Stuck in the Middle With You: A Case Study of the Ethical Implications of Conflicting State and Federal Marijuana Laws in Liver Transplant Social Work

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Abstract

The legalization of marijuana for recreational use in some states leads to conflicting laws and ethical dilemmas for social workers. In this case, a patient in need of a liver transplant may not secure housing due to marijuana use. The case is analyzed utilizing the National Association of Social Workers (NASW) Code of Ethics.

Keywords: professional ethics; marijuana laws; liver transplant; social work; NASW Code of Ethics

Introduction

Public attitudes toward marijuana are changing. In some areas, this has taken the form of local laws that allow for either medical or recreational marijuana use, or both. However, in the United States, the federal government does not share in this state- and local-level acceptance of marijuana use, creating conflicting laws and regulations. Social workers are stuck in the middle of this issue, in the unenviable position of both securing necessary services for clients, and in complying with federal laws that may prohibit clients from accessing services if they use marijuana. As the quasi-legality of recreational marijuana is a new development, there have been no published cases in the social work literature detailing how this conflict presents itself in social work practice, or analyzing the ethical issues of such a case. Social attitudes regarding marijuana will continue to evolve and the situation of conflicting laws will continue, thus increasing the need for an ethical analysis and approach to the issue from a social work perspective.

This article presents a case where a client's use of marijuana in a locally permissive context conflicts with the rules and regulations of a federal housing program, and in the situation of a life-or-death need for stable housing. The case is presented in some detail; However, to protect the client, the social worker, the medical team, and the medical system, details of the client have been removed, and details of the case have been altered to ensure anonymity. Changes to the case presentation do not compromise core facts or the essential ethical issues that the case illustrates. Ethical conflicts that arise from this case and from the medical setting and interdisciplinary staff are noted, with the presentation of a detailed ethical analysis from a social work perspective utilizing the National Association of Social Workers (NASW) Code of Ethics (NASW, 2008). The terms “client” and “patient” are both used as appropriate to the context of this article.

The Current Legal and Social Context of Marijuana Use

There is little legal and ethical literature about recreational marijuana use, as much of the previous literature concerns the use of medical marijuana (Beerel, 2007; Bulger, 2007; Isaacs & Kilham, 2015; Potthast, 2007; Rubens, 2014). The two situations of marijuana use, medical and recreational, are legally different in minor and often unclear ways. Federal law still classifies marijuana as a controlled substance, making the manufacturing, sale, purchase, possession, and use of marijuana illegal in the United States, regardless of whether for medical or recreational use (Rubens, 2014; Scheuer, 2015; Vitale, 2014). Medical use attempts to treat marijuana as a controlled substance by requiring a physician "recommendation" and is framed under conditions of "compassionate use" for patients with serious illnesses (Rubens, 2014; Vitale, 2014). Recreational use, where allowable under state law, is merely restricted to adults over the age of 21 (Guttmannova, et al., 2016; Mason, Hanson, Fleming, Ringle, & Haggerty, 2015; Ratzan, 2014; Vitale, 2014). The move toward medical marijuana use has been criticized by some as ultimately intending to result in the legalization of recreational use (Rubens, 2014), which appears to be happening. In states such as Colorado, Washington, and Oregon, recreational marijuana use and possession is now permitted, under specific regulatory conditions, legal, or at least not a criminal act under state statute.

The state laws do not necessarily establish legality; it is moreso that the state has declared that possession, production, use, and sale is not illegal per se, and/or will not be prosecuted at the state level. What is legal and illegal is not clear to many, even in states where recreational use is permitted (e.g., Mason, et al., 2015). Although a legal grey area, the situation is possible given Constitutional principles that allow overlapping Federal and state regulations on the same issues (see Vitale, 2014). In addition, "prosecutorial discretion" is allowable based on two facts (Vitale, 2014). First, law enforcement agencies must allocate resources and determine enforcement priorities, such as pursuing more serious and violent crimes. Second, these agencies are under no legal obligation to prosecute all violations of the law. Prosecutorial discretion seems to have been endorsed by the Federal government at this time in relation to state actions on marijuana (Vitale, 2014). However, even in those states where recreational use is permissible, federal law enforcement agencies may still pursue legal actions against citizens and a business operating within the laws of the state, as has already occurred in the medical marijuana industry (Scheuer, 2015; Vitale, 2014).

