



# Medical Cannabis Initiative Paving the Road to Recreational Use

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**M**ARIJUANA ADVOCATES ARE circulating a petition to put on the November 2018 ballot a complicated law to legalize “medical” marijuana. They are very likely to succeed in getting the “Utah Medical Cannabis Act” before the voters next year. It might be wise, therefore, to know just what this Act, if approved, would allow.

The Public Relations machine pushing the initiative makes it appear that proponents are merely responding to the suffering of countless patients (seemingly relieved only by cannabis), but the law that it is designed to enact has so many loopholes, that it will pave the way for recreational use by anyone willing to jump through a few minor hoops.

First, let’s look at the list of “qualifying illnesses” that would open the door to treatment with cannabis (and imagine the loopholes possible in these definitions). Despite a paucity of evidence as to its effectiveness in most instances, cannabis could be used to treat those with HIV, AIDS, or “an autoimmune disorder” (Arthritis? Type 1 diabetes? Thyroid problems?), Alzheimer’s disease, ALS, cancer, cachexia, or “a condition manifest by physical wasting, nausea, or malnutrition associated with chronic disease” (Bulimia? Anorexia?), Crohn’s disease, ulcerative colitis, or “a similar gastrointestinal disorder,” epilepsy or a “similar condition that

causes debilitating seizures,” MS or a “similar condition that causes persistent and debilitating muscle spasms,” PTSD, Autism, and any “rare condition or disease that affects fewer than 200,000 persons in the U.S.” (according to the federal definition).

In addition, cannabis would be approved to treat chronic or debilitating pain if the physician (physician being defined as MD, DO, dentist, Nurse Practitioner, Physician Assistant, Podiatrist and Optometrist) determines the person is “at risk of becoming chemically dependent on, or overdosing on opiate-based pain medication” or “is allergic to opiates or is otherwise medically unable to use opiates.” This allowance is so broad as to open the door for any and all illness and any and all individuals either through diagnoses or through being unable to take opiates.

The law would also establish a “Compassionate Use Board” composed of five physicians knowledgeable about medical marijuana that would make recommendations to the Dept. of Health to allow individuals who are not otherwise eligible for a medical cannabis card to get one if the person suffers from an intractable condition that substantially impairs quality of life and the Board determines it is in the person’s best interest to allow use of medical marijuana. Efficacy is not relevant here and the Board cannot reduce access to marijuana.

One of the biggest loopholes is in enforcement. Although certain aspects of the law would not be put into effect immediately, anyone who wants to use marijuana for virtually any reason could do so right away. Law enforcement will not be able to effectively stop them because they will have “an affirmative defense to criminal charges for

the use, possession, or manufacture of marijuana, THC, or marijuana drug paraphernalia” if “the individual would be eligible for a medical cannabis card, and that the individual’s conduct would have been lawful, after July 1, 2020.” Anyone could say, “I have [any one of the conditions listed above]” or “I have [some other condition] so the Compassionate Use Board will give me a cannabis card.” A prosecutor would then have to disprove that claim, which would be nearly impossible. This effectively opens the door wide to recreational use.

Again, the definition of “physician” in the law would include anyone with a controlled substances license (except a veterinarian) who can prescribe Schedule II substances within their scope of practice. In addition to MDs and DOs, that would include dentists, podiatrists, optometrists, APRNs, PAs, and even nurse midwives (with a consulting physician). Any of these could recommend cannabis to up to 20 percent of their patients; there would be with no limit if the prescriber is board certified in anesthesiology, gastroenterology, neurology, oncology, pain and palliative care, physiatry or psychiatry, which could include psychiatric nurses and dentist anesthetists.

The law would make it legal to possess up to 4 ounces of unprocessed cannabis (the equivalent of 112-224 joints depending on whether they are small or large) or 20 grams of THC or CBD, even though dispensaries would only be allowed to dispense up to 2 ounces or 10 grams within a 14-day period. Other states that have legalized medical marijuana only allow medical card holders to possess 1 ounce. Utah cannabis card holders would also be allowed to grow their own weed – six plants – if they don’t live close enough to a dispensary. There’s no regulation of any plants under 8 inches or that don’t have a root ball.

Marijuana has 483 known compounds, including at least 65 other cannabinoids aside from the delta-9-tetrahydrocannabinol (THC) and Cannabidiol (CBD) which is mostly what individuals are talking about when they refer to this initiative. We do not know how much of any of the compounds are in the plants or products that would be produced by individuals or distributors and distributed to “patients” with passage of this “medical” cannabis initiative. We do not know the effects of all of these compounds or interactions with medications these patients would be on in addition to these products. There would be no legal oversight of the potency of grown plants and products could legally vary by 15% from the weight listed on its label.

The law would prevent any real local controls as cities and counties could not enact zoning to prohibit cannabis production or distribution. Nor could they deny or revoke a license to operate a production facility or dispensary in their jurisdiction. Landlords would not be able to refuse to rent to cannabis card holders.

Dispensaries or production facilities would have minimal location restrictions, only having to avoid residential areas by

300 feet and stay only 600 feet from schools, churches, public libraries or public playgrounds or parks. They would also need to grow their product in the dark with covered windows which increases the THC content of the plants grown, according to the Department of Agriculture.

