclassification of marijuana at both the federal and state levels, citing its wide use to counter the painful side effects of traditional treatments like chemotherapy.<sup>154</sup> These efforts have failed consistently. Moreover, federal drug laws currently provide no exceptions for terminally ill patients,<sup>155</sup> or even for those individuals seeking certain drugs in connection with constitutionally protected activities.<sup>156</sup>

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150. See Bilz, *supra* note 126, at 122.

151. See *id.* at 117.

152. See Controlled Substances Act, 21 U.S.C. § 812 (1994); 21 C.F.R. § 1308.11 (1998) (listing Schedule I drugs, including marijuana (under the category of “[h]allucinogenic substances”).

153. See § 812; § 1308.11.

154. See, e.g., *Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 15 F.3d 1131 (D.C. Cir. 1994); *Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 930 F.2d 936 (D.C. Cir. 1991); *People v. Summit*, 517 P.2d 850 (Colo. 1974).

155. See, e.g., *United States v. Rutherford*, 442 U.S. 544 (1979) (holding that the Food, Drug, and Cosmetic Act provides no express or implied exception for the interstate shipment of Laetrile, an experimental cancer treatment drug, which had not been approved for distribution to terminally ill cancer patients).

156. See, e.g., *Department of Human Resources v. Smith*, 494 U.S. 872 (1990) (holding that the Free Exercise Clause of the First Amendment did not prohibit application of Oregon drug laws to ceremonial use of peyote).

*B. The Trend of Government Intrusion in the Practice of Medicine*

The federal government's refusal to allow the medical use of marijuana also continues in the midst of a national debate over the appropriate role of government in the delivery of health care.<sup>157</sup> Specifically, the current debate over medical marijuana reflects a growing intrusion by the government into the general practice of medicine in America.<sup>158</sup> Government intrusion is particularly invasive in medical specialty areas like oncology and infectious disease, which are most intimately embroiled in the medical marijuana debate given the nature of the diseases those areas treat.<sup>159</sup>

Until about the mid-1950s, the relationship between physicians and patients could be fairly characterized as a "silent" relationship based on blind trust and paternalism.<sup>160</sup> Patients placed complete trust in their physicians, who acted in whatever manner they thought was medically appropriate given a particular patient's disease and set of circumstances.<sup>161</sup> In short, medicine was viewed as an art form, and patients did not participate in the course of their treatments.<sup>162</sup> Neither, apparently, did the government. However, with advances in medical science and greater societal emphasis on individual liberty and self-determination, physician-patient relationships began to change in the 1950s and 1960s.<sup>163</sup> Notable among the changes was the rise of the doctrine of informed consent, which ultimately shifted medical decision making from physician to physician and patient by placing greater emphasis on physician-patient communication and patient education.<sup>164</sup>

Despite the increased emphasis on physician-patient communications and decision making, the federal government

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157. See, e.g., Elizabeth McCaughey, *No Exit*, NEW REPUBLIC, Feb. 7, 1994, at 21.

158. See *id.*

159. See Telephone Interview with Dr. Jonathan A. Dixon, Rheumatology Associates, P.C. (Feb. 2, 1999).

160. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 49-59 (1984).

161. See *id.*

162. See *id.*

163. See *id.* at 59-80.

164. See *id.* See also, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

more recently appears to advocate a move away from a health care system centered around independent medical decisions made by physicians with input from patients, and toward a system in which medical decisions are directed or influenced, at least in part, by administrative review and political and economic policies.<sup>165</sup> This trend is perhaps best illustrated by the Clinton Administration's 1994 health care proposal. The proposal included, among several other features limiting physicians' independence and discretion, a cost-cutting provision requiring utilization review.<sup>166</sup> Utilization review is basically a process in which patients must wait while their physicians telephone utilization review companies, organized by government insurance providers, for approval of medical tests and treatment.<sup>167</sup> Under this system, physicians describe the symptoms and medical history of each patient to a nurse or clerk at a computer terminal, then wait for authorization of the tests and treatment that they want to pursue for each patient.<sup>168</sup> Although the Clinton Administration's health care plan failed, it nevertheless indicated an intent to restrict physicians' independence and discretion concerning medical decisions. This intent translated into the government's attempt to limit physicians' medical autonomy by restricting doctor-patient communications concerning the use of medical marijuana, which in turn led to *Conant*.

### C. Impact on Patient Care

This section argues that the new possibility of criminal and administrative sanctions facing physicians who recommend the medical use of marijuana will, like civil liability, temper the independence of physicians and alter their delivery of health care. It goes almost without saying that the threat of civil liability—specifically, medical malpractice—has impacted the practice of medicine in America by lessening the independence of physicians and altering their delivery of effective health

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165. See McCaughey, *supra* note 157, at 21.