Regardless of the legalities, in the United States personal and public opinions are shifting on the issue of marijuana use (Millhorn, et al., 2009; Ratzan, 2014; Roffman, 2013; Rubens, 2014; Sarabia, 2015; Vitale, 2014), as is reflected in the ongoing state-level actions toward the decriminalization of recreational marijuana use. However, not all of the United States, nor even the residents of states where recreational use is permitted, agree on the legal or moral permissibility of either medicinal or recreational marijuana use (Roffman, 2013; Rubens, 2014). The effect of the state legalization laws on social issues such as crime and personal health impacts remain unknown, although research is pending (Guttmannova, et al., 2016; Hawken, Caulkins, Kilmer, & Kleiman, 2013; Roffman, 2013).

Although law enforcement agencies may choose not to pursue criminal or legal actions against individuals who use marijuana, social workers must still comply with both state and Federal eligibility rules for social services and assistance programs (Millhorn, et al., 2009). Many social assistance programs and services are federally funded or administered, and these ties to funding streams determine eligibility rules, up to and including mandatory drug testing. The contradiction between state and federal laws leaves social workers stuck in the middle alongside their clients, and in the untenable position of deciding which rules to break. Social workers need to consider the positive and negative connotations and consequences of client behaviors such as marijuana use (Millhorn, et al., 2009). Social workers also need to consider the implications and consequences of their own course of action or

inaction as informed by the NASW Code of Ethics (NASW, 2008).

To illustrate and carefully examine the ethical issues associated with the conflicting legal situation regarding recreational marijuana use, the following case study is presented for analysis. The case is situated in a permissive context, in a state where by citizen initiative and popular vote recreational marijuana has recently been approved for those ages 21 and over. Even prior to the change of law, the state was known for social and moral attitudes accepting of the use of marijuana. The state is in the top five in the United States in both the rates of adolescent marijuana use, and in low perceptions of harm from smoking marijuana (Hughes, Lipari, & Williams, 2015).

The Case

A social worker in a medical setting is tasked with helping a patient in need of a liver transplant to secure stable housing. Without stable housing, the patient will not be listed for a liver transplant. The patient must secure housing within the next year or will likely die from liver failure. The best and only housing option attainable within that period is a federally funded program that requires three sequential negative drug-screening tests within the twelve months prior to applying for housing. Once housing is secured, no further drug screenings are required. The liver transplant program routinely tests patients for drug and alcohol use, as the use of substances harmful to the liver is not permitted. Patients testing positive for substances harmful to the liver can be excluded from receiving a transplant. In the case of this transplant service, marijuana use is not exclusionary for transplant (although it is not permitted post-transplant due to other medical issues). The patient was aware of the transplant service rules on marijuana and other drugs, but was not aware of the possible effect on housing prior to the identification of the federally funded program as the only viable housing option. The patient had four drug screening tests within the past year. The first two were negative, the third one was positive for marijuana, and the fourth was negative.

The social worker is in the position of choosing to send the referral to the housing program either with or without the positive marijuana drug test. The social worker could have made this decision independently without consulting a supervisor or member of the medical team, or more appropriately, the social worker could seek consultation and supervision. The social worker should be aware of the consequences of omitting the positive test, including damage to relationships with referral agencies and the future possibility of not having referrals accepted. There may be legal consequences for knowingly falsifying a federal housing application, should it be discovered. The consequences for including the positive test are clear: the referral will not be accepted, the patient will be denied housing, and the patient will almost certainly die from liver failure before alternative housing is secured. There is not enough time to schedule and conduct further testing to obtain the three sequential negative tests required, nor is there any guarantee that subsequent tests would be negative.

A detailed patient history is excluded, both to preserve anonymity, and because social worth criteria, such as income, work history, social history, etc., are not included in organ transplant decisions (by policy and as interpreted from federal law; see 42 CFR part 121). The local transplant committee did screen, assess, and determine that this patient was a good candidate for transplant, if stable housing is secured. For analysis and argument, the patient could be given any number of histories ending with homelessness and the need for a liver transplant. For example, perhaps the patient was a university professor who was in a car accident, severely injured and experiencing the death of family members, and liver failure resulted from both injuries sustained in the accident and the use of pain control medications. Perhaps homelessness is the result of the physical and psychological trauma of that experience. Perhaps the patient is in liver failure due to chronic hepatitis acquired via sexual activity decades ago. Perhaps the patient is homeless due to a series of events stemming from the inability to work due to the health issues concomitant with liver failure.

