

2006

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Adam Hyatt

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Recommended Citation

Adam Hyatt, *Medicinal Marijuana and Palliative Care: Carving a Liberty Interest Out of the Glucksberg Framework*, 33 Fordham Urb. L.J. 1345 (2006).

Available at: <https://ir.lawnet.fordham.edu/ulj/vol33/iss5/2>

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MEDICINAL MARIJUANA AND PALLIATIVE CARE: CARVING A LIBERTY INTEREST OUT OF THE GLUCKSBERG FRAMEWORK

*Adam Hyatt**

INTRODUCTION

On August 15, 2002, Butte County deputy sheriffs and federal agents from the Drug Enforcement Administration (“DEA”) arrived at Diane Monson’s house with a search warrant and discovered six cannabis plants.¹ The deputies determined that Monson was a licensed user of medicinal marijuana, and thus her use of the cannabis plants was lawful pursuant to California’s Compassionate Use Act of 1996,² which protects from criminal prosecution “patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician.”³ Following a three-hour standoff, however, the DEA agents seized and destroyed Monson’s cannabis plants.⁴

The DEA’s seizure was problematic for Monson because she suffers

* J.D. candidate, 2007, Fordham University School of Law. Special thanks to Professor Tracy Higgins for her ongoing advice.

1. *Gonzales v. Raich*, 125 S. Ct. 2195, 2200 (2005). Cannabis plants may be processed into marijuana, which is also commonly referred to as pot, weed, reefer, grass, etc. See Drug Enforcement Admin., U.S. Dep’t of Justice, Drugs of Abuse (2005), <http://www.usdoj.gov/dea/pubs/abuse/7-pot.htm> (last visited Sept. 13, 2006).

2. *Raich*, 125 S. Ct. at 2198. California is one of nine states that have permitted the use of medicinal marijuana. The other states are Alaska, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington. See STATE POLICIES DEP’T, MARIJUANA POLICY PROJECT, STATE-BY-STATE MEDICAL MARIJUANA LAWS: HOW TO REMOVE THE THREAT OF ARREST 10 (2004), available at http://oldsite.mpp.org/pdf/sbs_report_2004.pdf.

3. Compassionate Use Act, CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(B) (West 1996). The purpose of the Act is

[t]o ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

Id. § 11362.5(b)(1)(A).

4. *Raich*, 125 S. Ct. at 2200.

from a degenerative disease of the spine, which causes her “severe, chronic back pain and constant painful muscle spasms.”⁵ The intensity of her pain is such that she is unable to work or sit down, and thus she is limited to lying down.⁶ Under the care of a Board-certified physician, Monson has tried an array of prescription drugs, including muscle relaxants and anti-inflammatories, but each has been ineffective as a painkiller or has produced extreme side effects.⁷ Medicinal marijuana, on the other hand, significantly alleviates Monson’s pain and eradicates her muscle spasms almost entirely.⁸ Accordingly, her physician has concluded that medical marijuana is the sine qua non of a successful treatment of her pain and suffering.⁹

Angel Raich is also afflicted with serious medical problems and uses marijuana for medical purposes pursuant to the recommendation of her physician.¹⁰ Prior to the DEA’s raid of Monson’s home, Raich had enjoyed protection regarding her use of medicinal marijuana under the Compassionate Use Act.¹¹ Raich’s ailments are both life-threatening and painful.¹² In 1996, she became paralyzed and was restricted to a wheelchair.¹³ Raich’s physician had attempted to treat her with an array of medications, but all proved to be ineffective or caused extreme and “unacceptable” side effects.¹⁴ When her physician told her that conventional medicine would not help, Raich attempted suicide.¹⁵ Subsequently, her physician recommended that she use medicinal marijuana, which significantly improved her medical condition and enabled her to be more active.¹⁶ Accordingly, her physician concluded that there is no legal alternative to medical marijuana, and that without it her body

5. Brief for the Respondents at 10, *Gonzales v. Raich*, 125 S. Ct. 2195 (2004) (No. 03-1454), 2004 WL 2308766.

6. *Id.*

7. *Id.*

8. *Id.* at 6.

9. *Id.*

10. *Id.* at 4-5.

11. *Raich*, 125 S. Ct. at 2199-2200.

12. Brief for the Respondents, *supra* note 5, at 12. Her medical conditions include life-threatening weight loss, nausea, severe chronic pain (from scoliosis, temporomandibular joint dysfunction and bruxism, endometriosis, headaches, rotator cuff syndrome, and uterine fibroid tumor causing severe dysmenorrhea), an episode of paralysis, post-traumatic stress disorder, non-epileptic seizures, fibromyalgia, an inoperable brain tumor, multiple chemical sensitivities, allergies, and asthma. *Id.*

13. *Id.* at 5.

14. *Id.* at 5-6.

15. *Id.* at 5.

16. *Id.*

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would deteriorate, hastening her death.¹⁷

Subsequent to the DEA's seizure of Monson's cannabis plants, Monson and Raich brought suit against the United States Attorney General¹⁸ and the DEA, seeking to enjoin the federal government from enforcing the Controlled Substances Act ("CSA"),¹⁹ which makes it unlawful to manufacture, distribute, dispense, or possess marijuana, and does not recognize an exception for medical use.²⁰ In their complaint, Monson and Raich argued that the CSA, as applied to them, violated the Commerce Clause, the Due Process Clause of the Fifth Amendment, the Ninth Amendment, the Tenth Amendment, and the doctrine of medical necessity.²¹

The United States District Court for the Northern District of California disagreed and denied plaintiffs' motion for a preliminary injunction. The court found that the government's interest²² "wane[d] in comparison with the public interests enumerated by plaintiffs and by the harm that they would suffer if denied medical marijuana,"²³ but nonetheless concluded that plaintiffs were not entitled to legal relief because they failed to establish a likelihood of success on the merits.²⁴

On appeal, a divided Ninth Circuit panel reversed and ordered the district court to enter the preliminary injunction.²⁵ The court held that plaintiff-appellants had demonstrated a likelihood of success based on their Commerce Clause argument.²⁶ The court also found that Monson and

17. *Id.*

18. At the time the action was brought, John Ashcroft was the Attorney General. By the time the case reached the Supreme Court, Alberto R. Gonzales had become Attorney General.

19. Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1242 (1970) (codified in scattered sections of 21 U.S.C. (2006)).

