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SHOULD THE FEDERAL GOVERNMENT REMOVE MARIJUANA  
FROM ITS LIST OF SCHEDULE I DRUGS?

THE BROOKINGS DEBATE:  
AND EVENING EXCHANGE OF IDEAS

Washington, D.C.

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## P R O C E E D I N G S

MS. CHURCHES: Good evening. How are you all? Welcome to the third Brookings Debate and a new series at Brookings. I'm Kim Churches. I'm the managing director here at Brookings. And on behalf of all of us, thank you for being with us this evening, and for those of you viewing online, spending an evening with us here at Brookings.

Convening events and encouraging conversations have always been fundamental to our culture here at Brookings. This year Brookings is turning 100. And while it's a time to celebrate our past, it's also an opportunity to focus on the future of policymaking.

Our unifying mission at Brookings is improving governance. It's the basis for all of our research, analysis, and practical solutions. And in the complex world in which we live it also means continuing real conversations with a variety of constituents to problem-solve together.

Tonight you'll have the opportunity to be a part of this new series that's not just an interesting way we hope to spend an evening, but an opportunity to showcase civil discourse, hear top minds debate the most important issues of the day. And the issue at hand tonight is a hot topic and relatively new research field for Brookings, marijuana. It was reported just last week, as many of you know that the DEA hopes to decide in the first half of 2016 whether to change the federal status of marijuana. And the question at hand tonight is whether or not the government should remove marijuana from the list of Schedule I drugs.

Before joining Brookings, I worked and lived in Denver and was there when Amendment 64 was passed. A lot has continued to change locally and nationally in this important debate. So in addition to hearing top experts tonight debate the issue, we also want to hear from you. If you've not yet voted in our poll, please do so now. Instructions are up on the wall behind me and in the handout you received when you were walking in, we hope.

We're also live webcasting this event and encourage you to get online in the conversation by using #brookingsdebate.

So, tonight, we're in for a treatment as we welcome some of the most accomplished minds on the issue to our stage. We're particularly pleased to welcome Congressman Blumenauer, who's joined this evening, as well. And without further ado, I'd like to invite our moderator this evening to

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the stage, Sarah Trumble, who's a social policy expert and senior policy counsel at Third Way. Thank you very much. (Applause)

MS. TRUMBLE: Welcome, everyone, to Brookings and thank you so much, Kim, for inviting me to join you. It is a privilege to moderate Brookings' third debate and their very first on domestic policy.

Tonight we'll be debating one of the day's topic domestic issues: marijuana reform. In order to gauge the strength of tonight's arguments and see if any of your minds change, we want to hear from you, the audience, both before and after we hear from our debaters. So if you have not already voted using your phone or computer, now is the time to do so. The pre-debate poll will only be open for about five more minutes. You can vote via text or online, and instructions are on the screen behind me and on handouts around the room. If you have questions, Brookings staff are in the back to help.

So please cast your vote now on the question should the federal government remove marijuana from its list of Schedule I drugs? Text the word "Brookings" to 22333, that's two 2's and three 3's, and then text a second text with the number 1, 2, or 3. Text 1 if you think the federal government should remove marijuana from its list of Schedule I drugs, text 2 if you think the federal government should keep marijuana listed as a Schedule I drug, and text 3 if you are undecided.

For those of you joining us online, voting information should be located directly below the video player on your screen. We also encourage everyone online and in the room to engage with us tonight and moving forward using the hashtag #brookingsdebate.

Tonight's debate will be very structured and fast-moving. Here's how it will work. Each of our panelists will have an eight-minute opening statement. Unlike the presidential primary debate, however, I will, in fact, cut you off after eight minutes. (Laughter) So please watch for the flashing lights.

We'll then move into the heart of the debate where I will moderate a back-and-forth between our panelists. In true debate style, the four of you are welcome to engage one another directly and even interact. But once you start comparing the size of your hands, again, I will intercede. (Laughter)

Then voting will open again as we listening to the final three-minute closing statements from each of our panelists. In order to get our results tallied in a timely manner, the polls will close the

moment the final speaker finishes her remarks, so you must vote in our post poll before the end of the last closing statement. After that, we'll take a few minutes to tally the votes and then I'll present the results.

Tonight's question is about rescheduling, so let me give you some context. As the invitation for this evening described it, marijuana is in the midst of a revolution. When I came to Third Way four years ago, marijuana was legal for medical purposes in only a relatively small number of states and it was largely off the federal radar. The president may have admitted that he inhaled, I'm told that's the point, but very few people were talking seriously about marijuana policy or reform on the federal level, current company excluded, of course.

But today and in the last few years, we've seen such a shift in state laws, federal interest, and public opinion that it's unlike almost anything we've ever seen before. There are currently 23 states that have legalized medical marijuana generally and 24 once Pennsylvania's governor signs their new law this weekend, and a total of 40 states allow some form of medical marijuana. That's 80 percent of the states and home to more than 200 million Americans.

In four states and the District in which we're standing it is also legal to use marijuana recreationally. There are currently more than a dozen marijuana bills pending in Congress, including the CARES Act, which is the first major piece of marijuana legislation to ever be introduced in the Senate. And this November, as many as half a dozen states could see marijuana on the ballot box.

But none of that impacts the fact that marijuana and its use for any purpose remains strictly illegal at the federal level. And while the administration has used guidelines and prosecutorial discretion to give the states some space, that does nothing to change that under the Controlled Substances Act marijuana is still categorized as a Schedule I drug.

Of the five drug schedules, Schedule I drugs are considered the most dangerous with potential risks of severe psychological and physical dependence. Drugs are classified as Schedule I when they are found to have high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use under medical supervision. To put this in context, other Schedule I drugs include heroin, LSD, ecstasy, and peyote, while Schedule II drugs, for example, include cocaine, meth, oxy, and Adderall.

Rescheduling marijuana to one of the Schedules II through V would not make it legal, but

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it would remove certain restrictions. And there are two ways that that rescheduling could happen: through congressional legislation or via the administrative process.

Under the Controlled Substances Act, the attorney general has the authority to potentially reschedule drugs, an authority which he has delegated to the DEA. And as Kim mentioned, as you all know, last week the DEA announced that it will make a decision on rescheduling in the coming months. What they'll decide remains a mystery, but I am sure our four distinguished panelists have some suggestions.

Before I invite them to the stage, I would like to remind and assure everyone in the room and that will be joining me on the stage that my role as moderator here tonight is to facilitate an objective discussion of this issue. I was invited to participate in tonight's marijuana debate because I have worked on this issue for several years, but my role tonight will be to encourage fair discourse and debate amongst the panelists and help articulate points on both sides of the issue evenly.

So let's get to the main event. The pre-poll will close in one minute, so now is your last chance to vote if you've not already done so. May I ask the panelists to join me on the stage?

(Applause)

Joining me on the stage tonight arguing in favor of rescheduling will be Representative Blumenauer and John Hudak. And on my right arguing against rescheduling will be Bertha Madras and David Evans. You have full detailed bios of each of our panelists in your handouts. So let's begin.

We'll first hear arguments for rescheduling from Representative Blumenauer. Congressman Blumenauer's a member of the Ways and Means Committee and represents the 3rd District of Oregon. He's been a leading advocate for changes for federal drug laws ever since he was lelected to Congress first in 1996 and even before that.

Congressman, the podium is yours.

CONGRESSMAN BLUMENAUER: (inaudible) audience here this evening, Kim, was actually in the galleries in the Oregon legislature in 1973 -- yes, I'm really that old -- when Oregon became the first state to decriminalize marijuana. But we're having this discussion today because of a political decision that was made in 1937 to make marijuana illegal on the federal level, and then in 1970, when Richard Nixon made marijuana the centerpiece of his war on drugs, classifying it as a Schedule I

controlled substance: no medical value and high potential for abuse. Let's remember that.

