

IN THE SUPREME COURT OF THE STATE OF OREGON

ROBERT WASHBURN,	)	Supreme Court No. S52254
	)	
Petitioner,	)	CA No. A116664
	)	
v.	)	Multnomah County Circuit Court
	)	No. 0012-12516
EMPLOYMENT DEPARTMENT and	)	
STREAM SERVICES, INC.,	)	
	)	
Respondents.	)	

---

**BRIEF OF AMICUS CURIAE**  
**AMERICAN CIVIL LIBERTIES UNION, NATIONAL ORGANIZATION FOR THE**  
**REFORM OF MARIJUANA LAWS, AMERICANS FOR SAFE ACCESS**

---

Opinion Filed:	January 12, 2005
Author of Opinion:	Deits, J. pro tempore
Concurring Judges:	Haselton, P.J., and Wollheim, J.
Dissenting Judges:	None
Before:	Haselton, Presiding Judge; Wollheim, J. and Deits, J. pro tempore

WILLIAM LATER, OSB #89283  
Attorney at Law  
815 SW Second Avenue, #500  
Portland, Oregon 97204-3005  
Tel. (503)-221-1792  
Fax. (503)-223-1516  
Cooperating Attorney, ACLU Foundation of  
Oregon

Leland R. Berger, OSB #83020  
Attorney at Law  
3527 NE 15<sup>th</sup> Avenue, #103  
Portland, Oregon 97212-22356  
Tel. 503-287-4688  
Fax 503 287-6938  
Cooperating Attorney, NORML and ASA

Scott G. Seidman, OSB #83320  
Lynda Hartzell, OSB #93294  
TONKON TORP, LLP  
1600 Pioneer Tower  
888 SW Fifth Avenue  
Portland, OR 97204-2099  
Tel: 503-802-2021  
Fax: 503-972-3721  
Of Attys for Petitioner on Review Columbia  
Forest Products, Inc.

Filed October 25, 2005

## TABLE OF CONTENTS

TABLE OF CONTENTS .....	ii
TABLE OF AUTHORITIES .....	iv
INTRODUCTION .....	1
ARGUMENT .....	1
I. WASHBURN IS ENTITLED TO PROTECTION OF THE OREGON DISABILITY ACT ..	2
A. THE OREGON DISABILITY STATUTE .....	2
1. CONSTITUTIONAL PROHIBITION .....	3
2. AT THE TIME THE OREGON STATUTE WAS ADOPTED, THE INTERPRETIVE GUIDANCE AND STATUTORY HISTORY INDICATED THAT DISABILITY WOULD BE DETERMINED WITHOUT CONSIDERATION OF MITIGATING FACTORS .....	3
B. OREGON'S DISABILITY STATUTE, AND ITS EXPLICIT PROVISION FOR BROAD INTERPRETATION, IS NOT CONTROLLED BY PRECEDENT INVOLVING THE FEDERAL ADA AND ITS JUDICIALLY-INVOKED NARROW INTERPRETATION .....	5
C. MITIGATING MEASURES SHOULD NOT BE TAKEN INTO ACCOUNT WHEN DETERMINING WHETHER OR NOT AN INDIVIDUAL IS DISABLED .....	6
II. WASHBURN IS ENTITLED TO THE PROTECTIONS OF THE OREGON MEDICAL MARIJUANA ACT .....	7
A. OREGON LAW PROHIBITS EMPLOYERS FROM DISCRIMINATING AGAINST OREGON MEDICAL MARIJUANA PATIENTS BASED SOLELY ON THEIR OFF-SITE USE OF THERAPEUTIC CANNABIS BECAUSE THE EXEMPTION IN ORS 475.340(2) OF THE OMMA FOR EMPLOYER ACCOMMODATION OF MEDICAL MARIJUANA APPLIES ONLY TO EMPLOYEE USE OF MEDICAL MARIJUANA ON THE ACTUAL WORK SITE .....	7
B. COLUMBIA FOREST PRODUCTS' <i>AMICI</i> MISUNDERSTAND THE ROLE OF THE ATTENDING PHYSICIAN IN THE OMMA .....	8

C. COLUMBIA FOREST PRODUCTS AND ITS *AMICI* MISUNDERSTAND THE  
IMPORT OF THE UNITED STATES SUPREME COURT DECISIONS  
REGARDING STATE MEDICAL MARIJUANA LAWS ..... 9

CONCLUSION ..... 11

ATTACHMENTS:

A. Copy of Court of Appeals Opinion ..... ATT. A

B. HB 2963 ..... ATT. B

## TABLE OF AUTHORITIES

### CASES:

<i>Seale et al v. McKennon</i> , 215 Ore. 562, 572-73, 336 P.2d 340 (1959) .....	3
<i>Hillman v. Northern Wasco County People's Utility District</i> , 213 Ore. 264, 323 P.2d 664 (1958) .....	3
<i>Sutton v. United Airlines</i> , 527 U.S. 471, 119 S. Ct. 2139, 144 L. Ed. 2d 450 (1999) .....	5
<i>Evans v. Multnomah County Sheriff's Office</i> , 184 Or App. 733, 57 P.3d 211 (2002), <i>rev. den.</i> 335 OR. 180; 63 P.3d 27; (2003) .....	6
<i>Gonzales v. Raich</i> , ___ US ___, 125 S Ct 2195 (2005) .....	9, 10
<i>United States v. Oakland Cannabis Buyers' Cooperative and Jeff Jones, et. al.</i> , 532 US 483, 121 S Ct 1711, 149 L Ed 2d 722 (2001) .....	9, 10