Ethical Issues and Disagreements

In this case, some social workers may want to exclude the positive result, citing the primacy of the patient's interests, the critical need for housing, and the locally permissive context regarding marijuana. Yet others may feel that it is appropriate to include the positive screen from the perspective of maintaining personal and professional honesty and integrity, and out of concern for the consequences to professional reputation for what could be viewed as a misleading or dishonest referral. Others' concerns may arise from circumventing socially sanctioned federal program rules to access and allocate scarce housing resources to one person over another. Some could argue that the patient's choice and engagement in questionable behaviors assumes the consequences of associated harms, including the loss of housing options. Some social workers and medical staff may want to consider the patient's history of why their liver is failing, and how they became homeless as relevant to ethical decision making in this case. Others may want to consider the patient's history and background for experiences of disadvantage or oppression that could enter into consideration and support reparative actions in the present. To help resolve these ethical issues, both the social worker and the medical staff should apply ethical models or principles to facilitate an analysis.

Bioethics Models

The social worker in this case is operating within a medical setting and medical models of ethics dominate. Different medical and social work ethical models can yield conflicting conclusions and courses of action. The dominant bioethics framework in the United States is "principlism" (McCarthy, 2003) as exemplified by Beauchamp and Childress (2009) and the application of the principles of Autonomy, Beneficence, Nonmaleficence, and Justice to ethical issues and dilemmas. Under principlism, each principle is applied to the case, with none taking precedence over the others. Beauchamp and Childress argue that all four principles have prima facie standing in that they should not be overridden without serious and compelling reasons. However, in clinical reality, autonomy always takes a central and overriding role (Callahan, 2003; Walker, 2009).

Under principlism, it is clear that the patient's capacity for action and autonomous choices, free from influence, would support the referral to housing. A denial of housing the patient wants would result in a loss of transplant eligibility and the eventual death of the patient. Although it could be argued that the patient made an autonomous choice to use illegal drugs, and that choice assumes future consequences such as loss of housing eligibility. Beauchamp and Childress (2009) argue that respect for autonomy does not require a provider to lie, rather it requires truth telling to the patient; however, the application of autonomy is to the patient and their free choices, not to the provider's choices to omit or not the positive drug test from the housing referral. Beneficence, a positive duty to do good and prevent harm, would support the housing referral, as it benefits the patient substantially and prevents serious harms. Nonmaleficence, to not harm, also supports aiding the patient in securing housing and avoiding death.

The application of Justice in principlism is a complex undertaking. It requires a look at the fair distribution of goods and resources, according to socially and legally sanctioned determinations of what is morally relevant between individuals and among all members of society (Beauchamp & Childress, 2009). It is the most difficult principle to apply, and the most often subjugated to the other principles, as Beauchamp and Childress note that under conditions of scarcity, principles of justice may be sacrificed (2009). In this case, it appears that it is just to deny the patient housing, as this would be fair and equal treatment in applying the federal housing rules to all citizens of the country. In addition, the locally permissive context may represent an unfair advantage of this patient over other patients in more federally compliant states. Justice may also consider the clear need of the patient and support the housing, but it may also consider merit and social utility, taking into consideration the social history and choices of the patient.

An apparent weakness of principlism is that it does not directly address issues of professional honesty and integrity. The framing in Beauchamp and Childress (2009) is from the perspective of conflicts with the patient, rather than conflicts with external, non-medical systems, such as supported housing programs. Under the principle of beneficence, there is consideration for cost-benefit analyses, which seems to support withholding the positive drug test from the housing referral, but again, focused on patient-level medical benefits. Within beneficence, there is support for honesty by providers. There is a strong caution within beneficence about soft-paternalism and making decisions on behalf of patients, which could apply to the provider choosing to disclose or not disclose the drug testing results without the patient's knowledge or consent.

In the case presented here, the medical staff and social workers are trained in and utilize the Jonsen model (Jonsen, Siegler, & Winslade, 2006) rather than principlism. Jonsen's approach emphasizes an analysis based on the four areas of medical indications, patient preferences, quality of life, and contextual features. These focal areas are meant to be a more practical approach with which to arrive at more direct actions than in principlism, while at the same time, the four areas are representative of the principles of principlism. In this case, the Jonsen model does seem to be more direct and actionable. The success of patient housing is directly related to the medically indicated transplant, and clearly, the patient's preference is to continue living, which would also enhance quality of life.