Congress went along and rejected hundreds of years of experience in the United States and thousands of years of history where hemp cultivation was very important and medicinal benefits were widely known and practiced. My conclusion is that the politicians were wrong then not just in terms of the weight of evidence to classify it as Schedule I, it should be scheduled at all.

In the course of this discussion I suspect we're going to hear some interesting points from my friends on the other side of this proposition, having read some of their testimony. And they'll tout their experience, persuasive-sounding, but highly selective evidence.

Most of what I do for a living as a politician is to listen and evaluate advocates. I encounter many, many people every day. They can be ordinary people who are highly motivated and well-informed. I encounter some crackpots and zealots. I encounter lawyers and doctors and lobbyists. Most make powerful, persuasive cases, but they can also be wrong.

Think of the tobacco companies misleading about the health effects of tobacco or more recently the NFL and concussions. My favorite is climate science where we have a few, a handful, of highly credentialed, I'm sure well-meaning people, who deny the overwhelming weight of the evidence. Well, my opinion that the debate tonight is a lot like the climate debate: we shouldn't make our policy decisions based on climate deniers no matter how sincere. From my perspective the weight of evidence is on the side of no scheduling at all.

First and foremost, there is little potential of abuse for marijuana compared to other controlled substances, and especially products that aren't even scheduled that are more damaging and addictive, like tobacco and alcohol. Studies suggest that up to two-thirds of the people who smoked regularly, tobacco, become addicted. Twenty-three percent of the people who use alcohol become addicted. Cocaine has a 21 percent dependence rate whereas marijuana it's less than 9 percent.

And remember, there has never been a documented case of a marijuana overdose death. There have been, by the way, 20,000 opioid deaths by prescription opioids in 2014 alone. A high potential for abuse?

Indeed, if we were doing the scheduling all over again, I think tobacco would be Schedule I, but tobacco and alcohol arguably should not be in this Schedule I notion. It would be a bad policy

decision. There are many things that adults do that are harmful. The solution is not prohibition. We tried it with alcohol and it didn't work out so well. We've tried it with marijuana and it is failing.

People can debate how harmful they think marijuana is. The reality is that nearly half American adults have tried it, 58 percent of the American public thinks it should be legal, and, as Sarah mentioned, 40 states have already state legalized it in some form. I accept that there may be some potential of harm, but harm is not the test. Remember, 20,000 opioid deaths.

Young people whose brains are still developing, I don't want them to use marijuana at all. And I'm sure there will be some adults who will use it and become dependent, but much less so than with non-scheduled tobacco and alcohol. With those substances we trust adults to make their own decisions and exercise good judgment, we hope.

Prohibition of marijuana has not slowed its use or turned people against it. To the contrary, but it has served to stifle the robust research that should have been conducted that would have made most of this debate irrelevant tonight.

There's abundant evidence of medicinal benefits of treatment of chronic pain, multiple sclerosis, glaucoma. There are -- we'll get into some of the studies that have come up. According to a study published by the Journal of the American Medical Association, a review of 79 studies in the United States revealed cannabinoids are effective in treatment of chronic pain and spasticity due to MS. But you don't have to look very hard for the evidence. You can find it on your own, but you're going to hear maybe we don't have the right kind of science. I disagree.

But more to the point, we don't need a lot of experts dancing on the head of the pin here. You have the opportunity to do what I've done for over 40 years, to talk to people who have benefited from the medicinal aspects of marijuana. Talk to people suffering from PTSD, chronic pain, debilitating nausea and loss of appetite from treatment for cancer. Medical marijuana has made a difference in their lives. I know them and I'll bet you know some people who've had that difference made themselves, as well.

Think of the families that are moving across the country to have access to cannabis as a medicine to stop the debilitating effects of the violent epileptic seizures that are torturing their babies. I sat and talked to doctors and neurologists at Oregon Health Science University and they told me, yeah, it

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works. We'd like to know more why it works, but we can't get the research capacity for marijuana to do so. But they've seen the results. Those families have seen the results. That's why they've moved across the country. That's why state after state is making it available.

Forty states have some version of medical marijuana based upon compelling public interest and persuasive testimony. That's the opinion that counts the most to me, the test of public interest based on what has already transpired in their lives. It has dictated that we are going to reverse this flawed and destructive political decision that was made in 1970, not because of politics, but because the evidence is available to us all, each and every one of you.

Removing marijuana from the list of controlled substances cannot happen fast enough in my judgment.

MS. TRUMBLE: That was extremely timely, congressman. Thank you very much.

CONGRESSMAN BLUMENAUER: I'll give you 10 seconds back. (Applause)

MS. TRUMBLE: Next we will hear from David Evans, who will be arguing against rescheduling. David is a practicing attorney in New Jersey and the executive director of the Drug Free Schools Coalition. He also serves as a special advisor to the Drug Free America Foundation.

David, the podium is yours.

MR. EVANS: I have talked a lot about my opposition. And one of the things that I get accused of is of not being compassionate, so I've learned that what I have to do is establish my compassion credentials before I speak about this. So, let me just lay this out for you.

I've had a spinal cord injury for six years. I was in a car crash that was not my fault six years ago. I have been in almost constant daily pain for six years. At one point I had to wear leg braces so that I could walk, so I understand chronic, debilitating pain. My left leg is atrophied.

Very often the proponents of marijuana legalization send me emails telling me they hope that I get cancer. I've had cancer, so I understand what that's all about. I understand what it's like to have a life-threatening illness and to desperately search for answers on how to save your life.

I'm also a volunteer emergency medical technician. I was the president of a rescue squad for many years. I spent hundreds of hours in those years taking care of sick and dying people as a volunteer.

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I also own a nursing home where we do hospice care. So I hope I've laid out my credentials for you. We're not going to be using marijuana. I've discussed it with my staff and they all decided that they do not want to use marijuana as medicine, that the medicines that we currently have are more than adequate.

I'd also like to congratulate The Brookings Institution. I read an article in The Washington Post where they had secured a \$500,000 donation from Peter Lewis, who has been a major donor to the marijuana legalization movement and a supporter of the marijuana industry. So I want to congratulate you on getting that \$500,000.

I notice that the congressman did not define what he meant by "marijuana." There is the marijuana which is the ditch weed that grows in Kansas along railroad tracks, there is the marijuana that's grown in greenhouses, there is CBD oil, various components of marijuana THC. So when you're talking about legalization of marijuana or moving it down to another schedule or not scheduling it at all, I wish they would define what they mean by that. If they're talking about Kansas ditch weed, I think they should say so.

I'd like to discuss a scenario with you. Let's say that there is a big pharmaceutical company. I know there's a lot of hostility now towards pharmaceutical companies. And let's say they don't want to deal with no stinking FDA process because it's too expensive, they're not sure if their medicine works or not, so what they've decided to do would be to go to a state legislature and spread around a lot of money, hire a lot of lobbyists.

Let's take the state of Michigan, for example. Let's say they're going to spend \$12 million to get their medicine approved by the Michigan state legislature. And let's say it's a medicine for kids who have epilepsy. They spread their money around, they hire the lobbyists, the people opposed to it are completely outgunned, and they get this bill passed. And then it turns out that this bill that the marijuana that they approved, turns out to cause intractable vomiting and worsening seizures that can be so severe in these children that they have to put the child into a coma to get the seizures to stop. Wouldn't we be outraged at that? Wouldn't we be outraged at Big Pharma buying their way into a state legislature and coming up with a medicine when there really wasn't enough scientific evidence for it? Well, this is exactly what's happened in state after state after state with medical marijuana.

I mentioned Michigan because in Michigan the marijuana industry, and it is an industry, spent \$12 million getting medical marijuana through the Michigan voter process. This is what's happened in the medical marijuana states.

