September 22, 2022
To the Chair and Members of the Senate Committee on Healthcare:

My name is Elizabeth Porter. Thank you for the invitation to provide testimony today to the Senate Health Committee. I return to speak again about a civil rights and technology issue. This morning I am here to ask you to advance legislation to prohibit employment related THC drug testing by any employer receiving state funds, especially in the public healthcare sector. A positive result for marijuana (THC metabolite) on a standard drug test is grounds for employment termination, even though this test is not a marker for impairment, a substance abuse problem, or on-the-job use. The health, safety, regulatory, and legal concerns voiced by some major healthcare employers to justify surveillance of their employees for past cannabis use are simply not supported by the facts.

As a matter of record, I represent Health Environment Justice Analytics, a science and systems engineering civil rights consultancy based in Eugene. I also am the Practice Manager and partner in an independent, family-owned, clinical practice serving Oregon. My background is in science and engineering. I had a thirty-year career with the federal government in research and policy, and as a regulatory program manager. I now consult on issues of concern consequent to mandated technology programs and monitoring, privacy, and surveillance in public health.

If I can communicate one important message to you, it is that the practice of drug testing employees does not have a safety or risk reduction benefit based on a review of the science. I am attaching a summary of a review of the evidence that includes several rigorous meta-analyses that address the body of scientific studies on the subject over the last two decades (since this practice became more commonplace). I looked for the evidence to support the safety rationale. What I found was that most citations that support drug testing for THC are position papers or opinion pieces, not scientific studies to evaluate the effectiveness of the practice to improve workplace safety, including accidents, absenteeism, theft, or employee morale.

In addition to the (invalid) safety rationale, the other top rationale employers use to justify THC drug testing is their obligation under federal mandate. This is true in the commercial transportation sector (which has a federal mandate to drug test), but the healthcare sector is the next most drug-tested employee group, and it does not have a federal drug testing mandate. The other federal supremacy argument used to justify drug testing employees is risk of loss of funds from federal contracts or grants. This fear also presumes that drug testing is integral to the Drug Free Workplace Act, which is not the case. An employer can set expectations for a drug free workplace without drug testing. The Drug Free Workplace Act has no drug testing mandate. In fact, the US Department of Labor offers companies a Drug Free Workplace Act compliance template (that I included in my attachments to testimony) that makes no mention of drug testing. The law requires employers to establish a drug-free awareness program for the workplace, to notify employees of available drug counseling, rehabilitation, and employee assistance programs, and to inform them of penalties for use of illegal drugs

in the workplace. It requires employees to notify their employer if they have been convicted of a criminal drug offense occurring in the workplace. In turn, employers are required to report all workplace drug offense convictions to the contracting entity.

Despite consensus that workplace safety is paramount, the argument that ending THC drug testing would compromise safety is not evidence based and harkens of fear-mongering or ignorance, two traits we do not want to associate with healthcare delivery. Yet healthcare entities in Oregon routinely test all clinicians (for THC) as a precondition of employment under the rationale of safety and substance abuse intervention, or federal mandate. This suggests that stigma, rather than evidence, is driving the policy.

It would be consistent with current health equity reform efforts and healthcare staffing initiatives to end this practice in the healthcare sector, specifically prohibiting any recipient of state funding to drug test for THC or prohibit employment based on a positive test result for cannabis. It is important to begin with the healthcare sector. This sector is presumed to follow best public health practices, and the state has a severe staffing shortage in delivery of healthcare services, and Oregon needs a healthcare sector, especially a behavioral health system, that can understand and differentiate between medical, therapeutic and safe cannabis use and unsafe misuse of cannabis.

Even if cannabis was not legal in Oregon, the standard “drug abuse” test panel is flawed. Whereas other substances on the standard drug test, like cocaine or heroin, can be metabolized quickly, in hours, the THC metabolite detected from past cannabis use can persist in the system for weeks, and the duration of detection is not dose or effect dependent. This also puts states with legal cannabis programs in a particularly vulnerable situation legally – since the standard drug test essentially is a THC detection test more than anything else.

