Testimony to House Human Services Committee regarding changes to medical marijuana law.

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Thank you for allowing me to testify.
I have two areas of concern:

1. Expansion of to include the diagnosis of Post-Traumatic Stress Disorder.
2. Challenges for DA system when put in conflict between state and Federal regulations

Expansion to include PTSD

I imagine that as law makers it is heart wrenching to hear the stories of people who suffer deeply and report relief from their suffering when they use cannabis. I also understand the challenges in proceeding with legalization. Approving marijuana for PTSD might seem like a good compromise.

Unfortunately, what may appear helpful from a distance is, in practice, more complex. As we expand the categories that are permissible for medical marijuana, the burden for doctors to determine eligibility will be grow. With diagnoses that are verifiable through independent means (for instance, cancer and multiple sclerosis), we do not rely solely on subjective report. This is not the case for PTSD. While I am in no way diminishing the suffering of those who have survived traumatic experiences, I also know that as a psychiatrist, I have no way to know for sure what a person's experience is beyond what they report to me. Some people report dramatic benefits from marijuana that is in contrast to what I have directly observed. I have met with patients who appear to develop psychotic symptoms when using marijuana yet insist that this drug is highly beneficial. The distinction between PTSD and a host of other common psychological experiences is a fuzzy rather than a distinct one.

Furthermore, the physician's role is only to indicate if the person has a qualifying diagnosis. The doctor does not prescribe the drug. There are many drugs on the market that people use in a way that can be deleterious to their overall function. We observe this with opiates, for instance. A person can experience relief from a host of symptoms without realizing the harm they are experiencing. We have observed the rise in addiction that ensued when physicians had more permissive prescribing patterns. But with opiates, a physician can stop prescribing. A physician would not say the person no longer has the syndrome for which the drug was prescribed, only that in the physician's opinion the drug has more harms than benefits. These are often contentious and disputed discussions. With medical marijuana, those sorts of discussions are moot since the doctor is not prescribing the drug only indicating that the condition exists. As noted above, this is especially problematic when you have a condition that is only verified by subjective report.

To include PTSD as a diagnosis you are essentially taking a back door to legalization under the guise of medical authority. As a physician, I would much rather be in the position of advising a person on the potential risks and benefits (as I do with a substance such as alcohol) than be the gatekeeper for legal access to this substance.

Conflict for DAs and other agencies who provide care and residential services

If you proceed, I urge your committee to address another issue that has arisen with the expansion of medical marijuana. I work for a Designated Agency. We have Federal requirements to be a drug free facility. However, we now are in the position of serving clients who have medical marijuana and request that they use this in our facilities. We have sought guidance from DMH, DAIL and the Attorney General's office to no avail. Case scenario: a person who has a card to treat chronic pain. The pain exacerbates depression and at times the person has intense desires to end his life. Cannabis is identified as critical to reducing pain. The person requests admissionIt is important that this issue is addressed so we can responsibly help our clients without risking Federal sanctions.