How State Laws Explicate Quality Patient Care in the Use of Medical Marijuana in Their Initial Legislative Acts

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Executive Summary

The public, organized medicine, and policy makers in the United States have had a range of attitudes toward the use of marijuana, over the years. Today, the fact remains that marijuana is considered by federal agencies as a Schedule I substance that has a high potential for abuse and has no medicinal value, thus it needs to be treated as a controlled substance. Regardless, before the 2020 election, 33 states, the District of Columbia and some US territories approved the use of medical marijuana in certain forms and for certain conditions, diseases, and illnesses. It is fair to expect that an overture at some level would be given in the legislation that allows for health care treatment that is controversial and is ostensibly counter to the federal government's ruling on use of this substance. This descriptive study reviewed state legislative acts, amendments to their constitution, or voter initiatives to legalize medical marijuana to determine the *nature* and *extent* of how *quality patient care is explicated in the initial rationale for these laws*. To this end the author identified and compared the language of the rationale statements in these initial acts against the highly recognized five domains of quality patient care as: a) safe; b) effective; c) evidence-based; d) standard practice; and e) patient centered to see if the language in these acts comport or do not comport with these quality patient care domains. Results of this descriptive study show that there are no strong, or even mild, rationale statements made for use of medical marijuana in the language of the 33 state legislative acts reviewed. It appears that the rationale for legalizing medical marijuana is driven by *compassion* not on evidence-based effectiveness reported by credible medical authorities. This study is one piece of evidence that legalizing use of cannabis has been given an evidence-based medicinal use pass. More disturbing is that health care organizations and professionals and public health professionals have remained silent as our next public health addictions crisis unfolds, given more states are "normalizing" use of marijuana.

Background and Rationale for This Study

The public, organized medicine, and policy makers in the United States have had a range of attitudes toward the use of marijuana, over the years. Beliefs, attitudes, and actions (use or control) have ranged from marijuana seen as an elixir, to a harmless—even recreational—mood altering substance for adults, to one with high potential for abuse with no medical value, to being favored as having some relief for those with a condition, illness, or disease. Today, the fact remains that marijuana is considered by federal agencies as a Schedule I substance that has a high potential for abuse and has no medicinal value, thus it needs to be treated as a controlled substance. Over time, both medical opinion of a possible medicinal use of marijuana and public opinion that adults smoking marijuana, even for recreation, is not so bad, has catapulted its popularity for both medical and recreational use by adults. Before the 2020 election, 33 states, the District of Columbia and some US territories approved the use of medical marijuana in certain forms and for certain conditions, diseases, and illnesses, according to the National Conference of State Legislatures. However, it is peculiar that a substance that has had a long-time reputation as an "evil weed" and a lack of consensus of its overall safety and has questionable medicinal value has become legalized.

Purpose of This Study

The purpose of this descriptive study is to **review state** legislative acts, amendments to their constitution, or voter initiatives to **legalize medical marijuana to determine the *nature* and *extent* of how *quality patient care is explicated in the initial rationale for these laws*.** To this end, I

- read closely the background, findings, purpose or what serve as the rationale statements in the legislative acts passed by states who have legalized medical marijuana.
- identified and compared the language of the rationale statements in these initial acts against the five domains of *quality patient care* as: a) safe; b) effective; c) evidence-based; d) standard practice; and e) patient centered.
- explained how the language in these acts comport or do not comport with quality patient care domains, and
- discussed how the rationale statements used resolve the clear paradox to a consensus by a range of credible medical bodies that the safety and efficacy of medical marijuana is still an open question; therefore,
- how do we account for these state legislatures allowing for the growing, production, prescription, promotion, and sale of medical marijuana?

Method of Review

I consulted two credible online sources to identify states with medical marijuana growing, production, sale, use, and oversight laws: the National Conference of State Legislatures and Britannica ProCon.org (just prior to the 2020 elections). Each of these organizations has substantial information and links on their websites about state laws concerning medical marijuana, such as the statutory language for each state's law, or documents about a voter referendum or change in the state's constitution.