Furthermore, it’s ironic, when citing safety concerns, that most workplace accidents are related to alcohol intoxication, a substance not on the drug test and not stigmatized (and a frequent reason for physician impairment problems). And according to NIH, benzodiazepines, a sedative class of drugs, are implicated in nearly 1 in 5 overdose deaths, but this class of drugs is not on the standard drug test. Despite alarming numbers of drug deaths from fentanyl, this drug is also not on the standard drug test.

The safety rationale for drug testing has been used in court to justify the invasion of individual privacy and to violate once-held standards of unreasonable search and seizure. An employer can demand supervised samples of employee private body fluids (urine usually, sometimes hair, blood or saliva) since drug testing is deemed justified to protect public safety. Since the safety rationale is not valid, the premise to allow the privacy invasion of drug testing is undermined. This is a potential risk for new legal challenges. And from an overall risk management point of view, employment drug testing, after scientific review of the practice for past twenty years, is not an effective strategy to combat the real problems of substance abuse and on the job impairment and safety. Screening for past cannabis use does not result in lower levels of employee substance misuse, employee accidents, employee health insurance claims or workers

compensation claims, employee sick days, workplace theft, or business underwriting rates.

There are alternatives to workplace drug testing that have a positive safety benefit. The review of public health and safety studies shows that targeted workforce training and EAP services have positive measurable outcomes whereas drug testing does not. We also need to focus on the problem that impacts employers – impairment on the job. Measuring impairment is not a simple task. Impairment affects cognitive and psychomotor skills. But human performance can also be impaired by health status, mood, medications, sleep, age, and other non-illicit drug factors. Supporters of drug testing claim drug tests are satisfactory, albeit imperfect, proxies for a real safety screen. They claim that drug testing for THC is an indispensable tool that will deter undesirable, presumably higher risk, employees from entering their workforce. This claim is also evidence-free, but it suggests systemic bias and reliance on cultural stereotypes.

There needs to be research and development on task oriented, nondiscriminatory, nonjudgmental assessments of variables of psychomotor and cognitive tasks that can determine if on-the-job performance expectations can be met.

To reiterate, the current Oregon clinician drug testing policy establishes a zero-tolerance policy. Zero tolerance means all use of cannabis at any time and for any reason is a valid justification for employment termination or other disciplinary action. This undermines the legitimacy of cannabis as a medicine and the underpinnings of the OMMA. This marginalizes the patients who rely on these medicines. Policies based in cultural bias and not science are corrosive to the integrity of our health system.

The laws regulating cannabis use and commerce have changed quickly, posing challenges to maintain consistent public health policy. Nonetheless, the current anti-cannabis policies and rules have biased the healthcare workforce to a great degree and limited much needed mental healthcare services to the most vulnerable people of Oregon leading to an untenable situation. This is a relatively easy problem to fix. Stakeholders should focus on the shared desired outcomes of enabling a safe and competent workforce, not impaired by drugs, alcohol or other safety factors, and not biased by cultural stereotypes of ‘slovenly stoners’. The systematic biasing of our healthcare workforce could explain why we frequently hear patient concerns of biased or limited access to healthcare services in Oregon related to their cannabis use.

The issue of zero tolerance policies and drug testing was debated in the 2019 Session’s Senate Judiciary Committee. There were several powerful employer organizations who supported employee drug testing for THC. They expressed safety, legal and economic fears if they ended employee drug testing for THC.

The article in the British Medical Journal on combating medical stigma offers remedies for addressing the fears that underly stigma. Education and information are foundational. I offer to participate in a problem-solving discussion with stakeholders to

address workplace concerns and alternatives to employment drug testing. Drug testing is not a valid safety proxy.

It is not ethical to institutionalize discrimination, as THC drug testing does, since the legal and safety rationales are not valid. It sets a terrible precedent that the state can defy federal law to collect revenue from its citizens but use this same federal law to erase the civil rights protections of some of the most vulnerable citizens in the state. This results in a series of indirect consequences, such as restriction of employment options for Oregon citizens and employers and the consequent loss of revenue, reduced access to healthcare and social services, and the re-enforcement of cultural anti-cannabis bias in state funded entities. These anti-cannabis policies are antithetical to the intentions of the voters and tax payers in Oregon and do not represent best public health practices.

Your work in the next session can correct this problem. Thank you for your service, your time, and consideration.

Respectfully, Elizabeth Porter, MSSM