An Interdisciplinary Analysis of the Legal and Ethical Issues Regarding Medical Marijuana in the State of Florida?

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Abstract

The use of Cannabis for medicinal purposes dates back to 2735 B.C. Despite proven benefits to a variety of patients, Florida is one of 36 states that continue legally to prohibit the use of Cannabis for any purpose, including medical use (Florida; State Statutes, Chapter 893.03, 2010). The medicinal use of Cannabis has been legalized in 14 states (PUFMM, 2010). Based on case studies, there is substantial evidence that supports the medical use of Cannabis to alleviate symptoms of chemotherapy, appetite suppression or muscular dysfunctions of MS and other related diseases (Stolic, 2009). When reviewing the principles of medical ethics, and applying them to the topic of Cannabis use for this specific demographic of the population, it would stand to reason that it should be considered for legalization of medical use. Despite medical evidence, the political climate in the state of Florida still resists the push to legalize medical Cannabis, and a recent attempt to put the question on the November 2010 ballot failed.
The use of marijuana (or cannabis) for medicinal purposes dates back thousands of years (Stolic, 2009). Despite proven benefits to patients who suffer from a variety of illnesses, Florida is one of 36 states that continue legally to prohibit the use of marijuana for any purpose, including medical use (Florida; State Statutes, Chapter 893.03, 2010). Case studies indicate there is substantial evidence to support the medical use of marijuana to alleviate symptoms of chemotherapy, appetite suppression or muscular dysfunctions of MS and other pain causing diseases (Stolic, 2009). Other studies have indicated the potential of marijuana’s active ingredient THC, to have cancer fighting properties (Velasco, Guzman, Lorente, Carracedo, 2006). Applying the principles of biomedical ethics to the issue of marijuana use for this specific demographic of the population further establishes a precedent for the legalization of medical use. Notwithstanding medical evidence, the political climate in the state of Florida still resists the push to legalize medical marijuana, and a recent attempt failed to amend the Florida state constitution on the November 2010 ballot. This paper will examine the historical aspects of medicinal marijuana, clinical research on marijuana, public opinion on medicinal use of marijuana and medical ethics as they apply to the medicinal use of marijuana.

Historically, the first documented medical use of cannabis was in 2735 B.C. (Earleywine, 2002). Claiming mystical powers, the Chinese Emperor Shen Neng introduced cannabis for pharmaceutical use and prescribed a cannabis tea for treatment of gout, malaria, beriberi, rheumatism and poor memory, and was also documented as having first discovered several other herbal medications including ginseng, ephedra, camellia sinesis and the first caffeinated tea (Earleywine, 2002). In Atharva Veda, the Indian sacred text, marijuana was considered a “holy plant”, through which mankind was cleansed of sin and was used as a prescriptive in 1400 B.C. as a remedy to congestion, coughs, asthma, leprosy and dandruff (Earleywine, 2002). The
ancient Romans used marijuana medicinally as a painkilling analgesic, yet warned of misuse or abuse of the herb would lead to possible impotence (Earleywine, 2002). Dioscorides, a Greek physician practicing during the time of Nero, authored the first example of a pharmacopoeia, and listed marijuana as an exotic plant with a medical use in this five volume document that remained in circulation for over 1000 years (Earleywine, 2002).

Galen, a Roman physician, surgeon and philosopher influenced Western medicine in the disciplines of anatomy, physiology, pathology, neurology and pharmacology used marijuana medically as a drug to treat pain and flatulence (Earleywine, 2002). Marijuana’s potential as an anesthetic were documented in China in 200 A.D. and, dated back to 4 B.C., where there was evidence in Jerusalem of marijuana used to offset the pains of childbirth (Earleywine, 2002). Cambodian and Vietnamese women are known to use cannabis tea still today as a remedy for postpartum distress (Earleywine, 2002).