To learn how states explicate quality patient care as a rationale for passing their law, I used the topology of domains seen in how credible medical organization groups **define quality patient care,** such as the Institute of Medicine. Quality patient care should be:

a) safe,
b) effective,
c) evidence-based,
d) standard practice by clinicians, and
e) patient centered

After retrieving the official bill, ballot, or initiative using the links from these two websites, I looked to find some type of **legislative purpose,** finding, rationale statement or the like to see **why the state passed such a bill.** I recognize that these statements may not exist in all bills—this itself is telling. A bill involving controversial medical care of patients should invoke some explanation as to why it is legal in the state. It is important to note that this is not a study on the legislative history of each state's act (committee hearings, debates, reports, public statements, etc.). However, **it is fair to expect that an overture at some level would be given in the legislation** that allows for health care treatment that is controversial and is ostensibly counter to the federal government's ruling on use of this substance. Thus, a close read and review

(**content analysis**) of these official documents should show the ***nature*** and ***extent*** of how these state legislatures **communicated quality patient care** in allowing for the exceptional use of medical marijuana, given federal agencies are clear that it does not have enough biomedical evidence to show medicinal benefit.

Findings

Understandably, while this is a subjective and qualitative assessment with limitations for making conclusions in the review of a single state's act, by taking information from these 33 state acts in the aggregate, one can learn the ***general impression*** for how state legislatures recognize and validate quality patient care in this health care measure, or not. Also, saying little about quality patient care in its purpose statement is a *res ipsa loquitur*.

Standard Practice is the most evident quality patient care domain of the five reviewed in these states' acts. All laws make it clear that citizens cannot partake in medical marijuana unless it is reviewed and approved by a physician and if this physician, by his/her own judgement, deems the use of medical marijuana necessary. There are no criteria for how the physician can arrive at this approval such as a clear reference to evidence-based practice or a medical authority. In reading these acts, the legislatures have given wide latitude to individual medical practice; there is no reference to an authoritative body that states the standard practice in prescribing this substance.

Effective. After standard practice, *effective* is the next most common of the five quality patient care domains evident in the 33 state laws legalizing medical marijuana. This is described in several ways ranging from a soft alluding to effectiveness to stronger statements. For example, in the soft category, there is common use of the term "may be effective." This is quite different from confident statements such as "given its history of effective use." The "may" descriptor must be here by design. It appears that the legislatures are backing into a rationale that is tentative. In this domain, it looks more as if *compassion* overshadows the *confidence* that medical marijuana is effective.

For example, Oregon's 1998 law says those can use "who may benefit from the medical use of marijuana; when their doctors advise that such use may provide a medical benefit to them." Similarly, Washington's 1998 law states: "The people of Washington state find that some patients with terminal or debilitating illnesses, under their physician's care, may benefit from the medical use of marijuana." Colorado has people "might benefit from the medical use of marijuana." New Mexico's 2007 law has "The legislature finds that recent research has shown that the use of marijuana is a medically valuable treatment for a variety of medical conditions." Missouri's 2018 law, even at this later date, reads about the same with the statement: "The section allows patients with qualifying medical conditions the right to discuss freely with their physicians the possible benefits of medical marijuana use." Pennsylvania's 2016 passage kicks the can down the road, so to speak to "promote high quality research into the effectiveness of utility of medical marijuana," ostensibly showing that the question of effectiveness is far from resolved.

Patient Centered: The patient-centered domain is not as common as standard practice and effectiveness, but it has some presence in these legislative acts and at some level may be seen as the **most driving force to explain the rationale** for allowing use of medical marijuana for certain patients treated in the state. To begin, the patient centered domain is evident in the

very names of several of these laws, i.e. "Compassionate Care" acts. California, New Jersey, Illinois, Louisiana, Maryland, and North Dakota have the title "compassionate care" in their acts. Florida uses the term "Debilitating Illness" which is a descriptor for compassion and patient centered and Connecticut uses the descriptor "Palliative Care Act." Massachusetts uses in its title "Humanitarian Medical Use." Two states have named their acts after citizens who died and who advocated for the medicinal use of marijuana (Maryland and Rhoads Island). In the narrative of the acts' purpose, intent, findings, etc., most have some reference to the passage of the law taking place to **help patients who are suffering.** They project a sense that this is the right thing to do, however, **little is said about safety and an evidence-based rationale.** Most laws allow caregivers to assist patients using medical marijuana and relieve them from any criminal penalties. This certainly can be considered patient centered.