Although “smoking” marijuana is not supposed to be allowed in theory, the prohibition does not include combustion below 750 degrees (F) that does not involve using a flame. Marijuana burns at a much lower temperature and there is no restriction on lighting up with an electric heater (car cigarette lighter, for example). THC is released at just under 400 degrees (F).

There are no restrictions on any other form of the marijuana plant or how it is ingested or used (including use of bong, inhalation, edibles, etc.) except that it cannot be made to look like candy. Even if there is a violation, the violation is an infraction that only has a \$100 fine attached to it. (See violation section below)

Cannabis dispensed to patients by dispensaries (since providers cannot dispense or even prescribe – they can only recommend) would be excluded from any reporting to the Controlled Substance Database.

To forestall worries about liability, the proposed law would give immunity to providers who recommend cannabis treatment under the Act from any civil or criminal liability or licensure sanctions. This level of immunity has only been available in the past for Good Samaritans performing voluntary medical service. It is unlikely that such immunity would hold up under legal challenge.

Violations under the Act would be reduced to mere infractions with a \$100 fine and no increase for subsequent violations. Even when determining parental fitness or child neglect, excessive use of cannabis would be excluded from being considered under the law, although excessive use of alcohol or any other drug could be considered.

Boiling all this down, it seems clear that what is being sold as a walkway to relieve suffering, is really paving a highway to recreational use of marijuana.

The Utah Medical Association is not trying to prevent real patients from obtaining relief from their real suffering. We support valid, ongoing and even expanded research into the possible uses of cannabis-based medications. We support changing the designation of marijuana from a Schedule I to a Schedule II controlled substance to facilitate more scientific research. We support the use of proven cannabis products for illness or disease once the research has been done and approved if it shows that there is efficacy for treating a particular illness or disease, just like any other medicine.

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We supported the CBD research and treatment bills that have been passed by the Utah legislature for those with intractable seizures and the continuing research to improve those treatments as well as other research bills. We support those patients who have intractable epilepsy (seizures) that are allowed to be on cannabidiol in Utah as part of ongoing research that records results and adjusts the doses accordingly to improve the efficacy of the product and the product itself as needed to help patients.

We have supported the research bills that have passed directing USTAR and the University of Utah to speed the process of cannabis research studies to determine efficacy of all cannabis products. We have helped pass bills that allow cannabis-based products that have gone through the proper FDA research process to be approved in Utah.

On a federal level, in addition to pushing to change the designation of marijuana to a Schedule II substance, we support Senator Orrin Hatch's MEDS Act of 2017 that provides for a more streamlined and faster process for researchers to apply for registration to conduct medical research on marijuana. But unfortunately, the Utah initiative is NOT about medicine or even about research on possible cannabis-based medicine; it is about recreational use. If the state of Utah wants to have that debate, have that debate. This initiative goes way beyond what any state has done even in the name of "medicine." This initiative attempts to mask the debate as medicine to get the general public's support for the issue. It makes it sound like the medical community is behind the effort – that physicians would know what to prescribe to their patients – that physicians would be able to prescribe to their patients. It is not true. Physicians could not prescribe. It would still be illegal regardless of what is passed. Physicians would only be able to **recommend**. Then, dispensary employees would be the people who would dispense and determine what individuals received with very little oversight by law enforcement or by the department of agriculture because of how the initiative is written. Individuals, who are not required to have any scientific or health care training will dispense and recommend when patients come in to the dispensaries. They are only required to be 21 years of

age and to have a background check. They are not even required to have a background check if they are volunteers. The initiative cannot be changed. This is what will be voted on in November of 2018 by the general public.

Physicians have taken an oath to "first do no harm." Physicians strive to adhere to this standard and keep this oath ~~that they~~ taken ~~to~~ enter medicine. With this in mind, our House of Delegates took a stance on marijuana and cannabis-based products in the fall of 2016 that has not changed. They determined that until a physician has the information that comes from sound and scientific research on the efficacy of a cannabis-based product on a particular illness, the dose for that product, which patient to prescribe that product to, and the contraindications and interactions of that product with other products or medications, they would not know what to give a patient and could not in good conscience even recommend such a product as a medicine. With few exceptions, such as mentioned above in the research portion of this article, we do not have these answers. Allowing an illegal drug into the state of Utah will only compound the problems we already have with opioids and drug abuse in the state. We need physicians to step up and educate their patients on the reality of what is in the initiative and what it really means to their patients.

Finally, this initiative would apply to all individuals without age restrictions to bar use by children or adolescents. As physicians know, since the human brain continues to develop well into one's twenties, careful consideration should also be given regarding chronic exposure of adolescent brains to cannabinoids, which has been linked to affective, behavioral, cognitive, and neurochemical consequences that last into adulthood. Animal data have demonstrated the long-term consequences of chronic cannabinoid exposure to developing brains including cognitive deficits and increased risk for psychosis.

We do not support the use of legislation to open up the floodgates to a dangerous drug disguised as a program for compassionate medical treatment. ■