In contextual features, however, the issues of financial and economic factors do affect the situation (preventing housing and thus transplant), as do concerns about the allocation of scarce resources. On a programmatic level, the transplant service already believes this patient to be a good transplant candidate. Yet, concerns may exist about the use of federal tax dollars to subsidize housing and health care for a patient engaged in federally illegal behavior. Others' concerns may include the ethics of a patient engaging in behavior that although not impermissible in one sense, may still jeopardize health and housing, and the fact that by their own behavior, the patient is now technically not eligible for the housing program. The patient's history, and how they came to be in a temporary homeless shelter setting and in need of both housing and a liver transplant is not necessarily considered in the deliberations, other than that all transplant program criteria for compliance, caregivers, housing, etc., must be and are met.

Like principlism, the Jonsen approach falls short on issues professional honesty and integrity. Jonsen et al. (2006) do address paternalism within patient preferences, making a case for an informed consent process that supports communication, shared-decision making, and mutual respect and participation. This supports the patient as knowing of the housing referral issues, but does not seem to provide direction on the potential omission of the positive drug test in this case. Under quality of life, Jonsen et al. (2006) discuss "proportionate care (p. 140)" in terms of the omission of medical information, but again, with a focus on patient-level information exchange, rather than with larger systems. They do argue that there is an obligation to preserve life that could be interpreted to support the omission of the positive drug test.

Under the Jonsen model it is clear that there are medical indications for transplant, and the transplant committee evaluation and recommendation seems to integrate the locally permissive context of the case. However, the most interesting applications to this case are found in contextual features. Jonsen et al (2006) note that some interpret a fiduciary duty wherein providers owe, "an undivided loyalty to clients and must work for their benefit (p. 163)." Additionally, Jonsen et al. discuss an "unrestricted advocacy" view that suggests a providers' "only allegiance is to individual patients; societal or institutional costs are not relevant to clinical decisions (p. 178)." However, Jonsen et al. disagree with this position, arguing for a restricted advocacy that allows for consideration of costs and benefits balanced against patient preferences. Like Beauchamp and Childress (2009), the framing and examples cited here speak primarily to patient-level concerns, rather than systemic issues.

A Social Work Ethical Analysis

The medical ethical models utilized by medical staff in discussing a case such as this can be used to interpret the ethical dilemmas, as noted above, but do not necessarily lead to definitive conclusions with which all would agree. In the interdisciplinary team setting, other methods of ethical analysis can enrich the deliberative process. Applying the NASW Code of Ethics (NASW, 2008) may enlighten this discussion further, and if possible, support a course of action. As ethical deliberation is more about a good and thorough process, multiple different courses of action can be ethically supported. In the end, a well-documented and engaging process that considers multiple perspectives and opinions is desired. The objective is to arrive at considered judgments, about which there is a high degree of confidence, and in which there is minimal bias (Beauchamp & Childress, 2009). The focus of this analysis section is on the NASW Code of Ethics and those standards that apply to this case and that will be used in order to reach considered judgements.

The NASW Code of Ethics (the Code) situates social work ethics within the primary obligation of social workers to enhance the wellbeing of both individuals and society, with particular attention to the vulnerable and oppressed (NASW, 2008). Social workers are challenged to promote social justice and social change on behalf of clients. The Code is used as a guide that can help identify and analyze issues. The Code does not specify which values, principles, and standards contained therein are the most important or which might outweigh others. Content of the Code must be balanced against other content, as well as the complexities and context of each situation and the people involved. The Code stresses the professional values of service, social justice, the dignity and worth of all people, and the integrity of the profession. Social workers are expected to help people in need, to strive for equality of opportunity and meaningful participation in life, to advocate for both clients and the broader society, and to behave in an honest and trustworthy manner (NASW, 2008). These values and principles are operationalized in the ethical responsibilities stated in the Standards of the Code.