The medicinal use of cannabis was not without concerns. In 1000 A.D. an Arabic text On Poisons warned against the use of hashish (closely related to cannabis) and foretold that using hashish could cause a human to become mute and blind and could lead to retching and death (Earleywine, 2002). In this same time period, a terrorist group known as the Brotherhood of Assassins was prevalent in the Arab world. A splinter group of Ismaili Muslims were alleged to have eaten hashish prior to committing acts of terror on the political opponents of their leader Hassan I Sabah (Combs, 2011). These terror events could easily have created a fear of the drug in the general public. Nicknamed “Dagga” by African tribes, it was used to treat snakebites, anthrax, childbirth, dysentery and malaria (Earleywine, 2002).

In the mid 1500’s, other alleged curative treatments were tried. In France, physician François Rabelais claimed cannabis relieved pain from gout, treated burns, and that it cured horses of
colic (Earleywine, 2002). Garcia da Orta described marijuana’s ability to stimulate appetite (Earleywine, 2002). In China, Li Shih-Chen found marijuana to have antiemetic (anti-nausea) and antibiotic benefits (Earleywine, 2002). The treatment of rheumatism was further substantiated in 1842 when William O’Shaughnessy studies indicated patients with rheumatism experienced an increase in both mood and appetite and reported less pain and nausea, along with the reduction of muscle spasticity, after using the marijuana treatment (Earleywine, 2002).

The Ohio State Medical Society acknowledged favorable outcomes for treating pain, inflammation and cough in 1860 (Earleywine, 2002). Eight years later, the U.S. Dispensatory listed several uses for a cannabis tincture to include increasing appetite, sexual interest, mental disorders, gout, cholera, hydrophobia and insomnia (Earleywine, 2002). Even Queen Victoria of England purportedly used cannabis herself to combat menstrual pain (Earleywine, 2002). By the beginning of the 20th Century, drug companies in the U.S. were manufacturing drugs from marijuana (Earleywine, 2002). Squibb produced a drug named Chlorodyne; a mixture of cannabis and morphine, prescribed for stomach ailments and found to have other treatment uses: as an antispasmodic; for its sedating effects; as an analgesic; and for its hypnotic effect. Within 30 years Eli Lilly and Parke-Davis were also manufacturing products containing cannabis (Earleywine, 2002).

The U.S. Marijuana Tax Act of 1937 was the first regulation of marijuana (Sloman, 1979). The act required anyone who produced, distributed, or used marijuana for medical purposes to register and pay a tax that effectively prohibited nonmedical use of the drug (Sloman, 1979). This regulation made the application of the drug, though still legal for medical purposes, expensive and inconvenient (Sloman, 1979). Marijuana was subsequently removed from the U.S. Pharmacopoeia in 1942 because it had been labeled a harmful and addictive drug (Joy,
Watson, Jr. & Benson, Jr. 1999). Harry Anslinger, who was the first chief of the U.S. Federal Bureau of Narcotics, put forth graphic reports that marijuana induced users to commit violent murders (Sloman, 1979). Due to the negative propaganda put forth by Anslinger, the public perception feared marijuana to be more dangerous than heroin (Earleywine, 2002).

Public perception still has a large influence on the general legalization of cannabis. Despite public understanding that marijuana does not turn users into deranged and criminal outlaws, a Pew Research Center Report found the 50% of citizens surveyed found smoking marijuana “morally wrong” (Stolic, 2009). In the Pew study, of the 50% who classified marijuana morally wrong, 74% of the respondents were 65 years old or older. Additional characteristics of this respondent group documented that 68% were white, evangelical Christians; 66% attended church on a weekly basis; 65% prescribed to a conservative ideology as well as identified themselves with the Republican Party (Stolick 2009). A 2006 Gallup Poll report documented that of the self-described liberals, 78% indicated their support of the decriminalization of marijuana. These statistics express the demographic polarization of the issue.