Let's take Colorado. Mr. Hudak has written a glowing paper about what a great job Colorado is doing in implementing marijuana legalization. Colorado also is a medical marijuana state.

And the congressman mentioned families that are moving to states where they can get marijuana for their children with epilepsy. I'd like to read you a quote from a letter from the American Epilepsy Society that was written to Representative Matt Bakker, head of the Pennsylvania House Health Committee. This is what they had to say. This is Epilepsy Society, not me, not some right wing crank group. This is the Epilepsy Society which wants to help children with epilepsy.

This is what they say, and I quote, "The families and children moving to Colorado are receiving unregulated, highly variable, artisanal preparations of cannabis oil prescribed, in most cases, by physicians with no training in pediatrics, neurology, or epilepsy. As a result, the epilepsy specialists in Colorado have been at the bedside of children having severe dystonic reactions and other movement disorders, developmental regression, and intractable vomiting and worsening seizures that can be so severe that they have to put the child in to a coma to get the seizures to stop."

That's what's happening in Colorado, a highly qualified, according to Mr. Hudak, medical marijuana state that has things under control. I think this is tragic. I think it's cruel. And it's all for the profit of the marijuana industry. They've been promoting this nationally.

Now, what's the reality of medical marijuana? This is an example of medical marijuana. It's a candy bar called Narc Bar. "It only takes one narc to ruin you. For medical use only." This is what medical marijuana is really all about. This is medical marijuana candy. My favorite is the Pot-Tarts. Very, very medical. (Laughter)

You're laughing. This isn't funny. This is exactly how they're selling medical marijuana in these states, in most of them. I happen to like peanut butter, so now we have medicinal medical marijuana peanut butter, Compassion Butter. Very good, very good. Make sure you have a glass of milk with that. (Laughter)

This is a typical medical marijuana recommendation that is provided in all of the states.

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It's not a prescription, it's a recommendation by a doctor. And I'm sure you can go to any state, go to Dr. Cheech, Dr. Chong, you'll get fixed up. (Laughter)

When I was in college and we were under 21, and my friends and I when we smoked pot, if we were told that all we had to do was go to a doctor and complain of aches and pains to get marijuana, we would have thought that was absolutely awesome. This is what this doctor recommends, and this is acceptable under state law. "The patient uses marijuana topically and it's recommended he be allowed to have up to 75 marijuana plants growing and up to 5 pounds of dry marijuana."

This is a typical medical marijuana dispensary. You've got the cannabis leaf, medical cannabis club, smoke shop open. They've got an ATM machine in case you run out of money. What I also like about this is it's open from 10 a.m. to 10 p.m., and I wonder why 10 a.m. Maybe because the folks can't get up that early, I don't know. But this is what medical marijuana is all about.

Mr. Blumenauer believes that the federal government should not intervene in medical marijuana states, that the Food and Drug and Cosmetic Act, which provides us with protection, should not be implemented in those states. And he's so written it in a document that he published.

I've got 12 seconds?

MS. TRUMBLE: You are 12 seconds over.

MR. EVANS: Twelve seconds, okay.

CONGRESSMAN BLUMENAUER: He can have my 11 seconds.

MS. TRUMBLE: That is very generous of you.

MR. EVANS: That's very gracious of you. I thank you very much.

CONGRESSMAN BLUMENAUER: But you're still over.

MR. EVANS: And so he has written in a document called "The Path to Rethinking Federal Marijuana Policy," where he thinks that the Federal Food, Drug, and Cosmetic Act should not apply in states with medical marijuana regarding the prescription or manufacturing of medical marijuana. Now understand what we're giving up by that. We're giving up drug supply chain labeling to make sure the products are labeled accurately. We're giving up medical health fraud protections that the FDA provides. We're giving up good manufacturing practices. We're giving up quality control systems, reporting of adverse events. For example, those --

MS. TRUMBLE: David, wrap up.

MR. EVANS: Thank you very much. (Applause)

MS. TRUMBLE: Thank you very much, David.

John, you're up. John Hudak from Brookings will be arguing for rescheduling. John is the deputy director of the Center for Effective Public Management and a senior fellow in Governance Studies here. John is also the recent author of a Brookings essay on medical marijuana and the author of a forthcoming book titled "Marijuana, A Short History," which will be out this fall.

John?

MR. HUDAK: Thank you and thank you, everyone, for coming. I'd also like to thank David for using an implicit attack to call into question the research that's done at The Brookings Institution. I could probably do the same with nursing homes by pulling a few exceptional anecdotes, but I'm above that, so I'm not going to do that. (Laughter)

But if a corporation like his would like to fund our research, you're welcome to cut us a check. You will get the same answer as if the Peterson Foundation had cut us a check. My guess is being on the losing side of history you will not do that because you'll be unhappy with the answer.

So the real question is: should voters make choices about what medicine is and what medicine is not? The answer is obviously no. We shouldn't leave to voters to make decisions about empirical questions, about scientific questions, and about questions that matter to the lives of everyday Americans. Whether marijuana is going to help them or whether it is going to hurt them should not be decided at a ballot box. It should be decided by doctors. It should be decided by medical professionals. It should be decided by a Congress and a president who listens to good information and encourages access to good information.

But that's not what we have. We have a system that's broken. We have a government that is purposefully hindering medical research into cannabis. And so voters have been left to take out their aggression at the ballot box. They can't get enough of elected officials together to support legislation like Congressman Blumenauer's or Senator Gillibrand's or Senator Booker's or Congressman Rohrabacher's that tries to free up resources and limit restrictions that stop legitimate scientific studies into cannabis as medicine or not as medicine to be done at hospitals and universities and research

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facilities across the country. They don't get enough of people elected to office to have science make these decisions, so they've been making the decisions for themselves.

Why have they been doing that? They've been forced to do that because they have a government that is not responsive to science, it's not responsive to research needs, and it's not responsive to policy realities. The policy reality in this country right now is that almost 200 million Americans have access to some form of medical marijuana, but questions exist, questions abound.

David's right, there is a lot we don't know about medical marijuana. He pointed to a few very convincing anecdotes about some of the side effects, some of the counter indications, some of the problems that can arise when this is applied. It's true of a lot of medicines. It's also true of cannabis.

But what we need to do is we need to understand rescheduling for what it is. We have to understand the scheduling of drugs for what they are.

Schedule I, as Sarah said earlier makes an emphatic judgment about a substance. It says that it has no medical value. It says that it can't be used safely in medical treatment and that it has a high probability of causing addiction or it has a high tendency toward addiction. What it doesn't say is that it's a drug -- or rather Schedule II has many of those same characteristics except it says that it can be used for medical value with severe restrictions. It doesn't say it can't have side effects. It can't say that it can't have addictive properties. Schedule II drugs are highly addictive according to the Controlled Substances Act.

But what we need to know for rescheduling or for the embrace of marijuana as medicine by the medical community is to understand whether it has medical value, what the risks are, what the dosages are, what the types of treatments it should be used for. We don't have that in as complete a form as necessary not because the answers aren't there, but because the government refuses to let those answers be had. That's a problem. That's government coming between doctors and patients. It's government going between science and the answers that they need to come to.

Now, with all due respect to Congressman Blumenauer, I don't trust Congress making decisions about my medicine. I, frankly, don't trust Congress to make decisions about much. Thankfully, they don't make too many decisions. (Laughter) But over the past 40 years, they've made one decision consistently and that is to make sure that there are roadblocks in the way to prevent legitimate research

into marijuana as a medicine.

What do we need to learn? We need to understand how to isolate individual cannabinoids or compounds of cannabinoids and understand how they target different symptoms, certain illnesses, certain conditions, or if they don't. We have to understand if there are side effects, if there are interactions, if there are any problems in their application for use as medicine. We don't have a system that lets that happen because under Schedule I status there are numerous roadblocks.

