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OREGON BOARD OF PHARMACY

Testimony for the Oregon Board of Pharmacy Concerning the Rescheduling of Cannabis

By John Sajo, Director, Voter Power Foundation

My name is John Sajo. I am the Director of the Voter Power Foundation, which is actively involved in promoting reform in marijuana laws and policies. Voter Power assisted in the drafting of the Oregon Medical Marijuana Act and worked on the campaign to pass that initiative. We have been involved with many aspects of implementing the law since then including assisting patients in qualifying for the OMMP, assisting patients in developing a safe reliable supply of medical marijuana, commenting on administrative rules, monitoring criminal prosecutions, and commenting on proposed legislation. Voter Power also drafted and is sponsoring Initiative # 28 which will create a regulated supply system for medical marijuana.

I have attended four conferences on Cannabis Therapeutics since 2002. Much of our work is motivated by the desire to have marijuana policy based on science and not fear and prejudice.

Voter Power has called for rescheduling of marijuana under both state and federal schedules. I testified at the Public Hearings on SB 728 and called for amending the original draft of that bill to place marijuana in a schedule higher than Schedule II.

I urge you to place marijuana in Schedule IV or V. I believe that this is the placement dictated by the science and will result in the best public policy.

First, let me comment that this is a challenging problem for the Board of Pharmacy. Marijuana is probably the most controversial and least understood of all the controlled substances. We can't even agree on how to spell the word marijuana. In the CFR, Title 21, Section 1308.11, the Drug Enforcement Administration schedules "marihuana" as substance # 7370, a hallucinogen, and spells it with an "h". Oregon law and most common usage spells it with a "j". This seemingly innocuous disagreement about how to deal with marijuana is reflected at nearly every level of marijuana policy.

There is conflict between federal law and state law on marijuana. There is even conflict within federal law and policy regarding marijuana. On the one hand the placement by the DEA of marihuana in Schedule I, implies that it has no accepted medical use. On the other hand the federal government provides medical marijuana to some patients under the Compassionate Investigational New Drug Program. And the federal government obtained a patent in 2003 on cannabinoids as neuroprotectants.

Oregonians decided that marijuana does have accepted medical uses in 1998 when voters passed the Oregon Medical Marijuana Act, which declares:

"ORS 475.300 Findings. The people of the state of Oregon hereby find that: (1) Patients and doctors have found marijuana to be an effective treatment for suffering caused by debilitating medical conditions.; and therefore, marijuana should be treated like other medicines;"

Twelve years after Oregonians made this idea law, we now have over 35,000 patients qualified for the OMMA by over 3200 different Oregon doctors. Yet Oregon law reflects the ongoing tension and conflict over marijuana policy by having the OMMA declare marijuana has accepted medical uses but the Oregon Schedules, determined by the Board of Pharmacy, declare that it doesn't. Why didn't the BOP reschedule marijuana once Oregon law indicated that it has accepted medical uses?

The legislature sought to eliminate this conflict between state laws and policies and ordered marijuana to be rescheduled. SB 728 originally called for placement in Schedule II. But the bill was amended to allow the BOP to determine the appropriate schedule. The differences between Schedules II, III, IV and V are largely an assessment of the potential for abuse and an evaluation of the consequences of that abuse.

The Legislature must have intended that the BOP seriously consider a higher schedule for marijuana or they would not have amended the original bill.

Unfortunately this evaluation by the BOP really has nothing to do with the use of marijuana as a medicine because patients that use marijuana do not get their marijuana at a pharmacy. Their doctor does not prescribe marijuana to patients and does not tell the patient how much marijuana to use, or on what schedule. Instead patients are exempted from arrest if they produce their own medicine and in fact patients are required to register a marijuana-grow-site in order for their application to be accepted by the OMMP!

The reason that marijuana production is outside the control system that we have established for controlling medicines is because the Drug Enforcement Administration has refused to reschedule marijuana, as the science indicates. Doctors can't prescribe and pharmacies cannot dispense medical cannabis products precisely because it is in Schedule I. Litigation to force the DEA to reschedule marijuana has continued for decades. Unwilling to let this bureaucratic decision thwart the right of the people to use a medicine that they believe relieves their suffering, fourteen states have passed laws declaring marijuana to be medicine.

Failure to reschedule marijuana and acknowledge that cannabis has medical uses has not meant that marijuana is not used as medicine. It has only meant that its medical use has been researched and developed, and continues to develop outside the control of our established medical system.

Clearly, the nature of and the best practices in the use of medical cannabis should be determined by scientific inquiry. But the federal government has obstructed rather than conducted the necessary research. The Director of NIDA recently admitted publicly that they fund only research designed to find harms from marijuana, not benefits. The science surrounding marijuana has been corrupted by the politics, specifically by the criminal prohibition of marijuana. The DEA has even refused to allow more than one research garden to produce marijuana for all government research. Litigation over that issue has now continued for eight years.

