

MEDICAL CANNABIS ADVISORY BOARD MEETING

PUBLIC HEARING TO REVIEW)
 REQUESTS TO ADD)
 DEBILITATING CONDITIONS TO)
 THE MEDICAL CANNABIS)
 REGISTRY PROGRAM)
)
)
)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
 PUBLIC HEARING

Springfield, Illinois
 May 2nd, 2016

WHEREUPON, THE HEARING was held pursuant
 to notice at 9:00 a.m., at the Illinois
 Department of Natural Resources, One Natural
 Resources Way, Springfield, IL, 62702.

MIDWEST LITIGATION SERVICES, by
 Kathy L. Johnson
 Court Reporter

1 APPEARANCES OF ADVISORY BOARD:

2

MS. LESLIE MENDOZA TEMPLE

3

MS. CONNIE MUELLER MOODY

MS. ALLISON WEATHERS

4

MS. THERESA MILLER

MR. ERIC CHRISTOFF

5

MR. DAVID McCURDY

MR. MICHAEL FINE

6

MR. JAMES CHAMPION

MR. NESTOR RAMIREZ

7

MR. JOHN KNAUS

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1 (Hearing start time: 9:00 a.m.)

2 MS. TEMPLE: Thank you, everyone, for
3 coming to this meeting. We welcome the public in
4 hearing these petitions that were received during
5 the January 2016 open petition period to request
6 the addition of debilitating conditions to the
7 qualifying conditions for our existing Medical
8 Cannabis Registry Program.

9 A total of 15 debilitating conditions
10 will be heard today, and we request that you
11 silence or put on vibrate your cell phones so we
12 can hear the proceedings, so our court reporter
13 can ensure an accurate transcript.

14 So I wanted to start with some welcoming
15 remarks. We will introduce the Board and we'll,
16 hopefully, Dr. Christoff will be here by that
17 time.

18 I do want to acknowledge the presence of
19 our House Minority Leader, Lou Lange, who is the
20 author of this Bill, for which we would not have
21 this program if it were not for him. So I thank
22 you very much.

23 (Applause.)

24 We are happy to have your here. I know

1 you have to leave early, so everyone knows. I
2 wanted to give some updates on the Cannabis,
3 Compassionate Cannabis Pilot Program from a
4 clinician's point of view, as well as a member of
5 the Advisory Board. Should I stand up? Okay.

6 So I wanted to go through what I have
7 seen so far as a physician who's been certifying
8 patients, and hands down I have seen nothing but
9 good come from this Pilot Program so, from the
10 existing conditions so far.

11 I wanted to stress to everyone here that
12 medicine is an art and a science. It's about art
13 just as much as science, and so we are going to
14 be discussing what is out there in the medical
15 evidence. But this is a Compassionate Pilot Act.

16 We are looking at more than just hard
17 core evidence seen in black and white. We need
18 to keep that in mind. At the same time, we must
19 respect the science.

20 Hello, Dr. Christoff. Thank you for
21 coming. And that this is a very, it's a tricky
22 business to weigh out what I feel is passable for
23 our scientific evidence, as well as using the
24 skills I have as a clinician for the patient in

1 front of me who is suffering. Keep in mind that
2 we are going to be talking about pretty much five
3 new conditions and others that have been passed
4 already, so we're going to order the agenda to
5 talk about the new conditions first so that we
6 can have more energy for those.

7 I also wanted to ask that at some point I
8 would love as a clinician to see cannabis be
9 rescheduled to Schedule II so we can get the
10 research we need to do the kind of work we're
11 doing here now.

12 And so that is probably the largest
13 obstacle we have here is that the evidence base
14 for using cannabis is not where it should be.
15 And if we release that restriction we can do a
16 lot more research.

17 The other thing is, I wanted to update
18 the group here that large health systems are
19 already adapting medical cannabis certification
20 policies for their staff.

21 So at Northwestern University and
22 NorthShore University Health System there are
23 already policies and procedures in place that
24 guide physicians towards whether, or how to

1 certify their patients for medical cannabis, but
2 it does not mandate that the physicians are
3 supposed to do it. It allows the physician to
4 opt out. And so what we need to do is continue
5 the education of our medical community to make
6 this more of a comfortable option for them.

7 So with that said, I want to thank you
8 for your presence here. And I don't know if
9 Michael has anything else to add?

10 MR. FINE: Sure. Good morning,
11 everybody. With regard to, I'll stand up in a
12 second because I have to read this and I can't
13 see to hold and read this at the same time. But
14 to begin with, the most important aspect of this
15 is we're going to break for lunch at a certain
16 point.

17 Although we don't know exactly when that
18 will be, but we'll let you know. Probably
19 around, probably around intractable pain. Just
20 like they withdrew the, yeah, we'll talk about
21 IBS after lunch.

22 So the room will be closed during lunch.
23 There's a small cafeteria right out here to your
24 right of this room for light snacks and sodas, or

1 you can have your lunch. Bathrooms are also to
2 the right of the room on either other side of the
3 staircase. And if you submitted a request to
4 present technical evidence, please make sure you
5 checked in with Ben who was at the door on the
6 outside when you came in.

7 So please make sure if you haven't seen
8 him already to check in with him so we'll be able
9 to call your name to come forward to present
10 testimony.

11 I offer the counter perspective of
12 Leslie. I'm a patient as well. And the owner of
13 my dispensary happens to be in the audience, so
14 I'll give Joe Friedman a shout-out as well. The
15 experiences that I've had since going to PDI
16 have just been incredible.

17 Knowledgeable staff, great product,
18 consistency in everything that they sell. And
19 it's been a real pleasurable experience, a
20 professional experience every time I've gone.

21 So just as Leslie has acknowledged the
22 experiences from the medical professional, from a
23 patient they've been just great, so just
24 something that hopefully expands with time. So

1 anyways, thank you.

2 MS. TEMPLE: Are there any other
3 housekeeping items, Connie, that we've missed?
4 Otherwise, we'll proceed with our introductions.

5 MS. MOODY: I would just urge everyone to
6 speak slowly and carefully for our court
7 reporter. I know that's been said before, but we
8 want to make sure that we have an accurate
9 transcription of this hearing.

10 MS. TEMPLE: So why don't we start with
11 Dr. Ramirez. We'll do our introductions of the
12 Board. Please list your name and your
13 affiliation.

14 DR. RAMIREZ: My name is Nestor Ramirez.
15 I'm representing Pediatrics. My name is Nestor
16 Ramirez and I'm the Pediatric representative on
17 the Board. I work at Illinois Masonic Medical
18 Center, but I officially represent the Illinois
19 State Medical Society. I've been nominated for
20 this.

21 DR. KNAUS: My wife says I have a big
22 mouth so I don't have to use this. My name's
23 John Knaus. I'm a gynecologic oncologist. I've
24 done mostly ovarian cancer and breast cancer

1 care, and I work primarily at St. Francis
2 Hospital in Evanston, Illinois. I'm Program
3 Director of an Obstetrics and Gynecology
4 Residency there.

5 MS. MILLER: And I'm Theresa Miller. I
6 am an Associate Professor at a nursing college
7 and I'm here representing Nursing.

8 MR. CHRISTOFF: Doctor Christoff, General
9 Internal Medicine and HIV at Northwestern. And
10 good morning, everyone.

11 MS. TEMPLE: I'm Leslie Mendoza Temple.
12 I'm the Medical Director of the NorthShore
13 Integrative Medicine Program. I'm also a
14 Clinical Assistant Professor at the University of
15 Chicago-Pritzker School of Medicine.

16 MR. FINE: I am a patient advocate. My
17 name is Michael Fine. I'm a recovering attorney
18 and have no medical background whatsoever, except
19 I see lots of doctors for a living.

20 MR. MCCURDY: I'm David McCurdy, retired
21 from a long time work in healthcare as a health
22 care anesthetist in the last 20 years, and also
23 adjunct faculty at Elmhurst College.

24 MS. MOODY: Good morning. I'm Connie

1 Moody, and I'm with the Illinois Department of
2 Public Health. I'm here with the Medical
3 Cannabis Program today.

4 MS. WEATHERS: Good morning. I'm Allison
5 Weathers. I am an Associate Professor in the
6 Department of Neurological Sciences at Rush
7 University Medical Center in Chicago where I'm a
8 neurologist, and also the Associate Chief Medical
9 Information Officer for Rush.

10 MR. CHAMPION: Good morning. I'm Jim
11 Champion. I'm the Veterans' representative on
12 the Advisory Board. I'm a 100% Service connected
13 disabled veteran, and I was diagnosed with
14 Multiple Sclerosis in 1988.

15 MS. TEMPLE: Thank you, everyone. I also
16 wanted to add one last comment that I know that
17 those who are not here in the room, who are not
18 here to witness what's going on with this Pilot
19 Act, I hope that they pay strong attention that
20 this Board will continue to do the work that we
21 were charged to do despite the outcome, and we
22 will continue to do that.

23 (Applause.)

24 MS. TEMPLE: So we need to actually make

1 a motion to reorder the agenda, to just reorder
2 the conditions to have our five new conditions
3 presented in the morning and a few more right
4 before lunch, and then previously heard petitions
5 will be heard later.

6 MR. RAMIREZ: I make a motion.

7 MS. TEMPLE: Oh. I don't know if I can
8 make the motion. Someone else needs to --

9 MR. RAMIREZ: I just made it, so.

10 MS. TEMPLE: Oh. Did --

11 MR. CHRISTOFF: Second.

12 MS. TEMPLE: A second. Okay. All those
13 in favor say aye?

14 (Board responded Aye.)

15 MS. TEMPLE: Those opposed?

16 (No response.)

17 MS. TEMPLE: So just for the record, are,
18 we're going to hear the following first, in this
19 order; Diabetes Mellitus. And from what I saw,
20 Connie, it's Type I Diabetes. So a big
21 difference between that.

22 Panic Disorder, Dysthymic Disorder, Lyme
23 Disease, Methicillin-Resistant Staphylococcus
24 Aureus, or MRSA, autism, Chronic pain due to

1 trauma, chronic pain syndrome, chronic
2 postoperative pain, intractable pain, Irritable
3 Bowel Syndrome, and migraine, neuropathy,
4 osteoarthritis, and post-traumatic stress
5 syndrome.

6 So we will hear those, hear everything in
7 those, in that order, and good to go. We have
8 now the next item, which is to review and approve
9 the October 7th, 2015 petition hearing Minutes,
10 and it requires a motion by the Board to approve
11 those Minutes, and we need a second.

12 MR. KNAUS: Motion to approve.

13 MS. WEATHERS: Second.

14 MS. TEMPLE: Comments from Jim?

15 MR. CHAMPION: I would like to make a
16 motion to table those Minutes until such time as
17 we can have ample time to review and approve
18 them.

19 MS. TEMPLE: Okay. So is that a motion?

20 MR. CHAMPION: That is a motion.

21 MR. RAMIREZ: That is an order. It needs
22 a second but it's an order. I second it.

23 MS. TEMPLE: Okay.

24 MS. MOODY: You have a second.

1 MS. TEMPLE: Either --

2 MR. RAMIREZ: You've got one on the table
3 still.

4 MS. MOODY: So you've now made it a
5 friendly amendment, so you may take a vote on
6 the amended motion.

7 MS. TEMPLE: Okay. So take a vote on the
8 amended motion to table the Minutes for a proper
9 review, and perhaps the next petition meeting
10 we'll go through those, or as a separate
11 conference call.

12 MR. FINE: I second.

13 MS. TEMPLE: Those who approve?

14 (Board responded aye.)

15 MS. TEMPLE: Those who oppose?

16 (No response.)

17 MS. TEMPLE: Okay. So we will table the
18 approval of the October 7th, 2015 petition
19 hearing Minutes for a separate conference call or
20 at the next petition meeting. Okay. So the next
21 item here is to discuss petitions for the
22 addition of debilitating conditions and to
23 present technical evidence.

24 And following that, those presentations,

1 the Board will deliberate. The voting approach
2 that we have followed in the past two meetings is
3 once the deliberation has occurred and where
4 everyone's ready to vote, we have paper ballots
5 so that our votes are confidential, and then they
6 are tallied and announced at the end.

7 So we will find out immediately after
8 these petitions if they were approved or not
9 approved. Another motion I'd like to have
10 someone propose is that we approved the
11 conditions that we have approved at either the
12 May 2015 or October 2015 meetings past.

13 So when there are several conditions that
14 have been repeated on here that the Board has
15 already deliberated on, we've already voted upon,
16 and for the sake of time and energy and the fact
17 that all of this is public record, we will hear
18 the Petitioners, but we as a Board don't need to
19 vote anymore. That is --

20 MR. FINE: So I hereby motion to not
21 require a vote on the conditions that we've
22 already previously passed.

23 MR. RAMIREZ: Second.

24 MR. KNAUS: Second.

1 MS. TEMPLE: All those in favor say aye.

2 (Board responded aye.)

3 MS. TEMPLE: Those opposed?

4 (No response.)

5 MR. MCCURDY: I just want to say, my only
6 concern is I hope that the petitioners won't fly
7 the coop, you know, now that they know that
8 they've got the request. I move, I would still
9 like to hear from them.

10 MR. CHAMPION: It becomes a part of
11 public record, and it's always good for review,
12 and when Dr. Shah receives it he receives
13 everyone's testimony. So it's always the more
14 testimony, the better. And I know I appreciate
15 it, and I'm sure everyone on the Board
16 appreciates you coming out today. Thank you.

17 (Applause.)

18 MS. TEMPLE: Thank you, James. So we, I
19 remind the speakers that they have three minutes
20 to present their technical evidence. Please
21 speak clearly and slowly for our court reporter.
22 Introduce yourself by your full name and your, if
23 you have an affiliation, an organization, or if
24 you're representing yourself as a patient or as a

1 caregiver or an advocate. Please spell your
2 first and last name for the record, and you will
3 actually be timed. So when it's time, when your
4 time is up, you have 30 seconds left. We are
5 going to be very strict about this. There's the
6 sign. Okay. Heed the sign, please.

7 Okay. Everyone ready? All right. We're
8 going to start with Diabetes Mellitus Type I, and
9 for that we have two speakers. We have Feliza
10 Castro from The Healing Clinic. And if she
11 would, is she present? Feliza Castro?

12 AUDIENCE MEMBER: She's not here.

13 MS. TEMPLE: Okay. Then we'll move on to
14 the next one, which is Farah Zala.

15 MS. ZALA: Yes.

16 MS. TEMPLE: Okay. Please. And please
17 state your full name, spell, and your
18 affiliation.

19 MS. ZALA: I have a ton of technical
20 evidence, so --

21 MS. MOODY: Do you wish to use the
22 microphone?

23 MS. TEMPLE: We have to use the
24 microphone.

1 MS. ZALA: Yes. Yes.

2 MS. TEMPLE: I turned mine off.

3 MS. MOODY: If you will turn the power
4 on, there's a power button at the top. Turn that
5 on. And then if you'll speak close to the
6 microphone and clearly for our court reporter to
7 hear.

8 MS. ZALA: Check, check. Can you hear
9 me? My name is Farah Zala Morales, and this is
10 daughter Meera Zala. And let me just get my
11 notes out. We are here today to present
12 technical evidence to support --

13 MS. WEATHERS: Spell, would you first
14 spell your name?

15 MS. ZALA: It's spelled F-a-r-a-h. My
16 last name is Zala. Z for zebra, a-l-a. Morales,
17 M-o-r-a-l-e-s. And my daughter's name is Meera.
18 M-e-e-r-a. Last name is Zala. Z for zebra,
19 a-l-a.

20 We are here today to present technical
21 evidence to support medical cannabis as a
22 treatment alternative and a complement to
23 conventional medicine for Type I diabetes. My
24 daughter Meera was diagnosed a Type I diabetic

1 November 24, 2014, with a blood sugar reading of
2 616 and an A1C that was off the charts. Today I
3 would like the opportunity to present Meera's
4 school blood sugar logs since using CBD tinctures
5 six months ago that is legal and available under
6 the Hemp Act.

7 I believe starting at the lowest possible
8 recommended dosage by the medical cannabis
9 industry standard of one milligram, one squirt
10 once a day, six months ago to present day of 30
11 to 36 milligrams, 10 to 12 squirts three to four
12 times a day, that not only has Meera's blood
13 sugars changed and are stabilizing, but we are
14 also seeing numerous other positive differences,
15 with the understanding from her endocrinologist,
16 and insulin therapy to help regulate Meera's
17 blood sugars and countless negative symptoms and
18 experiences that come along with Type I diabetic
19 at such a volatile, fragile and young age of 12.

20 With CBD supplementing, Meera's insulin
21 need and intake has consistently lowered and her
22 general well-being has improved, although not
23 100 percent, because of the dramatic lows and
24 detrimental spikes that come three to five hours

1 later from the excessive amounts of food she has
2 to take at school to be allowed to return to
3 class, which is a blood sugar reading of 80.
4 Getting back to 80 blood sugar takes a few hours
5 of time to quality healthy food choices that
6 don't spike her into 300's, and CBD to gradually
7 stabilize her to a normal or comfortable blood
8 sugar number and disposition, which usually
9 occurs within 15 minutes.

10 The past week alone, Meera has displayed
11 continuous long lulls for hours, despite healthy
12 food choices, between 60 and 115 grams of
13 carbohydrates in increments of 10 to 20 minutes
14 with testing and pricking of her bruised fingers
15 every time.

16 Pricking your finger 10 to 20 times a
17 day, and she's the only female bass player in our
18 district, and an athlete and a basketball player
19 and a straight A student, she still manages to
20 keep it all together and be an amazing person as
21 well as all this discomfort that she feels on a
22 daily basis.

23 She feels icky. She feels uncomfortable.
24 She feels yucky. She feels pain, burning

1 sensations all over her body when she's taking
2 injection sites. All I can say, and I have a
3 whole speech, and I don't have enough time to
4 even say it, but CBD has helped us so much.

5 I would like the opportunity to present
6 her blood sugar logs that state and show how much
7 her blood sugar has decreased over the last six
8 months with CBD and insulin. However, insulin
9 now seems to be less and less and less because of
10 the CBD.

11 MS. MOODY: Thank you very much for your
12 testimony today.

13 MS. ZALA: Thank you very much.

14 MS. TEMPLE: Can you turn the microphone
15 off so I can turn mine on?

16 MS. ZALA: Off?

17 MS. TEMPLE: Thank you very much for that
18 testimony. That must have been very hard, and
19 you must be so proud.

20 MS. ZALA: So proud. Can I give you the
21 testimony? Can I give you her medicine that she
22 hasn't used as wasted medicine?

23 MS. MOODY: If you have written testimony
24 that you would like to share with the Board,

1 please feel free to provide that to our Chairs.

2 MS. ZALA: Should I do it now or do you
3 want me to stick around and do that?

4 MS. MOODY: You can do that now.

5 MS. TEMPLE: Thank you very much.

6 MS. ZALA: These are her recent blood
7 sugar logs from just this past week that probably
8 show a year and a half worth of blood sugar highs
9 and lows but that CBD has helped her so
10 tremendously.

11 MR. CHRISTOFF: Could I just ask a
12 question?

13 MS. ZALA: Yes, sir.

14 MR. CHRISTOFF: Are you having any side
15 effects, do you notice, from taking this tincture
16 at all? Because that wasn't mentioned. Or if
17 you mentioned it, I didn't catch it.

18 MS. ZALA: No. In fact, her blood sugar,
19 and if I may answer for her, her blood sugar, you
20 know, causes so many, --

21 MR. CHRISTOFF: Right.

22 MS. ZALA: -- increases headaches, these
23 kinds of things. Pain, discomfort. With the CBD
24 tincture she doesn't feel all the things. In

1 fact, she feels quite happy, comfortable. Her
2 body works functioning very well.

3 MR. CHRISTOFF: And weight has been
4 stable this whole time?

5 MS. ZALA: She is, we just went to the
6 doctors at the endocrinologist on Friday. She is
7 103 pounds, five four. She's taller than me
8 without heels, and she's a growing, beautiful
9 child, and she just needs quality of life back.

10 MR. CHAMPION: How are you feeling? Do
11 you, how do you feel?

12 MS. ZALA: Are you asking me or her?

13 MR. CHAMPION: I'm asking her. I just
14 want to hear from her.

15 MS. ZALA: Sure.

16 MEERA ZALA: Yeah, I feel I'm doing much
17 better than before. It's better, and I'm able to
18 like do more stuff because when I'm like higher I
19 just have to like sit there until I feel better.

20 MS. ZALA: Or until it comes back. Low,
21 even low numbers cause her to feel a little
22 disoriented, but the high numbers are awful. And
23 then the sequence of events that occur with
24 insulin, receiving insulin to come back up from

1 those lows to then have to take insulin, food, to
2 bring her back up, to then have to take insulin
3 again to bring her lows down again, her highs
4 down again, it's a vicious cycle.

5 But with CBD before a meal or after a
6 meal it tends to lower out her blood sugar so her
7 insulin intake is not as dramatic.

8 MS. TEMPLE: Thank you so much for your
9 testimony.

10 MR. MCCURDY: Thank you. It's always
11 good to hear from the patient, so thank you.

12 MS. TEMPLE: Yes, thank you.

13 MS. ZALA: Thank you so much.

14 MS. TEMPLE: Okay. Comments from the
15 Board?

16 MS. ZALA: This is her bag of the wasted
17 insulin.

18 MS. TEMPLE: Thank you. Unfortunately,
19 we can't take meds.

20 MS. ZALA: Oh, Sorry. But just to let
21 you know, this is, this is one of seven bags of
22 wasted insulin.

23 MR. CHAMPION: I've been there.

24 MS. ZALA: It's an awful, terrible

1 disease.

2 MS. TEMPLE: Okay. So if you could turn
3 the microphone off. I'm sorry.

4 MS. ZALA: I turned it off.

5 MS. TEMPLE: You did?

6 MS. ZALA: Yeah.

7 MS. TEMPLE: Then it's me. Okay.

8 Comments from the Board regarding Diabetes
9 Mellitus Type I?

10 MR. CHAMPION: I was going to say, first
11 of all, that the thing that, the finger pokes are
12 no, them finger pokes are no joke. I used to get
13 in fights with my nurses when they'd come around.
14 I would be like no, this is too soon for another
15 finger poke.

16 But on a serious note, I think this
17 Petitioner did a much more thorough job of
18 explaining the three-pronged approach, how it
19 helps with proper diet, blood sugar levels, and
20 overall pain maintenance.

21 While not all patients will benefit from
22 cannabis, the same can be said for almost any
23 condition, including MS. I think we need to
24 trust our doctors to only prescribe to their

1 patients who would benefit. And I think --

2 MS. TEMPLE: Certifying.

3 MR. CHAMPION: Certifying. But I think
4 this petition did a much better job than the last
5 time.

6 MS. TEMPLE: Doctor Weathers?

7 MS. WEATHERS: I think you all did an
8 amazing job and it was so impressive at your age
9 to get up, and people like to participate in
10 this. And I've been involved with diabetes here
11 since I was a medical student and participated at
12 camp programs where we were helping students.