For marijuana there's the additional roadblock of all of the product research-grade marijuana that can be used in federally approved studies comes from a DEA-mandated monopoly through the National Institutes on Drug Abuse. All of the product has to come from one farm at the University of Mississippi. It's an insufficient supply for the researchers who want to conduct research on it, which is in violation of the single conventions through the U.N.

And so researchers are left using whatever marijuana they can get. Though to be fair to Old Miss, they are doing better at providing different types of marijuana and different combinations of cannabinoids and in different delivery vehicles, but that's only recently. That's only because of the pressure from the Obama administration.

So the researchers who are able to do research on this, which is very difficult for a variety of reasons, are left with suboptimal product. Well, that's not how research should be and it's an embarrassment, frankly. It's an embarrassment and it is despicable that the federal government would perpetuate a system that does this. And here's why.

All Americans who have access to medical marijuana and every American who's using it deserves better answers. They're self-medicating. They're self-dosing. Doctors are guessing about how much and how frequently and through which delivery vehicle marijuana should be used. Americans deserve better than that, but their government won't let them, so Americans are making those choices for themselves. It's not ideal, but neither is the status quo, and that's a very serious problem.

Rescheduling isn't perfect, for sure. There are legitimate reasons, technical reasons why it shouldn't happen. But the problem is there are alternatives that can be had that our elected officials are not allowing. You could come up with a different system that protects the integrity of science while helping to fund it and helping to get legitimate answers to legitimate questions, and we're going to hear a

lot of those legitimate questions raised tonight.

But here's what rescheduling doesn't do. It doesn't legalize marijuana. It doesn't even legalize medical marijuana. It doesn't even legalize medical marijuana in states that have approved it. It simply lowers the restrictions on researchers to conduct empirical studies, double-blind studies, placebo studies, gold standard studies that every medical professional in the United States expects.

And that's why we should move cannabis from Schedule I to Schedule II. Thank you.

(Applause)

MS. TRUMBLE: Thank you, John. Finally, we'll hear from Bertha Madras, who will argue against rescheduling. Bertha is a professor of psychobiology in the Department of Psychiatry -- say that five times fast -- at Harvard Medical School. And in addition to her decades-long academic career, she served as deputy director in the White House Office of the National Drug Control Policy.

Bertha, the podium is yours.

MS. MADRAS: Thank you very much for coming. My disclosures are World Health Organization, U.S. Department of Justice, the National Football League, and RiverMend Health. I thank everyone present who sacrificed the natural rewards of food, family, work, or workouts to discuss an unnatural reward of marijuana. The views I express are my own. They are sustainable with evidence regardless of future policies taken by the executive branch of the agency under constant political pressure to reexamine the current status of marijuana.

What motivates advocacy to reschedule marijuana? To accelerate research? There are now 23,282 manuscripts in the biomedical literature in a search term of "marijuana." There are currently 338 National Institutes of Health grants with the search term "marijuana." There are currently 556 clinical trials listed in ClinicalTrials.gov with the search term "marijuana." So we have a lot of research on it.

Rescheduling implies that we're going to have a rush of researchers going in, waiting in the wings before the paperwork to ease. But, in fact, the California Center for Medicinal Cannabis that had at least \$8 million of seed money and access to marijuana, to marijuana cigarettes could not fulfill their mandate in five major clinical trials because patients did not enroll in them. They couldn't enroll more than one or two patients. The reason they couldn't enroll them was because they put an end, they put a requirement that these people not drive during the clinical trials, which gives you the first hint of

what is the issue with marijuana being scheduled.

Too much paperwork. Is it motivated because marijuana is an ancient drug used by the Chinese and India and, therefore, we have thousands of years of experience with this wonderful, effective plant? But why have China and India made the medical use and the recreational use of marijuana illegal currently? Just because a plant is old and has been used for thousands of years does not mean that it's currently an effective medicine.

Is it to give access to people who want relief from symptoms that current medications don't? We all have to admit that modern medicine does not successfully address a number of conditions and symptoms, but is marijuana the answer?

We all have heard the three criteria for a Schedule I drug. I'm going to speak and restrict myself to plant, raw plant marijuana, not to cannabinoids which the congressman alluded to when he said there are 79 studies because there are plenty of studies on isolated cannabinoids, but on smoked marijuana there are very few. And those studies on isolated cannabinoids were done even though they were in Schedule I.

So, what is the abuse potential? That's criteria number one. It has a high potential for abuse. The statistics that Congressman Blumenauer has cited, which is James Anthony, 1994, are archaic. They're not currently valid. Over 6 million people currently in the United States have a cannabis disorder and the most recent data we have show that 30.6 percent of current marijuana users have a cannabis use disorder. Adolescents are at a much higher risk. Twenty-five to 50 percent of daily users are at risk of developing an addiction. And people who are using marijuana for chronic conditions such as listed in the ballot initiatives, these folks are at high risk because they use daily at least, sometimes more than that. The March 2016 World Health Report, which I was part of, two World Health Reports in the last two months, they show that the demands for treatment of cannabis use disorder is escalating very rapidly. That disabuses us of the abuse potential of this drug.

Now, let's look at the chemistry. Who would amongst us smoke a drug as a medicine? What dose would you use? There's no standard dosing? Would you use 3 percent, 10 percent, 80 percent? Would you use butane hash oil? Would you buy a drug that could be contaminated by herbicides and pesticides? Would you buy a drug that dispensaries claim different strains have different

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medical purposes when all this is science fiction and it does not reside in the realm of science fiction [*sic*].

Let's look at the medical benefits. My worthy opponent, Mr. Hudak, states the body of research demonstrates remarkable promise in using cannabis to treat the following illnesses: Parkinson's, Crohn's, pain, diabetes, seizure disorders, irritable bowel syndrome. Potential is not current evidence.

What is the reality? What's wrong with raw marijuana as a medicine? Would you use a drug that 12 meta analyses, that means all the literature from the entire world, out of 23,000 manuscripts, all the literature that's been gleaned from clinical trials has stated in 12 different analyses of all the literature that there is inadequate evidence for smoked marijuana as a medicine.

Would you use a drug endorsed by one group of people, the CMCR in California, but not large-scale studies based on 40 or 50 sites? Would you use a drug six times a day knowing that it may debilitate you and may progress to addiction? It may impair your cognitive function. It may degrade your brain. If you had a neurological disease that compromised brain function -- multiple sclerosis, Parkinson's, Alzheimer's disease, certain seizure disorders -- would you take a drug that added on top of that a compromised brain function?

The most embarrassing state of all is Illinois. So what about safety studies? Would you use a drug four to six times daily if you are a surgeon, a pilot, a truck driver, a coal miner, a construction worker? What about a school teacher, a babysitter, your own child's babysitter? Long-term marijuana use degrades brain function. It reduces IQ. It can lead to addiction, increased school dropouts, amotivation. And the problem is that the poor, the African Americans, the people who are unemployed, they're the ones at highest risk and they're the highest users.

Would you use a drug that really expert witnesses -- the American Academy of Neurology, the American Psychiatric Association, the American Academy of Pediatrics -- say there is not current evidence for its validity.

MS. TRUMBLE: Thank you, Bertha. Can we all give a hand to Bertha and all of our panelists? (Applause)

So now let's get down to the good stuff, my questions. The first question is for the congressman and John. The DEA has denied multiple petitions to reschedule marijuana as recently as

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2011. And in all of those instances, the health officials from the FDA have agreed that marijuana should remain a Schedule I. Why should this time be different? Has the science or understanding changed or were they wrong all along?

CONGRESSMAN BLUMENAUER: I think they were wrong. The notion here that there's a high degree of abuse and no medicinal purpose was not valid at the time. The DEA has been on sort of a jihad up until recently. I mean, I've had these people before me in congressional hearings. It was an extremely painful process for them to admit that marijuana was not more dangerous than cocaine. They cannot find any example of an overdose death from marijuana.