Evidence-Based Medicine is certainly nothing new but since the late 1980s, it is mentioned in almost every discussion related to patient care. Therefore, it is reasonable to expect in any discussion of prescribing a patient a medicinal substance. In this study of state acts to legalize medical marijuana, **I found relatively few references to actual authorities who spoke out officially to support medicinal use of cannabis.** There were a few authorities used by legislatures in writing their laws. These were credible authorities. Some of the statements were surprisingly dated, not showing new evidence. Dates of passage among these 33 states range from the first passage in 1996 (California) to 2018 (Utah). As noted earlier, two states passed medical marijuana laws in the 2020 election (South Dakota and Mississippi)

The most common authority mentioned is the Institute of Medicine of the former National Academy of Sciences and its March 1999 report *Marijuana and medicine: Assessing the science base*. Eight states used this Institute of Medicine reference as a credible source stating evidence that medical marijuana is beneficial to patients and therefore the state legislature should support legalizing its use with such evidence. Illinois in 2013 gives several authorities supporting medicinal use of cannabis. Other general statements have been made by states without citing an actual authority supporting medicinal use of cannabis. Some states include in their laws that money needs to be dedicated to research to learn more about evidence-based care.

Safe. The domain of "safety" is almost non-existent in the 33 state laws' rationale statements to the public for why they are legalizing medical marijuana. Three states California, Minnesota, and Pennsylvania are the only states that address safety, even if two do this in a cursory manner. A search of all language in these state acts for the terms "safe" or "safety" did not turn up other than the language cited above for these three states, with only one state making a strong statement about the importance of patient safety in the use of medical marijuana.

Discussion and Implications

Examining any healthcare system, unit, or practice is commonly organized around the Iron Triangle in health care of a) *Access,* b) *Quality,* and c) *Cost.* **Defining quality of patient care** is an enduring and challenging task for all: individuals, groups, organizations, community, and society. The task, while at times frustrating, is too important for us to throw our hands up in the air and say it cannot be done or revert to the fall back of "I cannot define it, but I know it when I do not see it practiced." This study aimed to learn **how states *explicate quality patient care*** in their **official documents** (acts, constitutional amendments, voter initiatives) **to legalize medical marijuana in their states**. We should expect that any new, innovative, or not thoroughly tested

patient care policy and practice **legislation** at a minimum **give the rationale** to pass such a law that:

- the act does not harm a patient; it is safe.
- there is some hope that the care act is effective.
- we are brought to a comfort level that there is good evidence for use of the treatment.
- patients appreciate the act.
- that the providers' peers view the patient care act as "the right thing to do," and it would be something they would do to care for a patient—*ceteris paribus*.

Results of this descriptive study show that there are **no strong, or even mild, rationale statements made** for use of medical marijuana in the language of the 33 state legislative acts reviewed that meet the highly recognized quality patient care criteria mentioned above. Patient safety is the cornerstone of high-quality health care. Surprisingly, patient safety is void in the language used to legalize medical marijuana in these states. It appears that legislatures displayed an understandable *compassion* for ill patients, but little *confidence* that medical marijuana is effective and is evidence-based. Furthermore, there is no groundswell of physicians wanting to prescribe medical marijuana, according to the language of these acts. Conversely, the patient-centered rationale was quite evident in many state laws ranging from using the words "compassionate care" in the title of the law and subsequent language that explains that the least we can do for patients who are suffering is to placate them, even though the effectiveness of the substance is not overwhelmingly evident.

During the public official response to the coronavirus outbreak, we heard strong appeals to "follow the science." It is uncanny to have state legislatures since 1996 passing either medical marijuana laws or legalizing marijuana use at some level when no medical body has endorsed its widespread use and our federal agencies charged with drug control have not lifted their concerns for the dangers of this substance.

This study is one piece of evidence that legalizing use of cannabis has been given an evidence-based medicinal use pass. More disturbing is that health care organizations and professionals and public health professionals have remained silent **as our next public health addictions crisis unfolds.** I predict the history of the use of medical marijuana will be a story of how economic benefits to some and socio-cultural and ideological pressure of policy makers won over quality patient care, including evidence of patient safety.

For a copy of this full manuscript replete with references write to Dr. Stephen F. Gambescia at sfg23@drexel.ed.