

Medical marijuana, individual autonomy, and state authority: the reclamation of r...

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In recent years, the debate over medical marijuana has become increasingly contentious and highly polarized. Patients, medical practitioners, citizens, lawyers, politicians, and lobbyists, to name a few, have joined the processes of deliberation and legislative activism; some advocate for the primacy of patient rights, while others stress points of medical research, state oversight, or federal supremacy. These points of advocacy intertwine, overlap, and inherently conflict, and, as such, legislative measures intended to resolve the debate seem only to inflame it.

While state-based legislation, in places like California, Vermont, and Rhode Island, seeks to regulate medical marijuana – and to protect patient rights of autonomy and practitioner rights of discretion, the federal government claims legal jurisdiction and authority. As such, medical marijuana is classified as an illegal substance, in accordance with the Federal Controlled Substance Act of 1970, and patients, practitioners, and states are deprived of their respective prerogatives regarding medical oversight. Though federal enforcement of medical marijuana prohibition is, unfortunately and unwaveringly, common, it represents a seizure of localized power and a gross expansion of federalism. The autonomy and privacy of citizens, particularly ill citizens seeking liberty in the most personal matters (those of physical health and medical treatment), is circumvented by federal intervention; the ability of state legislatures to fulfill their constitutionally endowed powers of oversight is severely impeded. Ultimately, the federal prohibition of medical marijuana [under the Controlled Substances Act of 1970] represents a centralized abuse of power in that (1) it violates individual rights of personal autonomy and privacy, as defined by the Due

Process Clause and (2) it violates states' rights to legislative authority and oversight, as defined by the Commerce Clause.

It is my intention, in the following paper, to examine the aforementioned violations; so, too, will I contend that federal drug enforcement manifestly infringes upon patients, practitioners, citizens, and states: On the rights of individuals to recommend and/or to pursue courses of medical treatment that they deem fit, that preserve their dignity, that place premium upon the tenet of compassionate care; on the rights of states, and their citizens, to determine how to treat and/or classify medical marijuana. Arguably, individual rights in matters of individual determination (i. e.

medical treatment), as defined through a constitutional purview, are the basis of autonomy, privacy, and freedom. These principles extend to the authority of states, and to the complimentary and subsequent limits of federal power, in order to preserve a balanced and sustainable political environment. The issue of medical marijuana may appear to affect only a small portion of the populous, but - as I hope to illustrate - it represents a federal encroachment on the most basic American tenets and a violation of our most valuable constitutional endowments. The Federal Controlled Substances Act vs.

Medical Marijuana The Federal Controlled Substances Act of 1970 (FCSA) represents the greatest obstacle to protective, state-based medical marijuana legislation, in that it prohibits and makes patients and practitioners liable for prescription, provision, or procurement of the drug (U.

S. Department of Justice, 1). The FCSA classifies marijuana as a Schedule I substance; such substances – according to the U. S. Department of Justice website, where the FCSA is provided in its entirety – have “ high potential for abuse,” “ lack of accepted safety for use... under medical supervision,” and “ no currently accepted medical use in treatment in the United States” (U. S.

Department of Justice, 1). Schedule I substances are highly illegal, and possession often materializes in felony crimes and consequential sentences, meaning that patients and practitioners are vulnerable to prosecution under federal statutes, regardless of state laws. Rhetorically, the FCSA negates any medical value of marijuana, despite substantial scientific studies and practitioner/patient testimonies that suggest otherwise, meaning that medical marijuana research and substantive evidence of its therapeutic potential is continually stifled. A number of medical marijuana activists have argued that “ the FCSA is not an appropriate model for regulating drugs with potential medical benefits.

It primarily addresses enforcement of drug laws, not clinical practice and research” (Gostin, 846). The current FCSA classification relies on definitional terms that are inaccurate and contradictory when compared to well-documented patient, practitioner, and scientific findings/testimony. Rather than attending to the need for alternative medical treatments, the FCSA asserts undue federal authority – of definition, supervision, and enforcement – over medical marijuana.

In so doing, the federal government precludes the medical communities' ability to pursue examination and prescription of effective treatments for suffering patients. Susan Trossman, a Senior Reporter for the American Nurse and a veteran caregiver, explains – from the practitioner perspective – the debate over issues of medical marijuana. In her article, “RX for Medical Marijuana,” she outlines state-based initiatives in Rhode Island, New York, and Wisconsin, noting that Rhode Island’s progressive legislation to allow distribution and possession of small quantities of marijuana for medical purposes indicates progressive and necessary state action (Trossman, 77). Trossman notes that nurse practitioners operate between the pull of ethical obligations (to provide compassionate care) and the push of criminalization regarding marijuana use; legislation like that in Rhode Island, then, frees nurses to cater to their patients as they deem necessary, without fear of prosecution or incarceration (78). The American Nursing Association, according to Trossman, supports and advocates for initiative-based legislation to further compassionate care goals, which the association enumerated in their 2003 House of Delegates Statement on Marijuana Use. In line with codes agreed upon and sworn to by nurse practitioners nationally, the statement invokes a fundamental ethical obligation: To advocate for patient’s rights (Trossman, 79). Trossman’s article illustrates the support of the medical community, on a wide scale (the entire ANA), for medical marijuana legislation and initiatives.

