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1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH
2 ------------------------------X
3 In Re the Matter of: :
4 Public Hearing to Review :
5 Petitions Requesting Addition :
6 of Debilitating Conditions to :
7 the Medical Cannabis Registry :
8 Program. :
9 ------------------------------X
10
11 ADVISORY BOARD MEETING
12 Chicago, Illinois
13 Monday, May 4, 2015
14 9:40 a.m.
15
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21
22
23 Reported by: Jean S. Busse, CSR, RPR
24 Notary Public, DuPage County, Illinois

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1 Report of proceedings held at the location of:
2
3 James R. Thompson Center
4 Concourse Level
5 Assembly Hall Auditorium
6 100 West Randolph Street
7 Chicago, Illinois 60601
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12 Pursuant to notice before Jean S. Busse, a
13 Certified Shorthand Reporter, Registered Professional
14 Reporter, and a Notary Public in and for the State of
15 Illinois.
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1 PRESENT:
2 LESLIE MENDOZA-TEMPLE, Chairperson;
3 MICHAEL FINE, Vice Chairman;
4 JAMES CHAMPION, Member;
5 ERIC CHRISTOFF, Member;
6 JACQUELINE LESKOVEC, Member;
7 DAVID MCCURDY, Member;
8 THERESA MILLER, Member;
9 JYOTIN PARIKH, Member;
10 NESTOR RAMIREZ, Member;
11 ALLISON WEATHERS, Member;
12 ALSO PRESENT:
13 CONNY MOODY;
14 ROBERT MORGAN;
15 ANDREW SCHWARTZ; and
16 MALLORY SINNER.
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1 C O N T E N T S
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1 PROCEEDINGS
2 CHAIRPERSON MENDOZA-TEMPLE: Good morning,
3 everyone, and thank you so much for coming to this
4 historic meeting on adding conditions and evaluating
5 them for medical cannabis for our patients in
6 Illinois.
7 This is our first meeting ever; hence, this
8 is going to be a learning process. So I appreciate
9 your flexibility. We've done our best to try and plan
10 everything as well as we could. We have a lot of
11 conditions, a lot of petitions to get through, and we
12 want to be sure we get to all of it today.
13 We have a few things we're going to start
14 with. All persons should sign in at the registration
15 table; and if you haven't, please do so. These are on
16 our sheet here.
17 We want to have a respectful meeting. So
18 please don't interrupt the proceedings if it's not
19 your turn. Also, be courteous and civil because this
20 is something we're all wanting to work towards.
21 The other thing that I wanted to mention --
22 for an introduction, maybe we should go around first.
23 It would be nice to introduce the Board and tell you
24 who we are. This is a very diverse mix of patients,

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1 clinicians, physicians, and bioethicists as well as
2 pharmacists.
3 So we are going to start with David, and
4 just a brief like two-word thing.
5 MEMBER MCCURDY: Okay. My name is David
6 McCurdy. I worked in health care for over 30 years as
7 a chaplain and a senior manager and health care
8 ethicist.
9 Do I need to repeat any of that? Surely
10 not.
11 Also, I currently teach courses in religious
12 studies at Elmhurst College.
13 MEMBER RAMIREZ: My name is Nestor Ramirez.
14 I'm a pediatrician and neonatologist by specialty. I
15 work at Illinois Masonic Medical Center.
16 I apologize to you all if I nod off
17 occasionally because I just came off of a 24-hour
18 shift at the hospital.
19 MEMBER CHAMPION: My name is Jim Champion.
20 I'm the veterans' rep for the Medical Cannabis Board.
21 I'm a 100-percent service-connected disabled veteran.
22 I've done this for 27 years. I'm proud to be here
23 today.
24 MEMBER LESKOVEC: Jacqueline Leskovec. I'm

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1 here as a registered nurse. I work as an information
2 specialist at the National Network of Libraries of
3 Medicine, Greater Midwest Region, located at
4 University of Illinois in Chicago.
5 MEMBER PARIKH: My name is Jyotin Parikh.
6 I'm a registered pharmacist. I work as a consulting
7 pharmacist. I'm glad to be here on the Board for the
8 first meeting.
9 CHAIRPERSON MENDOZA-TEMPLE: I'm Leslie
10 Mendoza-Temple. I am a family physician as well as
11 the Chairman of this Board. I also am the Medical
12 Director of the NorthShore University Health Systems
13 Integrative Medicine Program. I'm very excited to be
14 here.
15 VICE CHAIRMAN FINE: My name is Michael
16 Fine. I am a patient advocate. I lost my arm in a
17 car accident five years ago and suffer from chronic
18 residual limb pain. I'm Vice Chairman of this Board,
19 and I'm delighted to be here.
20 MEMBER MILLER: My name is Theresa Miller.
21 I am the RN representative here on the Board. I am a
22 nursing instructor. I teach nursing in a
23 baccalaureate program, and I've been a nurse for about
24 25 years.

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1 MEMBER WEATHERS: I'm Dr. Allison Weathers.
2 I'm a neurologist at Rush University Medical Center.
3 I'm an academic general neurologist, and I am also
4 the Associate Chief Medical Information Officer at
5 Rush.
6 MEMBER CHRISTOFF: I'm Dr. Eric Christoff.
7 I'm a general internist and HIV specialist at
8 Northwestern Medicine.
9 MEMBER MILLER: Good morning. I'm Andrew
10 Schwartz. I'm an Assistant General Counsel for the
11 Illinois Department of Public Health.
12 MS. MOODY: My name is Conny Moody, and
13 I'm the Acting Deputy Director for the Office of
14 Health Promotion, Illinois Department of Public
15 Health.
16 MEMBER MORGAN: Good morning. I'm Bob
17 Morgan. I'm the Statewide Project Coordinator for the
18 Illinois Medical Cannabis Pilot Program, at least for
19 two more years.
20 CHAIRPERSON MENDOZA-TEMPLE: Thank you,
21 everyone, for introduce yourselves.
22 I would like to make a motion to limit the
23 time frame for presenting technical evidence per
24 petitioner to three minutes.

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1 MEMBER CHRISTOFF: Second the motion.
2 MEMBER WEATHERS: Second.
3 CHAIRPERSON MENDOZA-TEMPLE: All in favor?
4 (The ayes were thereupon heard.)
5 CHAIRPERSON MENDOZA-TEMPLE: Okay. The
6 second motion I'd like to make is to adjust the order
7 of the agenda to move four of the conditions for
8 discussion to the end of the program because they
9 don't have petitioners scheduled so that if we run out
10 of time, we've been able to hear from all of the
11 petitioners who have been scheduled to speak.
12 So the proposed order I have is in
13 alphabetical order. So the first set of -- conditions
14 all have petitioners. So there's ten of them.
15 There's anxiety, diabetes, essential
16 thrombocythemia, IBS, migraine, neuropathy,
17 osteoarthritis, polycystic kidney disease, PTSD, and
18 superior canal dehiscence syndrome.
19 Then after that we will talk about anorexia
20 nervosa, chronic postop pain, Ehlers-Danlos syndrome,
21 and neuro-Behcet's autoimmune disease.
22 VICE CHAIRMAN FINE: I second the motion.
23 CHAIRPERSON MENDOZA-TEMPLE: All in favor?
24 (The ayes were thereupon heard.)

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1 CHAIRPERSON MENDOZA-TEMPLE: With that new
2 order in mind, you might change your agenda a little
3 bit. We go straight to anxiety.
4 I also wanted to lay down some time frames.
5 MS. MOODY: We have another motion. The
6 Board has another motion in regard to the voting.
7 CHAIRPERSON MENDOZA-TEMPLE: Oh, I missed
8 the third motion.
9 I move to recommend that all votes at the
10 end of each condition, after deliberation on the
11 debilitating conditions, be by ballot box and not by
12 raised hand.
13 MEMBER MCCURDY: Second.
14 MEMBER CHRISTOFF: Second.
15 CHAIRPERSON MENDOZA-TEMPLE: All in favor?
16 (The ayes were thereupon heard.)
17 CHAIRPERSON MENDOZA-TEMPLE: So we will
18 start with anxiety.
19 Actually, for the Board, you may need to
20 reorder your voting slips and just pull out the
21 anorexia, chronic postop pain, Ehlers-Danlos, and
22 neuro-Behcet's. We'll pull out anorexia nervosa,
23 chronic postop pain, Ehlers-Danlos, and
24 neuro-Behcet's.

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1 MS. MOODY: While the Board is reordering
2 their ballot slips, I'm also going to just address the
3 audience in the room.
4 There may be some conditions for which we
5 need to go into closed session because that was the
6 request of the individual who will be presenting
7 technical evidence.
8 So at that point in time, the Illinois
9 Department of Public Health Staff is going to clear
10 the room of everyone, except for the person who will
11 be speaking and the Board. The press, the media, and
12 all of the audience members will have to exit the
13 room.
14 Then once the Board votes to come back into
15 open session, we'll open the doors and have everyone
16 return into the auditorium.
17 So please be prepared that we may be
18 asking you at a couple junctures today to do that and
19 exit the room, but we'll give you notice when we do
20 so.
21 CHAIRPERSON MENDOZA-TEMPLE: Has everyone
22 got their papers in order? Okay.
23 Based on the time, we have our three-minute
24 petitions. Some of the conditions have more

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1 petitioners than others; but for the Board, we have
2 about 15 minutes to deliberate on this. Otherwise, we
3 will simply run out of time. We really want to get
4 through all of this, if possible.
5 If not, then we have to table whatever we
6 don't get to for another time. So we want to have a
7 quality discussion, but we also want to be sure to get
8 to as much as we can.
9 Anything else on a housekeeping basis?
10 MS. MOODY: I would just say to the Board
11 Members that as we move to the first condition, you
12 will find in your binder the first part of the tab
13 includes the petition information. Then there is an
14 orange piece of paper, and behind that are the
15 Statements to Present Technical Evidence from each of
16 the speakers.
17 So I think we'll just call the speakers in
18 order; and for the first condition for anxiety, we did
19 have a speaker who canceled, and that is JoJean
20 A. DeGeeter. She will not be here to testify.
21 So if you wanted to call the speakers in
22 order, speakers may come up to the podium and begin
23 their presentation. Mallory is going to keep an eye
24 on the timing and indicate when the time is up.

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1 CHAIRPERSON MENDOZA-TEMPLE: I have a Liana
2 Bran.
3 Is that what you have?
4 So after the orange page, the condition of
5 anxiety, we have Liana Bran.
6 MS. MOODY: Mallory, would you please raise
7 your hand?
8 CHAIRPERSON MENDOZA-TEMPLE: Okay. Please.
9 MS. MOODY: And then when each speaker
10 arrives at the podium, if you will very slowly,
11 please, speak and then spell your name, first name and
12 last name, for the court reporter. If you would speak
13 slowly, and Jean will give us an indication, if she's
14 able to, if she's got any problems capturing your
15 testimony.
16 MS. BRAN: Great. My name is Liana Bran.
17 That's L-i-a-n-a, last name B-r-a-n.
18 So first off, I want to thank the Members of
19 the Medical Cannabis Advisory Board for allowing me to
20 submit information on the proposed addition of
21 debilitating conditions to the Medical Cannabis
22 Registry Program.
23 Again, my name is Liana Bran. I direct the
24 Substance-Free Workplace Program at a Chicago-based

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1 Chamber of Commerce. Through my role I have connected
2 with numerous professionals in substance abuse
3 prevention. Amongst them there is broad consensus
4 that the trend in medical marijuana is troubling.
5 Today, though, I do not come in this capacity but as
6 that of a concerned citizen.
7 So with regard to the case of anxiety as a
8 debilitating condition, I speak to a report in the
9 New England Journal of Medicine which suggests that
10 while further studies need to be conducted regarding
11 the impact of marijuana use on mental health, evidence
12 links long-term use to increased rates of anxiety,
13 especially among those who initiate use during
14 adolescence.
15 In a study also published by the British
16 Medical Journal, researchers found that weekly or more
17 marijuana use among teenagers resulted in double the
18 risk of later anxiety with adolescent females being a
19 particularly vulnerable population, demonstrating up
20 to five times the risk of later anxiety with daily
21 use, which at the proposed rates of the medical
22 cannabis that will be made available to individuals, I
23 believe will be likely.
24 So for me the question is simple. Why would

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1 you use any substance to treat an ailment that it has
2 been shown to produce? And that is all I have for
3 this.
4 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
5 Thanks for being the first one.
6 The second petitioner is Joe Cotton. Is Joe
7 available? Joe Cotton, going once.
8 Then we have the fourth petitioner, and that
9 is Bruce Doblin, MD, MPH. Is Dr. Doblin here?
10 DR. DOBLIN: Yes.
11 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
12 DR. DOBLIN: I'd also like to thank you for
13 allowing me to speak in front of the panel this
14 morning. I'm a practicing physician --
15 MS. MOODY: Could you please provide your
16 name and spelling for the court reporter?
17 DR. DOBLIN: Sure.
18 MS. MOODY: Thank you.
19 DR. DOBLIN: It's Bruce Doblin, D-o-b-l-i-n.
20 As I was saying, I'm a practicing physician,
21 board certified in internal medicine, and for the last
22 20 years I've provided care to hospice and palliative
23 care patients, to their families, and their loved
24 ones.

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1 Medical cannabis has a 4,000-year-old
2 history of being safe and effective for a number of
3 medical conditions, and I think that's something we're
4 finally becoming aware of.
5 You may know that there is an oral form of
6 the medication called Marinol, which has one component
7 of marijuana in it, the THC component. In my
8 experience and in the experience of most physicians,
9 it's of minimal effectiveness mainly because smoked
10 marijuana has hundreds of active components called
11 cannabinoids. THC is one of them.
12 What we're finding is that many of the
13 effects that make medical marijuana so instrumental in
14 reducing suffering and controlling symptoms like
15 anxiety is the combination of those medications, so
16 that the oral pill provides one component, which is
17 the major component within medical marijuana but
18 may be the least interesting one in terms of really
19 providing relief for pain and suffering for many
20 patients.
21 What I wanted to do is tell you about one
22 patient named Dan, who is obviously not named Dan, who
23 suffers from severe anxiety, a patient in my practice
24 I've seen for over 16 years. When I first saw him,

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1 his ability to work and even to leave the house was
2 limited by severe social anxiety.
3 Many of the typical medications that we use
4 in the practice of medicine were either ineffective or
5 had side effects that were too extreme for him, and we
6 looked towards a future which would be very limited
7 for Dan until a friend of his introduced him to
8 medical marijuana.
9 He was reluctant to tell me that he had used
10 it. He came after almost a year of using it and
11 admitted that it was safe and effective. He has
12 started to leave the house. He has started to go back
13 to school to finish school. He was looking forward to
14 a job, which now he has that he has kept for the last
15 several years because he found something that was very
16 safe and very effective.
17 What he didn't find was something that was
18 very legal, and it continues to be his concern that in
19 order to treat his condition, he has to go outside of
20 the law and expose himself to being arrested, limiting
21 the major advances that he's been able to make in his
22 life that have been so profound.
23 Dan is probably not an unusual story. There
24 are probably hundreds or thousands or tens of

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1 thousands of people with similar conditions that could
2 be assisted with medical marijuana.
3 Many of my patients at some point or another
4 have admitted using marijuana for a variety of
5 conditions. It's something that they know that I'm
6 open to because I've been involved with the medical
7 cannabis law here in Illinois for a number of years,
8 but it's something they do in the shadows and they do
9 with some sort of embarrassment and some sort of
10 hesitation.
11 I think one of the great things about
12 the medical cannabis law here in Illinois is that
13 it allows people to come forward and get the treatment
14 for conditions like anxiety that they would find --
15 MS. SINNER: Thank you. That's your three
16 minutes.
17 DR. DOBLIN: Thank you.
18 CHAIRPERSON MENDOZA-TEMPLE: Thank you,
19 Dr. Doblin.
20 (Applause.)
21 CHAIRPERSON MENDOZA-TEMPLE: Just so that
22 the meeting can flow -- I'd like to applaud, too, but
23 let's keep on going. We'll save it until the end.
24 Also, on another housekeeping note, if you

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1 could put your cell phones on vibrate, that would be
2 great.
3 Joe Cotton, one more chance. If not, we'll
4 open up the discussion to the Advisory Board. We have
5 about 15 minutes.
6 So if you want to speak, from the Advisory
7 Board we have -- who would like to make some comments
8 about the proposed condition of anxiety?
9 David?
10 MEMBER MCCURDY: This is not about the
11 merits. It's really more of a procedural matter that
12 I think I ought to raise at the beginning.
13 That is in reviewing the petition for
14 anxiety disorder along with, actually, a number of the
15 other petitions, there is some language in sections
16 that represent to be an individual's personal
17 experience in which the "I" language in some sections
18 is all identical. I'm sure other people may have
19 noticed this.
20 But at any rate, it seems to me that this is
21 something that we should in some way consider as a
22 phenomenon that may cast a shadow on some of the
23 statements of personal experience, and maybe we'll as
24 a Board want to give that some thought.

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1 I don't have a specific recommendation. One
2 thing would be to, so to speak, throw them out, but I
3 don't know that that -- that seems precipitous, and it
4 just seems like there needs to be some thought about
5 that.
6 CHAIRPERSON MENDOZA-TEMPLE: And maybe I can
7 put a background to that.
8 The petitions that we received as a Board
9 are a combination of anecdotal personal testimonies
10 as well as scientific evidence and summary papers
11 about what cannabis might be used for whatever
12 condition.
13 So as a Board, we are weighing all of
14 these things in whole, which is challenging because
15 if you're just one way about things, we have to
16 really deliberate on this particular condition
17 itself.
18 I just want the group to know that's the
19 mix of evidence that we've gotten. Yes, there are
20 plenty of the personal stories as well that we must
21 consider.
22 MEMBER CHAMPION: I was just going to say
23 that I did notice that, too, that some of them were
24 almost like written from a template, but I don't think

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1 the people who were writing them should be punished
2 because they wrote from a template.
3 This was just giving them ideas like "Live
4 the life that I want to live." I read that on 14
5 different people's applications. That was just
6 something that went along.
7 MEMBER WEATHERS: I noticed that as well. I
8 assumed that there was, like you said, some template
9 that was found online, an advocacy group that was
10 supporting it.
11 I was more concerned that, for the most
12 part, the same two physicians seemed to be writing
13 support notes, which made me concerned about was there
14 a true occupational relationship.
15 That being said, going back to Jim's point,
16 I still didn't necessarily want to hold that against
17 them. This was the advice that they were given, but
18 I think that as a group, maybe separate from our
19 purpose here today, we need to determine how to handle
20 that.
21 Will we accept those letters from a provider
22 given our concerns?
23 MEMBER CHAMPION: I also want to remind
24 the Board that veterans do not need a doctor-patient.

