Medical Marijuana for Minors May Be Considered Child Abuse

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abstract

The Food and Drug Administration categorizes marijuana (cannabis) as a Schedule I drug, meaning that it has no currently accepted medical use, a high potential for abuse, and no good data on safety. Other Schedule I drugs are heroin, lysergic acid diethylamide, peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("ecstasy"). The authors of some studies have shown that marijuana can reduce nausea and vomiting from chemotherapy, can improve food intake in patients with HIV, can reduce neuropathic pain, and may slow the growth of cancer cells. In many states, marijuana use is illegal. No state has approved its use for children. What, then, should doctors do if they become aware that parents are using marijuana to treat medical conditions in their children? What if the children have adverse reactions to the marijuana? In this Ethics Rounds, we present such a case and ask experts in child protection and child abuse to discuss the appropriate response.

The use of marijuana for medical purposes raises difficult scientific, legal, and ethical questions. The authors of some studies have shown that marijuana can reduce nausea and vomiting from chemotherapy, can improve food intake in patients with HIV, can reduce neuropathic pain, and may slow the growth of cancer cells.[1] Nevertheless, in many states, marijuana use is illegal. No state has approved its use for children. The Food and Drug Administration (FDA) categorizes it as a Schedule I drug, meaning that it has no currently accepted medical use, a high potential for abuse, and no good data on safety. Other Schedule I drugs are heroin, lysergic acid diethylamide, marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("ecstasy").[2]

What, then, should doctors do if they become aware that parents are using marijuana to treat medical conditions in their children? What if the children have adverse reactions to the marijuana? In this Ethics Rounds, we present such a case and ask experts in child protection and child abuse to discuss the appropriate response.

THE CASE

A 4-year-old boy with a curable lymphoma was undergoing chemotherapy as an outpatient. One evening, he was brought to the emergency department (ED) for altered mental status and vomiting beginning that morning. The mother reported that he had been acting normal the day before. He had finished 5 days of oral chemotherapy a few days before. The mother reported that he had received ondansetron at home but that it wasn't working. He continued to vomit in the ED. His Glasgow Coma Score was 11 to 12 with nonsensical speech. He had trouble focusing his eyes and his left pupil was notably larger than the right. A computed tomography scan of his head revealed acute intracranial process. An EEG revealed unremarkable results.

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The results from his brain MRI were unchanged from those of a previous study from a month before.

His mental status improved throughout the night without specific treatment.

His toxicology screen results were found to be positive for cannabinoids. After being presented with this information, the mother told the doctors that she had purchased marijuana edibles in another state where the sale of marijuana is legal. She had provided the edibles to the patient to help with his pain and nausea.

The child abuse team was consulted on whether to report the case to Child Protective Services. The child abuse team asked for an ethics consultation. The question was should we report this as child abuse?

LARISSA HINES, MD, COMMENTS

Pediatricians who specialize in the evaluation of child abuse are often asked whether to report a family for suspected child abuse. Ethics consultants can also be helpful in these situations.

Each state has mandatory reporting laws. They vary slightly from state to state. In general, medical professionals are required to report if they have a "reasonable suspicion" or "reason to believe" that abuse has occurred. Each state uses different specific terminology. However, the general principle is the same. To adhere to this mandate, we must first understand what a reasonable suspicion is and what constitutes child abuse.

Many authors have attempted to define and understand reasonable suspicion. Study authors have sought to define reasonable suspicion and determine thresholds for reporting among community professionals, general physicians, and subspecialists. The authors of each of these studies have found that there is little agreement on what reasonable suspicion means and at what level of certainty a report is indicated.[3–5] The authors of 1 study showed that even child abuse experts do not agree on where the threshold for reporting lies.[6] Without a specific definition or cutoff for reasonable suspicion, there continues to be variability in reporting practices.[7] There are also numerous reasons that physicians may decide not to make a report, even when there is a suspicion for child abuse. These reasons include familiarity with the family, previous negative interactions with Child Protective Services, and resource limitations.[8]

Child maltreatment is defined as a situation in which acts (or omissions) by a caregiver lead to harm or potential harm to the child. Omissions can lead to charges of child neglect. Note that intent is not a part of these definitions. Many perpetrators of child abuse do not have a specific intent to harm the child. The majority of states have no laws regarding the obligation to report a suspected crime, except in the case of child abuse.

The question raised by this case, then, is whether the mother's actions rise to the level of harm that would mandate a report to Child Protective Services.