The American Medical Association and the American Nurse Association contend that the most basic tenets of medicine and treatment are: (1) to

provide compassionate care, (2) to alleviate suffering, and (3) to advocate for patient rights (American Medical Association, 1; Trossman, 79). As evidenced by expert and patient testimony, these standards can be upheld – in cases where ‘ traditional’ prescriptions have failed – only if medical marijuana (which has been documented to mitigate symptoms both of chronic illness and of traditional treatments for non-terminal diseases) is made accessible (Trossman, 80). Currently, however, federal restrictions impinge on the ability of practitioners to prescribe the best courses of treatment for suffering patients and of patients to pursue courses of treatments that best meet their needs. The Constitution, the U. S. Supreme Court, and the Onus of Medical Marijuana Ultimately, it is the responsibility of the populous – of popular consensus via ballot initiative or similar legislative processes – to assert its constitutional prerogative and, with due support, to establish protective legislative measures for patients and practitioners wishing to pursue medical marijuana treatments. As discussed above, such state-based initiatives have been pursued and passed in a number of localities, but these successful initiatives are regularly impeded upon and/or overturned by federal statutes and authorities.

In “ From Killer Weed to Popular Medicine: The Evolution of American Drug Control Policy, 1937-2000,” Kathleen Ferraiolo traces the history of marijuana legislation and prohibition in 20th Century America. Ferraiolo, a Professor of Public Health Policy at James Madison University, suggests that federal restriction of the substance has long been justified by traditionalist defenses of illegal substance control – like the War on Drugs, under the

auspices of the FCSA (170). It is not, then, in the interest of patients or with respect to state authority that federal authorities are involved in medical marijuana regulation, but in the interest of policy agendas and with respect to legislative preservation. These interests are preserved, it seems, in the credos of federal public health measures and magnified by conflicting U. S. Supreme Court decisions regarding medical marijuana. In *Gonzalez v Raich*, for example, the Court ruled that even in states where local legislation allows for medical marijuana use, federal drug legislation reigns superior - in other words, that patients and physicians can be prosecuted based on federal statutes despite local laws (Gostin, 842).

Lawrence Gostin, a Professor and Fellowship Scholar at the Georgetown Law Center in Washington D. C. , notes the implications of the *Gonzales* decision: The Court effectively ignored constitutional provisions of states rights, as outlined by the Commerce Clause, and gave judicial legitimacy to federal encroachments on individual autonomy and state authority (Gostin, 842). Yet the U. S. Supreme Court also found that Constitutional limitations on federal powers place oversight of medical practice under the umbrella of state authority. In *Linder v. United States*, the Supreme Court affirmed that “ direct control of medical practice in the United States is beyond the power of the federal government” (McCarthy, 337).

And, subsequently, in *Contant v. United States*, the Court asserted that “ principles of federalism... have left states the primary regulators of professional conduct” - which, arguably, includes professional medicine (McCarthy, 338). Judicial contradictions regarding matters of medical

oversight are indicative of the policy difficulties inherent to the debate over medical marijuana; ultimately, the Gonzales decision irresponsibly evaded Constitutional prescriptions in favor of federal superiority. Linder and Contant, on the other hand, upheld the provisions of the Commerce Clause – the basis of division of government, of our political system – but find judicial opposition in Gonzales. These decisions must be reconciled, in practice, if federalism is to be preserved in principle and state and individual rights preserved in perpetuity. B. Jill Jessie, an Assistant Professor at Case Western Reserve University School of Law, argues that matters of public health have yet – and in accordance with the aforementioned conflict of the Court – to be consolidated to a single frame of reference and judged with a cohesive and principled set of standards (330).