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1 They cannot have one. So please don't punish the
2 veterans. They do not have a duty. They don't have
3 to under our law.
4 MEMBER CHRISTOFF: I'd just like to say that
5 in my practice of general internal medicine, anxiety
6 is one of the psychiatric disorders that requires a
7 broad range of treatments in individuals in order for
8 them to be successful, including basics like improving
9 their sleep and getting enough exercise.
10 I think that -- moving beyond how this
11 might have been presented here, it is my belief that
12 this should be added as a practicing physician because
13 for years I have talked to patients who have used
14 this medicine in this way to manage anxiety, whether
15 it's to the level of panic disorder and disrupting
16 daily life or whether it is more occasional than
17 that.
18 I've seen the range of this in my patients
19 and heard this for years. So I am wholeheartedly in
20 support of this petition.
21 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
22 Dr. Weathers?
23 MEMBER WEATHERS: Thank you.
24 Just to add, to comment on Ms. Bran's, the

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1 first petitioner, evidence that we heard, I think
2 she raises certainly a valid point, and that's
3 something that we need to be cognizant of and
4 concerned about.
5 However, that being said, a number of the
6 currently prescribed medications for anxiety, which is
7 the whole class of benzodiazepines, are known to have
8 a risk of having paradoxical effects, especially in
9 older patients.
10 So we certainly don't rule them out.
11 They're still kind of the gold standard for how we
12 manage a lot of these conditions.
13 So I think, you know, that certainly they
14 can speak to the fact that we're not making individual
15 patient recommendations here today, obviously, and
16 that all of this needs to be taken in kind of
17 consultation with your patients as well; but it's been
18 a discussion of risks versus benefits and possible
19 adverse outcomes as you would for any medication that
20 you prescribe for a patient.
21 CHAIRPERSON MENDOZA-TEMPLE: Michael?
22 VICE CHAIRMAN FINE: While I have no doubt
23 that anxiety is a serious condition, my only issue is
24 not with regard to the specific merits of an

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1 individual that submitted a petition. It is with
2 regard to the specificity of anxiety.
3 There are many types of anxiety, and
4 classifying general anxiety as a condition to receive
5 medical cannabis opens a door to me that is a little
6 troublesome.
7 If it's severe anxiety, such as PTSD or some
8 other type of chronic disorder, I'd be much more apt
9 to be in favor of it; but I'm just concerned that -- I
10 don't want to open the door to someone creating a
11 condition with a doctor in order to get medical
12 cannabis.
13 It's something that's a little difficult
14 to prove, and I'm not doubting the veracity of
15 anyone's intentions; but that's my concern with the
16 condition.
17 CHAIRPERSON MENDOZA-TEMPLE: As a clinician,
18 I see everybody who has anxiety. I think that for the
19 purposes of the title "anxiety" as a condition, I
20 would like to see more of a definition of what kind of
21 anxiety. Mild anxiety? Moderate?
22 I'm definitely in favor of moderate to
23 severe anxiety or treatment-resistant anxiety that has
24 been documented to have treatment fail the patient --

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1 patients don't fail treatment; treatment fails
2 patients -- for six months or some other predetermined
3 amount of time.
4 One of my concerns is that I have a patient
5 coming to see me for the first time saying, "I have
6 anxiety. Can I get cannabis?" I'm going to say,
7 "Well, what else have you done?"
8 The Pilot Act gives me as a clinician
9 guidance that says, "Well, you know what? Let's
10 be sure we're trying these other approaches."
11 There is more than the use of medications.
12 There's mind-body approaches, et cetera, but I'd like
13 to see more definition and not just passing anxiety
14 as it is. It is too broad of a category, in my
15 opinion.
16 We are going to vote on this, and it may
17 pass; but if it doesn't pass, petitioners have an
18 opportunity to reapply under a more sophisticated
19 heading other than just plain anxiety.
20 So there are certain conditions on this list
21 as well that are very general that I may want to throw
22 that guidance out to. You can reapply, by the way.
23 This isn't the end of it all.
24 David?

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1 MEMBER MCCURDY: I guess this might be a
2 question for our Staff in terms of what the law and
3 the rule actually would permit us to do here.
4 Is what we're able to do limited to an
5 identified condition, say, with an ICD code or would
6 it be possible to impose conditions such as, for
7 example, what Leslie has tried to specify here, in
8 addition to a specific diagnosis?
9 MR. SCHWARTZ: At this point, Reverend, the
10 way the law and the rules are written is that the
11 recommendation of the Board is on the petition that's
12 proposed.
13 So at this point the recommendation would be
14 on anxiety as it's included in the petition, not -- in
15 law we call them "lesser and included offenses," but
16 that's not what we're going to call them here. We're
17 not going to some other form of condition which may be
18 included in a broader title. It will be a
19 recommendation on the petition as it is presented to
20 the Board.
21 CHAIRPERSON MENDOZA-TEMPLE: For instance,
22 severe fibromyalgia is on -- I believe it's written as
23 "severe fibromyalgia," not just "fibromyalgia."
24 So I would like to see more qualifications

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1 because I believe this will help our clinicians feel
2 more comfortable and feel more guided as to whether
3 they feel a patient would be eligible for
4 certification.
5 MEMBER PARIKH: I'm a practicing pharmacist
6 for the last 38 years, and anxiety is a very broad
7 thing.
8 I have seen patients coming in without any
9 kind of purpose, and I ask them, "What happened?"
10 They said, "Well, I was anxious in the doctor's
11 office. I had anxiety, and my blood pressure was
12 high."
13 So all those medicines can apply once we
14 approve cannabis for anxiety (inaudible). So we have
15 to define anxiety for the time being.
16 CHAIRPERSON MENDOZA-TEMPLE: And that would
17 be the job for future petitions in case it doesn't
18 pass.
19 Other comments?
20 VICE CHAIRMAN FINE: Motion to vote.
21 CHAIRPERSON MENDOZA-TEMPLE: Any other
22 comments?
23 MEMBER RAMIREZ: Second.
24 CHAIRPERSON MENDOZA-TEMPLE: So we will

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1 vote. The votes will be tabulated, and we will
2 announce the results.
3 Diabetes is next. Diabetes is the next
4 condition. So if the petitioner wants to start
5 getting ready to come down.
6 The nays have it. Eight voted nay, two
7 voted yea for the condition of anxiety. Thank you for
8 coming to provide your testimony.
9 Our next condition is diabetes. So for the
10 next topic of diabetes, the petitioner, Joe Cotton --
11 has he arrived yet? -- has also requested time at the
12 podium.
13 But if he's not here, we have to close the
14 session because we do have a request for a closed
15 portion of the hearing. So I move that -- I know
16 there's language.
17 MR. SCHWARTZ: You can use that language or
18 you cannot. It was just exemplary.
19 CHAIRPERSON MENDOZA-TEMPLE: I move that we
20 close the proceedings to listen to this portion of the
21 hearing, as requested by the petitioner.
22 VICE CHAIRMAN FINE: Second.
23 MEMBER MCCURDY: Second.
24 CHAIRPERSON MENDOZA-TEMPLE: All in favor?

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1 (The ayes were thereupon heard.)
2 (Whereupon at 10:13 a.m., the Board
3 adjourned into executive session, after which the
4 following proceedings were had in public session
5 commencing at 10:21 a.m.)
6 CHAIRPERSON MENDOZA-TEMPLE: If we can get
7 ourselves settled in. We are reconvening our meeting.
8 Thank you for bearing with us. We're going to do it
9 two more times. You have to get used to it. We are
10 going to reconvene. If we could have everyone in the
11 aisles please take their seats. Please turn your
12 phones on vibrate. I appreciate that.
13 The next condition up is diabetes. We have
14 a petitioner, Mr. Joshua Levy. If you could please
15 come up to the podium.
16 Is Mr. Levy present?
17 MEMBER WEATHERS: Were people told specific
18 times?
19 MS. MOODY: No.
20 CHAIRPERSON MENDOZA-TEMPLE: We're on the
21 topic of diabetes.
22 One more time for Joshua Levy.
23 If you have not signed in on the
24 registration list, please do so when you have an

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1 opportunity.
2 Mr. Levy is not here.
3 MEMBER WEATHERS: I think we're going to run
4 and check the list just to make sure.
5 CHAIRPERSON MENDOZA-TEMPLE: So Mr. Levy has
6 not signed in. We'll proceed with the deliberations
7 by the Board on the topic of diabetes.
8 Comments from the Board? Dr. Weathers?
9 MEMBER WEATHERS: I had significant concerns
10 about this application.
11 One, in speaking to our concerns, I mirror
12 our concerns for the first petition that this was
13 very, very generic. I do not think there's sufficient
14 evidence at all that medical marijuana has a true kind
15 of antiglycemic property.
16 I'm actually concerned that this would be
17 dangerous to put out there that this would be used
18 as a substitute for insulin or for diabetes
19 medication.
20 That being said, I think when we get to
21 neuropathy, there are certainly some very specific
22 diabetes-related conditions where it may be indicated;
23 but for diabetes as a whole, I do not feel there was
24 sufficient evidence provided.

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1 CHAIRPERSON MENDOZA-TEMPLE: Dr. Christoff?
2 MEMBER CHRISTOFF: As a general internist,
3 I think across-the-board use of marijuana tends to
4 contribute to appetite, therefore, weight gain.
5 So from my perspective, I'm not
6 understanding the application, and perhaps it's
7 because it's too broad. As you were saying, the
8 neuropathy component has another petitioner coming up
9 later today.
10 I think one study was provided, which I
11 did not get a chance to look over; but until this
12 petition was presented, I hadn't actually thought of
13 diabetes as being something we would treat with
14 marijuana.
15 CHAIRPERSON MENDOZA-TEMPLE: Jim?
16 MEMBER CHAMPION: I was just going to say
17 something similar.
18 My question was that do all people who have
19 diabetes suffer from neuropathic pain? While I think
20 diabetes is a terrible disease, I think that this
21 applicant would be better served if they filed for
22 medical cannabis under neuropathy.
23 CHAIRPERSON MENDOZA-TEMPLE: Which will be
24 discussed today. I read the article that accompanied

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1 the packet, and I didn't feel it was substantial
2 enough evidence to merit this as an eligible condition
3 as titled.
4 MEMBER RAMIREZ: Why not?
5 CHAIRPERSON MENDOZA-TEMPLE: It had a
6 pretty small study, as many of the cannabis studies
7 are.
8 MEMBER RAMIREZ: Just qualitative and
9 descriptive of five or six people?
10 CHAIRPERSON MENDOZA-TEMPLE: It was a
11 smaller study. It was a study that measured one
12 parameter of diabetes when it was measured, but we
13 know diabetes is a complex disease measured by many
14 aspects.
15 To use that as just the reasoning that we
16 should use it for diabetes, like one molecule is
17 affected so we should use it, I didn't think that was
18 enough at all. I also looked for other evidence just
19 for diabetes in my own literature, and I didn't find
20 any.
21 So I am concerned also about the appetite
22 stimulation and making blood sugars worse.
23 Other comments from the Board?
24 VICE CHAIRMAN FINE: Motion to vote.

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1 MEMBER CHRISTOFF: Second.
2 CHAIRPERSON MENDOZA-TEMPLE: Ayes?
3 (The ayes were thereupon heard.)
4 CHAIRPERSON MENDOZA-TEMPLE: The next topic
5 on the agenda is essential thrombocythemia with JAK 2
6 mutation. We have one petitioner. If the Board would
7 kindly turn to that tab.
8 MR. SCHWARTZ: Just give us a minute for the
9 tally.
10 CHAIRPERSON MENDOZA-TEMPLE: Okay. Just so
11 the petitioner is ready, we have one -- and it's an
12 open petition -- Jessica Harshbarger.
13 Is she present?
14 MS. HARSHBARGER: Yes.
15 CHAIRPERSON MENDOZA-TEMPLE: Okay. Good.
16 We'll start when we finish this vote announcement.
17 MR. SCHWARTZ: Take a seat in the front row
18 just for a minute.
19 MS. HARSHBARGER: Okay.
20 CHAIRPERSON MENDOZA-TEMPLE: Sorry. I just
21 wanted you to be ready.
22 The motion failed, ten to zero, nay, for the
23 condition of diabetes.
24 So the next topic is essential

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1 thrombocythemia with JAK 2 mutation. We have a
2 petitioner, Jessica Harshbarger. If you would kindly
3 step to the podium.
4 MS. HARSHBARGER: My name is Jessica
5 Harshbarger. I have essential --
6 MS. MOODY: If you could spell your name for
7 the reporter.
8 MS. HARSHBARGER: Sure. I'm sorry.
9 Jessica, J-e-s-s-i-c-a, Harshbarger,
10 H-a-r-s-h-b-a-r-g-e-r.
11 So I was recently diagnosed about 2 years
12 ago with essential thrombocythemia with JAK 2
13 mutation, which basically means that my body is
14 producing too many platelets. My platelet levels are
15 generally around 800, 900.
16 I have daily headaches. I have migraines.
17 I have migraine with aura. I've also had a couple
18 incidents where I've lost consciousness.
19 I'm a single mom. I have two boys. I'm
20 trying to stay working and stay healthy as much as I
21 can right now.
22 My only option that my doctor has given me
23 is to take something called hydroxyurea. Hydroxyurea
24 is a chemotherapy pill, which will cause me to have

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1 nausea, loss of appetite, a broken-down immune system.
2 There's lots of side effects, including death.
3 This particular bone disorder I feel could
4 benefit from medical marijuana because there aren't
5 the side effects that you would get with the
6 hydroxyurea. I wouldn't have to worry about my immune
7 system being broken down. I wouldn't have to worry
8 about being sick all the time or having to stay away
9 from the elderly and young children.
10 I work in an auto mechanic facility where
11 I'm a manager, and I am dealing with people every day.
12 I would really like to try medical marijuana just so
13 that I can see if that will work for me so that I can
14 stay working and can stay a viable part of our society
15 and not be home sick all the time. I really want to
16 be able to take care of my children and do the best I
17 can.
18 Of course, if that doesn't work for me, I
19 will eventually, if I have to, try the hydroxyurea,
20 but the hydroxyurea will give me all the same side
21 effects that a chemotherapy pill will give me,
22 including loss of appetite and all the rest that I'm
23 sure you're all aware of. So I do feel that even if I
24 do have to take the hydroxyurea, that the medical

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1 marijuana would still help me.
2 Thank you.
3 CHAIRPERSON MENDOZA-TEMPLE: Thank you for
4 your presentation.
5 Deliberation from the Board? David?
6 MEMBER MCCURDY: Not being a medical person,
7 I did notice in the petition materials that according
8 to them, many patients are asymptomatic. If that
9 would be true, then some distinction would have to be
10 made between those who were and those who weren't in
11 terms of eligibility.
12 CHAIRPERSON MENDOZA-TEMPLE: Jim?
13 MEMBER CHAMPION: I just wanted to add that
14 this is one of those conditions where I believe
15 medical cannabis would be beneficial not only to
16 counteract the side effects of the chemotherapy drug,
17 but it would also help with the migraine headaches and
18 the other symptoms of this disease.
19 So it seems like a prime condition for
20 medical cannabis. It would serve more than one
21 purpose.
22 CHAIRPERSON MENDOZA-TEMPLE: Dr. Weathers?
23 MEMBER WEATHERS: Just a couple of concerns
24 in reading through the petition.

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1 I think the incidence of migraine is so high
2 in the general population, as Dr. McCurdy pointed out.
3 Essential thrombocythemia is usually asymptomatic, so
4 I don't know that we can make a direct correlation.
5 It may be that the petitioner is suffering from severe
6 migraines on top of it.
7 Also, I think it sounds as if hydroxyurea
8 has not yet been tried, and I know we're talking
9 not about a specific case. Generally, although it is
10 in fact belonging to a class, it is generally much
11 better tolerated than some of the other
12 chemotherapies.
13 Again, speaking back to my concerns with the
14 diabetes petition, I think there's no significant
15 evidence, other than a few of those major trials, that
16 medical marijuana would lower platelet counts.
17 Again, I'm concerned about things coming out
18 there that it's not actually a treatment for the
19 condition that's being petitioned.
20 CHAIRPERSON MENDOZA-TEMPLE: Michael?
21 VICE CHAIRMAN FINE: Not being one of the
22 medical professionals onboard, I would put it in the
23 hands of the medical professionals that want to
24 determine whether this patient is in pain for

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1 prescribing medical cannabis.
2 I have the utmost respect and sympathy for
3 the petitioner. I really firmly believe that anything
4 pain related, severely, is worthy of passage into the
5 conditions.
6 Thank you.
7 CHAIRPERSON MENDOZA-TEMPLE: So in my
8 literature review -- I did a separate one from this --
9 I couldn't find any other data for the actual
10 condition of essential thrombocythemia.
11 Migraines, yes. The spin-offs from that
12 disease, yes, can have some symptoms. It's generally
13 something -- it's not felt to have patients with this,
14 and they do try hydroxyurea. No one likes it, but for
15 the most part, no complaints.
16 As a clinician, looking at the evidence base
17 for that particular disease population was more from
18 the laboratory level of things, and that's where it
19 gets tricky. We are going to see human trials. Let's
20 just face it. We're not at that phase yet with
21 cannabis research.
22 But I think for this particular condition, I
23 would rather see this particular petitioner look at
24 the migraine category, something else as a condition

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1 to shoot for because essential thrombocythemia itself
2 implies to me that we're treating the bone marrow and
3 we're trying to reduce the platelets.
4 There's not enough evidence in the
5 literature that I find for this particular condition.
6 Theresa?
7 MEMBER MILLER: Thank you, Leslie.
8 I also did a separate literature review
9 of this condition, and I did not find any current
10 literature out there to support the use of medical
11 cannabis with relation to essential thrombocythemia.
12 There was literature related to migraines,
13 again, as you mentioned spin-offs of this disease
14 process, but I didn't see anything.
15 The evidence that was affiliated with the
16 petition was not current evidence. It dated back to
17 2003, 2005, and 2006, and it was more related to
18 leukemia and not to thrombocythemia. So that was a
19 whole separate disease process.
20 So again, perhaps the petitioner could look
21 at something more related to the migraine, which seems
22 to be what the complaint was in the petition.
23 Thank you.
24 CHAIRPERSON MENDOZA-TEMPLE: And those were

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1 issues amongst the petitioner's issues as well.
2 MEMBER WEATHERS: The other category is --
3 and I'm trying to remember the specific ICD-9 code.
4 There's a B code for treatment of chemotherapy.
5 That would be something for a future
6 petition to consider given the known associated side
7 effects with chemotherapy usage with that in terms of
8 if a specific request was around the nausea and
9 possible other side effects from the hydroxyurea. So
10 that would be something I think, as I said, for future
11 petitions.
12 CHAIRPERSON MENDOZA-TEMPLE: The treatment
13 that's already approved is for cancer, which is a
14 broad category.
15 MEMBER WEATHERS: Yes, yes. This is a more
16 generic.
17 CHAIRPERSON MENDOZA-TEMPLE: Other comments
18 from the Board regarding essential thrombocythemia
19 with JAK 2 mutation?
20 MEMBER MCCURDY: Call for the vote.
21 MEMBER MILLER: Second.
22 VICE CHAIRMAN FINE: Second.
23 CHAIRPERSON MENDOZA-TEMPLE: The next
24 condition on the agenda is irritable bowel syndrome.

