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TO: Karen S. MacLean, Rules Coordinator
Board of Pharmacy
800 NE Oregon Street
Portland, OR 97232

RE: Rescheduling of Marijuana

I am the legal counsel for Oregon Green Free, a non-profit 501(c)(3) educational organization that has a membership of over 5000 Oregon Medical Marijuana cardholders. I have a Master's Degree in Biochemistry and Molecular Biology from Oregon Health and Sciences University where I was involved in medical research for over three years. I have a Bachelor of Science degree in Chemistry from Duquesne University where I was involved in undergraduate research for three years. I was previously an Assistant Attorney General for the State of Oregon under Hardy Myers, and led a team of attorneys in drafting administrative rules and acted as the hearing officer for those rules. During law school, I worked as a law clerk at Bonneville Power Administration, a federal power-marketing agency, where I advised the agency on questions of statutory authority, statutory construction, and administrative law.

Starting with the legal perspective, an administrative agency, such as the Board of Pharmacy is granted its authority under its enabling statute, and its rulemaking authority is limited to that granted by the legislature. In Oregon, the legislature has enacted specific criteria for rescheduling controlled substances that are different than the criteria under the federal Controlled Substances Act, and the federal criteria do not apply to determination of the schedule in Oregon. In fact, the Oregon Court of Appeals stated, "Oregon has its own standards for amendment of the schedule, as set out in ORS 475.035.⁸ We agree with respondent that, because ORS 475.035 antedates the federal act, ORS 475.005(6) and ORS 475.035 show a legislative policy to apply different criteria from those of the federal act." *State v Eells*, 72 Or. App. 492, 498 (1985). Therefore, the criteria under Oregon law must be applied and not the criteria under the federal Controlled Substances Act.

The first problem with the analysis and criteria used by the Board of Pharmacy (Board) in arriving at its proposed rule is that the Board addressed and used the criteria under the federal Controlled Substances Act and not the criteria under Oregon law. See the Brief prepared by Paige Clark setting out an analysis under the federal Controlled Substances Act dated January 19, 2010.

On March 29, 2010, at the Advisory Committee on Medical Marijuana Meeting, Gary Schnabel, Executive Director of the Oregon Board of Pharmacy spoke about the rulemaking process and the decision to propose that Marijuana be classified under Schedule II. Mr. Schnabel stated: “I can tell you one of the issues that I have heard discussed, but I think it relates to your question about whether it’s more appropriate for schedule III or schedule II, the issue of potential for abuse may appear like it’s a schedule III when you compare it to products like Ibuprofen (may have meant vicoprofen) or Tylenol 3 or the opiates that fit into Schedule III. The difference that I have heard discussed at the Board is that there is not a controlled distribution system for marijuana like there is the FDA approved drug products for pharmacies, and that could magnify the abuse potential making it more available outside of the controlled system.” (Transcribed from a recording of the March 29, 2010 ACMM meeting) This rationale is based on the “potential for abuse”, which is one of the criteria under the federal Controlled Substances Act. 21 USC § 812. Under Oregon law, the corollary is the “potential consequences of abuse.” ORS 475.035(1) In Oregon, the legislature is concerned about the “potential consequences of abuse”, instead of the “potential for abuse.” Therefore, using a less controlled distribution system as a criteria related to potential for abuse is beyond the scope of the Board of Pharmacy’s statutory authority. Additionally, once in the patients’ hands, drugs like oxycontin often make it into the hands of others regardless of the controlled distribution system causing much greater damage to society. The distribution system argument appears to be a red herring.

When examining the potential consequences of abuse, the definition of abuse must be considered. Under Oregon law, ““Abuse” means the repetitive excessive use of a drug short of dependence, without legal or medical supervision, which may have a detrimental effect on the individual or society.” ORS 475.005(1). When looking at this criterion, it becomes clear that marijuana is far less addictive than all of the Schedule II drugs, and most of the Schedule III drugs as well. The use of Schedule II

substances like hydrocodone is far more detrimental to the individual and society than marijuana. Hydrocodone has an ld50 of 375 mg/kg, while marijuana has never been known to independently cause an overdose, and it has been estimated that an individual would have to smoke 46 pounds of marijuana to overdose. The oral ld50 for pure THC in rats has been found to be 1000 mg/kg, while an ld50 was not attainable in monkey or dog models. “Assessment of risk-taking behavior revealed that under the influence of marijuana, users tend to become more conservative in their decision making.” *Acute Effects of Marijuana*, The Report of the National Commission on Marijuana and Drug Abuse. With marijuana, “[s]ome tolerance does occur with prolonged heavy usage; large drug doses are necessary for the desired effects. Abrupt withdrawal does not lead to a specific or reproducible abstinence syndrome and physical dependence has not been demonstrated in man or in animals.” *Marijuana - A Signal of Misunderstanding*, the National Commission on Marijuana and Drug Abuse.