20. Controlled Substances Act, 21 U.S.C.A §§ 823, 841(a)(1) (West 2006). The CSA places restrictions on controlled substances based on the schedule under which a particular drug is categorized. Because a Schedule I drug, such as marijuana, is deemed to have "a high potential for abuse" and "no currently accepted medical use in treatment in the United States," the only available exception for its legal use exists for government-approved research projects. *Id.* §§ 812(b)(1)(A)-(C), 823(f) (West 2006); *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 490 (2001).

21. *Gonzales v. Raich*, 125 S. Ct. 2195, 2200 (2005).

22. More specifically, this governmental interest is the presumption of constitutional validity of congressional legislation and the regulation of medicine by the FDA. *Raich v. Ashcroft*, 248 F. Supp. 2d 918, 931 (N.D. Cal. 2003).

23. *Id.*

24. *See id.*

25. *Raich v. Ashcroft*, 352 F.3d 1222, 1235 (9th Cir. 2003).

26. *Id.* at 1227.

Raich would endure “significant hardship[s]”²⁷ if denied the injunction and that the government’s interests were “weak in comparison to the real medical emergency facing” plaintiffs,²⁸ but did not reach the substantive due process claim or the medical necessity defense.

In *Gonzales v. Raich*,²⁹ which largely dealt with the issue of federalism, the Supreme Court vacated the Ninth Circuit’s judgment and held that the CSA was not an unconstitutional exercise of the Commerce Clause as applied to the plaintiff-respondents.³⁰ Because the Ninth Circuit did not reach respondents’ substantive due process claim or medical necessity defense, the Court remanded the case to determine whether Monson and Raich could succeed on these other avenues for judicial relief.³¹

This Comment will focus only on the substantive due process claim available to the plaintiffs on remand.³² More specifically, this Comment will assess whether there is a right to palliative care. In *Washington v. Glucksberg*,³³ which dealt with the right to assisted suicide, five Justices³⁴ suggested that there may be a liberty interest in avoiding or mitigating pain—even if it hastens death. Accordingly, the facts of *Raich* fit squarely within the fundamental liberty interest question addressed in *Glucksberg*, albeit with an additional hurdle over a statute illegalizing marijuana that is backed by significant policy concerns.

A recent *Harvard Law Review* note³⁵ argued that “a law completely banning the use of marijuana will, as applied to some patients, infringe upon an array of fundamental rights, and that substantive due process obliges” the courts to apply strict scrutiny to such a law.³⁶ The Comment does not, however, assert that there is indeed a right to use last-resort medical marijuana, but rather examines the burdens that the absolute anti-

27. It is relevant to note that the government did not dispute this. *See id.* at 1234.

28. *Id.* at 1235.

29. 125 S. Ct. 2195 (2005).

30. *Id.* at 2215.

31. *Id.*

32. For an interesting analysis of the medical necessity defense, see Andrew J. LeVay, *Urgent Compassion: Medical Marijuana, Prosecutorial Discretion and the Medical Necessity Defense*, 41 B.C. L. REV. 699 (2000). *See also* United States v. Oakland Cannabis Buyers’ Coop., 532 U.S. 483 (2001) (holding that medical necessity is not a defense to manufacturing and distributing marijuana).

33. 521 U.S. 702 (1997).

34. Justices O’Connor, Ginsburg, Breyer, Stevens, and Souter all filed concurring opinions.

35. Note, *Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana*, 118 HARV. L. REV. 1985 (2005) [hereinafter *Last Resorts*].

36. *Id.* at 1985.

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marijuana law has on “an array of fundamental rights rooted in both the traditional³⁷ and the autonomy³⁸ theories of substantive due process.”³⁹ It goes only so far as to say that such a law “make[s] it substantially more difficult to pursue these broader values by making it completely impossible for patients to exercise their narrower fundamental rights,” and ends the analysis at the strict scrutiny stage.⁴⁰

This Comment goes a step further by arguing that, in view of the Court’s precedents, there is a right, subject to limitations, to use last-resort medical marijuana. Part II examines substantive due process generally, as well as the precedent relating to medical decision-making. This Part primarily focuses on locating the right to palliative care, which was contemplated in *Glucksberg*, and discusses how medicinal marijuana fits within that right. Part III argues that there is indeed a fundamental right to palliative care and assesses whether an absolute anti-marijuana law burdens this right to the extent that the law is unconstitutional as applied to other cases. By analyzing a range of different factual scenarios, this Part constructs a framework to test the point at which the fundamental right is limited by strict scrutiny balancing. Part III concludes by considering the future of the medical decision-making spectrum of liberty interests articulated in *Glucksberg*.

I. MEDICINAL MARIJUANA & THE ROAD TO PALLIATIVE CARE AS A FUNDAMENTAL RIGHT

This Part works through the doctrine of substantive due process in the context of medical decision-making. In particular, this Part reconstructs the framework established in *Glucksberg* and suggests that the Court in *Raich* is headed in a direction as to preserve a fundamental right to palliative care that protects use of medicinal marijuana.

A. Modern Substantive Due Process Jurisprudence

Modern substantive due process precedent “forbids the government to infringe upon certain ‘fundamental’ liberty interests [protected by Fourteenth Amendment] *at all* . . . unless the infringement is narrowly tailored to serve a compelling state interest.”⁴¹ The Supreme Court has

37. *See infra* notes 45-47 and accompanying text.

38. *See infra* notes 48-50 and accompanying text.

39. *Last Resorts*, *supra* note 35, at 2006.

40. *Id.*

41. *Reno v. Flores*, 507 U.S. 292, 302 (1993). This reflects the language of the strict

been cautious, however, when confronted with an opportunity to “expand the concept of substantive due process because guideposts for responsible decisionmaking in this uncharted area are scarce and open-ended.”⁴² Accordingly, to “break new ground”⁴³ within the doctrine, the Court has required the claimed liberty to be fundamental.⁴⁴

The traditional approach,⁴⁵ articulated in *Glucksberg*, characterizes a right as fundamental when it is “deeply rooted in this Nation’s history and tradition . . . and . . . implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed.”⁴⁶ Furthermore, “a careful description of the asserted right or liberty” is necessary.⁴⁷

Recently, in *Lawrence v. Texas*,⁴⁸ the Court recognized a second vehicle for finding fundamental rights. This approach is premised on the notion of autonomy⁴⁹ and “emphasizes self-definition as the core of constitutionally protected liberty.”⁵⁰

Although both approaches are plausible, this Comment suggests that the right to palliative care fits within the *Glucksberg* paradigm. At the same time, however, because medical decision-making is inherently related to individual choice, discussion of personal autonomy is inevitable.