166. See *id.* at 23.

167. See *id.*

168. See *id.* A more detailed description of the utilization review process is outside the scope of this casenote. For a general discussion of the utilization review process, see J. Scott Anderson, Commentary, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431 (1998).

care.<sup>169</sup> No longer does the proverbial "country doctor" leave the office to make house calls, nor will many physicians willingly stop to render aid at the scene of an automobile accident for fear of being sued.

It is clear from the actions (or inactions) of physicians that the threat of civil liability has already invaded the province of physician-patient communications. Consider, for example, the widespread impact of the California Supreme Court's decision in *Tarasoff v. Regents of the University of California*.<sup>170</sup> In *Tarasoff*, the court held that, once a therapist determines, or should have determined, that a patient under his or her care poses a serious danger of violence to others or to himself, the therapist bears a duty to exercise reasonable care to protect the foreseeable victims of that danger.<sup>171</sup> In essence, notwithstanding the sanctity and confidentiality of physician-patient communications, the court in *Tarasoff* imposed a duty on physicians to warn others when patients under their care constitute threats to foreseeable victims.<sup>172</sup> The *Tarasoff* court reasoned that, while there is a strong public interest in preserving the confidentiality of physician-patient communications, this interest is outweighed by the public's interest in safety.<sup>173</sup> Similarly, physicians are often forced by state law not only to warn potential victims, but also to commit or restrain their patients involuntarily, arguably despite their medical judgments to the contrary.<sup>174</sup> Consequently, physicians in many states no longer enjoy the full independence of directing and treating patients free of

169. Currently, medical malpractice cases arise mainly in the areas of failure to diagnose illnesses like cancer or heart disease, and in suits alleging lack of informed consent, complications from treatment, and detrimental side effects of medical prescriptions. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). Cf. *Daubert v. Merrell Dow Pharms., Inc.*, 113 S. Ct. 2786 (1993).

170. 551 P.2d 334 (Cal. 1976).

171. See *id.* at 344.

172. See *id.*

173. See *id.* at 346. Although *Tarasoff* is a California case and might still be considered a minority view, it has been cited in several jurisdictions throughout the United States, including Colorado, and generally provides the standard for failure to warn cases involving physicians and their communications with potentially violent mental patients. See, e.g., *Perreira v. State*, 768 P.2d 1198 (Colo. 1989). See generally Timothy E. Glammon & John K. Hulston, *Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749 (1995).

174. See, e.g., COLO. REV. STAT. § 13-21-117 (1998).

government intervention.<sup>175</sup> Thus, physicians are forced to adjust their treatment and delivery of health care according to state government guidelines.<sup>176</sup>

Similarly, as the plaintiffs in *Conant* contended, if physicians are threatened with criminal and administrative sanctions for recommending marijuana, patients will not receive the most effective medical care possible.<sup>177</sup> Specifically, if the physicians' affidavits are accurate, medical decisions will not be made on the basis of complete medical histories, nor will the risks and benefits of all treatments be discussed with patients.<sup>178</sup> Perhaps most significantly, those terminally ill patients who rely on medical marijuana to withstand the effects of conventional medical treatments will suffer. In short, purely medical decisions concerning treatments involving marijuana inevitably would be affected and tempered by the physicians' concerns that they might subject themselves to criminal or administrative sanctions.

This feared impact on the delivery of health care in the medical marijuana context already has begun to materialize, as is evident from the reactions of many physicians in California to the federal government's response to Proposition 215.<sup>179</sup> Medical organizations, like the California Medical Association, the California Academy of Family Physicians, and the San Francisco Medical Society, whose members include approximately 100,000 physicians, already have warned their members not to recommend the medical use of marijuana for fear of government prosecution and incarceration for felonies potentially carrying ten-year sentences.<sup>180</sup> Also, despite signs of an increase in physician sophistication concerning medical marijuana, several physicians individually have indicated that the risks of government prosecution have forced them to abandon recommendations of medical marijuana as a viable

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175. See, e.g., *id.*; *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

176. See, e.g., § 13-21-117.

177. See *Conant*, 172 F.R.D. at 689 (citing the plaintiffs' Class Action Complaint for Declaratory and Injunctive Relief).