The opiates and synthetic opiates can induce a stupor or sleep and even cause death in much lower doses than marijuana, and are therefore far more dangerous to society in terms of potential accidents and neglect of duties, or in the case of overdose. Schedule II drugs have been shown to cause deaths, while marijuana has not. In fact, even codeine, a Schedule III pain relief drug is far more dangerous with an oral ld50 in rat at 427 mg/kg. According to NIDA, opioids can be taken orally, or the pills may be crushed and the powder snorted or injected. A number of overdose deaths have resulted from the latter routes of administration, particularly with the drug OxyContin, which was designed to be a slow-release formulation. Snorting or injecting opioids results in the rapid release of the drug into the bloodstream, exposing the person to high doses and causing many of the reported overdose reactions. Opioid addiction is very difficult to overcome and requires medical supervision and often the substitution of other opioids or receptor agonists, and many of those addicted are unable to ever overcome their addiction. *NIDA InfoFacts: Prescription and Over-the-Counter Medications*.

Another consideration is the classification of marinol or dronabinol, which is classified as a Schedule III drug under both Oregon law and federal law. Marinol is a synthetic, purified form of the primary active ingredient of marijuana, delta-9 THC. If we look at other purified forms of drugs versus compounded, less pure counterparts, we find that the less pure counterparts

are all scheduled in either the same schedule as the purified form or one schedule below. For example, hydrocodone is Schedule II, but vicodin, which is Tylenol plus hydrocodone is in Schedule III. With oxycodone, both the pure form and compounded forms like Percocet are all in Schedule II. In fact, under ORS 475.035(3), “[i]f a substance is an ingredient of a controlled substance, the ingredient shall be considered to be in the same schedule as that controlled substance.” In the current case, dronabinol is a synthesized delta-9 THC, which is the primary active ingredient of marijuana and is a currently a Schedule III, and therefore, ORS 475.035(3) appears to suggest that dronabinol and marijuana should be in the same schedule, Schedule III, and based on the scheduling of other substances that are pure versus their compounded counterparts suggests that marijuana should be in Schedule III or Schedule IV.

It is interesting to note that a previous version of the Oregon Controlled Substance Act created the:

“Committee on Controlled Substances (Committee), ORS 475.075, and authorized the Committee to review the federal controlled substances schedules and to "add, reclassify or delete" any drug from the federal schedules "based on the total hazard potential of the substance." ORS 475.025, 475.015. The Act established the federal schedules as the interim classifications, ORS 475.015(2), which apply until new schedules are adopted. Upon completion of the Committee's review, the State Board of Pharmacy (Board) is required to "issue a rule controlling the substance consistent with the schedules in ORS 475.015 (i. e., the schedules created by the Committee)." ORS 475.035(3). The Board is required to act within thirty days following the Committee's classification of a substance. ¹ ORS 475.055.”

State of Oregon v Joyce, 54 Or.App. 924 (1981)

The Committee classified marijuana under Schedule IV, the Committee completed its work in August, 1979, and the Board of Pharmacy was notified of the Committee's schedules soon after. The Board of Pharmacy never acted, and under the law at that time, the Board of Pharmacy had no discretion but to adopt the schedules proposed by the Committee. See 39 Op.Att'y Gen. 376 (Or.1978). See

State of Oregon v Joyce, 54 Or.App. 924 (1981) The Board of Pharmacy never adopted the mandated schedule under the former law, but should take into consideration the fact that it should have adopted marijuana as a Schedule IV drug in 1979, which was based on the study and recommendation of a committee specifically established for that purpose.