13 So even though it's not my area of
14 specialty, I do have a long history of
15 involvement. And I'm not minimizing at all what
16 the Petitioner's going through. The needle
17 sticks are horrible, but I have a couple of
18 significant concerns.

19 One is, I think we need to be cautious
20 that there's not a causal relationship. By
21 providing CBD you still need very strict blood
22 pressure.

23 There is absolutely no evidence that this
24 would be curative and would not take away that

1 requirement for very close blood sugar
2 monitoring. And I think our, I know there's a,
3 we have very compassionate people on the Board,
4 as well as parents.

5 I would never want that for my child, but
6 I think we need to not link the two, that by
7 proving this it's not going to spare people that
8 strict monitoring of their blood sugars.

9 I know we've debated extensively in the
10 previous meetings the lack of evidence and how
11 strong we can use that for our decision making.
12 And there are certainly conditions where I feel,
13 as Leslie, you pointed out early, it is
14 compassionate use, and that means a lot that
15 we're not going to always have that level of
16 evidence because the history of this drug,
17 because of it being, the way it was classified.

18 However, when you look at PubMed, which
19 is our, in the medical field kind of, the
20 articles that are put on PubMed have a certain
21 cache about them. They have to be from a
22 reputable journal, they're peer reviewed.

23 And when you look at this topic on PubMed
24 the articles that do come up, there are a few and

1 there are some that the Petitioner did submit,
2 but the one that was submitted as evidence
3 actually concludes that the evidence right now is
4 too weak for casual inference and that we need a
5 more stable evidence base.

6 And this just provides new lines for
7 translational research. The articles that are
8 there discuss the risk of aspergillosis. There
9 are few case reports. And also, very, very
10 conservatively, there are a number of articles
11 and there are case reports, but they're still
12 there about how the use of CBD, or cannabis, in
13 diabetes can mask DKA, and of course the fatality
14 with that.

15 And there's some also in PubMed articles
16 that it can increase insulin insensitivity. So
17 while I certainly am, and the Board's heard me
18 before, people who have been in the audience
19 multiple times before know I'm the first to say
20 when I think that the adverse effects are not
21 significant, that the benefit, potential benefit
22 outweighs the risk. In this case, I just don't
23 feel comfortable making that conclusion.

24 MS. TEMPLE: May I go next, or do you

1 have, so I, because it's not related to Dr.
2 Weathers. So I did an extensive literature
3 review on my own which included the Petitioner's
4 presentation, plus, plus. And what I found were
5 pros and cons.

6 In Weiss, W-e-i-s-s, et al., 2006, they
7 looked at cannabidiol, which is CBD, lowering the
8 incidence of diabetes in non-obese diabetic mice.
9 So the researchers took mice and injected
10 Streptolysin into their peritoneal cavities and
11 made them diabetic, and then tested this group of
12 mice with CBD and with placebo, and they found
13 that those treated with CBD had less diabetes.
14 They were not obese to begin with, so they were
15 baseline.

16 We have to keep in mind what we know
17 about animal research and going straight and
18 leaping into humans, that's really not how it's
19 done. But this is, cannabis is one of those
20 situations where we're already doing that.

21 Another pro article was from Rieder,
22 R-i-e-d-e-r, et al., which looked at bench
23 research. This is a difference where you look at
24 petri dishes and cell cultures, and they found

1 that CBD helped the death of immune cells and
2 helped with, as a pathway to immunosuppression.
3 And they looked at it that way to help quell the
4 inflammatory response you get from autoimmune
5 diseases like rheumatoid arthritis, MS, and
6 Lupus.

7 So now we have mice. We have bench data.
8 Clinician's, okay. We want to see trials in
9 humans. Another great rat model was in 2010 by
10 Toth, T-o-t-h, et al., and they found that in the
11 spinal cord there was less, sorry, CB2 receptors,
12 CBD main players in chronic diabetic peripheral
13 neuropathy states. And that we as a Board
14 approved neuropathy as an additional condition.

15 The most interesting study was on
16 Diabetes Type II by Penner, et al., and it
17 actually showed that marijuana use on glucose
18 insulin and insulin resistance in U.S. adults
19 showed, and this blew my mind, it actually showed
20 an improvement in hemoglobin A1C's and fasting
21 insulin.

22 And this goes directly against what I
23 said at the first meeting. I thought you would
24 get the munchies and your sugars would go out of

1 control, but that apparently is not the case.
2 The thing is, then I read the cons. And in
3 Hogendorg, the spelling, I'll just,
4 H-o-g-e-n-d-o-r-g, et al., they found that in
5 Type I diabetic teenagers in Poland who were
6 surveyed, okay.

7 This is like, just like your peer group,
8 Miss Zala, is that they found that they had
9 poorer diabetes control. Now, this is all self
10 report. But the kids who were serving with Type
11 I diabetes, we're comparing apples to apples
12 here, they did worse.

13 Now, these were kids who were using in an
14 illicit way and not with wonderful surveillance
15 and monitoring, and they were using full spectrum
16 cannabis.

17 So what the Petitioner, that this
18 petition asked, is to provide full spectrum
19 cannabis, not just CBD which you can get from
20 hemp oil, and it is legal over the counter.

21 The part I have as a clinician, I'm
22 having trouble leaping to letting the whole
23 enchilada be allowed in terms of that. So I know
24 you can get more CBD in the cannabis that's

1 available, but it opens, it opens the door, and
2 that's where my discomfort level comes. That if
3 there is hemp oil available I want to see more
4 research that shows, because that's the only
5 human data I could find on diabetes.

6 And because there are treatments, I know
7 you brought the huge bag of medications and they
8 haven't, you know, served well. They, this is a
9 bigger deal to add this to diabetes. So I
10 thought that it was very interesting to see that
11 the data is compelling to me so far.

12 Okay. But the cause and effect
13 relationship is what gets me, is that we, we
14 can't tell what diabetes, what cannabis is doing
15 exactly with diabetes.

16 It's too early to say and I'm reluctant
17 to pass the petition right now with the evidence
18 that we have. And, remember, I said in the
19 beginning that we must balance the science with
20 the art of medicine with our compassion.

21 So I have to call that out. Diabetes
22 therapy has many options. There's hemp oil,
23 which is available over-the-counter. It's not
24 like there is anything, we already see data that

1 it's working. And so when you open up the
2 ability for patients to get full blown, full
3 spectrum cannabis, we cannot control whether
4 they're getting full THC or getting CBD only. So
5 I know we closed our comments for the --

6 MS. ZALA: I just wish I could answer
7 that question for you. Because I'm a dispensary
8 agent at a dispensary in Illinois, I have the
9 experience and knowledge to stand before whole
10 plant cannabis as a medical alternative. With
11 the CBD alone it does anti-inflammatory,
12 antioxidant. It does certain things.

13 But with whole cannabis extract just in
14 oil form rather than in bud form, we have the
15 ability to use all cannabinoids. CBN, CBG, all
16 that have beneficial therapeutic benefits for the
17 endocannabinoid system in a child.

18 And I'm not asking for large quantities.
19 I'm asking for extremely, extremely minor, very
20 small amounts of THC just to, just to create some
21 apoptosis in her body so that there is cell
22 communication and cell regeneration.

23 If I, if we can't get to the cell level
24 to take out inflammation, we can't get to the

1 cell level to take out pain or to control blood
2 sugars. So there are options and I have seen, I
3 have seen it with my own eyes. Every single day.
4 I see testimony every single day in our
5 dispensary.

6 MS. TEMPLE: Thank you.

7 MS. ZALA: Thank you.

8 MS. TEMPLE: And so just out of fairness
9 for the rest of those who only get three minutes,
10 I really, we have to draw the line there. So
11 thank you. And that should be, with that, we
12 have Feliza Castro who actually is here to give
13 her testimony, and then we'll resume our
14 conference agenda.

15 MS. CASTRO: Yes. Hi. Thank you so
16 much.

17 MS. TEMPLE: And if you would like to
18 come up to the podium, please state your full
19 name and spell it for the court reporter.

20 MS. CASTRO: Hi. My full name is
21 Feliza --

22 MS. MOODY: Feliza, you'll need to turn
23 the power on switch, please.

24 MS. CASTRO: Okay.

1 MS. MOODY: Thank you.

2 MS. CASTRO: Hi. My name is Feliza
3 Castro, and I am the owner of The Healing Clinic,
4 and I --

5 MS. MOODY: Spell your name, please.

6 MS. CASTRO: My name is spelled F, like
7 family, e-l-i-z-a. My last name is Castro,
8 C-a-s-t-r-o. I own an advocacy center for
9 medical cannabis patients. Speak louder?

10 MS. MOODY: Hold the microphone.

11 MS. CASTRO: Okay. Is that better?

12 MS. MOODY: Sorry, we have some
13 limitations with our older phones.

14 MS. CASTRO: That's okay. We hear from
15 patients at our advocacy centers. We have one in
16 Chicago and we have one in Highland Park, and we
17 hear from patients all of the time that could
18 benefit from medical cannabis but can't because
19 their conditions are excluded from the Program.

20 I feel as though diabetes is one of them.
21 I am here to actually speak on behalf of the
22 patient who's turned in testimony. If it's all
23 right with members of the Board, I would like to
24 read the testimony on behalf of this patient. It

1 says: My daughter and I have been suffering
2 together for far too long. I'm a little nervous.

3 MS. TEMPLE: You might get a little cue
4 too when you're out of time, so you get --

5 MS. CASTRO: I got it. My daughter and I
6 have been suffering together for far too long. I
7 have crippling neuropathy caused by my diabetes,
8 which until recently was entirely uncontrolled.
9 On a normal day I could not keep my blood sugar
10 above 50 and had absolutely no appetite.

11 It's a vicious and dangerous cycle to
12 fall into. At one point I lost five pounds in
13 two days. My daily life is a constant struggle.
14 Just last Friday I got sugar up to 225 for the
15 first time in weeks, and then immediately it
16 started to downfall.

17 Every part of my body started to hurt and
18 my muscles felt like they were deteriorating.
19 When this happens my extremities go numb and I
20 can't hold things or walk. It feels as though my
21 palms are on fire, and every moment, every
22 movement causes shooting pains.

23 Amber, my 18-year old daughter, is far
24 too young to have to put up with the amount of

1 pain she has every day. Also a diabetic, I see
2 this illness getting worse for her, just like it
3 did for me at her age. Not only is she beginning
4 to suffer with diabetes neuropathy, but she has
5 crippling PTSD, which prevents her from leading a
6 normal, teen-aged life.

7 And her flashbacks are getting more and
8 more frequent during they day, and her night
9 terrors have prevented her from getting regular
10 sleep on day's end. Amber, too, cannot work or
11 go to school.

12 With both of us being so mentally and
13 physically unwell, we are always financially
14 strapped and at risk of losing the roof over our
15 heads. We cannot afford to suffer like this any
16 longer.

17 A friend suggested that we both try using
18 medical cannabis to ease our pains, and I started
19 to regain hope. The difference was night and day
20 for both me and Amber. Our appetites finally
21 returned, and we were cooking together for the
22 first time.

23 The numbness and tingling in my hands and
24 feet disappeared, and I finally get around the

1 house on my own. I could actually walk. I felt
2 truly happy for the first time in years. Amber
3 was also incredibly relaxed and didn't have any
4 flashbacks for days, which brought tears to a
5 mother who hasn't seen her baby (inaudible) for
6 far too long.

7 It would mean the world to us to be able
8 to have safe and regulated cannabis at our
9 disposal. I cannot stress enough how much my
10 outlook improved when I use marijuana medically.
11 I do not want to put me and my daughter at legal
12 risk to get this relief any longer. Please
13 expand access so that people like us who try
14 cannabis ease our suffering. Is that really so
15 criminal?

16 MS. MOODY: Thank you very much for your
17 testimony.

18 MS. WEATHERS: I have a question for you.
19 I'm sorry, to clarify, and I don't know if you'll
20 know the answer. The patient and her daughter,
21 were they, do they have Type I or Type II
22 diabetes?

23 MS. CASTRO: She did not specify. In her
24 testimony she did not specify. And this is all

1 she has authorized me to share.

2 MS. TEMPLE: Thank you very much.

3 MS. CASTRO: You're very welcome.

4 MS. TEMPLE: Comments from the Board?

5 MS. CASTRO: Thank you for having me.

6 MS. WEATHERS: Will you turn off your

7 mic?

8 MS. CASTRO: Sure.

9 MS. TEMPLE: Yes, Theresa.

10 MS. MILLER: One of my concerns, I have
11 two. The first concerns the use of cannabis in
12 developing brains. Young people. There's lots
13 of evidence out there that indicates the impact
14 on adolescents and developing and brain function
15 in young children. That would be my first
16 concern.

17 The second concern I have is with the
18 petition. The support letter was written by a
19 Certified Nursing Assistant, and that is actually
20 out of their scope of practice. So I'm not
21 really sure what treatments that this Certified
22 Nursing Assistant is providing, but it is out of
23 their scope of practice when you look at the
24 Illinois Nursing Practice Act.

1 MS. WEATHERS: And the point, oh, I'm
2 sorry. Is that sufficient as a
3 provider-supported letter?

4 MS. MOODY: So we did, the Department
5 did, the Department did consider that because we
6 do request in our resumes a letter of support
7 from a certifying physician if the person
8 submitting the petition is a patient. A
9 qualifying patient or a registered patient.

10 In this case we decided to be sympathetic
11 and allow the petition to proceed to the Board
12 for consideration because we had no indication
13 whether the individual was a registered patient
14 or not.

15 MS. WEATHERS: Got it. Thank you.

16 MR. MCCURDY: Can I make a comment? I
17 guess this would be a question to Theresa about,
18 and really to anybody who would be knowledgeable
19 about this. The effects of cannabis on the
20 developing brain I think are typically what we
21 hear about with regard to recreational use.

22 My question is, would doses of cannabis
23 at the legal limit allowed under the current law
24 have the same effect, or is that actually at a

1 lower level than you might expect than people who
2 are using it recreationally?

3 MR. FINE: I have the same question. And
4 to follow up with that, and correct me if I'm
5 wrong, but if these are children under the age of
6 18, their access is limited to the oils and some
7 of the other products, but not the flower. So
8 it's the CBD oils as well as the oils.

9 So in this specific case this young lady
10 wouldn't be able to get access to flower, to the
11 actual cannabis plant. It would be the oils.
12 Please correct me if I'm wrong.

13 MS. MILLER: They still have the THC in
14 this. So with lower levels there is a lower risk
15 of, from what I've read, a lower risk of that
16 cognitive impairment, but the research still
17 isn't out there conclusive.

18 MS. TEMPLE: Other comments?

19 MR. RAMIREZ: The problem that I see is
20 that we talk about cannabis and we talk about
21 cannabis generically. There are four or five
22 different super duper active compounds, and
23 there's about 111 other phytocannabinoids present
24 in cannabis, and 80 of the substances that are

1 there are only present in cannabis. So cannabis
2 is a huge variety of things, and you can do like
3 you do with corn and do like you do with peas,
4 you can cultivate it and genetically alter it so
5 it only produces certain kinds of substances. In
6 Colorado this has become a science.

7 There are people that study this and can
8 produce strains of cannabis that have almost no
9 THC. There are others that have very high THCD,
10 which is an appetite suppressant and has very
11 much use. But this, with high THC it would not
12 be good in cancer or AIDS because you want to
13 stimulate the appetite.

14 So they want the part that stimulates the
15 appetite. So we cannot generalize the word
16 cannabis to all kinds of things. And I agree
17 with Theresa that the ones that have the most THC
18 are the ones that are more psychoactive, and the
19 ones that produce more problems for brain
20 development.

21 But right now there are botanists
22 devoting their full lifetime to creating strains
23 that have very specific actions. And that's
24 where medical research is going to come in. The

1 advantage of all this is that on April 21st the
2 DA turned its face around and said that yes, they
3 were going to allow research on smoking marijuana
4 as legitimate medical use. So then we're
5 standing in front of four or five years of
6 tremendous findings, tremendous evidence, and
7 tremendous proof of some of the things people
8 say.

9 (Applause.)

10 MS. TEMPLE: Actually, Nestor, as a
11 pediatric, you know, I wonder, I'd love to hear
12 your comments too, Dr. Christoff. That there is,
13 like, as I said, I really went through the
14 evidence base and found that there's a plausible
15 mechanism of action, not from a pain management
16 perspective but from an altering of the immune
17 system.

18 But then we're charged as a Board to
19 decide if we're going to open up the whole thing,
20 the whole, and I know Michael brings up a great
21 point. Kids aren't going to be getting marijuana
22 they smoke, they can only get oils. It will be
23 strictly under the supervision. You need two
24 physicians to sign off on this.

1 MR. FINE: Until they're 18.

2 MS. TEMPLE: Until they're about, until
3 they're 18 and they're able. But we also have to
4 speak to, well, first of all, the evidence base,
5 there's one that was not included in the petition
6 where it really was lifetime and is 12 months'
7 use of cannabis, and I'm quoting this, were
8 associated with poorer glycemic control, which is
9 hemoglobin A1C. Those numbers going over 8%.

10 And adolescents with diabetes Type I
11 reported using illicit drugs, and they did
12 specify cannabis to a lesser extent. So the
13 folks who were using, who had Diabetes Type I in
14 this Polish study, did not use recreational drugs
15 as much as their peers.

16 But those who did use it, the use of
17 cannabis was associated with poorer metabolic
18 control in teens with diabetes Type I. And this
19 is clearly not the case in Miss Zala. But we are
20 also opening this up to the rest of the world.
21 Okay?

22 This is what's tricky about the
23 compassionate use is when we say okay, we are now
24 allowing it for all, we have to understand what

1 the public health impact of that would be when we
2 have a study that really flies in the face of it.
3 This was a study of not 10 kids. This is 209
4 adolescents with diabetes Type I, which again I
5 emphasize is very different from II.

6 These were age 15 to 18 years old
7 compared to 12,000 of their non-diabetic peers.
8 So when I read that, that gave me a lot of pause.
9 I would hate to potentially cause more problems
10 without a really, really solid evidence base I
11 want to see in this particular condition because
12 I want to see it.

13 Because there are no other states that
14 have Diabetes Mellitus Type I or II in any of
15 their Pilot Acts. In any of their Compassionate
16 Use Acts. So we're asking to be a front runner
17 in that, and that is going to take a lot more
18 evidence base than we have here to be the first
19 state to pass it.

20 So I just want you to keep in mind, there
21 aren't like five other places that are doing
22 this. This is a new thing. Yes.

23 MR. KNAUS: Can I just ask you a quick
24 question? Maybe clarification. It seems like if

1 we're charged with compassionate use, it seems
2 like we're burdening any of those decisions by
3 this need for this evidence-based medicine which
4 just doesn't exist. If we were charged with
5 medical or evidence-based approval of these
6 medical conditions with use of CBD or THC, that's
7 one thing.

8 But it seems like we're charged with
9 compassionate use, yet we're basing all our
10 decisions on medical evidence that can go either
11 way or vice versa. I think it's going to impair
12 our decision making if we're structuring our
13 compassionate approval based on medical evidence.

14 MS. TEMPLE: And this was discussed in
15 our first two meetings.

16 MS. WEATHERS: Can I, yeah, I'd like to
17 respond to that. I feel that's something that
18 I've certainly struggled with. And I think we've
19 done a really good job here is balance that. So,
20 and I, you know, a little self-congratulatory,
21 but I feel as a committee we have to very, very
22 carefully consider that for each petition before
23 us, over a year and a half now I guess that we've
24 been doing this. And I feel that there's, I

1 recognize when there's not sufficient evidence,
2 and I try not to hold that against the petition.
3 I think my concern in this case is that, you
4 know, I actually do have evidence based that this
5 could be detrimental to patients.

6 Maybe, you know, the several case reports
7 of masking of DKA, which could result in a
8 fatality. So there's not only just a lack of
9 evidence, it's actually the peer reviewed PubMed
10 evidence against it that in this case has given
11 me pause.

12 MR. KNAUS: Do you prescribe
13 medications --

14 MS. WEATHERS: Yes.

15 MR. KNAUS: -- with the awful side
16 effects?

17 MR. CHAMPION: I was going to say one of
18 the, one of the other medications that you no
19 longer take, what are the side effects of those?

20 MS. WEATHERS: But see --

21 MR. CHAMPION: And by decreasing those
22 and, you know, I mean, we're left with a, you
23 know, it is cannabis. It does less harm than
24 that bag of medicine that she presented in front

1 of the Board. Also, like Nestor said, there are
2 strains that control the appetite, and we have to
3 put some reliance in our doctors to prescribe it
4 only to those who they feel would need it and
5 they would need two doctors.

6 MR. RAMIREZ: A question on that research
7 you read. It said where teens were using illegal
8 marijuana?

9 MS. TEMPLE: Yeah, they were using it
10 recreationally.

11 MR. RAMIREZ: Illegal?

12 MS. TEMPLE: Illegally.

13 MR. RAMIREZ: Illegal, but on the street?

14 MS. TEMPLE: Yep. Yep.

15 MR. RAMIREZ: Because most of the street
16 strains are indica strains, and the indica
17 strains as opposed to the sativa strains are very
18 low in THC.

19 (Applause.)

20 So most of the street strains have a lot
21 of indica which has a lot of THC and not enough
22 THCV, so the effects are going to be totally
23 different. There are strains of, with high THC.
24 For example, there's one called Doug's Varin

1 which has a THC/THCV ratio of six to seven. So
2 it's actually more THC than THCV. So, you know,
3 I think that we've got to realize that we're not
4 dealing with pot is pot is pot. No. We've got
5 to think that some of the research has been done
6 indiscriminately is like saying okay, we're going
7 to give you carbonated soft drinks. What the
8 hell does that mean?

9 We're going to give you Diet Coke, Diet
10 Pepsi, Dr. Pepper, what are we going to give you?
11 So we can't just say pot is pot is pot. I think
12 we've got to start demanding of our medical
13 community when they start doing research now to
14 really clarify what strain, what concentrations
15 of products they have, and what the effects of
16 each of those products are. Otherwise, we're
17 going to be --

18 MR. FINE: In that regard to all of the
19 physicians on this Board, is this something that
20 you would feel comfortable with based on the
21 personal relationship that you've established
22 with your patients to monitor?

23 I mean, obviously in the context with
24 children under the age of 18, the only thing that

1 they have access to, you know, are the oils and
2 some of the other products as well. Is it
3 something as doctors that you feel comfortable
4 monitoring? I know you don't have the control of
5 what they can buy in the dispensary after they're
6 18, but up until that point is it a monitoring,
7 you know, capacity that you feel comfortable, you
8 know, undertaking?

9 MR. CHRISTOFF: Well, I'm not a
10 pediatrician, but I manage adults with Type I
11 diabetes, so I would answer yes to your question.
12 Allison, were there actually deaths from DKA, or
13 just ICU admissions where this was covered up?