To answer this, we first have to determine if harm or potential harm occurred to the child. This child was seen in the ED and admitted to the hospital because of the change in mental status, which was presumably secondary to the marijuana ingestion. Although the symptoms improved, the giving of marijuana to a child should be considered as harm to the child, in much the same way that bruises or fractures, which go away, are considered to constitute harm. The fact that the child recovered without any apparent sequelae is not relevant to the mandate for reporting.

In this case it is important to weigh not only the harm and/or potential for harm to the child from the ingestion but also the harm and/or potential for harm by reporting to Child Protective Services. This child's cancer is likely curable. Cancer treatment can be toxic, and the side effects, including nausea and vomiting, can be difficult to manage. These side effects can have significant morbidity. The harm in reporting, then, includes both the potential harm to the child in being denied effective treatment, the psychological harm to the mother in being accused of child abuse, and the burden on an already stretched and underfunded child protection system. There is also a possibility that the child would be removed from his family during an already stressful time, given the cancer diagnosis, which could cause significant psychological harm.

Now we must consider the ethical dilemma rather than just the legal mandate. We can consider both the harm threshold and the best interest standard. When considering the harm threshold, harm was caused to this child, as evidenced by the altered mental status, from which he fully recovered. This mother has done a good job caring for this child who has cancer. However, she gave him a Schedule I narcotic, legally available in some states to purchase but illegal here, as a part of caring for him, which, instead of helping him, caused him harm. However, given her previous good care of the child, prompt response to his side effects, and apparent intentions that she wants to continue to do what is right for the child, it is, in my opinion, in the best interest of this child to have his mother continue to direct his medical care, on the condition that she does not continue to give him tetrahydrocannabinol and cause him more harm, at which point this would not only be considered above the legal threshold for reporting but also no longer in the child's

best interest. Although intent is not an explicit component of reporting laws, it is ethically relevant. This mother was clearly trying to help her son feel better and not trying to harm him. Although her intent was not to harm, her failure to disclose what she had done initially made this clinically more complicated and potentially risky and/or harmful to the patient. Being forthcoming when using treatments beyond what the medical team recommends or knows about can present a problem due to intended consequences, potential cross reactions, and other unforeseen consequences.

Although there is a legal mandate to report, ethically, it would be appropriate to forego reporting. There is no clear answer in this case, and the decision must be a judgement call by the providers involved in the case. Overall, looking at the total picture and giving the mother the benefit of the doubt, I would not report in this case. Instead, I would counsel the mother about the dangers of using marijuana to treat her son and give her a stern warning that, if this happens again, we would be compelled to report her to child protection.

DR JILL GLICK, MD, AND MS KRISTEN BILKA, PA, COMMENT

In the Child Abuse Prevention and Treatment Act,[9] child abuse and neglect are defined as, at a minimum, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation" or "an act or failure to act which presents an imminent risk of serious harm." In the Child Abuse Prevention and Treatment Act, a minimal federal standard is defined and then each state is required to develop its own definitions of child abuse and neglect. Note that the legal definition of child abuse does not include intent; however, in the scenario above and in any question of medical neglect, it must be considered.

As mandated reporters, we are required to call Child Protective Services if we have "reasonable cause to believe" that abuse or neglect has occurred. Reasonable cause to believe means that a person with the same level of education and training would arrive at the same conclusion on the basis of the facts presented. In some clinical scenarios, the threshold to report is well defined. If, for instance, an infant presents with unexplained bruising and brain injury or a child discloses child sexual abuse, one clearly must report. In other cases, such as this one, the threshold for reporting is fuzzy.

Our interdisciplinary child advocacy team meets weekly to review all the consultations of the previous week. The most intense discussions arise from cases in which there is ambiguity and disagreement about our obligation to report a family to the child protection authorities. Different child maltreatment categories require a different decision algorithm: in the case of a child with physical injuries, we consider the age of the child, the nature of the injury, the history provided and its plausibility, the ways in which the caretaker recognized and responded to the injury, and any additional clinical findings, such as other occult injuries. When determining our obligation to report, we consciously exclude previous child welfare involvement and avoid speculation about the intent to harm. In cases of medical neglect, by contrast, we must consider whether the provision of questionable medical care or lack thereof resulted in harm or potential harm to the child. We consider parental capacity to understand the need for treatment, any barriers to care, and the resulting harms to the child. In these situations, we do consider the caretaker's intent.