Critics of medical marijuana warn that smoking marijuana as a treatment may actually exacerbate and accelerate the problems patients are trying to cure (Tashkin, 1997). Marijuana has 483 chemical compounds (Stolick, 2009). Clinical studies have suggested that marijuana is an immunosuppressant, meaning it reduces the body’s ability to fight infection (Earleywine, 2002). In patients with already suppressed immunity (i.e. AIDS or cancer patients) marijuana use could catapult the patient into a serious danger for infections such as pneumonia or Kaposi’s Sarcoma (Tashkin, 1997). Individuals with schizophrenic or psychotic disorders are at risk for an adverse psychiatric reaction to heavy cannabis use (Joy, et.at, 1999). What has not been substantiated is that marijuana is the biological precipice for the psychiatric disease.
Schizophrenics use marijuana in the same percentage as that of the regular population; yet tend to prefer it over other drugs such as alcohol or cocaine (Joy, et.al, 1999). Researchers speculate that the schizophrenic patient may obtain some type of symptomatic relief when consuming marijuana in a moderate amount (Joy, et.al, 1999). Other scholarly articles claim marijuana is an addictive gateway drug which leads users on a path to more perilous drug addictions (Executive Office of the President, Office of National Drug Control Policy. 2008).

As the public obtains most information through the media, there is still much misunderstanding that marijuana is a gate-way drug to other, more risky drugs. The Federal Government published the “2008 Marijuana Sourcebook” which is subtitled “Marijuana: The Greatest Cause of Illegal Drug Abuse” and claims that marijuana serves as a conduit to the abuse and potential addiction to more serious drugs (Executive Office of the President, Office of National Drug Control Policy. 2008). The Drug Enforcement Agency (DEA) website lists marijuana as DEA number 7360. Classified a Schedule I drug under the Controlled Substance Act (CSA) marijuana is ranked by the DEA to have a “high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use of the drug or other substance under medical supervision”. Additionally, the DEA describes marijuana as a precursor to the use of more dangerous drugs. This position initiates conflict in theories between the DEA and federal government in that a synthetic version of the active ingredient in marijuana (THC) is already legally available by prescription. Dronabinol (brand name Marinol) is a synthetic THC and mimics some of the therapeutic effects of increasing appetite and decreasing nausea (Unimed, 2008). Dronabinol was approved for use by the FDA for use by cancer patients in 1985 (AEGis-PRn, 1997). The application of Dronabinol was expanded to include HIV/AIDS treatment in 1992 (AEGis-PRn, 1997). Originally classified a
Schedule II drug, the FDA reclassified Dronabinol to a Schedule III in July 1999 (AEGis-PRn, 1997). Reclassification lessened the paperwork necessary for physicians to prescribe the drug to their patients. Despite this synthetic version of THC with a classification that has been relaxed specifically to aid physicians to provide prescriptions to their patients, the federal government refuses to relax the classification of marijuana as a Schedule I drug with no medical potential (Executive Office of the President, Office of National Drug Control Policy, 2008).

The clinical efficacy of Dronabinol is mixed among patients. Whereas some have responded with success to the medication, there remain a percentage of people who do not respond to the medication (Earleywine, 2002). Published accounts in Omni magazine in September 1982, state the probable efficacy of Marinol at about 13% of those who use it (Herer, 1985). The clinical insert provided by Unimed, the manufacturer of Dronabinol states that the drug taken orally, has an onset of effectiveness between .5 and one hour, with a peak effect between two and four hours (Unimed, 2010). Based on the published clinical trials, 10% of patients who use Marinol may experience: abdominal pain, nausea and vomiting; paranoid reaction; dizziness; euphoria; somnolence; and abnormal thinking. Dronabinol is administered in a gel cap static dose of 2.5 mg, 5mg and 10mg (Unimed, 2008). Chemotherapy patients already suffering from nausea and vomiting can often experience difficulty swallowing a pill (Earleywine, 2002). Most patients, already sick, find enduring additional side effects overwhelmingly undesirable (Earleywine, 2002). Patients unable to eat or drink without throwing up are at an elevated risk for malnutrition, dehydration and a worsening medical condition (Earleywine, 2002). Some patients have complained of feeling overly drugged by the Dronabinol. For these patients, smoking marijuana offers them the availability to not only titer the dose to their individual effective level but also affords them almost instant relief (Earleywine, 2002).
Supporters of medical marijuana argue that in addition to being potentially less effective, Marinol can also be cost prohibitive, a claim the government refutes (Joy, et.al., 1999). The website ProCon.org lists a side by side comparison of the costs of Marinol and Marijuana and claims that yearly the cost of marijuana averages $6256. The cost for Marinol for the same time span is $8258. These prices were calculated using rates from Unimed, the Marinol manufacturer and averaging samples of marijuana costs from physicians, cannabis clinics and government officials.