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1 We have two petitioners, including a closed session.
2 So this will be another opportunity to use the
3 restroom.
4 MR. SCHWARTZ: We have to call for a closed
5 session.
6 CHAIRPERSON MENDOZA-TEMPLE: We're going to
7 wait for the vote first so everyone is teed up and
8 ready.
9 MEMBER WEATHERS: There's two. One is
10 closed and one open.
11 Should we do the open first?
12 CHAIRPERSON MENDOZA-TEMPLE: With the next
13 condition of IBS we will have one petitioner present
14 at the podium. Then we will close the session for the
15 other petition.
16 So if the Board would turn to IBS.
17 VICE CHAIRMAN FINE: While the votes are
18 being tabulated, the next petitioner, Mr. Joe Cotton,
19 if you would please come down and sit down. Wave and
20 let me know if you're here.
21 Did Joe Cotton sign in?
22 MS. SINNER: The name again?
23 VICE CHAIRMAN FINE: Joe Cotton.
24 MS. SINNER: No.

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1 VICE CHAIRMAN FINE: No sign-in? Thank you.
2 CHAIRPERSON MENDOZA-TEMPLE: For the
3 condition of essential thrombocythemia with JAK 2
4 mutation, the nos have it eight to two. The motion
5 has failed.
6 The next condition is for irritable bowel
7 syndrome, and I'll make one last call for Joe Cotton.
8 Otherwise, we have to close.
9 MEMBER WEATHERS: All right. I make a
10 motion to enter a closed session.
11 Subsection 2a of the Open Meeting Act,
12 5 ILCS 120/2(c)(4), allows for "Evidence or testimony
13 presented in open hearing, or in closed hearing where
14 specifically authorized by law to a quasi-adjudicative
15 body, as defined in this Act, provided that the body
16 prepares and makes available for public inspection a
17 written decision setting forth its determinative
18 reasoning."
19 "B. 77 Illinois Administrative Code
20 946.30(j)(4) provides, "A petitioner may request to
21 close a portion of the hearing to protect the
22 disclosure of confidential information."
23 CHAIRPERSON MENDOZA-TEMPLE: This petition
24 is only three minutes, so don't get too comfortable.

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1 MEMBER WEATHERS: I'll second.
2 (The ayes were thereupon heard.)
3 (Whereupon at 10:41 a.m., the board
4 adjourned into executive session, after which the
5 following proceedings were had in public session
6 commencing at 10:49 a.m.)
7 CHAIRPERSON MENDOZA-TEMPLE: We have moved
8 to the session for the topic of irritable bowel
9 syndrome. We have heard from our closed session. Now
10 we open it up to the Board for discussion.
11 Comments?
12 MEMBER LESKOVEC: I want to commend the
13 petitioner who came forth in our closed session not
14 only to share his condition but also for doing
15 research support.
16 Sometimes we have the patient come forth
17 providing personal anecdotal information. Sometimes
18 that is all we have, particularly with medical
19 cannabis, and I think it is really important for us to
20 know that someone who is affected with diseases or
21 disorders or symptoms can come forth and self-advocate
22 so that we have a better understanding of what the
23 patients are going through.
24 CHAIRPERSON MENDOZA-TEMPLE: Other comments?

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1 MEMBER CHAMPION: I just wanted to say that
2 I know firsthand how cannabis can help with stomach
3 problems. I myself have chronic bowel blockages. I
4 also know that the pharmaceutical prescriptions that
5 they prescribe can constipate severely and make this
6 condition worse.
7 The appetite stimulant and everything, it
8 just relaxes my stomach. I'm lucky I'm able to put on
9 weight because of the cannabis.
10 CHAIRPERSON MENDOZA-TEMPLE: Other comments?
11 MEMBER CHRISTOFF: I'd just like to say that
12 it is true, similar to my comments about the anxiety
13 construct, but this case is actually more compelling
14 because it has been difficult to get approved
15 medications to effectively manage IBS symptoms.
16 Even though it has been useful because it's
17 very targeted and specific as a mechanism of action,
18 it is not, as the petitioner stated, effective
19 probably for the majority of patients that try it, in
20 my own experience.
21 VICE CHAIRMAN FINE: As a patient in other
22 capacities that has been on, for the most part, every
23 known pain narcotic prescribed, the side effects in
24 many of those instances are as bad or worse than the

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1 actual pain that I feel.
2 I think this is a perfect situation for
3 cannabis as a narcotic alternative.
4 CHAIRPERSON MENDOZA-TEMPLE: Just for the
5 group to know, there's a difference between irritable
6 bowel syndrome, which is a functional problem with the
7 gut, versus inflammatory bowel diseases, which
8 ulcerative colitis is on the eligible list for
9 cannabis here in Illinois.
10 I also know there are moderate, mild, and
11 severe instances of this. So I just wanted to call
12 that to your attention that maybe some guidance on
13 that would be helpful as well.
14 I can differentiate this from anxiety
15 because this has a pretty debilitating effect on the
16 body that is brutal. You can see it through the
17 symptoms that come out on the other end.
18 So to me, I feel more comfortable with this
19 as a condition, but part of me is also thinking we
20 need -- I'd like to define it a little bit further
21 with it being severe, but we can say that about a lot
22 of conditions. That's my opinion.
23 VICE CHAIRMAN FINE: Again, hopefully, the
24 medical professional involved in the relationship

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1 would differentiate between something moderate to
2 something severe.
3 While I think in the future petitions, you
4 know, as we all move along as a learning curve, will
5 specify, you know, the severity, especially the
6 condition -- it could be mild, medium, questionably
7 situated to warrant medicinal cannabis -- I put my
8 trust in the medical professionals to be able to
9 ferret that out as to what they think their patient is
10 suffering from based on the term of their established
11 medical relationship.
12 CHAIRPERSON MENDOZA-TEMPLE: I would say
13 just from a consistency standpoint, though, and the
14 way we do the anxiety, it's also going to have
15 definition.
16 IBS is a much narrower definition. It's
17 got constipation and diarrhea. It causes dysfunction,
18 but we can't find a reason on the colonoscopy why.
19 Also, this is a condition that's not
20 supposed to wake someone up from sleep, which is a
21 red flag that tells us that it's probably an
22 ulcerative or irritable bowel -- or inflammatory bowel
23 disease or potential cancer.
24 So IBS to me is also in that spectrum of

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1 anxiety-related diseases, but it that has, obviously,
2 really tough digestive consequences; but for the sake
3 of being consistent, if we did that with anxiety, I'm
4 thinking why it would be different with IBS if it does
5 have a spectrum.
6 Now, I also agree the physician should be
7 the one deciding, "Yeah, this person has a very severe
8 case." Then I would write the physician certification
9 letter and leave it to the clinician to make that
10 decision, but then we could say that about anything.
11 MEMBER WEATHERS: Just to simply counter
12 that, I think, as you've alluded to, that each concern
13 is unique. It would be hard for us as a panel to
14 determine what constitutes moderate to severe.
15 Moderate, given the nature of digestive
16 disorders, can still have a significant impact on the
17 quality of life. I'm not, frankly, quite as concerned
18 with this one.
19 Also, there's very limited FDA-approved
20 medications. Those that are out there have
21 significant side effects. Given the relative safety
22 profile and limited adverse reactions, this is helpful
23 even for a moderate case, and I think it could be
24 warranted in this one.

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1 CHAIRPERSON MENDOZA-TEMPLE: I think you
2 swayed me.
3 Theresa?
4 MEMBER MILLER: I wanted to point out, too,
5 that the difference here, in my opinion, with regards
6 to irritable bowel and anxiety, as we talk about that
7 consistency with the definition, is that there isn't
8 any current literature on the effectiveness of
9 cannabis with generalized anxiety.
10 There are a few studies from 2011 and some
11 current studies on the effect of irritable bowel
12 syndrome as well as fibromyalgia. So I'm more
13 comfortable with that because in reviewing the
14 literature, there is some evidence out there to
15 support that where there isn't any literature to
16 support generalized anxiety.
17 There are cognitive-based therapies that are
18 out there and medications which can have some harmful
19 side effects, but there's a lot of success with
20 cognitive-based therapy.
21 CHAIRPERSON MENDOZA-TEMPLE: Any other
22 comments? David?
23 MEMBER MCCURDY: Call for the vote.
24 MEMBER WEATHERS: Second.

1 (The ayes were thereupon heard.)
2 CHAIRPERSON MENDOZA-TEMPLE: While the votes
3 are being tallied, the next condition on the agenda is
4 migraine, for which we have five petitioners,
5 including a closed session. That's the last closed
6 session.
7 We'll see the petitioners first, and then
8 for the closed session we'll do the same thing.
9 CHAIRPERSON MENDOZA-TEMPLE: Motion passed,
10 ten to zero.
11 (Applause.)
12 CHAIRPERSON MENDOZA-TEMPLE: We're moving on
13 to the next topic, which is migraine. We have four
14 petitioners for the open session and one for the
15 closed.
16 MR. SCHWARTZ: Madam Chair, just to clarify,
17 I've reviewed the sign-in log as well as other Staff
18 has reviewed the sign-in log. The presenter --
19 A VOICE: I can't hear.
20 MR. SCHWARTZ: Hold on.
21 It does not appear that the presenter of
22 technical evidence that requested a closed session is
23 here.
24 Is there any objection? I don't want to

1 call the name. Hold on. I thought I heard "I'm
2 here."
3 A VOICE: I said, "I can't hear."
4 MR. SCHWARTZ: That's much different than
5 "I'm here."
6 It doesn't appear that the presenter of
7 technical evidence for the closed session signed in.
8 The sign-in log has been reviewed by myself and
9 other Staff. So there won't be a need for a closed
10 session.
11 CHAIRPERSON MENDOZA-TEMPLE: We'll have four
12 petitioners in open session. You don't have to leave
13 the room.
14 So our first petitioner is Dela
15 Annani-Akollor. Sorry if I mispronounced that.
16 Is that petitioner here? Dela
17 Annani-Akollor?
18 Did they sign in? Did this petitioner sign
19 in?
20 MR. SCHWARTZ: I'm going to go check.
21 CHAIRPERSON MENDOZA-TEMPLE: No?
22 So this petitioner hasn't signed in, is not
23 present. We'll move to the second one, which is
24 Dr. Bruce Doblin.

1 DR. DOBLIN: My name is Bruce Doblin,
2 D-o-b-l-i-n. I'm a practicing physician and a hospice
3 physician here in the Chicago area.
4 Three minutes goes very quickly, so I'll
5 just make a few points. One is I'm speaking on behalf
6 of the use of medical cannabis for migraines.
7 I'm conscious of the panel's concern about
8 not opening up broad categories of use. Migraines by
9 definition are very different than headaches. They
10 are more debilitating, they are more symptomatic, and
11 they are more profound. So the diagnosis of migraine
12 already puts a patient in a different kind of category
13 than the usual headache.
14 The law in Illinois has been referenced very
15 wisely with the prescribing physician in a meaningful
16 relationship with the patient. So I think we're
17 talking about a condition that's being monitored
18 overall.
19 It seems to me that there are many
20 impressive things that medicine does today, but what
21 they don't do very well is they don't experience
22 patients' pain. They don't experience many of the
23 symptoms that we're talking about treating with
24 medical cannabis.

1 We can't take a temperature of somebody's
2 migraine disability, but we can know that many
3 patients don't respond well to typical medications.
4 We often use one after another after another in a vain
5 attempt to find something that's helpful.
6 It would be my suggestion we just include
7 medical marijuana as one of those things. I am
8 not even saying necessarily the first thing but one
9 of those things that is possible given the fact
10 that going back to 1999, the Institute of Medicine,
11 in reviewing all the literature at the time,
12 clearly indicated that there are therapeutic ways in
13 which medical marijuana can help in the treatment of
14 pain. I would put migraines in that category very
15 clearly.
16 Thank you.
17 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
18 Our next petitioner is Jessica Harshbarger.
19 Then after that testimony will be Dr. Greg Kuhlman.
20 If you could come down to the front as well. Dr. Greg
21 Kuhlman.
22 Thank you, Ms. Harshbarger.
23 MS. HARSHBARGER: So I'm speaking again on
24 behalf of medical cannabis for migraines and,

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1 hopefully, migraines with aura.
2 As we all know, medical cannabis has a lot
3 of benefits for people with pain. Of course, when
4 you're experiencing a lot of pain from a migraine, it
5 can be as simple as not being able to handle light but
6 as severe as being trapped in a dark room for hours
7 and hours trying recuperate.
8 So obviously, anything that can take the
9 edge off that pain is going to be beneficial,
10 especially with the least possible side effects. So I
11 definitely feel that medical cannabis could benefit me
12 for my migraines, help keep me a little more
13 functional.
14 So, you know, I would like to have the
15 opportunity to try that. I'm certainly not somebody
16 who is just looking to try to smoke cannabis. I would
17 like to be able to ingest it, the oils and things, so
18 for the medical benefit purely.
19 So that's really all I have to say.
20 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
21 Dr. Greg Kuhlman --
22 VICE CHAIRMAN FINE: Did he sign in?
23 CHAIRPERSON MENDOZA-TEMPLE: -- is our last
24 petitioner. Dr. Greg Kuhlman.

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1 Is he on the sign-in sheet?
2 So we'll open the discussion to the Board.
3 Comments from the Board on migraine?
4 VICE CHAIRMAN FINE: A perfect case of an
5 alternative. I think this is a textbook example of
6 what cannabis would be, a wonderful alternative to the
7 drugs that are often prescribed for the pain
8 associated with migraines.
9 MEMBER CHRISTOFF: I second that use
10 regarding narcotic use of migraines, which is often a
11 very slippery slope.
12 I think this is also a candidate condition
13 that has a range of responses to traditional both
14 preventive and abortive therapy, and there is a
15 apparently a lot of published evidence on this topic
16 as well that we were provided.
17 MEMBER WEATHERS: So just to speak to this,
18 opioids, that whole class of drugs, are actually not
19 recommended for the chronic treatment of migraine.
20 There is a physician statement out from the American
21 Academy of Neurology against their use.
22 They can lead to significant medication
23 overuse, headache -- what we call rebound headache,
24 and other issues.

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1 So I agree that although I feel more
2 research and several more studies need to be done,
3 cannabis can potentially act as an alternative
4 abortive therapy.
5 MEMBER MILLER: I would agree.
6 When I read the literature, I also know
7 that opiates as a drug class are not used to treat
8 migraine headaches. It's actually contraindicated in
9 that because of the same reasons that Allison spoke
10 of.
11 There is some recent literature out there,
12 but it does all go back to the use of narcotics; and
13 there does need to be more research out there for this
14 diagnosis I feel.
15 I also agree that anytime you can see an
16 alternative for that particular pain, that that would
17 be helpful.
18 CHAIRPERSON MENDOZA-TEMPLE: Other comments?
19 MEMBER LESKOVEC: I think having to limit
20 our discussion to migraine specifically as a symptom
21 and diagnosis that could be consistent with pain
22 control is definitely much more direct than the other
23 conditions that we talked about before, which is
24 rather broad.

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1 CHAIRPERSON MENDOZA-TEMPLE: Other comments?
2 VICE CHAIRMAN FINE: Motion to vote.
3 CHAIRPERSON MENDOZA-TEMPLE: Excuse me.
4 So as a personal migraine sufferer, I do
5 understand what this pain is like. What I do know is
6 there are also many other treatments that can be used.
7 This is an important one for me because there are
8 categories of mild, moderate, severe.
9 I would like to see on this particular
10 instance that that's defined because migraines are
11 quite common. I'm telling you as a sufferer myself, I
12 would just like to see a little more qualification on
13 this, but I welcome comments from the Board.
14 MEMBER WEATHERS: Again, my final concern is
15 that there's no necessarily established criteria for
16 what's to be found mild, moderate, severe.
17 We've talked about prophylactic therapy
18 being indicated on the consistency of one a week or
19 greater. However, for those people who suffer from
20 what we call complicated migraines -- (Inaudible)
21 Also, there's people who have migraines less
22 frequently; but because they don't respond well to the
23 abortive medication, they can be significantly longer.
24 They can last for a month; they could last for three

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1 days -- (Inaudible)
2 It's sticky, and it's a hard distinction. I
3 think it goes back to the point that Michael raised
4 that, unfortunately, by nature what we've been tasked
5 to do, we're choosing ICD-9 codes in addition, and
6 then it's up to the individual patient provider to
7 have that discussion and say, "I'm not recommending
8 this as a treatment until I know that you have failed
9 current established abortive therapy, just work our
10 way down to the triptans class. You're not responding
11 to other therapies."
12 I think I just worry we get into practice of
13 it.
14 CHAIRPERSON MENDOZA-TEMPLE: I'm very open
15 to suggestion as well about putting a little more
16 definition in the title of the condition.
17 As a clinician, how can that also help our
18 doctors, who are definitely the gatekeepers of all of
19 this, and give some guidance on this?
20 Dr. Christoff?
21 MEMBER CHRISTOFF: To my knowledge, there's
22 not a distinction in the Neurology Society's
23 definition of migraine as to severity.
24 CHAIRPERSON MENDOZA-TEMPLE: Maybe

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1 "treatment resistant" might be a better term.
2 MEMBER CHRISTOFF: Well, I'm not a
3 neurologist, so I'm not going to pretend I know the
4 specifics here.
5 I'm not aware that with migraine, as
6 distinguished from cluster, from rebound, from muscle
7 tension headache, and the other ways these are
8 defined, I'm not aware that they are defined as mild,
9 moderate, and severe.
10 So I think this is one where provider
11 discretion, having a relationship with the patient,
12 given that conventional abortives and preventives have
13 failed, means that it is not necessary for us to
14 distinguish that it has to be a particular category.
15 I think that's overstepping on our part here.
16 If we believe that this is a disorder, once
17 it's failed conventional therapy, that is eligible for
18 cannabis in the State, then we should approve this
19 petition.
20 MEMBER CHAMPION: I was just going to say
21 that this is a condition that may be mimicked by
22 some.
23 I've seen the firsthand effect. My wife
24 suffers from terrible migraines. I think extreme

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1 cases should be approved. I also feel that approval
2 of this condition will cover many other conditions
3 that cause migraines.
4 Research for cannabis as being beneficial
5 for these patients is crucial.
6 CHAIRPERSON MENDOZA-TEMPLE: There's also a
7 condition that's rare, superior canal dehiscence,
8 which we'll talk about at the end, which is featured
9 with migraines, which might be helpful for the Board
10 as well.
11 MEMBER PARIKH: I think mild, moderate,
12 severe, that's subjective on who is treating the
13 condition. (Inaudible) Once we approve this condition
14 then there is no saying that it's mild, moderate, or
15 severe. If it's approved, it's approved.
16 So if we have a concern about it, then we
17 should put some sort of restriction that they have
18 tried traditional medications and nothing has helped
19 before they approve. I don't know if we can do that
20 or not.
21 MEMBER LESKOVEC: I don't think that we
22 should consider cannabis as an alternative. I think
23 that it should be made available (Inaudible) to help
24 alleviate the pain of the patient.