178. See *id.*

179. See *id.*

180. See *Voelker*, *supra* note 52, at 1786; Herbert A. Sample, *Clinton May Punish Doctors Who Recommend Marijuana*, SAN DIEGO UNION-TRIB., Dec. 30, 1996, at A1; Luz Villarreal, *Court Fight Looms on Pot Measure*, L.A. DAILY NEWS, Dec. 31, 1996, at N1.

treatment for their patients with serious, debilitating illnesses.<sup>181</sup>

*D. Weighing Government Arguments Against Medical Use of Marijuana*

Notwithstanding the sharp criticism of its policy against the medical use of marijuana, the federal government contends that its response to Proposition 215 is based on science, not on an ideology disfavoring recreational drug use.<sup>182</sup> The federal response to the medical use of marijuana has four goals: (1) preserving the established medical process for determining safe and effective medicines; (2) protecting American youth; (3) upholding existing federal drug laws; and (4) preserving drug-free workplaces.<sup>183</sup>

First, the government is concerned that resolving purely scientific and medical issues concerning drug use without prior government testing and approval will undercut the safeguards established by Congress and the Pure Food and Drug Laws.<sup>184</sup> Specifically, the government is concerned about determining whether marijuana is a safe and effective drug for treating serious debilitating illness by popular referendum.<sup>185</sup> This is a legitimate concern, particularly in light of the immense pressures that the AIDS epidemic placed on the United States Food and Drug Administration ("FDA") to allow for more experimentation with non-approved drugs.<sup>186</sup> Since the 1980s,

181. See GRINSPOON & BAKALAR, *supra* note 2, at 232-33; Voelker, *supra* note 52; *Supporters of Prop. 215 Smoldering: The Clinton Administration Is Accused of Intimidating Doctors*, ORANGE COUNTY REG., Dec. 31, 1996, at A4.

182. See *Marijuana Referenda Hearing*, *supra* note 2, at 1997 WL 14151535 (statement of General Barry R. McCaffrey, Director, Office of National Drug Control Policy, submitted for the record).

183. See *id.*

184. See *id.* For a general discussion of the federal drug approval process, see Crites-Leoni, *supra* note 2, at 285-89.

185. See *Marijuana Referenda Hearing*, *supra* note 2, at 1997 WL 14151535 (statement of General Barry R. McCaffrey, Director, Office of National Drug Control Policy, submitted for the record). For a thorough discussion of the benefits and detriments of the ballot initiative process, including a specific examination of Colorado's ballot initiative process, see Richard B. Collins & Dale Oesterle, *Structuring the Ballot Initiative: Procedures that Do and Don't Work*, 66 U. COLO. L. REV. 47 (1995). See also Michael Vitiello, *Proposition 215: De Facto Legalization of Pot and the Shortcomings of Direct Democracy*, 31 U. MICH. J.L. REFORM 707 (1998).

186. See George J. Annas, *Faith (Healing), Hope and Charity at the FDA:*

the FDA has been widely criticized for not producing a cure for AIDS and for not allowing experimental use of several non-approved drugs to treat AIDS and other diseases like cancer.<sup>187</sup> Such pressures “threatened to transform [the FDA] from a consumer protection agency,” which regulates “safe and effective” drugs by insisting on strict standards of testing, into a “medical technology promotion agency,” which simply rubber-stamps approval of drugs.<sup>188</sup> Arguably, such a transformation would do little, if anything, to ease the pain of AIDS patients.<sup>189</sup> Rather, because many experimental drugs would have no therapeutic effect, a transformation of the FDA would place AIDS patients at greater risk of psychological, physical, and financial exploitation by those who would sell them useless drugs.<sup>190</sup>

Nevertheless, it is important to note that the government consistently demonstrates little, if any, willingness to test adequately and impartially the beneficial effects of medical marijuana, despite evidence of its benefits.<sup>191</sup> Rather,

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*The Politics of AIDS Drug Trials*, 34 VILL. L. REV. 771 (1989). Some commentators, however, contend that the FDA drug approval process should not apply to medical marijuana at all, because this process tends to ignore or undervalue the anecdotal evidence on which the therapeutic effects of medical marijuana are largely based. See GRINSPOON & BAKALAR, *supra* note 2, at 227-33. These commentators instead liken the anecdotal evidence of the therapeutic effects of medical marijuana to the anecdotal evidence in the 1970s that taking an aspirin a day could significantly lower risks of heart attacks—a practice that is well-accepted today. See *id.* Although it may seem strange to test the effects of aspirin for reducing heart disease using anecdotal evidence rather than clinical studies, by contrast it might make more sense to test the palliative effects of medical marijuana using anecdotal evidence, because a patient's comfort level is by definition subjective and difficult to assess.

