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# Written testimony for the United States House Committee on Energy and Commerce, Subcommittee on Health, on "Cannabis Policies for the New Decade"

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Doctors for Cannabis Regulation (DFCR) writes today in support of cannabis regulation as an alternative to the failed policy of prohibition – a prohibition that is rooted in the federal Controlled Substances Act (CSA).

DFCR is the nation's premier physicians' association dedicated to the legalization, taxation and – above all – the effective regulation of cannabis for adults. DFCR has hundreds of respected physician members in nearly every US state and territory. DFCR physicians include integrative medicine pioneer Andrew Weil, former Surgeon General Joycelyn Elders, renowned public health physician and Johns Hopkins professor Chris Beyrer, and retired clinical director of SAMHSA, H. Westley Clark.

While we are disappointed that this hearing has included only government witnesses who support the continued illegality of cannabis, we appreciate the committee's willingness to accept this written testimony into the record. We would like to share the scientific and historical evidence that contradicts frequently repeated myths about cannabis, its inclusion in the Controlled Substances Act, and its resultant prohibition.

## History

In 1937, the American Medical Association sent Dr. William Woodward to the House of Representatives to testify against the proposed prohibition of cannabis.[1] Refuting hyperbolic tabloid claims, he testified that cannabis is not highly addictive, does not cause violence in users, and does not cause fatal overdoses. He reasoned that cannabis should, therefore, be regulated rather than prohibited. Scientific evidence now confirms that Dr. Woodward was correct.[2,3,4]

[1] *Taxation of Marihuana, hearings before the House Committee on Ways and Means*, 75th Congess, lst Session, May 4, 1937, cited in "The Prescience of William C. Woodward." Doctors for Cannabis Regulation, 2015. https://dfcr.org/the-prescience-of-william-c-woodward/.

[2] National Academies of Sciences, Engineering, and Medicine. *The health effects of cannabis and cannabinoids: The current state of evidence and recommendations for research*. Washington, DC: The National Academies Press, 2017. https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and-cannabinoids-the-current-state

[3] "Learn About Marijuana: Marijuana and Aggression," Alcohol and Drug Abuse Institute, University of Washington, 3/2015. http://learnaboutmarijuanawa.org/factsheets/aggression.htm

[4] Collen, Mark. "Prescribing cannabis for harm reduction." *Harm Reduct J.* 2012; 9:1. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3295721/

In 1969, when the US Supreme Court declared the 1937 law against cannabis to be unconstitutional, the Federal Government was faced with a choice between legalization or another means of continuing the drug's prohibition. President Nixon appointed the Shafer Commission to study the health effects of cannabis and recommend a course of action. To the surprise of many, this blue-ribbon commission concluded that cannabis should *not* be included in new controlled substance legislation, but rather should be regulated like alcohol, which is not scheduled at all.

The commission's findings were ultimately rejected by the Federal Government, which was eager to include cannabis in its nascent "War on Drugs." Fear, not science, was the motivation for cannabis' inclusion in the Controlled Substances Act (CSA), where it was placed in the most restrictive category, along with heroin and PCP.

**Cannabis, the Controlled Substances Act, and obstacles to research**

According to the CSA, a Schedule I drug must meet three specific criteria: "high potential for abuse," "no currently accepted medical use," and "lack of accepted safety." Cannabis does not meet any of these criteria. Cannabis does not share the high abuse potential associated with other Schedule I drugs or other legal recreational substances. According to a comprehensive review by the National Academy of Medicine, cannabis's dependence liability is similar to that of caffeine (9 percent), and it is far lower than dependence associated with alcohol (15 percent) and tobacco (32 percent).[5] Cannabis has a well-researched safety profile, and it possesses no documented risk of lethal overdose.[6] According to a United Nations Report, "There are no confirmed cases of human deaths from cannabis poisoning in the world medical literature."[7] FDA-approved trials[8] and a comprehensive 2017 review by the National Academies of Science, Engineering, and Medicine[9] support the safety and efficacy of cannabis in various patient populations. Today, most states and a majority of physicians recognize the therapeutic value and relative safety of cannabis.[10]

But even if it had no medical value, a free society does not punish competent adults for the personal use of a non-lethal plant. The Federal Government must stop using a sledgehammer to kill a weed.

For years, DFCR has urged the FDA to remove cannabis from the CSA. They have repeatedly refused to do so, citing support for their position from the DEA and NIDA. These groups have claimed that they support more research on cannabis, yet they have continued to block most research.

They have also refused to allow facilities other than the University of Mississippi to

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[5] National Academies of Science, Engineering and Medicine. *Marijuana and Medicine: Assessing the Science Base*. Washington, DC: The National Academies Press, 1999. Page 95: Table 3.4: Prevalence of Drug Use and Dependence in the General Population. https://www.nap.edu/catalog/6376/marijuana-and-medicine-assessing-the-science-base

[6] Calabria B, et al. (2010) "Does cannabis use increase the risk of death? A systematic review of epidemiological evidence on adverse effects of cannabis use." *Drug Alcohol Rev* 2010 May;29(3):318-30. https://www.ncbi.nlm.nih.gov/pubmed/20565525

[7] Martin, B.R. and Hall, W. "The health effects of cannabis: key issues of policy relevance." United Nations Office on Drugs and Crime, December 1, 1999 https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1997-01-01_1_page005.html

[8] Grant, I., Atkinson, J. H., Gouaux, B., & Wilsey, B. (2012). "Medical marijuana: clearing away the smoke." *The Open Neurology Journal*, 6, 18–25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3358713/

[9] National Academies of Sciences, Engineering, and Medicine. *The health effects of cannabis and cannabinoids: The current state of evidence and recommendations for research*. Washington, DC: The National Academies Press, 2017. https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and-cannabinoids-the-current-state

[10] Rappold, R. Scott. "Legalize Medical Marijuana, Doctors Say in Survey." WebMD, 2014. http://www.webmd.com/news/breaking-news/marijuana-on-main-street/20140225/webmd-marijuana-survey-web

cultivate strains for research, despite several years of court orders to do so. This is a major impediment to research that they have cynically claimed to support, because cannabis grown at the University of Mississippi has THC levels that are closer to those of non-psychoactive hemp than they are to today's psychoactive cannabis strains.

