Cannabis Research Review Board
Utah Department of Health and Human Services
Center for Medical Cannabis

Re: Medical Cannabis Qualifying Conditions

To whom it may concern:

The Cannabis Research Review Board (CRRB) of the Utah Department of Health and Human Services (DHHS) feels obliged to comment on the upcoming discussion on qualifying medical conditions by the Medical Cannabis Policy Advisory Board (MCPAB) since the proposal from the Utah Patients Coalition directly relates to the CRRB's mission and recommendations and since it was directly cited in the proposal's background section. Furthermore, the CRRB is made up of several Qualified Medical Providers (QMPs) who actively treat patients with medical cannabis and their professional opinions may be highly valued as the MCPAB is currently lacking two of its voting members that were obligated to be QMPs. Therefore, we have prepared this statement in order to provide insight and experience to the discussion about the need for qualifying conditions in the treatment of patients with medical cannabis.

First, it is important to note that the board agenda document for the meeting on 12/19/2023 includes 4 different proposals as options for voting, but all of the supporting statements directly address option 4, which is to eliminate the qualifying medical condition list. The other 3 options are to either keep things the way they are or to compromise on adjusting the list or having exceptions in some way.

It is also important to note that recommendations by either board (the MCPAB or the CRRB) continue to remain recommendations only and the state representatives may or may not choose to abide by them. This has been true in the past with the CRRB and that is the way the program has been designed. With these facts in mind, we hope to offer as much help as possible to determine the best course of action.

Position

The position of the CRRB is to maintain the existing qualifying condition list.

The Problem

Before offering the reasoning behind our position, it would be best to help define the real problems faced by the medical cannabis program and by patients in Utah. The principal challenge faced by patients is the lack of access to cannabis therapy through qualified medical providers. There are many patients who already have qualifying conditions, but have many barriers to treatment because there are too few providers, too little education, too high costs and other reasons. Adding more qualifying conditions to an already expansive list or removing the list altogether won't solve this problem. Moreover, it would likely only exacerbate the problem by increasing demand without increasing supply. Rather, increasing the number of QMPs and providing more education to medical providers about the cannabis program and how to participate may prove more effective at addressing the current challenges..

Response

In response to the provided arguments for removal of the qualifying condition list, we would offer some insight from clinical experience.

The claim that removing a qualifying condition makes treatment more patient centered is a hollow argument that just sounds nice. Having restrictions on treatment doesn't make clinical decisions un-"patient centered". Clinicians often have to restrict the use of medications (such as antibiotics, opiates and other controlled substances) in order to provide safe and effective care. The restrictions may come from practice guidelines, institution regulations, state or federal law. Where they come from is irrelevant, but the fact that they are there to maintain patient safety and efficacy is what is important.

The second argument is similar to the first and suggests that the state should not dictate medical care and it should be completely in the hands of the patient and the provider. This argument also sounds better than it is because we need to remember that medical providers need to be governed too. Even though a certain amount of freedom is needed to navigate the complexity of "patient centered" care, there is also a need to set boundaries and guidelines so as to avoid pitfalls and prevent negative outcomes which are all too common, especially with psychoactive controlled substances. It would be nice to say that doctors never make mistakes, but it is all too common that they do. Providing a structure to care even if it makes it less convenient is often necessary to ensure patient safety and appropriate use of medicine. The process for obtaining Compassionate Use Board (CUB) petitions is in place for these exceptions and according to the data presented, the CUB has approved the vast majority of the completed submissions. Therefore a process is already in place to handle some of the unforeseen situations encountered by patients and clinicians that may warrant exceptions, and by all accounts seems to be working.

The third argument is a little misleading. It implies that the medical program data will be more accurate if we allow more conditions or dismiss the conditions so that patients or providers will be more honest as to the real reason the medicine is being used. While that is technically true, the real argument being stated here is that if people aren't obeying the rules, then we should just change the rules or get rid of the rules altogether. This is not a good reason to dismiss rules! They are there for a reason. Having said that, ongoing discussion about changing the guidelines or indications as more knowledge and research is available is acceptable. Adding qualifying conditions to the list when the research is compelling is much more desirable than dismissing all of them.