14 MS. WEATHERS: It was, it looked like ICU
15 admissions but, I mean, it can --

16 MR. CHRISTOFF: Like how many of these
17 were, it looks like a case report?

18 MS. WEATHERS: Yeah. I mean, that's what
19 I'm saying. There's not many --

20 MR. CHRISTOFF: There were --

21 MS. WEATHERS: But there's growing
22 evidence that --

23 MR. CHRISTOFF: -- a few reports?

24 MS. WEATHERS: Yeah.

1 MR. CHRISTOFF: Like they didn't notice
2 because this was covering up their, --

3 MS. WEATHERS: Yeah. Because --

4 MR. CHRISTOFF: -- you know --

5 MS. WEATHERS: -- change, yeah. With
6 respect to acid base, so it impacted the acid
7 base balance. When they presented the usual
8 markers to diagnose it, it altered it. It's not
9 like that because of the drug they didn't present
10 in time. It's that once at presentation it
11 masked the usual labs that led to a delay in
12 diagnosis.

13 MR. CHRISTOFF: So what is her hemoglobin
14 A1C?

15 MS. ZALA: Her A1C as of April 29th,
16 which was this Friday that passed, was 8.8.

17 MR. CHRISTOFF: And what was it the time
18 before?

19 MS. ZALA: 17.

20 MR. CHRISTOFF: Oh.

21 MS. ZALA: Off the charts.

22 MS. TEMPLE: Connie, did you have
23 something you wanted to say?

24 MS. MOODY: Yes. I just, I just wanted

1 to read from the Medical Cannabis Registry
2 Program rules to remind the Board about what
3 needs to happen after this hearing as you make a
4 recommendation to the Department, and that may
5 help answer some of your questions in terms of
6 consideration.

7 Our rules in, let me find the correct
8 section reference here. Bear with me just a
9 moment. This is Section 946.30, addition of
10 debilitating medical conditions. And section L
11 states: Upon final determination, the Advisory
12 Board shall provide the Director a written Report
13 of Findings recommending either the approval or
14 denial of the Petitioner's request.

15 The written Report of Findings shall
16 include a medical justification for the
17 recommendation based upon the individual or
18 collective expertise of the Advisory Board.

19 The medical justification shall delineate
20 between the Findings of Fact made by the Advisory
21 Board and scientific conclusion of evidence based
22 medical research. I don't know if that's helpful
23 to answer the questions that have been raised
24 about what should be considered as part of this

1 decision made by the Board.

2 MR. MCCURDY: Well, clearly we've been
3 talking about both, that's for sure.

4 MS. TEMPLE: Just on another note since
5 we are talking about diabetes, there's data on
6 diabetes Type II in Penner, P-e-n-n-e-r, et al.,
7 that talked about, which I thought had the most
8 teeth with respect to diabetes in favor of.

9 And remember, I do get it that we're
10 talking about physician/patient relationship. I
11 get that. At the same time when we, when we pass
12 the recommendations at the end our letter goes
13 to, and all of the proceedings, goes to Dr. Nirav
14 Shah, who is the Medical Director of IDPH, and he
15 goes through and he actually does his own
16 literature review of all of this.

17 So I want you to know that without
18 attending here, without the added human element,
19 that the people who are not in this room are the
20 physicians who would never even hear about this.
21 I actually, you know, I hate to say, but I read
22 some conditions out to some of my colleagues and
23 I got like no ways, no way.

24 So the burden on this group is to provide

1 overwhelmingly, I mean, not overwhelmingly,
2 decent, good evidence that this may not be the
3 time. And don't say, you know, today just
4 because you don't get what you want, we've
5 learned we don't get everything that we want on
6 this Board anyway, several times over.

7 So don't despair because, you know, we
8 don't even know where a lot of these
9 recommendations will go, but know that there is a
10 compelling evidence base that this is a bigger,
11 this is a bigger deal to pass diabetes.

12 And the fact that you have hemp oil out
13 there and you're already making an impact doesn't
14 mean that folks are left high and dry. I just
15 want you folks to know that, that we have the
16 burden of, we can't just use compassion. We do
17 use it when we passed conditions that have zero
18 evidence. Zero.

19 But then those conditions may have zero
20 treatment options other than using cannabis.
21 Diabetes is complex. We even had, yeah. I mean,
22 we can talk all day about how we don't have a
23 great evidence base for everything we do in
24 conventional medicine, but that's for another

1 day, that today we need to consider what the
2 impact of this will be, and that there are, there
3 is evidence for it, but there's also evidence
4 against. This is what's going to be one of the
5 most challenging votes for this Board because of
6 that. So are there any other comments before
7 from the Board before we --

8 MR. MCCURDY: Move to approve.

9 MS. TEMPLE: Okay. Approved. Those in
10 favor?

11 (Board responded aye.)

12 MS. TEMPLE: So if the Board would get
13 out their paper ballots.

14 MS. MOODY: In your blue packet you have
15 green paper ballots, one for each of the
16 conditions that you'll be considering today. You
17 may mark either yay or nay, and I will collect
18 those and tally those.

19 MR. RAMIREZ: Now, when we're voting on
20 this we're voting on --

21 MS. TEMPLE: Wait. We have a question on
22 the floor.

23 MR. RAMIREZ: When we're voting on this
24 we're voting on conditions for patients that are

1 over 18 years of age?

2 MS. TEMPLE: No, this is for everybody.

3 MR. RAMIREZ: For everybody.

4 MS. MOODY: No, for everyone.

5 MR. RAMIREZ: The law says that we only
6 do it for people over 18.

7 MS. TEMPLE: No, it's for everyone.

8 MR. RAMIREZ: It had over 18 for one
9 specific condition but not generalized?

10 MS. MOODY: We have, the way that our
11 rules read at this point in time is that any of
12 the list of debilitating conditions that are
13 currently approved for the program are open for
14 both, for individuals of all ages.

15 MR. RAMIREZ: On the current list?

16 MS. MOODY: On the current list, yes.

17 MR. RAMIREZ: But otherwise?

18 MS. MOODY: The way that our, again, our
19 rules read, is that any action, any
20 recommendations the Board takes would allow that
21 condition to be open to any person of any age.

22 MR. FINE: They're regulated the same
23 way. Two physicians and, --

24 MS. MOODY: Yes.

1 MR. FINE: -- you know.

2 MS. TEMPLE: This is for Diabetes
3 Mellitus Type I, so it doesn't say that on the
4 ballot but it's diabetes Type I. This might be a
5 nice time if people need to take a break because
6 it takes a few minutes to tally.

7 (Break taken at this time.)

8 MS. TEMPLE: Okay. I wanted to announce
9 that the condition of Diabetes Mellitus Type I
10 passed with a vote of five yay, four nay. All
11 right. We're still waiting for Nestor who's also
12 on his break, and panic disorders is next.

13 We can maybe queue up the next speaker.
14 When Mr. Ramirez comes back in the room we'll
15 have Feliza Castro speak again. So just give him
16 a little moment here.

17 We're going to go ahead and get started
18 now. Shifting gears to panic disorder. Okay.
19 And we have petitioner Feliza Castro who will
20 come to the podium for her three-minute
21 discussion.

22 MS. CASTRO: Hi. Thanks again. I'm
23 going to read testimony on behalf of a patient
24 who wanted to speak anonymously. Hi. I, myself,

1 also suffered from anxiety disorder, and I can
2 say that medical cannabis helps me a lot
3 personally. But I'll read this testimony. I'm a
4 28 year old woman from Chicago, and before
5 medical cannabis you wouldn't have seen or heard
6 from me because I'm agoraphobic.

7 MS. MOODY: Would you slow down, please?

8 MS. CASTRO: Sure. Before medical
9 cannabis you wouldn't have seen or heard from me
10 because I am agoraphobic. The widespread panic
11 that washes over me is enough to make me cringe
12 at the thought of going out and seeing people.
13 It's easier in many instances to disregard the
14 thought all together and to sit at home.

15 It's embarrassing. I'm a grown woman and
16 it's hard for me to leave the house. When I was
17 approved for my medical cannabis card for
18 rheumatoid arthritis and fibromyalgia, my life
19 changed in every possible way.

20 Not only could I almost eliminate the
21 chronic pain I experienced on a daily basis, but
22 for the first time ever I didn't need to take a
23 Valium or tranquilizers just to be at social
24 gatherings. I was able to leave the house.

1 Cannabis alone has brought a whole new lease on
2 my existence. I haven't had a panic attack in
3 almost six months. I haven't hyperventilated or
4 cried at a single public function since I started
5 this regimen.

6 I haven't had to miss out on one of the
7 most precious parts of life because of crippling
8 anxiety. Medicinal marijuana has improved my
9 ability to be a good friend, partner, caregiver,
10 and overall has made me a healthier person.

11 In all honesty, I hate that I require
12 anything to do what a normal person sans anxiety
13 and panic does on a daily basis, but this is the
14 first alternative I've ever tried that has given
15 me hope.

16 Every day is a little bit better because
17 of this medicine. Thank you. I'd also like to
18 point out that cannabis is much less addictive
19 than Benzodiazepines, which are often prescribed
20 for panic disorders and anxiety.

21 There are also studies on this by a Dr.
22 Irit Akirav, who is published in 39 different
23 studies. She's an expert in biological
24 psychology, and she published one study entitled

1 Cannabinoids Prevent the Development of
2 Behavioral and Endocrine Alterations in a Rat
3 Model of Intense Stress. That's it. Thank you.

4 MS. TEMPLE: Thank you. Comments from
5 the Board regarding panic disorders?

6 MS. WEATHERS: So I know in the past that
7 we have not approved anxiety. I personally am
8 more comfortable with this one because of the
9 specificity of the nature of the condition. As I
10 was saying, from a medical standpoint I'm more
11 comfortable because of the specificity of this
12 condition and the difficult nature to treat
13 conventionally.

14 So to me, getting down to this kind of
15 level of granularity, it makes more sense I think
16 to approve it.

17 MR. CHAMPION: I don't need a mic.

18 MR. FINE: Oh, I'm sorry.

19 MS. WEATHERS: Jim.

20 MR. CHAMPION: Go ahead, you go first.

21 MR. FINE: I agree from the --

22 MS. WEATHERS: No, go ahead.

23 MR. FINE: I tend to agree from the
24 standpoint of specificity as we do not approve

1 general anxiety as a, I think the degree of pain
2 threshold that we had looked at to qualify
3 things. This, you know, panic disorders I would,
4 you know, lump in the same category as PTSD
5 because it's chronic and specific and much more
6 intense than a general anxiety disorder.

7 MS. TEMPLE: Go ahead.

8 MR. CHAMPION: I was just going to say
9 due to the nature of this condition and the
10 medications that are prescribed to control this,
11 I can certainly see how cannabis would be
12 helpful.

13 Most, most strains of cannabis give the
14 user a relaxed and euphoric state, which would
15 certainly be beneficial for this diagnosis. I
16 know that when I'm stressed out and wound up,
17 cannabis provides me with instant and
18 unparalleled relief.

19 It's an instant relaxer, mood stabilizer.
20 So I believe that's why some people get the
21 false, the false sense that they're addicted to
22 it. They're not really addicted to it, they just
23 like the relaxing feeling that they achieve from
24 it.

1 MS. TEMPLE: I wanted to also clarify and
2 just go over some definitions, that what's the
3 difference between a panic attack and panic
4 disorder, plus the whole spectrum of anxiety
5 disorders, because at the first petition hearing
6 we were asked to pass anxiety, which was just way
7 too broad. It covers so many, of course, we
8 understand it's supposed to be debilitating
9 anxiety.

10 But when we get into the specifics, I
11 looked into the literature regarding panic
12 disorders and I didn't find anything, but I found
13 social anxiety disorder responded well to
14 cannabidiol, back to the CBD only, that people
15 who used higher amounts of THC had more anxiety
16 than those who used a strain that had less THC in
17 it or all CBD.

18 So we're back to, you know, that
19 conversation, which I think happens at the
20 dispensary with the patient and the staff worker
21 figuring out what's the best strain for you. So
22 that education needs to be out there, that the
23 higher the THC is, the greater the anxiety can
24 be. A panic attack is classically present with

1 spontaneous, discreet episodes of intense fear
2 that begins abruptly and lasts for several
3 minutes to an hour. In panic disorder, patients
4 experience recurrent panic attacks, at least some
5 of which are not triggered or expected, and
6 there's about a month or more of either worry
7 about future attacks or consequences or a
8 significant maladaptive change in behavior
9 related to the attacks to avoid future panic
10 attacks.

11 So there's a lot of avoidance of
12 potential triggering circumstances, and these
13 folks tend to just lock up. Panic disorder, we
14 have to keep in mind that the disturbance must
15 also not be from a physical condition from using
16 a medication.

17 And it can't be from a condition like
18 hypothyroidism, and that the disturbance can't be
19 better explained by another mental disorder like
20 social anxiety disorder, specific phobias,
21 obsessive-compulsive disorder, or PTSD, or
22 separation anxiety disorder.

23 So I just described for you a whole realm
24 of sub types of anxiety that we as physicians,

1 when we write our, and evaluate people for, we
2 have to really categorize those things. So what
3 the petition asks for is panic disorder. And
4 when I looked at the evidence base I thought to
5 myself well, okay, am I going to pull that, the
6 strict scientific card, or do we make a little
7 bit of a leap.

8 And panic attacks to me are a more severe
9 case of anxiety. Even though social anxiety
10 Disorder, which is by definition a marked
11 persistent fear of social circumstances, of
12 unfamiliar people or possible scrutiny by others,
13 which sometimes I have at this meeting.

14 But the exposure typically promotes
15 anxiety. The patient usually recognizes their
16 anxiety or fear as excessive, and a patient tends
17 to avoid peer situations or public speaking.

18 So that's social anxiety, and that was
19 studied by Bergamaschi and Crippa. I'll spell
20 it. B-e-r-g-a-m-a-s-c-h-i. And Crippa,
21 C-r-i-p-p-a. And they talked exclusively about
22 cannabidiol in these studies. They used it in
23 humans.

24 600 grams of CBD seemed to work best in

1 social phobia, public speaking anxiety, amongst
2 the human participants. They also found that
3 higher doses of THC created more anxiety than the
4 lower dose THC. Another important educational
5 pearl.

6 Now, do we make this leap since social
7 anxiety disorder is different from panic disorder
8 and consider that as sort of a confluence of
9 syndromes? Because we did pass PTSD, which is
10 also part of the anxiety disorder spectrum.
11 Also, PTSD is a very granular, specific
12 diagnosis.

13 And for that reason I am interested to
14 hear what the rest of the Board says about panic
15 disorder, knowing that the evidence base is as it
16 is. And if anyone has anything that I missed,
17 please say so.

18 MR. MCCURDY: With the usual disclaimer
19 that, of course, I'm not a physician or any other
20 clinical practitioner, I guess I would say that
21 the leap of inference that Leslie described seems
22 to me to be a much smaller one than we would have
23 had with some other things. There's enough
24 evidence in the neighborhood that I would support

1 this.

2 MR. CHRISTOFF: I would just say the
3 opportunity to use this instead of a
4 benzodiazepine would always be a welcome option
5 to consider if we had it available, because
6 benzodiazepines tend to be very alluring and
7 highly addictive and very much a problem to
8 maintain the program when people do get to a
9 better place.

10 So having the option instead of just
11 putting somebody in four times a day on Xanax is,
12 would be very useful.

13 MS. MILLER: I would just like to add as
14 well in doing my own research as well, Leslie, I
15 found that a lot of the research was focused on
16 social anxiety. And so, again, I too had to look
17 at do I make that leap. And I think it is less
18 of a leap, and in hearing the description it
19 really is more social anxiety than a panic, so.

20 MS. TEMPLE: I did want to throw in one
21 little negative study I found. Not little,
22 actually pretty big, that gave me pause, which
23 is why I said I want to hear what the rest of the
24 Board has to say. And that's Lev-Ran, et al,

1 meaning et cetera, they found that quality of
2 life in surveys given to people who are using
3 cannabis who had anxiety disorders actually
4 expressed poorer self reported mental health
5 outcomes, which I found interesting.

6 I found that they discovered this in the
7 patients they surveyed with depression or
8 dysthymia, which will also be discussed today,
9 that those who used it more heavily, meaning more
10 than once a week, so that's heavy. The
11 occasional users were once in awhile, and then
12 there's the never users.

13 So if we had to categorize, again,
14 another educational pearl, those who use it more
15 frequently didn't do as well. And this is then
16 where the chicken and the egg discussion comes.
17 Was it because of the cannabis use that made them
18 worse, or is it because they already had come in
19 with a higher baseline of anxiety that required
20 more, more medication, and so they were going to
21 be, they tended to report poorer mental health
22 outcomes.

23 And when we talk about quality of life
24 data, this is a huge area in the research

1 literature that looks at energy, sleep, function,
2 happiness, pain. It covers the whole thing that
3 you would think a quality of life survey would
4 be. It's mental and emotional.

5 And so that has been quantified very,
6 very well in the QOL, quality of life, research
7 community. So this was actually a very well done
8 study. And we also have to call to mind that
9 using it more heavily also poses a potential
10 risk. So we have to be mindful of all the
11 potential.

12 MS. WEATHERS: Was that, were you asking
13 about the study?

14 MR. MCCURDY: I was going to ask --

15 MS. WEATHERS: Okay.

16 MR. MCCURDY: -- about it. So the use,
17 level of use that you found, that they found in
18 the study, how, you know, is there any way that
19 you could compare that to what we would expect
20 with people who are able to receive only the
21 certified amount --

22 MS. TEMPLE: No.

23 MR. MCCURDY: -- through medical
24 cannabis? I mean, that sort of recreational use

1 sounds like it's sort of cooked into it, that
2 it's going to be more --

3 MS. WEATHERS: Well, was it a
4 recreational study or was it --

5 MS. TEMPLE: Well, everyone in here is
6 going to be recreational because they're all
7 self-reported. I'm assuming these are, it did
8 not specify this is a medical marijuana study.

9 MS. WEATHERS: Okay. Yeah. That's why I
10 didn't know where the study originated or what.

11 MS. TEMPLE: Which also speaks to Dr.
12 Ramirez's point about this is cannabis from the
13 street, it's different, and so you're going to
14 get different responses. Yet this is what we've
15 got. We have to work with what we have,
16 recognizing the differences.

17 So that's the one thing that gave me
18 pause, and that's why I wanted to hear from the
19 Board, that we have to recognize that cannabis
20 does have its risks, and acknowledge that.

21 But I think in the properly vetted
22 patient/physician relationship that can be
23 determined. I'm not a big fan of
24 benzodiazepines. I'm not a big fan of certain

1 pharmaceutical medication that in my particular
2 patient is not working and we're creating side
3 effects that mimic the worst side effects of
4 cannabis, then, well, we should I think consider
5 opening this up as a treatment option for those
6 carefully selected patients.

7 MS. WEATHERS: I make a motion to vote.

8 MS. TEMPLE: Okay. So the Board will
9 fill out their ballots to vote on the condition
10 of panic disorder. So the vote for panic
11 disorder was nine in favor, zero against.

12 (Applause.)

13 MS. TEMPLE: Okay. I think we're making
14 good headway. We have the next condition of
15 dysthymic disorder, so we'll open it up to the
16 Board for discussion. And I might add that
17 dysthymia, from a definition standpoint, is major
18 depressive disorder.

19 MR. FINE: As somebody who has suffered
20 from a great deal of depression and anxiety and
21 was on so many different medications that I can't
22 begin to tell you a time in my life that caused
23 additional medications you prescribed for the
24 side effects in the original medications,

1 medications for the side effects for the side
2 effects. Anything that could help, you know, as
3 an additional weapon in your arsenal to deal with
4 that type of stuff that is not, you know, known
5 to be addictive and have a side effect of
6 suicide, is a welcome, you know, is a welcome
7 weapon to be added to the arsenal.

8 MR. MCCURDY: I probably should ask Dr.
9 Mendoza Temple for a point of clarification. I'm
10 reading the petition. The petition says it's
11 persistent depressive disorder, and it appears
12 that it's a fixture of sort of this lower level
13 depressive symptoms with some episodes of major
14 depression.

15 MS. TEMPLE: Yeah.

16 MR. MCCURDY: If I read it right.

17 MS. TEMPLE: Thank you for that
18 clarification. Yes.

19 MR. MCCURDY: So, and in my perspective
20 and so less severe, longer lasting, that's the
21 tradeoff. It's no fun in any way to do it, but
22 according to this, and assuming this is accurate.
23 So I guess the, that's, that's really the first
24 comment I would have.

1 MS. WEATHERS: I was going to say
2 initially, I think in reading through I did have
3 some concerns because, again, worrying are we
4 losing that appropriate level of specificity.
5 But I think going to Michael's point, that given
6 the duration and the difficulty in treatment,
7 that because of the nature of the disorder that
8 some people are very intractable to the
9 medication that we have, that I do think that
10 this is a reasonable one to approve.

11 MR. CHAMPION: I just want to say at the
12 beginning it says dysthymic disorder, and then at
13 the end they said please approve my petition for
14 panic disorder at the end, so I think --

15 MS. TEMPLE: You think they petitioned
16 twice? We don't have names. We don't get to see
17 the names of these petitioners, so it might have
18 been the same one.

19 MR. CHAMPION: And as I previously
20 stated, cannabis when you're stressed out and
21 wound up, provides excellent, instant relief, the
22 euphoria, all of that, which would be beneficial.

23 MR. MCCURDY: I don't want to hog the
24 mic, but does somebody else want to make a

1 comment?

2 MS. MILLER: I would prefer, one of the
3 notes I had written down was that in the petition
4 the petitioner cited that they stopped taking
5 their SSRI, and it was hard to determine whether
6 or not the cognitive strategies were actually
7 working or if they were doing the cognitive
8 strategies, which evidence shows do work for
9 depressive disorders.

10 And that he's still struggling with
11 anxiety. And so, I mean, we've already approved
12 anxiety so with the panic, it was panic, so.

13 MS. WEATHERS: Interestingly, we haven't
14 approved major depressive disorder.

15 MR. MCCURDY: That's what I wanted to --

16 MS. WEATHERS: Yeah. Sure.

17 MS. TEMPLE: I kind of don't know about
18 this one. It's, when I looked at depression, so
19 I'm being a stickler with the research and the
20 literature base to stay balanced as a Board, and
21 we went back to ask okay, this is a hard one to
22 say, A-s-p-s-i, et als.' Work, the title of the
23 article was Cannabis Use and Mental Health
24 Related Quality of Life Among Individuals With

1 Depressive Disorders, and they pointed out mixed
2 contradictory data about whether the quality of
3 life was better or worse for people with
4 depression and anxiety. So I had mentioned this
5 in the previous commentary about panic disorder.

6 And all the quality of life studies
7 looked at questionnaires regarding, one,
8 self-perceived mental and physical health, pain,
9 vitality, social functioning, and role
10 functioning.

11 And those who used cannabis and had
12 depression, so not anxiety and not panic, but
13 depression, reported poorer mental quality of
14 life if they used it every week or were
15 considered heavy users.

16 The occasional users of cannabis, which
17 is less than that obviously, was not associated
18 with lower quality of life when compared to
19 non-users.