Additionally, on the federal level, “the National Commission on Marihuana and Drug Abuse was created by Public Law 91-513 to study marijuana abuse in the United States. While the Controlled Substances Act was being drafted in a House committee in 1970, Assistant Secretary of Health Roger O. Egeberg had recommended that marijuana temporarily be placed in Schedule I, the most restrictive category of drugs, pending the Commission's report. On March 22, 1972, the Commission's chairman, Raymond P. Shafer, presented a report to Congress and the public entitled "Marijuana, A Signal of Misunderstanding," which favored ending marijuana prohibition and adopting other methods to discourage use.” The commission found that marijuana should be decriminalized stating: “the criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use. It implies an overwhelming indictment of the behavior which we believe is not appropriate. The actual and potential harm of use of the drug is not great enough to justify intrusion by the criminal law into private behavior, a step which our society takes only 'with the greatest reluctance.” The Commission went on to state that: “while the judiciary is the governmental institution most directly concerned with the protection of individual liberties, all policy-makers have a responsibility to consider our constitutional heritage when framing public policy. Regardless of whether or not the courts would overturn a prohibition of possession of marihuana for personal use in the home, we are necessarily influenced by the high place traditionally occupied by the value of privacy in our constitutional scheme.” Apparently, the commission viewed the prohibition of marijuana as potentially unconstitutional. *Wikipedia*

http://en.wikipedia.org/wiki/National_Commission_on_Marihuana_and_Drug_Abuse

In the current process of rulemaking by the Board of Pharmacy, we see discriminatory, baseless accusations about marijuana use being brought before the Board of Pharmacy in a meeting with the Oregon Narcotics Enforcement Association, the Oregon District Attorney's Association, and various other individual police officers who came in and requested that

marijuana be rescheduled no lower than Schedule II. The minutes based on statements made by the foregoing parties at Board of Pharmacy meeting state: "Marijuana use is directly linked to a high percentage of crimes including: neglect of children, sexual abuse, child abuse . . ." Saying it is directly linked makes it sound like there is a causal connection between marijuana use and sexual abuse or child abuse but there is absolutely no scientific, psychological, or statistical evidence that even vaguely supports this contention. While marijuana may have been found where people have been arrested for child abuse or sexual abuse, so have prescription drugs, alcohol, methamphetamine, and many other substances; looking at the fact that the National Commission on Marijuana and drug abuse found that marijuana users tend to become more conservative in their decision making, it is not appropriate to find that marijuana is somehow causally connected to abusive behavior; it might be more appropriate to say that there is a beneficial side effect to marijuana in making the user more cautious in his or her decision making process. The contention made by law enforcement is unsubstantiated, contradicts a federal study, and it should not be considered.

Washington County Deputy District Attorney (DDA), Bracken McKey states that "I'm not suggesting that everyone who smokes marijuana beats their wife and withholds medical attention from their children, but in cases where there IS neglect or abuse, marijuana is often a component." However, the testimony presented by DDA McKey is revealing in that it does suggest that marijuana is equivalent to child abuse, and downplays methamphetamine, alcohol, or other factors that are likely the true contributing factors to abuse and violent crimes, such as robberies of grow sites, which are seen rarely in the news when considering the number of registry cardholders. If a pharmacy gets robbed, do we blame the patients who legitimately use the prescription drugs? Another interesting point to dissect from DDA McKey's comments is related to the positive tests for marijuana for DUI offenses; it is well established that marijuana is fat soluble and stays in your system an extremely long time compared to methamphetamine and virtually all other drugs. How many of the positive tests were for people under the influence of marijuana at the time of the incident? How many of the positive tests were people actually impaired by marijuana at the time? Again, remember that the federal study shows that marijuana users tend to become more conservative in their decision making, so the answer is that very few were likely a danger to anybody due to marijuana use, while those who tested positive for meth or alcohol were far more likely to be actually impaired and prone to violence.

Anecdotally, I spoke with an Oregon Sheriff regarding a person on close street supervision who lived at a medical marijuana grow site. I asked the Sheriff whether the marijuana grow site was going to present a problem. The Sheriff stated that there was no concern that a marijuana user smoking a joint would get up off the sofa and take a swing at the Sheriff, unlike alcohol or meth users where the danger of violence is increased. As a humorous aside, it has been said that the only thing a marijuana user might attack is his or her refrigerator, which speaks to its efficacy for severe nausea or cachexia. Upon examination, the idea that marijuana users are violent or reckless simply does not hold water.