### STATUTES AND RULES:

ORS 659A.100(1)(a) .....	2, 3, 6
ORS 659A.139 .....	3
ORS 659A.100 et seq .....	3
42 USC §12116 .....	4
29 C.F.R. pt. 1630, App., p. 348 .....	4
28 C.F.R. §35.104 .....	4
28 C.F.R. §36.104 .....	4
28 C.F.R. pt35, App.A, p.442 (1998) .....	4
28 C.F.R. pt 36, App.B, p.583 (1998) .....	4
ORS 659A.103 .....	5
ORS 659A.112 .....	6

ORS 659A.115. ....6

ORS 475.340(2) .....7

ORS 475.316(1)(b) .....7

ORS 161.015 .....7

ORS 475.302(1) .....8

OAR 333-008-0010(1) .....8

ORS 475.309(7)(a)(B) .....9

42 USC §12111(6)(A) .....9

**LEGISLATIVE HISTORY**

S. REP. NO. 101-116 .....5

H.R. REP. NO. 101-485 .....5

HB 2963 .....7

SB 1085 .....7

## INTRODUCTION

### **Amici and their Concerns**

The American Civil Liberties Union of Oregon Inc., (ACLU) is a nonprofit, nonpartisan, corporation dedicated to maintaining civil rights and liberties guaranteed or reserved to the people by the Oregon and the United States Constitutions. To that end, the ACLU has appeared in numerous cases in this and other Oregon courts as *amicus curiae* concerning civil liberties and civil rights generally. ACLU participated in drafting the Oregon Medical Marijuana Act (OMMA), and lobbied the 1999 and 2005 legislative sessions' amendments to the OMMA and testified before the 2005 legislature opposing a bill concerning the issue in the case at bar.

The National Organization for the Reform of Marijuana Laws (NORML), has long supported policies and legislation which permit seriously ill patients to use physician recommended cannabis therapeutically, without fear of arrest, prosecution or forfeiture. This support dates back to NORML's first assertion of the medical use of cannabis in a 1972 administrative petition seeking to enable doctors to prescribe cannabis by rescheduling it from Schedule 1 to Schedule 2 under the federal regulatory scheme. The NORML Board of Directors endorsed the Oregon Medical Marijuana Act prior to the November 1998 general election which enacted it, and the NORML Legal Committee member who is participating in this amicus brief helped draft the OMMA and lobbied the 1999 and 2005 legislative sessions' amendments to the OMMA and testified before the 2005 legislature opposing a bill concerning the issue in the case at bar.

Americans for Safe Access (ASA) is the largest national grassroots coalition working solely to protect the rights of patients and doctors to use marijuana for medical purposes. ASA's

mission is to ensure safe, legal access to marijuana for all who are helped by it. ASA provides legal training for lawyers and patients, medical information for doctors and patients, media support for court cases, activist training to organizers, and rapid response to law enforcement problems. ASA works with local, state and national legislators on issues concerning medical marijuana patients. ASA's successful media and legal campaigns have resulted in important court precedents, new sentencing standards, and more compassionate community guidelines.

ACLU, NORML and ASA are concerned that the rights of Oregon Medical Marijuana patients be protected in the workplace.

## **ARGUMENT**

### **I. Washburn is entitled to the protections of the Oregon Disability Act**

#### **A. The Oregon Disability Statute.**

At issue in this case is ORS 659A(1)(a), the definition of the term "disabled person." Under that statute, "disabled person" means an individual who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment." ORS 659A.100(1)(a). The employer, Columbia Forest Products, Inc., has argued that Washburn is not a disabled person because his use of marijuana is a "mitigating measure" which alleviates Washburn's inability to sleep to the extent that he should not be considered a disabled person.

The question then is whether or not mitigating measures should be taken into account before determining whether an individual is disabled. As discussed below, the early federal interpretations which were in effect at the time the Oregon statute was enacted, and the legislative history of the federal disability law, were clear in stating that such mitigating measures

should not be taken into account in determining whether an individual was disabled.

The Oregon legislature also enacted a “lockstep” statute which provides that Oregon’s disability law should be interpreted consistently with the federal law. However, as is also discussed below, that “lockstep” provision does not apply to the definition of “disabled individual,” and, even if it did, it would be an unconstitutional delegation of authority to adopt future federal interpretations.

### **1. Constitutional prohibition.**

ORS 659A.139 states: “ORS 659A.112 to 659A.139 shall be construed to the extent possible in a manner that is consistent with any similar provisions of the federal Americans with Disabilities Act of 1990, as amended.”

In our case, the relevant statute is ORS 659A.100(1)(a), the definition of “disability.” That statute is *not* included in the ORS 659A.139 “lockstep” provision.