20 So we can't say that the use of cannabis
21 caused, you know, the chicken versus the egg
22 story, the people who are using it more heavily,
23 are those folks having more severe issues with
24 their depression, or is cannabis causing it to

1 get worse? We have no data to show cause or
2 effect. Just know there's a relationship and
3 that's important. Especially from like, I think,
4 from a patient/dispensary point of view, because
5 its the dispensaries that are giving the advice
6 to our patients, and they should know this.

7 So I thought that was interesting. Now,
8 us as a Board, we can't say well, you can only
9 use, you can only mandate patients use it once a
10 week or less. You know, we can't do that. When
11 we pass something or we recommended to pass
12 something, it's for everyone.

13 And that's, the fact that I didn't see
14 specific depression oriented human trials leads
15 my inclination to be less favorable compared to
16 panic disorder where we did see some evidence
17 base for social anxiety, and I did make that
18 leap.

19 So there, I also want to call to mind
20 there was one article on depression, which was on
21 animal experiments, based by Saito, S-a-i-t-o, et
22 al., that was in favor of using cannabis in
23 depression. But it was, again, an early study.

24 I'd like to see more evidence developed

1 on this because this will cover, this is a pretty
2 prevalent disease, and we also have to be careful
3 about that. But I also understand that we are,
4 in a patient in front of us, and if the
5 medications have failed them, then it would be a
6 nice option.

7 So I'm, you know, that's where I'm at.
8 That's one I struggle with all the time as a
9 clinician. Thank you. So any other comments?

10 MR. CHAMPION: I was going to say this
11 might help some of the patients too that it does
12 make it a more difficult decision on the Board
13 when there's no one to testify for a condition.
14 So, just for future reference, it all, personal
15 testimony is always compelling and always helps,
16 or helps my vote, especially everyone's vote.

17 MR. MCCURDY: The other thing that struck
18 me was that, at least the literature that was
19 submitted with the petition, seemed to be the
20 same literature as was submitted with panic
21 disorder intended to address those issues rather
22 than this issue specific to dysthymic disorder,
23 if I read it right. So it's hard to gather any
24 real support from that angle from the --

1 MS. TEMPLE: That's why I looked, I
2 looked outside of that and I didn't find very
3 much. Okay. Any other comments before voting?

4 MR. FINE: Motion to vote.

5 MS. MILLER: Second.

6 MS. TEMPLE: So the vote for the
7 condition dysthymic disorder was yay three, nay
8 six. The condition does not pass. Any
9 questions? Okay. So next on the agenda is Lyme
10 disease, and we don't have any petitioners for
11 that condition, so we will open this conversation
12 up to the Board.

13 MS. MILLER: I was just concerned a
14 little bit with this petition. In looking at the
15 evidence that was attached to it, the, one of the
16 main articles that was specific to, most of the
17 articles were not related, but the one specific
18 to Lyme disease really had nothing to do with the
19 use of cannabis with it. It was just the
20 treatment of Lyme disease.

21 So it really didn't do anything to sway
22 me one way or the other. And when I looked on
23 PubMed and I looked at some of the other evidence
24 based search engines for cannabis use, there

1 were, there was no literature that I found
2 related to this particular disease process.

3 MS. WEATHERS: I agree. And I think the
4 point the Petitioner was trying to make was that
5 the existing treatments aren't efficacious, and I
6 certainly recognize that. I think, I had a, I
7 had a number of concerns. I think carefully
8 going through the petition, many of the symptoms
9 that they were raised could be classified as
10 their own conditions I think.

11 Chronic pain was mentioned. Fatigue,
12 PTSD I believe was there as well. And I think
13 that this is, so my concerns are one, I think
14 we're better fulfilling our duties as a Board and
15 helping patients, again, you've all heard me say
16 it multiple times, to get to the level of
17 specificity those individual conditions need to
18 be approved, and I think we evaluate those.

19 I think this is such a controversial
20 disease overall, chronic Lyme disease, I think
21 that there's substantial evidence that really
22 raises concern about this diagnosis itself in the
23 first place, and then the absolute lack of
24 evidence at all, so nobody's even tried it, and

1 as well as the fact that we have recommended for
2 approval some of the various conditions that were
3 looped in, I absolutely cannot support this.

4 MS. TEMPLE: So Lyme disease is a tic
5 borne disease and can cause joint pain,
6 neuropathy, and long-term, purported to create
7 chronic fatigue and all of the things that go
8 with it, depression, much of the conditions we've
9 discussed and symptoms thereof.

10 And even in the New England Journal of
11 Medicine, which is the big journal to be
12 published in, it couldn't even, they don't even
13 know how to treat it in conventional medicine in
14 a very consistent way.

15 So I would say Lyme, of all of the
16 diseases, I think was probably one of the more,
17 most controversial to pick. I am intrigued about
18 the research ongoing about cannabis' use in
19 inflammatory autoimmune and infectious
20 conditions. And this is our first look at an
21 infectious condition for cannabis.

22 All I really could find in the literature
23 about anti-bacterial, anti-viral properties that
24 seemed intriguing was by, was by Russo,

1 R-u-s-s-o. It was called Taming THC: Potential
2 Cannabis Synergy and Phytocannabinoid Terpenoid
3 Entourage Effects. And they talk about the
4 entourage effect of cannabis with all of the
5 other cannabinoids.

6 Because we talk about THC and CBD all
7 day, but there's so many more we're not talking
8 about that exist in other substances like lemons,
9 pine, lavender, hops, pepper, lemon balm, orange,
10 and green tea, that have been shown to have maybe
11 some anti-bacterial effects.

12 So I thought that was interesting, and
13 it's important to note that we can take advantage
14 of these effects in hemp oil, which is another
15 form of cannabis sativa, except without the
16 higher amounts of THC in it. So I want to call
17 out that potential, and that's over the counter
18 so hey, why not look at that.

19 The articles that were presented in the
20 Lyme petition were not specific for Lyme so I'm
21 reiterating what others have said, but rather for
22 the potential symptoms of Lyme.

23 And the articles presented took a look at
24 anti-bacterial activity of cannabis sativa

1 itself, but not of the spirochete called Borrelia
2 that causes the Lyme disease. So we just don't
3 have enough at all to vote upon, I think to even
4 consider this as a disease. But my inclination
5 is a strong no against this condition until we
6 have more research.

7 MS. WEATHERS: Move to vote.

8 MS. TEMPLE: Okay. So we will vote. And
9 on your ballots, switch it. It's, Lyme is
10 underneath MRSA.

11 MR. RAMIREZ: So to me cannabis is
12 something like aspirin. We've had aspirin for a
13 couple of hundred years and we still don't know
14 exactly how it works on some things. So
15 cannabis, we've had it for several thousand years
16 and we still don't know how it works in certain
17 things. We know that it has anti-bacterial
18 properties, but not which bacteria specifically
19 to.

20 We know that sometimes it's been used
21 topically and it cures certain infections. We
22 know it's being used to smoke, it's being used
23 inhaled, it's being used orally in cookies and
24 brownies. But, in general, we do not have enough

1 studies. Hopefully now that the DA has turned
2 its back and said okay, I'm going to accept the
3 cannabis research as legal and as valid medical
4 research, that will answer those questions that
5 at this point we don't have answers for.

6 Right now we don't even know the right
7 questions, so how can we know the answers. So I
8 think if we wait two or three more years we'll
9 have a lot more knowledge and we'll have a lot
10 more validity in everything we say.

11 MS. TEMPLE: Okay. So we're going to
12 announce the votes for the condition Lyme
13 disease. The condition failed with the vote of
14 yays zero, nay nine.

15 Okay. So the next condition is MRSA, or
16 Methicillin-resistant staphylococcus aureus, for
17 which we don't have a speaker, and so we'll open
18 up to the Board MRSA. Another infectious
19 condition. Go right ahead.

20 MR. RAMIREZ: No, you talk.

21 MS. TEMPLE: Okay. So there was one
22 study, the Appendino Study, A-p-p-e-n-d-i-n-o,
23 and it was an invitro, meaning in a test tube
24 situation, that looked at MRSA versus, well, and

1 cannabis. There was another study called the
2 Lone Study, L-o-n-e, that looked at cannabis at
3 Vibrio cholera. V-i-b-r-i-o, c-h-o-l-e-r-a, and
4 it looked at pseudomonas aeruginosa.

5 Spell that? All right, I'll help you
6 out. P-s-e-u, pseudo, p-s-e-u-d-o-m-o-n-a-s.
7 And then aeruginosa is a-e-r-u-g-i-n-o-s-a.

8 And Candida Albicans. Okay. Cannabis
9 was effective in all of the mentioned, all of the
10 studies mentioned above, in a test tube
11 situation. There was another article, this is
12 all in the petition and what I also looked at.

13 There was an article by Das, D-a-s, that
14 was very, it was pretty poorly done, but it did
15 show that cannabis in individually obtained
16 samples of urine, ear swab and mouth swab had
17 activity in vitro activity against a very vague
18 group of organisms called mouth, skin and ear
19 microflora, which could be just anything.

20 And they did find that it was effective
21 against E. Coli from a person who had a urinary
22 tract infection in that study. So basically the
23 researchers just took swabs of like various body
24 parts. They didn't describe the health of these

1 individuals. And then they took urine from
2 somebody who said they were having a urinary
3 tract infection. They plated those things on
4 petri dishes and then had a placebo and a CB. I
5 forgot if it was full, they weren't even that
6 specific, and said wow, look at the ring around
7 the colony of bacteria. It's a lot bigger with
8 the cannabis-treated petri dishes versus the
9 non-treated petri dishes.

10 So that's what we see in the literature.
11 We've got the Khadem article. K-h-a-d-e-m. It
12 was in a journal called Molecules, which was also
13 non-specific and not in depth enough about
14 cannabis, which was included in the petition and
15 it just talked about other, a lot of other plant
16 substances that have antibacterial and antiviral
17 activity.

18 Lastly, there was another article by
19 Radwan, R-a-d-w-a-n, which looked at biologically
20 active cannabinoids from high potency cannabis
21 sativa. This was in the Journal of Natural
22 Proceedings. Probably even a better study of
23 this group.

24 From the University of Mississippi, which

1 is the only sanctioned Federal facility where
2 people can get their cannabis from and research
3 it. Hence the bottleneck. And they discovered
4 nine new cannabinoids out of that. So that, I
5 mean, I just kept going on tangents when I was
6 looking for anything about MRSA.

7 But two of those cannabinoids showed mild
8 activity against MRSA. So I think we're really
9 at just the very infantile neonatal level of --

10 MR. RAMIREZ: Well, wait, wait, wait.

11 MS. TEMPLE: Hold on a second. Okay.

12 Sorry. Very, how about just really early?

13 MR. RAMIREZ: There you go.

14 MS. TEMPLE: Very early stage of
15 understanding that there are potential benefits
16 in the infectious disease world. And my
17 inclination is to vote against MRSA. Did you
18 have anything else?

19 MR. RAMIREZ: No.

20 MS. TEMPLE: He's correcting my neonatal
21 comment.

22 MR. MCCURDY: I did have a, I suppose a
23 comment and a question at least. So if I
24 understood the petition correctly, it sounds as

1 if the petition was claiming that there was an
2 antibacterial effect and also an
3 anti-inflammatory effect. It seemed to be
4 claiming in the petition, and I don't know how
5 they assessed either that, but it also seemed it
6 was, I mean, the person themselves framed it as a
7 hypothetical thing.

8 Maybe we should let the cultivators here
9 know antibacterial strains which would be a
10 different kind of recommendation than approving
11 it as a condition it seems to me. And the
12 person, or I mean the petitioner's claim was that
13 there was a major improvement in their health,
14 but I didn't get a clear sense of how that, what
15 that improvement actually was.

16 The other question I had though was the
17 actual use to which cannabis here would be put.
18 I had the impression that it would mean a topical
19 application.

20 MS. WEATHERS: Yes.

21 MR. MCCURDY: And then that made me
22 wonder so if it's not ingested but it's used
23 topically, in what sense does that fall even in
24 our purview, or in the, you know, one's, I

1 suppose, not supposed to possess the substance at
2 all, but if it's not ingested but it's applied to
3 your skin, is that a different category somehow?
4 I mean, maybe Connie would have a sense of that,
5 or maybe I'm missing the boat.

6 It just strikes me that, and maybe it's a
7 different kind of thing.

8 MS. MOODY: So, Dave, the topical product
9 falls under our definition of medical cannabis
10 infused product.

11 MR. MCCURDY: Okay.

12 MS. MOODY: Persons under 18 are only
13 allowed access to those medically infused,
14 medical cannabis infused products.

15 MR. MCCURDY: So that's considered
16 infused?

17 MS. MOODY: So that's considered infused.
18 Does that help?

19 MS. WEATHERS: I think this was another
20 one that was difficult, and I don't want to speak
21 for the whole Board, but where the Petitioner was
22 truly mixing issues. So they started talking
23 about their PTSD by being diagnosed with MRSA,
24 which, again, the petition, the Board has

1 approved. It then went on to say that it,
2 expressing that the research into this was in
3 necessarily stages, they acknowledged that this
4 is not something that can be administered in a
5 hospital setting.

6 Even if there was proof that intravenous
7 affects, which there's not, and then concluded
8 with maybe somebody could look into the possible
9 development of creams for this, which is not
10 currently even how we treat that condition.

11 So, so in all, between the lack of
12 evidence and the lack of cohesiveness even within
13 the petition itself, I feel that there's, there's
14 overall no way that I am able to support this one
15 at this time.

16 MR. CHAMPION: I was just going to say
17 that because MRSA has such varying degrees from
18 colonized that have little effect on the person
19 to causing death, that, you know, it would be
20 very hard to define.

21 Also, that approving it for its
22 antibacterial properties, our program currently
23 doesn't say well, you can only buy antibacterial
24 to another person if they're over 18, they would

1 be opening it up to the full array, so we can't
2 differentiate that, so.

3 MR. CHRISTOFF: I think that this
4 presents an interesting research question but I'm
5 not sure it's, I think because if it's
6 dermatologic or it's very superficial, you can
7 use it, in comparison, and a triple antibiotic
8 ointment and things like that could not only be
9 used to treat what is probably MRSA and it's very
10 superficial and not, you know, too deep of an
11 infection, and it's a deep subcutaneous infection
12 it has to be drained and antibiotics won't work
13 of any sort and then, you know, you have all the
14 hospitalized types of context which MRSA
15 represents in an in-patient setting.

16 But, but I think that's how I'm seeing
17 this one, is that it's something interesting to
18 look at for the research in general, but I'm not
19 sure why we would not find our current, there are
20 actually, besides the comparison, I think one or
21 two other topicals that have been approved in the
22 last three years to treat this.

23 MS. MILLER: This was another one I had
24 some concerns with. One, because, again, going

1 back to the CNA that wrote the support letter,
2 and again I'm going to reiterate is outside the
3 scope of practice for that person. And, two, on
4 the application it bothered me, where they're
5 supposed to write a brief description of the
6 illness specific to them, usually on the
7 petitions we hear how it's affected them as a
8 person, and it was word for word from the Mayo
9 Clinic's website.

10 MR. MCCURDY: Was it?

11 MS. MILLER: Yeah. It was completely
12 lifted from the Mayo Clinic's website. So it
13 really didn't give me a sense of how it had
14 impacted them, so that bothered me. And then
15 they talked in the petition about how MRSA isn't
16 responding to treatments but, and the antibiotics
17 have had such severe consequences, but they
18 didn't really talk about were they impacted by
19 those severe consequences at all.

20 So I just really, I have trouble
21 supporting this particular petition.

22 MS. WEATHERS: Theresa, I think you make
23 a great point that, again, due to the public
24 nature of this I think we should take the

1 opportunity to formally put into the Minutes and
2 convey to the public how much we really very
3 carefully read the petitions and look for things
4 like this. It's a type of inconsistency, it's
5 flat out plagiarism when people aren't carefully
6 reading the application and providing us with the
7 personalized information that we as a Board
8 really look for and need to understand the, --

9 MS. MILLER: Exactly.

10 MS. WEATHERS: -- the rationale.

11 MS. MILLER: Yeah. I think it's a good
12 teaching opportunity because the beginning of the
13 petition asks you for a brief description of the
14 disorder and how it's applying to you, and so I
15 didn't see that. I saw how, I learned to see how
16 Mayo Clinic defined MRSA, and so, yeah.

17 MS. TEMPLE: Nestor.

18 MR. RAMIREZ: Well, the other thing is
19 that I'm not a real doctor but I play one on TV,
20 so I don't see MRSA cases in adults when they're
21 very sick. But in the babies that I treat what
22 we have 99 percent of the time is MRSA
23 colonization.

24 And like Eric said, we use Search Results

1 Mupirocin all the time, we don't treat them
2 systemically with antibiotics. We just isolate
3 them and give them, treat them for their
4 colonization. So if we consider MRSA as a
5 specific infection by a bacteria that is
6 resistant to methicillin and the group of
7 medications of methicillin, then it's something
8 that you either treat with antibiotics that will
9 work, Vancomycin, and all the other that are
10 specific, or you consider that it's an
11 intractable disease and the patient's going to
12 die from that infection anyways.

13 It's not a chronic, debilitating
14 condition. You either die from it or you get
15 better from it. So it's not something that we
16 think should be the purview of when we talk about
17 chronic, debilitating conditions to be submitted
18 to, for approval to treatment by cannabis.

19 MS. WEATHERS: Motion to vote.

20 MS. TEMPLE: Motion. Oh, by the time
21 it's an acute condition, by the time a person
22 gets a card, you know, it's --

23 MR. RAMIREZ: They die very quickly.

24 MS. TEMPLE: Okay.

1 MS. MILLER: I'll second.

2 MS. TEMPLE: Okay. So let's vote. And
3 following the announcement of the results, we're
4 going to move to autism for which we have
5 multiple speakers. We have six speakers. We'll
6 not be acting on the condition, we've already
7 voted to approve autism, but we do welcome
8 comments to further educate the Board and the
9 public.

10 MR. RAMIREZ: If at first you don't
11 succeed, try, try again.

12 MR. MCCURDY: Can I make a comment while
13 we're counting? I want to read a couple of
14 sentences from one of the petitions we received.
15 This was for, I think, dysthymic disorders.

16 There's a sentence describing proposed
17 benefits that said that as a result of the relief
18 that I get from cannabis I'm able to spend more
19 time with my family and friends, and I'm able to
20 go to and enjoy sporting events, concerts and
21 festivals, and more of a normal life.

22 We have seen that sentence in any number
23 of petitions over the years and others like it.
24 So I think petitioners should be advised that

1 this sort of boilerplate stuff does not serve you
2 well. We really are asking you to give a
3 personal account, not just borrow from somewhere
4 else, pull from borrowing things from the
5 website.

6 MR. RAMIREZ: All lives matter.

7 MS. TEMPLE: So the vote is, for MRSA,
8 methicillin staphylococcus aureus infection is
9 zero yay, nine nay. The condition fails. Okay.
10 So we'll have to wait for Dr. Weathers to come
11 back, but our first, I'll talk about the order of
12 the speakers for autism.

13 We have Mr. Jared Taylor, Miss Feliza
14 Castro, Angela Basolo-Bond, Tina Higen, or
15 Higen, sorry. Amanda Dickerson, and Dana Hall.
16 So we'll do it in that order, and you each get
17 three minutes.

18 Our first speaker is Mr. Jared Taylor.
19 Oh. I want to, I want to preface this by the
20 next, from this point forward all of the
21 petitions that we're going to be discussing have
22 already been approved by the Board, and we're not
23 going to vote on them.

24 We may have some deliberations, some

1 discussion, but we don't need to vote anymore.

2 They've already been approved.

3 MR. TAYLOR: All right.

4 MS. WEATHERS: And I'm sorry, Jared.

5 Just to clarify a point, and I know, Connie, you

6 said that, I thought we had to vote as a group

7 but we don't have to reenter, because I thought

8 once the Director says no it kind of invalidates

9 everything that we did.

10 MR. MCCURDY: We voted earlier this

11 morning.

12 MS. MOODY: There was a motion made

13 earlier, and we can check that --

14 MS. WEATHERS: Okay.

15 MS. MOODY: -- motion, that the Board was

16 going to approve the entire list of petitions.

17 So we can, we can check that on the transcript if

18 you'd like to. Are we able to read that back?

19 MS. WEATHERS: Okay. I'm sorry.

20 MR. FINE: I made a motion before that

21 everything that we had approved, approved

22 previous, at previous hearings, --

23 MS. WEATHERS: Okay.

24 MR. FINE: -- this would the last one, if

1 we approved it before that there's no need to
2 approve, --

3 MS. WEATHERS: Okay.

4 MR. FINE: -- even though the Director of
5 Public Health denied them all.

6 MS. WEATHERS: Okay. I mean, that's --

7 MR. FINE: We still go down there.

8 MS. WEATHERS: I think maybe we should
9 just wildly all vote just to have that on the
10 transcript.

11 MS. TEMPLE: Should we do it again?

12 MS. WEATHERS: Yes.

13 MS. TEMPLE: Okay. Let's hear a motion.

14 MS. WEATHERS: We'll do it again.

15 MR. FINE: I hereby motion to approve all
16 the prior conditions that we have previously
17 approved up until this meeting if they come up
18 again in today's hearing.

19 MR. CHAMPION: Second.

20 MS. TEMPLE: All those in favor?

21 (Board responded aye.)

22 MS. TEMPLE: Nestor?

23 MR. RAMIREZ: Aye.

24 MS. TEMPLE: Okay.

1 MS. WEATHERS: Do you know what you're
2 voting for? I just want to make sure.

3 MS. WEATHERS: Okay. Thank you for doing
4 that. I just wanted to --

5 MS. TEMPLE: No, that's very organized.
6 Okay. So we're good to go. Everything we're
7 going to talk about now has already been
8 approved, but we want to at least thank you.
9 And, please, proceed, Mr. Taylor.

10 MR. TAYLOR: Please, Jared. All right.
11 So my name is Jared Taylor. J-a-r-e-d,
12 T-a-y-l-o-r. And I come before you to urge the
13 recommendation of autism as a qualifying
14 condition for the Medical Cannabis Pilot Program.

15 According to the Mayo Clinic, autism
16 spectrum disorder is a serious neurodevelopmental
17 disorder that impairs a child's ability to
18 communicate and interact with others.

19 It also restricted repetitive behaviors,
20 interests and activities. Now, these issues do
21 cause significant impairment in social,
22 occupational, and other areas of function.

23 Because autism is a spectrum, there are a
24 variety of symptoms, including poor eye contact,

1 or lacking facial expressions. A child that may
2 repeat words or phrases verbatim without knowing
3 their meaning, constantly moving, or more
4 specific routines/rituals, and basically becoming
5 disturbed at the slightest change of these
6 routines or rituals.

7 So I actually did some research and found
8 that cannabinoids within cannabis interact with
9 the body's endocannabinoid system and help to
10 regulate emotion and focus for individuals that
11 have autism.

12 According to a father who administered
13 medical cannabis to his autistic child; my son
14 was having another horrible day. After 30
15 minutes we could see that the medical cannabis
16 was taking effect.