I appreciated David talking about potential side effects. I mean, that's one of the reasons why I want to delist it, have robust research. I want to regulate and tax it so we know what we're getting. We're in the Wild West now and it shouldn't be.

But as a practical matter, has anybody read about any adverse consequences from pharmaceuticals? I mean, put aside the 20,000 people who died from overdose. We find this all the time where there are negative consequences. Stuff has to be pulled back. I mean, give me a break. If that's the standard, we'll probably remove about two-thirds of the pharmaceuticals from the market.

I don't think we should be hyperbolic about this. I think we ought to open it up, do the research, by all means I don't think it should be the Wild West. I want people to know what it is that they're buying. I think there should be regulations and it should have a significant tax, not so high that it perpetuates the black market, which is available in virtually any playground in America right now. Any of you think your junior high daughter has a tougher time getting a joint than a six-pack of beer? Most people tell me it's easier to get the joint than the six-pack because nobody checks their ID and nobody has a license to lose.

So let's get out of the Wild West. Let's do the research. Let's have good regulatory approaches so that we can answer these questions and we can provide people with something that they know what they're getting. But the train has left the station. Forty states have made their decision and millions of Americans are doing it every month.

So I think de-schedule, get real, regulate, tax, research, and answer those questions rather than the arcane debate.

MR. HUDAK: And I'll add one small thing and that is if the potential for abuse, which actually should be irrelevant because it's true for Schedule I and Schedule II, if the potential for abuse was a problem, if the idea, as Bertha had mentioned, that a pilot could use it and operate a plane or a surgeon or a babysitter is the basis for keeping something at Schedule I, let's move all the opioids. Let's move a lot of drugs that you don't want pilots flying high. I don't want my pilot using marijuana and I don't want him taking Percocet either. But you put rules in place, like a regulatory system demands, to prevent those bad actions.

But the point is that marijuana certainly has negative impacts. Anyone who tells you otherwise is fooling you. But a lot of things have negative impacts. A lot of things have problems. But you weigh the bad with the good, particularly if you have research that tells you what is good and what is bad. The presentation about whole flower, that's great, but it ignores the isolation of cannabinoids, which is where science is moving, where science probably should move, and certainly where the pharmaceutical community, whether you consider that Big Pharma or small-scale operators who are trying to produce legitimate medical marijuana, those should be identified.

You have cannabidiol, CBD oil. That doesn't have a potential for abuse. It doesn't make you high. There are so many myths about what is real and what is not real, and the standards and the burdens that researchers will require to move to Schedule II, and a lot of them are myths.

SPEAKER: Excuse me.

MR. HUDAK: And the addiction is the --

MR. EVANS: I'm looking at the time. Are we going to get any questions for our side?

MS. TRUMBLE: Of course.

MR. EVANS: Okay.

MS. TRUMBLE: Please, feel free to interrupt.

MR. EVANS: Well, I'm doing so. We'd like equal time, please.

MS. TRUMBLE: Turn on your mic then. What do you think?

MR. EVANS: Okay. Well, ask me a question.

MS. TRUMBLE: All right. Well, like the congressman just said, marijuana does share Schedule I with several other drugs, including heroin and LSD. And Chuck Rosenberg, the DEA head,

has said that marijuana is “certainly not as dangerous as other Schedule I controlled substances. It’s not as dangerous as heroin clearly.” Is Director Rosenberg right? And do you think that marijuana is more dangerous than cocaine and meth, both of which are scheduled lower in Schedule II?

MS. MADRAS: You want to take that?

MR. EVANS: Well, why don’t we both take it? We can both answer that question.

I think you have to look at an assessment of there are different types of dangerousness. I mean, the congressman is correct, nobody died from a marijuana overdose. Plenty of people have been hospitalized with marijuana overdoses, though, and that’s not the only criteria for whether something is dangerous. Marijuana kills people slowly, just like tobacco kills people slowly. I don’t know of anybody that died from smoking too many cigarettes [*sic*].

The assessment of dangerousness, though, is something that is going to have to be done in a medical, scientific process. And I’m a little confused because the congressman said when he just spoke --

CONGRESSMAN BLUMENAUER: Just for the record, just 30 seconds, I had 10 seconds I gave you, my father died from smoking too many cigarettes. (Applause)

MR. EVANS: But we’re talking about the overdose deaths, Congressman, that’s what you brought up and that’s what I was responding to. Both my parents died from tobacco-related illnesses, also, so I’m very sympathetic to you and my condolences about your father. But we’re here to have a rational discussion and let’s try to keep away from emotional arguments if we can.

MR. HUDAK: Like your signs?

MR. EVANS: The dangerousness should be assessed in a scientific, medical process, going through the FDA process. The congressman in his paper said that the Food and Drug Cosmetic Act, which is really the FDA going through that process, Congress should pass a law forbidding that act to be applied in the medical marijuana states. Mr. Hudak seems to counteract that by calling for regulation and science and study. So they have a conflict on their side. I hope that they’ll be able to resolve it.

I’d like to have Dr. Madras address the issue that you raised about Rosenberg.

MS. MADRAS: Well, there are so many issues that have been raised. One, the relative harm of different drugs is something that I have dealt with a number of times in a number of venues. I do

not think that comparing relative harms is a valid point. LSD is in Schedule I, as is psilocybin, as are the harmala, indolamine analogs, phenylethylamine analogs. These drugs are not addictive. They have abuse potential. They are not addictive. And yet we know that because of their hallucinogenic effects they can cause tremendous harm to individuals.

If a pilot smoked a cigarette before getting on a plane, I'd sit back, relax, and enjoy the ride. If a pilot smoked a marijuana cigarette, I wouldn't. We cannot really do side-by-side comparisons between drugs. The real issue is all of the drugs in Schedule I and Schedule II have high abuse potential regardless of the nature and quality of the abuse potential.

In terms of death rates, no, there are no cannabinoid CB1 receptors in the brain stem that control heart rate and breathing, but how explain Callahan's work that show that people with a cannabis use disorder have four times the death rate of people who don't have one. These are in hospitalized patients in California. And the death rates were higher than those with cocaine, higher than those with alcohol. I can give you the reference. It's cited in a very good journal.

MS. TRUMBLE: Unfortunately, if we're going to be fair on time, we don't have time for the reference. Gentlemen, would you like to respond or do you want your next question?

MR. HUDAK: I'll take my next question.

MS. TRUMBLE: Excellent. Well, Mr. Evans pointed, in fact, to some of the concerns about danger around marijuana. And it is true that marijuana is the most commonly used illicit substance and the drug most often linked to crime in the United States, according to the U.S. drug czar. Doesn't that mean that it is potentially more dangerous than cocaine and maybe does deserve to be classified a higher schedule? Certainly that's a public safety risk, right?

MR. HUDAK: So part of the reason why it is associated with incidents of crime or violence and other behaviors like you mentioned is it's also the most prevalent drug in American society. And so surely, if you introduce something that alters the mind, the state of mind in some way, which I don't think anyone worth their weight would tell you marijuana doesn't do or at least a product with THC in it, it's going to have serious effects.

Now, if cocaine were as prevalent as marijuana or LSD was as prevalent as marijuana, my guess is those statistics would change. But as the other side had mentioned, putting those statistics

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into context is extraordinarily important. And when it comes to crime, when it comes to usage rates -- which I need to correct Dr. Madras. African Americans do not use marijuana at a higher incidence than white Americans. Simply because they get arrested more often is not a reflection of use. (Applause)

MS. MADRAS: Not use, addiction.

MR. HUDAK: Oh, well, no, you --

MS. MADRAS: Addiction, that's the statistic.

MR. HUDAK: You must have misspoke then because you said those are the groups that use more often.

MS. MADRAS: Those are the groups that have higher addictive rates than others: the poor, the unemployed, the people who are the lowest income brackets, African Americans. And that is the tragedy of this drug with regard to those people.