Even if ORS 659A.100(1)(a) were included in ORS 659A.139, it is well established that the Oregon legislature may not delegate its authority by adopting as the law of Oregon future laws of the United States. *Seale et al v. McKennon*, 215 Ore. 562, 572-73, 336 P.2d 340 (1959) (state law cannot incorporate future federal regulations); *Hillman v. Northern Wasco County People's Utility District*, 213 Ore. 264, 323 P.2d 664 (1958). Therefore, even if this “lockstep” provision incorporated the relevant Oregon statute (which it does not), any new federal interpretations regarding similar Oregon statute could not apply to the Oregon statute.

### **2. At the time the Oregon statute was adopted, the interpretive guidance and statutory history indicated that disability would be determined without consideration of mitigating factors.**

The Oregon Disability Act (ODA) became law in 1997. ORS 659A.100 et seq. At that

time, the federal Americans with Disabilities Act of 1990 was interpreted by the Equal Employment Opportunities Commission and the U.S. Department of Justice. The EEOC, responsible for issuing regulations relating to Title I, 42 USC §12116, adopted Interpretive Guidance at the same time as its regulations. The interpretive guidance to the regulation defining the term “substantially limits,” 29 C.F.R. §1630.2(j), provides, in relevant part: “The determination of whether an individual is substantially limited in a major life activity must be made on a case by case basis, *without regard to mitigating measures such as medicines, or assistive or prosthetic devices.*” 29 C.F.R. pt. 1630, App., p.348 [*emphasis added*].

The regulations issued by the Department of Justice to implement Titles II and III of the ADA reached the same conclusion. 28 C.F.R. §35.104 and 28 C.F.R. §36.104 contain regulatory definitions of “disability.” The accompanying analysis prepared by the Justice Department provided:

The question of whether a person has a disability should be assessed without regard to the availability of mitigating measures, such as reasonable modifications or auxiliary aids and services. For example, a person with hearing loss is substantially limited in the major life activity of hearing, even though the loss may be improved through the use of a hearing aid. Likewise, persons with impairments, such as epilepsy or diabetes, that substantially limit a major life activity, are covered under the first prong of the definition of disability, even if the effects of the impairment are controlled by medication.

28 C.F.R. pt.35, App.A., p. 442 (1998); 28 C.F.R. pt.36, App.B, p.583 (1998).

The EEOC and Department of Justice interpretations were supported by legislative history. The Senate Report on the ADA states:

A person is considered an individual with a disability for purposes of the first prong of the definition when the individual’s important life activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.... Moreover, whether a person has a disability should

be assessed without regard to the availability of mitigating measures, such as reasonable accommodations or auxiliary aids.

S. Rep. No. 101-116, at 23.

The report from the House Education and Labor Committee repeats this guidance virtually verbatim, then adds: "Likewise, persons with impairments, such as epilepsy or diabetes, which substantially limit a major life activity are covered under the first prong of the definition of disability, even if the effects of the impairment are controlled by medication.: H.R. Rep. No. 101-485, pt.2, at 52. The report from the House Judiciary Committee also stated: "the impairment should be assessed without considering whether mitigating measures, such as auxiliary aids or reasonable accommodations would result in a less-than-substantial limitation." H.R. Rep. No. 101-485, pt.3, at 28.

The U.S. Supreme Court rejected these interpretations in 1999, two years after the Oregon Disability Act was passed. *Sutton v. United Airlines*, 527 U.S. 471, 119 S. Ct. 2139, 144 L. Ed. 2d 450 (1999).

**B. Oregon's Disability Statute, and its Explicit Provision for Broad Interpretation, Is Not Controlled by Precedent Involving the Federal ADA and its Judicially-Invoked Narrow Interpretation.**

The rule promulgated in *Sutton* is irrelevant to the Oregon statute because Oregon law differs markedly from the Federal law, both in their text and in their dramatically disparate rules of interpretation. While the fed law is to minimize employer's burden where ever possible, Oregon's statute explicitly expands the rights of the disabled.

ORS 659A.103 provides:

"(1) It is declared to be the public policy of Oregon to guarantee disabled persons the fullest possible participation in the social and economic life of the state, [and] to engage in remunerative employment \* \* \* without discrimination.

"(2) The right to otherwise lawful employment without discrimination because of disability where the reasonable demands of the position do not require such a distinction, \* \* \* [is] hereby recognized and declared to be the right[] of all the people of this state. It is hereby declared to be the policy of the State of Oregon to protect these rights and *ORS 659A.100 to 659A.145* shall be construed to effectuate such policy."

As the Oregon Court of Appeals found in *Evans v. Multnomah County Sheriff's Office*, 184 Or App. 733, 57 P.3d 211 (2002), *rev. den.* 335 OR. 180; 63 P.3d 27; (2003), "[i]t is not possible to achieve consistency between an implicit federal policy mandating a narrow interpretation of the ADA and an explicit Oregon policy mandating a broad one." *Evans* at 743, 216.