17 His behavior was relaxed and less
18 anxious. Less anxious. My son started laughing
19 for the first time in weeks, and his anxiety,
20 rage and hostility melted away. He slept that
21 night with no problems and slept all through the
22 night.

23 So I realize that Illinois in its time
24 last year, October, was the first, first state, I

1 don't believe that any other state has currently
2 approved --

3 MS. TEMPLE: Pennsylvania.

4 MR. TAYLOR: Pennsylvania. Okay, so
5 great. So Pennsylvania's on board. So, you
6 know, we read in the newspaper about how Illinois
7 is slipping on this or that issue, and I realize
8 that there is some trepidation on adding a
9 condition that no other state has added before,
10 but I really think that we shouldn't be so
11 concerned about, you know, opening the flood
12 gates, if you will.

13 I think that a doctor previously had said
14 opening the flood gates on a different condition,
15 but I really don't think that should be a concern
16 here. So we've already approved this but, you
17 know, myself, I don't have any children.

18 I don't have a child who has autism, but
19 my heart goes out to the people, the parents, the
20 families, the actual patients themselves who do
21 have autism. And I can really only imagine the
22 day-to-day challenges that both the parents and
23 the child face.

24 There is no cure for autism. But if

1 cannabis can be of benefit to children with
2 autism and their parents, cannabis should be an
3 option for Illinois families. Thank you for your
4 time.

5 MS. TEMPLE: Thank you. Okay. Miss
6 Feliza Castro.

7 MS. CASTRO: Thank you. And, again, I
8 would like to thank you, the Board, for allowing
9 me to submit testimony on behalf of other
10 patients. So this is an anonymous testimony from
11 a patient, oh, from the, I'm sorry, from the
12 father of a patient.

13 He says I have never really considered
14 marijuana until my son was diagnosed with autism.
15 It all started when he was around two, and he
16 would throw violent fits in reaction to small
17 changes to his routine.

18 Things only got worse as he started
19 pre-school and was formally diagnosed. It was
20 exhausting for me to manage his rage while trying
21 to give him a happy childhood.

22 After trying a couple of mood
23 stabilizers, I decided I no longer wanted him to
24 be a guinea pig while they figured out the right

1 cocktail of pharmaceuticals to sedate him. He
2 wasn't responding well, if at all, and I couldn't
3 watch my four-year old baby boy taking all of
4 these toxic substances while he was still
5 developing. Another mother and online support
6 group suggested that I look into cannabis oil.

7 More and more families were coming out
8 into the light to share how marijuana improved
9 their home and gave their kid with autism a more
10 normal childhood. I decided to take a huge risk
11 and flew him to Colorado.

12 We stayed for two weeks and I began
13 giving him very small doses of what was
14 recommended by other mothers. I noticed
15 immediately how calm and kind he was being. We
16 went on walks and enjoyed nature together without
17 a single fit.

18 My job, family and friends are all in
19 Illinois. I don't want to move, but if I have to
20 do what is best for my son, I will. This is our
21 last effort to stay here before we have to start
22 a new life in a more compassionate state. And
23 there are some pretty compelling studies out
24 there around the benefits of cannabinoids for

1 autism. MAMMA is a great organization. It's
2 Mother's Advocating Medical Marijuana For Autism.
3 They have a really great selection of resources
4 and studies. Thank you for your time.

5 MS. TEMPLE: Thank you. Our next speaker
6 is Angelo Basolo-Bond. She's present.

7 MS. BASOLO-BOND: Yep. I brought a
8 couple pictures I want you guys to look at. This
9 one here was December before he started. This
10 here was last Wednesday. And my name is Angela
11 Basolo-Bond.

12 MS. MOODY: And could you take, could you
13 take the mic close to you?

14 MS. BASOLO-BOND: Actually, I've got a
15 big mouth.

16 MS. WEATHERS: Please spell your name for
17 me.

18 MS. BASOLO-BOND: Okay. It's Angela,
19 A-n-g-e-l-a. Basolo, B-a-s-o-l-o. Bond,
20 B-o-n-d. And I'm here, my little boy is 16 and a
21 half. He was diagnosed when he was about two and
22 a half. He got, I'm trying to think, it was
23 January 5th of this year he was able to get his
24 first dose of the candy form of the marijuana.

1 Prior to all this, we have been everywhere. He
2 developed normally. He was perfect. About
3 22 months old we started having the loss of eye
4 contact. He stopped talking, he started using
5 the bathroom in his pants again.

6 He wouldn't sleep. His tastes changed.
7 It was unreal. He wouldn't eat, only carbs. He
8 would only eat carbs. He became withdrawn, and
9 he wouldn't sleep. I mean, the sleeplessness was
10 just out of this world. And he basically
11 regressed to like a newborn.

12 He went to school at three. He started
13 pre-school. He was eventually put into special
14 ed. Three years ago he was put in a
15 self-contained classroom that was padded. He had
16 to wear a helmet. He had to have four aides with
17 him at one time. They were all dressed in body
18 guard, more or less. They had things, you know,
19 they had things to protect them.

20 He has been, I've had him everywhere. My
21 husband and I have had him everywhere. Bethesda,
22 Maryland, St. Louis. He goes to Riley Children's
23 Hospital and sees the autism team there. He
24 started having grand mal seizures. With the

1 grand mal seizures the anxiety, the flapping, the
2 barking, not able to communicate, getting out of
3 our house at night. And it was basically we'd
4 take him to the doctor and they'd give him this
5 pill to give him this pill to give him this pill.

6 So we gave him all these pills. His
7 liver's shutting down. His kidneys are shutting
8 down. He can't take a crap. I mean, he's on, at
9 one time, probably 15 to 20 different fricking
10 meds. I was allowing him to die. I was watching
11 him die. And, you know, I didn't know what else
12 to do.

13 I mean, we just didn't know what to do.
14 We didn't know what we could do to help him. Our
15 neurologist suggested about two and a half years
16 ago that we try the medical marijuana. She's in
17 Indianapolis and we're in Illinois. And I'm like
18 well, you know, I'll try anything. But how are
19 we going to get it, what are we going to do.

20 Finally it became available, and you can
21 see from the pictures what it's doing. He's
22 wonderful contact, eye contact, talking. He
23 fixed eggs the other day. Join me on Facebook,
24 follow his story. We do weekly Wednesday photos

1 of him. It's unreal. He's in school. He's got
2 one, he's got two teacher's aides, self-contained
3 classroom. He's reading, he's writing. We went
4 and bought shoes yesterday. He wanted to go to a
5 store and he wanted shoes. It's unreal in five
6 months the change in my kid.

7 MS. MOODY: Thank you.

8 MS. BASOLO-BOND: And I do thank you guys
9 for passing this.

10 MS. TEMPLE: I have a question for you
11 before you go. So did he get the card based on
12 seizures?

13 MS. BASOLO-BOND: On seizures. We had to
14 get it on seizures.

15 MS. TEMPLE: So that's how you were able
16 to see how --

17 MS. BASOLO-BOND: That's how we got it.

18 MS. TEMPLE: And what are you using for
19 him? What is your --

20 MS. BASOLO-BOND: The sea salt dark
21 chocolate, we use that one. The gummies didn't
22 work. They tried to, they told us to try the
23 gummies at night. They did not work for Dalton.

24 MR. KNAUS: In the sativa in a dark

1 chocolate?

2 MS. BASOLO-BOND: The sativa.

3 MS. TEMPLE: Was it a primarily CBD focus
4 or was it a mix, do you remember?

5 MS. BASOLO-BOND: It's mixed. It's
6 mixed. It's got, actually I was going to bring
7 one in and forgot, you know. I got one.

8 MS. TEMPLE: That's okay. You can't
9 bring one in a government building.

10 MS. BASOLO-BOND: I kind of remember
11 that. I was like yeah, I can't do that. But I
12 can't bring it to work either. I work for the
13 Department of Corrections. Because I wanted to
14 show everybody at work, this is what's saving
15 Dalton. When it saves him it saves them because
16 they don't have to listen to me.

17 MS. TEMPLE: Bring us the photo of the
18 wrapper.

19 MS. BASOLO-BOND: I've got a photo on my
20 phone. Get on Facebook, I'll show you. But,
21 seriously, he gets a square a day. So we break
22 it in half. He gets one in the morning, one in
23 the evening. And sometimes at school they have
24 to give him one. It just depends.

1 MS. TEMPLE: So they allow it at school?

2 MS. BASOLO-BOND: Yes.

3 MS. TEMPLE: So you needed to get
4 permission from people I'm sure?

5 MS. BASOLO-BOND: They said it was a
6 prescribed medication. Our school, little podunk
7 Christopher, Illinois, way down there south.
8 They said it's a prescribed medication, they
9 would give it, because they guaranteed there was
10 kids there on worse drugs than what this
11 marijuana was going to do to Dalton, you know.

12 MR. CHAMPION: That's the truth.

13 MS. TEMPLE: And, you know, hey, go shake
14 down the lockers, you're going to find it anyway,
15 you know. But at least his was prescribed. And
16 I can always control it because, unfortunately,
17 he's never going to be able to do a smokeable.

18 He's never going to be able to do the
19 flower. He's just, you know. But God, this is a
20 good thing you guys are doing. You're going to
21 give a lot of kids a chance. I mean, he may
22 eventually get to go to a group home, where
23 before we didn't know what we was going to do
24 with him, so, you know.

1 MS. TEMPLE: Please send us feedback and
2 your stories for our policy makers.

3 MS. BASOLO-BOND: Oh, I will. I will.

4 MS. TEMPLE: That was nice to hear.
5 Thank you.

6 (Applause.)

7 MS. TEMPLE: Next we have Tina Higen, or
8 Higen.

9 MS. HIGENS: My name is Tina Higen. The
10 last name is spelled H-i-g-e-n-s. I'm
11 representing Autism As Medical, and it's a group
12 that promotes the treatment of all the comorbid
13 disorders of autism to help bring a person with
14 autism to their best level. So thank you for
15 allowing me this opportunity to speak.

16 As a mother of two boys diagnosed with
17 autism and a medical cannabis patient myself, I
18 have new perspective regarding the use of
19 cannabis in autism.

20 Currently, the only FDA approved
21 medication to treat autism is Risperdal, which is
22 used to treat behaviors associated with autism.
23 These behaviors include aggression, self injury
24 and temper tantrums. This medication has

1 horrific side effects, including development of
2 breasts in males, neuroleptic malignant syndrome,
3 which causes confusion, irregular heartbeat,
4 fever, stiffness. Other side effects include
5 dizziness, fainting and seizures. My sons also
6 have mitochondrial disease, which is often seen
7 in autism.

8 If you read studies by Dr. Frey, et al.,
9 they think mitochondrial dysfunction or disease
10 is indicated in about 30 percent of all people
11 with autism. Giving this medication to somebody
12 with mitochondrial disease and/or other metabolic
13 disorders can be fatal.

14 I have many friends that gave this
15 medication and other psychiatric medications to
16 their children with horrific side effects with
17 their children being in-patient in places like
18 Lorace (phonetic) for 90 days and having them on
19 all types of meds, and their symptoms becoming
20 worse and worse.

21 April was just Autism Awareness Month and
22 we see cute pictures with autism children
23 displaying musical and artistic talents on
24 television. What the public does not see is

1 children and adults with autism jumping through
2 and shattering sliding glass doors, ripping the
3 interior of a vehicle to shreds, mothers with
4 black eyes and broken teeth. These are all
5 examples of the dark side of autism that myself
6 and/or friends have experienced.

7 People with autism also have, often have
8 autonomic nervous symptom differences. They have
9 a broken fright and flight system, which can lead
10 to very aggressive behaviors. And to try to
11 control that type of behavior, especially as
12 these children grow older and become adults is
13 very, very hard.

14 We need help with our children's
15 behaviors and their pain. Cannabis is already
16 helping people with autism and depression and
17 comorbid medical disorders for people that
18 already are qualified under conditions like
19 seizures.

20 People with autism have so many different
21 comorbid disorders, including severe bowel
22 disease, seizures, muscle pain and weakness from
23 mitochondrial disease, anxiety. A lot of parents
24 have said that the use of cannabis has led to the

1 production of more speech, better mood regulation
2 and states a more qualifying condition for the
3 person who qualifies one of the other comorbid
4 disorders.

5 MS. MOODY: You have 30 seconds.

6 MS. HIGENS: There's lot of research
7 showing that there is neuro information in the
8 brain. There's this famous story that showed
9 postmortem there was a high level of neuro
10 information. My younger son, we had done a study
11 with Dr. Gupta at UC Irvine where his
12 inflammatory cytokines were off the charts.

13 If your brain is completely inflamed and
14 on fire you're not going to be able to regulate
15 your mood, you're not going to be able to have
16 proper behaviors. So, so for further reading I
17 suggest Dr. Sadir Gupta, et al's., literature,
18 Fran Kendall, et al., Richard Frey, et al., and
19 Jill James, et al.

20 Thank you for the time.

21 (Applause.)

22 MS. TEMPLE: I have a question for you
23 actually.

24 MS. HIGENS: Uh-huh.

1 MS. TEMPLE: Have you tried hemp oil?

2 MS. HIGENS: I personally have not, but I
3 have a lot of friends that have. I think it
4 really depends on the particular child and their
5 comorbid disorders. A lot of, you know, there
6 was just a recent study that showed that persons
7 with autism actually died 30 years younger than
8 your typical people.

9 So there is a lot of immunological
10 disease. My sons have CBID, so they're on IVIG
11 for that. They have mitochondrial disease, so
12 there's a whole cocktail of different types of
13 vitamins and supplements. But all of these
14 things are kind of band-aids.

15 And when you get into the
16 neuropsychiatric medicines, a lot of them just
17 have such horrific side effects, you take a
18 problem and you're making it worse and worse, and
19 sometimes these kids are on just a cocktail of
20 SSRI's and all kinds of antidepressants, and
21 things like Risperdal, which I don't think should
22 ever be given to children.

23 So I think that this is a much safer
24 alternative for children.

1 MR. CHRISTOFF: Is that FDA approved for
2 children or are you saying it's given to them --

3 MS. HIGENS: Risperdal was actually the
4 only medication FDA approved for the, for the
5 treatment of autism.

6 MR. CHRISTOFF: That's it?

7 MS. HIGENS: That is it. And the thing
8 that's scary is that so many of these children
9 have these comorbid metabolic disorders. So
10 unless you go to a place of excellence like The
11 Medical Center For Excellence at Arkansas
12 Children's Hospital with Dr. Frey, which my
13 children go to.

14 For things like the comorbid
15 immunodeficiency, we have Dr. Gupta at UC Irvine.
16 But for a person like myself, I'm literally
17 traveling all over the country. I go to UC
18 Irvine, I'm going to Arkansas Children's. I'm
19 going to Ochsner for geneticist Dr. Niyazov.

20 So you can see great improvements with a
21 lot of these treatments. But cannabis is the
22 only thing that I know of that we know is not
23 fatal. When we give all these kids all these
24 drugs, a lot of times they have liver failure and

1 it's just, it's just a hot mess. I don't know
2 how else to say it, you know.

3 MS. TEMPLE: Okay. Our last speaker is,
4 thank you very much for your testimony. Dana
5 Hall is our last speaker. She's present?

6 MS. DICKERSON: I got skipped.

7 MS. TEMPLE: Pardon?

8 MR. RAMIREZ: She said she got skipped.

9 MS. TEMPLE: Oh, there is another person.
10 Amanda, I'm sorry. I checked it and then I,
11 sorry. Amanda Dickerson. Then Dana. Sorry.

12 MS. TEMPLE: And please spell your first
13 and last name.

14 MS. DICKERSON: Okay. My name is Amanda
15 Dickerson. A-m-a-n-d-a, D-i-c-k-e-r-s-o-n. I'm
16 here to support adding autism to the list of
17 qualifying conditions approved for treatment by
18 medical marijuana.

19 MS. MOODY: Could you hold the mic closer
20 to you?

21 MS. DICKERSON: Is this working?

22 MS. MOODY: Yes.

23 MS. TEMPLE: Much better.

24 MS. DICKERSON: Okay. I'll start over.

1 I'm here to support adding autism to the list of
2 qualifying conditions approved for treatment by
3 medical marijuana. I'm here to improve my son's
4 quality of life. My son Cameron was diagnosed
5 with autism at two and a half years old.

6 Today at six years old he has nearly
7 recovered, and his success is due to none other
8 than alternative intervention. After seeing very
9 limited success with traditional therapy, we
10 implemented a number of alternative treatments
11 which have been proven to be safe and incredibly
12 effective.

13 But an eating disorder remains my son's
14 final and toughest challenge. We work with a
15 team of practitioners in Colorado to treat
16 comorbid conditions that autism encompasses.
17 Those same professionals whose expertise brought
18 Cameron to his current level of recovery -- I'm
19 sorry.

20 AUDIENCE MEMBER: Do you mind if I read
21 for her?

22 (Audience member proceeded to read.)

23 Those same professionals whose expertise
24 brought Cameron to his current level of recovery

1 have recommended trying medical marijuana to get
2 him over the final hurdle. They have documented
3 great success using cannabis as it is proven to
4 decrease anxiety sensory issues, all of which are
5 likely to be a contributing cause of my son's
6 eating disorder.

7 A quick Google search by thousands of
8 parents who are effectively treating their
9 autistic children with cannabis, many of whom are
10 reporting success in the area of eating
11 disorders.

12 A mom of two previously very severely
13 affected boys described their experience with
14 their youngest son whose diet was extremely
15 limited just like my son's. She described his
16 improvement using cannabis as follows: My other
17 son is also autistic. He was already talking,
18 but now he's talking better.

19 He's asking for more food, different
20 items. We would, he would self restrict his
21 diet. This morning he asked for scrambled eggs.
22 This is new. Joshua has been taking CBD and THC
23 only a few weeks.

24 I believe that I should have the right to

1 try this for my son. Lack of options in feeding
2 him severely limits our life more than just
3 breakfast, lunch and dinner. It makes it hard to
4 leave our house for extended periods of time
5 because nearly everything he can tolerate
6 requires preparation in the kitchen with a stove
7 with oven.

8 (At this point, Ms. Dickerson resumed
9 reading and testifying.)

10 There are thousands of testimonials from
11 parents about cannabis lessening or even
12 completely removing their children's autism
13 systems. The same is true for adults. Doctors
14 continually prescribe drugs for kids, and not
15 only put them into a state of high being, but
16 also cause awful side effects, including death.

17 Risperdal and five other antipsychotic
18 drugs were responsible for 45 deaths between 2000
19 and 2004 according to the US, according to USA
20 Today's review of FDA data. As you would expect,
21 marijuana-related deaths total zero.

22 The potential benefit of medical cannabis
23 far outweighs the risk. The underlying
24 conditions of autism make life for our son and

1 our family very difficult. Our goal is to
2 alleviate symptoms, not create additional
3 symptoms. Furthermore, pharmaceuticals don't
4 always work. When they do ease symptoms they
5 tend to lose effectiveness over time.

6 MS. MOODY: Thank you for your time.

7 MS. DICKERSON: Oh, I'm sorry.

8 MR. MCCURDY: Thank you.

9 (Applause.)

10 MS. TEMPLE: Thank you, Miss Dickerson.
11 And lastly, Dana Hall, please.

12 MS. HALL: Hi. My name is Dana Hall.
13 D-a-n-a, H-a-l-l. My son Keller is seven years
14 old, and he was also diagnosed with autism when
15 he was two and a half. I am also here advocating
16 as a representative from the group MAMMA, Mothers
17 Advocating For Medical Marijuana For Autism, a
18 grass roots organization with no benefactors or
19 outside source of income, whose mission is to
20 educate parents and legislators about the healing
21 powers of medical marijuana for our kids.

22 Given that autism now affects
23 approximately one percent of the population
24 worldwide, we can conservatively assume that

1 there are over 100,000 people in Illinois on the
2 spectrum. There is no globally effective
3 medical, dietary or therapeutic protocol that
4 helps them all.

5 Keller's pediatrician also suggested the
6 FDA approved pharmaceutical Risperdal. The drug
7 has terrifying common side effects. I've done
8 hours of research, spoke with dozens of families,
9 and declined his offer.

10 Government patent number 6630.507 states
11 that no signs of toxicity or serious side effects
12 have been observed following chronic
13 administration of cannabidiol to healthy
14 volunteers, even in large acute doses of 700
15 milligrams per day.

16 It should be my right to treat my son
17 with a natural plant that has no known deaths or
18 side effects. By 2013 Johnson & Johnson and its
19 Janssen unit were facing over 500 class action
20 lawsuits for harmful side effects of Risperdal.

21 With only an autism diagnosis, patients
22 also commonly suffer from several underlying
23 conditions, as we've mentioned, that have already
24 been approved for qualifying conditions in the

1 State of Illinois or elsewhere. Allowing access
2 to medical marijuana for autism would give
3 parents a safe alternative and a better quality
4 of life. If my goal was to get my son stoned so
5 I didn't have to deal with him, I already have
6 that option, through pharmaceuticals and a
7 pediatrician that's willing to prescribe them.
8 That's not what I want for my son.

9 I want to give him a future. I want to
10 see him be the best person he can possibly be.
11 Excuse me. Isn't that what every mother wants?
12 Keller can get there with access to the plant
13 with which I have watched families across the
14 country have groundbreaking success.

15 The power of social media has given me a
16 glimpse into the lives of autistic children going
17 from non verbal to reciting the pledge of
18 allegiance. Children that were once aggressively
19 violent, as my son is, calm and engaging
20 appropriately with others using medical
21 marijuana. Excuse me.

22 My husband, Keller, his brother Grady,
23 and I have built a life surrounded by family and
24 friends, but we want this medicine for Keller.

1 Should we move out of the State to obtain it?
2 According to the Illinois Policy Institute, more
3 than 850,000 people have moved out of Illinois
4 since 1995, which comes to a rate of one resident
5 leaving every 10 minutes.

6 Let's not make medical marijuana laws
7 another reason to leave. Thank you.

8 (Applause.)

9 MR. MCCURDY: I have an entirely naive
10 question. I'm sorry. And this is not
11 necessarily a question just for you --

12 MS. DICKERSON: Sure. Yes.

13 MR. MCCURDY: -- but from people who have
14 spoken. But, so we have all these anecdotal
15 accounts from all kinds of folks who have this.
16 And I suppose in a way, so one question is what
17 is the means of administration that seems to work
18 best for these kids, if there is one?

19 And then the other question, I suppose,
20 is how is it, what would make it possible to
21 gather all of these stories together and sort of
22 look at them and say so what do they all have in
23 common that could be put together in a, more of a
24 proposal kind of thing? My naive question.

1 MS. DICKERSON: Well, we, there are
2 several grass roots organizations like MAMMA that
3 are trying to gather the evidence in one cohesive
4 place. The website itself is mammausa.org is a
5 great resource where a lot of the anecdotal
6 evidence can be seen. The so far supporting
7 scientific evidence can also be found.

8 AUDIENCE MEMBER: There's linked studies
9 on that page.

10 MS. DICKERSON: Yes. And as far as
11 administration, the anecdotal evidence shows
12 children with edibles, with oils, smoking the
13 flower. There's several different accounts of
14 the story. I view myself as, for my son we have
15 attempted the CBD oil. We've seen very little of
16 success.

