Address:
712 H STREET NE,
SUITE 1290
WASHINGTON, DC 20002 USA

Phone: (+1) 202-930-0097

Email: info@dfcr.org
Website: www.dfcr.org

Feb 23, 2021

Committee on Federal and State Affairs
24 February, 2021; Room 346-S—Statehouse

RE: HB 2184

Chairman Barker and committee members:

My name is Dr. Rachel Knox, MD, and I am a board member for Doctors for Cannabis Regulation, a physician organization dedicated to the effective regulation of cannabis. It's an honor to represent DFCR in championing sensible cannabis regulation, and I am appreciative of the opportunity to share my testimony with you today.

My background is in family, integrative and functional medicine, and healthcare administration, but I now specialize in cannabinoid medicine and endocannabinology. I am also a resident of the state of Oregon where I chair the governor-appointed Oregon Cannabis Commission. This commission has been tasked with developing a new framework for medical cannabis in Oregon, 21 years after medical cannabis was legalized in the state.

I believe my testimony will prove valuable being that my commission has had to evaluate a failing medical program in the context of an unsophisticated adult use market in Oregon. May we all use hindsight to our collective advantage in building sustainable medical cannabis programs of the future.

The prohibition and criminalization of cannabis has failed and continues to fail. It is time to regulate both its use and commercialization in a sensible and equitable way, but not just because the war on drugs is futile and socially unjust, but also because masses of people, in both legal and non-legal cannabis states, are turning to it for medical and wellness purposes. Simply put, people are using cannabis regardless of legality, and they are using it now. As such, it's the job of health and health policy professionals, with the full backing of local and state governments, to leverage both science and hindsight in order to mitigate risks in cannabis use - first and foremost - and to work collaboratively with legislators and regulators to establish the parameters of a medical cannabis framework that is safe, sustainable, and equitable. This has not happened in Oregon to date, and adult use has complicated efforts further. Why? Because legalization and regulation of neither the medical nor adult programs were informed by science, but rather by revenue.

So, towards the goal of establishing a safe, sustainable, and equitable medical cannabis program in my own state, I have charged the Oregon Cannabis Commission with modeling the medical cannabis program of our future as an ecosystem. An ecosystem driven by science and productive of data. An ecosystem that prioritizes research and health equity above all else, and an ecosystem built to include and protect the spirit of compassionate care, patient and consumer rights, and locally grown businesses. It is an ecosystem proud of its product integrity and sustainable practices, cannabis competency and informed policy making through which sound cannabis regulatory practices and industry standards can be established and scaled as states determine the value of broadening access to adults, or even looking ahead to the possible future of interstate and international trade, and health tourism opportunities.

Looking at a legal cannabis framework as an ecosystem of beneficence and productivity will help avoid many of the pitfalls, inefficiencies, injustices, redundancies, and confusion that continue to plague most states that have legalized with fear-based regulations.

In such an ecosystem I recommend that all health leadership as well as health professionals who engage with persons using cannabis should take a minimum amount of mandatory training (offering CE where appropriate) in cannabis history, cannabinoid medicine, and endocannabinology to establish cultural, plant, and endocannabinoid system (ECS) competencies. In order to minimize stigma and discrimination in healthcare environments this is paramount. In regards to the health professional, it is his/her duty to objectively understand the physiology of the endocannabinoid system upon which cannabis works, as well as the pharmacology of cannabis phytochemicals so to employ pragmatic and intelligent counsel and management of patients with minimal bias or disparagement. Additionally, policies that censor doctors from discussing cannabis or its pharmacological effects with patients are dangerous to both the patient and the practitioner, as omission of information is a basis for malpractice. The censoring of doctors by healthcare systems or hospitals for fear of federal retribution must stop.

Likewise, cannabis history, cannabinoid science and ECS competency should also extend well beyond the healthcare professional to all licensed cultivators, processors, retailers, testing laboratories and their respective employ; law enforcement; legislators; regulators; schools and its administrators; and everyone who participates in the supply chain of the program or has authority in overseeing or regulating it. Legalization and regulation must be informed. When everyone is informed, better decisions are made about cultivation, processing, distribution, testing, packaging, labeling, serving sizes, potency limits, patient protections (including a minor's right to use under medical management), impairment testing, employment policies, school policies, healthcare facility policies, probation policies, public health policies, public and youth education initiatives, and more. "Proper" implementation and oversight of all these things cannot exist without a minimal amount of cannabis competency across all stakeholder groups. I have witnessed what a medical cannabis program and adult use market looks like without it.

Please do not rush to legalize medical cannabis without a stakeholder education plan in place before establishing statutory rules and regulations. However, with that being said, I do recommend creating a pathway for sensible patient access to medical cannabis in Kansas. Creating pathways to safe access, as opposed to prohibition, is in the best interest of public safety.

In facilitation or in addition to the aforementioned, I recommend the following as high priority items for consideration:

- Establish a neutral medical cannabis advisory committee or regulatory commission consisting of a cannabis science and endocannabinoid system clinician, a pharmacist competent in cannabis pharmacology, a cannabis researcher, a public health agency representative, a patient, a cultivator, a processor, a retailer, a testing laboratory representative, a representative from the department of agriculture, a representative from the department of justice, a social equity expert,

and a law enforcement representative. Diverse expert and stakeholder representation will set the pace for a well contemplated and equitable program. If and when considering legalizing adult use, expand this commission's scope of work and adult access to the same high quality products (just taxed differently with/without a medical card) instead of creating a dueling, and in most ways redundant, agency or industry.

- Establish a cannabis fund for cannabis tax revenues to fund 1) ongoing administrative and maintenance costs of the medical program and its regulation, 2) agronomic, medical, public health, and safety research, 3) economic and ecological sustainability research, 4) consumer and patient education and other competency training, and 5) reparative justice and health equity. Additional revenue can then be distributed to general funds or other non-cannabis related funds and purposes.
- Create comprehensive and easy to understand laws.
- Understand that creating a medical cannabis program creates a cannabis industry by default, so take the time to assess, research, craft, and implement a sustainable supply chain (i.e., industry) model rooted in sound market economics and minimal operating and safety standards (i.e., best practices).
- Consider the medical program a pilot study, including establishing an IRB. Prepare, upfront, to collect data from every touch point (from cultivation to patient use outcomes to use of tax revenue to market dynamics—CA, OR, WA have 20+ years of limited to no informative data), and prioritize research.
- Establish a state reference lab to set testing standards against which all other testing labs are held.
- Establish statutory protections for patients of all ages who use cannabis as medicine from discrimination in healthcare settings, employment, housing, schools, interactions with law enforcement, child protective services, etc.
- Prevent censorship of healthcare professionals, and allow all practitioners of primary or specialized care (i.e. MDs/DOs/NDs/NPs) to authorize use after complying with minimal competency training; this improves patient access issues that will arise.
- Use existing agencies to the program's benefit. For example, consider the Department of Agriculture for overseeing cultivation and processing because that's their wheelhouse. Try not to reinvent wheels just because it's cannabis - it is still a crop.
- Begin to consider how cannabinoid products from hemp fit into the medical program.

In legalizing medical cannabis and establishing a medical cannabis program, I encourage Kansas to take a bold step towards redefining medical cannabis in the U.S. as several legal states are already re-evaluating their existing programs. We are all wanting to get it right.

Thank you for your time and this opportunity to share my testimony with you.

Dr. Rachel Knox, MD