**C. Mitigating measures should not be taken into account when determining whether or not an individual is disabled.**

Using proper, logical analysis, the court should first determine whether an individual's physical or mental impairment substantially limits that person in some major life activity. That is the plain reading of ORS 659A.100(1)(a). This first step in the analysis is simply to determine whether the individual has the type of medical condition contemplated by the legislature to be protected by the statute.

A second step in the analysis is whether the disabled individual is able to perform the job in question. The second step is implicit in ORS 659A.112 and 659A.115. At this stage of analysis, mitigating measures are appropriately considered in order to determine whether the disabled individual can perform the job.

When mitigating corrective measures are taken into account to determine whether an individual is disabled, the disabled individuals most likely to be qualified for a position would be excluded from legal protection, and, conversely, individuals who do not mitigate their medical

condition would remain protected by law. The Oregon legislature could not have intended this absurd result, and the statutory/regulatory history of the ADA confirms this.

Washburn is disabled because he is substantially impaired in the major life activity of sleeping. His use of marijuana mitigates that impairment so that he is able to function and work. The employer's position, that he is not protected by the law because he is enabling himself to work, is contrary to the intent of the statute.

## II. Washburn is entitled to the protections of the Oregon Medical Marijuana Act

### A. Oregon law prohibits employers from discriminating against Oregon medical marijuana patients based solely on their off-site use of therapeutic cannabis because the exemption in ORS 475.340(2) of the OMMA for employer accommodation of medical marijuana applies only to employee use of medical marijuana on the actual work site.

*Amici* agree with both the Court of Appeals and with Washburn that the text of ORS 475.340(2) compels the conclusion that the exemption for employer accommodation is limited to on-site use. When this issue arose during the initiative campaign in 1998, proponents explained that employers, who are required by disability laws to build ramps and otherwise accommodate wheelchair bound workers, would not be required to construct 'medication stations' where workers could medicate in private and not in public view. *See*, ORS 475.316(1)(b) (limiting the exception from criminal prosecution by denying it to those who: '[e]ngage[] in the medical use of marijuana in a public place, as that term is defined in ORS 161.015, or in public view...').

Further evidence of legislative intent is found in co-chief petitioner Dr. Richard E. Bayer's testimony before the Oregon Senate's Rules Committee during its hearing on HB 2963<sup>1</sup>,

<sup>1</sup> This bill, a copy of which is appended to this brief, would have changed the law consistent with the interests of Columbia Forest Products and its *amici*. Although it passed out of the House twice (once, prior to the hearing involving the above-cited testimony, and once as an amendment to SB1085, a comprehensive revision of the OMMA) it was twice defeated in the Senate and as a consequence never became law.

a copy of which is attached to this brief. Specifically, regarding the statute at issue here, Dr.

Bayer testified:

ORS 475.340 Section 1 (2) (a) should remain as the voters passed in 1998 with **in any workplace** remaining and [regardless of where the use occurs]; removed. Although the authors of the OMMA did not intend for the Act to require employers to accommodate the medical use of marijuana inside any workplace, the OMMA authors did intend medical marijuana to be accommodated like other medicines. That is why ORS 475.300 (1) states, “. . . marijuana should be treated like other medicines;” and the Oregon voters agreed.

Emphasis in original.

**B. Columbia Forest Products' amici misunderstand the role of the attending physician in the OMMA**

The OMMA defines an attending physician thusly:

"Attending physician" means a physician who has established a physician/patient relationship with the patient, is licensed under ORS chapter 677, who has primary responsibility for the care and treatment of a person diagnosed with a debilitating medical condition.

ORS 475.302(1)

The Department of Human Services (DHS) had promulgated an administrative rule to further explain the concept. ORA 333-008-0010(1) provides:

For the purposes of OAR 333-008-0000 through 333-008-0090, the following definitions apply:

- (1) "Attending physician" means a physician who has established a physician/patient relationship with the patient, is licensed under ORS chapter 677, and who, with respect to a patient diagnosed with a debilitating medical condition:
  - (a) Is primarily responsible for the care and treatment of the patient;
  - (b) Is primarily responsible for recognized, medical specialty care and treatment of the patient;
  - (c) Has been asked to consult and treat the patient by the patient's primary

care physician; or,

- (d) Has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file.

In addition to providing 'a treatment plan and/or follow-up care' the patient needs to see the physician annually to renew the registration, so that the physician can confirm in writing that the patient continues to suffer from a debilitating medical condition. *See*, ORS 475.309(7)(a)(B), so requiring.

This ought qualify medicinal cannabis as a drug 'taken under supervision by a licensed health care professional' as that phrase is used in 42 USC §12111(6)(A), excluding the therapeutic use of cannabis from the definition of 'illegal use of drugs.'

**C. Columbia Forest Products and its amici misunderstand the import of the United States Supreme Court decisions regarding state medical marijuana laws.**

In its merits brief, Columbia Forest Products asserts that '[a]fter the Supreme Court's decision in *Gonzales v. Raich*, \_\_\_ US \_\_\_, 125 S Ct 2195 (2005), it can no longer be doubted that even the purely intrastate cultivation, possession and use of marijuana for personal medical use is illegal under federal drug laws.'" Petitioner's Merit's Brief at 7. Their amici cite to *United States v. Oakland Cannabis Buyers' Cooperative and Jeff Jones, et. al.*, 532 US 483, 121 S Ct 1711, 149 L Ed 2d 722 (2001) for the proposition that a medical necessity defense is unavailable as against a prosecution under the federal Controlled Substances Act(CSA). Neither assertion is completely accurate.