187. See Annas, *supra* note 186, at 795.

188. See *id.* at 771, 795.

189. See *id.* at 795.

190. See *id.* at 771.

191. See Annas, *supra* note 23, at 438; Christopher S. Wren, *Phantom Numbers Haunt the War on Drugs*, N.Y. TIMES, Apr. 20, 1997, § 4, at 1. More recently, however, following public discussion of Proposition 215 in California and Proposition 200 in Arizona, the National Institutes of Health sponsored a conference in February 1997 to discuss medical marijuana and the possibility of funding medical marijuana research. See U.S. Dep't of Health & Human Services, *Investigating Possible Medical Uses of Marijuana* (visited Jan. 5, 1999) <<http://www.nih.gov/news/medmarijuana/hhsfact.htm>>; see also *Hearing on the 1998 National Drug Control Strategy Before the Subcomm. on National Security, International Affairs and Criminal Justice of the House Government Reform and Oversight Comm.*, 105th Cong. (Mar. 26, 1998), available in 1998 WL 8993743 (testimony of Barry R. McCaffrey, Director, Office of National Drug Control

government officials continue to contend that “[m]arijuana is not medicine and backers of the medical marijuana movement are not doctors. . . . [M]arijuana is a dangerous and addictive drug with high potential for abuse . . . [and] voters [in California] would have rejected Proposition 215 if they had simply known the facts.”<sup>192</sup> As mentioned above, the government’s unwillingness to consider and test the medical uses of marijuana stems largely from the politics of the war on drugs.<sup>193</sup>

The government is also concerned that permitting the medical use of marijuana will send the wrong message to adolescents that marijuana use is beneficial.<sup>194</sup> Underscoring the Administration’s concern is the belief that marijuana is a “gateway” drug that leads children into more harmful drug use and eventual addiction.<sup>195</sup>

Some commentators, however, point to different empirical evidence and flatly reject the notion that marijuana is a “stepping stone” to more dangerous drugs like cocaine or heroin.<sup>196</sup> Still other commentators point out that the notion that lifting the ban on medical use of marijuana would send a signal to adolescents that “marijuana is okay” is speculative and even doubtful given the relatively limited circumstances in which marijuana would be used for medical purposes.<sup>197</sup> Notwithstanding the government’s concerns about the general legalization of marijuana in small amounts,<sup>198</sup> in the context of

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Policy). For a complete copy of the NIH report, see *Workshop on the Medical Utility of Marijuana* (visited Jan. 5, 1999) <<http://www.nih.gov/news/medmarijuana/MedicalMarijuana.htm#EXECUTIVE>>.

192. *Marijuana Referenda Hearing*, *supra* note 2, at 1997 WL 14151533 (testimony of Ronald Brooks, Past President of the California Narcotic Officers’ Association).

193. *See supra* Part IV.A.

194. *See Marijuana Referenda Hearing*, *supra* note 2, at 1997 WL 14151535 (statement of General Barry R. McCaffrey, Director, Office of National Drug Control Policy, submitted for the record).

195. *See id.* The federal government contends, for example, that a teenager who smokes marijuana is 85 times more likely to use other, more dangerous drugs than a teenager who does not smoke marijuana. *See id.*

196. *See, e.g.*, GRINSPON & BAKALAR, *supra* note 2, at 245-47.

197. *See* Jerome P. Kassirer, M.D., *Federal Foolishness and Marijuana*, 336 *NEW ENG. J. MED.* 366 (1997).

198. The Clinton Administration notes that, when the Alaska Supreme Court decided to legalize personal possession of small amounts of marijuana, reported drug use among children doubled. *See Transcript of Briefing by General Barry McCaffrey and Frederico Pena*, U.S. NEWSWIRE, Dec. 12, 1996, available in

medical use by terminally ill patients, the government's concern is unfounded. There is no indication that adolescents would identify beneficial effects of marijuana with someone who is suffering from AIDS or cancer. For example, the medical use of marijuana by terminally ill patients would no more encourage children to experiment with the drug than the use of AZT to treat AIDS would encourage children to try that drug.<sup>199</sup> Therefore, if the medical use of marijuana were monitored and limited to those patients who suffer from debilitating terminal illnesses, the risks that it would send the wrong message to adolescents should at least be minimized.<sup>200</sup>

In essence, it appears that the federal government's undifferentiated approach to drugs, which by Schedule I classification "equates smoking [marijuana for medical purposes] with mainlining heroin, is essential to the edifice" of the Clinton Administration's policy on drugs.<sup>201</sup> While the government does have some legitimate interests in regulating drug use in America, these attacks on marijuana are often simplistic and based on a proposition that all drugs are addictive and evil, which many people, including children, can see is not entirely correct.<sup>202</sup> Accordingly, such propositions exaggerating the effects of all drugs may lead to a "culture of disbelief" in government policies and education.<sup>203</sup> It may also increase the chance that young people, who discover that the government's broad propositions concerning more benign drugs like marijuana are not entirely truthful, will believe the same thing about more dangerous drugs like crack cocaine.<sup>204</sup> In short, government untruthfulness concerning some types of drugs could lead to disbelief of all government statements concerning drugs.

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1996 WL 12124805.

199. See Ellen Goodman, *Clear Thinking in the Medical Marijuana Debate*, BOSTON GLOBE, Feb. 21, 1997, at C7; Wren, *supra* note 191.