The slide show presented to the Board of Pharmacy was also presented by the police at the Oregon legislature in 2009 and was substantially discredited. They showed legal grow sites and called it abuse, when many patients use an outdoor garden as a once a year grow to supply their medicine for an entire year. If we look at DHS statistics regarding complaints about the OMMP over the fifteen-month period from March of 2008 to June of 2009, there were a total of 122 complaints for a program with over 36,000 cardholders. This is a very small figure equivalent to 3 complaints per 1000 cardholders over a 15 month period. Clearly, the OMMP is not a program rife with abuse.

Law enforcement has a clear conflict of interest in its desire to keep marijuana in a classification that allow them to jail users and continue in their attempts to overturn the Oregon Medical Marijuana Act (OMMA), as demonstrated in the Oregon Sheriffs Association's latest newsletter calling for an end to the OMMA. The Board of Pharmacy should be aware that the law allows 6 plants over 12" and 18 plants less than 12" tall or 12" wide. A medical marijuana patient who does not check on the garden for a day or two may discover that some of the smaller plants have outgrown the 12" limitation and need to be trimmed back, but if law enforcement shows up at their door, they are now convicted of a Class A Felony. Marijuana is a rapidly growing plant and it is very difficult under the current law for a patient to stay in compliance and have medicine, while the police use this same untenable provision to arrest patients, and in turn attack the OMMA. There was an Oregon case where a patient cut each branch of the plant and had their medicine hanging to dry, and the District Attorney had the judge instruct that each hanging branch was a plant; needless to say, those patients were convicted and went to prison. Therefore, to say that the choice of Schedule does not affect patients is not true as they face discrimination

based on the attempts of law enforcement to arrest patients so that they can repeal the OMMA. See *Oregon Sheriff*, Oregon Sheriffs Association Volume 27, Number 8, Spring 2010. Law enforcement has a financial stake in the continued criminalization of marijuana with stiff penalties for patients, property seizures, and job security, none of which are appropriate considerations for the Board of Pharmacy under its enabling statute. The legislature is the appropriate forum for the issues law enforcement has brought before the Board of Pharmacy. The Board of Pharmacy is not a criminal justice commission or legislative body.

At the March 29, 2010 ACMM meeting, Gary Schnabel, the Executive Director of the Board of Pharmacy also spoke about the law enforcement view that the rescheduling could create a conflict with existing laws, and wanting to keep the criminal penalties for marijuana high. This is clearly not within the purview of the Board of Pharmacy to consider; again, this is a matter for law enforcement to take up with the Oregon legislature after the rescheduling is completed based on the Board of Pharmacy's statutory authority.

The statutory criteria under Oregon law are as follows: “[i]n arriving at any decision on changes in or addition to classification when changes or additions are proposed by the federal Drug Enforcement Administration or by any other reliable source, the State Board of Pharmacy shall review the scientific knowledge available regarding the substance, its pharmacological effects, patterns of use and misuse, and potential consequences of abuse, and consider the judgment of individuals with training and experience with the substance.” ORS 475.035(1)

The scientific knowledge regarding marijuana has shown it to be a non-toxic, safe, and effective medicine for a variety of conditions, with a unique pharmacology based on the endocannabinoid retrograde signaling pathway, which is less addictive and toxic than its opiate counterparts and more effective for neuropathic pain and a variety of conditions. Many patients now use vaporization to effectively titrate dosage for optimal relief and avoid any of the health problems associated with smoking. For thousands of years, marijuana was considered a safe and effective herbal medicine and used in many parts of the world as such. It is only over the last 83 years that use has been denied in the United States based on prejudice and fear-mongering. Current medical use in Oregon indicates a very low level of abuse as shown by the very low rate of complaints to DHS, and the

very few arrests for non-compliance in comparison to the number of registry cardholders. The program shows very low abuse rates, and the potential consequences of abuse are far lower than any Schedule II, and most, if not all Schedule III substances, including but not limited to the synthetic opiates, natural opiates, and diazepam family of drugs, all of which can and do cause overdose deaths. The patients and scientific community, including the AMA recognize the medical use of marijuana and support it's use as a medicine, while law enforcement refuses to accept the science and continues the path of discrimination and fear-mongering in an attempt to turn back the clock and recriminalize all use of marijuana. You can trust the AMA and the scientific community to provide valid, substantiated information, and they are the experts with training and experience who should be listened to, and whose knowledge should be applied in accordance with the statutory mandate. The analysis is clear and unambiguous that the application of the factors under Oregon law call for a scheduling marijuana in Schedule III or lower, but do not substantiate placing marijuana in Schedule II.