In 1999, the National Academy of Sciences, Institute of Medicine (IOM) published a comprehensive study of study titled *Marijuana and Medicine*. This 1999 IOM report explains the deceptive nature of the argument that Marinol is cost prohibitive in comparison with marijuana. The IOM report claims the lower price of marijuana can be misleading, based on the illegal status of the drug, therefore having the potential for expense of legal fees incurred for charges of engaging in criminal activities (Joy, et.al., 1999). In Florida, possession of 20g or less is considered a misdemeanor offense punishable with a $1000 fine, a possible one year prison sentence, a mandatory six month (and up to two year) suspension of a Florida Driver’s License.

Yet, the IOM report also indicates that patients without health insurance bear a greater financial burden, in which case marijuana might be cheaper, depending on the dosage of Marinol prescribed compared to the amount of marijuana smoked to achieve the same result (Joy, et.al. 1999).

The National Organization for Reform of Marijuana Laws (NORML) publishes information on its website to document nearly every government commissioned study. These studies documented favorable results regarding the positive potential for medical marijuana. Statistics also indicate over 60 U.S. and International health organizations support granting patient access
to medical marijuana under the supervision of a physician. In May of 2004, the American Public Health Association published a press release that concluded decriminalizing marijuana does not cause an increase in drug use. Criminalization of the drug as well does not constrain its use. (Reinarman, Cohen, & Kaal, 2004) Another study examining the Gateway theory, published in the American Journal of Psychiatry, discounts the theory and found the key factor in young teen boys using marijuana was based on their proneness to deviancy and the availability of the drug. (Tarter, Vanukov, Kirisci, Reynolds, & Clark, 2006). The World Health Organization published results from a 1995 study on the Gateway theory and concludes that:

*The causal significance of this sequence of initiation into drug use remains controversial. The hypothesis that it represents a direct effect of cannabis use upon the use of the later drugs in the sequence is the least compelling. There is better support for two other hypotheses which are not mutually exclusive: that there is a selective recruitment into cannabis use of nonconforming adolescents who have a propensity to use other illicit drugs; and that once recruited to cannabis use, the social interaction with other drug using peers, and exposure to other drugs when purchasing cannabis on the black-market, increases the opportunity to use other illicit drugs.* (Hall, Room, & Bondy, 1995)

The American Medical Association supports future clinical research of the medicinal uses of marijuana using a wide-scaled approach in order to enable physicians to gain access to the potential medical benefits of cannabis. In November 2009, the Board of Trustees and Council Reports-Recommendations by the AMA recommended the following statement to replace previous statements of position:

*Our American Medical Association (AMA) urges the marijuana’s status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current stands for a prescription drug product. (New HOD policy)*
The IOM declared that “scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting and appetite stimulation. This value would be enhanced by a rapid onset of drug effect” (Joy, et.al, 1999). The IOM encouraged future research to develop rapid-onset, reliable and a safer delivery method of the drug other than smoking, to alleviate chemical smoke harm to the patient. However, in recognizing that those methods were not available, the IOM study also found that the harms associated with smoking, or the general adverse effects of marijuana are within the range tolerated for other medications (Joy et.al, 1999) and delineated the benefits of using marijuana in short-term use outweighed any potential or actual harm. The Federal authorities did not follow the recommendations of the IOM and continues to classify marijuana as a Schedule I drug with no medical purpose.

A new area of research indicates that marijuana may act as a cancer inhibitor. As a nation the U.S. is very cancer phobic, and factually, cancer is a serious public health issue in both the nation and in Florida. In 2007 the National Cancer Institute projected 458.7 annual incidents of cancer per 100,000 per population. Seventeen Florida counties showed rates above the national average. In 2010, Florida ranks second, behind only California in the number of projected cases of breast cancer, with an approximate 17% increase in the number of cases of breast cancer over the next five years (NCI, 2010).