B. Medical Decision-Making & the Right to Refuse Treatment

The Supreme Court considered the notion of fundamental rights in the medical decision-making context as early as the turn of the twentieth century when it decided *Jacobson v. Commonwealth of Massachusetts*.⁵¹ In *Jacobson*, a criminal defendant argued that a state statute infringed upon

scrutiny balancing test. When a right is not deemed fundamental, the state’s action merely needs to be rationally related to a legitimate government interest. See *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

42. *Glucksberg*, 521 U.S. at 720 (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992)).

43. *Id.*

44. *Last Resorts*, *supra* note 35, at 1986.

45. See Robert C. Post, *The Supreme Court, 2002 Term—Foreword: Fashioning the Legal Constitution: Culture, Courts, and Law*, 117 HARV. L. REV. 4, 89 (2003).

46. *Last Resorts*, *supra* note 35, at 1986 (quoting *Glucksberg*, 521 U.S. at 721 (internal quotation marks omitted)).

47. *Id.*

48. 539 U.S. 558 (2003).

49. See Post, *supra* note 45, at 97.

50. *Last Resorts*, *supra* note 35, at 1987.

51. 197 U.S. 11 (1905).

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his liberty by subjecting him to punishment for refusing to submit to a compulsory vaccination.⁵² The Court rejected the defendant's assertion and upheld the statute because the state legislature passed it as a public safety measure designed to stop the spread of disease.⁵³ The Court concluded that the Constitution "does not import an absolute right in each person to be . . . wholly freed from restraint" and that "[t]here are manifold restraints to which every person is necessarily subject for the common good."⁵⁴

Eighty-five years later, the Supreme Court revisited the issue of the right to refuse medical treatment in *Cruzan v. Director, Missouri Department of Health*.⁵⁵ Using the logic of *Jacobson*, the Court concluded, "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."⁵⁶ This notion was premised on the common-law informed consent rule, which supported the proposition that "even the touching of one person by another without consent and without legal justification was a battery."⁵⁷ The Court noted, however, that locating a fundamental right is merely the first step because ascertaining whether one's substantive due process has been violated then requires balancing that fundamental right against the corresponding state interest.⁵⁸ In this case, the Court found that the liberty interest outweighed any state interest, and thus "assume[d]" a competent person has "a constitutionally protected right to refuse lifesaving hydration and nutrition."⁵⁹

Embedded in this right to refuse treatment is the notion of autonomy in

52. *Id.* at 26.

53. *Id.* at 27.

54. *Id.* at 26. The idea of the "common good" (in this case, stopping spread of disease) is equivalent to the "compelling state interest language" in modern substantive due process doctrine. Accordingly, it can be said that there was indeed a liberty interest in refusing medical treatment, but it was not strong enough to survive strict scrutiny. In other words, *Jacobson* turned on the compelling state interest prong of the test, rather than the "fundamental liberty" prong of the test. *Id.*

55. 497 U.S. 261 (1990). The Court focused on this right in the context of both mentally competent and mentally incompetent people. This Note does not consider the rights of mentally incompetent people, nor the evidentiary requirements necessary to terminate life support.

56. *Id.* at 278. At this time, however, the Court did not articulate a level of scrutiny or define this right as "fundamental." The Court later used this language in *Glucksberg*. See *Washington v. Glucksberg*, 521 U.S. 702, 724 (1997).

57. *Cruzan*, 497 U.S. at 269.

58. *Id.* at 279.

59. *Id.* Five justices expressly asserted that this includes the right to refuse food and water to bring about death. For example, in his dissenting opinion, Justice Brennan contended there is "a fundamental right to be free of unwanted artificial nutrition and hydration, which . . . is not outweighed by any interests of the State . . ." *Id.* at 302 (Brennan, J., dissenting).

medical decision-making, or more simply, the right “to choose effective medical treatment pursuant to a doctor’s recommendation.”⁶⁰ Accordingly, as Justice O’Connor asserted in her *Cruzan* concurrence, “[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.”⁶¹ In the context of a competent terminally ill patient then, requiring life support or other forced medical treatment would “burden that individual’s liberty interests as much as any state coercion.”⁶²

Of course, the holding in *Cruzan* cannot be directly applied to the facts of *Raich* because the former concerns the right to refuse treatment, while the case at bar concerns obtaining treatment.⁶³ Nonetheless, because both cases fall under the broad umbrella of medical decision-making while under the care of a physician, it may be logical that the Due Process Clause also protects the right to palliative care even if such care hastens death.⁶⁴ In this case, the Court would be following the autonomy trajectory established in *Lawrence* by emphasizing self-definition as a significant source of fundamental rights.⁶⁵

C. Medical Decision-Making, Physician-Assisted Suicide & the Future

Seven years after *Cruzan*, the Court confronted the controversial issue of physician-assisted suicide in *Glucksberg*.⁶⁶ The plaintiff-respondents, Washington physicians who treated terminally ill patients, sought a declaration that Washington’s assisted suicide ban was unconstitutional on its face.⁶⁷ In rejecting respondents’ facial challenge and holding that there is no fundamental right to assisted suicide, the Court’s method of constitutional interpretation seemed to be evolving as it introduced a more pronounced doctrinal test for substantive due process analysis.⁶⁸ The

60. *Last Resorts*, *supra* note 35, at 1995.

61. *Cruzan*, 497 U.S. at 287 (O’Connor, J., concurring).

62. *Id.* at 288.

63. *Last Resorts*, *supra* note 35, at 1993.

64. *See id.* at 1995-98. At the same time, however, the common-law tradition draws a line between action and inaction: while touching another without permission is considered tortious conduct, failing to rescue another is not. *See generally* Jackson v. City of Joliet, 715 F.2d 1200 (7th Cir. 1983).

65. *See* Lawrence v. Texas, 539 U.S. 558, 562 (2003).

66. The Court decided a companion case, *Vacco v. Quill*, 521 U.S. 793 (1997), at the same time.

67. *See* Washington v. Glucksberg, 521 U.S. 702, 707 (1997).

68. *See supra* notes 45-47 and accompanying text.