**The folly of cannabis prohibition**

As physicians, we believe that cannabis should never have been made illegal for consenting adults. It is less harmful to adults than alcohol and tobacco, and the prohibition has done far more damage to our society than the adult use of cannabis itself.

Of course, cannabis is not harmless. People who are predisposed to psychotic disorders should avoid any cannabis use. Also, as with alcohol and other drugs, heavy cannabis use may adversely affect brain development in minors.[11] But cannabis prohibition for adults doesn't prevent underage use nor limit its availability. The government's own statistics show that 80-90% of eighteen-year-olds have consistently reported easy access to the drug since the 1970s.[12] For decades, preventive education has reduced the rates of alcohol and tobacco use by minors,[13] At the same time, underage cannabis use rose steadily despite its prohibition. In the past several years – as more states legalize cannabis for adults – the rate of underage cannabis use has stopped increasing.

Some have argued that if cannabis is legal for adults, then minors will think it's safe for them. But when cannabis is against the law for everyone, the government sends the message that cannabis is dangerous for everyone. Teenagers know that's not true. By creating a legal distinction between cannabis use by adults and minors, we teach our children a respect for scientific evidence – and the sanctity of the law. This may be why teen use has remained level or decreased in legalized states.[14,15]

There is a persistent misconception that cannabis is a "gateway" drug. While users of hard drugs often try cannabis first, they're even more likely to try alcohol and tobacco. People generally try less dangerous drugs before trying more dangerous drugs, but the vast majority of those who try cannabis, alcohol and tobacco never go on to use harder drugs. The risk of drug misuse and addiction is now known to be largely due to pre-existing genetic and environmental risk factors,[16] not the use of cannabis, alcohol, or other so-called "soft" drugs. As we learned in high school, correlation does not imply causation.

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[11] Schweinsburg, et al. "The Influence of Marijuana Use on Neurocognitive Functioning in Adolescents." *Curr Drug Abuse Rev.* 2008 Jan; 1(1): 99–111. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2825218/

[12] Johnston, Lloyd. *Monitoring the Future: National Survey Results on Drug Use, 1975-2008: Volume II: College Students and Adults Ages 19-50.* Bethesda, MD: National Institute on Drug Abuse, 2009. http://monitoringthefuture.org/pubs/monographs/vol2_2008.pdf

[13] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm

[14] Hasin et al. 2015. "Medical marijuana laws and adolescent marijuana use in the USA from 1991 to 2014: results from annual, repeated cross-sectional surveys." *Lancet Psychiatry* 2: 601-608. http://www.ncbi.nlm.nih.gov/pubmed/26303557

[15] Colorado Department of Public Safety. Impacts of marijuana legalization to Colorado. 2018. https://www.colorado.gov/pacific/publicsafety/news/colorado-division-criminal-justice-publishes-report-impacts-marijuana-legalization-colorado

[16] Quenqua, Douglas. "A Comeback for the Gateway Drug Theory?" *The New York Times*, December 7, 2017. https://www.nytimes.com/2017/12/07/well/live/a-comeback-for-the-gateway-drug-theory.html?_r=0. See also: Valdez, Avelardo et. al. "Aggressive Crime, Alcohol and Drug Use, and Concentrated Poverty in 24 U.S. Urban Areas." *Am J Drug Alcohol Abuse*. 2007; 33(4): 595–603. http://www.tandfonline.com/doi/full/10.1080/00952990701407637

In 2020, even those who oppose legalization generally believe that cannabis should be decriminalized. But decriminalization is an inadequate substitute for legalization. In legalized states, government licensed retailers scrupulously check IDs and only sell cannabis products to adults.[17] But where cannabis is merely decriminalized, the point-of-sale remains in the hands of drug dealers who sell cannabis – along with more dangerous drugs – to children.

**Conclusion**

Cannabis should never have been included in the Controlled Substances Act, and today the science is clearer than ever that cannabis – like alcohol – is best controlled when it is regulated rather than criminally prohibited.

Informed physicians may disagree about the specifics of good regulation, but we can no longer support a prohibition that has done so much damage to public health and personal liberty. Members of the House Energy and Commerce Committee, please work with us to advance public health and protect our children by supporting effective, evidence-based regulation that pending legislation – including the MORE Act – would make possible.

We thank you for your attention to this timely issue.

Respectfully submitted on behalf of the DFCR Board of Directors,

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[17] Buller DB, Woodall WG, Saltz R, Buller MK. "Compliance With Personal ID Regulations by Recreational Marijuana Stores in Two U.S. States." *J Stud Alcohol Drugs* 2019; 80 (6), 679-686. https://www.ncbi.nlm.nih.gov/pubmed/31829920