A 1974 Medical College of Virginia study (funded by the National Institute of Health) to collect evidence that marijuana damaged the immune system discovered instead that cannabis inhibited three types malignant tumor cell growth in cultures and mice. Reported nationally by the Washington Post on August 18, 1974 that THC, the active ingredient found in marijuana “slowed the growth of lung cancers, breast cancers and a virus induced leukemia in laboratory
mice and prolonged their lives as much as 36%”. The study was dismissed by the federal government and President Ford in 1976 halted all funded research on cannabis. President Ford granted exclusive research rights to pharmaceutical companies to create a synthetic form of THC that would eliminate the “high” or euphoria (Herer, 1985). No follow-up funding or research was authorized until the mid 1990’s when the National Toxicology Program conducted a $2 million secret study and concluded that mice and rats experienced increased cellular protection from malignant tumors after being administered high doses of THC over a long period of time. The results of this study were not publicized and were only released in to a medical journal in 1997 after being secretly leaked. Additional studies on apoptosis (program on cell death) were led in Madrid, Spain and a research team in 1998 discovered that THC can “selectively induce apoptosis in brain tumor cells without negatively impacting the surrounding healthy cells”. A subsequent study was published two years later that malignant glioma (a type of brain tumor) had been eradicated in 1/3 of the rats treated in the study. In addition to the 1/3 cured, another 1/3 had life extended for an additional six weeks after treatment (Velasco, et.al, 2006).

More studies have been done regarding the efficacy of THC as a selective inhibitor. A research team at the University of South Florida documented that THC selectively inhibited the activation and replication of the gamma herpes virus which is a virus key in the development of several cancers to include Kaposi’s sarcoma (common in HIV/AIDS), Burkett’s Lymphoma and Hodgkin’s disease (Medveczky, Sherwood, Klein, Friedman, & Medveczky, 2004). The organization NORML is collecting data to show that the active ingredients in cannabinoid may also prevent the growth of colorectal cancer, skin carcinomas and breast and prostate cancer. Additional research shows that the natural cannabinoid were superior to the synthetic alternatives available legally in the pharmacy today.
Whereas the legalization of cannabis for recreational use remains polarized, the public opinions on medical marijuana are more broadly accepted. A Gallup Poll in October 2009 documented that although only 44% of Americans support the legalization of marijuana in general, 75% of Americans were supportive of allowing doctors to legally prescribe marijuana to patients to reduce pain and suffering.

Fourteen U.S. states have enacted legislation legalizing the use and cultivation of marijuana for medical use, and eight additional states have legislation pending on the issue (PUFMM, 2010). Should the pending legislation of these eight states pass, nearly one-half of the United States would allow the use of medical marijuana. Florida is not among the states that either have legalized or have legislation pending to legalize medical marijuana. A group called the People United for Medical Marijuana received approval from the Florida Division of Elections to circulate a petition to gain the signatures necessary to add a constitutional amendment that would allowed the legalization of medical marijuana on the 2010 November ballot (PUFMM, 2010). The petition drive fell short of the 700,000 signatures needed, so the question will not be included in this election (PUFMM, 2010). The organization is already working to obtain the 676,811 required signatures that will support the constitutional amendment, which gives patients the right to grow, obtain, purchase and possess medical marijuana under a doctor’s supervision (PUFMM, 2010). The deadline for obtaining the petition signatures in order to add the question to the 2012 election ballot is February 1, 2011. The proposed amendment would also create a health care registry to enable law enforcement to distinguish these law abiding citizens from recreational abusers (PUFMM, 2010). In addition to providing pain and suffering for seriously and terminally ill patients, PUFMM claims that by legalizing medical marijuana, the State of Florida will produce new tax revenue for the state (PUFMM, 2010). These revenues are
projected to equal up to $200 million per year.