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Court's methodology reflected an originalist ideology: it emphasized history and legal tradition as the sources of liberties rather than emerging norms,⁶⁹ and defined the asserted right more specifically (i.e. the right to physician-assisted suicide instead of the more generally defined right to personal autonomy in medical decision-making).⁷⁰

Although a patient's decision to request lethal medication can be equated to the decision to refuse treatment, the notion of assisted suicide as a fundamental right is problematic under the Court's test because there is no legal tradition of condoning suicide.⁷¹ In fact, "for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."⁷² Furthermore, anti-suicide laws are not recent "innovations," but rather are "longstanding expressions of the States' commitment to the protection and preservation of all human life."⁷³ Accordingly, recognizing assisted suicide as a constitutionally protected liberty interest would "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."⁷⁴

Glucksberg repudiates or limits the notion that narrowly defined rights pertaining to medical decision-making are primarily established under a broad personal autonomy justification.⁷⁵ Although self-determination and physical control over one's body are relevant to the inquiry, those interests are trumped by history and legal tradition. Thus, the right to refuse treatment assumed in *Cruzan* "was not simply deduced from abstract concepts of personal autonomy," but rather "[g]iven the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, [the Court's] assumption was entirely consistent with this Nation's history and constitutional traditions."⁷⁶ Assisted suicide, on the other hand, though a similarly personal decision, contradicts the legal tradition and is thus outside the gamut of constitutionally protected liberties.⁷⁷

Because the Court concluded that physician-assisted suicide was not a fundamental right, Washington's anti-suicide law merely had to survive

69. See *Glucksberg*, 521 U.S. at 705.

70. See *id.* at 710.

71. See *id.*

72. *Id.* at 711.

73. *Id.* at 710.

74. *Id.* at 723.

75. See *id.* at 727.

76. *Id.* at 725.

77. *Id.*

rational basis review.⁷⁸ In this case, the State easily satisfied this requirement with a plethora of legitimate government interests in banning assisted suicide, including the preservation of human life,⁷⁹ combating suicide as a disease,⁸⁰ protecting the integrity of the medical profession,⁸¹ protecting vulnerable groups,⁸² and avoiding a slippery slope that could lead to voluntary or involuntary euthanasia.⁸³ Accordingly, the Court upheld Washington's statute, but also left the door open in the legislative arena for the assisted suicide debate to continue.⁸⁴

Although the law prevents facial challenges to the anti-suicide law, the concurrences of five Justices left open the possibility of challenges relating to a scenario in which a patient is restricted from obtaining palliative care.⁸⁵ In particular, "a patient who is suffering from a terminal illness and who is experiencing great pain [should face] no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."⁸⁶ The Justices also suggested that an as-applied challenge may also succeed when a patient's pain is so severe that it cannot be alleviated by medication.⁸⁷ This liberty interest is related not only to avoiding pain, but also to controlling the end of one's life with dignity.⁸⁸ In totality then, the *Glucksberg*

78. *Id.* at 728.

79. This is the same "unqualified interest" at the core of homicide laws. *Id.*

80. Suicide is a public-health problem that needs to be meticulously studied and treated. *Id.* at 730.

81. *Id.* at 731.

82. The concern is that the poor, elderly, and disabled could be coerced into consenting to assisted suicide toward the end of life. *See id.* at 731-32. This protection is also necessary because assisted suicide could denigrate the notion that the disabled and terminally ill can lead valuable lives. *Id.* at 732.

83. *See id.* at 732-33.

84. *Id.* at 735. Practically, this meant that assisted suicide was left to the political process of each state. Accordingly, Oregon's Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800-127.890 (West 2006), which legalized physician-assisted suicide subject to certain limitations, remained good law. In fact, several months after *Glucksberg* was decided, the Oregon law withstood a ballot measure to repeal it. *Gonzales v. Oregon*, 126 S. Ct. 904, 911 (2006). The Act then faced and withstood a challenge by the Attorney General. *Id.* at 925-26. The case, one of the first heard by the newly composed Roberts Court, turned on an issue of federal administrative law. Linda Greenhouse, *Justices Explore U.S. Authority Over States on Assisted Suicide*, N.Y. TIMES, Oct. 6, 2005, at A1.

85. *See Glucksberg*, 521 U.S. at 736 (O'Connor, J., concurring); *id.* at 738 (Stevens, J., concurring in the judgment); *id.* at 752 (Souter, J., concurring in the judgment); *id.* at 778 (joint opinion of O'Connor, Kennedy, and Souter, JJ.); *id.* at 789 (Ginsburg, J., concurring in the judgment); *id.* (Breyer, J., concurring in the judgment).

86. *Id.* at 736-37 (O'Connor, J., concurring).

87. *Id.* at 745 (Stevens, J., concurring in the judgment).

88. *Id.*

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concurrences represent the notion that there is a fundamental right to palliative care. Furthermore, they suggest that this liberty interest may outweigh state interests, such as those articulated in *Glucksberg*, and therefore survive strict scrutiny, even if the practical result is permitting assisted suicide in limited situations.⁸⁹

After *Glucksberg*, it became clear that the Court had created a framework for analyzing a range of fundamental rights relating to medical decision-making. On one end of the spectrum is the right to refuse treatment, even if such a decision inevitably would lead to death.⁹⁰ On the other end of the spectrum are two categories relating to suicide, which of course includes physician-assisted suicide. The outermost category is the decision to commit suicide when death is not imminent.⁹¹ A less extreme category is the decision to commit suicide when death is imminent and the end of life is physically painful. This category, which falls between the right to refuse treatment and the right to suicide at will, infuses notions of death with dignity and self-definition during the last days of life by controlling the manner of death. The Court has drawn the line between the right to refuse treatment and the right to commit suicide, but has signaled openness to hearing an as-applied challenge in which the line could be redrawn to define a right to assisted suicide as fundamental in very limited circumstances.⁹²

In the center of the spectrum is the right to palliative care even if such care hastens death. Whether the Court will deem this a fundamental right is difficult to predict. On one hand, using medication prescribed by a physician seems similar to refusing medical treatment in that it is a medical decision over which the individual has autonomy. At the same time, the physician plays a more affirmative role by recommending treatment, which is closer to the administration of lethal drugs in assisted suicide. Accordingly, the right to palliative care presents a tension that the Court has not yet had a chance to resolve. Because *Raich* is not a case about assisted suicide, however, it is not clear whether it fits squarely within the *Glucksberg* scenario. On the other hand, the liberty interests of Monson and Raich clearly parallel those at issue in *Glucksberg*.

89. See generally *Last Resorts*, *supra* note 35, at 1993-95.

90. See *supra* Part I.B. Tied to this category, but moving more to the middle, is the decision to discontinue treatment, which relates more to incompetent adults and is thus outside the scope of this Note. See *supra* notes 55-56 and accompanying text.