200. Although AZT, unlike marijuana, was not in high demand by healthy people for recreational use before it became an AIDS treatment, this casenote maintains that the medical use of marijuana by terminally ill patients would not provide a "positive" association with marijuana for children looking for an excuse to use marijuana recreationally.

201. Robert Scheer, *'Reefer Madness' Lingers on in White House Drug Policy*, SAN DIEGO UNION-TRIB., Jan. 3, 1997, at B5. Also, for purposes of clarity, "mainlining heroin" means that the heroin user injects the drug intravenously.

202. See *id.*

203. *Id.*

204. See *id.*

Perhaps the government's best argument against the medical use of marijuana is that the legalization of medical marijuana is simply a calculated step toward legalizing the drug for recreational use.<sup>205</sup> Legitimization of drugs through medical use is not a new phenomenon in America.<sup>206</sup> At the turn of the century, for example, morphine, codeine, and laudanum were used commonly to treat illnesses like coughs, with the result that one in every 200 Americans was addicted to some form of drug.<sup>207</sup> Indeed, it appears that there are many indications that the medical use of marijuana in California is intended as a step toward outright legalization of the drug.

After the passage of Proposition 215 in California, several illegal marijuana buyers' clubs arose across the state in order to fill the demand for medical marijuana.<sup>208</sup> While many of these clubs have strict protocols for acquiring the drug, such as a signed doctor's recommendation, a detailed health questionnaire, and follow-up visits with a doctor,<sup>209</sup> many clubs simply require verification of a doctor's legitimacy without any inquiry into whether the physician actually recommended the medical use of marijuana or the nature of the illness.<sup>210</sup> For

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205. See *Marijuana Referenda Hearing*, *supra* note 2, at 1997 WL 14151533 (testimony of Ronald Brooks, Past President of the California Narcotic Officers' Association); see also Drug Enforcement Admin., U.S. Dep't of Justice, *Say It Straight: The Medical Myths of Marijuana* (visited Jan. 5, 1999) <<http://www.usdoj.gov/dea/pubs/sayit/myths.htm>>.

206. See Rosin, *supra* note 37, at 20.

207. See *id.*

208. See *Doctors May Talk About Pot*, S.F. EXAMINER, Mar. 1, 1997, at A3. There are roughly twenty marijuana buyer's clubs in California. See James Brooke, *Moving to Semantical High Ground*, N.Y. TIMES, Mar. 1, 1998, § 1, at 1. These clubs are cooperative organizations that arose throughout California following the passage of Proposition 215 in order to supply medical marijuana to patients. See generally *United States v. Cannabis Cultivators Club*, 5 F. Supp. 2d 1086, 1091-92 (N.D. Cal. 1997) (enjoining clubs and club owners from possessing with intent to distribute, manufacturing, selling, and distributing marijuana). However, according to one California appellate court decision, which the California Supreme Court declined to review, Proposition 215 does not allow anyone to sell marijuana and does not allow commercial enterprises to furnish marijuana. See *People ex rel. Lungren v. Peron*, 70 Cal. Rptr. 2d 20 (Ct. App. 1998); *Court Rejects the Sale of Medical Marijuana*, N.Y. TIMES, Feb. 26, 1998, at A4. In short, the clubs are illegal and are currently being closed by the state of California and the federal government.

209. See Rosin, *supra* note 37, at 19.

210. See *Doctors May Talk About Pot*, *supra* note 208, at A3.

many of the latter clubs, the “only guiding principle is deference to the patient.”<sup>211</sup>

Moreover, from reported discussions with many patients at these clubs, it is apparent that they are concerned not with medication but with legalization.<sup>212</sup> They speak primarily about legalization and often use medical marijuana not to treat AIDS or cancer but, rather, as prevention against questionable, undiagnosed illnesses like insomnia, migraine headaches, and common colds.<sup>213</sup> In fact, some so-called patients believe that “all marijuana use is medical—except for [use by] kids.”<sup>214</sup> Such an assertion may offend common sense and fail medical scrutiny, but similar statements concerning the medical uses of marijuana are not uncommon given the panacea folklore of medical marijuana.<sup>215</sup> In short, the patients who are often found using marijuana medically are a far cry from the patients whose debilitating terminal illnesses are the rallying point for the medical use of marijuana.

Even so, as much as the medical marijuana movement is about legalization of the drug, it is also about compassionate extension of relief to those patients who suffer from AIDS, cancer, and similar terminal diseases.<sup>216</sup> For those patients suffering from AIDS or cancer, smoking or ingesting marijuana does provide relief from nausea and loss of appetite, and it is doubtful that it could worsen their medical conditions.<sup>217</sup> It is no answer to the problem of drug addiction and abuse, or the efforts of some advocates to use medical marijuana to legalize the drug for recreational use, to tell patients with AIDS and cancer that marijuana is not medicine and therefore will not be tested for approval and regulation by the FDA.<sup>218</sup>

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211. Rosin, *supra* note 37, at 22.