MR. HUDAK: And, again, putting that into context, when African Americans are forced into drug rehab because they are put into the court system that may skew how those statistics look. But I think we have to be very careful when we talk about race and marijuana use because there are a lot of institutional problems that make it look like this is a black problem when those are Nixon era words and not a reflection of reality. (Applause)

CONGRESSMAN BLUMENAUER: Could I just -- goes to your question about seeing people who have smoked marijuana being involved in crime. What would that look like if we talked about cigarettes? I mean, because there's linkage, there's not causation, and a lot of that is socioeconomic. But I've had a lot of conversations with people in law enforcement. I campaigned on behalf of our ballot measure in Oregon all over the state. I talked to people who are emergency room docs.

I talked to police officers, they're not -- and talking about the potential danger from their professional perspective if there was more marijuana. They said they're not worried about road rage from people who smoke marijuana. They're more like to pull over and sleep it off or go buy a bag of Cheetos. (Laughter) It's alcohol that fuels road rage and violence. I mean, that is precisely, I think -- the emergency room folks, yes, they see some incidents, but it's not what caused them to go to the emergency room.

Remember, 18 million or thereabouts smoke marijuana every month. And it persists in

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the system, if anybody would test. We don't have good tests for impairment, but we can find that there are (inaudible).

So, I mean, this is totally bogus. It's what I come to expect from some of the drug hierarchy in the federal government, which is out of step with the president and which desperately needs to change, and maybe they'll start doing it this year.

MS. TRUMBLE: Thoughts?

MR. EVANS: Well, I've been a criminal defense attorney for 40 years and I know a little bit about the system. I was a public defender in Newark. Most of my clients were African Americans.

The cities in New Jersey and other places, like Baltimore, are run largely by African Americans have minority police forces. They're still arresting people for marijuana. I believe Freddie Gray in Baltimore, that was the guy that was killed in the back of the truck, was because they were doing a drug sweep ordered by an African American D.A. because there had been complaints from African Americans that there were drugs being sold in their neighborhood.

In Denver right now, the marijuana stores are largely concentrated in minority neighborhoods, lower-income neighborhoods. They have one marijuana business for every 47 residents. So that's what's happening. I'm very concerned about that.

And I don't see people doing a lot of jail time for possession of small amounts of marijuana. I've never known anybody to do and I've represented hundreds of people. Usually they get arrested for something else, they find marijuana on them, and then they have a marijuana possession.

By the way, the average amount of marijuana that somebody's in federal prison for is 115 pounds. That's not personal use.

MR. HUDAK: But most people are in state prisons, that's the problem.

CONGRESSMAN BLUMENAUER: It's very interesting --

MR. EVANS: State prison is the same.

CONGRESSMAN BLUMENAUER: It's interesting --

MR. EVANS: It's about 1 or 2 percent are there for marijuana possession and they are there for possession of large amounts or trafficking. It's just not true people are going to jail for small amounts of pot.

CONGRESSMAN BLUMENAUER: It's interesting that at time when we have reached 58 percent or more public acceptance of legalizing marijuana, we've got 4 states and the District of Columbia that have legalized adult use, and as we've referenced 40 states have some form legal, we still arrested or cited over 600,000 people last year. That's part of the outrage. Now, whether they go to jail or not for this particular offense, I'll tell you, for a young African-American kid who gets caught in a sweep, who, by the way, if it was my kid probably wouldn't have been arrested in the first place and wouldn't have a problem getting a defense attorney for these kids, maybe they don't show up later, maybe they get caught in on something else, it can compound. And for them, they end up not having -- having an issue on their record, something that can mean that they cannot get access to student loans.

MR. EVANS: That's not true, Congressman.

CONGRESSMAN BLUMENAUER: If they're living in public --

MS. TRUMBLE: I'm actually going to call this right here.

MR. EVANS: There's a federal law and that --

MS. TRUMBLE: No, no, sorry.

MR. EVANS: -- and that's not true.

MS. TRUMBLE: I get to play. I'm in charge.

MR. EVANS: You're right.

MS. TRUMBLE: And we are going to stop this particular conversation, largely because there are five white people on this stage and not a single person of color, and I don't think any of us are qualified. (Applause)

So, instead, I'm going to ask you folks the next question. As John has alluded to in his opening remarks, there's been a lot of discussion that when it comes to rescheduling we may have created our own Catch-22, that in order to know whether marijuana should be rescheduled, we need more research, but we can't do more research until it's been rescheduled. Do you agree with that statement or how would you respond?

MS. MADRAS: I completely disagree with that statement. I've heard complaints about the paperwork that's being done, that's required in order to do clinical trials. My animal protocols to do animal research are 69 to 85 pages long. I have to go through three or four agencies. Anybody who has

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a determination to do research in this area will do it. And as I said, there are 356 grants currently dedicated to cannabis, marijuana, cannabinoids, whatever designation you wanted.

There are seven steps in order to be able to do clinical research with marijuana. From my perspective, the real problem is that not many people really are interested in doing it with whole plant marijuana. And the reason they aren't is that the therapeutic window for marijuana overlaps completely with the intoxicating window. And it would be the first and only drug in the pharmacopeia in which the drug is clearly intoxicating at therapeutic doses, not with misuse, not with abuse, but at the dose that it's prescribed it is intoxicating. That's the real problem.

These seven steps that are required in order to do research, it didn't stop Marinol from being approved. It didn't stop Nabilone from being approved. It hasn't stopped phase 3 clinical trials for nabiximols and for cannabidiol for seizures. They're Schedule I. It's moving along without any complaints from the people who are conducting the research. It is a canard. It is used as a reason to try to pick and to hammer away at the prescription of this drug. And the reason that we are concerned about the drug is that it is at therapeutic doses intoxicating and has long-term effects.

The World Health Organization published a paper that was authored by 35 experts from 15 countries in this month. And I authored a different one for them on the medical uses and it documents the long-term harm and the concerns we should have a society in legitimizing and medicalizing a drug that is, frankly, intoxicating at therapeutic doses. That's the heart of the matter.

MR. HUDAK: Well, intoxicating at therapeutic doses makes an assumption about those doses. Not all types of cannabinoids are intoxicating and it's not intoxicating in all types of combinations of cannabinoids either.

MS. MADRAS: You're not talking about --

MR. HUDAK: But the 300 --

MS. MADRAS: We are not talking about isolated cannabinoids. We are talking about whole plant marijuana --

MR. HUDAK: Well, what is happening with the federal government --

MS. MADRAS: -- and isolated cannabinoids, cannabidiol --

MR. HUDAK: -- the federal government's status of Schedule II --

MS. MADRAS: -- is clearly --

MR. HUDAK: -- is preventing research on isolated cannabinoids. And the sloppy --

MR. EVANS: It's not.

MR. HUDAK: It is not.

MR. EVANS: It's not.

MR. HUDAK: Well, it is.

MR. EVANS: There are two drugs --

MR. HUDAK: If you talk to a lot of medical professionals they will tell you that it is true.

MR. EVANS: -- going through the FDA process right now.

MR. HUDAK: And I respect that, but there should be a lot more studies than two drugs.

And the 356 studies that a search terminology pulls up cannabinoids also captures a lot of studies that are not clinical, that are observational, that are not double-blind, that are not placebo studies.

MS. MADRAS: Yes, yes.

MR. HUDAK: And that is not what matters. What matters are the studies that are going to give us the best evidence and that 356 does not --

MS. MADRAS: And the best statements that we have so far -- the best evidence we have so far with whole plant marijuana is conducted in experienced marijuana users almost exclusively and for two weeks. And that's not because they were limited by federal regulations. It is not because they were limited by any bureaucracy or the federal government. It's because they chose not to do long-term studies.

