To: Senate Committee On Health Care
Re: SB 758

March 17, 2021

Chair Patterson, Vice-Chair Knopp, and Members of the Committee,

My name is Dr. Rachel Knox, immediate past chair of the Oregon Cannabis Commission (OCC) and new appointee to Oregon's Psilocybin Advisory Board. I represented Attending Physicians on the OCC, and my professional background is in family, integrative, and functional medicine, healthcare administration, cannabinoid medicine and endocannabinology, and health equity. I am also a board member for several national medical cannabis associations including the Association for Cannabis Health Equity and Medicine (ACHEM), American Academy of Cannabinoid Medicine (AACM), and Doctors for Cannabis Regulation (DFCR).

I testify today in favor of SB 758, and will speak to three elements within it: provider expansion, expanding the debilitating condition list, and attending provider security.

Modernizing the Oregon Medical Marijuana Program is overdue. ORS 475B.785 Section 1 states that *"patients and doctors have found marijuana to be an effective treatment for suffering caused by debilitating medical conditions and, therefore, marijuana* ***must be treated like other medicines****."*

Under this codification, Oregonians have had the lawful right to the medical use of cannabis since 1998. However, the institutions governing the practice of medicine do not treat cannabis like other medicines, and have not adjusted their own behaviors and policies to align with statute. This has had pervasive and negative effects as it relates to access and parity, and to the competent, informed care of our most vulnerable patients.

One reason is that there remains a dearth of medical providers willing or able to evaluate and manage medical cannabis as a result of systemic bias and institutional barriers. Another reason is that Oregon's debilitating condition list does not reflect the breadth of serious conditions for which cannabis may be beneficial.

There are three parallel pathways that SB 758 takes to remedy this in sections 7 and 23, respectively.

First, it expands the definition of the "Attending Physician" to that of an "Attending Provider" to include additional provider types also responsible for the primary care and treatment of patients, care that includes prescribing and managing the use of controlled substances. Any medical provider upon whom this responsibility has been bestowed should have the leeway, in their professional judgement, to evaluate patients and their medical problems for the appropriateness of medical cannabis use, and authorize and manage that use should they determine that

cannabis may be beneficial. An immediate benefit of this change would be an increase in the available care providers accessible to patients for medical use authorization and oversight. In many cases this will finally allow patients to discuss medical cannabis as an option with their existing primary care providers.

It also expands debilitating conditions to bring the management of medical cannabis use under the complete purview of the medical provider, where it should be. It is not customary for state law to restrict medical management in such detail, so in accordance with long-established protections for professional autonomy in medicine (and the freedoms, even, to prescribe pharmaceutical drugs off label), we should allow attending providers to authorize and manage the medical use of cannabis for any condition or side effect that their patients and they, in their professional judgement—and guided by research, science and clinical experience—believe cannabis can help treat.

Lastly, it is time for our licensing boards to modernize their positions on medical use and adult use of cannabis more broadly. In an adult use state such as ours, increasing numbers of people—many with complex medical pictures—are using cannabis at their discretion, and medical providers are utterly unprepared to provide informed, intelligent counsel to the consumers they happen to care for. Licensing boards should be encouraging provider education and preparedness for the real world—not censoring them—especially when we understand there do exist clinical risks to cannabis use, such as cannabinoid-drug interactions, that medical providers are best equipped to navigate.

Attending providers also need protection against disciplinary action by licensing boards on the sole basis of counseling, evaluating, authorizing, or managing the medical use of cannabis, including (and perhaps especially) where pediatric patients are concerned.

11 states include autism on their debilitating condition lists, and mounting research and clinical evidence validates cannabis as a viable treatment option. As a pervasive neurological condition, Oregon providers do and should have the latitude—on a case-by-case basis—to evaluate, authorize, counsel, and manage the medical use of cannabis for autism and related conditions and symptoms in the pediatric population under parental consent, and without threat of being reported or investigated so long as they observe the accepted standards of medical management and oversight.

Grassroots organizations like Mothers Advocating Medical Marijuana for Autism (MAMMA) and Whole Plant Access for Autism strongly advocate for pediatric access because they have found cannabis profoundly beneficial for their children where conventional therapies have failed. Where a patient's pediatrician is unable or unwilling to manage the medical use of cannabis, that patient (and their parents) should be able to seek a second opinion from an experienced attending provider willing to do so, and that provider should be protected in their effort to provide compassionate care to that patient.

We must bolster the medical program for the future to ensure ongoing, holistic access to medical cannabis care for our most vulnerable populations: children and adults suffering from debilitating medical conditions. In order to do so we ask that both statute and our licensing boards facilitate maturation. As the cannabis industry continues to mature, it is imperative that our medical institutions and constructs mature too.

In light of this, we should also understand that adult access allows adult patients to circumvent the medical program. We call the adult use market the “recreational market,” but this is truly a misnomer and misrepresentation of consumer trends. Adults use cannabis for medical, recreational, spiritual, and wellness purposes, and often to address legitimate medical concerns not listed on Oregon’s debilitating condition list. This makes it imperative that the adult market become one that serves the most vulnerable denominator of consumers - the complex medical patients not accessing cannabis through the medical program. There is folly in framing adult use as a vice market as opposed to a responsible use market.

While I am no longer the chair of the Oregon Cannabis Commission, I do recommend that the committee meet with the OCC to learn more about the medical cannabis governance plan we developed over the past three years. I will continue to advise the commission as a member of the public, remain a member of Portland’s Cannabis Policy Oversight Team (CPOT), and continue my work with ACHEM, AACM, and DFCR.

It would also be a distinct honor to work with this committee in any capacity to advance safe, sensible, and health-equity centered cannabis policy in Oregon.

I ask the committee to support the passage of SB 758.

Thank you for your time and consideration.

Sincerely,

Dr. Rachel Knox, MD, MBA
Immediate Past Chair, Oregon Cannabis Commission
Member, Cannabis Policy Oversight Team (Portland, OR)
Oregon Attending Physician