The fourth argument presented is also misleading. It is true that off-label prescribing is legal and common in the practice of medicine. In fact many guidelines presented by medical associations promote some medicines even without the FDA approval and this is for various reasons. However, it is unfair to compare all existing medicines to this standard in order to justify the use of one particular medicine. Medical cannabis can be psychoactive, cause impairment, become addictive and has a high abuse potential. Therefore, comparing this medicine to the whole of the Pharmacopeia is not justified. It would be more fair to compare it to other psychoactive substances in which case there is far less "off-label" use. For those reasons, it *does* deserve some practice guidelines, restrictions and regulations.

Reasoning

The reasoning to support our position includes several points. The first of them were included in the agenda so they will not be repeated here except in summary:

1. People will join the program despite little or no evidence that medical cannabis is an effective treatment for their medical condition.
2. No qualifying condition list equates to a quasi-recreational program.
3. When compared to FDA-approved drugs, not a lot is known about medical cannabis so a list of qualifying conditions is necessary.
4. Individuals with non-qualifying conditions already may receive a medical cannabis card if their petition is approved by the CUB.

Other reasons that support the use of a qualifying condition approach as evidenced in clinical practice and from observations from the program since its inception are listed here. It is by no means a comprehensive list, but will suffice for the time allowed:

- **Education:** Having the indications spelled out helps facilitate discussion with patients and providers about medical cannabis and improves the education surrounding its appropriate use.
- **Qualified Medical Providers:** It adds a certain legitimacy to the program and the public perception. This may also help teaching and training more QMPs which will help the access problem in Utah.
- **Discouraging Misuse:** Reinforces messaging and teaching about its appropriate use and helps guide against misuse. It helps discourage overuse and "recreational" use which is not the intention of the cannabis program in Utah.
- **Research:** Increased research and reporting regarding medical cannabis use, its indications, and patient experience (plug for the new Center for Medical Cannabis Research at the U of U) are encourage. The data collected helps categorize its use for tracking and research purposes that is essential for the future of high quality research and developing treatment guidelines.
- **Mitigating Potential Harm:** The CRRB has evaluated many reports both on the use and efficacy of cannabis as well as the potential adverse effects associated with it. The evidence based clinical research strategy utilized by the CRRB is well defined to provide a rigorous, structured approach utilizing specific indications to mitigate potential harms to both the patient and the public. Public data from the State of Utah (and surrounding states) show that the rise in cannabis use (regardless of purpose) has led to a significant increase in patient harm (as evidenced by increase in ER visits for cannabis induced hyperemesis syndrome, The potential for developing cannabis use disorder and other adverse effects such as sedation, drug-drug interactions, and potential increase in cardiovascular risk, etc.) as well as harm to the public (increased DUI related accidents and deaths). We as leaders in healthcare, public health, government and other areas are obligated to consider the impact of any change in policy or decision for both positive and negative impacts.

Conclusion

As medical providers and research scientists, the CRRB joins with all of those involved to promote the medical cannabis program in Utah in order to serve the patients and the public in a safe and effective manner. To do so, we rely on the governance of the state by the DHHS to provide fair and evidence based guidance on the appropriate use, as well as boundaries to discourage misuse, of medical cannabis. We recognize that its unique properties and pharmacological profile offer many useful benefits, but, consequently, may also have significant negative potential. As more and more clinical studies expand our knowledge regarding the safety and efficacy of medical cannabis, more and more new questions arise about the best practices and the potential risks associated with its use. Therefore, there will always be an ongoing need to regulate it in such a manner to avoid causing harm to both the patient and the public. To this end we would promote keeping the existing qualifying condition list and welcome the opportunity to modify it as the need arises or the body of knowledge supports it.

Thank you for your time and consideration.

Members of the CRRB