They chose to use experienced marijuana users instead of the general population because they were worried about high dropout rates, which would call into question the acceptability of a drug as a medicine. If an inexperienced, the drug naïve person takes marijuana for the first time and thinks they're getting a medicine and they're suddenly intoxicated, they are dizzy, they may be nauseated, they may be depersonalized, they would drop out of the study and then the FDA would have that as a mark of the fact that this drug has a high proportion of people who find it unacceptable.

MS. TRUMBLE: All right. Well, we're going to leave it right there because we have two minutes left of Q&A and I have a really good question that I've saved. So this is for all four of you.

All of the presidential candidates still in the running for November have shown tentative acceptance of state marijuana laws with even social conservative Ted Cruz saying that he wouldn't vote for legalization in his state, but he probably supports states' ability to make that decision for themselves. Senator Bernie Sanders, of course, has introduced a bill that would de-schedule marijuana altogether. Obviously, we have many more painful and endless months between now and November. (Laughter) But do each of you think that rescheduling will be more or less likely under the next president?

We'll start with you, David.

MR. EVANS: Well, it depends on who's going to be elected president. The candidates that said they were absolutely going to enforce federal law were Chris Christie and Rubio. If Rubio becomes vice president to Cruz, you might see it; you probably won't see it happen. Look at Hillary Clinton, she has been -- you know, questioned medical marijuana, so it's really hard to say.

I would hope that whoever becomes president would rely on the professionals in the DEA and the FDA to make this decision, and that it shouldn't be made as part of a campaign promise based on politics. I think John would agree with me on that, that it shouldn't be a state legislature or any politician doing something for political consideration, deciding what is medicine and what is not. It should be left to science. John and I agree on that.

MS. TRUMBLE: Well, following presidential debate rules, John, you got called out. That means you can only answer my question, though. So, next president, easier, harder?

MR. HUDAK: I agree with David, with most of what he said. I do think it will obviously be easier. It won't be easier because the research says it. It won't be easier because it's necessarily the right thing to do. It will be easier because there has been decades of growing political pressure to move those candidates in that direction.

What many of the candidates do talk about is that they do want expanded research; they do want good answers to important empirical questions. And I think it's a recognition that many in the community have, not on this stage, but many in the community have that there are still open questions about the use of cannabinoids, perhaps not whole flower, but cannabinoids, isolated or compounded cannabinoids.

But I think in many ways it is refreshing that presidential candidates are talking about

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marijuana as a policy and not as a punch line. But the reason for rescheduling should not be political. It should be because, at the end of the day, it's the right thing to do.

MS. TRUMBLE: Thank you.

MR. EVANS: If I can just follow up on that.

MS. TRUMBLE: Two seconds.

MR. EVANS: This political pressure's been generated by the marijuana industry. They have done focus groups. They've hired lobbyists. They've done big public relations campaigns just like big tobacco and big alcohol have done.

MR. HUDAK: That's oversimplified.

MR. EVANS: And that's shaping public opinion a lot and people should be aware of that. They've got a lot of money.

MS. TRUMBLE: Bertha, next president, easier or harder?

MS. MADRAS: Depends on the president. And I would hope that the next president, lord help this nation, is rational enough to listen to qualified experts who have studied this. I come to you because I have read over 400 scientific manuscripts that I had to read in order to build this World Health Report for them. And I've read many others along my 100-year journey through neuroscience. And my opinion is based not on politics, not on passion, not on personal emotions or personal encounters with drugs, but it's based on what the published literature says.

MS. TRUMBLE: Well, Bertha said the word "politics," which basically called you out, Congressman. You get the last answer.

CONGRESSMAN BLUMENAUER: It will be easier. Nobody will be elected who is going to unwind what's happened in 40 states. And I've had conversations with Hillary Clinton and I think she's very likely to keep the policies in place of the current administration or go further.

All of them, I think, understand the main thing that the marijuana industry needs is to get out of being an all-cash enterprise. That's going to go away. That doesn't serve anybody's interest. But there are going to be elections. You say it shouldn't be political, but there'll be elections in Nevada, California, Florida, Maine, Arizona perhaps, Massachusetts. And this is going to be an issue in the fall that people cannot duck.

Now, I hope, Bertha, that it is based on science and smart people, and I hope that they cast a broad net. And if they do, they will de-schedule, but we're not going back in time on that, in my humble opinion. It will be very likely delisted with either Bernie or Hillary. And I don't think Trump is going to walk that way. He's whatever he is, and you've already mentioned Cruz. (Laughter)

But this is, in fact, a political issue. You don't think this factored into the decision of the Nixon administration and the Congress when they put it as Schedule I in the first place?

MS. TRUMBLE: All right, all right, we're going forwards --

CONGRESSMAN BLUMENAUER: Give me a break.

MS. TRUMBLE: -- not backwards.

CONGRESSMAN BLUMENAUER: Let's hope, forward.

MS. TRUMBLE: And we are, unfortunately, out of time for our Q&A, which went way faster than I thought it was going to. But before we hear closing remarks, I do want to let you know that the polls are now open again for our post poll to see if anyone has changed their minds.

Should the federal government remove marijuana from its list of Schedule I drugs? This time around you only get two options, so text 1 if you think marijuana should be removed from the list of Schedule I drugs and text 2 if you think marijuana should remain a Schedule I drug. Voting will stay open throughout the panelists' closing remarks, but will end as soon as Bertha, who is our final speaker tonight, finishes talking.

The debaters will now each have three minutes to make closing statements from their chairs. Congressman, you're up first.

CONGRESSMAN BLUMENAUER: Thank you. I really appreciate Brookings providing a forum like this. And actually, if you dig a little deeper there isn't actually as much difference between our positions as would be suspected by some of the rhetorical flourishes and the positions.

I want more research. I want it based on evidence. I want marijuana to be in a situation where we are legalizing, regulating, taxing, people know what they're getting, like what we've done with tobacco that killed my father. We've had smoking rates go down two-thirds. We didn't have prohibition. We didn't lock people up. But we educated, we engineered the product, we had some tests, and we have taxed the dickens out of it. I think an approach like that will help us go forward.

I think we will find all sorts of therapeutic applications once we strip it away and be able to do it properly. But as I said, that train has left the station already. If you think it's not going to be largely legalized in the course of the next five years, you may be smoking what we're talking about. (Laughter) It will be.

I think it was just interesting, Keith [*sic*], when you heard a conservative pig farmer from Eastern Oregon, who was at that point an elderly guy -- he seemed elderly to me; actually he's a youngster, he's probably only 60 -- who never smoked, didn't drink, who walked through the most compelling speech I have yet heard on this issue, talking about its effects, its consequences, and what policy should be. Nothing I've seen has been any better than that 43 years ago.

But it was interesting, you know, I knew that it was game over in my community for sure this last month. I've had not one, not two, but three kind of older baby boomer pillars of the community, I mean, people who are well-established, well-known, people who I've known for years, kind of buttoned down tight, who in separate conversations talked to me about how they had used medical marijuana. They were frustrated that they didn't quite know what they were getting, but they had three separate medical conditions. They were concerned about opioids and they used it to great effect that they volunteered. When people like that are on board, that train, as I say, has left the station and we're going to see a big change.

MS. TRUMBLE: Thank you, Congressman. David, your turn.

MR. EVANS: Just to be courteous, do you want another 11 seconds?

CONGRESSMAN BLUMENAUER: Nope, I'm done.

MR. EVANS: Okay, great.

MS. TRUMBLE: Turn on your mic.

MR. EVANS: I think it's one.

MS. TRUMBLE: Okay, perfect.