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1 CHAIRPERSON MENDOZA-TEMPLE: The other thing
2 in the language of the Act is that it's severely
3 debilitating.
4 So I just wanted to point out that
5 clarification, that these conditions are already
6 supposed to be severely debilitating. That to me
7 presumes that many things have been tried already.
8 Am I correct in that?
9 VICE CHAIRMAN FINE: I agree, also.
10 Again, I don't think cannabis should be
11 strictly an in-lieu-of medication. It could be in
12 addition to; and if it could help alleviate symptoms
13 as part of a treatment regime that could be, you know,
14 partially narcotic, partially holistic, I'm all for
15 that as well, and provide some aid.
16 I feel that it's warranted.
17 CHAIRPERSON MENDOZA-TEMPLE: Okay. So
18 motion to vote?
19 MEMBER MCCURDY: So move.
20 VICE CHAIRMAN FINE: Second.
21 CHAIRPERSON MENDOZA-TEMPLE: While the votes
22 are being tallied, the next condition up is
23 neuropathy.
24 MR. SCHWARTZ: I was going to say we could

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1 probably beat the lunch rush. It's about 11:15 now.
2 I know it's early for some, but that may be the most
3 efficient way after the vote is presented if we go
4 into a short lunch recess.
5 CHAIRPERSON MENDOZA-TEMPLE: After the votes
6 are tallied and announced, we'll go into our lunch
7 recess and reconvene at --
8 MR. SCHWARTZ: 11:45.
9 CHAIRPERSON MENDOZA-TEMPLE: It's now 11:15.
10 Let's take a minute still to tally.
11 We can't bring food in here. We'll meet
12 back here at 11:45.
13 The motion for migraines has passed eight to
14 two.
15 (Applause.)
16 CHAIRPERSON MENDOZA-TEMPLE: We need to vote
17 on the recess.
18 MEMBER MCCURDY: I move.
19 VICE CHAIRMAN FINE: Second.
20 (The ayes were thereupon heard.)
21 (Recess taken at 11:17 a.m.)
22
23
24

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1 AFTERNOON SESSION
2 Monday, May 4, 2015
3 11:54 a.m.
4 CHAIRPERSON MENDOZA-TEMPLE: We're back from
5 lunch. The next item on the agenda -- I move to open.
6 MEMBER MCCURDY: So move.
7 MEMBER LESKOVEC: Second.
8 CHAIRPERSON MENDOZA-TEMPLE: We're opening
9 up the session again with the next topic being
10 neuropathy. There are three petitioners signed up.
11 So the first petitioner is Dr. Bruce Doblin.
12 If you would come down to the podium if you're here.
13 A VOICE: I heard he might have left.
14 CHAIRPERSON MENDOZA-TEMPLE: Dr. Bruce
15 Doblin. False alarm. Dr. Greg Kuhlman, and the last
16 is Dr. Bart Wilsey. Okay.
17 MEMBER WEATHERS: Did we check the sign-in
18 list again? It looked like Dr. Wilsey was in
19 California.
20 MS. MOODY: We heard earlier that he may not
21 appear.
22 CHAIRPERSON MENDOZA-TEMPLE: Of the three
23 petitioners, none of them are present?
24 Okay. All right. We'll open up discussion

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1 on the topic of neuropathy.
2 MEMBER MCCURDY: I've found myself wondering
3 a little bit how to proceed because, obviously, the
4 department ordering these has put all the neuropathy
5 categories together on the one hand, and on the other
6 hand we see diabetic neuropathy and peripheral
7 neuropathy as if they were somehow distinct. Then,
8 also, there's more than one ICD code for the
9 peripheral neuropathy.
10 So I suppose it would help me to get more
11 clarity on that aspect and whether we should really
12 look at these as a group or split them out in some
13 way.
14 MEMBER WEATHERS: I think some put in their
15 petition that they really went into detail about
16 the -- (Inaudible)
17 For purposes of the discussion, the
18 overwhelming feeling seems to be that they were
19 discussing peripheral polyneuropathy, and I don't know
20 how much we want to delve into peripheral
21 polyneuropathy, all the etiologies.
22 So that would be, I think, what we're stuck
23 here trying to tackle. I mean, you can get diabetic,
24 you can get renal failure, B-12, B-6 deficiency.

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1 There's just a million causes. I don't know if that's
2 really going to help us help the patient.
3 I would say I think we try to tackle the
4 condition of peripheral polyneuropathy and all of the
5 ICDs that follow after that, and that we're not
6 talking about approving this for carpal tunnel or
7 ulnar.
8 MS. MOODY: So I just wanted to point out
9 that the petition -- the first petition that was
10 submitted was specific to peripheral neuropathy.
11 MEMBER WEATHERS: I would say peripheral, it
12 has to be polyneuropathy.
13 MS. MOODY: The second one is diabetic
14 neuropathy. The third one -- I'm sorry. So there are
15 distinctions made in the petitions that were
16 submitted.
17 CHAIRPERSON MENDOZA-TEMPLE: So we have
18 several petitions. Just to reiterate, we have
19 diabetic neuropathy and peripheral neuropathy.
20 Are we going to vote on those as two
21 separate?
22 MEMBER CHRISTOFF: I think we need
23 peripheral sensory neuropathy. It's not caused by an
24 anatomic issue like carpal tunnel.

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1 MEMBER WEATHERS: So do we include
2 autonomic?
3 MEMBER CHRISTOFF: Is there a request
4 regarding autonomic neuropathy as well? Because
5 that's yet another disorder entirely.
6 MEMBER WEATHERS: Diabetes can include
7 autonomic. I mean, if you looking at Page 205 in one
8 of the petitions, they really -- I mean, a lot of them
9 reference all the autonomic manifestations of
10 peripheral as well.
11 MR. SCHWARTZ: So what we attempted to do --
12 as you said, the Department attempted to organize
13 these by the category of neuropathy, but it's at the
14 Board's discretion if they want to vote to hear the
15 petitions individually.
16 The first one is listed as peripheral
17 neuropathy, which I believe was not the one that
18 Dr. Weathers was talking about with all the
19 significant citations. That was the second one, and
20 then the final petition was for diabetic neuropathy.
21 So you could hear them all separately, and
22 then I guess we could hold three different votes.
23 MEMBER RAMIREZ: If we don't have any
24 testimony on any of the three, can we postpone it and

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1 table it to a future meeting?
2 MR. SCHWARTZ: That's also at your
3 discretion.
4 MEMBER RAMIREZ: She could table this issue.
5 MR. SCHWARTZ: I wouldn't recommend that
6 because there's a certain time frame in which the
7 Department has to decide on petitions that were
8 received.
9 Since a secondary hearing date hasn't been
10 established, it's in the best interest of the
11 Department as well as the people that the discussions
12 and the deliberations are held today.
13 MEMBER WEATHERS: Just for my two cents
14 about that, Nestor, I think we have to be careful
15 because the petitions were set forth, it sounds like,
16 by patients versus the three people that were going to
17 speak were all physician advocates.
18 I think it's a big category we'd have to
19 tackle or hear later. I'd rather -- I think we just
20 need to have a conversation.
21 CHAIRMAN FINE: I motion to separate the
22 categories of neuropathy based on the conditions that
23 were listed in the petitions.
24 MEMBER CHRISTOFF: Second.

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1 MEMBER MCCURDY: It was seconded. Now we
2 can discuss the issue.
3 So the question is: How are you going to
4 divide them?
5 VICE CHAIRMAN FINE: By the petitions as
6 they are listed. So we can start with diabetic
7 neuropathy. Is that No. 1?
8 MR. SCHWARTZ: That's No. 3.
9 MEMBER WEATHERS: It's the easiest. We can
10 start with that.
11 MEMBER MCCURDY: Aren't there four?
12 MR. SCHWARTZ: I have it as 3, Dr. McCurdy.
13 So I have peripheral neuropathy, and the
14 second one begins -- I'm just reading under "Proposed
15 Medical Conditions." The first line is ICD-9. That's
16 Code 72, peripheral neuropathy, and then that one
17 continues for quite some time.
18 MEMBER LESKOVEC: Question: If we're going
19 to address them separately, then we will be voting
20 separately?
21 MR. SCHWARTZ: Yes.
22 VICE CHAIRMAN FINE: Let's modify our
23 ballot. We can write the categories on our ballot as
24 to the conditions and then talk about them.

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1 MEMBER CHRISTOFF: I think we need to come
2 to a better consensus about the peripheral neuropathy,
3 which I think means a distal sensory neuropathy
4 secondary to a disorder or a medication, such as
5 long-standing HIV infection or medications used to
6 treat HIV caused by distal sensory neuropathy. I
7 think that's what is intended.
8 MEMBER WEATHERS: If we're talking about
9 peripheral polyneuropathy, I think it could be
10 sensory-motor. Diabetic is sensory-motor.
11 What we're trying to separate out is that
12 we're not talking about -- (Inaudible)
13 I want to also clarify that I think we're
14 not talking about -- I think some of the ICD-9 codes
15 that are listed are symptoms, not conditions.
16 (Inaudible) I'd like to distinguish those.
17 MEMBER MCCURDY: May I also -- to get back
18 to the question of how many we have --
19 CHAIRPERSON MENDOZA-TEMPLE: There are four.
20 MEMBER MCCURDY: Yes. I see the 356.8 or
21 whatever, also. So we have three peripheral and one
22 diabetic.
23 MS. MOODY: That is correct.
24 CHAIRPERSON MENDOZA-TEMPLE: So just as a

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1 background for the group here, neuropathy is a big,
2 harry condition. It's featured with numbness and
3 tingling in various body parts.
4 What we're working on is differentiating
5 there's different causes of neuropathy, and it's just
6 such a big category that the Board has moved to
7 separate it into diabetic neuropathy, if I'm saying
8 this right, and then peripheral neuropathy. Then
9 we're going to vote on those two.
10 MS. MOODY: On two conditions, peripheral
11 and diabetic.
12 MR. SCHWARTZ: Peripheral polyneuropathy.
13 VICE CHAIRMAN FINE: Shall we write
14 "Number 1" on this thing, peripheral polyneuropathy,
15 and then put the checkboxes there next to it?
16 One is peripheral-- do you want to spell it
17 because I can't do that.
18 MS. MOODY: Would you like to spell that
19 out?
20 CHAIRPERSON MENDOZA-TEMPLE: Peripheral,
21 p-e-r-i-p-h-e-r-a-l, and polyneuropathy.
22 MEMBER RAMIREZ: I have a question.
23 Are we including the various categories of
24 the classification, which include hypoesthesis and

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1 hyperesthesis? They're are types of neuropathy.
2 MEMBER WEATHERS: I think all of those fall
3 under 70(e)2.0. Those are all symptoms. They're not
4 specific diagnoses.
5 VICE CHAIRMAN FINE: So 1 is peripheral
6 polyneuropathy.
7 CHAIRPERSON MENDOZA-TEMPLE: Number 2 will
8 be diabetic neuropathy. We're voting on two
9 conditions.
10 Then just if all the Board members could
11 mark their ballots a yea or nay.
12 VICE CHAIRMAN FINE: So are there two or
13 four?
14 CHAIRPERSON MENDOZA-TEMPLE: Two conditions,
15 but we've got four petitioners that none of them --
16 MS. MOODY: There were three for peripheral
17 and one for diabetic, yes.
18 CHAIRPERSON MENDOZA-TEMPLE: We have three
19 peripheral petitions and one diabetic neuropathy
20 petition. We called it, and no one is here.
21 On another editorial note, if people are
22 taking the time to petition these conditions and have
23 us evaluate these, please show up.
24 Did Dr. Doblin come in?

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1 A VOICE: Dr. Doblin had to leave.
2 CHAIRPERSON MENDOZA-TEMPLE: Okay. We
3 understand there are circumstances that don't allow
4 for this. So we will start with peripheral
5 neuropathy.
6 Comments from the Board?
7 MEMBER CHAMPION: I was going say that he
8 having MS, I'm very familiar with this type of pain.
9 I'm actually shocked that neuropathy itself was not
10 included on the original bill.
11 On Page 78 of "Medical Marijuana as
12 Medicine," what we were given to read, it states that
13 narcotics are not effective in treating neuropathic
14 pain. I found that to be untrue myself.
15 The feeling that your legs or feet or
16 whatever are frozen in a block of ice or feel like
17 they're on fire is just not a very pleasant feeling at
18 all.
19 I took gabapentin for many years. I had
20 seizures on gabapentin from taking me off too
21 abruptly. I had water gain. I got up to 240 pounds
22 from the medicines they gave me to help with my
23 peripheral pain. When I started taking cannabis, I no
24 longer needed gabapentin. The weight fell off me like

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1 nothing.
2 Like I said, I can say firsthand that I know
3 neuropathy is very painful, and I'm shocked it wasn't
4 on the original bill; but it's something I feel
5 strongly on, and I urge you guys to vote.
6 VICE CHAIRMAN FINE: I agree with Jim
7 wholeheartedly. For the most part, the condition that
8 I suffer from, chronic residual limb pain, is a form
9 of neuropathy.
10 I, too, was on gabapentin. I'm on Lyrica.
11 I still feel my arm isn't attached. It's encased in a
12 block of ice and being squeezed all the time.
13 Sometimes I file literally pins and needles, almost
14 like a frostbite feeling into my hand, and it changes
15 with varying degrees of pressure and temperature and
16 so forth.
17 So again, even though hand and limb pain is
18 one of the covered conditions, it is a specific type
19 of this neuropathy. I again wholeheartedly encourage
20 you guys to vote.
21 CHAIRPERSON MENDOZA-TEMPLE: I think, as a
22 clinician who has treated a lot of patients with
23 neuropathy from various sources, I can say even with
24 the integrative therapies I've tried with acupuncture

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1 and massage, they are all helpful to a point.
2 But I think that this is, as a clinician,
3 one of the toughest conditions that I have had to
4 treat with a very long course of improvement that is
5 so-so.
6 I feel that with the literature review that
7 was provided, that is ample evidence for me,
8 scientifically as well as clinically, to promote this
9 to be approved.
10 MEMBER MCCURDY: I guess I would pretty much
11 echo, as a layman. There was an article from the
12 Journal of Pain in 2013 that I thought was quite good
13 sort of supporting it.
14 The other thing was the fact that the
15 physician at the San Francisco Hospital, the
16 University of California, the San Francisco doctor
17 was willing to write a letter in support of this
18 to the Department. That was about severe pain, not
19 just neuropathy, but the literature, including the
20 articles he coauthored, seemed to be persuasive on
21 this point, also, I think.
22 CHAIRPERSON MENDOZA-TEMPLE: Other comments
23 from the Board on peripheral neuropathy?
24 VICE CHAIRMAN FINE: Call the vote.

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1 MEMBER SCHWARTZ: You might as well keep
2 moving on to diabetic.
3 CHAIRPERSON MENDOZA-TEMPLE: We will vote on
4 our discussion after both conditions, peripheral
5 neuropathy and diabetic neuropathy.
6 We'll talk about -- have comments on
7 diabetic neuropathy.
8 MEMBER WEATHERS: For diabetic, just to
9 clarify, I think that can include the manifestations
10 of diabetic nerve disease, polyneuropathy, diabetic
11 myopathy (Inaudible) severe diabetic autonomic
12 neuropathy, which can lead to some of the GI
13 conditions that we discussed.
14 So specifically for that one, I think we
15 should include all the related diabetic neuropathic
16 conditions.
17 CHAIRPERSON MENDOZA-TEMPLE: I think
18 clinicians in general -- again, we had a discussion
19 about diabetes, that it can promote appetite as well.
20 From a clinical standpoint, I want to make sure I warn
21 my patients of watching their blood sugars. That's on
22 a side note.
23 MEMBER CHRISTOFF: Practically speaking,
24 we've had diabetes out of control for a lot of

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1 patients who have neuropathy as a disorder. The train
2 has left the station a long time ago with respect to
3 sugar control and their nerves.
4 So this is palliative care in that sense for
5 an issue that I think doesn't always manifest in
6 diabetics necessarily universally related to the
7 degree of sugar control that they have.
8 MEMBER WEATHERS: For the most part, yes.
9 (Inaudible)
10 CHAIRPERSON MENDOZA-TEMPLE: Other comments
11 from the Board on diabetic neuropathy?
12 So we will call the vote. We're voting on
13 peripheral neuropathy and diabetic neuropathy. So
14 we're handwriting our vote.
15 The next condition on the list, while we're
16 tallying the votes, is osteoarthritis for which we
17 have two petitioners. We have no more closed
18 sessions. We have Dr. Greg Kuhlman and Jared Joshua
19 Taylor.
20 Is Mr. Taylor here? Sort of start making
21 your way down here while we tally.
22 For the condition of peripheral neuropathy,
23 the motion was a vote of ten to zero. For the
24 condition of diabetic neuropathy, the motion passed

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1 ten to zero. Let me clarify. It's peripheral
2 polyneuropathy and diabetic neuropathy.
3 Thank you.
4 (Applause.)
5 CHAIRPERSON MENDOZA-TEMPLE: Okay. Our next
6 topic is osteoarthritis. We have a petitioner before
7 us.
8 Please proceed.
9 MR. TAYLOR: Good afternoon, Ladies and
10 Gentlemen. My name is Jared Taylor, J-a-r-e-d
11 T-a-y-l-o-r.
12 I'm here today to voice my support to add
13 osteoarthritis as a qualifying condition to the
14 Illinois Medical Cannabis Pilot Program.
15 According to the Mayo Clinic,
16 "Osteoarthritis is the most common form of arthritis,
17 affecting millions of people worldwide. It occurs
18 when the protective cartilage on the ends of your
19 bones wears down over time.
20 "Although osteoarthritis can damage any
21 joint in your body, the disorder most commonly affects
22 joints in your hands, knees, hips, and spine.
23 Osteoarthritis often gradually worsens, and no cure
24 exists."