The first Standard in the Code, reflecting the value and principle of the Dignity and Worth of the Person, is Standard 1.01, Commitment to Clients. This Standard clearly states that the "social workers' primary responsibility is to promote the wellbeing of clients" but also notes that there is a responsibility to the larger society, which "may on limited occasions supersede the loyalty owed to clients." Standard 1.02 on Self Determination furthers the interest of clients by specifying the social workers obligation to "respect and promote the right of clients to self-determination." In both of these Standards, it seems that the social worker would be ethically supported in omitting the positive drug test. This action will promote the well-being of the client to a great extent (preventing death), and would certainly be the client's self-determined choice of action. The responsibility to society clause could be interpreted to support the social worker including the positive drug test, given that this is the determined and sanctioned rule of the larger society, although the conflicting state and federal laws on marijuana weaken this argument substantially. This and the term, "limited occasions" suggest that, in this case, the ethical responsibilities to the client are primary, and the positive drug test should be omitted from the housing referral.

Given that the housing referral itself is a disclosure of confidential information protected by both professional ethics and the law, Standard 1.07 of the Code on Privacy and Confidentiality must also be considered. The social worker must have appropriate and valid consent (section (b)) from the client to make the referral, and in this process, section 1.07(c) states that, "in all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed." This section of the Standard suggests a contradiction in this case; that the "least amount necessary to achieve the desired purpose" could be interpreted to support the omission of the positive

drug test, as the desired purpose of the referral is access to stable housing. And yet this same information, by the housing program rules, is "directly relevant to the purpose for which the disclosure is made." However, the conflicting state and federal perspectives on marijuana call into question the relevance of the positive drug screen, and again this supports the omission of the positive drug test in this case.

Thus far in this analysis the role of the client and their knowledge of the ethical dilemmas related to the housing referral have not been noted. Standard 1.07(d) of the Code on Privacy and Confidentiality notes that, "Social workers should inform clients, to the extent possible, about the disclosure of confidential information **and the potential consequences**, when feasible before the disclosure is made [emphasis added]." Standard 1.07(e) extends the obligation of the social worker to inform clients of disclosures and consequences "as needed throughout the course of the relationship." The privacy and confidentiality Standard clearly indicates that the client in this case must be informed of the disclosure, and its potential consequences, which places the social worker in the uncomfortable position of having to either disclose the lie of omission, or lie about it, or having to disclose their intent to include the positive drug test in the referral, the consequences of this disclosure, and deal with the patient's reaction. Standard 1.07(d) and (e) do not contribute to the resolution of the issues in this case, but do add contextual considerations that would influence the social worker's decision making process. Thus far, this analysis and the primacy of the client's interests do seem to support the omission of the positive drug test in this case.

Further contextual or process-oriented guidance from the Code is noted given the fact that the social worker in this case is functioning as a member of an interdisciplinary liver transplant team, and has ethical responsibilities to colleagues. Standard 2.03(a) of the Code on Interdisciplinary Collaboration states, "social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients," and in particular should contribute the unique perspectives of the social work profession. Standard 2.05(a) on Consultation adds, "Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients." Both of these Standards strongly support the social worker involving the team in the decision about the housing referral and the positive drug test. The social worker in this case should not be making this decision alone, without collaboration, consultation, and supervision.

Returning to the Code for guidance on the opposing courses of action of disclosing or omitting the positive drug test, the social worker's ethical responsibilities as a professional and to the social work profession must be considered. A core value and principle of the Code and the profession is that of Integrity, with the ethical principle stated as, "social workers should behave in a trustworthy manner." The Code clearly states, "social workers act honestly." This principle is reflected throughout the Code, most prominently in Standard 4.04 which states "Social workers should not participate, condone, or be associated with dishonestly, fraud, or deception." Standard 5.01(a) on the Integrity of the Profession further states, "Social workers should work toward the maintenance and promotion of high standards of practice." These are the strongest elements of the Code that support the honesty of the social worker and the potential consequences to their own reputation and that of the profession should they omit the positive drug test. These sections and the central values of honesty and integrity strongly support the inclusion of the positive drug test in this case. However, given that this conflicts with the other courses of action supported by the Code thus far, it could be argued that on whole or on balance, the Code and this analysis are more supportive of the omission of the positive drug test in this case.

