**Report raises concerns about medical marijuana program in Arizona**

**National Monitor**, *Albert Greenwood* | November 10, 2012

A report released Friday by the Arizona Department of Health and Human Services has revealed that 24 doctors certified nearly 75 percent of all medical marijuana cards issued in the state between April 2011 to June 2012, [according](http://www.sfgate.com/news/article/24-doctors-certify-most-in-Ariz-s-pot-program-4024442.php) to The Associated Press. The news outlet notes that 475 doctors certified approximately 29,000 patients during that time period.

The report brings into question whether the state’s medical marijuana program is being abused by both doctors and patients. Arizona voters passed a ballot initiative legalizing medical marijuana in November 2010. The passage of the ballot initiative made the state the fourteenth state to adopt a medical marijuana law.

“A physician that is writing 1,000 to 1,500 certifications each year is not acting in his patients’ best interests,” Will Humble, the state’s Health Services Director, told The AP.

[According to the report](http://www.azdhs.gov/medicalmarijuana/documents/reports/az-medical-marijuana-program-annual-report-2012.pdf), the majority of the qualifying patients (approximately 77 percent) had one medical condition with the remaining patients reporting two or more medical conditions. “Severe and chronic” pain was the most commonly cited reason for receiving a medical marijuana card.

The report also found that a far greater number of medical marijuana certifications came from doctors of naturopathic medicine not primary care doctors.

“The vast majority of medical marijuana certifications were coming from physicians who were not primary care docs,” Mr. Humble said, [according](http://www.kjzz.org/content/1211/small-group-doctors-sign-most-medical-marijuana) to KJZZ. “[They] put out a shingle and are seeing potential medical marijuana patients all day long. That’s not to say that if somebody’s signing a thousand certifications a year for medical marijuana and is a naturopath, I’m not saying that they’re not acting in their patient’s best interests.”

Given its findings, the Arizona Department of Health and Human Services and the University of Arizona College of Public Health recommended that intensive training be developed for physicians who are “high volume” certifiers of medical marijuana cards. This, the report notes, should be done in conjunction with respective licensing medical boards for improved patient provider coordination and adherence to Arizona Medical Marijuana Act statutory requirements.

The report was released just a few days after voters in Washington State and Colorado approved recreational marijuana. The passage of the Centennial State’s Proposition 64 legalizes the personal use, possession, and limited home-growing of marijuana for adults 21 years of age and older. Proposition 64 also puts into place a system of regulation and taxation similar to the one that regulates alcohol. The passage of the Evergreen State’s Initiative 502 legalizes the possession of as much as an ounce of marijuana.

Marijuana is banned at the federal level, a fact that has forced many states to deal with the issue themselves. While a few states have already legalized medical marijuana, Colorado and Washington State are the first states to legalize recreational marijuana.

The report released by the Arizona Department of Health and Human Services as well as the laws passed in California and Washington State suggest that regulation, oversight and taxation of marijuana will become increasingly important as recreational and medical marijuana laws are passed in states across the nation.

# Medical marijuana for a child with leukemia

##### November 24, 2012 By [Noelle Crombie, The Oregonian](http://connect.oregonlive.com/user/ncrombie/posts.html)

Mykayla Comstock's family says marijuana helps her fight an especially aggressive form of leukemia, keeps infection at bay and lifts her weary spirit. Twice a day she swallows a potent capsule form of the drug. Some days, when she can't sleep or eat, she snacks on a gingersnap or brownie baked with marijuana-laced butter.   
  
Mykayla is one of 2,201 cancer patients authorized by the state of Oregon to use medical marijuana.   
  
She is 7.   
  
The [Oregon Medical Marijuana Program](http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/index.aspx) serves 52 children who have a qualifying medical condition, [parental consent](http://media.oregonlive.com/health_impact/other/marijuana-parental-consent.pdf) and a [doctor's approval](http://media.oregonlive.com/health_impact/other/marijuana-physician-statement.pdf). Like adults, most cite pain as a qualifying condition, though many list multiple health problems, including seizures, nausea and cancer.  
  
Allowing adults to consume [medical marijuana](http://www.oregonlive.com/health/index.ssf/wide/medical_marijuana_in_oregon.html) is gaining acceptance nationwide. But Mykayla's story underscores the complex issues that arise when states empower parents to administer the controversial drug to children.   
  
Oregon's law, approved by voters 14 years ago, requires no monitoring of a child's medical marijuana use by a pediatrician. The law instead invests authority in parents to decide the dosage, frequency and manner of a child's marijuana consumption.   
  
The state imposes no standards for quality, safety or potency in the production of marijuana.   
  
Little is known about how the drug interacts with the developing body, leading pediatricians say. A [recent international study](http://www.pnas.org/content/early/2012/08/22/1206820109.abstract) found sustained cannabis use among teens can cause long-term damage to intellect, memory and attention.   
  
Many doctors worry about introducing a child to marijuana when they say other drugs can treat pain and nausea more effectively.   
  
Mykayla's father, who is divorced from the girl's mother, was so disturbed by his daughter's marijuana use that he contacted child welfare officials, police and her oncologist. Jesse Comstock said his concerns were prompted by a visit with Mykayla in August.   
  