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1 Signs and symptoms of osteoarthritis include
2 pain, tenderness, stiffness, loss of flexibility,
3 grating sensation, and bone spurs.
4 A prominent medication that is used to treat
5 osteoarthritis is acetaminophen, known by the brand
6 name of Tylenol, which can relieve pain but does not
7 reduce inflammation. Taking more than the recommended
8 dosage of acetaminophen can cause liver damage.
9 As well, nonsteroidal anti-inflammatory
10 drugs, NSAIDs, may reduce inflammation and relieve
11 pain. NSAIDs include medications such as Advil,
12 Motrin IB, and Naproxin.
13 NSAIDs can cause stomach upset, ringing
14 in your ears, cardiovascular problems, bleeding
15 problems, and liver and kidney damage. As well,
16 NSAIDs should not be used by individuals over 65
17 years of age.
18 Other ways to manage arthritis include
19 physical therapy, occupational therapy, attending a
20 chronic pain class, cortisone shots, and lubrication
21 injections.
22 I was officially diagnosed with
23 osteoarthritis earlier this year but have experienced
24 many of this disease's symptoms for the past few

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1 years. Specifically, my osteoarthritis is in the
2 facet joints of my lower spine. This condition makes
3 it painful and difficult for me to sit. Even in the
4 brief time I have been here today, I'm already in pain
5 from sitting.
6 In order to cope with the daily pain that my
7 condition causes, I've gone through physical therapy,
8 take NSAIDs and acetaminophen on an almost daily
9 basis, and perform stretches almost every morning and
10 every evening.
11 Today I'm introducing into the record a
12 medical journal article titled "Cannibanoid CB2
13 Receptors Regulate Central Sensitization and Pain
14 Responses Associated with Osteoarthritis of the Knee
15 Joint."
16 This study was conducted in 2013 by the
17 University of Nottingham. The basic premise of the
18 article is that when cannibanoid receptors are
19 activated through the use of cannabis, the CB2
20 receptors in our brain inhibit pain sensitization
21 and chronic osteoarthritis pain.
22 Therefore, I urge the Illinois Department of
23 Public Health to add osteoarthritis as a qualifying
24 condition to the Illinois Medical Cannabis Pilot

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1 Program.
2 For the citizens of Illinois, including
3 myself, who struggle with osteoarthritis on a daily
4 basis, medical cannabis would be another option to
5 relieve the pain caused by our condition.
6 Thank you for your time, and God bless the
7 State of Illinois.
8 CHAIRPERSON MENDOZA-TEMPLE: Those are all
9 of our petitioners.
10 Comments from the Board?
11 MEMBER CHRISTOFF: Again, this is a complex
12 disorder. A range of FDA-approved therapies are
13 always suggested and tried but often have risks to the
14 patients.
15 This is another group that I see a lot of
16 narcotic pain drugs used in eventually. Not all
17 osteoarthritis can be ameliorated by a joint
18 replacement, as the facet joint example well
19 illustrates.
20 So in the realm of chronic pain and being
21 more specific about its cause, this I think is a
22 compelling diagnosis that calls for addition to the
23 list because this could be a safer alternative
24 than FDA-approved therapies, specifically narcotics.

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1 And depending on the patient, the older they
2 are, the more likely because NSAIDs have a lifetime
3 cumulative toxicity in terms of liver and kidney
4 function. So for older patients, that becomes less
5 available as an alternative anyway.
6 MEMBER CHAMPION: Because of the physical
7 demands of the military, this is a common symptom
8 among veterans.
9 I myself have osteoarthritis and know how
10 painful it can be. Cannabis is very helpful to me in
11 relieving my arthritic pain.
12 If our program covers one form of arthritis,
13 I fail to see that it is any less painful than this
14 form of arthritis because it is quite painful. One of
15 our applicants took methadone for quite some years to
16 treat his osteoarthritis. I took methadone for ten
17 years. It caused chronic bowel blockages, more side
18 effects than I even have time for.
19 But this is another one of those symptoms
20 that we already covered regarding arthritis; and I
21 will say firsthand that over the years I've developed
22 several different symptoms, and osteoarthritis is one
23 of them.
24 It helps me. I would tell the Board that it

1 helps me with the pain.
2 MEMBER MILLER: I just have some concerns.
3 A lot of the evidence that was included in
4 the petition are not recognized as valid evidence or
5 scientific evidence. They are .com websites, and
6 those aren't usually recognized as having
7 evidence-based literature research behind it,
8 especially in support of medical treatment. It's not
9 usually what we base medical treatment on is
10 the .coms.
11 With that being said, there is a study that
12 was done -- and I don't have the date in front of me.
13 It was 2011 or 2013 -- regarding end-stage
14 osteoarthritis.
15 I know as a nurse I've not ever seen a
16 diagnosis of end-stage osteoarthritis before, but it
17 was clearly labeled in this article as being helpful
18 for end-stage.
19 I know plenty of patients who have
20 osteoarthritis. Yes, it is painful. I have
21 lupus/rheumatoid arthritis. It's painful. It's
22 painful. I live with it every day. They don't know
23 what it is. It's either lupus or rheumatoid
24 arthritis. Nobody seems able to agree. That's

1 neither here nor there.
2 I think we need to make sure that we're not
3 opening this up. I see this as a generalized
4 diagnosis, a generalized category. I want to express
5 some caution.
6 MEMBER CHRISTOFF: Perhaps this is one where
7 we could clarify the diagnostic situation and say
8 that -- I hadn't heard end-stage as a description.
9 You know, I guess what's the definition of that?
10 To me it's when the patient has toxicity
11 from acetaminophen or NSAIDs and/or once they are
12 taking Tramadol or narcotics to control their pain and
13 they also aren't eligible for a joint replacement or
14 they're too young to have one. So that's what it
15 would mean to me.
16 So here again, the issue about
17 provider-patient relationship and provider discretion,
18 you know, I think we can trust providers --
19 physicians, I should be saying, since we're the only
20 ones who can certify -- to know that their patient
21 doesn't need medical cannabis because they had a
22 little bit of osteoarthritis seen incidentally on
23 their lumbar spine film and they're 25 years old and
24 it is not believed to be a cause of any chronic pain

1 requiring narcotic.
2 I think maybe we don't have to be that
3 specific; but if it is necessary for some members of
4 the Board to feel okay voting as to this that we
5 qualify it, then I think we should do that because I
6 think we know what this means and who this doesn't
7 apply to.
8 MEMBER LESKOVEC: I think it's important
9 that the way they have the system set up today to
10 evaluate these conditions and such is left to the
11 layperson to describe, and then we talk about general
12 terms such as osteoarthritis.
13 We can consider those things that were
14 mentioned, which are that this is end-stage.
15 Has it been ameliorated by other types of
16 treatment previous?
17 So I think that this is, unfortunately, one
18 of the diagnoses that does not really allow us to
19 differentiate.
20 If we are going to be evaluating these
21 petitions based on the petitions, I think this should
22 more be a consideration of patient education that's
23 necessary for the patient coming forth being able to
24 know about the disorder that should be treated.

1 CHAIRPERSON MENDOZA-TEMPLE: So this is
2 another one of those conditions that is to me very
3 broad. I as a clinician would like to see in
4 particular this one defined.
5 I know we've talked about principles of
6 defining severity or not, but this is so wide open
7 that I think, at least from a clinician and patient
8 guidance standpoint, that we need to know how bad it
9 is, how treatment resistant has it been for our
10 petitioner here, just to give a little guidance versus
11 the plain label of osteoarthritis.
12 I would like to see -- because people can
13 petition over and over again, I'd like to see a more
14 sophisticated, somehow qualified description of
15 osteoarthritis.
16 MEMBER WEATHERS: I think we're back to --
17 do we ask, though, does the petition process lend
18 itself to that qualification?
19 If we're asking people to just submit a
20 ICD-9 code, I don't know that we'll ever get that
21 level of specificity.
22 Are we allowed as a Board in our
23 recommendation back the IDPH to add those qualifiers
24 on our vote for today?

1 Do we say that we're approving this petition
2 for -- whether we add trackable or severe, treatment
3 resistant?
4 I just think to extend this out another
5 year, by the time we go back and petition, the
6 petition didn't call for that, let alone specificity.
7 We clarified neuropathy.
8 MS. MOODY: I think that's a good point, but
9 I think on neuropathy there were clearly two separate
10 petitions that were specifically one specific -- out
11 of the four petitions that were submitted for
12 neuropathy, there were three for peripheral and one
13 for diabetic. So that's not necessarily a
14 clarification of the condition for which the petition
15 was submitted.
16 In this case, the petitions were specific to
17 osteoarthritis.
18 VICE CHAIRMAN FINE: While I understand
19 everybody's -- the medical professionals' concerns and
20 I certainly agree that there needs to be some level or
21 element of severity to whatever condition that we're
22 talking about here, I again put my trust in that
23 medical professional to determine that it is at a
24 point where cannabis -- again, keep in mind I feel

1 that cannabis doesn't need to be an alternative when
2 all other medications fail.
3 It could be an alternative that could help,
4 you know, with a regime of other treatments, including
5 narcotics or acupuncture or other holistic means to
6 treat a condition.
7 So I don't think it needs to be the only
8 thing that could help after everything else has
9 failed. It could be something in the arsenal that a
10 patient would be able to use and access, depending on
11 the level and variance of degree of pain.
12 That's why with regard to this condition,
13 I'm going to defer to the medical professional as
14 well as the patient in determining if it could be
15 helpful.
16 MEMBER CHRISTOFF: I agree with your
17 comment.
18 I think we are overthinking this one in
19 particular. So the distinction from the anxiety
20 example this morning, this is more clear because it
21 has objective evidence, for starters, on what the
22 disorder is, whereas anxiety is less clearly defined.
23 It has many different diagnostic descriptions and
24 underpinnings. This is discrete in terms of the

1 objective evidence.
2 So moving from there to your point, just
3 considering conventional therapies is not necessarily
4 how we would want to proceed with this either.
5 My assumption is if patients and doctors are
6 talking about this as an option, it's because other
7 more conventional approaches have been explored and
8 were found not to be ideal. So I don't think we
9 should spend a lot of time worrying about opening the
10 floodgates or something like that.
11 Yes, it's a common disorder; but speaking
12 for myself, the vast majority of patients that I have
13 in my practice with osteoarthritis of some type,
14 probably 80 percent of them don't have it to a degree
15 where they need chronic pain management in any
16 context.
17 So while the numbers of people who have this
18 disorder are high, the ones that need this therapy as
19 part of their care regimen is not large. So I think
20 we as clinicians can define who would need this. It
21 would be part of the discussion, part of the
22 doctor-patient relationship that is built into this
23 law in the first place.
24 To not approve it means that we are removing

1 a significant cause of debilitation and time away from
2 work and time out of life; and then taking this option
3 off the table I think just condemns people to their
4 current state of affairs, which is not suitable for
5 any kind of engagement in life.
6 CHAIRPERSON MENDOZA-TEMPLE: I see some
7 guidance that we could use from IDPH.
8 This forum has been extremely helpful for me
9 to at least have everyone understand what are our
10 thought processes in approving or not approving
11 conditions and also just as an educational tool for
12 all of us.
13 So I wonder if there's a way we can get an
14 emphasis that the statute is for clinicians to decide
15 because that's where all the decision-making goes when
16 it comes to certifying or not certifying.
17 So I'm just glad that we're having this
18 discussion. Now it comes to the second part where I
19 keep being a stickler about I'd like to see a little
20 more description. That's my opinion.
21 There are opportunities to reapply for
22 petitions if for some reason they don't pass, are too
23 controversial. They can always be repackaged into
24 something. So you're getting that feedback here. The

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1 public is getting that feedback.
2 Thank you.
3 MEMBER LESKOVEC: I'd like to say that I
4 think we sometimes lose sight of the fact that the
5 physician-patient relationship is one that is
6 actually going to determine what the treatment
7 modality is.
8 I think if this were made available to
9 clinicians and patients who decide this is really
10 useful in the treatment of chronic pain and some level
11 of debilitation that's caused by osteoarthritis, that
12 it would be best if we could allow that decision to be
13 made.
14 CHAIRPERSON MENDOZA-TEMPLE: We are
15 running out of time, so Jim is going to be the last
16 one.
17 MEMBER MCCURDY: Really, this is not a
18 new point but to say I am persuaded by Dr. Christoff's
19 last set of comments, I think, about the reality
20 that you have a spectrum of possibilities, and in most
21 cases the physician and the patient would agree you
22 don't want to do something complicated if you don't
23 have to.
24 That really does narrow the field to

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1 decision-making when the symptoms are more difficult.
2 I think that makes sense.
3 MEMBER PARIKH: I think when we are relating
4 this patient-doctor relationship, specifically I think
5 it boils down to communication.
6 Everything is related to the doctor-patient
7 relationship, and the Board has no authority to decide
8 which conditions are there. If it's going to be like
9 that, then we might as well approve one condition for
10 severe pain.
11 Osteoarthritis is a very vast condition.
12 (Inaudible) If we approve it, the patient can deceive
13 the doctor and say, "This isn't helping" without even
14 trying.
15 MEMBER CHRISTOFF: I must make one more
16 comment because I'm an HIV treater, as I mentioned at
17 the beginning.
18 Probably 80 to 85 percent of my HIV patients
19 don't need medical cannabis. It won't get certified
20 by me even if they ask for it, but somehow that was
21 included on the list.
22 In the original legislation, if we look for
23 corollary examples of a disease state where you can
24 have well-managed all the way to in decline, not doing

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1 well, not able to leave the house, you know, and also
2 not knowing how long someone has suffered that way,
3 back to the certifying physician's discretion along
4 with shared decisions with the patient, this is the
5 critical element.
6 I don't see that as a problem for us to add
7 disorders to this list, like this one, osteoarthritis,
8 that are of a chronic nature and for which
9 conventional treatments do not necessarily afford
10 relief enough so that people can get on with their
11 lives.
12 But I can give the opposite example, too, of
13 things that were included in the legislation that are
14 equally broad.
15 Again, it's not the role of this Board, I
16 think, to be so specific. These petitions were
17 submitted for this diagnosis in the general sense, but
18 it is up to the certifying physician and the patient
19 to make the decision that this makes sense to the
20 patient to use cannabis.
21 MEMBER MILLER: I don't mean -- I agree that
22 physicians do have that authority, and it is very
23 important, that physician-patient relationship, but
24 I've got to go back to the evidence because that was

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1 what we were also charged with, making sure that these
2 are supportive by medical evidence.
3 There is no medical evidence to support
4 this, osteoarthritis. The only thing I found, current
5 evidence, is end-stage osteoarthritis. The evidence
6 support that was attached to the petition is not
7 scientific evidence.
8 MEMBER CHRISTOFF: There were two packets of
9 info. I'm not sure you saw both. Some were from
10 peer-reviewed journals.
11 MEMBER MILLER: I didn't see that.
12 MEMBER CHRISTOFF: The one had a media
13 account, and the other one had a couple of
14 peer-reviewed articles.
15 MEMBER MILLER: The ones I saw that I read
16 were not peer reviewed.
17 MEMBER WEATHERS: I know what you're talking
18 about. There were scientific articles attached.
19 CHAIRPERSON MENDOZA-TEMPLE: Unless we have
20 burning comments that must be made, I think we should
21 call the vote.
22 VICE CHAIRMAN FINE: Call for the vote.
23 MEMBER MILLER: Second.
24 VICE CHAIRMAN FINE: Second.

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1 CHAIRPERSON MENDOZA-TEMPLE: While they're
2 tallying this, I think just this whole discussion is
3 helping us understand further as clinicians, also, to
4 spread the word about the benefits of medical cannabis
5 but also for our physician colleagues who are
6 reluctant to even go there.
7 I hope that this activity and the news and
8 the spin-off that comes from that will help increase
9 the comfort level of those physician groups who have
10 these patients but yet won't write the letter,
11 regardless. I think that is a waste of an opportunity
12 to help patients do better, to feel better, have a
13 quality of life.
14 So I think it needs to be said that we do
15 have what we would call a bottleneck. Physicians are
16 the ones who certify, and, hopefully, through
17 education and advocacy we'll at least show physicians
18 what is useful, what is not, what are the benefits,
19 what are the risks, truly, rather than relying on
20 preconceived notions or lack of comfort level.
21 So the motion for osteoarthritis has passed
22 with a vote of seven yeah and nay three.
23 (Applause.)
24 MR. SCHWARTZ: Doctor, before we continue

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1 on, the next one is polycystic kidney disease. We
2 received a late request for this to be called into
3 closed session for a presentation of technical
4 evidence.
5 CHAIRPERSON MENDOZA-TEMPLE: Okay. So I
6 need to close the session for our petitioner to
7 present their technical evidence.
8 MR. SCHWARTZ: Hold on. Before everyone
9 starts closing stuff, can you just wait one second so
10 we can read something? Then you can all start closing
11 stuff. It gets very loud.
12 CHAIRPERSON MENDOZA-TEMPLE: Because Allison
13 tried to read it.
14 So we really need to put this on the record
15 that Subsection 2(a) of the Open -- do I read that?
16 Oh, here.
17 5 ILCS 120/2(c)(4) allows for, "Evidence or
18 testimony presented in open hearing, or in closed
19 hearing where specifically authorized by law, to a
20 quasi-adjudicated body, as defined in this Act,
21 provided that the body prepares and makes available
22 for public inspection a written decision setting forth
23 its determinative reasoning."
24 Then "77 Ill. Admin. Code 946.30(j)(4)

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1 provides, "A petitioner may request to close a portion
2 of the hearing to protect the disclosure of
3 confidential information."
4 MR. SCHWARTZ: Now you can all close your
5 stuff.
6 (Whereupon at 12:40 p.m., the Board
7 adjourned into executive session, after which the
8 following proceedings were had in public session
9 commencing at 12:49 p.m.)
10 CHAIRPERSON MENDOZA-TEMPLE: Please take
11 your seats. We have finished our closed session, and
12 we are looking for comments to the Board for the
13 condition of polycystic disease.
14 MEMBER WEATHERS: I have more of a question.
15 I don't know if any of us here are going to be able to
16 answer it.
17 I guess if it was -- does the national
18 listing -- even though it's State approved, does being
19 on medical cannabis in any way affect your ability to
20 be listed on the transplant list?
21 Because of that whole State versus Federal
22 thing and the way the transplant list works, I wanted
23 to know if any of us know about whether being on
24 medical cannabis affects your ability to be listed on

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1 the transplant list. I don't think so but I just
2 wanted to --
3 MEMBER CHRISTOFF: I've often wondered how
4 the legislators came up with the list that we got.
5 However that process occurred, this would be, I think,
6 a compelling diagnosis that should have been
7 considered, but I just think it's not a common
8 diagnosis.
9 I'm thinking about my entire practice. I've
10 been in practice for 18 years; and I've seen one or
11 two people with this disorder, and neither of them had
12 it to the degree that they were making cysts and
13 thinking about transplants or things like that in the
14 short time I knew them.
15 Beyond the concerns you are expressing
16 about the substances and ability to be transplantable,
17 again, this is a provider-physician relationship sort
18 of thing.
19 There was a letter of support for this
20 petitioner from her nephrologist suggesting that it
21 was either not considered or it's not an issue, but I
22 endorse that we should put this on the list of
23 disorders that qualify.
24 MEMBER WEATHERS: So that's interesting.