We are aware of the drastic consequences that may follow a report to child protection. These consequences could affect the patient, the parents, the family, and the doctor. When we get it right, we can halt ongoing maltreatment and ensure a child's safety. But reporting can also be an adverse event. It can lead to the parent being permanently labeled as a "perpetrator," regardless of the type of maltreatment. The child may be removed from the home for days or months during the investigation. The physician-family relationship may be damaged, strained, or severed. The parents may never trust a physician again. The physician may hope for a specific intervention as a result of reporting, only to find child welfare moving in a different direction. The physician may sense a loss of control of the process after the filing occurs. A substantiated or indicated report can impact the parents' livelihood if they are teachers, child care providers, or in other professions that require background checks.

Given all of this, should we report this mother for giving her child an admittedly illegal substance that apparently caused harm?

Marijuana legalization is a controversial topic. Study authors have shown that the 2 main cannabinoids from marijuana reduce nausea and vomiting from chemotherapy, improve food intake in patients with HIV, reduce neuropathic pain, and may slow the growth of cancer cells.[10]

Still, marijuana is categorized as a Schedule I drug by the FDA (along with heroin and lysergic acid diethylamide), indicating no medicinal use. Nevertheless, 29 states have legalized medicinal use of this substance. In most of those states, it is only legal for adults. Currently, legal marijuana for medicinal use by children is limited to just a few situations, such as the use of cannabis

oil for children with intractable seizures.

The use of marijuana in any context is laden with ethical, legal, political, economic, and even spiritual controversies. But the law is fairly straightforward. The mother's use of marijuana in this case was illegal. And it seems to have led to harm. The mother knowingly took a risk and crossed over a legal threshold by purchasing marijuana. Each state's child welfare system has their own definitions of suspected maltreatment, and, regardless of our ethical opinions, we are obligated to attempt to report this to the child's state welfare system because marijuana is illegal. We don't know what the response will be. Some state child welfare systems may not take the report. Many states do not accept reports for in utero exposure of infants to marijuana.

That said, we ourselves would feel ambivalent about this case. We know that the mother's intent was to help her child. We can't help but ask ourselves whether, if we were in this mother's shoes, we would have done the same thing. We can't help wondering how we would have felt if the boy had improved after eating marijuana macaroons. What if his anxiety had resolved, his appetite had improved, and he was no longer nauseous? Wouldn't we feel that we had done the best possible thing for our child?

We would recommend informing the mother that we are legally mandated to report but that our common goal is to improve the health and well-being of her child. We would suggest that we work together toward our common goal. This would require close medical follow-up with more attentive efforts to control the side effects of chemotherapy. We would stress to the child protection workers that the mother's intentions were good.

In summary, when approaching how to define the threshold to report a family to a child welfare system, we must first take into account our state laws. Our medical opinion, however, must be directed by many other factors, including an understanding of the circumstances and the motivation of the parent. Child welfare systems rely on medical providers to make clear statements regarding our medical opinion about whether a child has been abused or neglected. This is a powerful role. We might also use this case to advocate for a change in state laws or policies regarding the well-intentioned use of marijuana in dire circumstances such as the ones that this mother faced.

JOHN D. LANTOS, MD, COMMENTS

Some cases beautifully illustrate the difference between legal considerations and ethical ones. It may be legally preferable to report this family to Child Protective Services. It is not ethically preferable.

Child protection laws mandate the reporting of suspected child abuse. Nevertheless, in many cases, the provider has some discretion in deciding whether a report to child protection agencies is obligatory. It is both necessary and appropriate for doctors to consider the circumstances of the case in deciding whether to report. As we know, there are many gray zones, much ambiguity, and significant practice variation in reporting practices. We also know that child protection systems are overburdened.

This mother needs compassionate care and good medical advice about the dangers of marijuana. She needs to know that she can trust doctors and the health care system and that we are on her side. She needs to know that she made a mistake in giving her child an unmeasured dose of cannabinoids. But she doesn't need to be accused of a crime and investigated as a criminal.

Doctors who care for children with diseases or symptoms for which cannabinoids might be an effective treatment have a duty to advocate for better studies of the efficacy of these agents in such clinical circumstances. Thus, for children with intractable seizures or with chemotherapy-induced nausea and vomiting, we should have institutional review board–approved protocols in place, and we should seek FDA approval for clinical trials. Children deserve such advocacy, just as they deserve the best medical care that we can provide. Nobody would be served by reporting this family to Child Protective Services.

All of the cases in Ethics Rounds are based on real events. Some incorporate elements of a number of different cases in order to better highlight a specific ethical dilemma.

ABBREVIATIONS

ED: emergency department
FDA: Food and Drug Administration

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