In *Raich*, the limited holding is that application of SCA provisions criminalizing

manufacture, distribution, or possession of marijuana to intrastate growers and users of marijuana for medical purposes does not violate the Commerce Clause. At least one commentator<sup>2</sup> has explained that all the Court did was remove this one defense (no commerce clause authority to enact) from the list of possible defenses to a federal prosecution under the CSA. Similarly, in the *Oakland CBC* case, the government had used the injunction power of the CSA to enjoin the distribution of therapeutic cannabis. The Ninth Circuit Court of Appeals reversed the injunction (190 F3d 1109 (1999)) holding that the distributors had a medical necessity defense. The Supreme Court reversed the Ninth Circuit but, as the concurring opinion points out “Most notably, whether the defense might be available to a seriously ill patient for whom there is no alternative means of avoiding starvation or extraordinary suffering is a difficult issue that is not presented here.” 532 US 483 at 501, 149 L Ed 2d 722 at 738.

In *Raich*, the Court expressly acknowledged that

evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I. *See, e.g.*, Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base* 179 (J. Joy, S. Watson & J. Benson eds. 1999) (recognizing that “[s]cientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC (Tetrahydrocannabinol] for pain relief, control of nausea and vomiting, and appetite stimulation”); see also *Conant v. Walters*, 309 F3d 629, 640-643 (C.A.9 2002)(Kozinski, J., concurring)(chronicling medical studies recognizing valid medical uses for marijuana and its derivatives).

125 S Ct at 2211, n. 37.

Acknowledging the therapeutic use of medicinal cannabis is the condition precedent to authorizing a medical necessity defense.

---

<sup>2</sup> Oregon Assistant Attorney General Steven Bushong (speaking for himself, and not on behalf of the Attorney General), Oregon State Bar Health Law Section Brown Bag Lunch CLE “Medical Marijuana Legal Update” Noon, August 3, 2005, 208 Multnomah County Courthouse, Portland.

**CONCLUSION**

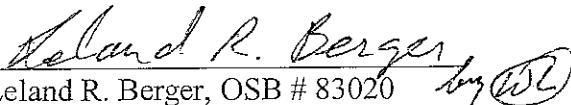
As Dr. Bayer explains in his testimony on HB 2963, off-site use of therapeutic cannabis does not necessarily equate with on- site impairment. Oregon employers ought not be able to defeat Oregon workers' rights as disabled people and as registered medical marijuana patients based solely on their choice of medicine.

For all the above-stated reasons and authority, *amici* ACLU, NORML and ASA respectfully request that this Court affirm the Court of Appeals' ruling reversing the trial court's issuance of summary judgment for Columbia Forest Products, and remanding the case to the trial court for trial on the merits.

Respectfully submitted this 25<sup>th</sup> day of October, 2005.



William N. Later, OSB #89283  
Cooperating Attorney, ACLU Foundation of Oregon  
Attorney for *Amicus Curiae* ACLU



Leland R. Berger, OSB # 83020 *by (DL)*  
Cooperating Attorney, NORML Legal Committee  
Attorney for *Amicus Curiae* NORML  
Cooperating Attorney, ASA Board of Legal Advisors  
Attorney for *Amicus Curiae* ASA

Richard E. Bayer, MD, FACP

Voice: 503-292-1035 6800 S.W. Canyon Drive

Fax: 503-297-0754 Portland, OR 97225 - 3210

ricbayer@comcast.net

July 10, 2005

To: Oregon Senate Rules Committee

Re: Public testimony on HB 2693A

Dear: Senators Brown, Ferrioli, Atkinson, Ringo, and Shields

Thank you for taking my testimony. I am board certified in internal medicine and practiced in Lake Oswego, Oregon where I routinely cared for chronically ill patients. In addition, I was awarded a Fellowship in the American College of Physicians (FACP), co-authored: *Is Marijuana the Right Medicine For You? A Factual Guide to Medical Uses of Marijuana* by Zimmerman, Bayer, and Crumpacker (1998 Keats Publishing), and was a chief petitioner, co-author, and spokesperson for the Oregon Medical Marijuana Act (OMMA) Oregon voters approved in November 1998. I maintain a website with a medical cannabis bibliography, authored an article in the peer-reviewed *Journal of Cannabis Therapeutics*, regularly review medical literature concerning cannabis, and have testified as a medical cannabis expert in Oregon courts.

The gut and stuff version of HB 2693 or HB 2693A that recently passed the House is a discriminatory bill because working disabled persons must sometimes take medication.

1. HB 2693A is not based in science. Cannabis and cannabis-based or cannabinoid products are superior to placebo and about equal to codeine in pain management. But because of differing side effects, they are sometimes medically necessary - particularly as an alternative to opioids and anti-inflammatory medications. The duration of impairment measured after a marijuana cigarette is 3 to 4 hours. There is no evidence showing significant impairment or increase risk of accidents beyond four hours after smoking a marijuana cigarette.