"She was stoned out of her mind," said Comstock, 26. "All she wanted to do was lay on the bed and play video games."   
  
But Mykayla's mother and her boyfriend, Erin Purchase and Brandon Krenzler, see the drug as a harmless antidote to leukemia's host of horrors. The couple, regular cannabis users raised in Pendleton, said Mykayla relies almost exclusively on pot to treat pain, nausea, vomiting, depression and sleep problems associated with her cancer treatment.   
  
Mykayla, who favors a knit cupcake cap to cover her fuzz of strawberry-colored hair, said marijuana makes her feel better.

"It helps me eat and sleep," she said, nestled against her mother on a couch. "The chemotherapy makes you feel like you want to stay up all night long."   
  
Marijuana, she said, "makes me feel funny, happy."   
  
"She's like she was before," her mother said. "She's a normal kid."

**Brain Gain:The underground world of “neuroenhancing” drugs.**

#### by [Margaret Talbot](http://www.newyorker.com/magazine/bios/margaret_talbot/search?contributorName=margaret%20talbot) April 27, 2009, The New Yorker

A young man I’ll call Alex recently graduated from Harvard. As a history major, Alex wrote about a dozen papers a semester. He also ran a student organization, for which he often worked more than forty hours a week; when he wasn’t on the job, he had classes. Weeknights were devoted to all the schoolwork that he couldn’t finish during the day, and weekend nights were spent drinking with friends and going to dance parties. “Trite as it sounds,” he told me, it seemed important to “maybe appreciate my own youth.” Since, in essence, this life was impossible, Alex began taking Adderall to make it possible.

Adderall, a stimulant composed of mixed amphetamine salts, is commonly prescribed for children and adults who have been given a diagnosis of attention-deficit hyperactivity disorder. But in recent years Adderall and Ritalin, another stimulant, have been adopted as cognitive enhancers: drugs that high-functioning, overcommitted people take to become higher-functioning and more overcommitted. (Such use is “off label,” meaning that it does not have the approval of either the drug’s manufacturer or the Food and Drug Administration.) College campuses have become laboratories for experimentation with neuroenhancement, and Alex was an ingenious experimenter. His brother had received a diagnosis of A.D.H.D., and in his freshman year Alex obtained an Adderall prescription for himself by describing to a doctor symptoms that he knew were typical of the disorder. During his college years, Alex took fifteen milligrams of Adderall most evenings, usually after dinner, guaranteeing that he would maintain intense focus while losing “any ability to sleep for approximately eight to ten hours.” In his sophomore year, he persuaded the doctor to add a thirty-milligram “extended release” capsule to his daily regimen.

Alex recalled one week during his junior year when he had four term papers due. Minutes after waking on Monday morning, around seven-thirty, he swallowed some “immediate release” Adderall. The drug, along with a steady stream of caffeine, helped him to concentrate during classes and meetings, but he noticed some odd effects; at a morning tutorial, he explained to me in an e-mail, “I alternated between speaking too quickly and thoroughly on some subjects and feeling awkwardly quiet during other points of the discussion.” Lunch was a blur: “It’s always hard to eat much when on Adderall.” That afternoon, he went to the library, where he spent “too much time researching a paper rather than actually writing it—a problem, I can assure you, that is common to all intellectually curious students on stimulants.” At eight, he attended a two-hour meeting “with a group focussed on student mental-health issues.” Alex then “took an extended-release Adderall” and worked productively on the paper all night. At eight the next morning, he attended a meeting of his organization; he felt like “a zombie,” but “was there to insure that the semester’s work didn’t go to waste.” After that, Alex explained, “I went back to my room to take advantage of my tired body.” He fell asleep until noon, waking “in time to polish my first paper and hand it in.”

I met Alex one evening last summer. [He] was happy enough to talk about his frequent use of Adderall at Harvard, but he didn’t want to see his name in print; he’s involved with an Internet start-up, and worried that potential investors might disapprove of his habit.

“One of the most impressive features of being a student is how aware you are of a twenty-four-hour work cycle. When you conceive of what you have to do for school, it’s not in terms of nine to five but in terms of what you can physically do in a week while still achieving a variety of goals in a variety of realms—social, romantic…extracurricular, résumé-building, academic commitments.” Alex was eager to dispel the notion that students who took Adderall were “academic automatons who are using it in order to be first in their class, or in order to be an obvious admit to law school or the first accepted at a consulting firm.” In fact, he said, “it’s often people”—mainly guys—“who are looking in some way to compensate for activities that are detrimental to their performance.” He explained, “At Harvard, at least, most people are to some degree realistic about it. . . . I don’t think people who take Adderall are aiming to be the top person in the class. I think they’re aiming to be among the best. Or maybe not even among the best. At the most basic level, they aim to do better than they would have otherwise.” He went on, “Everyone is aware of the fact that if you were up at 3 A.M. writing this paper it isn’t going to be as good as it could have been.”