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1 I give full credit to Theresa, who just
2 found this. There's an act that's been introduced in
3 California where medical cannabis has been legal for
4 quite some time that's out there to protect medical
5 cannabis patients from discrimination in the organ
6 transplant process.
7 The bill will prohibit a hospital,
8 physician, or any participant in the organ transplant
9 process from using the patient's use of medical
10 cannabis as the sole reason in denying his or her
11 eligibility as an organ recipient, except when the
12 cannabis use is clinically significant as to that
13 decision.
14 This is a proposed act in California.
15 CHAIRPERSON MENDOZA-TEMPLE: I think that
16 with poorly functioning kidneys, you have even less
17 choices in terms of your pain management medication.
18 That pool shrinks dramatically because we're worried
19 about hurting the kidneys even more.
20 So I think given the relatively good safety
21 on cannabis, I would support this petition, even
22 though it's rare and I have not had any patients in my
23 practice.
24 Any more comments from the Board?

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1 VICE CHAIRMAN FINE: Motion to vote.
2 MEMBER MILLER: Second.
3 CHAIRPERSON MENDOZA-TEMPLE: The next
4 condition on the list is posttraumatic stress
5 disorder. We have six petitioners.
6 Our first petitioner will be Liana Bran. If
7 you could get ready to present while we make this
8 announcement on the vote.
9 The motion for polycystic kidney disease has
10 passed ten to zero.
11 (Applause)
12 CHAIRPERSON MENDOZA-TEMPLE: Liana, please.
13 MS. BRAN: My name, again, is Liana Bran,
14 L-i-a-n-a B-r-a-n. Good afternoon. Thank you again
15 for allowing me to share my comments.
16 With regard to the addition of posttraumatic
17 stress disorder, no scientific evidence currently
18 exists to support the efficacy for long-term
19 consequences of using marijuana to treat the disorder.
20 For this reason, the American Psychiatric
21 Association officially does not endorse marijuana use
22 for PTSD.
23 A recent review led by the Vermont
24 Department of Health further confirms that marijuana

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1 use among PTSD patients in fact results in poor
2 treatment outcomes with the worst outcomes produced at
3 higher doses of marijuana.
4 Evidence-based therapy zens that are proven
5 effective in the treatment of PTSD patients are
6 compromised by the introduction of medical marijuana.
7 According to the US Department of Veteran
8 Affairs, individuals diagnosed with PTSD also
9 demonstrated greater risk of abusing marijuana and,
10 additionally, have more difficulty in recovering from
11 marijuana addiction.
12 Development of a substance abuse disorder
13 only complicates the recovery process, adding a new
14 mental health issue that requires attention.
15 Higher marijuana potency and its ability to
16 produce episodes of paranoia and psychosis is a
17 significant risk for individuals diagnosed with PTSD
18 as well, given that patients already suffer from
19 unrealistic perceptions as a consequence of their
20 trauma.
21 The possibility of marijuana to encourage
22 these perceptions presents a real risk of harm to PTSD
23 patients and those with whom they come in contact.
24 Though medical marijuana may provide

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1 short-term relief of symptoms associated with PTSD,
2 the long-term effects are unclear; and based on the
3 available scientific evidence, it is likely to
4 worsen rather than better the outcomes for these
5 individuals.
6 I believe the citizens of Illinois and
7 certainly the veterans who served our country deserve
8 better. They need improved access to tried and tested
9 treatments that currently exist as well as a
10 commitment from our legislative leaders to invest in
11 newer therapies, which may include something
12 eventually derived from marijuana, that are subjected
13 to a level of medical standard that can demonstrate
14 that they are safe and effective.
15 Thank you.
16 CHAIRPERSON MENDOZA-TEMPLE: Thank you for
17 your testimony.
18 If you could kindly refrain in the audience,
19 please, and give the petitioners and the Board members
20 the respect they deserve when they have the floor.
21 Our next speaker and petitioner is Dr. Bruce
22 Doblin. He's not here still.
23 We do have a petitioner. The next one is
24 Joel Erickson.

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1 MR. ERICKSON: Hi, my name is Joel Erickson,
2 J-o-e-l E-r-i-c-k-s-o-n.
3 Good afternoon. I'm an 80-percent disabled
4 Air Force veteran with service-connected PTSD due to a
5 TBI with a postconcussive syndrome, and I am
6 testifying in favor of adding PTSD as a qualifying
7 condition.
8 I have tried prescription treatments for my
9 symptoms. I spent a week in the hospital dealing
10 with suicidal ideations I did not have prior to taking
11 Zoloft and that I have not had since I stopped taking
12 it. I continue to refuse to take it each time it is
13 offered, but other SSRIs I have had significant
14 adverse side effects to.
15 Let me be clear. PTSD affects civilians as
16 well as members of the military, but for veterans who
17 can benefit from cannabis and who rely on the VA for
18 their health care, the Federal interference that keeps
19 doctors from having open and honest conversations with
20 their patients continues.
21 This past Thursday, the U.S. House of
22 Representatives came within three votes of
23 acknowledging that the doctor-patient relationship is
24 sacred, and I'm thankful that the MCPP delivers on

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1 Illinois' promise of state sovereignty and national
2 union when it comes to taking care of its veterans
3 when Federal policies fail, especially when
4 conservative estimates are that 22 veterans take their
5 lives each day.
6 Giving vets the ability to legally choose
7 cannabis instead of pills for relief is commendable.
8 I hope other states take Illinois' example into
9 consideration when crafting their medical cannabis
10 programs.
11 If I could ask you for a moment to imagine a
12 Venn diagram. Over this circle is this TBI with
13 postconcussive syndrome; over this circle is PTSD.
14 There is a frequent but not yet understood connection
15 between the two. It's not uncommon for some overlap
16 in terms of symptoms.
17 In my case, as far as the VA is concerned,
18 there's almost complete overlap between the two,
19 meaning it's difficult to tell the difference between
20 the two based on symptoms. So it's possible to have
21 PTSD without a TBI.
22 This is important because PTSD is not a
23 condition that only afflicts military members. It
24 also affects civilians who have never stepped foot

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1 into combat, but their struggles are a result of the
2 most personal kind of terrorism, like rape, domestic
3 violence, and other forms of abuse, and the outcomes
4 in terms of symptoms are the same.
5 Please consider the study in the packet I've
6 given you entitled "PTSD Symptom Reports of Patients
7 Evaluated for the New Mexico Cannabis Program," which
8 states that patients reported over a 75 percent
9 reduction in 3 areas of PTSD symptoms, which were
10 reexperiencing avoidance and arousal while using
11 cannabis.
12 The symptoms covered by these three
13 categories include anxiety, difficulty obtaining
14 restorative sleep due to nightmares, persistent
15 avoidance of reminders of trauma, and an exaggerated
16 startle response.
17 A 75 percent reduction in all these areas
18 isn't a 75 percent increase in quality of life, but it
19 would go a long way in helping treat the invisible
20 wounds of PTSD and reducing the number of Illinois
21 veterans who take their own lives.
22 Thank you.
23 CHAIRPERSON MENDOZA-TEMPLE: Thank you for
24 your testimony.

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1 MEMBER CHRISTOFF: And thank you for
2 providing the articles, Joel. We appreciate that.
3 CHAIRPERSON MENDOZA-TEMPLE: We have another
4 petitioner, Daniel Jabs.
5 MR. JABS: My name is Dan Jabs. The last
6 name is J-a-b-s, Jabs. I'd like to thank you all for
7 giving me the opportunity to speak here on behalf of
8 myself, on behalf of the rest of the veterans that I'm
9 trying to represent here.
10 I'm currently a veteran peer support
11 specialist, and what that is is basically a connection
12 between a veteran and their service provider, whether
13 it be their primary care provider or mental health.
14 The information that our doctors receive is
15 not the same information that I receive from our
16 patients. The reason is because everything that
17 happens in the VA is written down. Our patients are
18 not able to discuss with their provider what they're
19 going through or what they're using as a substance in
20 order to treat their symptoms.
21 Real quick, my military experience, I joined
22 the Service back in '99 as a military police officer.
23 I was a reservist. In 2001 I helped my unit in Egypt.
24 In 2005 I was a patrol leader in Iraq. I spent about

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1 a year on the ground there. My unit went through a
2 difficult time, very unique experiences, ambush, being
3 attacked by small-arms fire, IEDs.
4 Multiple team members of mine have traumatic
5 brain injuries from those results. Of course, they
6 are not at this point able to access cannabis.
7 Some of the symptoms that we deal with when
8 we come back are depression, anxiety, nightmares,
9 restlessness, hypervigilance. All of these
10 conditions, every single one of them, can be managed
11 with cannabis. Okay?
12 The VA's current position is generally once
13 you go in and actually get some help, they spend the
14 first year utilizing you as Guinea pig testing you on
15 five, ten different medications to find out what
16 works.
17 So basically they're using a sledgehammer to
18 get to one little problem; right?
19 The negative side effects of these
20 medications can be deadly. I think we're all familiar
21 with some of the side effects that are possible; but
22 the fact that you can die from this, that's not
23 something that happens with cannabis. There have been
24 no known related deaths with cannabis.

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1 So I think it's about time that we start
2 treating our veterans, rather than as criminals, as
3 the heroes that they are coming back. We all have
4 certain scars that we have to deal with. I find
5 cannabis to be the most effective.
6 I also think that using five or ten
7 different medications to try and get a person right is
8 not the best way to do it because all the side effects
9 that -- some of the side effects that I've mentioned
10 are tough, but also start to look at the veterans
11 themselves.
12 We come home. We're not the same person
13 that we were before. Physiologically our bodies have
14 changed, and we're going through things that nobody
15 else can really deal with.
16 I was telling some folks earlier before,
17 Thanksgiving, you know, the day that I got -- or not
18 the day that I got back but the --
19 MS. SINNER: Thank you. That's your three
20 minutes.
21 MR. JAB: Thank you.
22 CHAIRPERSON MENDOZA-TEMPLE: Thank you for
23 your testimony.
24 Next we have Ms. Kathryn Ross. Please spell

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1 your name for the reporter.
2 MS. ROSS: Hello, Ladies and Gentlemen. My
3 name is Kathryn Ross, K-a-t-h-r-y-n R-o-s-s.
4 Ladies and Gentlemen, I'm here today to
5 voice my support for adding posttraumatic stress
6 disorder to the Illinois Medical Cannabis Pilot
7 Program.
8 I was into abusive -- mentally, physically,
9 and sexually -- relationships when I was in my late
10 teens. Because of these relationships, I was unable
11 to engage in any normal intimate relationships with
12 any partners for many years.
13 In 2011 I was diagnosed with PTSD
14 officially. Prior to and since that time, I have
15 personally been placed on numerous medications to
16 attempt to treat some of these symptoms of PTSD with
17 little to no success.
18 I will not elaborate on the benefits of
19 medical cannabis for IBS or vascular conditions that I
20 also suffer from other than to say that the effects of
21 those conditions on my life combined with the PTSD
22 have not enabled me to be able to enjoy a normal
23 adolescence or college experience.
24 However, when I was in college is when I

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1 tried medical cannabis. Because of medical cannabis
2 is why I was able to finish college and engage in the
3 postgraduate studies that I eventually graduated from
4 and pursue the career that I have today.
5 I feel that without medical cannabis, I
6 would have been unable to achieve these things.
7 However, as of today, opiate medications are the best
8 prescription legal alternative that most of my
9 physicians have been able to find to treat these
10 symptoms.
11 Specifically, there have been no medications
12 other than forms of medical cannabis which have been
13 consistently and reliably found to work to enable me
14 to have normal intimate relations with my partners,
15 specifically due to the PTSD.
16 As someone who has been prescribed opiates
17 for multiple years to try and treat some of these same
18 symptoms that cannabis has been able to assist me
19 with, I urge you to please add posttraumatic stress
20 disorder to the list of qualifying conditions.
21 Thank you.
22 CHAIRPERSON MENDOZA-TEMPLE: Thank you.
23 Stephen Trapp. Is Stephen Trapp present?
24 Is he on the list? I think that's everyone;

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1 right?
2 Thank you, all of the petitioners who came
3 up and had the bravery to share your story. I know
4 that was not easy.
5 We will open up the comments session for
6 PTSD.
7 MEMBER CHAMPION: While PTSD is something
8 that I worry can be mimicked, I think that if the
9 Federal Government can give a person a medical
10 discharge for PTSD, I definitely feel that they should
11 be showing compassion for our programming, especially
12 given all of the evidence in support of cannabis as
13 a treatment for PTSD, which has a success rate of
14 75 percent.
15 Veterans' suicide rate due to PTSD is as
16 high as 8,000 per year. PTSD affects over 30 percent
17 of all Vietnam, Iraq, and Afghanistan veterans.
18 Cannabis can help clear the mind, even if it is only
19 temporary, which is a great relief to many. PTSD in
20 all forms should be approved, but we especially owe it
21 to our veterans who gave their all for us.
22 I highly urge a yes vote. I spent a lot of
23 time at Hines VA Hospital. I talk to PTSD vets all
24 the time, some of the greatest people in the world.

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1 They're just looking for a little bit of relief. They
2 can't find it. So please consider your vote.
3 CHAIRPERSON MENDOZA-TEMPLE: Thank you, Jim.
4 Comments? Dr. Christoff?
5 MEMBER CHRISTOFF: This one is very
6 straightforward in my mind. It's a little different
7 than the chronic conditions that are already on the
8 list and that we've considered today.
9 The risk of not correctly and appropriately
10 in a patient-centered way arresting PTSD, which is the
11 same thing as saying we should take an option off the
12 list, is death from suicide.
13 So the stakes are high. In fact, in that
14 sense this could be lifesaving medication for people
15 if it allowed them to reacclimate to some semblance of
16 normal living.
17 So I would strongly endorse this proposal.
18 VICE CHAIRMAN FINE: Jim's discussion in and
19 of itself warrants passage or acceptance of this as a
20 condition.
21 On a personal level, it's not just veterans
22 who definitely deserve the utmost respect and this
23 medication. For three months after my accident -- I
24 was hit head-on by a truck while driving a convertible

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1 at work. It took my arm off in the accident.
2 For three months I woke up every night with
3 nightmares and sought treatment through a pain and
4 drama therapist, who helped me tremendously.
5 Fortunately, I'm no longer having those nightmares,
6 but those three months were just as difficult as the
7 physical pain that I feel now from the pain syndrome.
8 It's absolutely a real-deal thing. The
9 stakes are way too high not to pass this.
10 CHAIRPERSON MENDOZA-TEMPLE: Any other
11 comments? Reverend?
12 MEMBER MCCURDY: I took seriously -- I do
13 take seriously the comments -- the first set of
14 comments from Ms. Bran that we heard earlier, in
15 addition to the other ones, in terms of what is the
16 medical evidence that we have and is there a downside
17 that we need to pay attention to, particularly for
18 some populations.
19 At the same time, it did seem to me in the
20 literature that we received that at least one of
21 the Israeli studies and the study of veterans in
22 New Mexico seemed to show that there's something to be
23 said in terms of an evidence base on the side of
24 supporting this.

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1 So I think I'm inclined to go in that
2 direction myself.
3 MEMBER WEATHERS: I'm just adding on.
4 Overall, I think we all certainly recognize
5 the risk in adolescence for long-term neurocognitive
6 impact. I think it began as (Inaudible) especially
7 those who suffered severe traumatic events, who suffer
8 from PTSD (Inaudible) but that each situation would
9 need to be carefully considered.
10 CHAIRPERSON MENDOZA-TEMPLE: Just a point of
11 clarification, when a condition is recommended by the
12 Board and sent to the IDPH, who makes the ultimate
13 decision, these conditions are also being approved for
14 pediatrics if the caregiver, the parent -- you know,
15 we follow all the rules, you have two physicians who
16 sign a certification letter.
17 So everything that we're talking about also
18 applies to children, just as a point of clarification.
19 It's important.
20 Any other comments?
21 MEMBER MILLER: I move to vote.
22 VICE CHAIRMAN FINE: Second.
23 CHAIRPERSON MENDOZA-TEMPLE: While that
24 is being tallied, our next condition is

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1 superior canal dehiscence syndrome. We have a
2 petitioner.
3 Glen Hoffman, if you want to start making
4 your way down to the front.
5 CHAIRPERSON MENDOZA-TEMPLE: Jim Champion
6 will make the announcement.
7 MEMBER CHAMPION: I'm very, very proud to
8 say that PTSD passed by a vote of ten to zero.
9 (Applause)
10 CHAIRPERSON MENDOZA-TEMPLE: So we have our
11 next condition on the list, which is superior canal
12 dehiscence syndrome. We have our petitioner.
13 If you'd state your name and spell it.
14 MR. HOFFMAN: Hi. My name is Glen Hoffman,
15 G-l-e-n H-o-f-f-m-a-n.
16 One of the problems with my condition is my
17 own voice creates nausea. So it's very hard for me to
18 speak loudly.
19 This is a condition that I'm not sure that
20 many of you have ever heard of before you saw this
21 petition, but it is very rare. I had a craniotomy in
22 2011. At that time there were approximately 300
23 confirmed cases in the world.
24 The surgeon that did mine had only performed

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1 one other in the state of Illinois. So this petition
2 would basically benefit myself and one other person in
3 the State. It's that rare.
4 I would ask the Board to please not hold the
5 rarity against the lack of direct evidence or studies.
6 You will never find a study of marijuana on superior
7 canal dehiscence syndrome because there just aren't
8 enough of us in the world to perform an accurate
9 study.
10 For those of you who aren't familiar with
11 what this is, in laymen's terms it's a condition where
12 a hole forms in your temporal bone, which is supposed
13 to be one of the most dense bones in the body to
14 protect the brain from sounds.
15 The hole forms, whereas then the sound of my
16 voice, the sounds around me enter right here, go
17 directly into my brain and are picked up by my optic
18 nerve. As I'm talking to you, you're all jumping
19 around. It's basically like being in a state of
20 constant seasickness.
21 Traditional anti-nausea medications just
22 don't seem to work. What happens is that my optic
23 nerve and my vestibular system are giving me
24 conflicting information as to my balance and basic

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1 positioning.
2 MEMBER WEATHERS: I'm sorry. Can we pause
3 here for one second?
4 I'm sorry. Because it's hard for him to
5 speak loudly, we'd really appreciate it if the rest of
6 the room would try to be as quiet as possible right
7 now so we can do our best to hear him. Thank you all
8 very much.
9 MR. HOFFMAN: This is one situation in my
10 life that is very hard for me to take with all the
11 noise, people talking. The noise makes me dizzy.
12 Honestly, there's no escape from it.
13 One of the strange things of this condition
14 is being able to hear your own eyeballs move in your
15 head. As I'm moving, I hear a "swish, swish, swish."
16 I hear my own heartbeat going through.
17 I always thought it was odd that people
18 would be jogging and trying to check their pulse when
19 you could just hear it for me.
20 I also have trouble eating due to the
21 nausea, so marijuana does help me. I'm embarrassed to
22 say that the only thing that helps me makes me a
23 criminal basically, for somebody who has never had a
24 traffic ticket or been arrested.