In the final sections of the Code for consideration, the social worker's ethical responsibilities to the broader society need to be considered in terms of advocacy opportunities in this case, as is consistent with the core value and principle of

Social Justice. Standard 6.01of the Code on Social Welfare states in part, "social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice." This Standard supports the social worker advocating for the living conditions that will allow the client to fulfill their basic human need for housing, and for continuing to live. This Standard and Standard 6.04(a) and (b) on Social and Political Action also support the social worker promoting social change, advocating for equal access to resources, and acting to expand choice and opportunity for all people.

Given the conflicting state and federal perspectives on marijuana, at a minimum social workers should be advocating for clarity and consistency on this issue. As applied to this case, these Standards, particularly 6.01 on "living conditions conducive to the fulfillment of basic human needs" suggest that the social worker should be advocating for the client's right to access housing despite the positive drug test. This is a difficult position to take though, as it draws the client into a political situation, and this approach would most likely not lead to stable housing. Advocacy in the face of a federal program rule backed by federal law will not benefit this client at this time. The social worker would be better advised to seek changes or exemptions from the housing program rules separately from this individual case. The tone and spirit of the advocacy and social justice content of these sections of the Code do seem to support the omission of the positive drug test in this case and/or are overridden by the primacy of the client's interests and other sections of the Code.

Conclusion and Implications

The social work ethical analysis based on the Code suggests that in this case and the situation as it now stands the social worker is stuck in the middle of unresolved conflicting laws and varied social beliefs about marijuana. The client also occupies this conflicted space, where the social worker stands beside them in the helping role. Notably, nowhere in the ethical analysis from the social work and Code perspective did the history of the client enter into consideration, nor did client demographics that might influence social justice concerns in terms of advocating for the vulnerable and oppressed. It is notable that the Code speaks to social worker's challenging social conditions on a macro and advocacy level that does not suggest or imply such actions in an immediate or emerging clinical situation. The conception of social justice within the Code is lacking in terms of specific guidelines on distributive justice and the allocation of scarce resources (Furman, 2003). Although the Code emphasizes justice as a core value (Galambos, 1999), it is highly focused on advocacy for the disadvantaged and oppressed (NASW, 2008; Reamer, 2006), and weak in terms of concerns for the equitable distribution of social goods.

The moral permissibility of the client's quasi-illegal drug use did not enter into the ethical deliberations either. Interestingly, the locally permissive context and conflicting laws did contribute to the analysis and arguments in some areas, where these facts seemed to weaken support noted within the Code for disclosure of the positive drug test. In the end, the primacy of the client's interests and overwhelming need for continuing to live support the omission of the positive drug test.

The central values and principles of Social Justice, and the Dignity and Worth of the Person seem to come into conflict with the value of Integrity, which is a classic form for an ethical dilemma (Beauchamp & Childress, 2009). Actions in support of one principle would violate the other and vice versa. Looking at the case analysis in its entirety, the most supported conclusion and course of action is to omit the positive drug test from the housing referral. Though this is the considered judgment in this case, reasonable people may disagree (Reamer, 2006) and this conclusion is not fully supported. The social worker, the interdisciplinary team, and the client will determine the outcome in this case, and every case should be decided individually and contextually. Simply moving this case to another jurisdiction that does not permit or allow marijuana

use could easily tip the balance in favor of including the positive drug screen. This raises further issues of consistency and fairness (and social justice) across jurisdictions.

In terms of social work practice, in addition to individual and contextual case analyses, this case indicates the need for social workers and social work agencies to consider practice guidelines and policies that could help resolve this and similar ethical dilemmas. Social work as a profession and individual practitioners need to determine a policy stance regarding the issue of recreational marijuana use, beyond considerations of whether or not marijuana use promotes the wellbeing of the individual client (Milhorn, et al., 2009), although this remains a concern. At a minimum, advocacy for changes in legislation and clarity between state and federal law is needed. Further social work research on the social impact and implications of marijuana use and changing social attitudes would also help to clarify the issue and inform future cases.

Social work education programs should consider how and what to teach on the issue of marijuana use, especially as it arises in ethical dilemmas such as this case. Social work education needs to stress the complexity of ethical cases and dilemmas, and to teach a process of ethical analysis and decision-making. The unique contributions of the social work ethical perspective are a great addition to the medical ethical models, as this case analysis demonstrates. As states and localities continue to evolve and change on the issue of marijuana, these dilemmas will only become more prevalent and potentially problematic. Social workers need to be prepared for these types of cases, and the uncomfortable position of being stuck in the middle alongside clients.

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