212. *See id.* at 19.

213. *See id.*

214. *Id.* at 22 (quoting Dennis Peron, owner of the San Francisco Cannabis Cultivators Club).

215. *See supra* note 127.

216. *See* Rosin, *supra* note 37, at 19.

217. *See id.* at 22.

218. *See id.*

V. IMPACT OF *CONANT* IN COLORADO

This part relates the *Conant v. McCaffrey* debate and the issues discussed above to debates over a recent Colorado ballot initiative, and offers the argument that any resolution of the Proposition 215 debate will have widespread implications for similar measures proposed, debated, or enacted by other states.

Regardless of how the debate over the medical use of marijuana is ultimately resolved in *Conant*, the end result will undoubtedly have far-reaching implications for other states that have adopted or proposed initiatives modeled after California's Proposition 215.<sup>219</sup> Despite the Clinton Administration's opposition to the medical use of marijuana, general support for such a use appears to be growing in several states.<sup>220</sup> Virginia, for example, has had a law allowing the medical use of marijuana for many years.<sup>221</sup> Some states, like Washington, have wavered in support of similar laws.<sup>222</sup> Recently, however, several states have revisited medical marijuana proposals.<sup>223</sup> Specifically, in the latest round of state elections, medical marijuana ballot proposals passed in Alaska, Arizona, Nevada, Oregon, and Washington.<sup>224</sup> Citizens in Washington, D.C. also voted on a medical marijuana ballot initiative, although Congress intervened and ordered that the results be "impounded" and not counted.<sup>225</sup> Several state

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219. See Rachel Zimmerman, *Marijuana for Pain Ruled Out: State Supreme Court Sees No Constitutional Right*, SEATTLE POST-INTELLIGENCER, July 25, 1997, at A1; Rachel Zimmerman & Scott Sunde, *Gun, Marijuana and Gay Initiatives Are Defeated*, SEATTLE POST-INTELLIGENCER, Nov. 5, 1997, at A1.

220. See Zimmerman, *supra* note 219, at A1.

221. See *Medicinal Marijuana Legal in Virginia*, SEATTLE TIMES, Jan. 6, 1997, at A5. In 1978, New Mexico was the first state to enact a medical marijuana law. See GRINSPOON & BAKALAR, *supra* note 2, at 17-18. While over 30 states enacted similar laws through the 1970s and into the 1980s, many of these states abandoned them in the face of conflicts with the federal government. See *id.*

222. See Editorial, *Don't Tread on Them*, WALL ST. J., Nov. 6, 1998, at A14.

223. See Zimmerman, *supra* note 219, at A1.

224. See *Don't Tread on Them*, *supra* note 222, at A14. It is, perhaps, important to note that, in response to the many proposed medical marijuana ballot initiatives, President Clinton solicited and received from former Presidents Bush, Carter, and Ford a letter condemning the initiatives as undercutting public confidence in the safety of medicines. See *National News Briefing*, ROCKY MTN. NEWS, Oct. 29, 1998, at 63A.

225. See *Don't Tread on Them*, *supra* note 222, at A14.

legislatures have also taken up discussion of, or will soon begin to debate, various medical marijuana bills.<sup>226</sup>

Colorado voters also recently confronted the issue of medical marijuana. In October 1997, medical marijuana activists in Colorado filed a ballot initiative with the Colorado Office of Legislative Services to permit people with certain serious, debilitating illnesses to obtain marijuana legally for medical use.<sup>227</sup> The proposed amendment to the Colorado Constitution would have allowed the use of marijuana by people suffering from certain debilitating medical conditions, and would have protected doctors who discuss or recommend the medical use of marijuana by requiring only that they diagnose an eligible illness.<sup>228</sup> Moreover, the proposal would have created a state registry of everyone diagnosed with a medical condition eligible for treatment with marijuana in order to monitor the use of medical marijuana and ensure the program's credibility.<sup>229</sup> The initiative specifically proposed in relevant part:

[A]n amendment to the Colorado Constitution authorizing the medical use of marijuana for persons suffering from debilitating medical conditions, and . . . establishing an affirmative defense to Colorado criminal laws for patients and their primary care-givers relating to the medical use of marijuana; establishing exceptions to Colorado criminal laws for patients and primary care-givers in lawful possession of a registry identification card for medical marijuana use and for physicians who advise patients or provide them with written documentation as to such medical marijuana use; defining "Debilitating Medical

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226. These states include Arkansas, Hawaii, Maine, Massachusetts, Minnesota, New York, and Ohio. See H.R. 1043, 82d Leg., Reg. Sess. (Ark. 1999); S. 2438, 19th Leg. (Haw. 1997); S. 319, 118th Leg., 1st Sess. (Me. 1997); H.R. 742, 118th Leg., 1st Sess. (Me. 1997); H.R. 2304, 181st Leg., Reg. Sess. (Mass. 1999); S. 473, 182d Leg., Reg. Sess. (Mass. 1998); H.R. 1025, 80th Leg., Reg. Sess. (Minn. 1997); A.B. 6407, 221st Leg., Reg. Sess. (N.Y. 1997); S. 2, 122d Leg., Reg. Sess. (Ohio 1997).