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1 The other thing is the nausea, to help with
2 the food. I've basically treated it as a
3 prescription. I smoke one bowl before each meal, one
4 before bed.
5 I also use it as a sleep aid where when I go
6 into an REM state, when I'm in my sleep, the sound of
7 my eyeballs wakes me up at night. I don't sleep very
8 well without marijuana.
9 I'm not really a pill person. I've tried
10 the anti-nausea things. I've had a craniotomy
11 performed. What they do with that is they attempt to
12 fill that whole, and --
13 MS. SINNER: Thank you. That's three
14 minutes.
15 MR. HOFFMAN: -- there's varying successes
16 and a very high failure rate.
17 MR. SCHWARTZ: Excuse me, Mr. Hoffman.
18 MR. HOFFMAN: Yes.
19 MR. SCHWARTZ: If I could interrupt you for
20 one moment.
21 Allison, I know you had some issues here. I
22 don't know about the rest of the Board. If you all
23 want to take a motion to extend his time slightly so
24 he can reiterate some points that may not have been

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1 heard.
2 VICE CHAIRMAN FINE: Motion to extend the
3 time.
4 MEMBER CHRISTOFF: Second.
5 MEMBER MILLER: Second.
6 MR. HOFFMAN: Thank you. I appreciate that.
7 Again, this is very hard to convey. It took
8 me about 20 years to get a proper diagnosis for this.
9 When I first started having problems, I went to a
10 doctor. At the time she had told me, "Well, you seem
11 depressed." I said, "Well, I don't feel very happy
12 about this." She put me on antidepressants for about
13 five years, and that wasn't helping any.
14 So later I went back to her; and as the
15 symptoms progressed, I told her that the sound of my
16 own voice in my head was just booming. Her question
17 to me was, "What is the voice telling you?" At that
18 time I knew, okay, we're not on the same page. This
19 is not a psychiatric problem. So I left that.
20 I ended up having to do all the research on
21 my own, and I did actually find via Wikipedia that if
22 you can hear your own eyeballs in your head, there's
23 only one thing it can be, which is superior canal
24 dehiscence syndrome.

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1 At that time I went to my new doctor. He
2 seemed interested, sent me on to a specialist. As I
3 was talking to her, she sat on the other side of the
4 desk. I told her my symptoms. I told her, "This is
5 exactly what I have."
6 She sat and looked at me and said, "You
7 don't have that. It's too rare. Wait another few
8 years." So I waited another few years.
9 I finally found online a paper written by a
10 doctor who really seemed to know something about this,
11 who happened to be in Chicago, and I made an
12 appointment. I underwent a battery of tests, and
13 sure enough, it was superior canal dehiscence
14 syndrome.
15 This is nothing that's objective. It's
16 very -- the testing is very -- what's the word I'm
17 looking for? -- very thorough. You go through hearing
18 tests, vestibular tests, tests for nystagmus, which is
19 the movement of the eye. If everything indicates,
20 then a high-resolution CT scan does confirm the hole
21 in the temporal bone.
22 When I finally found a surgeon who was
23 willing to do the surgery, he had warned me of the
24 side effects, which include facial palsy, loss of

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1 hearing, possible stroke. At that time I got
2 frustrated. I asked him, "How soon can you do it?"
3 After the recovery, there's no way I would
4 ever do that again. I literally had to relearn up,
5 down. During my recovery I was tumbling, tumbling. I
6 would really just hold on to the side of my bed, and I
7 was not able to verbalize what was wrong.
8 They ended up sedating me and sending me
9 back for an emergency CT scan.
10 CHAIRPERSON MENDOZA-TEMPLE: Mr. Hoffman, at
11 this time we probably will need to go to our
12 discussion.
13 MR. HOFFMAN: That's fine.
14 CHAIRPERSON MENDOZA-TEMPLE: The time
15 extension was helpful?
16 MR. HOFFMAN: Yes.
17 Due to the rarity, if anyone has any
18 questions, by all means, I'll be happy to answer
19 them.
20 CHAIRPERSON MENDOZA-TEMPLE: Thank you for
21 your testimony.
22 We will open it up to discussion from the
23 Board.
24 MEMBER WEATHERS: So I'll start by saying I

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1 think a lot of what we struggle with today is this
2 incredibly specific -- it's a very specific diagnosis.
3 It's rare, but essentially in my practice we suspect
4 it a lot, we report it a lot because it is something
5 that we would be treat. A high-resolution CT shows it
6 or doesn't.
7 This isn't open for interpretation. It's
8 not like somebody can come in and say they're dizzy.
9 We do have a specific diagnosis.
10 VICE CHAIRMAN FINE: To all of you medical
11 professionals on the Board, is there something
12 associated with this condition, because it's so rare,
13 that it would be basically forwarded to a different
14 condition?
15 And are migraines something frequently
16 associated with this condition or no?
17 Again, I have no doubts of the veracity of
18 this. I can't imagine what it's like to go through
19 life like this. I thank you so much for having the
20 courage to come up and discuss it with us.
21 But is it more effective from a standpoint
22 of just, you know, applying it under migraines or
23 applying it under something else is my question for
24 all of you.

1 MEMBER WEATHERS: I think we need to take
2 this specific one as the petition before us.
3 I think certainly by approving this, we're
4 helping a limited number of people; but I don't think
5 it's within our realm -- it would be under generalized
6 vertigo. So we would have to expand it out to
7 vestibular neuritis, Raniers, BPPV, which has physical
8 therapy treatments.
9 So again, I almost like this one because of
10 the specificity of it. I think you're right. As you
11 said, it's a very limited number of people, but people
12 can certainly put it out there that we would entertain
13 petitions for some of the more -- some of the other
14 vertiginous conditions that impact a wide number of
15 people.
16 MEMBER LESKOVEC: Thank you.
17 I think what we're seeing here is a
18 challenge that we have between identifying the
19 symptoms and diseases or disorders.
20 If we limit this to migraine, I think
21 we're losing out on the larger aspects of this
22 particular syndrome, and it's not only -- as we've
23 seen from the testimony, it's not only migraine
24 symptoms but also others that would be very limited if

1 we were not to acknowledge this as one of the
2 diagnoses.
3 MEMBER CHAMPION: I just want to ask one
4 question: Are migraines and vertigo -- do all people
5 with SCDS suffer from migraines and vertigo?
6 MEMBER WEATHERS: No, they don't all suffer
7 from migraines. Vertigo, though, is one of the
8 classic symptoms of it.
9 I'm more used to it being vertiginous.
10 Being vertiginous all the time can make people feel
11 head strain and eye strain. It's not a true
12 diagnosis.
13 VICE CHAIRMAN FINE: Vertigo is not a
14 condition?
15 MEMBER WEATHERS: Vertigo is a symptom.
16 MEMBER MCCURDY: It would seem to me that in
17 terms of whether or not the cannabis is effective, the
18 comments about nausea alone would be enough to
19 convince me on that point, let alone the other
20 things.
21 CHAIRPERSON MENDOZA-TEMPLE: I think as a
22 condition, I also did an independent search for SCDS,
23 cannabis, found nothing.
24 So we also have to keep in mind that from an

1 evidence-based perspective, we don't have anything,
2 but the corollary symptoms are the key here and the
3 fact that the treatment options are really pretty
4 dismal.
5 So while I was on the fence about this
6 particular condition because it's so -- to me, I've
7 never seen anyone with it. It's so rare. But that
8 all aside, I think that I'm on the same page with
9 David.
10 VICE CHAIRMAN FINE: Again, the value of
11 your personal testimony swayed me. If you go through
12 the troubling of filing a petition, specifically come
13 and talk to us, please, because it helps tremendously
14 getting really firsthand experience from anyone that's
15 going through this.
16 Thank you very much, again, for your
17 courage.
18 CHAIRPERSON MENDOZA-TEMPLE: Any other
19 comments?
20 MEMBER WEATHERS: Motion to vote.
21 VICE CHAIRMAN FINE: Second.
22 MEMBER MILLER: Second.
23 CHAIRPERSON MENDOZA-TEMPLE: While the votes
24 are being tallied, our next condition, since we moved

1 some of these to the end, will be anorexia nervosa.
2 We have no petitioners.
3 MR. SCHWARTZ: Madam Chair, I was actually
4 going to recommend -- it appears that there are no
5 more presenters for any of the remaining petitions.
6 So if you wanted to take a ten-minute
7 recess, let people stretch their legs, and then try to
8 power through, I believe, the remaining four in one
9 block.
10 CHAIRPERSON MENDOZA-TEMPLE: We can do that.
11 It's 1:30. So we'll wait for the vote.
12 So the motion for superior canal dehiscence
13 syndrome has passed ten to zero.
14 (Applause)
15 MEMBER WEATHERS: I make a motion that we
16 break for ten minutes.
17 MEMBER MILLER: Second.
18 CHAIRPERSON MENDOZA-TEMPLE: Please be back
19 here by 1:40.
20 (A recess was taken from 1:29 p.m. to
21 1:47 p.m.)
22 CHAIRPERSON MENDOZA-TEMPLE: If everyone
23 will commence their seats, we'll do the last four
24 petitions.

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1 What we have left is anorexia nervosa,
2 chronic postoperative pain, Ehlers-Danlos syndrome,
3 and neuro-Behcet's autoimmune disease. Then we,
4 fortunately, should have time for public comment.
5 So I move we open reopen the proceedings
6 again. We will start with anorexia nervosa, for which
7 we have no petitioners or presenters. So let's take
8 comments from the Board.
9 VICE CHAIRMAN FINE: Second.
10 MEMBER WEATHERS: This one kind of makes
11 sense to me.
12 VICE CHAIRMAN FINE: So after reviewing
13 the data and just to share the appetite stimulant
14 aspect of the potential, you know, side effects to
15 cannabis, I'm all for this one. It makes perfect
16 sense to me.
17 MEMBER MCCURDY: Perhaps not having seen all
18 the studies, I guess what was here, though, I didn't
19 see much in the research side of evidence for medical
20 benefit for this condition. So I'd like to be
21 persuaded about that.
22 MEMBER CHAMPION: I just wanted to say that
23 under anorexia, I know firsthand how it helps with
24 the --

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1 THE REPORTER: I'm sorry. I can't hear
2 this. Please go a little slower, and speak into the
3 microphone.
4 MEMBER CHAMPION: (Inaudible) Cannabis is a
5 highly effective appetite stimulant. Anorexia affects
6 both men and women. Only 40 percent ever fully
7 recover from anorexia. It has a high mortality rate.
8 10 percent die within the first ten years of being
9 diagnosed, but we can't help these people in
10 stimulating their appetite. I don't know if we can
11 help.
12 CHAIRPERSON MENDOZA-TEMPLE: I think we
13 have to differentiate between anorexia and nervosa,
14 which is the condition before us, which is --
15 I'll read the definition to you officially from
16 here.
17 This is anorexia nervosa, which is
18 characterized by anhedonia, which means lack of
19 interest in anything, whereby patients experience
20 little pleasure or reward in many aspects of their
21 lives regarding -- let me start over from that.
22 Okay. Anorexia nervosa is a psychiatric
23 disorder with a complex etiology resulting in
24 extraordinarily high rates of mortality, 12.8 percent

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1 and suicide 6 percent.
2 It is characterized by an onset during
3 adolescence, predominantly in females, with food
4 restriction, food-related anxiety, dramatic weight
5 loss, increased physical activity, hypothermia, which
6 is feeling cold, and abnormal endocrine function,
7 which means a loss of menstrual period.
8 Importantly, in terms of the present study
9 that was given by the petitioner, there's anhedonia or
10 reduced pleasure.
11 So this is different. This is a condition
12 that -- maybe Dr. Weathers had some comments. I want
13 to define that for the group.
14 MEMBER WEATHERS: One of my only
15 reservations, not to influence necessarily how people
16 vote but, I believe, to discuss it as a group, is that
17 this is a disorder that by nature primarily impacts
18 adolescents.
19 That's the one group that we've raised
20 concerns about today in terms of the known serious
21 adverse effects of cannabis in the long-term,
22 especially the long-term psychological neurocognitive
23 impact.
24 I just still think it may be a reasonable

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1 treatment for what can be a very deadly condition,
2 and I just think we should discuss that as a group.
3 CHAIRPERSON MENDOZA-TEMPLE: In my
4 literature research I did find a human trial which
5 I thought was intriguing, small as they are, that
6 did show that there was an increase in kilogram
7 body weight. The type of cannabis was discussed,
8 though. That is more than what was presented in the
9 petition.
10 I would urge petitioners also to do a more
11 comprehensive literature search, if you can. As a
12 Board, we will look ourselves; but when it's all there
13 for us, not in a link but a full-text article in your
14 packet, it's just a much better case.
15 So I find some evidence, albeit small.
16 MEMBER MILLER: I will concur with that,
17 Leslie. I did a literature search as well and came up
18 with a small study.
19 It was from 2012 that talked about the
20 efficacy of THC in anorexia patients, and they found
21 it's successful with increasing the weight in
22 kilograms when it was combined with a high-fat diet.
23 They were very specific about that in their
24 conclusions.

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1 My concern is there is a body image,
2 self-esteem, self-worth usually attached to anorexia,
3 the mental health disorder of anorexia nervosa.
4 Again, it usually effects adolescents. I'm not sure
5 in reading the literature that they would combine that
6 therapy with a high-fat diet. I think it just seemed
7 to contradict. That's what I found.
8 MEMBER CHRISTOFF: This is a disorder that
9 I have no personal experience with by and large
10 because I guess I didn't treat many teenagers over the
11 years.
12 It is a good example of one where there's
13 typically -- if it's going to be done correctly,
14 there would be a multidisciplinary team that is taking
15 care of a patient like this. So there would a
16 psychiatrist and a psychologist and a primary care
17 doctor.
18 So the diagnosis of this is serious enough
19 that I don't think generalist physicians would be
20 tackling it alone, although I guess there's a lot of
21 places where there's not a team to call on
22 necessarily.
23 So in that sense, I think there would have
24 to be some shared decision-making, not just with one

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1 doctor and one patient, to certify a patient like
2 this because I think there would have to be some
3 agreement amongst the broader care team before this
4 would seem like a reasonable thing to do or a safe
5 thing to do.
6 Regarding the teenager thing with this,
7 parents have to consent and agree to be sponsors for
8 their children; right? Children can't -- whoever is
9 the responsible adult in this child's life has to,
10 first and foremost, give consent to engage in the
11 treatment.
12 But in the sense that it is a serious
13 disorder that can lead to a relatively high rate of
14 suicidality and risk of death, then the parents, in my
15 opinion, go for the best of all the options being
16 available.
17 CHAIRPERSON MENDOZA-TEMPLE: I think this is
18 another situation with anorexia nervosa, for those who
19 walked in late, that it's a treatment decision that
20 should be with the treating clinician.
21 In the case of an adolescent, so anyone
22 under 18, who presents with this and, say, the parents
23 or the physician feel that cannabis would be helpful
24 in the treatment of anorexia nervosa for the purpose

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1 of appetite stimulation and weight gain to possibly
2 save their life or their quality of life, then I
3 think, because the rules are so strict for certifying
4 kids under 18 for cannabis, it would require a
5 parent -- just one parent?
6 MS. MOODY: A caregiver.
7 MEMBER WEATHERS: -- or a caregiver, and
8 you need two physicians to sign the certification
9 letter.
10 So this isn't something that could be done
11 super easily. It's hard enough as it is. So I think
12 that allowing that option will be useful.
13 MEMBER MILLER: Motion to vote.
14 VICE CHAIRMAN FINE: Second.
15 MEMBER MILLER: Second.
16 CHAIRPERSON MENDOZA-TEMPLE: Our next
17 condition on the list, while the votes are being
18 tallied is chronic postoperative pain for which we
19 have no petitioner.
20 The condition for anorexia nervosa has
21 passed with a vote of seven to three in approval.
22 (Applause.)
23 CHAIRPERSON MENDOZA-TEMPLE: We're going to
24 make a motion regarding public comment that will be

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1 following this session after we discuss the last
2 condition.
3 VICE CHAIRMAN FINE: I motion for public
4 comments for the three minutes, which would be
5 reserved for two individuals after we finish this
6 final order of business.
7 CHAIRPERSON MENDOZA-TEMPLE: Three minutes
8 for the public comments.
9 MEMBER MCCURDY: Aye. Second.
10 (The ayes were thereupon heard.)
11 CHAIRPERSON MENDOZA-TEMPLE: Okay. Chronic
12 postoperative pain.
13 Comments from the Board? Postoperative
14 pain.
15 MEMBER CHAMPION: Is this a permanent
16 condition? That's what I wanted to know.
17 CHAIRPERSON MENDOZA-TEMPLE: Let's look at
18 the definition. The question is: Is chronic
19 postoperative pain a permanent condition?
20 I will go ahead and read the definition for
21 your edification.
22 Persistent post-operative pain is defined
23 as a pain in the location of the surgery that persists
24 for many months or even years beyond the usual course

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1 of an acute injury and is different of that
2 suffered preoperatively. Persistent pain can be due
3 to long-lasting nociception caused by processes such
4 as inflammation, chronic infection, or tumor. The
5 most important causes are neuropathic pain states
6 due to nerve compression, entrapment, or other
7 damage.
8 Acute postoperative pain, which is not what
9 we're discussing today, is defined as pain lasting
10 more than three to six months after surgery.
11 Chronic postoperative pain develops when the
12 pain continues to linger longer than six months. It
13 has been estimated that acute postop pain will develop
14 chronic postop pain in 10 to 15 percent of individuals
15 after common operations.
16 Since the pain can be severe in up to 10
17 percent of these patients, chronic postop pain
18 represents a major clinical problem affecting at least
19 450,000 people each year.
20 Comments from the Board?
21 MEMBER MCCURDY: When I read the petition,
22 at least according to the notes I have on it, I just
23 didn't get a sense that the benefits and the research
24 base that was cited really goes to chronic

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1 postoperative pain.
2 I see some evidence for relief of acute
3 postoperative pain and some, you know, personal claims
4 about what may have benefited this person, but I don't
5 see a lot of evidence, actually, with regard to the
6 chronic postoperative pain. Maybe others found other
7 things.
8 MEMBER MILLER: I looked for the evidence as
9 well. It's all pointed more towards acute. I didn't
10 see any recent evidence that pointed towards chronic
11 postoperative pain.
12 Did anybody else find anything?
13 CHAIRPERSON MENDOZA-TEMPLE: So the
14 research article that we were provided with in the
15 petition, there is a human trial in here. Patients
16 18 to 75 were recruited, so this was an acute pain
17 trial.
18 So we're talking about chronic postsurgical
19 pain, folks who just cannot seem to get over the pain.
20 They haven't healed. It's ongoing.
21 MEMBER WEATHERS: I agree with the other
22 comments that noted that as well.
23 That being said, I felt like this is another
24 one -- we talked about a lot of different chronic pain

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1 conditions today, and there are a lot that are already
2 approved, but this didn't seem to fall under that
3 umbrella.
4 Also, concerns have already been raised
5 about if this could be a viable alternative for
6 longstanding narcotic use and all the risks and
7 adverse effects that go along with it.
8 Understanding that the scientific supports
9 it, as much as I would like to see it, I think from
10 just my clinical understanding, this one didn't seem
11 to make sense to me.
12 MEMBER CHAMPION: When I did some research
13 on this, not only did it seem close to neuropathy, but
14 it also stated that 60 percent of amputees suffer from
15 chronic postoperative pain.
16 With that being said, amputees are already
17 covered under our program. It seems appropriate that
18 this might be, too.
19 CHAIRPERSON MENDOZA-TEMPLE: One of the
20 larger questions I'd like to pose -- and this is not
21 on this list of conditions -- but chronic
22 treatment-resistant pain. That is a larger umbrella
23 for all of these conditions that might be proposed in
24 the future because postop pain is just one source of

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1 it.
2 I've seen a pattern here. Opioids are being
3 used. We're seeing side effects or treatment
4 resistance or failure of the stuff to work. I'm
5 wondering if -- and this is my personal opinion --
6 chronic treatment of resistant pain with some caveats
7 with it might be something to consider in a future
8 petition.
9 But for the chronic postsurgical pain, other
10 comments from the Board?
11 MEMBER MCCURDY: Call the question.
12 CHAIRPERSON MENDOZA-TEMPLE: Motion to vote?
13 VICE CHAIRMAN FINE: Second.
14 CHAIRPERSON MENDOZA-TEMPLE: While the votes
15 are being tallied, we'll be evaluating Ehlers-Danlos
16 syndrome.
17 Chronic postoperative pain has passed with a
18 vote of seven to three.
19 (Applause.)
20 CHAIRPERSON MENDOZA-TEMPLE: On to the next
21 with Ehlers-Danlos syndrome. Maybe it would help if I
22 just read the diagnosis, what it is, for the group.
23 We're on Ehlers-Danlos Syndrome. It's a little bit
24 out of order in our notebooks.