91. One example of a situation where death is not imminent is if the individual has a severe physical disability or depression.

92. Whether this would survive strict scrutiny, however, is another issue entirely.

D. The Marijuana Curveball

Raich is further complicated by the fact that the case involves marijuana, an illegal drug under the CSA. First, it is problematic to classify marijuana as a form of palliative care, since there is tremendous disagreement as to whether the substance has any therapeutic value. Second, because of its illegality, marijuana adds an extra hurdle in the substantive due process analysis.

1. The Marijuana Efficacy Issue

As Professor Tatiana Shohov points out, the question of whether marijuana has therapeutic use for patients with conditions ranging from migraines to terminal illnesses has been a topic of recent debate.⁹³ Less controversial, however, is the notion that marijuana has both short- and long-term adverse effects on the brain, the heart, the lungs, the immune system, and on learning and social behavior.⁹⁴ Notwithstanding its adverse effects, marijuana, according to Shohov, has medicinal value. Shohov provides scientific evidence proving that marijuana can provide relief from nausea and increase appetite, reduce intraocular pressure, reduce muscle spasms, and provide relief from chronic pain: it can thus treat symptoms of cancer, AIDS, and multiple sclerosis.⁹⁵ This evidence has also entered the legal arena and has given credibility to the great “number of health care professionals and organizations [that] have concluded that the use of marijuana may be appropriate for a small class of patients who do not respond well to, or do not tolerate, available prescription drugs.”⁹⁶

On the other side of the controversy, the Food and Drug Administration (“FDA”), which assesses the safety and effectiveness of drugs, has not found a medicinal use for marijuana.⁹⁷ Similarly, Congress determined

93. See generally MEDICAL USE OF MARIJUANA: POLICY, REGULATORY AND LEGAL ISSUES (Tatiana Shohov ed., 2003).

94. *Id.* at 3-8.

95. *Id.* at 11, 23-39.

96. *Conant v. Walters*, 309 F.3d 629, 640-41 (9th Cir. 2002) (Kozinski, J., concurring). For more sources that conclude marijuana has medical use, see *Marihuana Medical Access Regulations*, SOR/2001-227 (Can.), available at <http://www.canlii.org/ca/regu/sor2001-227/>; Select Committee On Science & Technology, *Cannabis: The Scientific and Medical Evidence*, 1997-8, H.L. 151-1, at § 8.2, available at <http://www.publications.parliament.uk/pa/ld199798/ldselect/ldsctech/151/15101.htm>; In re *Marijuana Rescheduling Petition*, No. 86-22 (Drug Enforcement Admin. Sept. 6, 1988); INST. OF MED., *MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE* (Janet E. Joy et al. eds., 1999), available at <http://www.nap.edu/books/0309071550/html>.

97. MEDICAL USE OF MARIJUANA, *supra* note 93, at 79. For an article on the FDA’s regulation of pain management drugs, see Lars Noah, *Challenges in the Federal Regulation*

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that marijuana has “no currently accepted medical use in treatment in the United States.”⁹⁸

Putting this debate aside, the empirical evidence admitted at trial in *Raich* suggests, at the very least, that medicinal marijuana has therapeutic value for both Monson and Raich.⁹⁹ Furthermore, both the district court and the Ninth Circuit found that traditional medicine failed to help the plaintiffs and that restricted access to marijuana would be unduly burdensome.¹⁰⁰ Even the Supreme Court recognized that “despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes.”¹⁰¹ Accordingly, for the purposes of substantive due process analysis, this Comment will assume *arguendo* that marijuana has therapeutic value.

2. *The Illegality Hurdle*

Marijuana’s illegality under the CSA may create a problem in locating a fundamental right. Of course, this depends entirely on whether the right is framed at a broad or specific level of generality.¹⁰² At a specific level of generality (i.e. the right to use medicinal marijuana), finding a fundamental right would be unlikely given the Nation’s history and legal tradition. Thus, rational basis review would apply.¹⁰³ A recent *Harvard Law Review* note points out, however, “the Court must not take such a myopic view of the claimed right that it loses the sight of the values at stake.”¹⁰⁴ Accordingly, defining the right in *Raich* narrowly as the right to use medicinal marijuana is analogous to the error committed by the *Bowers v. Hardwick*¹⁰⁵ Court in defining the claimed right as the right to engage in homosexual sodomy.¹⁰⁶ That is, “[t]he mistake lies in viewing the claimed right as identical to the conduct that the law prohibits,” which in turn ignores significant values underlying the claimed right.¹⁰⁷ At a broad level of generality, however, there is concern that “the scope of substantive due process becomes limitless.”¹⁰⁸ This would preclude the right from being

of Pain Management Technologies, 31 J.L. MED. & ETHICS 55 (2003).

98. 21 U.S.C.A. § 812(b)(1)(B) (West 2006).

99. *See supra* notes 5-17 and accompanying text.

100. *See supra* notes 22-28 and accompanying text.

101. *Gonzales v. Raich*, 125 S. Ct. 2195, 2201 (2005).

102. *See Lawrence v. Texas*, 539 U.S. 558 (2003).

103. *Id.* at 570 (O’Connor, J., concurring).

104. *Last Resorts*, *supra* note 35, at 1988.

105. 478 U.S. 186 (1986).

106. *See Last Resorts*, *supra* note 35, at 1988.

107. *Id.*

108. *Id.*

framed as one of personal autonomy in medical decision-making.¹⁰⁹ Framing it as a right to palliative care, then, is neither too broad nor too narrow, and seems to be most consistent with *Lawrence*, *Cruzan*, and the concurrences of *Glucksberg*.

If the right is properly framed as the right to palliative care, the legal status of marijuana enters the analysis at the point of determining whether the state interest is compelling. The government has an undeniable interest in eradicating drugs from society, which is highlighted by codified anti-drug policy in the CSA.¹¹⁰ This governmental interest dates back to 1969 when President Richard Nixon launched a national “war on drugs.”¹¹¹ Thereafter, Congress passed the Comprehensive Drug Abuse Prevention and Control Act of 1970,¹¹² which includes the CSA within Title II. In passing the Act, Congress’s objectives were “to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances.”¹¹³ In particular, Congress sought to “prevent diversion [of legitimate drugs] into illegal channels, and strengthen law enforcement tools against the traffic of illicit drugs.”¹¹⁴

More specifically, marijuana is classified as a Schedule I drug, in part because of its high potential for abuse.¹¹⁵ Illustrative of this is the fact that marijuana is used more in the United States than any other illegal drug, with over twelve million Americans, age twelve and over, using the drug at least once a month in 2001.¹¹⁶ This statistic is troubling because of the scientific evidence documenting the health risks associated with the use of marijuana.¹¹⁷ Furthermore, many scientists adhere to the notion that marijuana is a gateway drug that may lead to the use of more dangerous

109. *See id.* at 1988-89.