17 So that's, you know, why we have exposed
18 ourselves to the anecdotal evidence that THC may
19 be the missing piece that my son needs. Thank
20 you.

21 MR. MCCURDY: Thank you.

22 MS. TEMPLE: Are there comments? Well, I
23 very much applaud the bravery that these mothers
24 came up and their helpers to assist in delivering

1 a story that must have been very difficult.

2 (Applause.)

3 MS. TEMPLE: It's already on the record
4 that we passed this to the mother who has a
5 petition before you that broke ground. It was
6 very moving, so it's very challenging to hear
7 that this is going on, and we need to do
8 something.

9 I just hope that the recommendations we
10 make the third time around stick. Okay. And
11 that's why I also urge you to write and keep up
12 with your advocacy.

13 Okay. It is now 11:39, and I think we
14 have lunch coming at noon, which kind of then
15 tells me we should just keep going until lunch
16 comes. We will probably bisect talking about
17 chronic pain syndrome spectrum that we have
18 going. The two speakers next are for chronic
19 pain due to trauma.

20 Following that, we have five speakers for
21 chronic pain syndrome. And then just depending
22 on how time goes we might do the chronic
23 postoperative pain and intractable pain. We'll
24 see how it goes. So without further ado, we have

1 one speaker for chronic pain due to trauma, and
2 that's Dr. Charles Bush-Joseph. And if you would
3 come up for your three-minute testimony. Yeah.
4 There's one speaker here who is on multiple
5 times, and he has declined to come up so that he
6 can speak for other conditions. So it's just
7 going to be Dr. Bush-Joseph talking about chronic
8 pain due to trauma.

9 DR. BUSH-JOSEPH: Thank you. If it's
10 okay with the Board I can speak to the four
11 conditions of pain that I was actually going to
12 discuss, so I can do it in one fell swoop and it
13 would be relatively time efficient.

14 I was hoping to speak on neuropathy,
15 chronic pain due to trauma, chronic postoperative
16 pain, and intractable pain. Those are the four
17 areas. My name is Charles Bush-Joseph. B-u-s-h,
18 hyphen, J-o-s-e-p-h. I'm an orthopedic --

19 MS. MOODY: Since we've allocated three
20 minutes only for you, do you want to combine
21 everything? That would be at the discretion of
22 the Board. Otherwise, if you'd like to use three
23 minutes for each of the conditions that you would
24 like to speak on, that would be, because we're

1 only allowing three minutes.

2 MR. FINE: Can we give him a little bit
3 more time?

4 MS. TEMPLE: But then you might not speak
5 at the other --

6 DR. BUSH-JOSEPH: That would be fine.

7 MS. TEMPLE: Okay.

8 DR. BUSH-JOSEPH: Yeah. My comments are
9 relatively generic for pain.

10 MS. TEMPLE: You think like five to six
11 minutes would be doable if you're going to be
12 covering --

13 MS. WEATHERS: What are you requesting?
14 What time are you requesting?

15 DR. BUSH-JOSEPH: Five to six minutes
16 would be fine.

17 MS. TEMPLE: Okay.

18 DR. BUSH-JOSEPH: And, certainly, if I
19 may read into the record, I'm an orthopedic
20 surgeon working at a tertiary Medical Center in
21 downtown Chicago. And generally about 30 to
22 35 percent of the patients I see are patients,
23 unfortunately, that failed care.

24 They've had prior injuries, prior

1 treatments, prior surgeries, that have generally
2 unfortunately failed, and they were left with
3 very difficult conditions to manage, and in many
4 instance those conditions we cannot correct and
5 those patients are unfortunately left for chronic
6 pain management.

7 Recent data from the CDC noted that there
8 was over 25,000 deaths in 2015 of prescription
9 opiate drug use alone. In its data up just
10 recently it termed over 255 million prescriptions
11 of opiates are prescribed on an annual basis.
12 Certainly, the numbers are quite high.

13 And, certainly, I think the CDC Director,
14 Thomas Friedman, was quoted as saying we know of
15 no other medication more routinely used for non
16 fatal conditions that kills patients so
17 frequently than opiates.

18 So with that in mind, the CDC has now
19 initiated new guidelines for primary care
20 physicians to dramatically curb the use of
21 opiates, which unfortunately makes the
22 practitioner's ability to manage patients with
23 chronic un-resolvable conditions much more
24 difficult. Josephine Briggs, who is the Director

1 of the National Center for Complementary and
2 Integrative Health Center of the NIH, reports in
3 the United States over 23 million people suffer
4 from chronic pain, in which 14.4 million are
5 considered to have severe pain.

6 As I said, reconciling these conditions,
7 or these two concerns, physicians and patients
8 need alternative strategies to manage these
9 difficult problems. And as an orthopedic surgeon
10 in a tertiary medical center, many of these
11 patients I have unfortunately come to me with
12 unresolved and incurable conditions and are
13 forced to leave, to live with them in a very
14 difficult circumstance.

15 The uncontrolled pain of failed treatment
16 and progressive deterioration lead many patients
17 into opiate dependency for simple activities of
18 daily living. As we've noted, and you've heard
19 testimony today, medical cannabis provides a very
20 acceptable treatment option for many patients as
21 long as it's provided in a safe and regular
22 manner, like it is here in Illinois.

23 The evolving body of knowledge in the
24 medical literature supports the efficacy of

1 treating a variety of non-cancer pain. Peer
2 reviewed studies, which we'll present today, and
3 I think many of you are well aware of the
4 literature, suggests that it's very effective in
5 the relief of pain leading to a significant
6 decrease in opiate use.

7 But the NIH for 2015 has funded over
8 \$49 million dollars in grants for the medical
9 treatment of cannabis for a variety of these
10 types of conditions, and according to the
11 Director they anticipate that number to go north
12 from there considerably.

13 The Foundation for Peripheral Neuropathy
14 will hold their annual 2016 Research Symposium
15 here in Chicago. They have over four hours of
16 scientific presentations devoted strictly to the
17 use of medical cannabis in the treatment of
18 neuropathic pain.

19 Again, these facts all testify to the
20 efficacy and the scientific validity of these
21 types of treatments. Certainly, any therapy that
22 involves medication compounds that have
23 psychoactive effects warrants some concern.

24 And, certainly, these concerns must be

1 addressed with regulation to allow the intended
2 benefits to minimize the side effects for leading
3 to uncontrolled, uncontrolled use. And it's my
4 belief that the Medical Cannabis Pilot Program of
5 Illinois is one of the most tightly regulated in
6 the United States, and is well crafted to
7 minimize and prevent, minimize its use and
8 prevent abuse of what I believe is a beneficial
9 therapy.

10 I believe the physician oversight and
11 dispensing regulations allow safe use of medical
12 cannabis for patients suffering with chronic pain
13 due to chronic trauma, chronic pain due to
14 postoperative pain, intractable pain, and
15 neuropathy.

16 You know, I was just going off the cuff.
17 You know, I take care of a lot of patients,
18 unfortunately, that really do have difficult,
19 unresolved problems. And I have to tell you, in
20 many of these patients we do think that there are
21 conditions that we can benefit with further basic
22 treatment, the surgeons, but the patients are on
23 such high doses of opiates that we deem their
24 condition totally unmanageable postoperatively,

1 and we've had horrible consequences of trying to
2 operate on these patients and end up with very
3 serious, because of the serious level of opiate
4 failures. And years ago, and sort of what drew
5 me into this, I had several patients who, I said
6 listen, I'm not operating on you until you're off
7 our Vicodins or you're off your Fentanyl, you're
8 off all these, you know, all the analgesics
9 you're taking, and so we can manage them
10 postoperatively, take one more whack at their
11 non-union fracture or their shoulder or their
12 back problem.

13 And many patients said listen, yeah, I'm
14 just using a lot of cannabis, and that helped
15 them. And to me, that helped open my eyes to see
16 that these are things that really help patients
17 move the needle on their care and treatment.

18 Now, there's still lots of patients that
19 unfortunately we can't help, and many of these
20 patients are referred to David Walega and some of
21 my other colleagues in the Chicagoland area where
22 we do have to manage their problem on a
23 palliative basis.

24 But I think this is one option, the way

1 it's crafted in Illinois, should be adopted on a
2 wider use, and I think has greater benefit, and I
3 would encourage this Board to certainly attempt
4 to move the Illinois Department of Public Health
5 in that direction. I can answer any questions.

6 MS. WEATHERS: Have you certified any of
7 your patients?

8 DR. BUSH-JOSEPH: I have not. As a
9 representative, I'm a consultant with Cresco.
10 The Act defines that I cannot, so any
11 relationship with a medical cultivator, which
12 I've developed a consulting relationship with
13 them in the last six months, prevents me from
14 doing that.

15 But I have several partners who are
16 involved, you know, in the treatment of cancer
17 patients and in the non-cancer related patients
18 with chronic pain or unresolved therapeutic
19 patients who have.

20 MS. WEATHERS: So, that was a question.
21 I know our policy and our institution is
22 relatively new, so that's, the medical cannabis
23 policy at Rush is relatively recent. It was only
24 recently passed by the medical staff. So my

1 question was, the orthopedics representing
2 Midwest Orthopedics, and I wanted to know if
3 other providers in the practice were now
4 certifying patients.

5 DR. BUSH-JOSEPH: You know, some of our
6 doctors have referred patients to physicians who,
7 back to the primary care. Sort of the Act, as
8 you know, defines, number one, that the patient
9 has a clear-cut medical history that is well
10 defined and well examined, or commit to ongoing
11 care.

12 And so in these instances maybe patients
13 with unresolved conditions will communicate with
14 primary care physicians, say listen, we're not
15 going to help this patient. Unfortunately, the
16 only way we're going to get them off their
17 opiates and help manage their chronic pain is to
18 consider that.

19 And so the role that I've taken with
20 Cresco Labs is really as a role of purely medical
21 education. I mean, as a Professor of Orthopedic
22 surgeon, Orthopedic Surgery, I, you know, I'm
23 experienced in sort of educating physicians on
24 various modes of treatment. And I found this to

1 be an effective mode, and so I see my role as to
2 try to help, help practitioners understand the
3 pros and cons of this type of therapy.

4 MR. MCCURDY: Another question. So post,
5 so the reason you can't do, or think it's unwise
6 to do surgery on some of your patients who are
7 already on a high dose of opiates, so what
8 actually, what more specifically would happen if
9 you did the surgery and they were on the high
10 dose of opiates? What is the aftermath that you
11 would expect?

12 DR. BUSH-JOSEPH: You know, these
13 patients, unfortunately, they require such high
14 doses of opiates --

15 MR. MCCURDY: To begin with.

16 DR. BUSH-JOSEPH: -- to begin with, for
17 activities of daily living, you impart a
18 significant surgical trauma and all the morbidity
19 that goes with that. I hate to say the analogy
20 would be, I know the simple one would be having a
21 root canal without anesthesia.

22 And so, in essence, that's what many of
23 these patients go through. If we do a third or a
24 fourth operation on their shoulder or re-plate a

1 non-union or a fracture, or attempt to fuse a
2 spine where they've had, where they're on chronic
3 levels, you cannot manage their pain
4 postoperatively. And unfortunately --

5 MR. MCCURDY: Because you can't increase
6 the dose anymore so you --

7 DR. BUSH-JOSEPH: You get to the level of
8 opiates where basically, I'm sure many of the
9 panel knows as well, but, you know, the
10 endocannabinoid system, which is nerve receptors
11 throughout the body, do not exist in the
12 hypothalamus where opiate receptors do occur.

13 And so when you get super high doses of
14 opiates and they get into the hypothalamus, you
15 get respiratory suppression and cardiac
16 suppression, and that's ultimately what kills
17 patients. That doesn't happen with the
18 cannabinoids.

19 So, you know, we like if we can take
20 patients down to an acceptable level of function
21 with activities of daily living using
22 cannabinoids, then we've still got the opiate as
23 a means of managing postoperative or intermittent
24 use of serious pain. To me, you know, we use

1 patients, you know, patients with, and this is
2 certainly not on the, you know, not on the
3 discussion here, but, you know, patients with end
4 state osteoarthritis. And certainly I'm not
5 speaking to that as an indication, but we
6 typically use, when patients have end stage
7 osteoarthritis and they're taking narcotics on a
8 regular basis for activities of daily living, I
9 say go get your damn knee replaced, you know. I
10 mean, despite what, quote, medical fears of my
11 non --

12 MR. CHRISTOFF: We approved that too.

13 MS. TEMPLE: We approved that.

14 DR. BUSH-JOSEPH: I'm sorry. I
15 apologize.

16 MS. TEMPLE: This is more for the Board,
17 and since you're a physician, if you can please,
18 you know, comment if you find an opportunity is,
19 I've been having in my own institution and others
20 whole physician groups just saying we don't write
21 letters, like the pain specialist who prescribed
22 opioids, because it violates their pain
23 contracts.

24 So these patients who are on those

1 prescribing programs that they want to be in the
2 practice, they have to get drug tested
3 periodically and they can't have any cannabinoids
4 or any other illicit Schedule I substances, or
5 else they lose their ability to go to that doctor
6 and get Norco, Fentanyl, etc.

7 So I don't know if others have had that
8 experience, but it, then it has created, I know
9 Dr. Christoff and I have talked about it too, a
10 huge glut, a huge demand of, for a physician that
11 will certify a patient, because your prime
12 audience in terms of these categories are
13 intractable pain, pain due to trauma, et cetera,
14 their, their current physicians, in my
15 experience, are not certifying because these are
16 policies within a group internally.

17 DR. BUSH-JOSEPH: Well, you know, I would
18 answer that to say, again, that's part of the
19 role of the educators to, essentially what I
20 believe, is demystify the recommendation of
21 medical cannabis to the general physician
22 population.

23 You know, I would certainly agree that we
24 are all fearful, in every doctor that I talk to,

1 whether it be with any new therapy, the last
2 thing I want to do is see my name in the Chicago
3 Tribune associated with a controversial therapy.
4 So, you know, again, that's part of the process.
5 The administrative process is to essentially put
6 rules and regulations behind it and sort of
7 ensure safety and efficacy into how these things
8 are done.

9 I think that what I see and what many
10 physicians, I've got a lot of patients who are
11 using it and they're underground, they're doing
12 it in the dark, and we want to bring them above
13 surface where we can sort of regulate it and
14 provide more appropriate use.

15 And certainly for the State of Illinois,
16 yeah, let them tax it. I mean, let there be some
17 benefit to its use. I mean, the State of, you
18 know, the hundreds of million dollars that the
19 State of Colorado has garnered from the medical
20 marijuana industry, obviously it's totally
21 discordant to Illinois but, you know, that has
22 beneficial use to allow a supervision or
23 supervisory function to its use.

24 So, again, this is, these are all issues

1 that I think that this Board is charged with to
2 help, at least I think bring out into the open,
3 to demystify to patients, as well as to demystify
4 to physicians, to really find what I think is a
5 reasonable treatment option.

6 This is not curing cancer, at least in my
7 mind. I mean, we're not, we're not, you know,
8 this is, I know, you know, Dr. Ramirez talked
9 about aspirin. Aspirin's a great drug, and it
10 does a lot of things, but it still works in
11 defined areas. And we're trying to attempt to
12 put boundaries, but we think there are some very
13 good areas that this has benefit, so.

14 I have, I can submit into the record a
15 series of medical literature of recent articles
16 that are peer reviewed journals. Many of them
17 are double blinded and randomized controlled
18 studies that you may be aware of and I think, and
19 to aid my testimony.

20 MR. MCCURDY: That would be great.

21 MS. TEMPLE: Thank you very much.

22 (Applause.)

23 MS. TEMPLE: I assume then since we let
24 you go longer, when it's time to talk about the

1 other conditions, then you'll pass, right?

2 DR. BUSH-JOSEPH: I've spoken my piece.

3 MS. TEMPLE: Okay. Doctor Ramirez.

4 MR. RAMIREZ: Well, just to amplify Dr.
5 Bush's comments about this is not something new,
6 et cetera, the U.S. Pharmacopoeia had marijuana
7 officially as listed as one of the pharmacology
8 products approved in the United States until
9 1942, so this is not something new. This is not
10 something weird.

11 And to me it seems ironic that in order
12 to get people off Class II and Class III drugs we
13 have to try to prescribe a Schedule I drug. So
14 we need to reschedule a Class II or a Class III.
15 And the FDA in the rules says that anybody can
16 apply for rescheduling of a drug.

17 You just have to have the adequate
18 resources and the adequate evidence. So national
19 groups can petition in the FDA to reschedule.
20 Now, the Director of the DEA said that they were
21 going to try to apply for rescheduling in June.
22 But you know how government works.

23 So in the meantime the public, the users,
24 should try to put enough force together before a

1 petition to reschedule to at least a Class II. A
2 Schedule II, I'm sorry.

3 MS. WEATHERS: I have a motion, but I
4 want to make sure everybody's had their comment.

5 MS. TEMPLE: There's a motion in front of
6 you.

7 MS. MILLER: Second.

8 MR. RAMIREZ: Enthusiastic.

9 MS. TEMPLE: Okay. There's a second.
10 And then after this we will reconvene and talk
11 about chronic pain syndrome starting with Dr.
12 Walega. Wait a minute.

13 MS. WEATHERS: I think we need to take a
14 vote on my motion.

15 MS. TEMPLE: Oh.

16 MR. RAMIREZ: I said enthusiastically.

17 MS. TEMPLE: I know, but that was just
18 you. I was internally saying yes. Internally
19 saying yes.

20 MR. RAMIREZ: Approved by acclimation.

21 MS. TEMPLE: Then a second question
22 was --

23 MS. WEATHERS: No.

24 MS. TEMPLE: He declined. Okay. So Mr.

1 Jared Taylor --

2 MR. TAYLOR: For pain due to trauma I
3 declined.

4 MS. TEMPLE: He declined about, to speak
5 for chronic pain due to trauma and chronic
6 postoperative pain and neuropathy, so that's why
7 we've skipped over his name.

8 MS. WEATHERS: Are you going to talk
9 about intractable pain?

10 MR. TAYLOR: For what?

11 MS. TEMPLE: Intractable pain.

12 MR. TAYLOR: For chronic pain syndrome,
13 intractable pain, and IBS, migraine, OA and --

14 MS. TEMPLE: Okay. So we're crossing off
15 Jared Taylor for chronic postop pain and for
16 neuropathy, so those are the two next upcoming
17 topics that he will not speak at. He did sign up
18 but he's declining to speak because there are
19 others.

20 Okay. It is now 11:57. So how about we
21 come back at 12:45? You want to keep going? At
22 12:45 please come back to the room. The Board
23 will stay here and eat our lunches, and so enjoy
24 your break. We'll see you here at 12:45 to talk

1 about chronic pain.

2 (Lunch break taken at this time.)

3 MS. TEMPLE: Thank you for being here.

4 We have now the opportunity to officially reopen
5 the meeting. We need a motion and a second to
6 resume proceedings.

7 MR. FINE: I hereby motion to resume the
8 meeting.

9 MR. KNAUS: Second.

10 MS. TEMPLE: Okay. All those in favor
11 say aye.

12 (Board responded aye.)

13 MS. TEMPLE: Another motion I wanted to
14 ask of the Board is to allow additional comments
15 from those who have not signed up per the
16 deadline for making public comments, to limit
17 those to three minutes at the end of this set of
18 testimonies that are scheduled.

19 MS. WEATHERS: I think given the people's
20 travel requirements and train schedules I would
21 like to actually hold off making that motion
22 until we see what time it is once we've completed
23 formal testimony. And then I believe we'll be in
24 a better place to determine that.

1 MS. TEMPLE: So let's revisit that when
2 we get to the end, which is after we discuss Post
3 Traumatic Stress Syndrome, ending with Miss
4 Feliza Castro. Then we can re-evaluate how our
5 time is going.

6 Okay. On another note, Mr. Joel Erickson
7 has had to leave, so he will not be speaking on
8 migraine nor on PTSD, so that will shorten up our
9 conversations a little here.

10 Okay. Any other business before we
11 begin? And the other request, again, is for our
12 court reporter to hear everything as clearly and
13 slowly as possible, especially when we're
14 talking, speaking with medical terms to give her
15 a chance to catch up.

16 Okay. So the next condition is chronic
17 pain syndrome, which the Board did approve. And
18 our first speaker is Dr. David Walega.

19 And, Dr. Walega, I had heard earlier, did
20 you want to speak to the multiple conditions and
21 then save your testimony, save from not
22 testifying?

23 DR. WALEGA: Yes. If I could just
24 combine everything --

1 MS. TEMPLE: Okay. So you'll get six
2 minutes.

3 DR. WALEGA: -- in about six minutes.

4 MS. TEMPLE: Okay.

5 DR. WALEGA: And I don't think I need the
6 microphone, but --

7 MS. TEMPLE: And if you could also state
8 your affiliation.

9 DR. WALEGA: Sure. Sure. My name is
10 David Walega. D-a-v-i-d. Last name,
11 W-a-l-e-g-a. I'm a medical doctor. I am an
12 Associate Professor of Anesthesiology at
13 Northwestern University in Chicago.

14 I double booked my clinic today in order
15 to, or tomorrow in order to be here today. I
16 wear many hats at Northwestern. I am the Chief
17 of the Division of Pain Medicine for the hospital
18 system. I am and have been the Medical Director
19 of the Galter Pain Medicine Center since 2004.

20 I was the Program Director of the Pain
21 Medicine Fellowship between 2007, and I finally
22 passed it off to someone last year. In addition,
23 I sit on some other community boards.

24 I'm the President of the Midwest Pain

1 Society starting this year. I'm the President
2 Elect now. I'll assume that role in November.
3 I'm also the President of the Association of Pain
4 Program Directors, which is a group of academic
5 physicians who help set and support educational
6 curricula for pain medicine trainees.

7 And I am here today on behalf of my
8 physician colleagues in pain medicine and in
9 general medicine, as well as my pain patients to
10 advocate for the inclusion of chronic pain
11 syndrome, chronic pain following surgery, and
12 neuropathic pain to be included as qualifying
13 diagnoses for the Illinois Pilot Medical Cannabis
14 Program.

15 I hope I said that correctly. I see
16 patients on a day-to-day basis with chronic pain.
17 About 60 percent of the patients that I see have
18 a neuropathic pain disorder. Maybe 10 percent of
19 my practice is patients with a chronic pain
20 problem following surgery or trauma, et cetera.

21 Many of you on the Board may have had an
22 outpatient surgery or a minor elective surgery.
23 There's actually a pretty significant incidence
24 of chronic pain following what we would assume to

1 be simple straightforward surgeries. Six months
2 after a total knee replacement, 50 percent of
3 patients still had pain at the site of their knee
4 replacement. After a simple inguinal hernia
5 repair, about 20 percent of patients have chronic
6 pain in the groin of the surgical site six months
7 after surgery.

8 And I can go on and on. Neuropathic pain
9 affects about 10 percent of the United States
10 population. Probably the most common cause is
11 diabetes. What is neuropathic pain? Imagine
12 your hands in an ice bucket, not just for a few
13 seconds but for every minute of every day.