The Florida Supreme Court cases have ruled in favor of medical marijuana use. In the State of Florida v. Jenks, the defendants appealed a conviction of cultivating cannabis and the possession of drug paraphernalia in Bay County, Florida (Jenks v. State of Florida, 1991). Kenneth and Barbara Jenks appealed on the grounds that the trial court erred in refusing to recognize the medical necessity of their use of marijuana. Both of the Jenks, a married couple, had contracted AIDS. Kenneth Jenks was a hemophiliac who contracted the disease in 1980 through a tainted blood transfusion and subsequently and unknowingly infected his wife Barbara.

Neither responded favorably nor effective to various medications prescribed to them for nausea, vomiting or lack of appetite. Acting upon a recommendation from a support group member, the Jenks used marijuana to curb their symptoms and found that it was very effective. Unable to obtain a prescription from their physician, the Jenks decided to cultivate two marijuana plants to be sure they had access to the drug, to eliminate dealing with drug dealers and to avoid arrest. At arrest, both Jenks advised the arresting officer that they used the marijuana for medical purposes. Despite medical expert testimony, the judge in the lower court rejected the defense of medical necessity and found the Jenks guilty of manufacturing marijuana. He withheld adjudication of guilt and gave them a year of unsupervised probations and ordered each to perform 500 hours of community service. The Florida Supreme Court reviewed the evidence and heard the argument for medical necessity and reversed the lower court’s decision and acquitted both Jenks on the ground that they did not intend to contract AIDS; they had sufficient medical expert and physician testimony, there was no other treatment that could have as effectively treated their conditions and that uncontrolled, their nausea put their lives in danger.

In the State of Florida v. Musikka (1989), a woman charged with the cultivation of six
marijuana plants asserted the medical necessity defense at trial in Broward County Florida (State of Florida v. Musikka, 1989). The Woman testified that she had suffered from glaucoma, had already lost sight in one eye after a failed medical procedure, and used marijuana to keep from going blind in the other eye. The woman’s own physician, an ophthalmic researcher with the Bascom-Palmer Eye Institute in Miami testified at trial that he knew she was using marijuana to treat her condition and believed that without it she would go blind. Judge Mark E. Pollin, heard the testimony from several witnesses, including additional medical experts and found her not guilty and excused her use and cultivation of marijuana under the “medical necessity defense”.

His statement included the following quotes:

In our haste to rightfully prosecute those who profit from the social trafficking and sale of illicit drugs we cannot become blind to the legitimate medical needs of those who are afflicted by incurable diseases and require appropriate medical care. To ignore the plight of such people renders the law callous to the most basic of all human rights; the right of self-preservation...

This is an intolerable, untenable legal situation. Unless legislators and regulators heed these urgent human needs and rapidly move to correct the anomaly arising from the absolute prohibition of marijuana which forces law abiding citizens into the streets - and criminality - to meet their legitimate medical needs, cases of this type will become increasingly common in coming years. There is a pressing need for a more compassionate, humane law which clearly discriminates between the criminal conduct of those who socially abuse chemicals and the legitimate medical needs of seriously ill patients whose welfare and very lives may depend on the prudent therapeutic use of those very same chemical substances.

In Sowell v. the State of Florida, Mr. Sowell had been diagnosed with glaucoma in 1977 (Sowell v. State of Florida, 1998). He suffered kidney failure and lost a kidney from the medications taken in treatment of his glaucoma. Mr. Sowell endured a kidney transplant and continued with the prescribed medications although the medications did not stabilize his condition and his glaucoma continued to damage his vision. He decided to try marijuana after hearing about its potential effectiveness with glaucoma and found it stabilized his condition. Unable to obtain
marijuana from his physician he decided to grow his own plants to have a ready supply for use. His personal physicians were aware of his use and encouraged him to continue smoking marijuana for the medical benefits he obtained. Mr. Sowell was arrested for cultivation and went to trial. Anticipating that the medical necessity defense (used in Jenks) would be used, the State obtained a pretrial ruling barring the defense. The Supreme Court overturned the conviction based on:

> Whether the chapter 93-92, Laws of Florida, amendment to the section 893.03 (1)(D), Florida Statues, effects a clear and unequivocal abrogation of the Common Law Defense of Medical Necessity as recognized in Jenks and as applied to a seriously ill individual who cultivate marijuana solely for personal use to obtain medical relief?