The criminal prohibition of marijuana and the harsh penalties for its possession have created a climate where it is more difficult to conduct science and flesh out the nature of cannabinoids. However, research has continued in other countries, and the state of California established a Center for Medicinal Cannabis Research that issued a report earlier this year detailing the results of that research. These results include double blind, placebo-controlled studies indicating that cannabis does indeed have a significant analgesic effect. I have attached a copy of this report to my testimony.

Despite the prohibition of marijuana, its medical use and production has continued to advance. A production and quality control system is being developed by private dispensaries in California, Colorado and other states where patients can now obtain marijuana that is labeled with the percentage THC and

percentage CBD in the marijuana and certified to be free of a list of potential contaminants. Medical cannabis is now available in a variety of formulations including edibles, tinctures, salves and sub-lingual sprays. The quality of medical cannabis products is superior to that provided by the federal government marijuana farm operated under contract to NIDA. The government marijuana is not labeled for percentage CBD even though research by GW Pharmaceuticals and others indicates that THC and CBD have a synergistic effect. The US government marijuana provided to the IND program patients is often over ten years old. It consists of pre-rolled cigarettes that contain ground up flowers, leaves, sticks, and stems. Even patients forced to produce their own medicine by the Oregon law understand that it is primarily the flowers that contain the cannabinoids that provide the drug effects. The government marijuana is guaranteed to be adulterated with non medicinal cellulose and other materials. All research approved by NIDA uses this low quality marijuana produced by NIDA on the Mississippi farm. The fact that all research done in the United States on marijuana is based on such a low grade product, further calls into question the findings and the scheduling of marijuana based on this research.

Marijuana is medicine. It is here to stay. The question is how to deal with it. The current system of "control" is a complete failure and much of that failure stems from institutional intransigence and refusal to schedule marijuana appropriately or to remove it from the schedules completely.

We should deal with marijuana following the same principles that we apply for other medicines. We should seek to create a system where research illuminates the risks and benefits of medical cannabis products and allows doctors to freely use this information to establish the best practices for its use. Patients who are recommended marijuana by their doctors should be able to obtain quality-controlled, contaminant-free, consistent-from-batch-to-batch medicine, in the best form for administration for their condition. This common sense approach to medical marijuana continues to develop in a parallel system, outside of and distinct from the existing system of controlling medical quality that is based on pharmacists. This failure of the drug control system to deal responsibly with marijuana has forced the creation of alternative distribution models.

Marijuana is a unique medicine. While it differs from the traditional model of medicines as isolated single chemicals produced in laboratories, it nevertheless has medical properties that should be studied completely and thoroughly and the safest and most effective formulations should be available to patients where they can relieve suffering, often better than the pharmaceutical alternatives. The fact that marijuana contains dozens of cannabinoids that may interact in complex ways does not mean that it should be rejected as medicine.

In the future, there are likely to be more cannabis based medicines. Marinol is already approved for use in the United States and has been placed in Schedule III. Marinol is synthetic THC in sesame oil. THC is one of many cannabinoids derived from crude marijuana. It is inappropriate for Marinol, an isolated component refined from marijuana to be placed in a higher schedule than the precursor marijuana. Most patients report that Marinol is harder to titrate properly and often has stronger unwanted side effects. Almost all patients prefer natural marijuana to Marinol.

The BOP may have considered that Marinol is available by prescription through pharmacies whereas natural marijuana varies widely in its strength and other characteristics. However, the lack of an established distribution system should not be used to further restrict access to cannabis medicines. For one thing we hope to create a regulated distribution system with Initiative 28 which will make quality controlled medical cannabis available to patients. Patients should have the choice to use whatever formulation of a medicine works best for them.

The existence of the endocannabinoid system raises profound questions about why our bodies produce marijuana-like chemicals and why these are used to regulate many physiological processes. These

mysteries and questions should be studied thoroughly and will yield better understanding of human biology. The improper scheduling of cannabis has inhibited research and has slowed the beneficial use of cannabis based medicines beyond any reasonable concern about safety or potential abuse. The Oregon BOP should reschedule marijuana to Schedule IV or Schedule V. This will have some practical effects within Oregon and will also send a clear message to the DEA that the failure to reschedule marijuana is causing harm.

Due to marijuana prohibition and the scientifically unjustified scheduling in Schedule I, pharmacists are separated from the dispensing of medical marijuana. The BOP is not here to determine best practices for medical cannabis. Instead the BOP assumes a very different role. Because the primary tangible effect of rescheduling is to determine sentencing guidelines, the BOP assumes the role of judge and will influence how much time offenders will serve for selling or cultivating marijuana outside the narrow exception provided by the OMMA.