110. Controlled Substances Act of 1970, 84 Stat. 236 (1970).

111. *Gonzales v. Raich*, 125 S. Ct. 2195, 2201 (2005); *see also* DAVID F. MUSTO & PAMELA KORSMEYER, *THE QUEST FOR DRUG CONTROL* 60 (2002).

112. 84 Stat. 1236. Prior to that, Congress passed legislation, such as the Harrison Narcotics Act of 1914, 38 Stat. 785 (repealed 1970), and the Marihuana Tax Act of 1957, Pub. L. No. 75-238, 50 Stat. 551 (repealed 1970), which did not legalize marijuana but instead established harsh regulations that had the practical effect of curtailing the market for marijuana. *Raich*, 125 S. Ct. at 2202.

113. *Raich*, 125 S. Ct. at 2203.

114. *Id.* at 2201.

115. *Id.* at 2204.

116. MEDICAL USE OF MARIJUANA, *supra* note 93, at 1-2.

117. *Id.* at 42. The long-term risks associated with chronic use include damage to the respiratory system, cardiovascular system, the immune system, and the reproductive system. *Id.* In addition, there are many possible short-term complications users of marijuana may confront. The number of hospital emergency room visits induced by or relating to the use of marijuana increased fifteen percent from 96,426 in 2000 to 110,512 in 2001. *Id.* at 2.

substances.¹¹⁸

Accordingly, it is clear that the government has an interest in curtailing the use of marijuana in the United States. Because the medication in this case is illegal, *Raich* is an excellent test case for the right to palliative care. In balancing the liberty interest against the government's interest in this case, it is significant to note that the latter remains fixed. Conversely, one individual claiming the right to palliative care might have a stronger liberty interest than another. This notion comes to fruition in *Raich* because Monson's interest is alleviating severe pain, while Raich's interest is not only treating her pain but also staying alive. Because legislation such as the Compassionate Use Act permitted the use of marijuana for medicinal purposes for an array of medical conditions, a spectrum of liberty interests is necessary to determine where to draw the line at the strict scrutiny balancing stage—thereby distinguishing constitutional and unconstitutional government intrusion.

II. CONSTITUTIONAL PROTECTION FOR MEDICINAL MARIJUANA: LIMITED USES SUBSUMED BY THE RIGHT TO PALLIATIVE CARE

This Part contends that the *Glucksberg* framework applies to the liberty interest asserted by plaintiffs in *Raich*. Moreover, in light of the Court's substantive due process precedents in the medical decision-making context, this Part argues that the use of marijuana for medical purposes is within a sphere of constitutional protection, subject to limitations, when it falls within the right to palliative care. This section suggests an approach to evaluating individual circumstances with a view to distinguishing palliative care from physician-assisted suicide, which the Court in *Glucksberg* declined to include within the scope of individual liberty protected by the Constitution.

A. Applying *Glucksberg* To *Raich*

In the broadest sense, the *Glucksberg* framework applies to the facts of *Raich* because of the assertion of a liberty interest in the medical decision-making context. The cases clearly differ, however, in that the liberty interest at issue in *Glucksberg* was physician-assisted suicide, while the plaintiffs in *Raich* are seeking to protect their ability to receive palliative care. Furthermore, because the Court emphasizes an originalist ideology when locating rights, the liberty interests asserted in these cases conflict. That is, the United States clearly does not have a history or legal tradition

118. *Id.* at 42.

of condoning suicide.¹¹⁹ On the other hand, the common law protected individuals from bodily encroachment by others because of notions of personal autonomy.¹²⁰ The Court in *Cruzan* pointed to this tradition as the justification for a right to refuse treatment, even if the underlying motivation of the decision was to cause death.¹²¹ An argument can be made that opting for lethal medication is analogous to refusing treatment because both lead to death, but there is a significant distinction between the two options. In refusing treatment, the underlying objective may be to die, but the decision is still a step removed from the result that will ultimately occur.¹²² Conversely, in the case of physician-assisted suicide, the decision is directly linked to the result.

The right to palliative care should be viewed as an extension of this logic. Palliative medication is more akin to refusing treatment than opting for physician-assisted suicide, because there is still a gap between the decision to use a pain-alleviating medication that will hasten death and death itself. Ergo, in opting for palliative care, only the objective to lessen pain may be assumed. Furthermore, similar to the right to refuse treatment, the decision to choose a treatment is both supported by tradition and notions of personal autonomy. When a competent adult seeks medical advice for a particular illness or condition, although the physician may recommend various treatments and discuss the possible outcomes and side effects, ultimately the individual is autonomous in selecting the course of action. Out of traditional respect for the doctor-patient relationship, the government stays outside the walls of the physician's office.¹²³ This is not to say that the physician's office is beyond the law; clearly such a rationale would be a slippery slope in the same manner that an absolute right to privacy in the bedroom would have been in *Lawrence*. Rather, absent a compelling government interest, a government intrusion would offend one's liberty. Accordingly, the presumption should favor the liberty interest of the patient, thereby placing the burden of proving a compelling interest on the government at the strict scrutiny balancing stage.¹²⁴ When a

119. See *supra* notes 71-74 and accompanying text.

120. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990).

121. See *supra* notes 56-59 and accompanying text.

122. And there may be a significant passage of time between the decision to refuse treatment (or food and hydration) and death. See NAT'L HOSPICE & PALLIATIVE CARE ORG., ARTIFICIAL NUTRITION & END-OF-LIFE DECISION MAKING (2005), available at http://www.caringinfo.org/files/public/QA_Artificial_Nutrition_booklet.pdf.

123. See 98 C.J.S. *Witnesses* § 341 (2006).

124. For example, it should be presumed that an individual who needs to have a cavity filled in by a dentist should have the option to undergo the procedure with Novocain. If the government wanted to restrict this option, it would have the burden of proving a compelling

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treatment is palliative in nature, notions of physical freedom and self-determination strengthen the individual's liberty interest. For the state to deny a patient in great pain the ability to ameliorate her condition would be an "incursion" just as "repugnant" as forcing treatment upon that patient.¹²⁵ Based on these arguments and the concurrences of five justices in *Glucksberg*, it is probable that the Court will determine that the right to palliative care is fundamental.