Alex’s sense of who uses stimulants for so-called “nonmedical” purposes is borne out by two dozen or so scientific studies. In 2005, a team led by Sean Esteban McCabe, a professor at the University of Michigan’s Substance Abuse Research Center, reported that in the previous year 4.1 per cent of American undergraduates had taken prescription stimulants for off-label use; at one school, the figure was twenty-five per cent. Other researchers have found even higher rates: a 2002 study at a small college found that more than thirty-five per cent of the students had used prescription stimulants nonmedically in the previous year.

# Embryonic Stem Cell Debate

November 4, 2012, By: [Mark Williams](http://www.examiner.com/green-living-in-tampa-bay/mark-williams), www.examiner.com

A global debate is raging on the ethical implications of embryonic stem cell research. In the United States, this debate is closely related to the debate over the ethics of abortion. In essence, the kernel of the issue boils down to this: is the creation of a blastocyst for the purpose of producing stem cells morally allow-able?

The answer to this question depends on what you think the blastocyst is. If you believe, as many people do, that human life begins at conception and that even a single-celled zygote is a human being entitled to the full protection of the law, then the destruction of the blastocyst and the harvesting of stem cells is equivalent to murder. If, on the other hand, you believe that a organism consisting of a few hundred cells is no more equivalent to a human being than a blueprint is equivalent to a building, then there is a powerful moral compulsion to harvest the stem cells in order to relieve the real suffering of real people.

This is an example of a conflict that arises from advances in science but that cannot be answered by the scientific method. A biologist can tell you in great detail what the cellular structure and function of the blastocyst is, but cannot tell you whether the blastocyst should have legal protection. In the end, that is a question decided on moral, legal, religious, and ethical grounds. It is a question of when the embryo becomes a “person” in the legal sense, entitled to the full protection of the law. The answer to this and many other question like it vary from one society to the next and has little to do with science and more to do with belief. Many people have wrestled with this question without producing a consensus.

**The ethics of assisted suicide**

Arthur Caplan, Nov 04, 2012, [GateHouse News Service](http://www.metrowestdailynews.com)

Of the numerous ballot initiatives that will be decided at the state level on Tuesday, none is more hotly contested than the Massachusetts bill to decide whether to legalize physician-assisted suicide. The citizens of Massachusetts, my home state, should vote to legalize.

The proposed measure allows terminally ill patients to be given access to lethal drugs. A terminally ill patient is defined as someone with six months or less to live. The patient’s terminal diagnosis and mental competency must be attested to by two doctors. Patients would have to make a request to their doctor twice orally and once in writing. The written request would have to be witnessed.

Yet even with such restrictive conditions, opponents of the proposal say doctors should never, as a matter of professional ethics, intentionally hasten the death of one of their patients, even one who is terminally ill. The codes of medicine and nursing ethics reject helping patients die.

Many professional organizations, including the American Medical Association, agree. The AMA "strongly opposes any bill to legalize physician-assisted suicide" because the practice is "fundamentally inconsistent with the physician's role as healer."  The Massachusetts Medical Society also opposes the bill. “Allowing physicians to participate in assisted suicide would cause more harm than good,” Dr. Lynda M. Young, the society’s past president told Massachusetts legislators earlier this year. “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer."

Some disability groups and religious organizations are fighting hard to get a "no" on the “Question 2,” initiative as well.  They believe that the terminally ill who are disabled deserve better palliative care and emotional support rather than a prescription of deadly medicine. They also worry that people may feel compelled or coerced into choosing death because their care is expensive, they see themselves as a burden to others or because relatives are thinking that they do not want to spend the grandchildren's college tuition to keep grandpop going in a nursing home or ICU. Given the current push to contain medical costs, the biggest fear is that the vulnerable will get the bum’s rush to the hereafter.

These objections are concerning, but not convincing. Two states have already enacted legislation very similar to that proposed in Massachusetts. The disturbing scenarios against legalizing physician-assisted suicide for the terminally ill are not supported by what has happened in Oregon and Washington.

Although there are requests from the dying for lethal pills, few ask and almost no one takes them. In Washington in 2010, 68 physicians wrote lethal prescriptions for 87 patients, 51 of whom took the pills and died. The rest never took the pills. That is an incredibly tiny number relative to all those who are terminally ill in Washington. The Oregon experience is the same.

The critics are worrying about a shift to mass suicide inspired by heartless doctors and families pressuring dying patients to end it. That has simply not happened in Oregon or Washington. There is no persuasive evidence that the dying are being rushed, duped or bullied to die by anyone.

The interesting thing is that many people find it more empowering to have the ability to end their lives if they want to do so. Many say the ability to choose gives them the strength not to do so.

The question about a doctor’s involvement can be overcome by giving each physician the right of conscience to be involved or not. Some doctors will want nothing to do with assisted suicide. Others will. Given the polarizing nature of physician-assisted suicide, the decision ought to be each physician’s to make. Medicine does not have to be all in or all out.

The proposed Massachusetts law is very restricted and contains important safeguards. Experience in other states shows little reason for worry about abuse or misuse.  Instead the more people who are going to die know they can end their lives sooner if they choose, the more many of them fight harder to live. Making assisted suicide possible in Massachusetts rightly puts a choice in the hands of a very few who may not use it, but value having it.