Based on the factors and analysis presented, classifying marijuana as a Schedule II drug would be arbitrary, capricious, and an abuse of agency discretion; and subject to judicial reversal.

Historically, marijuana has been used as a non-toxic herbal medicine for thousands of years; it is only over approximately the last 83 years that it has been outlawed and denied to patients. Those who use marijuana medically still face stigmatization and are discriminated against. That stigmatization is based on fallacies and prejudices that were originally stated as the reasons for the prohibition of marijuana and continue to this day.

Some quotes about marijuana over the past 115 years:

"In their mad excitement the men tear the garments from their bodies, throw away their weapons, fling the turbans from their heads and, naked to the waist, with disheveled hair and eyes ablaze and extended arms, they continue their mad antics, until foaming at the mouth and bleeding from the nostrils, they sink to the earth and lie huddled in heaps, hopelessly and helplessly intoxicated with the hemp." - New York Herald: Orgies of the Hemp Eaters, 1895

"Marihuana is the most violent drug in the history of mankind." "There are 100,000 total marijuana smokers in the US, and most are Negroes,

Hispanics, Filipinos and entertainers. Their Satanic music, jazz and swing, result from marijuana usage. This marijuana causes white women to seek sexual relations with Negroes, entertainers and any others. -Harry Anslinger Assistant Prohibition Commissioner in the Bureau of Prohibition testimony to US Congress supporting Marihuana Tax Act, 1937

"We felt the effects of herb were so dangerous that it was better to lie to the American public to save them rather than tell them the truth..." - the Media Partnership for a Drug Free America admitted on November 17, 1989 that they had used the brain waves of a person in a coma and represented them as those of a marijuana user. When asked by ABC reporters why they did that, they replied with the quoted statement. Partnership for a Drug Free America

"Permanent brain damage is one of the inevitable results of the use of marijuana." Ronald Reagan, in the Los Angeles Times (1974).

"Marijuana leads to homosexuality, the breakdown of the immune system, and therefore to AIDS." -- Carlton Turner. White House Drug Czar under Ronald Reagan.

"Marijuana use is directly linked to a high percentage of crimes including: neglect of children, sexual abuse, child abuse . . ." Minutes from presentation by the Oregon Narcotics Enforcement Association, the Oregon District Attorney's Association, and various other individual police officers to the Oregon Board of Pharmacy, August 12, 2009.

On behalf of all medical marijuana patients in Oregon, I am requesting that the Board of Pharmacy follow the science, the law, and common sense in making its decision on rescheduling marijuana. Patients are trying to overcome the historical and ongoing stigmatization and discrimination as evidenced by the quotes above. Do not allow the Board of Pharmacy to assist in the continuation of discrimination and stigmatization by making its decision based on political pressure. At the ACMM meeting, when Mr. Schnabel suggested that marijuana may seem more like a Schedule III than a Schedule II, he was absolutely right. Schedule II is not the right classification for marijuana, and the lack of a controlled distribution system is not an appropriate consideration. It should not be forgotten that the Board of Pharmacy was mandated by Oregon law to reschedule marijuana as a Schedule IV in 1979, but failed to do so. We are simply asking the Board of Pharmacy to fulfill its duties today in conformity with

its statutory authority, as any actions taken or considerations outside of the agency's statutory authority are arbitrary and capricious, and an abuse of discretion.

Thank you for your consideration of my comments and those of the medical marijuana patient community as a whole. We look forward to the day when discrimination against patients with debilitating and chronic medical conditions who choose marijuana, a natural medicine with low consequences of abuse, over highly addictive pharmaceutical pain killers, with high consequences of abuse, are no longer stigmatized and singled out by those who would take away their right to a medical treatment recommended by their doctor. Medical decisions should be left between a doctor and a patient.

Sincerely,

A handwritten signature in black ink, appearing to read 'Gregory P. Barton', with a long horizontal flourish extending to the right.

Gregory P. Barton
OSB # 95208