The three Florida Supreme Court rulings indicate the willingness of the court to recognize the significance that marijuana can offer to a specific segment of the population for medical use.

The medical community applies principles of ethics in making decisions regarding patient care. Biomedical Ethics are powered by four basic principles: respect for Autonomy, nonmaleficence, beneficence and justice. In defining Respect for Autonomy the Belmont Report states in part:

> An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons’ considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

To clarify this in greater depth, an autonomous person must be free to voluntarily make a decision that has not been influenced by others. According to Beauchamp and Childress, two preeminent medical bioethicists, there are three types of influence. The first type of influence is coercion, which voids autonomy. An individual is coercively influenced when the individual’s
behavior and/or choices are controlled by the intentional and credible threat of harm. The second type of influence is persuasion, which is defined as “influence by appeal to reason”.

Manipulation is the third type of influence which is neither persuasive nor coercive but in which the individual’s choice tends to be swayed by emphasizing particular points of a narrative. An example of this style of influence would be to explain to a patient that a procedure with a 42% success rate was successful almost half of the time, rather than to state the procedure actually failed more often than succeeded. Although the ultimate decision whether or not to consent to the procedure still remains with the patient, the patient has been presented information in a skewed manner that would reframe the results more positively, raising the likelihood of the patient’s consent to treatment.

Nonmaleficence is broken down into moral codes based on the Hippocratic Oath of “bring benefit and do no harm”. Among the more specific codes are “do not cause pain or suffering” and “Do not deprive others of the goods of life”. In essence, the principle of nonmaleficence pertains to the physicians’ duty to prevent harming the patient. Beneficence then would be the principal that applies to “bring benefit”.

The fourth principle of justice relates to the allocation of resources. It concerns the ideas of social benefit and burdens, and how the resource should be distributed. When dealing with limited resources the principle of justice can become very contentious. For example, if two patients are in equal need for a particular medication or treatment that is in scarce supply, and one patient is financially more established than the other, which patient should receive the treatment? (Beauchamp & Childress, 1994).

In applying the principles of bioethics to the debate of legalizing medicinal marijuana, the principle of autonomy mandates that the patient be able to formulate their own choice, free of
outside or undue influence. Nonmaleficence and beneficence principles incorporate the requirement of bringing benefit, which in the case of medical marijuana is the reduction or resolution of the unwanted symptoms or distress; and doing no harm which would indicate that the physician has a moral obligation to offer the patient the means to obtaining pain relief at the least harmful dose and method of administration. In seeking justice, each individual or patient, should be entitled to obtaining the medications necessary to alleviate suffering.

In the State of Florida v. Baranoff, a “Medical Necessity Distribution” was established, allowing patients in need to access their medication. These principles provide in theory, additional support that the legal use of marijuana be made available to patients under a physician’s supervision to provide the relief from untoward side effects suffered from illnesses and treatments of illnesses.

The historical applications of marijuana as a medical treatment are proven. Recent medical studies have shown cannabis as an effective remedy for specific patients in society today. Following the principles of biomedical ethics, some physicians advise their patients to use whatever resources are available to alleviate pain and suffering, including the use of marijuana. Regardless of clinical proof, the federal government continues to ignore the validity of marijuana’s medical potential, and maintains its status as a Schedule I drug. The public perception is changing and a majority of citizens polled in the United States support the availability of physician supervised marijuana use. The Florida Supreme Court set a precedent in allowing the Medical Necessity Distribution rulings, which uphold an individual’s right to cultivate and consume marijuana as a remedy to illness. Despite the ongoing debate to amend the State Constitution, Florida remains one of the 34 states that do not recognize marijuana for legal medical use. Will the petition to add the Amendment Change to the 2012 ballot succeed in
allowing Florida citizens the right to grow, possess and use marijuana for medical purposes?
Only time will tell.
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