**Guided Annotated Bibliography**

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**Approach Paragraph**

My approach to finding sources has been to seek out the newest scientific information about medical marijuana, beyond anecdotal. The research is advancing every day, and where serious, well-conducted studies were not extremely common in past decades, and while even now, many doctors will not take a serious look at medical marijuana, there is now much more evidence offering information about benefits and limitations. One particular goal of mine is discovering if side effects, short term and long term, of using marijuana for physical conditions, including those affecting the brain, are less severe than for pharmaceuticals. Because so many states now have passed, at a minimum, medical marijuana legislation, we should have a wealth of new information coming out of those states. I also want to see why some states, year after year, reject medical marijuana when it is on their ballots, and what the health impact is, if people are moving or traveling to other states to treat their conditions and, if so, what the implications are. Ultimately, I hope to argue that medical marijuana should be legal across the U.S. because of its healing properties and much lower risks as compared to traditional drugs.

**Annotated Bibliography**

Habib, G. & Yaacobi, A. (2020). Sarcoidosis following treatment with medical cannabis. *IMAJ,*

*22*(5), 326-327.

This article refers to cannabis, in 2020, as an “illicit” drug, and while it is indeed illegal in many places in the world, the word choice is concerning to me. The article is from the Israeli Medical Association, but regardless of the laws in any country or state, grouping cannabis (not THC, but simply cannabis) with drugs like methamphetamines and heroin is misleading. The purpose of the article, however, is to suggest that a patient who had used cannabis for four years to relieve fibromyalgia symptoms had developed sarcoidosis, which is an autoimmune inflammatory disease, as a result. Considering that there had, at the time, been only one other reported case of cannabis-related sarcoidosis, and considering that sarcoidosis is much more common in the general population, with no real known cause, I would point to this study as an opposing viewpoint while using logic to illustrate that the connections and arguments are weak. The study itself reports that sarcoidosis is likely genetic and has no known direct cause.

Lashley, K. & Pollock, T. G. (2021). Waiting to inhale: Reducing stigma in the medical cannabis

industry. *Administrative Science Quarterly, 65*(2), 434-482. https://doi.org/10.1177/

0001839219851501

This is a very interesting look at, among other items, the history of marijuana stigma. The authors have created charts representing notable years, decades, and events, starting in the 1800s, that share public attitudes and laws. For example, 1937 is noted as the year the film *Reefer Madness* was released, and from around the year 2000 and forward, acceptance and “moral infusion” have occurred more and more (p. 442). I find it impressive that, as the authors demonstrate by looking at the rebranding of marijuana from illicit, back-alley, and gateway in nature into healthy, clean, safe, homeopathic, holistic, “green” medicine, a single substance so demonized not so long ago has completely altered its image. While stigma and the historical journey of murder-inducing reefer to effective medicine aren’t main focal points in my essay, I do wish to use some of the powerful language and history here to address the suppression of marijuana/THC/cannabis while narcotics like codeine were common household staples.

Roberts, J. (2020). Medical cannabis in adult mental health settings: Reconstructing one of the

most maligned medications in the United States. *Clinical Social Work Journal, 48*(4),

412-420. https://doi.org/10.1007/s10615-018-0670-9

I was drawn to this article because cannabis is referred to not as a “substance” but as a “medication” directly in the title. I feel it is important to use words like this as often as possible, words with positive healing connotations as opposed to those with illicit shades of meaning. In fact, the damaging semantics (and classification) dominate the article’s main concluding point, that one major roadblock in getting this good medicine available to people who need it is its classification by the DEA as a Schedule I drug. The article implores mental health professionals to look at the reality of cannabis vs. bias brought on by decades of demonization and even by their formal advanced education.

Sarris, J., Sinclair, J., Karamocoska, D., Davidson, M., & Firth, J. (2020). Medicinal

cannabis for psychiatric disorders: A clinically-focused systematic review. *BMC*

*Psychiatry, 20*(1), 1-14. https://doi.org/10.1186/s12888-019-2409-8

This study describes trials for the treatment of psychiatric disorders with cannabis and reveals that it has recently been shown to be effective for a wide range of conditions, from PTSD to ADHD. The authors of this article do concede that these trials are early examples and that we do not have a rich history of the correlation, although the trials that have been performed clearly indicate that there likely is a connection that will be further substantiated in coming months and years. What is interesting and relevant about this article, in conjunction with other sources in this annotated bibliography, is that some sources, published in the same year, one in the same month, as this study, contradict these finding by asserting that despite what others have reported about psychiatric use, there is absolutely no proof that it is effective. Therefore, Farris et al. will work well as a rebuttal to those opposing articles for two major reasons. Firstly, Farris et al. employ the scientific method and provide many rich statistics and clear numbers, yet some opponents do not. Finally, when accompanied by my other supporting sources, those that argue in favor of cannabis for mental health, this well-documented study will strengthen the overall arsenal of support for my central argument.

Stuyt, E., M.D. (2020). Calling marijuana “medical” makes it safe? No way! *Missouri Medicine,*

*117*(6), 532-533.

This correspondence of dissent by an M.D. in Missouri, during an opinion-gathering session for the November/December 2020 issue of *Missouri Medicin*e toward a consensus on legalization in Missouri, presents information about Colorado and claims that legalization there has created “heavy drug users” (p. 533). Stuyt asserts, without evidence, that when marijuana is legal medicinally, kids, adolescents, and adults are overdosing, going to ERs in psychotic and suicidal states, and other sensational (non) facts regarding THC. Stuyt does credit a source, a study about ER visits that occur after a person has partaken in marijuana use, but that source does not support what Stuyt extrapolates. Stuyt engages in Post Hoc fallacies and in a number of other clear fallacy types in what ultimately seem like scare tactics in order to push her agenda of placing marijuana on the Prescription Drug Monitoring Program, essentially treating marijuana with the caution with which we are now treating truly deadly, life-destroying drugs like Oxycodone. This source is a useful opposing viewpoint because it is full of logical leaps and unfounded fearmongering.

Vacaflor, B. E., Beauchet, O., Jarvis, E. G., Schavietto, A., & Rej. S. (2020). Mental health and

cognition in older cannabis users: A review. *Canadian Geriatrics Journal, 23*(3), 237-244. https://doi.org/10.5770/cgj.23.399

This article suggests that older users of medical cannabis/marijuana suffer cognition decline more than non-users and that the risk is lower with lower dosages and different types of delivery, like misting. The authors also note that cognition decline occurs in older patients who use other legal substances like opioids, nicotine, and alcohol. The study recommends the lowest possible doses of cannabis/THC, but it does encourage caution in general, stating that medical cannabis can cause uniquely serious issues in older people, like hallucinations and psychosis. I would present this source not as a dissenting voice but as containing a reasonable opposing viewpoint, in order to strengthen my argument through concession to the risks many drugs have and to the heightened risk of most drugs in older and compromised patients.