2. The gut and stuff of HB 2693 is not what Oregon voters passed in 1998 as The Oregon Medical Marijuana Act. ORS 475.300 (1) says ". . . marijuana should be treated like other medicines". HB 2693 contains language that makes it impossible for patients to hold a job because of getting fired for presence of inactive urine metabolites.

3. Registration in the Oregon Medical Marijuana Program should never be sole cause for termination of employment; nor, should inactive metabolites in the body for a registered patient be sole cause for termination.

Specifically, HB 2693A contains three highly objectionable sections that need extracting; one section that may achieve a goal to reduce impairment in the workplace and requires one additional amendment to be acceptable.

ORS 475.340 Section 1 (2) (a) should remain as the voters passed in 1998 with **in any workplace** remaining and [regardless of where the use occurs]; removed. Although the authors of the OMMA did not intend for the Act to require employers to accommodate the medical use of marijuana inside any workplace, the OMMA authors did intend medical marijuana to be accommodated like other medicines. That is why ORS 475.300 (1) states, “. . . marijuana should be treated like other medicines;” and the Oregon voters agreed.

Section (2) (b) looks like the sponsors of this bill ask patients to refrain from using pain medicine during work hours. On the surface this seems moderate but would we pass this amendment if we removed the word “marijuana” and substituted “morphine” or “codeine”? Would it be OK for employers to prevent possession of morphine or codeine at work under all circumstances? When the answer to those questions becomes “yes”, this section may become more reasonable. Meanwhile, it looks very discriminatory and should be removed until it can be clarified.

Section 2 (c) is fine. No one supports impairment of any kind in the work place.

Section (3) is hypocritical at best and should be changed. We know that “. . . enforcing a policy to achieve or maintain a drug-free workforce” means ONLY federally legal drugs are allowed. It has little if anything to do with impairment and everything to do with discriminating against persons who use marijuana - even as medicine. The medical marijuana law was passed to protect Oregonians - not fire them. Section (3) [*Preclude or restrict an employer from establishing or enforcing a policy to achieve or maintain a drug-free workforce*] should be removed. In it's place, a new Section (3) should read: **Registration in the Oregon Medical Marijuana Program will not constitute sole cause for termination of employment.”**

The rest of my testimony contains material already presented to the House Judiciary Committee when I testified against HB 2693-1.

Cannabis has been used to relieve pain for centuries throughout the world, including the US, prior to the enactment of the Cannabis Tax Act of 1937. Cannabinoids are a category of substances with cannabis-like properties and include the natural cannabis plant, synthetic cannabinoids, and internal (endogenous) hormones that mimic cannabis. Case reports of the benefit of smoked cannabis to relieve pain are published. The major psychoactive cannabinoid, THC, is as effective as codeine for relieving pain. Researchers wrote, “This trial has demonstrated an analgesic [anti-pain] effect of THC in patients with cancer pain”. Experiments with monkeys and rats show unequivocal science for the analgesic effect of cannabinoids in laboratory animals. Endogenous cannabinoids are important in pain control. GW Pharmaceuticals has performed randomized double-blind placebo-controlled trials showing Sativex®, a cannabis extract administered under the tongue, markedly improves pain and muscle spasm. Canada recently approved Sativex® for treating pain with applications pending in the US and other countries. The International Association for Cannabis as Medicine (IACM) lists dozens of clinical studies including studies on pain. Perhaps the best summary is from the prestigious Institute of Medicine, “In conclusion, the available evidence from animal and human studies indicates that cannabinoids can have a substantial analgesic effect”.

The Oregon Medical Marijuana Act passed by Oregonians in 1998 states in **ORS 475.300 Findings**, “The people of the state of Oregon hereby find that: (1) Patients and

doctors have found marijuana to be an effective treatment for suffering caused by debilitating medical conditions, and therefore, marijuana should be treated like other medicines;" An important part of the law is "**marijuana should be treated like other medicines**". This means Oregonians voted to make medical marijuana treated like medical morphine, medical synthetic THC, or Food and Drug Administration-approved medicines.

The psychoactive effects of both synthetic THC (Marinol® brand of dronabinol) and herbal marijuana are due primarily to THC. The timing issues about how a drug behaves in the body are called pharmacokinetics and are mostly dependent on the method of administering the drug. For example, an inhaled medicine typically works faster but the effects usually do not last as long as a medicine taken by mouth that must be absorbed by the digestive tract. Inhaling cannabis through smoking or vaporizing cannabis bypasses the digestive tract.

In *A Primer of Drug Action*, pharmacologist Robert Julian, MD, PhD, states, "absorption of inhaled drugs is rapid and complete. The onset of behavioral effects of THC in smoked marijuana occurs almost immediately after smoking begins and corresponds with the rapid attainment of peak concentrations in plasma. Unless more is smoked, the effects seldom last longer than 3 to 4 hours."