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1 So there are six categorized types of
2 Ehlers-Danlos syndrome, and we're not talking about
3 all the subtypes of this. We're talking about the
4 syndrome as a whole.
5 But individuals with this syndrome have a
6 genetic disconnect in their connective tissues. These
7 are the tissues that provide support to many body
8 parts, like the skin, muscles, tendons, ligaments,
9 blood vessels, organs, gums, eyes, et cetera.
10 It provides the structural strength in most
11 human tissue, including the heart and blood vessels,
12 eyes and skin, cartilage and bone, as mentioned.
13 When muscles, ligaments, tendons, and large
14 organs are built with defective collagen, their is
15 systemic weakness and instability evident throughout
16 the body. The problem results from one's body being
17 built out of a protein that behaves unreliably and can
18 be widespread and show up in places that seem
19 unrelated until the underlying connection to EDS is
20 recognized.
21 This disease is characterized by joint
22 hypermobility, loose and unstable joints prone to
23 frequent dislocation and subluxation, hyperextensible
24 joints in multiple areas of body that I won't read and

1 early onset of osteoarthritis.
2 Osteoarthritis, a degenerative joint
3 disease, occurs at a younger age than in the general
4 population possibly because of chronic joint
5 instability resulting in increased mechanical stress.
6 Osteoporosis, which is bone marrow density,
7 in individuals with EDS may be reduced in some
8 individuals. Back and neck pain are the most common
9 reports among these patients.
10 I won't go on any further, unless you'd like
11 me to.
12 Comments on Ehlers-Danlos syndrome?
13 Motion to vote?
14 MEMBER WEATHERS: Motion to vote.
15 MEMBER MILLER: Second.
16 CHAIRPERSON MENDOZA-TEMPLE: We've made
17 amazing progress at this meeting. I'm really pleased
18 with how our inaugural petition has gone.
19 I'm just thrilled with the passion that has
20 been brought to this room but also the thoughtfulness
21 that we've brought to certifying or not certifying
22 conditions.
23 I hope that the feedback that we've given to
24 the public regarding conditions was helpful in terms

1 of making the next round of petitions, which will be
2 occurring in the fall -- and I believe, Conny, is it
3 June 1 we start accepting --
4 MS. MOODY: July 1.
5 CHAIRPERSON MENDOZA-TEMPLE: That's right.
6 July 1 we'll be accepting new petitions.
7 For those of you who weren't in the room
8 when I said this, I think it's really important that
9 the petitioners who signed up really show up for
10 these. It's very valuable to hear the testimonies.
11 We really want to hear those.
12 Provide full-text articles and not just
13 links -- website links that we have to copy and paste
14 it. We've got so much material to cover. We've got
15 that all under our fingertips.
16 We'll announce the vote.
17 For the condition of Ehlers-Danlos syndrome,
18 the condition has passed -- the motion passes yeah,
19 nine votes to one.
20 (Applause)
21 CHAIRPERSON MENDOZA-TEMPLE: This is the
22 last condition on the list, and it's 2:11. Amazing.
23 Do we have any other announcements?
24 MS. MOODY: We have one more. We have

1 neuro-Behcet's.
2 MEMBER WEATHERS: Just for the Board,
3 Neuro-Behcet's combines the neuropathology cirrhosis
4 with superimposed supraoral genital ulcerations.
5 CHAIRPERSON MENDOZA-TEMPLE: I remember in
6 medical school -- I remember these were "Can't see,
7 can't pee, can't climb a tree." That's how you
8 remembered what symptoms were involved. We have to
9 learn so many different diseases.
10 MEMBER WEATHERS: Just to add on -- and I'll
11 give credit to Eric -- it doesn't respond to the
12 normal immune modulations. It requires
13 immunosuppression, which comes with its own side
14 effects.
15 CHAIRPERSON MENDOZA-TEMPLE: I have a
16 question for you, Dr. Weathers.
17 Do you see a lot of patients with this,
18 since we have no testimony?
19 MEMBER WEATHERS: It's pretty rare. It sort
20 of descends from Turkish patients. It can be in other
21 patient populations as well, but we certainly do have
22 a few patients. It certainly pales kind of in
23 incidence compared to multiple sclerosis and
24 neuromyelitis, which are much more common autoimmune

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1 disorders.
2 CHAIRPERSON MENDOZA-TEMPLE: Dr. Christoff,
3 have you seen this?
4 MEMBER CHRISTOFF: I have not seen a case of
5 this.
6 CHAIRPERSON MENDOZA-TEMPLE: Other comments
7 from the Board? Questions? Parikh?
8 VICE CHAIRMAN FINE: Motion to vote.
9 MEMBER PARIKH: Second.
10 MEMBER MILLER: Second.
11 CHAIRPERSON MENDOZA-TEMPLE: The condition
12 of neuro-Behcet's autoimmune disease passed with a
13 yeah vote, ten to zero.
14 We've made miraculous, wonderful time. I
15 really appreciate everyone's cooperation in keeping
16 the flow going very smoothly. We're ahead of
17 schedule.
18 So I invite our public comment session to
19 begin, and we have two individuals signed up. We
20 previously moved on the Board to limit the discussion
21 to three minutes at the podium, which is the same
22 amount of time that petitioners received. Even though
23 we have more time, it's only fair to keep their time
24 the same. So three minutes.

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1 Two people signed up. We have Ben -- sorry,
2 I can't read your last name -- Rediger.
3 MR. REDIGER: Thank you. My name is Ben
4 Rediger, R-e-d-i-g-e-r. I'm a CEO off CBD Education
5 Services and CBD Education Charities.
6 I would like to thank all of you for taking
7 the time out of your day to do this. I know the
8 patients in the industry appreciate this effort. On
9 my end, my responsibility is to provide education not
10 only to the community but to medical professionals as
11 yourself.
12 If you all did not know, there are now
13 online continuing medical education courses to explain
14 to the medical industry how the endocannabinoid system
15 works in the human body. I would take more of your
16 time today; but I feel that since Sue Sisley is here,
17 she would do well with it. So I'm going to yield the
18 rest of my time to her.
19 Thank you.
20 MS. SISLEY: Hi. My name is Sue Sisley.
21 I'm a physician from Arizona.
22 THE REPORTER: Could you spell your name,
23 please?
24 MS. SISLEY: Oh, sure. The last name is

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1 S-i-s-l-e-y.
2 I'm an M.D. I practice internal medicine
3 and psychiatry in Scottsdale. I'm the principal
4 investigator on a randomized control trial looking
5 at whole-plant marijuana for PTSD in military
6 veterans.
7 Sadly, this study has been stonewalled by
8 the Government for over five years now. We've had
9 FDA approval since 2011. We've hurdled all the
10 Federal Government obstacles, except the NIDA
11 monopoly.
12 The National Institute on Drug Abuse is the
13 only legal supply of marijuana in the country for any
14 Federally regulated marijuana research. So this is a
15 big problem, and that's why our study continues to be
16 delayed waiting over a year now for a marijuana study
17 drug from the Federal Government.
18 But in the meantime, this Committee has made
19 some really excellent decisions. I wanted to applaud
20 you for having the sensibility, the compassion, the
21 courage to embrace these diagnoses that may not have a
22 randomized control trial behind each one of them but
23 certainly have a mountain of anecdotal evidence
24 suggesting that marijuana could be an effective

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1 treatment intervention for them.
2 So I just want to really acknowledge the
3 incredible amount of work. You've read and pored over
4 hundreds of pages of documents in order to get to this
5 point. You've listened to all this compelling
6 testimony, but you've already made some wonderful
7 decisions.
8 The diagnosis that I was particularly
9 interested in advocating for you've already passed,
10 PTSD. As you'll see here, many of us are wearing this
11 dog tag today. Our military veterans created this
12 awareness campaign. Instead of a ribbon, they
13 developed the number 22 engraved on a dog tag to
14 signify the number of military veterans who kill
15 themselves each day in this country presumably due to
16 untreated or undertreated PTSD.
17 So I'm grateful that you all have made the
18 decisions that have happened today. I hope that the
19 Governor's Office has the wisdom and the sensibility
20 to uphold the decisions.
21 I look forward to being a resource for your
22 Committee or for your administration to call on us.
23 In Arizona we've had a medical marijuana law for over
24 four years now. We've added PTSD back in January of

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1 this year.
2 It's been a real gift to all the PTSD
3 sufferers, not just our military veterans but folks
4 with trauma of all causes. They have been able to
5 access -- they have been able to safely access
6 lab-tested marijuana in a legal framework, and that's
7 been crucial.
8 So thank you all very much, and please call
9 on us in Arizona. We can help guide you as you
10 continue your rulemaking process. We can share our
11 experiences, help you avoid pitfalls, and also help
12 optimize your programming.
13 Thank you.
14 (Applause.)
15 CHAIRPERSON MENDOZA-TEMPLE: Thank you,
16 Dr. Sisley.
17 So we're closing public comment. In the
18 future, we will have individuals sign up on the sheet
19 so it remains a streamlined process.
20 I thought it would be useful to go through
21 the list of conditions that were approved and which
22 were not approved.
23 Do we need a yeah or nay?
24 MS. MOODY: No.

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1 CHAIRPERSON MENDOZA-TEMPLE: So just to
2 reiterate, for those who haven't been here the whole
3 day, anxiety did not pass. Diabetes did not pass.
4 Essential thrombocythemia with JAK 2 mutation did not
5 pass.
6 Irritable bowel syndrome passed. Migraine
7 passed. Neuropathy, which we broke into peripheral
8 neuropathy, passed, and diabetic neuropathy passed.
9 Both categories were passed.
10 Osteoarthritis passed. Polycystic kidney
11 disease passed. Posttraumatic stress disorder passed.
12 Superior canal dehiscence syndrome passed. Anorexia
13 nervosa passed. Chronic postoperative pain passed.
14 Ehlers-Danlos syndrome passed. Neuro-Behcet's
15 autoimmune disease passed, for a total of three failed
16 and eleven passed.
17 (Applause.)
18 CHAIRPERSON MENDOZA-TEMPLE: Thank you very
19 much.
20 Just as a reminder, July 1 we'll be
21 accepting a new set of petitions.
22 MEMBER CHRISTOFF: What is the timetable on
23 the decisions of the Director?
24 CHAIRPERSON MENDOZA-TEMPLE: What is the

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1 rulemaking process?
2 MEMBER CHRISTOFF: The Director has a
3 specified period of time to respond?
4 How is this next stage handled?
5 MS. MOODY: So it is a 180-day period from
6 the time that the open petition period closes; and
7 within that 180 days, the Board must review and hear
8 petitions, make recommendations to the Director of
9 Public Health.
10 The Director of Public Health makes his
11 final decision and would direct the program to begin
12 administrative rulemaking, which then is a separate
13 step that is required before those conditions would be
14 added into the program.
15 MEMBER CHRISTOFF: And this period for
16 petitions closed when?
17 MS. MOODY: So this period for petitions
18 closed February 28th. So by the end of August, a
19 final decision -- final recommendation by the Director
20 is required.
21 MR. SCHWARTZ: So we just finished the
22 portion which is the Board making its recommendation
23 to the Director.
24 MEMBER CHRISTOFF: So it will be by the end

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1 of the six months post-February 28th that it has to be
2 in, but it could come sooner than that.
3 MS. MOODY: That's correct.
4 CHAIRPERSON MENDOZA-TEMPLE: I imagine that
5 the updates from our recommendations will be posted on
6 our website.
7 MS. MOODY: So the first step that we will
8 make is to put together a document that outlines the
9 decisions that were made today that will be approved
10 by the Board for submission to the Director.
11 So you'll have one more opportunity to
12 review to ensure that we have correctly captured all
13 of the proceedings, and then that will be submitted to
14 the Director for review.
15 As far as when it will actually be posted
16 for the public, that's something that we're going to
17 have to look at.
18 MR. SCHWARTZ: Right.
19 MS. MOODY: Yes.
20 CHAIRPERSON MENDOZA-TEMPLE: The petition
21 from July 1 until when?
22 MR. SCHWARTZ: July 31.
23 CHAIRPERSON MENDOZA-TEMPLE: So July 1 to
24 July 31 is the next petitioning period.

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1 MR. SCHWARTZ: Correct.
2 MS. MOODY: Now, our administrative rules
3 require the Department to provide notice 30 days in
4 advance of the open petition period.
5 So I recommend that everyone watch the
6 Department's website and also the MCPP.Illinois.gov
7 website, which is the statewide Medical Cannabis
8 Program website, because we will post notice in
9 advance and indicate that within 30 days the open
10 petition period will be opened so that everyone has
11 notice about that process.
12 CHAIRPERSON MENDOZA-TEMPLE: Another note on
13 the petitioner presentations, I think that clarifying
14 the deadlines, I don't know if you want to --
15 MR. SCHWARTZ: We'll definitely look at that
16 after. We'll review our internal processes after this
17 meeting to try and make sure that it is as effective
18 and as streamlined as possible, Madam Chair.
19 VICE CHAIRMAN FINE: Motion to adjourn.
20 MEMBER RAMIREZ: I think before we adjourn,
21 we should give a round of applause for Robert Morgan's
22 work for the program and all his work.
23 (Applause.)
24 CHAIRPERSON MENDOZA-TEMPLE: And also an

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1 incredible amount of work by our IDPH Staff as well,
2 Conny, Andrew, Mallory. I know I'm missing someone,
3 I'm sure, but a ton of work has gone into it.
4 By the way, these are all volunteers on this
5 Board. So that's how passionate we are about this.
6 (Applause)
7 MEMBER MCCURDY: I just wondered, is there
8 some opportunity that we should look -- and this could
9 involve another meeting or some such, and that may not
10 be what people want -- but to look at our own
11 process and see how did all of this -- did all of this
12 serve us well today or are there things that we would
13 want to suggest be tinkered with in the petition forms
14 or any of that sort of thing. I guess that would be a
15 question.
16 You all will be reviewing, but is this
17 something that should involve the Board as well?
18 MS. MOODY: Well, I think the answer to that
19 is definitely yes. I think we've learned a lot from
20 this process today.
21 Obviously, as Leslie said as we started the
22 day, this is all very new to us. We were learning as
23 we went along. I'm very pleased by how well we
24 learned and how quickly we learned, but I think there

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1 might be recommendations that the Board has, that the
2 Staff has that could make this a process that is new
3 and improved.
4 We will seek and opportunity to obtain that
5 kind of input from the Board and perhaps even more
6 informally through a meeting because we had discussed
7 at our first Board meeting the possibility of having a
8 summer Board meeting prior to the next petition
9 hearing to discuss the rules that we have passed
10 already for the Board, the process, any
11 recommendations that the Board would like to make to
12 the Department.
13 Definitely, I agree with that.
14 MEMBER CHAMPION: Our next petition hearing,
15 that will be in Springfield; is that correct?
16 Probably or no?
17 MS. MOODY: I see some heads shaking. I see
18 some folks -- I think that will be, honestly, at the
19 discretion of the Board where you would like to have
20 that meeting.
21 MR. SCHWARTZ: That's definitely something
22 that could be ripe for discussion at a nonpetition
23 hearing meeting to discuss location and logistics as
24 well as petition applications and receipt.

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1 CHAIRPERSON MENDOZA-TEMPLE: Mike?
2 VICE CHAIRMAN FINE: Sure. Motion.
3 MEMBER CHRISTOFF: Maybe there is a case to
4 make here, like we should be doing this meeting in
5 other places, but I think most of us live in this
6 region. I don't know that for a fact, but those of us
7 that don't are probably not necessarily a lot closer
8 to Springfield.
9 MEMBER RAMIREZ: But Springfield is the
10 capitol of our state. We're all working for the
11 people of Illinois.
12 People downstate might have to present their
13 case and have to travel here.
14 MEMBER CHRISTOFF: That's true, but it will
15 be expensive to move all of us there as well.
16 MR. SCHWARTZ: I think we all appreciate
17 this debate. I think it definitely is meritorious
18 and should be continued at possibly the summer
19 meeting.
20 MEMBER RAMIREZ: Thank you.
21 MR. SCHWARTZ: Motion to adjourn.
22 MEMBER MCCURDY: Second.
23 CHAIRPERSON MENDOZA-TEMPLE: All in favor of
24 closing the meeting?

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1 (The ayes were thereupon heard.)
2 PROCEEDINGS CONCLUDED AT 2:30 P.M.
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1 STATE OF ILLINOIS)
2) SS.
3 COUNTY OF DU PAGE)
4
5 I, Jean S. Busse, Certified Shorthand
6 Reporter No. 84-1860, Registered Professional
7 Reporter, a Notary Public in and for the County of
8 DuPage, State of Illinois, do hereby certify that I
9 reported in shorthand the proceedings had in the
10 above-entitled matter and that the foregoing is a
11 true, correct and complete transcript of my shorthand
12 notes so taken as aforesaid.
13
14 IN TESTIMONY WHEREOF I have hereunto set my
15 hand and affixed my notarial seal this 11th day of
16 May, 2015.
17
18
19
20 ____________________________________
21 Notary Public
22
23 My Commission Expires
24 July 25, 2017.

A

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