Although the right to palliative care applies to both plaintiffs, Monson's and Raich's situations should be viewed as distinct cases at the strict scrutiny balancing stage because their liberty interests are different. Monson's liberty interest represents the right to palliative care in the manner contemplated by the *Glucksberg* concurrences. That is, Monson requires medicinal marijuana to treat the severe pain and muscle spasms she experiences as symptoms of her degenerative spine condition.¹²⁶ Because her physician has concluded that medicinal marijuana is the only drug that can effectively treat her symptoms, it represents her last resort at palliative care.¹²⁷ Raich's interest, albeit also partly to ease her physical pain and discomfort, is stronger, since her use of medicinal marijuana is predominantly for the purpose of preserving her life. Cannabis is her last resort; without it her body would deteriorate, rapidly causing her death.¹²⁸ Accordingly, at the strict scrutiny balancing stage, because the government's interest remains constant, and the outcome turns on the strength of the fundamental right, it is possible for the Court to reach a favorable result for Raich and an unfavorable result for Monson. In other words, the Court could conclude that Raich's interest in staying alive outweighs the government's interest in fighting the war on drugs, but that Monson's interest in reducing her pain does not.

Despite this possibility, it seems likely that both Raich and Monson have sufficiently strong liberty interests to render the anti-marijuana law unconstitutional as applied to them.¹²⁹ But this begs the question: where should the line be drawn, separating permissible and impermissible uses of medicinal marijuana as a form of palliative care? After all, the Compassionate Use Act bestows the right to obtain and use marijuana for medical purposes for "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which

anti-Novocain interest.

125. See *Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring).

126. See *supra* notes 5-9 and accompanying text.

127. See Brief for the Respondents, *supra* note 5, at 7.

128. See *id.* at 5.

129. See *infra* Part II.A.1-2.

marijuana provides relief.”¹³⁰ The Act indicates that there are many medical uses for marijuana, but surely not all subsets fall into an area of constitutional protection. Consequently, a spectrum clearly establishing a limit is necessary to avoid a slippery slope dilemma. Furthermore, as a caveat to constitutional protection, the use of medicinal marijuana should be a last resort for treating a particular medical condition. In other words, a plaintiff claiming that the use of medicinal marijuana is constitutionally protected shall have the burden of proving that traditional forms of medicine have failed and that medical marijuana is the only effective treatment. Furthermore, the plaintiff must have first attempted an exhaustive inventory of traditional medications pursuant to the care of a physician before turning to marijuana as a last resort.

The following spectrum is a range of factual scenarios relating to the use of medicinal marijuana, in which the level of constitutional protection weakens as the medical condition becomes less “serious.”¹³¹

1. Medical Conditions That Threaten Life

For a patient with a life-threatening medical condition such as Raich, medicinal marijuana is not only palliative but actually prevents the body from deteriorating.¹³² In such cases, medical marijuana is used to prolong the life of the patient: thus the liberty interest is at the height of constitutional protection. First, from a textual perspective, the right to life interest is specifically articulated in both the Declaration of Independence and the Fifth and Fourteenth Amendments of the Constitution.¹³³ Second, our legal tradition elevates the life interest over all other rights, which is most clearly expressed in homicide laws.¹³⁴ Third, avoiding death seems to represent the apex of personal autonomy because it relates to bodily integrity and self-definition. Finally, the life interest seems to be in accord with the substantive due process doctrine. In *Glucksberg*, the preservation

130. Compassionate Use Act, CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 1996).

131. By no means is this a thorough list of the medical conditions that medicinal marijuana can treat. For a more thorough list see AMA Council on Scientific Affairs, *Medical Marijuana*, http://www.ama-assn.org/ama/pub/category/13625.html#major_proposed_medical_uses (last visited Aug. 31, 2006).

132. This could apply to patients diagnosed with cancer or patients experiencing AIDS “wasting.” See Brief for the Respondents, *supra* note 5, at 5.

133. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776). U.S. CONST. amends. V, XIV § 1.

134. *Washington v. Glucksberg*, 521 U.S. 702, 710-11 (1997); James A. Alesandro, *Physician-Assisted Suicide & New York Law*, 57 Alb. L. Rev. 820, 923 (1994).

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of life was the predominant impetus behind the Court's holding at both stages of the substantive due process inquiry.¹³⁵ At the liberty interest stage, the Court rejected the notion of a fundamental right to assisted suicide because "of the States' [longstanding] commitment to the protection and preservation of human life."¹³⁶ At the state interest stage, the Court similarly found the States' ban on assisted suicide as rationally related to the "unqualified interest in the preservation of human life."¹³⁷ Accordingly, because patients such as Raich are trying to prolong life, the palliative care interest is the exact antithesis of the concerns echoed in *Glucksberg*. After rejecting a right to physician-assisted suicide on the basis of this interest in the preservation of life, to hold that Raich's liberty interest falls short of the government's interest in curtailing the marijuana trade would seemingly conflict with a right enumerated in the Constitution, the Nation's history and legal tradition, notions of personal autonomy, and the Court's precedent.

2. *Medical Conditions Associated With Severe Pain*

Although the right to palliative care is not as strong as an interest in preserving life, patients such as Monson, who use medicinal marijuana to reduce severe pain, should fall within the sphere of constitutional protection. Monson's condition restricts her ability to move around, stand, or sit, because the intensity of her pain completely incapacitates her.¹³⁸ In other words, her condition has rendered it impossible for her to lead a normal life. When treated with medicinal marijuana, however, her symptoms are significantly reduced.¹³⁹ Accordingly, the anti-marijuana law offends her personal autonomy because it impedes both her physical freedom and her ability to define herself. At the strict scrutiny balancing stage, this personal autonomy interest outweighs the government's anti-drug interest for two reasons. One, both the short- and long-term health risks associated with marijuana are moot because she is already battling a condition that is severely worse than the possible conditions she may possibly face due to the drug. Moreover, her physician concluded that medicinal marijuana does not cause Monson unacceptable side effects, unlike the many other medications she has tried.¹⁴⁰ Two, it seems inequitable for the government to make patients such as Monson martyrs of

135. See *infra* Parts II.A.2.

136. *Glucksberg*, 521 U.S. at 711.

137. *Id.* at 728.