This follows the strange role that doctors play in patient's use of medical cannabis. As I stated earlier, doctors do not prescribe marijuana. They do not authorize patients to use a particular formulation of cannabis. They do not indicate the potency of marijuana a patient should use or on what schedule. The improper scheduling of cannabis makes all that a federal crime. Instead, under the OMMA, a physician qualifies a patient for the OMMP by declaring that "marijuana might help" which then exempts the patient from arrest for possessing or cultivating marijuana. Many of these patients have already discovered that marijuana is more effective than other drugs prescribed by their doctors so the doctor's role is to determine who is exempt from arrest.

These strange roles for doctors and the pharmacy board are an unfortunate consequence of marijuana prohibition. Rescheduling marijuana appropriately in Schedule IV or Schedule V will begin to return doctors and pharmacists to their proper roles in the use of medical marijuana.

The BOP is looking at a wide array of materials in making this scheduling determination. Evaluating the consequences of abuse of marijuana is challenging given the large amount of conflicting research and perspectives. However, it is clear that, compared to most pharmaceutical drugs, marijuana is relatively safe. It does not cause overdose deaths at all. The significance of marijuana dependence is inexorably intertwined with its legal status. For the vast majority of users, the biggest risk from marijuana is the risk of being arrested, prosecuted and incarcerated. This risk is very real. The number of Americans who have been arrested for marijuana is approaching twenty million. Countless lives have been ruined by marijuana arrests and billions of dollars have been spent in the futile war to absolutely prohibit marijuana. The federal rescheduling guidelines call for consideration of the economic impact of scheduling. Any serious look at the economics of marijuana prohibition indicates that Schedule I status for marijuana has wasted billions of dollars and caused tangible harm to many Americans.

I recently debated Clatsop County Sheriff Tom Bergin about the future of medical marijuana. He complained that marijuana was a lifestyle. Other medicines are not used in that way he claimed. But the lifestyle is shaped partly by the prohibition. As an expert observer of marijuana use over several decades, I have noticed that when marijuana use is framed as "medical" it often becomes healthier than when it is framed as "recreational". College students learning to party, generally smoke as much as they can in an effort to get "wasted". Patients using marijuana medically, on the other hand, generally learn quickly to self-titrate their dosage and are much more likely to stop their intake of marijuana at a point where they achieve relief from their symptoms, long before they become seriously impaired.

Rescheduling marijuana to Schedule IV or Schedule V will begin to allow its use to be regulated appropriately. Rescheduling will assist in the development of new formulations of cannabis medicines and deliver systems that are healthier and reduce the harm from marijuana use. For example, the science

indicates that vaporizing marijuana is much safer than smoking because the most dangerous elements of marijuana come from the combustion process rather than the marijuana itself. Rescheduling marijuana to a higher schedule will expand the possibilities for the development of vaporizers that will have a positive impact on marijuana use.

Marijuana policy has been flawed for years and has failed to distinguish use from misuse and abuse. The improper placement of marijuana in Schedule I has inhibited this important distinction, one that we make for most substances. This leads to the underlying question: "How are we going to deal with marijuana?"

The paradigm which placed marijuana in Schedule I has led to policy which relied on deterring use by arresting and incarcerating marijuana users. This policy has been a failure. Instead we need marijuana policy that distinguishes marijuana use from misuse and abuse. Such a policy will rely on science to determine the actual harms and education to provide Americans with the best information on marijuana's risks and benefits.

Some public testimony on this matter has called for marijuana to be removed from the scheduled substances. Alcohol and tobacco are treated differently because policy makers recognized long ago that prohibiting these harmful substances caused more harm than appropriate regulation. We should look to the success we have had with reducing tobacco use. We have done this not by prohibition but primarily by science and education. The Framingham study and other large scale epidemiological studies have convinced Americans that smoking is harmful. Many people have stopped smoking or never started because government played an appropriate role in conducting research and educating Americans about the results.

The existence of SB 728, ordering the BOP to reschedule marijuana, highlights the failure of the legislative branches of our government to deal with the marijuana issue. Oregon legislators really have not taken a comprehensive look at marijuana policy since 1973 when they decriminalized marijuana.

Resolving most of the issues raised here is beyond the scope of the BOP and the mandate of SB 728. However, the BOP can follow the science. That indicates that marijuana should be in Schedule IV or Schedule V. Placing marijuana there will cause the least harm, will assist in the creation of appropriate regulation and will send a message to the Oregon Legislature and the U.S. Congress that a comprehensive review of marijuana policy is long overdue.

Thank you

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