MR. EVANS: Yeah, it's on. The public opinion that the congressman talked about has been shaped by the marijuana industry. We are with marijuana where we were with tobacco in about the 1950s. People were becoming aware, but not quite yet aware of the dangers of tobacco. And the tobacco industry did the same thing that the marijuana industry is doing today, propaganda. I remember

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when I was a kid seeing advertisements that doctors say that Camel cigarettes soothes your throat, all this kind of stuff. And if you look at the lawsuits against the big tobacco industry, it eventually curbed them to some degree. If you take the word "tobacco" out and put the word "marijuana" in and it matches up almost exactly.

The marijuana industry has been deceptive. They are very powerful. I have lobbied against them for 10 years on the state level. Most of the people on our side are volunteers at this point, just like they were when we fought big tobacco. We walk into a senator's office and there's three or four highly paid lobbyists there that have been hired by the marijuana industry.

If you want the truth there are some organizations that are getting the truth out. One of them is Smart Approaches to Marijuana. You can look on their website, learn about SAM, and they will give you the data about what's going on in the legalization states: Colorado, Washington, Oregon. They provide accurate information about what's really happening there.

In time what's going to happen is when the word gets out and people see what we're seeing, all the bad data coming out of those states now, people are going to regret this decision. And they're going to look back and they're going to say, you know, we were influenced by big marijuana.

When I go out and talk about this, I ask people how many of you think that the big tobacco industry is looking out for your family's interests? Nobody raises their hand. And I say how many of you think that the drug cartels are looking out for your family's best interest? And then I ask how many of you think that the big marijuana industry is going to be any different than the big tobacco industry? They're not. They are pursuing profits over people. They are pushing medical marijuana because it gives marijuana a good name. They want to have it rescheduled because then they can claim that marijuana has some medicinal benefit.

So don't be fooled. Take a look at what's going on. The pro marijuana movement was started by a couple of very wealthy people: George Soros and Peter Lewis. Lewis funded the Marijuana Policy Project; George Soros funded the Drug Policy Alliance. They are the leading organizations going for marijuana. This is, in many cases, not grass-roots. They've got tremendous money. When we were arguing against medical marijuana in New York State, they were providing free lunches at a restaurant for anybody that showed up to argue on behalf of medical marijuana. So that's what we're up against now.

History will ultimately vindicate us. Thank you.

MS. TRUMBLE: Thank you very much, David. John, take it away.

MR. HUDAK: I think picking up on history is a really important point because the power of the marijuana industry has been wildly overstated just now. There are a lot of people who support marijuana not because George Soros is paying them to, but because they see people around them getting therapeutic benefit from it. And I think to characterize all marijuana supporters as being under the haze not of marijuana but of its industry is, frankly, an insult to a lot of good Americans who are not beholden to the corporate interests that you discuss.

But more to the point at hand, we have a problem and it's a political one. It's a system that is in place that is providing limited answers to a very important question. And we've heard about a lot of studies tonight and I don't question or doubt either of them. They're peer reviewed; they're in very good journals. They found what they found and I am certainly in no position to question it. But what we haven't heard about tonight are other double-blind placebo studies that look at the benefits for appetite stimulation or reductions in nausea or pain relief or helping with muscle relaxation and a variety of other conditions that there are important studies that have shown real promise.

And Bertha is right; promise is not a medical answer. But what it should be is a carrot and a stick to get better medical answers. And so what we need is a system in place that helps provide those. And it's not more important than on the issue of marijuana and here's why: marijuana's being used for medicine all over the United States. It's being recommended every day by doctors. And Americans deserve legitimate medical questions around a drug that is being used widely.

And so anything that we can do to improve our knowledge, there are certainly studies that suggest that marijuana lacks therapeutic benefit or that it has harmful side effects, but there are also ones that say that it helps glaucoma and that it helps a variety of other disorders. And so if we can have benefits, if we can have better research, we'll all be better positioned to either take a look at the medical marijuana system and say this is entirely phony or to look at the medical marijuana system and say, you know what, now we have the right information about exactly how to use this like a pharmaceutical and not like a street drug. And we all deserve that.

MS. TRUMBLE: Thank you, John. Last but not least, we'll hear from Bertha. But before

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she starts, I want to remind everyone in the audience that the polls will close as soon as she stops talking. So if you want your vote to count, vote now.

Bertha?

MS. MADRAS: Thank you. John, in terms of glaucoma, the American Ophthalmological Society has said do not use it, do not recommend it because lowering intraocular blood pressure may, in fact, harm the eye even worse. There is currently no recommendation for using it for that indication.

The real issue is 90 percent of the people who are currently using marijuana with recommendations for its medical uses are using it for pain. And unless we have a current national rampant epidemic of pain, which we never had before in young men who are largely in their twenties, thirties, and forties, who seem to have a lot more pain on weekends than during the week, this reeks of a misuse of the term "medicine," as well as contaminating medicine.

I think that the most important thing to summarize is that if you put a drug into a Schedule II, which is, I think, a more realistic issue -- and I have a copy here of Judge Kimberly Mueller's ruling on de-schedulizing marijuana if anybody would like my single copy -- the purpose of a Schedule II drug is that it is a medicine, and right now we do not have the evidence. There is not the evidence for it as a medicine, whole plant marijuana.

We do not have evidence that it's effective. We do not have evidence that it's safe under conditions in which it will be used chronically and for people who have cognitive impairment or cognitive degradation. So to put it into a schedule just for bureaucratic convenience makes no sense because Schedule II drugs do have medical purposes.

And I want to close by just asking the audience a simple question. Why do nations schedule drugs? I was just at a World Health Organization meeting that was charged with scheduling drugs, and it's a simple question. Nations schedule psychoactive drugs because we revere this three-pound organ differently than any other part of our body. It is the repository of our humanity. It is the place that enables us to write poetry and do theater and conjure up calculus and send rockets to Pluto 3 billion miles away and to create iPhones and 3D computer printing. And that is the magnificence of the human brain and drugs can influence it adversely, so this is not a war on drugs. This is a defense of our brains, the source, the ultimate source of our humanity.

Thank you.

MS. TRUMBLE: Thank you, Bertha. (Applause)

Well, ladies and gentlemen, the polls are now closed. That was certainly a riveting discussion. And as I step offstage to get the results, I'll return shortly, why don't you give all of our panelists one more round of applause. (Applause)

All right, folks, I have the results. If you would please resume your seats.

Well, the results are in. Before the debate here's how the audience voted: 6 percent felt that marijuana should remain a Schedule I drug while 88 percent thought that marijuana should be removed from the list of Schedule I drugs -- this is before -- and 6 percent of you were undecided. After the debate: 91 percent felt the federal government should remove marijuana from the list of Schedule I drugs and 9 percent believed that marijuana should remain Schedule I.

For those of you who can add, that means the undecideds split perfectly evenly. Very interesting and just goes to show the high quality of our panelists today.

So where does that leave us? Waiting on the DEA and waiting on Congress, hoping someone's listening. These numbers are pretty clear, but also very nuanced, and I think that's an important point we need to recognize when we're looking at polling numbers on marijuana. Third Way and many other organizations do lots of marijuana polling and I have to tell you that no matter what the top lines say, people are very conflicted about this.

So while our debate audience is all in for rescheduling, that's probably not the case for the general public and it is definitely not the case for Capitol Hill. This issue is complicated, which is why the policy solutions need to be nuanced and smart in order to appeal to those conflicted people in the marijuana middle. Tonight was a step in that direction and I appreciate all of you joining us for it.

When Third Way first got involved in the marijuana discussion it was because the members of Congress with whom we worked, again, present company excluded, were very bad at talking about marijuana. There was usually giggling involved. And in the last several years we've seen a real maturity happen on this issue, but none of that can hold a candle to what we saw on this stage tonight. So I would like to thank our panelists one last time for joining us. (Applause)

And thank all of you in the room and online for spending your evening here with us. We

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certainly hope you enjoyed the program. We plan to do more debates in the future and Brookings welcomes your feedback on this debate and how it went. Goodnight and thank you for joining us.

(Applause)

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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