227. See Ann Schrader, *Medical Pot Use Sought Proposition Could Make 1998 Ballot*, DENV. POST, Oct. 18, 1997, at B4. The activists included Martin Chilcutt, a retired psychotherapist, and Dr. Marshall Stiles III, a retired psychiatrist, in coordination with Coloradans for Medical Rights, a newly-formed non-profit organization. See *id.*

228. See Genevieve Anton, *Proposed Initiative Outlines Medical Marijuana Use*, COLO. SPRINGS GAZETTE-TELEGRAPH, Oct. 29, 1997, at 4.

229. See *id.*

Condition" and authorizing the state health agency to approve other medical conditions or treatments as debilitating medical conditions; . . . establishing and maintaining a confidential state registry of patients receiving an identification card . . . and defining eligibility for receipt of such a card and placement on the registry; restricting access to information in the registry; . . . specifying the form and amount of marijuana a patient may possess and restrictions on its use; . . . and providing that no employer must accommodate medical use of marijuana in the workplace.<sup>230</sup>

In order to get the measure on the November 1998 ballot, medical marijuana advocates had to obtain at least 54,000 signatures from registered Colorado voters.<sup>231</sup> In October 1998, after apparently receiving enough valid signatures, the initiative was placed on the November ballot as Amendment 19.<sup>232</sup> Once the initiative was placed on the ballot, it required only a simple majority vote to amend the Colorado Constitution.<sup>233</sup>

Prior to the November elections, however, Colorado Secretary of State Vikki Buckley ruled that there were not enough valid signatures to place the initiative on the November ballot.<sup>234</sup> Basing her finding on a random sampling of over 88,000 signatures submitted in support of Amendment 19, she determined that there were insufficient signatures for the matter to be considered by voters.<sup>235</sup> In response, sponsors of

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230. *Certified 1998 Initiatives and Referenda General Election Ballot—November 3, 1998* (last modified Sept. 19, 1998) <[http://www.state.co.us/gov\\_dir/sos/elections/measures.htm](http://www.state.co.us/gov_dir/sos/elections/measures.htm)> (Amendment 19). For additional defined terms, see *Coloradans for Medical Rights* (visited Jan. 5, 1999) <<http://www.medicalmarijuana.com/initiative.html>>.

231. See Schrader, *supra* note 227. It is important to note that, aside from the signature requirement and other modest barriers, state limitations on initiative procedures often are unconstitutional. See *Buckley v. American Constitutional Law Found., Inc.*, 119 S. Ct. 636 (1999) (holding that Colorado limitations on its state initiative process violate the First Amendment); *Meyer v. Grant*, 486 U.S. 414 (1988) (same); see also Collins & Oesterle, *supra* note 185, at n.311 (criticizing the Supreme Court's *Meyer* decision).

232. See Colorado Ballot Measure No. 4, 61st Gen. Assembly, 2d Sess. (Colo. 1998), available in WESTLAW, CO-BILLTRK.

233. Cf. *Romer v. Evans*, 116 S. Ct. 1620 (1996).

234. See Karen Abbott, *Secretary of State Wins Case: Medical Pot Initiative Rightly Taken off Ballot*, ROCKY MTN. NEWS, Nov. 24, 1998, at 7A.

235. See *id.*; see also Howard Pankratz, *Supreme Court Won't OK Pot Vote*, DENV. POST, Oct. 30, 1998, at A16.

the medical marijuana initiative went to court claiming that Buckley's assessment of the signatures was inaccurate.<sup>236</sup> In September 1998, a Denver district court determined that Buckley's staff indeed had erroneously disqualified many signatures, that the statutory parameters for a line-by-line recount of the signatures had expired, and that Amendment 19 should be placed on the ballot as if the state had reached no initial conclusion at all.<sup>237</sup> Nevertheless, after the ballot was printed, the Colorado Supreme Court reversed the district court ruling by holding that Buckley met the statutory deadline for a line-by-line recount.<sup>238</sup> Consequently, Buckley was given thirty days to recount the signatures. The recount was not completed by the time of the election, and the votes for and against the medical marijuana initiative were not counted.<sup>239</sup>

Despite the fact that the medical marijuana votes were not counted in Colorado, supporters of Amendment 19 claimed victory, contending that fifty-seven percent of those people tallied at exit polls said they voted for the measure.<sup>240</sup> Regardless of whether the initiative would have passed, and regardless of whether it is placed on the Colorado ballot in the year 2000,<sup>241</sup> the debate concerning medical marijuana in Colorado is important because it illustrates and indeed mirrors the national strife over medical marijuana.