According to Jessie, members of the legislature and the judiciary, respectively, must respect constitutional provisions of individual rights; otherwise, the scholar notes, the institutions meant to protect individuals and issues of public health are made deferent to politically-based interpretations of medical findings – and such deference undermines the legitimacy of any initiatives intended to protect either (331). The Courts' rulings regarding individual autonomy and state authority, in terms of Due Process, offer greater consistency in terms of medical marijuana legislation and its implications. So, too, do they provide reconciliation of the judicial inconsistencies that Jessie warns against. Based on the decisions of *Lawrence v Texas*, *Washington v Glucksberg*, and *Bowers v Hardwick*, Angel McClairy-Raich – a terminally ill patient and medical marijuana activist –

determines that Constitutional Due Process guarantees patients' rights to pursue medical treatment as well as states' rights to protect such pursuance (1). McClairy-Raich writes, The denial of the only effective treatment [medical marijuana]... implicates an array of fundamental rights rooted in both the traditional and the autonomy theories of substantive due process: to live, to die with dignity, to avoid pain, and to exercise medical autonomy. By making it impossible for... patients to exercise one or more of these rights, a complete ban on the use of medical marijuana imposes a heavy - indeed, total - burden on such rights. The fundamental rights are infringed even though absolute anti-marijuana laws do not themselves constitute a total deprivation of dignity or freedom of self-definition; the important fact is that the laws make it substantially more difficult to pursue these broader values by making it completely impossible for patients to exercise their narrower fundamental rights. McClairy-Raich's determination synthesizes cohesive and complimentary Supreme Court decisions in the way that Justice suggests is necessary.

Until individual autonomy and state authority are given precedence and paramount status in the realm of medical - and self - determination, the notion of rights (in the most fundamental sense) will continue to be threatened. The Solution: Restoring Constitutional Rights through FCSA Reclassification Ultimately, the medical marijuana conundrum presented above is grounded in the perpetual debate over individual, state, and federal rights to authority. As illustrated, constitutional provisions of individual and state rights have been continually impeded upon in the interest of federal

prerogative. Because of the entrenched perspectives of debate participants, the way to reconcile these constitutional infringements would best be achieved through compromise. Rather than eliminating federal oversight altogether (which, as outlined, seems nearly impossible and highly confounded by structural constraints), federal oversight should be implemented. Were marijuana to be reclassified under the FCSA, and under the auspices of federal approval, both individuals' and states' rights could be restored. Experts, such as Gostin, advocate for the reclassification of marijuana from a Schedule I to a Schedule II class drug (based on the definitions outlined in the FCSA) in order to allow for marijuana to be appropriately and constitutionally regulated by federal bodies. By virtue of simple reclassification, which would legally qualify marijuana's potential medical benefits, all of the aforementioned legal discrepancies and authoritative disparities could be effectively addressed.

Similarly, Kathleen McCarthy, a third year law student at Southern Illinois University School of Law, advocates for a reconciliation of drug policy - one that shows greater reverence to and works within the confines of constitutional provisions to state sovereignty, one that, like reclassification, would adhere to the institutional framework already in place (334). Perhaps the greatest advocates of reclassification, The Medical Marijuana Policy Project Political Action Committee, support patients' rights via specific and definitive policy changes regarding medical marijuana. The MPP's site lists over seventy credible studies, published in peer-reviewed legal and medical journals, that demonstrate the physical and psychological benefits of

marijuana consumption for chronic pain and/or terminal illness. These studies focus on patient comfort and ameliorated suffering; they provide substantial and credible evidence regarding the need to reclassify marijuana under the Federal Controlled Substance Act of 1970 and, subsequently, to allow physicians and patients - not government officials - to determine the appropriate course of action throughout treatment. Effective medical marijuana reform is, of course, ultimately up to citizens.

Ferraiolo contends that by propping initiatives on patient rights and practitioner prerogative (compassionate care and attention to patient suffering), proponents of marijuana reform have achieved and garnered widespread support for state-based reforms regarding medical use (170). Because initiatives with a humanistic focus have the potential to cause major policy and paradigm shifts regarding marijuana use, public demands for FCSA reclassification have the potential to garner widespread support (Ferraiolo, 171). The substantive value of advocacy is derived of arguments based on patient rights and, thus, the notion that medical marijuana use is - in the popular view - an issue of personal determination rather than government oversight.

Public opinion surely has the potential to overturn longstanding and relatively entrenched federal classifications of medical marijuana - and, in so doing, to restore basic constitutional tenets. The subjective or politically motivated perceptions of specific medical treatments and options are inconsequential - until they wreak palpable havoc on the principles on which our system of governance and our way of life are based. The debate over

medical marijuana, the scramble for oversight, represents a singular threat to these principles, but the representation is vivid; it is a microcosm of circumvented rights. The exertion of federal authority over medical prerogative violates individual autonomy and state authority, and it does so under the auspices of misrepresented and misinterpreted constitutional provisions. In order to reconcile these abuses of power, at least in this microcosm, marijuana must be reclassified under the FCSA - and citizens and states must demand that this change take place.