14 Imagine your feet being stung with
15 hundreds of bumble bees or walking on pins or hot
16 coals. How do we treat this in pain medicine?
17 We use a multi-modal technique, or multiple
18 treatments in order to get as much efficacy in
19 pain treatment as possible.

20 This would include medications. What are
21 those medications? Opiates, anti-depressants,
22 topicals, compounded medications, intravenous
23 Ketamine, anti-inflammatories, muscle relaxants.

24 In addition, we do a variety of

1 injections, nerve ablations, spinal cord
2 stimulator implants, and intrathecal opiate
3 delivery system implants where we're actually
4 delivering opiates to the spinal sack. And this
5 is obviously in patients with severe refractory
6 neuropathic pain or other types of chronic pain.

7 That said, about a third of patients who
8 are on all of these cocktails of medicines
9 getting the best medical care possible, still
10 suffer with their pain and don't have any
11 response to these medications or therapies.

12 Medical cannabis and cannabinoids do
13 offer a new way to manage these types of chronic
14 pain syndromes, and the medical literature has
15 shown repeatedly, specifically for chronic
16 neuropathic pain, that this is an effective and
17 safe treatment modality.

18 Last year in the New England, excuse me,
19 not the New England Journal, the other great
20 journal, JAMA, Journal of the American Medical
21 Association, Kevin Hill published a systematic
22 review of six clinical trials, which included
23 about 400 patients with neuropathic pain.

24 Medical cannabis was used in this group,

1 specifically with neuropathic pain, and the
2 conclusion was that the literature supported that
3 medical cannabis was helpful for neuropathic
4 pain, and that this was high quality evidence.

5 In addition, last year the Journal of
6 Pain, Andrae, A-n-d-r-a-e, did a meta analysis of
7 five randomized trials of inhaled cannabis for
8 patients with chronic pain.

9 This was 178 patients and 405 observed
10 responses. The conclusion was that this was an
11 effective pain management tool that not only
12 improved pain scores, pain intensity, and quality
13 of life, but also seemed to be more effective
14 than Gabapentin, which is a membrane stabilizer
15 medication very commonly used for the treatment
16 of neuropathic pain and other chronic pain
17 disorders.

18 Safety. We're all concerned about
19 safety. 40, 40 people, 40 Americans per day die
20 of an opiate overdose. To my knowledge, no one
21 has died from a medical cannabis overdose. There
22 is a safety trial called the Compass Trial,
23 C-o-m-p-a-s-s, that did support the safety of
24 medical cannabis.

1 Long term efficacy has also been shown in
2 a prospective open labeled cohort study by
3 Haroutounian, H-a-r-o-u-t-o-u-n-i-a-n, in the
4 Clinical Journal of Pain this year. This was a
5 study out of Israel but was watching patients in
6 their program who were getting medical cannabis
7 for chronic pain for over a year, and found it to
8 be a safe and effective method.

9 And I've extended my time. Thank you.

10 MS. MOODY: Thank you.

11 MS. TEMPLE: Thank you.

12 DR. WALEGA: Any questions from the
13 Board?

14 MR. MCCURDY: Not too long ago I was
15 involved in some correspondence, part of which
16 came from a pain physician elsewhere, and this
17 person was reporting on attending a conference at
18 Harvard recently where a number of pain experts
19 he said were there. The sense the person said
20 they got at the conference is that first there
21 were too many strains of cannabis to know what
22 specifically your patients will be getting.

23 And, secondly, there's not enough data to
24 support the concomitant use of both cannabis and

1 opiates, which to me is a, would be a, you know,
2 maybe a real life, or potentially a real life
3 question. And then there, some people were aware
4 of that trial in France where they were testing
5 something having to do with cannabis and opiates
6 and one person died and several were critically
7 ill after the trial. Now, I don't know if
8 you're --

9 DR. WALEGA: I don't know of the details
10 of that particular trial.

11 MS. TEMPLE: I can speak to that.

12 MR. MCCURDY: But in any case, I think
13 the cannabis and opiates question, I mean, what's
14 your sense of, part of it is what you hear from
15 colleagues but how you would see that as well?

16 DR. WALEGA: So everyone on this Board
17 knows that we are living through an opiate
18 epidemic. Opiates are not the answer to every
19 single pain problem. I feel that the CDC
20 guidelines that were released in March, just a
21 couple of months, it's a little too little, a
22 little too late.

23 We already have a really huge problem.
24 We have a patient population and a public

1 population that is expecting a hundred percent
2 relief of their pain by any means necessary. And
3 for many physicians, that means writing another
4 prescription for Norco or escalating that up to a
5 Fentanyl patch. We don't know what happens to
6 that medication after the patient gets it filled.
7 Are they using it? Are they using it all at
8 once? Are they using a 30 day supply in one
9 week? We don't know.

10 But I do want to speak to the concomitant
11 use of opiates and CBD. So, specifically for
12 neuropathic pain, opiates are really not a great
13 drug to be using. And yet, we use it more
14 commonly, almost as commonly as membrane
15 stabilizers.

16 Side effects. The constipation, the
17 fogginess, the opiate-induced hyperalgesia, which
18 is a state to wherein our central nervous system
19 becomes sensitized to pain due to the presence of
20 opiates. We don't receive that yet from
21 cannabinoid use.

22 But what many of these studies have shown
23 in the peer reviewed literature is that when
24 patients are on a CBD type drug they decrease, if

1 not discontinue, their opiates. One study, the
2 Israeli study that I mentioned, showed a 44
3 percent decrease in opiate use. There was a
4 retrospective study out of the University of
5 Michigan, I think 2015. Dan Clauw, who's a
6 colleague and a friend who was the anchor author
7 on that, C-l-a-u-w, they showed that there were,
8 there was a significant portion of patients in
9 the Michigan Registry who stopped using opiates
10 for pain control because they had adequate pain
11 relief with the cannabinoid.

12 Or the side effect profile was more
13 favorable with cannabinoid as opposed to other
14 medications.

15 Harvard. I've spoken there myself as a
16 visiting professor. There are a lot of smart
17 people that are there and a lot of controversial
18 things that are said there. That said, just
19 because it came out of Harvard doesn't mean it
20 was sent down by God.

21 And I feel that, you know, we fail our
22 patients when we don't give them the opportunity
23 to improve their quality of life, level of
24 functioning, ability to interact with their

1 families, with their community, and go back to
2 work, et cetera. Doctor Temple, you asked an
3 interesting question that I hadn't thought about
4 too much, and that was the distinction between
5 chronic pain patients who are being treated in a
6 pain center on an opiate contract, or what we
7 prefer to call a narcotic agreement, and the
8 presence of a cannabinoid, or cannabinoid
9 metabolite in their urine tox screen test.

10 MS. TEMPLE: I was about to ask you if
11 you --

12 DR. WALEGA: Good. I anticipated your
13 needs. So what do we do with that? I feel as a
14 practitioner, so I have certified three patients
15 thus far this year. I see 15 to 20 patients a
16 day. I have certified just a handful, and I have
17 turned away a few people.

18 That said, patients who are being, I
19 would say, I'm not going to speak on behalf of
20 every pain specialist in the State of Illinois,
21 but I would say that my peers, most of my peers,
22 are frustrated by the fact that some of these
23 pain disorders are so challenging to treat
24 effectively, that the tools that we have in our

1 tool box, you said weapons in your armamentarium,
2 I like tools in the tool box, the tools in our
3 tool box are not effective. They're not helping
4 every patient. If you had a bug strain or an
5 antibiotic regimen that only helped 60 percent of
6 the patients who were being treated for an
7 infection, you'd say wow, infectious disease as a
8 specialty is really not doing a very good job.
9 We need other tools, right?

10 But with a pain condition, something that
11 we can't always see with our eyes, where we can
12 see bacteria growing in a petri dish, we seem to
13 have a separate set of ideals. So I would say
14 that most physicians who do what I do on a daily
15 basis would welcome the use of their patients
16 using a cannabinoid product if it was
17 concomitantly showing an improvement in quality
18 of life. Perhaps a decrease in medication use.

19 And as long as, and we screen our
20 patients for misuse, abuse and diversion every
21 time they come in. We use different outcome
22 measures. There's one called the SOAPP,
23 S-O-A-P-P, that helps stratify no, mild, moderate
24 and severe risk of medication misuse, abuse and

1 diversion. So I think that if we use the same
2 standards in, or some of the same standards in
3 qualifying cannabinoid use as we do with opiates,
4 then we'll be in a good place. We'll have
5 another effective tool in our tool box.

6 MS. TEMPLE: What I think needs to happen
7 on those, these policies I believe are generated
8 internally within a medical group, right? I
9 would say.

10 DR. WALEGA: Yes.

11 MS. TEMPLE: It's not a State mandated --

12 DR. WALEGA: No.

13 MS. TEMPLE: -- contract?

14 DR. WALEGA: No.

15 MS. TEMPLE: I don't even know how
16 enforceable it is. But these contracts allow
17 patients to stay on a physician's panel. So if
18 you break the rules you don't get to see that
19 doctor anymore and then you don't get your Norco
20 prescription.

21 And that's where my tension has been as a
22 clinician, since I'm not a pain specialist I will
23 get patients referred to me and they want to go
24 on cannabinoids. I think it's a good idea. I

1 certify them. But then they have their Norco
2 scrips they still need. I can't just take them
3 off Norco and get them on cannabi, you know,
4 cannabis. First of all, it's going to take a few
5 weeks to get their card.

6 So there's been a tension between well,
7 the pain doctor can no longer write the scrips,
8 so we've had to transfer that activity to their
9 primary care physician, if I can get them to do
10 it, since I don't want to do both. I would
11 rather them work with their primary.

12 DR. WALEGA: Yeah.

13 MS. TEMPLE: And I think that's where
14 we're hitting some road blocks. Because if these
15 groups have the policy that if cannabinoids are
16 found in the urine or any other testing, you
17 can't get it, then you can't do concomitant
18 cannabinoid opioid dosing, and you can't see that
19 response like in terms of decreasing opioids.

20 I have seen clinically when I have put
21 patients on medical cannabis we've been able to
22 successfully reduce their opioids by a lot. It's
23 been astounding. And it's just hard when you're
24 the only one in your institution who is doing it

1 and they send you all the referrals because
2 nobody else in the institution wants to do it.
3 And that's where the education comes. And I'm
4 really heartened that we have a pain physician up
5 here talking about this. This is the first time
6 ever. So you can come to all our meetings.

7 DR. WALEGA: Okay.

8 MR. KNAUS: Could I ask two unfair basic
9 science questions --

10 DR. WALEGA: Sure.

11 MR. KNAUS: -- that I don't remember from
12 medical school?

13 DR. WALEGA: Okay.

14 MR. KNAUS: Are pain receptors generic,
15 and is it true that there's more cannabinoid
16 receptors in our body than any other receptor?

17 DR. WALEGA: So did you mean generic or
18 genetic?

19 MR. KNAUS: Generic.

20 DR. RAMIREZ: Generic.

21 DR. WALEGA: So there are multiple pain
22 pathways, too numerous to mention, and I don't
23 want to bore you with the neurochemistry and the
24 biochemistry. But there are, every individual

1 has really an individual way of modulating pain.
2 So if you have this ethnic background and this
3 genetic makeup, you may have more of this
4 particular receptor and therefore have more
5 effect with a medication or treatment that
6 affects that receptor system.

7 Whereas, if we did that same thing to
8 this person that has a different genetic makeup,
9 we're not going to see the same positive effect.
10 The second question?

11 MR. KNAUS: Cannabinoid receptors.

12 DR. WALEGA: As far as the number of
13 them, I don't know how they compare to the number
14 of opiate receptors and norepinephrine receptors.

15 MR. KNAUS: Do you think pharmacogenetic
16 testing is reliable?

17 DR. WALEGA: It depends on what you're
18 looking at. We are, in general, we are moving
19 toward individualized medicine. We see it in
20 cancer, in your field of oncology, increasing,
21 and we do some genetic testing with regard to if
22 a patient will respond to an opiate or not. Back
23 to your point about education.

24 I have inadvertently become the voice of

1 medical cannabis at Northwestern, like it or not.
2 And I think that the physician education is
3 really important. Several physicians are now
4 sending their patients to me to certify them.
5 And, you know, I'll evaluate the patient and
6 stratify their risk for you, but I don't have a
7 relationship with this person.

8 I think communication is really key when
9 you are certifying that patient in your practice
10 and you know they are getting treatment by
11 another pain specialist. And maybe having that
12 dialogue of hey, you may not want to certify
13 every patient in your practice and go down that
14 road, but I'm doing it.

15 I find that it's effective. My personal
16 experience is that opiate use decreases.
17 Patients are happier, they're more satisfied with
18 their care. And what else can I teach you about
19 this.

20 MR. FINE: I use weapon, you use tool
21 because, I use weapon because I'm fighting. It's
22 an interesting distinction, and I applaud your
23 efforts. I suffer from all the conditions that
24 you talked about. I suffer from chronic residual

1 limb pain syndrome. So all the drugs that you
2 talked about, The Gabapentin, the Lyrica, the
3 Cymbalta, the side effects were just awful. And
4 my cannabis use has caused a dramatic decrease in
5 all of that. So, I mean, I'm case in point in
6 line. And I'm completely aligned with what
7 you're saying from a a life perspective
8 standpoint.

9 And my primary care physician is my pain
10 doctor. My last two surgeries were at
11 Northwestern with Josh Rosenow for the Boston
12 Scientific.

13 DR. WALEGA: I know Josh very well.

14 MR. FINE: You know, the pain device that
15 I have, the spinal stimulator that I have, it's,
16 but it is, it's one more weapon, one more tool in
17 our arsenal to deal with it. And if it's one
18 less Vicodin that I have to take a day or one
19 less Norco or Methadone or Oxycontin or a
20 Fentanyl patch or any of that stuff, then why
21 not? And without any side effects. So, so thank
22 you for being here to legitimize that point of
23 view.

24 DR. WALEGA: My pleasure.

1 MS. TEMPLE: Are you familiar with the
2 National Pain Strategy --

3 DR. WALEGA: Yes.

4 MS. TEMPLE: -- and stuff that they're,
5 and I, so the National Pain Strategy was started
6 after a huge call to recognize this terrible pain
7 epidemic we have and what a crappy job we're
8 doing at managing it. The opioid epidemic, et
9 cetera.

10 So the Institute of Medicine, NIH, and
11 another couple of governing bodies got together
12 to put together this National Pain Strategy again
13 in groups of people looking at various areas of
14 how to manage pain.

15 But when I read the document I saw
16 nothing about cannabis, because obviously this is
17 a Federal initiative, which I think is very
18 interesting. So I wonder if, you know, there's
19 any talk amongst your Society about medical
20 cannabis. I know it's jumping way ahead, but
21 about medical cannabis as a potential factor in
22 the National Pain Strategy.

23 DR. WALEGA: I would say that physicians
24 as a group are conservative. I would say that

1 pain specialists who almost feel like a scapegoat
2 for the opiate epidemic are a little bit gun shy
3 and may not be as informed as they should be
4 about the efficacy of medical cannabis in the
5 treatment of multiple pain disorders.

6 And, again, that goes back to education.
7 Even people in my own field, there are some
8 people that don't know this data. And, you know,
9 we prescribe things like Gabapentin and Fentanyl
10 with an absence of almost any randomized
11 controlled data. And here we have five trials
12 that all showed efficacy in multiple domains.

13 Unfortunately, you know, dealing with the
14 Federal Government, you know, I'm also trying to
15 initiate some research in this specific realm. I
16 have four clinical trials right now. None of
17 them have anything to do with medical cannabis.

18 And I feel like I'm an experienced
19 researcher. I have over 20 publications in the
20 peer reviewed literature. But I am finding
21 multiple obstacles getting this operationalized
22 in a tertiary top ten Medical Center in the
23 United States.

24 And that's primarily due to a lot of

1 Federal obstacles, Federally imposed obstacles.
2 So I hope that my voice is heard as a physician
3 who deals with this in the trenches dealing with
4 chronic pain patients every day so that we can
5 potentiate positive change and help our patients.

6 MS. TEMPLE: I think Jim Champion has --

7 MR. CHAMPION: Oh. I was just going to
8 say along the lines of what you were saying about
9 neuropathic pain. I suffer from severe
10 neuropathic pain in my right knee. And I
11 testified until I'm green about how narcotics
12 have little to no effect.

13 Gabapentin was causing me extreme weight
14 gain. I've been narcotic free since November
15 2014 and also after 28 years of MS and all the
16 pain that goes along with it. I'm also bowel
17 blockage free and all the other things that go
18 along with all those narcotics. So, yes, I'm
19 living proof of what you're talking about.

20 DR. WALEGA: That's excellent.

21 MS. TEMPLE: Any other comments or
22 questions for Dr. Walega?

23 MR. MCCURDY: Thank you so much.

24 MS. TEMPLE: Thank you very much for your

1 testimony.

2 (All Board members thanked Dr. Walega.)

3 DR. WALEGA: Thank you all for listening
4 to me.

5 (Applause.)

6 MS. TEMPLE: And so, Dr. Walega, we're
7 going to mention your testimony when the
8 conditions come up regarding neuropathies since
9 you've already spoken to that, as well as Dr.
10 Charles Bush-Joseph's testimony for the other
11 conditions.

12 So I want to make sure that it's in the
13 record that they have spoken about the conditions
14 that we're going to be setting forth. Okay. So
15 next on the list for chronic pain syndrome is
16 Jared Taylor.

17 Jared, do you want to, so just like with
18 the physicians, they had multiple conditions they
19 wanted to talk to? Or do you want to go one at a
20 time?

21 MR. TAYLOR: I have a speech prepared for
22 each. Whichever is more convenient for the
23 Board.

24 MS. TEMPLE: It doesn't matter. It might

1 be more disruptive not to follow your speech.

2 Like keep it the way you have it --

3 MR. TAYLOR: Okay.

4 MS. TEMPLE: -- and just, because you
5 prepared it, so if you speak off the cuff we've
6 just lost all of it.

7 MR. TAYLOR: No, I'll just do, I'll just
8 do them separate. No, no way. No way. All
9 right.

10 MS. TEMPLE: All right.

11 MS. WEATHERS: We wanted to make sure we
12 were being fair in extending the same offer.

13 MR. TAYLOR: Sure. No, I appreciate it.
14 I'm ready whenever Connie is. You good? Okay.
15 All right. Good afternoon. My name is Jared
16 Taylor. We'll get down to business.

17 Chronic pain syndrome, also known as CPS,
18 is a common problem that presents a major problem
19 to healthcare providers because of its complex
20 history, unknown causes and poor responses to
21 therapy.

22 CPS is poorly defined, yet many medical
23 professionals consider ongoing pain that lasts
24 more than six months as a qualifying criteria.

1 Other medical professionals have used three
2 months of chronic pain as the minimum criteria.
3 However, with chronic pain demarcation of time it
4 is arbitrary. CPS is a conglomeration of
5 syndromes that don't typically respond to medical
6 treatments, and is best managed by combining a
7 variety of approaches, including avoiding bad
8 posture, exercising, good sleeping habits, and
9 balanced meals.

10 Approximately 35 percent of Americans
11 have some element of chronic pain, and
12 approximately 50 million Americans are disabled
13 partially or totally due to chronic pain.
14 Chronic pain also is reported more commonly in
15 women.

16 CPS affects sufferers on a daily basis.
17 Whether sufferers are affected by a depressed
18 mood, poor quality, or non-restorative sleep,
19 being fatigued, a lack or reduction of libido,
20 and experience disability out of proportion with
21 impairment.

22 Chronic pain also may lead to prolonged
23 physical suffering, marital or family problems,
24 loss of employment, and it may cause adverse

1 medical reactions and long-term treatments. I
2 myself have experienced chronic pain for the past
3 three years. While I now know that my chronic
4 pain is caused exactly by my osteoarthritis, many
5 patients with CPS don't know what the underlying
6 cause is.

7 As I can personally attest, chronic pain
8 makes daily life much more difficult. It's hard
9 sometimes to see the proverbial silver lining in
10 dark clouds when one has chronic pain, as chronic
11 pain causes sufferers to have gray skies for many
12 days.

13 Mundane activities such as going to work,
14 household chores, caring for dependants and other
15 day-to-day activities are difficult with chronic
16 pain. Cannabis is a proven medicine that
17 effectively inhibits pain signals from being
18 transferred from the brain to the point of
19 origin.

20 Pain is subjective, and what's painful to
21 me might not be painful to you. I do realize
22 that the Advisory Board is proceeding carefully
23 with blanket conditions such as chronic pain, but
24 I do admit that chronic pain is a very broad

1 condition. However, like I said, I did suffer
2 with chronic pain for nearly three years without
3 having a diagnosis. Other individual patients
4 that have chronic pain are not so lucky to be
5 afforded diagnosis. Because chronic pain
6 syndrome is a disease that affects every facet of
7 a patient's life, it's truly a debilitating
8 condition. Thanks for your time.

9 (Applause.)

10 MS. TEMPLE: Our next speaker is Jesse
11 Fosdick. Is Jesse present? Okay. Then we'll
12 move on to, let's see. To enter for the record
13 that Dr. Charles Bush-Joseph has spoken on
14 chronic pain syndrome in his previous testimony.

15 And then we can move on to Timothy --

16 MS. MOODY: Could you also enter into the
17 record that Melanie Dillon also submitted a
18 request to present technical evidence. So
19 Melanie Dillon, D-i-l-l-o-n, also submitted
20 information for the intent to present technical
21 evidence, and that is in the Board packets also
22 for you.

23 MS. WEATHERS: So she was unable to
24 attend?

1 MS. MOODY: That she was unable to
2 attend, yes.

3 MS. WEATHERS: Do we need to review that?

4 MS. TEMPLE: No.

5 MS. WEATHERS: Okay.

6 MS. TEMPLE: So our next speaker is
7 Timothy Coughlin. Did I see that once? I don't
8 think, Timothy Coughlin not here?

9 MS. MOODY: No.

10 MS. TEMPLE: All right. So moving right
11 along, we, our next topic is chronic
12 postoperative pain, for which Mr. Taylor has
13 already provided his testimony. And also, Dr.
14 Charles Bush-Joseph has provided testimony
15 regarding chronic postoperative pain, a condition
16 that he passed last time.

17 So the next condition to discuss is
18 intractable pain, and we have Jared Taylor also.

19 MR. TAYLOR: It's like a frequent flier
20 or something. I thought about, you know,
21 combining them all but I just couldn't do them
22 with six of these. All right. You ready? Okay.
23 My name is Jared Taylor.

24 We've already approved this, but

1 intractable pain is actually defined by the
2 Minnesota Department of Public Health as a pain
3 state in which the cause of pain cannot be
4 removed or otherwise treated with the consent of
5 the patient, and which in generally course, an
6 accepted course of medical practice, no relief or
7 cure of the cause of pain is possible, or none
8 has been found after reasonable efforts.