Immediately upon filing the Amendment 19 ballot initiative in Colorado, there were protests from those people in the state of Colorado who were opposed to any use of marijuana for many of the reasons articulated in the debate concerning Proposition 215.<sup>242</sup> Some people viewed the proposed ballot

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236. See Pankratz, *supra* note 235.

237. See Abbott, *supra* note 234; Pankratz, *supra* note 235; Editorial, *Reward for an Error the Issue: Supreme Court Explains Its Ruling on Marijuana Initiative*, ROCKY MTN. NEWS, Nov. 27, 1998, at 85A.

238. See Abbott, *supra* note 234; Pankratz, *supra* note 235.

239. See *Reward for an Error the Issue: Supreme Court Explains Its Ruling on Marijuana Initiative*, *supra* note 237.

240. See Dan Luzadder, *Medicinal Pot Activists Claim "Victory"*, ROCKY MTN. NEWS, Nov. 5, 1998, at 33A. It is also significant to note that over \$800,000 was spent lobbying for and against the medical marijuana initiative. See Burt Hubbard, *Ballot Measure Funds Set Record*, ROCKY MTN. NEWS, Dec. 4, 1998, at 7A.

241. See Pankratz, *supra* note 235.

242. See John Wesley Anderson, *Legalizing "Medical Marijuana" Is the Wrong Prescription for Colorado*, COLO. SPRINGS GAZETTE-TELEGRAPH, Feb. 10, 1998, at 7.

initiative as "opening the door for legalization" and posing a threat to adolescents.<sup>243</sup> Others simply recited the concerns voiced by Barry McCaffrey: marijuana is neither humane nor good medicine; a popular vote is not an appropriate way for Americans to decide which medicines are safe and effective; a constitutional amendment would undermine the FDA approval process; marijuana has no remedial medicinal value; and marijuana is a gateway drug for children.<sup>244</sup> Accordingly, resolution of the controversy in *Conant* surrounding California's Proposition 215 appears likely to influence, if not inform, the growing controversy over the use of medical marijuana in Colorado. Not only do Coloradans echo the arguments for and against Proposition 215; the ultimate success of Proposition 215 is likely to foretell whether a Colorado medical marijuana initiative would survive federal challenges if successfully passed in the year 2000.

## VI. CONCLUSION

As the Physician Leadership on National Drug Policy noted, "[t]he current criminal-justice-driven approach [to America's drug problems] is not reducing, let alone controlling, drug abuse in America."<sup>245</sup> Physicians are not the object of the war on drugs.<sup>246</sup> The government's proposed response to California's Compassionate Use Act will in no way help to solve America's drug problem. Rather, an attempt to control physician-patient communications and prevent the recommendation of medical marijuana will result only in lessening physicians' medical independence and, consequently, in poorer delivery of health care. Accordingly, the federal government should rescind its prohibition of the medical use of marijuana for seriously ill patients and allow physicians to decide the appropriate treatment for their patients based only on medical factors, including consideration of a patient's quality of life.

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243. Dan Luzadder & Hector Gutierrez, *Ballot Initiative for '98 Calls for Approving Medical Use of Marijuana*, ROCKY MTN. NEWS, Oct. 16, 1997, at 5A.

244. See Anderson, *supra* note 242, at 7.

245. Anthony Lewis, *Politics Holds Drug Use Hostage*, ROCKY MTN. NEWS, Oct. 14, 1997, at 40A (quoting Dr. Lonnie Bristow, former president of the American Medical Association).

246. See Annas, *supra* note 23, at 438.

If the government declines to take these actions, it will continue to force many physicians like Dr. Marcus Conant to choose between treating terminally ill patients and breaking the law. More importantly, for patients like Jo Daly and our life-long friends and relatives who are dying of malignant brain tumors and other horrible illnesses, the government's medical marijuana policy will mean continuation of the unbearable pain and suffering that inevitably accompany chemotherapy and other radical treatments. It will mean endless pain, nausea and vomiting, and loss of appetite. For these people, however, political and moral judgments about illegal drugs coupled with promises of future medical marijuana studies ring hollow. Their needs are tangible and immediate. In the meantime, until the federal government changes its policy toward medical marijuana, its opposition to medical marijuana will compel patients to purchase the drug illegally, like common criminals.

