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Open Cannabis in a Safe & Standardized Industry:
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Thank you for allowing me to offer testimony to improve S. 16 in its current form.

Allow me to start with some kudos to the committee on waiving the 3 month rule when necessary and the expansion of the list for qualifying conditions. This shows some true progress. Now onto what needs to be amended with S. 16 to make it better.

I: Outdoor:
Why does the Committee insist that patients have to grow medical cannabis indoors while with this bill it allows for dispensaries to cultivate outdoors? Why can't an individual patients or caregivers follow the same rules for outdoor growing shielded from public view? The Department of Public Safety has already granted waivers so that cannabis can be grown by dispensaries in outdoor environments. Why can't patients and caregivers take advantage of the sun's energy and grow medicine with a much smaller carbon footprint? Shouldn't Vermont be embracing medical cannabis agriculture rather than fearing it or putting a law in place that is fair to dispensaries but unfair to home medical cannabis cultivators in terms of outdoor?

II: More medicine = More Plants
There seems to be an underlying fear of the cannabis plant here in Montpelier. In September, I told the Joint Committee that a minimum of 3-6 pounds of cannabis should be on hand to address shortages and supply chain issues for an individual. The federal government gives 210 grams per month as a minimum to patients enrolled in the federal IND Program. So this Committee has decided to increase the amount to be purchased every month from 2 ounces to 3. The issue here is that the Committee hasn't increased plant limits for dispensaries or patients/caregivers growing their own medicine. Should this law pass, we can purchase 84 grams per month from a dispensary, still less than half of what the federal government gives the survivors in the IND program that was started in 1978. Please increase plant limits and possession limits when considering an amendment of S. 16 in 2017. 3 mature plants and 10 immature sounds like a logical start point.

Does this committee realize that plant numbers do not dictate how much cannabis is grown? The yield from a cannabis garden is generated by the proper exposures to darkness and usable light, with sunlight being the most optimal light for the plant. Cannabis grown indoors is more dependent upon the concentration of light than the number of plants under that light. The federal government is most concerned with gardens of 99 plants or more by statute. Dispensaries could easily become the target of a federal crackdown whereas homegrown medical cannabis would likely not be the subject of such interference should there be a rewind in federal policy beyond what we've witnessed in less than two weeks. Giving all patients the ability to grow and utilize the dispensary system is important to keep access alive and affordable.

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III. Cannabis Algebra

The algebra the committee is using isn't sufficient. Patients need quality, affordable and consistent medicine. There is no consistency in Vermont due to the fixation of 2 mature plants and 7 immature plant formula for dispensaries. After now trying a third dispensary here, I am still not able to get from visit to visit, a particular strain found effective from a previous visit. It is totally hit or miss. It equates with going to the pharmacy needing Aspirin and having to settle for Tylenol or Advil. This experience is compounded when switching from one dispensary to another as a patient has to pay $25 to visit another dispensary and also wait for the State to issue a new ID card. Does the state of Vermont force its citizens to choose one pharmacy in the state and only get its medicine from that pharmacy? Why is the medical cannabis program the exception to this norm? Patients shouldn't be taxed for the State's paranoia.

Since the Committee has considered allowing patients to cultivate and also get 3 ounces per month from a selected dispensary, can the Committee come up with a solution beyond forcing patients to use only one dispensary in a system that is about to be open to possibly 8 choices? Perhaps the Registry can expand its function and keep a gram count secured to our patient ID numbers/registry number that can be seen from dispensary to dispensary to track monthly purchases.

In order for the medical cannabis system to work optimally, these facilities should be open to any medical cannabis registry ID card holder. My suggestion is to scrap the current hierarchy of access and plant counts. Allow patients to grow their own, select a favorite/preferred dispensary and create a new structure for dispensaries to cultivate to meet their needs and vend between themselves in order to alleviate supply chain issues and shortages.

Dispensaries need to be providing consistent product and not reacting to a structure that is almost inherently designed for failure due to over regulation. These facilities are not operating a restaurant, they are cultivating medicine that takes months to grow.

IV: Testing and Standards

Patients shouldn't be left in the dark in terms of understanding the cannabinoids present in their cannabis. The State lab that is being utilized for medical cannabis testing should be open to the public that is purchasing hemp derived products and open to medical cannabis patients and caregivers growing their own plants. The State should also make sure that what is being tested is safe for consumption and not just be concerned with THC content. The language presented in S. 16 is haphazard in this singling out of THC content.

Personally I believe there is a conflict of interest for dispensaries to be publishing lab results they generate internally without 3rd Party Verification. A 3rd Party, ISO 17025 certified lab should be checking lab results from every dispensary publishing their own results. All labs operating in the state that are working with medical cannabis should have ISO 17025

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credentials. Cannabis and cannabis products need to be screened for heavy metals, pesticides, plant growth regulators, residual solvents and microbial/fungal limits and held to American Herbal Pharmacopoeia (AHP) and American Herbal Products Association standards for the cultivation, manufacturing and distribution of medical cannabis and hemp. These standards have been adopted by over a dozen states and most recently were adopted in Guam.

The cannabinoid content should not be isolated to testing for Delta-9 Tetrahydrocannabinol (Δ9THC) alone, other cannabinoids need to be tested for such as Cannabidiol (CBD) which is being isolated from Hemp crops in Vermont. The acids for both of these molecules also need to be accounted for as well as Cannabichromene (CBC), Cannabigerol (CBG), Cannabinol (CBN)and Delta-8 tetrahydrocannabinol (Δ8THC). Terpenoid content should also be measured as a better way of documenting strains beyond the current haphazard strain names.

V: More Access

In terms of the expansion to 8 dispensaries, the Committee should address the current production capability and maximum production capacity of the 4 operating licenses. It is wise to increase the number of dispensaries operating as the number of patients increases with the expansion of conditions. Once the current license holders reach maximum capacity, additional licenses should be considered by a more piecemeal approach versus doubling the number of license holders outright in S.16. We need a path forward that works for patients first and the organizations providing for them. Let's fix what we have in front of us and make it work for patients by making all dispensaries open and accessible to every patient so that those with the medical need can find the medicine that is best for them. It shouldn't be a scavenger hunt in a bread line, and that is what we have now.