In the *Journal of Cannabis Therapeutics*, Franjo Grotenhermen, MD wrote "Clinical Pharmacokinetics of Cannabinoids" and summarizes, "Pulmonary [lung] assimilation of inhaled THC causes a maximum plasma concentration within minutes, while psychotropic effects [the "high"] start within seconds to a few minutes, reach a maximum after 15 to 30 minutes, and taper off within 2 or 3 hours." On page 29, he states, "The peak psychotropic effects ("high") after intravenous and inhaled THC application were noted after 20-30 minutes and decreased to low-levels after 3 hours and to baseline after 4 hours (Hollister et al 1981, Lindgren et al 1981, Chiang and Barnett 1984)". He continues on page 30, "Hence about 1-4 hours after smoking there is a good correlation between plasma level and effects (Chiang and Barnett 1984). There was also a good correlation between THC plasma levels and other effects in this phase, with heart rate (Cocchetto et al 1981) and with psychomotor impairment (Barnett et al 1985)". In summary, this peer-reviewed scientific article informs us that **the impairment resolves when plasma THC levels return to low-levels at 3 hours and baseline around 4 hours after smoking marijuana.**

Since THC acts identically whether synthetic or herbal, we should look at the warnings section of the US Food and Drug Administration (FDA)-approved Marinol® brand of synthetic THC or dronabinol: "**WARNINGS: Patients receiving treatment with Marinol should be specifically warned not to drive, operate machinery, or engage in any hazardous activity until it is established that they are able to tolerate the drug and perform such task safely.**" This is sound advice.

In the above studies, impairment from smoked cannabis or marijuana resolves within four hours. Since synthetic THC and herbal THC are identical once inside the body, there is no scientific rationale for discrimination against those who prefer medical THC from an herbal rather than a synthetic source. **The Marinol® package insert warnings should be heeded regardless of whether a person uses synthetic FDA-approved THC (as in Marinol) or herbal THC (as in marijuana or cannabis).**

When a clinician monitors drug therapy, s/he educates a patient through a careful explanation of the procedure (method of use and expected results), alternative therapies, and risks involved in using or not using the medicine. There are many medicines - prescription or nonprescription - that cause drowsiness or impairment. These include medicine for blood pressure, diabetes, arthritis, respiratory infection, allergies, mood stabilization, and pain. Physicians and patients use good communication to lessen risks of adverse drug reactions.

It is important to avoid impairment when driving, operating machinery, or engaging in any hazardous activity whether in the workplace or not. Monitoring by family, friends, peers, and co-workers for anyone's impairment can improve safety. One reason that direct observation of impairment is important is that impairment can be caused by health problems not related to prescription medicines. Things like non-prescription over-the-counter medicines, acute influenza, or a family emergency resulting in lost sleep can cause impairment. This means good communication between employees and employer can lessen risk of impairment at work.

Urine drug testing to monitor therapy is not routinely used in clinical medicine. It is helpful in toxicology or poisoning cases when a doctor is uncertain what drugs are in the body. Urine tests are also used in medical-legal settings. The standard urine test for "marijuana" does not test for the "parent drug" THC, but tests for an inactive non-psychoactive "metabolite" or breakdown product of THC. Inactive breakdown products in a standard "urine marijuana test" can remain positive for weeks to months after consuming cannabis even when there is no impairment. The US Department of Transportation commented about urine drug testing stating that, "while a positive urine test is solid proof of drug use within the last few days, it cannot be used by itself to prove behavioral impairment during a focal event". In other words, **urine drug testing does not prove impairment - it only proves recent use.**

Between 1976 and 1991, there were at least four flight-simulator studies published according to a Library of Medicine search. One showed impairment for at least 2 hours that resolved by 4 to 6 hours. Three others by a different research team showed conflicting results. Two of those three show some impairment at 24 hours while one of the three studies showed abnormal flight simulator results only at 4 hours but none at 8 or 24 hours. Another unpublished study by the same group failed to find impairment bringing the total studies to five. These mixed results create confusion. Since blood levels of THC are near baseline 4 hours after smoking cannabis and impairment beyond 4 hours cannot be consistently demonstrated, the researchers actually call this flight simulator result a "hangover effect" rather than intoxication. According to Dr. Leirer, the purported hangover effect is "very marginal" and is only detected in tests of "very complex human/machine performance". Comparable, subtle effects are reported at very low blood alcohol levels of 0.025%, which is even under the .04% level allowed in commercial motor vehicle drivers .

Possibly because of confusion surrounding flight simulator data, other researchers study actual motor vehicle accidents. In 2002, authors Gregory Chesher and Marie Longo concluded, "At the present time, the evidence to suggest an involvement of cannabis in road crashes is scientifically unproven" 25. However as they note, some of this may be because of evolving science. As mentioned above, testing for inactive urine metabolites does not test for impairment. Recent studies continue to show that "no increased risk for road trauma was found for drivers exposed to cannabis" 26.

But, there is also an effort to base impairment on measuring the "parent drug" responsible for impairment, namely THC. Dr. Olaf Drummer, measured THC levels in fatal crashes in Australia and noticed an association between high THC levels and risk of traffic fatality even in the absence of other drugs 27. Based on forensic evidence he determines whether a driver is "culpable" or responsible for the fatal accident and correlates it to blood THC levels. Drummer and colleagues conclude, "Recent use of cannabis may increase crash risk, whereas past use of cannabis does not" 28. Dr. Franjo Grotenhermen's review of Dr. Drummer's work adds, "While drivers with low concentrations [of THC] in their blood had a lower probability of causing a traffic accident than drug free drivers, higher THC concentrations were associated with a considerably higher culpability ratio" 29.

