

Dear Board of Pharmacy member,

As background, which I am sure you are familiar with, Oregon's Schedule of Controlled Substances was brought into being by the following OAR:

855-080-0020

Schedules

Pursuant to ORS 475.005(6) those drugs and their immediate precursors classified in Schedules I through V under the Federal Controlled Substances Act, 21 U.S.C. Sections 811 to 812 and as amended by the Board pursuant to ORS 457.035 (sic) are the controlled substances for purposes of regulation and control under the Act. ...

In accepting 21 U.S.C. Sections 811 to 812 as Oregon's Schedule of Controlled Substances without setting new criteria and types of required findings to guide the Board of Pharmacy when carrying out provisions of ORS 475.35, the criteria and required findings found in 21 U.S.C. Section 812 are by default adopted as Oregon's also.

Reviewing them (See Appendix 1) it can be seen that each Schedule has three findings required: A) The potential for abuse of the substance under consideration, B) The existence or absence of accepted medical use and C) The type or relative severity of abuse which may occur. It should be noted that all three required findings deal explicitly only with the medical physiologic or psychiatric affects of the substance on a human and not at all with any other aspect of that substance or its role, good or bad, in society. Only medical scientifically verifiable information is to be considered.

Thus, when acting under the scope of ORS 475.35 (relevant excerpt below):

475.035 "the State Board of Pharmacy shall review the scientific knowledge available regarding the substance, its pharmacological effects, patterns of use and misuse, and potential consequences of abuse, and consider the judgment of individuals with training and experience with the substance." the Board of Pharmacy must use as a basis for their considerations, the scientific knowledge referred to in the statute and similarly, the expressed judgments in the testimony of "individuals with training and experience with the substance" must also deal with those medical scientific criteria found in 21 U.S.C. Section 812, and not other subjects.

Because there are only three required findings, each dealing with scientific evidence, and not a fourth one dealing with the fears of those engaged in law enforcement, those fears and the views of the substance which drives those fears are not eligible for consideration when determining the proper placement of a substance on a given schedule. The problems law enforcement has are a function of the societal popularity for uses other than medical that the substance under consideration has, and there has been no evidence presented that the placement of a substance on any schedule has any relationship to its non-medical societal popularity.

Given that that there is a statutory recognition that marijuana has a recognized medical use, the only findings to resolve are those dealing with the potential for abuse and the type of abuse likely. As a person with "training and and experience with the substance" marijuana, I can well testify as to the realities of the abuse questions in the context of medical use of marijuana.

For personal background I am sixty five years old, retired and in good mental and physical

health. I have been an active pioneer in the work of allowing access to marijuana for medical uses since 1991 and helped author the 1998 Oregon Medical Marijuana Act. Since its passage I have been very active in assisting Oregonians register under the act and in assisting them to establish means for a supply of marijuana for medicine.

I am also a patient registered with the Oregon Medical Marijuana Program (OMMP) and grow medicine for myself and three other patients. I have worked with thousands of patients in the last dozen years and have a good understanding of the issues surrounding the medical use of marijuana. Almost all of the patients I have encountered, including me, use approximately one ounce of marijuana per week, though some, like one of my patients need two or more ounces per week. These are usage rates which are high enough to be seen as indicators of marijuana dependency in some drug treatment circles dealing with non-medical users.

I am well aware of the classic symptoms of marijuana dependency and abuse, as are most people over 10 years of age due to the ubiquitous Just Say No type of drug education. However, I must state categorically that I have never observed any person using marijuana medically, even in the amounts mentioned, who exhibited any such signs of marijuana dependency or abuse. That such abuse appears in non-medical users may be a fact, but also a fact is that I have never seen those signs in medical users.

Given that scientific medical considerations of the abuse potential for marijuana are truly benign compared to drugs found in Schedules 2 and 3, such consideration would argue that the proper placement for marijuana is in either Schedule 4 or 5. Placement in a Schedule other than that would require the record be adulterated with inappropriate inclusion of criteria other than scientific, such as the personal opinions of non-scientifically oriented witnesses, those of persons with a financial stake in the drug treatment industry or concerns regarding a lack of a controlled distribution system .

The medical use of marijuana in common therapeutic high dosages has for twelve years been accommodated without a corresponding rise in marijuana dependency among marijuana using patients. Such a safety record must be recognized by properly placing marijuana in Schedule 4 or 5.

Thank you for your attention.

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Appendix follows.

Appendix 1

The findings required for each of the schedules are as follows:

(1) Schedule I. -

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has no currently accepted medical use in treatment in the United States.

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

(2) Schedule II. -

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

(C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

(3) Schedule III. -

(A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) Schedule IV. -

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) Schedule V. -

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