138. See *supra* note 6 and accompanying text.

139. See *supra* notes 8-9 and accompanying text.

140. See Brief for the Respondents, *supra* note 5, at 5-6.

the government's perpetual war on drugs. In other words, the government's interest is just not compelling enough for the absolute anti-drug law to survive strict scrutiny, as applied to plaintiffs with such significant liberty interests at stake.

Of course, such a holding inevitably creates both institutional concerns and a slippery slope problem because there can be no bright line rule to distinguish between "severe" pain and "ordinary" pain. Nevertheless, the task of weighing the liberty interest against the government's interest is not unmanageable.¹⁴¹ Courts should execute a cost-benefit analysis, in which the inquiry turns on evidence presented by the plaintiff's physician. In assessing this evidence, courts should consider factors such as whether the pain is chronic or sporadic and whether or not the pain causes physical immobility.

3. *Other Medical Conditions: When Pain Is Not "Severe"*

The other medical conditions permitting the use of medicinal marijuana under the Compassionate Use Act that are beneath the "severe" pain benchmark, such as migraines, glaucoma, and anorexia, are outside the scope of constitutional protection.¹⁴² This is not to say that these conditions—from which millions of Americans suffer—are not serious, but rather that the liberty interests associated with them do not outweigh the government's anti-drug interest. Although these conditions emphasize personal autonomy, they do not reach the point at which the patient's life is completely in the hands of the medical condition, as is the case for individuals such as Raich and Monson.

Furthermore, with regard to institutional concerns, this seems to be an appropriate point to draw the line in order to keep the analysis from becoming unwieldy. For example, if a patient who suffered from migraines once a week was deemed to have a liberty interest strong enough to bring her use of medicinal marijuana into a sphere of constitutional protection, the Court would surely be creating a slippery slope. This decision would open the door for the line to be pushed even further: subsequent plaintiffs would claim a similar right to palliative care because of migraines suffered monthly, yearly, and so on. Accordingly, for the doctrine to have any value, the line must be drawn clearly below the "severe" pain echelon—that is, the point at which the pain unduly restricts one from leading a

141. This task is arguably comparable to assessing the amount of pain a plaintiff has suffered in order to award monetary damages in a tort action.

142. See Compassionate Use Act, CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 1996). Similarly, this excludes the "any other illness for which marijuana provides relief" part of the Compassionate Use Act from being constitutionally protected. *Id.*

normal life.

B. The *Glucksberg* Spectrum Of Liberty Interests: Drawing A Line That Excludes Physician-Assisted Suicide

In revisiting the spectrum of liberty interests relating to medical decision-making set forth in *Glucksberg*, it is clear that the right to palliative care is fundamental. The facts of *Raich* provide the Court with an opportunity to articulate the strength of this liberty interest by focusing on as-applied challenges to the absolute anti-marijuana law. And it seems that in the cases of *Raich* and *Monson*, access to medicinal marijuana as integrated within the right to palliative care is sufficiently “fundamental” to outweigh the government’s policy objectives that underlie the CSA. What *Raich* does not do, however, is assess what could be a thin line between palliative care hastening death and physician-assisted suicide. Although marijuana poses health risks, this type of drug is not what the authors of the *Glucksberg* concurrences had in mind when they discussed the right to palliative care.¹⁴³ Rather, the five justices were referring to a drug, which while lessening the patient’s pain, simultaneously accelerated death.¹⁴⁴ And as previously mentioned, such cases should qualify as a fundamental right because the act of administering palliative medication that hastens death is a step removed from choosing death itself.¹⁴⁵ Moreover, at the end of life, the personal autonomy interest increases as notions of self-determination and dignity become more prevalent.¹⁴⁶

A final issue outside the scope of *Raich*, alluded to in the *Glucksberg* concurrences, is the issue of physician-assisted suicide in a situation in which the patient’s pain is so severe that it cannot be alleviated by medication. Recently, this contemplated situation came to fruition at Memorial Hospital in New Orleans in the aftermath of Hurricane Katrina.¹⁴⁷ The hospital’s electricity was shut down, causing the temperature to rise inside the hospital and severely ill patients to be disconnected from life-sustaining medical equipment.¹⁴⁸ After the storm, Louisiana’s attorney general launched an investigation into possible mercy killings (killing patients that were too sick to survive the hurricane) by

143. *Washington v. Glucksberg*, 521 U.S. 702, 791-92 (1997).

144. *Id.*

145. *See supra* Part II.A.

146. *See supra* Part II.A.

147. *See* Beth Musgrave, *73 Hospital Workers Facing Mercy-Killings Subpoenas*, MIAMI HERALD, Oct. 28, 2005, at A9.

148. *Id.*

doctors and nurses.¹⁴⁹ In an extreme context such as this, the question should be whether the constitutional limit excluding assisted suicide encroaches too far on an individual's personal autonomy. While such a case would be a difficult decision for the Court to make given its reliance on originalist ideology, the Court would not find a right to assisted suicide even under such a rare factual scenario. Ultimately, the Court would fear that opening the door just a crack would blur the distinction between what is permissible and impermissible under the Constitution. Moreover, the slippery slope concern in finding an assisted-suicide exception is quite deleterious to society as a result of the government's profound interest in the preservation of human life, protecting vulnerable groups, and avoiding the road to voluntary or involuntary euthanasia.¹⁵⁰

CONCLUSION

This Comment argues that the right to palliative care is a logical outgrowth of *Glucksberg* in light of both the Court's originalist approach and the emerging emphasis on personal autonomy within substantive due process jurisprudence. For a small number of patients who are terminally ill or living with chronic, severe pain, such as Diane Monson and Angel Raich, however, the only effective life-sustaining or palliative treatment comes in the form of medicinal marijuana. Despite the illegality of marijuana and the government's corresponding policy, such use of medicinal marijuana falls under the umbrella of constitutional protection, because the government's interest in an absolute anti-drug law does not outweigh the liberty interest in staying alive or defining one's own existence. At the same time, access to medicinal marijuana for patients with symptoms treatable by the drug is not unqualified, and is limited by both the severity of the patient's condition and proof that traditional forms of medicine are ineffective. Finally, this Comment asserts that despite finding a right to palliative care—even if it hastens death—the line should be not be extended further to include assisted suicide within the sphere of constitutional protection. This is the case even in extreme circumstances due both to compelling government interests and the risk of the doctrine becoming unworkable.

149. *Id.*

150. *See supra* notes 79, 82-83 and accompanying text.