It remains unclear how to define the gray area about what is "recent" and what is "past" use of cannabis even if one supports using parent drug blood THC levels as a marker for impairment. This is because the THC level below which there is no impairment, varies dramatically among individuals. Plus, the actual numbers of persons who have only THC in the blood and are involved in accidents is low and studies still lack adequate statistical significance to draw scientifically firm conclusions. Those concerned about legislation suggest that since no culpability appears to exist below blood levels of 10 nanograms per milliliter (ng/ml), that any proposed cutoffs be above 10 ng/ml of THC 30. A study using coordination testing showed inevitable failure on field sobriety testing if blood THC levels were 25-30 ng/ml but many failed testing at 90 and 150 minutes after smoking even though plasma concentrations were rather low. The researchers had the foresight to conclude that "establishing a clear relation between THC plasma concentrations and clinical impairment will be much more difficult than for alcohol 31". This is primarily because alcohol and THC are chemically different and are metabolized differently inside the body. With passage of medical marijuana laws, we need additional research to show if there is a correlation between clinical impairment and blood THC levels. Daily cannabis users (like patients) can have levels as high as 6 to 10 ng/ml without clinical impairment even after 24 or more hours of abstinence 32 33. While the science evolves, most experts think it remains premature to make firm conclusions about the proper cutoff levels using blood THC for "Driving Under the Influence" suspicion 34. Proper clinical discussion of medical marijuana therapy and necessary clinical observation for impairment remain the primary methods of monitoring for possible adverse reactions at this time.

In summary, there is no consistent scientific evidence showing any impairment beyond four hours from smoking marijuana and no scientific evidence of any increased risk of motor vehicle accidents beyond four hours after smoking marijuana. As a medical cannabis expert, I do not condone any medical marijuana use of cannabis at work. But, private employer-employee agreements to abstain within 4 or 8 hours prior to work seem a reasonable type of compromise. This still preserves safety, and would be consistent with medical treatment plans using other medicines that may impair.

**Registration in the Oregon Medical Marijuana Program should never be sole cause for termination of employment.** Medical use of marijuana within Oregon law should be treated like medical Marinol, medical morphine, and other medications both in and out of the workplace. It is discriminatory to fire an unimpaired worker whose only cause for firing is registration with the Oregon Department of Human Services Oregon Medical Marijuana Program.

Thank you very much for allowing me to submit testimony against HB 2693A as written and suggest solutions.

Sincerely,

Richard Bayer, MD

**A-Engrossed  
House Bill 2693**

Ordered by the House June 27  
Including House Amendments dated June 27

Sponsored by COMMITTEE ON JUDICIARY

**SUMMARY**

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

*[Modifies provisions related to possession of medical marijuana by authorized person. Requires Department of Human Services to adopt rules for growing and cloning of medical marijuana.]*

**Specifies that Oregon Medical Marijuana Act may not be construed to require certain employment practices or preclude or restrict employer from establishing or enforcing drug-free workforce policy.**

**A BILL FOR AN ACT**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17

Relating to medical marijuana; amending ORS 475.340.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 475.340 is amended to read:

475.340. Nothing in ORS 475.300 to 475.346 shall be construed to *[require]*:

(1) **Require** a government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana; *[or]*

(2) **Require** an employer to:

(a) Accommodate the medical use of marijuana *[in any workplace.]* **regardless of where the use occurs;**

(b) **Allow an employee or independent contractor to possess, to consume or to be impaired by the use of marijuana during working hours; or**

(c) **Allow any person who is impaired by the use of marijuana to remain in any workplace;**

**or**

(3) **Preclude or restrict an employer from establishing or enforcing a policy to achieve or maintain a drug-free workforce.**

NOTE: Matter in boldfaced type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in boldfaced type.

LC 3156

EXHIBIT     B      
PAGE   1   OF   1

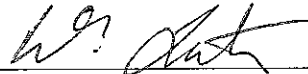
**CERTIFICATE OF FILING and SERVICE**

I hereby certify that I filed the foregoing Brief of Amicus Curai on October 25, 2005, by depositing the original thereof, together with twelve copies, with the United States Post Office in Portland, Oregon, sealed in an envelope with first class postage prepaid and addressed to:

State Court Administrator  
Records Section  
Supreme Court Building  
1163 State Street  
Salem, Oregon 97310

I further certify that I served the foregoing Petition for Review on Respondents on October 25, 2005, by depositing two certified true copies thereof with the United States Post Office in Portland, Oregon, sealed in an envelope with first class postage prepaid and addressed to:

Scott G. Seidman, OSB #83320  
Lynda Hartzell, OSB #93294  
TONKON TORP, LLP  
1600 Pioneer Tower  
888 SW Fifth Avenue  
Portland, OR 97204-2099



William N. Later OSB #89283  
Of Attorneys for Petitioner