9 To put it simply, intractable pain is
10 persistent and constant pain, and is happening
11 for an unknown reason. Intractable pain, IP, is
12 different from chronic pain. IP causes a patient
13 to become bedridden or housebound, and can even
14 cause early death.

15 IP actually causes adverse biological
16 effects on a patient's cardiovascular, hormone
17 and neurological systems. Patients experienced
18 changes in testosterone, estrogen, cortisol and
19 thyroid or pituitary hormones. There is no cure
20 for IP. The common treatments include opioid
21 medications, Methadone, a TENS unit, or an
22 intrathecal pain pump.

23 Other treatments include muscle
24 relaxants, stimulants, NSAIDs or physical

1 therapy. And similar to chronic pain treatment
2 for IP is merely throwing a treatment to the wall
3 and seeing what sticks. In December 2015, the
4 State of Minnesota added intractable pain to its
5 list of qualifying conditions.

6 Minnesota's medical cannabis program was
7 passed in 2014, and Minnesota patients with IP
8 will have access to medical cannabis in August of
9 this year. As I'm sure you are all aware,
10 Illinois has had our Medical Cannabis Pilot
11 Program longer than the State of Minnesota. And
12 for some, I don't know whatever reason, but
13 things are getting done in Minnesota much faster
14 here than in the State of Illinois.

15 I lived in the State of Minnesota for
16 three years. It's a great state, but we really
17 here in the State of Illinois are the powerhouse
18 of the Midwest and we need to be making head
19 gains rather than the North Star state.

20 Getting back to this, Minnesota
21 Commissioner of Health, Dr. Ed Ehlinger, stated
22 upon the passage of intractable pain that the
23 relative scarcity from evidence to add IP made
24 this a difficult decision. However, given the

1 strong medical focus of Minnesota's Medical
2 Cannabis Program, and the compelling testimony of
3 hundreds of Minnesotans, it became clear that the
4 right compassionate choice was to add intractable
5 pain to the Program's list of qualifying
6 conditions.

7 This gives new options for clinicians and
8 new hope for suffering patients. That's what he
9 said. Like I said to you, Minnesota's Medical
10 Cannabis Program is younger than Illinois, and
11 really Minnesota took the advice of its Advisory
12 Board and its Commissioner of Health and the
13 advice of its citizens.

14 MR. FINE: Wow, what a concept.

15 MR. TAYLOR: And they actually thought
16 about the compassion of people suffering with
17 intractable pain. We've already approved this,
18 but as I mentioned to you, as a person who
19 suffers from chronic pain caused by
20 osteoarthritis, I know what it's like to have
21 pain and not know the cause.

22 And it really sucks, to be honest with
23 you, to not know what's causing the pain. And
24 intractable pain is a lot worse than chronic

1 pain. Thanks for your time.

2 MS. TEMPLE: I have a question, Jared.
3 Who was the person that made that quote from
4 Minnesota?

5 MR. TAYLOR: Yeah. The Minnesota
6 Commissioner of Health, Dr. Ed Ehlinger.

7 MS. TEMPLE: Okay.

8 MR. TAYLOR: Very similar to the State of
9 Illinois, there's also an Advisory Board that
10 reports to this Director of Health that
11 apparently --

12 MR. FINE: So what do you think the
13 difference is, just out of curiosity.

14 MR. TAYLOR: From Minnesota to Illinois?
15 A couple hundred miles, but --

16 MR. FINE: Yeah.

17 MR. TAYLOR: To be honest, it's, in
18 theory there should be no difference. There is
19 an Advisory Board, there is a person that makes
20 that decision. And as Dr. Ehlinger from
21 Minnesota stated, he focused on the relatively
22 scarce evidence presented by technical evidence,
23 but took into account the compassion of this
24 program, of their program, and listened to the

1 patients --

2 MR. FINE: The what?

3 MR. TAYLOR: The compassion.

4 MR. FINE: Oh, okay. Thanks.

5 MR. TAYLOR: The compassion of the
6 program. So I hope that IDPH will also follow in
7 Minnesota's tracks of allowing compassionate
8 treatment of cannabis for those that suffer from
9 intractable pain. Thank you.

10 MR. FINE: Thank you.

11 (Applause.)

12 MS. WEATHERS: I certainly, I share the
13 frustration of the Board members, of our Board
14 members and many of the audience, and I know
15 we've discussed this to have our recommendations
16 kind of repeatedly not be approved. However, I
17 would like to be careful and again not deflate
18 the, kind of that decision with all the work the
19 IDPH does.

20 I think they've, I'm sitting next to
21 Connie so I will give you credit. I think
22 they've done kind of just an incredible amount of
23 work on behalf of this Act and the patients and
24 getting those that are approved moving through,

1 getting this program started. And I think, you
2 know, there's a lot of people who really, who are
3 involved in the IDPH who really do care, who are
4 compassionate advocates, tireless advocates for
5 the patients, and I think that needs to be
6 recognized.

7 I think we are, we are a critical part of
8 it but we are a small part, and I think the lack
9 of movement for this aspect shouldn't cast a
10 shadow over all the accomplishments of all the
11 people that worked so hard on behalf of this Act.

12 MR. FINE: Here, here.

13 MR. MCCURDY: That's true.

14 MS. MILLER: Can I just coattail on that?
15 I just want to say too, building on that, I think
16 it's important too, we're all adults, and to
17 remain and maintain a level of professionalism
18 and adult-like mannerisms with that.

19 MS. TEMPLE: Also to acknowledge again,
20 the hard work of the IDPH in particular with very
21 limited resources, a lot of passion goes into
22 this. And the fact that my patients are getting
23 their cannabis cards and going to the
24 dispensaries and getting quality product is huge.

1 And so I hope that that, for the record, how it's
2 going down in my view as a clinician has been
3 excellent. So, yes, I definitely want to also
4 give credit to Connie Moody, who has worked
5 tirelessly. And it hasn't been perfect, it's not
6 going to be when you don't have a lot of help.
7 And so thank you very much.

8 MS. MOODY: Thank you.

9 (Applause.)

10 MR. KNAUS: Can I ask a question?

11 MS. TEMPLE: Yes.

12 MR. KNAUS: Is there a predictable
13 outcome of things that we've approved or
14 recommended and then have gotten to the point?

15 MS. TEMPLE: Predictable outcome, if we
16 go on the track record, is that the likelihood of
17 what we passed today getting passed again is
18 probably pretty slim if the same set of criteria
19 and decision makers are at the helm.

20 MR. KNAUS: Is it possible that the
21 people making those decisions should be here at
22 the hearing?

23 MS. TEMPLE: Okay. So --

24 MR. FINE: We have --

1 MS. TEMPLE: Yes. I would like to call
2 attention to Mr. Wright here who is from the
3 Governor's Office. Thank you for coming. So we
4 do have representation there. We would have, you
5 know, we would like to see more folks coming to
6 hear this.

7 But in the meeting that Michael Fine, and
8 Jim Champion and I had with Dr. Shah, the
9 evidence base is what his hugest hang-up was
10 about all of the conditions we've talked about.
11 It's the evidence base, the black and white.

12 And we did stress that compassion is a
13 very important part of this ruling, but he was
14 quite focused on the evidence base, and nothing
15 has really met the level of his criteria to move
16 forward with these conditions.

17 MR. BACHTELL: It's subject to the
18 clinical information that was brought forth by
19 the physicians with the, right with the
20 additional list of clinical studies.

21 MR. FINE: Just come up here and speak
22 up.

23 MS. TEMPLE: I guess informally we're
24 going to have a little chat.

1 MR. BACHTELL: I didn't mean to disrupt
2 anything.

3 MS. TEMPLE: Then go ahead and state your
4 name.

5 MR. BACHTELL: Sure. Charles Bachtell.
6 Last name is B-a-c-h-t-e-l-l. I think one
7 distinguishing factor between previously approved
8 conditions and the ones that are going to be
9 approved today would be the additional clinical
10 information that was presented in written form by
11 the physicians that appeared. So I hope that's a
12 distinguishing factor.

13 MS. TEMPLE: Every bit of extra
14 testimony, evidence, it all counts and it should
15 be reevaluated with fresh eyes. Nestor?

16 MR. RAMIREZ: Just as a point of
17 curiosity, the original 39, what kind of evidence
18 base did they have and who came up with that
19 list?

20 MR. FINE: None. The Legislature passed
21 it.

22 MR. RAMIREZ: Oh.

23 MS. TEMPLE: I actually did a little
24 literature review. I cherry picked one

1 condition, I won't say what it is, but it had
2 much less evidence base.

3 MS. ZALA: We had, we had a lot of
4 advocates and a lot of sick people come in, and
5 that's how the conditions were chosen. They were
6 based on their relief that they found with
7 cannabis, what their doctors felt and so forth.

8 It wasn't just somebody made up a group
9 of list of conditions and said well, let's pass
10 this. A lot of people had personal compassion
11 and --

12 MR. RAMIREZ: That's what we have today,
13 and we had in January, and we had in June.

14 MS. ZALA: That's why they call it the
15 Compassionate Medical Cannabis Program.

16 MR. CHAMPION: That's exactly what we
17 brought up to Dr. Shah that the 39 conditions
18 that currently exist on our program have about
19 the same amount of research and studies as the
20 ones being presented to the Board, and that
21 didn't seem to matter.

22 MS. TEMPLE: So just to keep everything
23 back under control, back to the format, because
24 we still have several testimonies to go through.

1 Let's, we're going to again reevaluate the
2 opportunity for members of the public to come up
3 and give their commentary at the end just based
4 on train schedules and travel schedules.

5 So any other, I can't think of any other
6 comments regarding this. And I'm sure the theme
7 will come up again. The next topic is Irritable
8 Bowel Syndrome, and we have Jared Taylor.

9 MR. TAYLOR: All right. So in my prior
10 testimony, I just want to make very clear, I'm
11 very happy with Connie and all the people who are
12 part of her team. My frustration doesn't lie
13 with the Advisory Board or the people that really
14 have done the work.

15 My frustration kind of lies where what
16 happens to these conditions after they're kind of
17 passed up the loop. So that's where my
18 frustrations lie. So my apologies for not making
19 that clear.

20 According to the Mayo Clinic, Irritable
21 Bowel Syndrome, IBS, is a common disorder that
22 affects the large intestine. IBS commonly causes
23 cramping, abdominal pain, bloating, gas,
24 diarrhea, and constipation, and it affects

1 between 25 and 45 million Americans, and it's
2 estimated to affect one in 10 people worldwide.
3 It's a chronic condition that will require
4 long-term management. There's no known cause of
5 IBS, and in a normal functioning adult, a
6 person's intestines contract or relax in a
7 coordinated rhythm as food is moved from the
8 stomach through the intestinal tract to the
9 rectum.

10 With IBS, the contractions may be longer
11 and last longer causing gas, bloating and
12 diarrhea. It's also possible that contractions
13 may be weaker, which will slow food passage.

14 These poorly coordinated signals between
15 the brain and the intestines can make the body
16 overreact to normal changes in the digestive
17 process. The overreaction can cause pain,
18 diarrhea or constipation.

19 While many people have signs and symptoms
20 of IBS, there are four distinct groups of people
21 who have a higher risk of IBS; those under the
22 age of 45, females who are twice as likely to
23 have the condition, those with a family history
24 of IBS, and those who have a mental health

1 problem such as anxiety, depression, and
2 personality disorders. Since it's not clear as
3 to what causes IBS, treatment options focus on
4 the relief of symptoms. Dietary changes that
5 have alleviated symptoms of individuals with IBS
6 who had eliminated high gas foods, such as
7 broccoli, cabbage and cauliflower.

8 There are currently two medications that
9 are currently approved for IBS, Alosetron and
10 Amentiza. Alosetron to relax the colon to slow
11 the movement of waste. It can only be prescribed
12 by doctors enrolled in a special program and is
13 not approved for the use of, by men.

14 Its effectiveness in men is not proven,
15 and its side effects, well, actually, Amentiza
16 works by increasing fluid secretion in the small
17 intestine to help with the passage of stool. Its
18 effectiveness in men is not proven, and its side
19 effects include nausea, diarrhea, and abdominal
20 pain, which are the symptoms of IBS that this
21 medication is trying to prevent.

22 In 2004 the University of Naples
23 conducted a study titled Cannabinoids and
24 Intestinal Motility - Welcome to CB2 Receptors.

1 This study found that cannabinoids, which are
2 found in cannabis, inhibit gastric and intestinal
3 motility through the activation of enteric CB1
4 receptors. In plain English, the use of cannabis
5 slows down the digestive process for those with
6 IBS by activating receptors in the intestine.

7 IBS, like I said, has no cure. Modern
8 medicine doesn't have an explanation for its
9 occurrence. The symptoms that this disease
10 causes are painful and inconvenient for those
11 affected with IBS.

12 Cannabis is a proven medicine that can
13 better help to regulate the digestive process for
14 those with IBS, and is effective to manage the
15 pain that IBS causes. Thank you for your time.

16 (Applause.)

17 MS. TEMPLE: I don't see Tina Higen here
18 anymore. Tina.

19 MS. HIGENS: I'm hiding back here.

20 MS. TEMPLE: Okay.

21 MS. HIGENS: Hi. My name is Tina Higen.
22 The last name is spelled H-i-g-e-n-s. First, I'm
23 just going to talk about my personal experience.
24 I'm a qualifying medical patient under the

1 diagnoses of interstitial cystitis and
2 fibromyalgia. But today I want to speak to you
3 about how medical cannabis is helping me with my
4 IBS as well. I've seen a dramatic decrease in
5 IBS flares since becoming a medical cannabis
6 patient.

7 I no longer need to locate where the
8 bathroom is as soon as I enter a store or a
9 public area, knowing that at any time I may only
10 have a few minutes to run to and to avoid an
11 embarrassing accident.

12 This has dramatically improved my quality
13 of life. This allows me to be more comfortable
14 going out and enjoying time with my family and
15 friends. Cannabis helps combat the painful and
16 awful debilitating cramping that accompanies many
17 GI disorders, because cannabinoids relax the
18 smooth muscle of the intestines.

19 In fact, the smooth muscle relaxing
20 properties of cannabinoids are well established
21 that preparations of guinea pig intestines are
22 routinely used as an in vitro screening tool to
23 test the potency and function of synthetic
24 cannabinoids. Research on a variety of rodents

1 has shown that endogenous cannabinoids play
2 crucial, neuromodulatory roles in controlling the
3 operation of the gastrointestinal symptoms. With
4 synthetic and natural cannabinoids acting
5 powerfully to control GI motility and
6 inflammation, cannabinoid receptors compromise G
7 protein coupled receptors that are predominantly
8 in enteric central CBV1R and immune cells CB2R.

9 These digestive tracts contain endogenous
10 cannabinoids and cannabinoid CB1 receptors can be
11 found in mucosal nerves. But basically it really
12 helps what I would call intestinal, like, it's
13 almost like a seizure.

14 Your GI system just cannot stop having
15 these horrific contractions. You can get very
16 sick. You can be sweating. You feel like you're
17 going to pass out. And since using medical
18 cannabis for my qualifying conditions, I've
19 noticed that it has just had a dramatic decrease
20 of Irritable Bowel Syndrome, which I've been
21 suffering for for over half my life.

22 So I really would like to see this as a
23 qualifying condition to be, you know, added.
24 Thank you for your time.

1 MS. TEMPLE: Thank you.

2 (Applause.)

3 MS. TEMPLE: Comments from the Board? Or
4 we move on to Miss Feliza Castro on Irritable
5 Bowel Syndrome.

6 MS. CASTRO: Hi. Thanks again for having
7 me. I'm going to read two testimonies from two
8 separate patients that turned these testimonies
9 into The Healing Clinic. One was from Pamela
10 Santos of Chicago, Illinois.

11 She says: My name is Pamela J. Santos,
12 and I have been suffering with irritable bowel
13 syndrome for many years with severe cramping and
14 constipation and diarrhea, which has made me pass
15 out many times alone in the house, even causing
16 me to fracture my arm.

17 I've done so much research on medical
18 cannabis for pain management. I have been a
19 nurse all of my life, now currently on SSD due to
20 severe osteoarthritis, IBS, panic disorder,
21 anxiety, depression, migraines and insomnia.

22 I know that cannabis would be a more
23 natural, less harmful option for me than taking
24 so many of the pills I am taking now. I have dry

1 mouth and dry eye syndrome caused by all of the
2 prescription drugs I have had to take for these
3 conditions, while I could be using just one plant
4 that would not cause such adverse reactions.

5 Please consider how cannabis can help
6 make life easier for people like me, and all the
7 rest of the poor people that are suffering in
8 this state due to our restrictive cannabis
9 program. We all desperately need your help.

10 And then I have a second testimony from
11 an Ian Oraveck from Chicago, Illinois as well.
12 And he says: Four years ago I started presenting
13 symptoms of Irritable Bowel Syndrome, and was
14 shortly after diagnosed with IBS.

15 IBS has drastically changed my life. It
16 complicates simple, everyday errands, and
17 prevents me from being able to perform timely
18 tasks required at work. My doctor prescribed me
19 Dicyclomine and multiple probiotics, which mildly
20 helped my symptoms but did not prevent them all
21 together.

22 If I was having a bad IBS day, none of
23 the medicine prescribed would help calm my
24 stomach. I did some research online and found

1 that marijuana has been shown to help with IBS
2 and can calm the stomach. I finally gave it a
3 chance and never looked back. Almost instantly
4 my stomach was settled and the pain and bloating
5 started to subside. The most surprising thing
6 was that I no longer felt the urge to have to
7 consistently use the bathroom.

8 At my worst, I used to find myself on the
9 toilet in pain between 10 to 15 times every
10 single day. Cannabis is the most effective
11 medicine I have used in relieving my IBS
12 symptoms. Since I have been using the natural
13 medicine I have never felt better.

14 I am no longer having to look out for a
15 bathroom when I'm out doing errands, and I can
16 now be a much more efficient and effective
17 employee at my company. There have been some
18 published studies about the benefits of
19 cannabinoids for gastrointestinal problems.

20 One was published by the British Journal
21 of Pharmacology in 2008. It says the body
22 produces its own cannabinoid molecules, called
23 endocannabinoids, which we have shown increase
24 the permeability during inflammation, the

1 permeability of the epithelium during
2 inflammation, implying that overproduction may be
3 detrimental. However, we were able to actually
4 reverse this process using plant-derived
5 cannabinoids, which appear to allow that
6 epithelial cells to form tighter bonds with each
7 other and restore the membrane barrier. Thank
8 you.

9 MS. TEMPLE: Our next speaker is Amanda
10 Wilson. She's not here. Neither comments about
11 Irritable Bowel Syndrome have passed at least
12 twice in our petition meeting. I know we talk
13 about it a lot, especially after lunch. Perfect.

14 It's interesting about the research on
15 leaky gut, as we would call it, but I think it's
16 interesting that many of our patients,
17 particularly Miss Higen's who's had interstitial
18 cystitis and fibromyalgia with the IBS would see
19 these syndromes and that there may be an entity
20 called endocannabinoid deficiency syndrome, which
21 is something that, it is a bit of a wastebasket
22 term for every condition that we can't seem to
23 fit basically, but I find it intriguing that the
24 research that we see out there is looking at the

1 endocannabinoid system specifically in the gut
2 pain receptors behavior and such. So more needs
3 to be done but, you know, we've already passed
4 IBS. So, okay. And now the third. Okay. Let's
5 see. We've got next up migraine with Jared
6 Taylor.

7 MR. TAYLOR: Okay. All right.

8 MR. FINE: Change your shirt or something
9 or put a hat on, sunglasses.

10 MR. TAYLOR: Well, I came all the way
11 down from the suburbs. You know, I wanted to
12 make the best use of my time, so.

13 MS. TEMPLE: Perfect.

14 MR. FINE: Awesome.

15 MR. TAYLOR: All right. So good
16 afternoon, everyone. According to the Mayo
17 Clinic, a migraine headache can cause intense
18 throbbing or a pulsing sensation in one area of
19 the head, and it's commonly accompanied by
20 nausea, vomiting and extreme sensitivity to light
21 and sound.

22 Migraine attacks can cause significant
23 pain for hours to days, and be so severe that all
24 a patient thinks about is finding a dark, quiet

1 place to lie down. Migraines might be caused by
2 changes in the brainstem and genetics, or
3 environmental factors may play a role. Triggers
4 for migraines include foods, food additives,
5 drinks such as alcohol, wine specifically,
6 stress, change of weather, and certain
7 medications.

8 Risk factors for migraines include family
9 history, age (the majority of the patients
10 experience migraines during adolescence), sex
11 (women are more than three times as likely to
12 have migraines than men), and hormonal changes.

13 Migraines have no cure, but medications
14 such as aspirin, NSAIDS, acetaminophen, also
15 known as Tylenol, ergons and triptans are also
16 used to treat migraines. While I did not
17 formally submit this study into evidence, a
18 January 2016 study titled Effects of Medical
19 Marijuana on Migraine Headache Frequency in an
20 Adult Population, discovered that medical
21 cannabis helped with migraines.

22 From the 121 participants, researchers
23 saw a decrease of 10.4 migraines per month, to
24 roughly 4.6 migraines per month. 40 percent of

1 the 121 participants experienced positive
2 effects, and roughly 85 percent reported having
3 fewer migraines per month. Migraines may be
4 treated with cannabis by the activation of CB2
5 receptors.

6 That's also what the study had found, not
7 my personal opinion. I've seen friends and
8 people that I care about experience migraines,
9 and I know that migraines are not pleasant.

10 Even though medical cannabis is not a
11 cure for migraines, individuals should be able to
12 choose what medication works best to treat their
13 condition. Thank you for your time.

14 (Applause.)

15 MS. TEMPLE: Thank you. Tina Higen's.

16 MS. HIGENS: Tina Higen's. Last name is
17 spelled H-i-g-e-n-s. Once again, thank you for
18 giving me this opportunity to speak. As I told
19 you before, I'm a qualifying patient for medical
20 cannabis for fibromyalgia and interstitial
21 cystitis.

22 I have severe migraines of all different
23 types, but the ones that are most troublesome and
24 potentially life threatening for me are my

1 abdominal migraines. This is because I have a
2 metabolic disorder called mitochondrial disease.
3 I would vomit violently with the abdominal
4 migraines. I would often vomit 10 to 12 times in
5 an hour for up to 12 hours. The vomiting would
6 not subside even while I was retching up bile.

7 I would need to go to the ER to get
8 hydrous dextrose, Reglan, and sometimes all
9 different types of medications because I would
10 become severely dehydrated, and with the
11 mitochondrial disorder that can cause, you know,
12 a metabolic crisis.

13 Most months I would need to go to the ER
14 probably at least one time a month. I would
15 often have to drag my children out of bed at 3:00
16 a.m. to go to the hospital. This process was
17 very upsetting to my sons, and they would cry
18 asking family if I was going to be okay.

19 Since becoming a medical cannabis patient
20 in December I have not needed to go to the ER
21 once. This has had a huge impact on my life, as
22 I would live in fear that another episode would
23 be coming soon.

24 The last episode I had was on Christmas

1 Eve. As soon as I feel an episode coming on, I
2 can medicate with cannabis and it aborts the
3 episode. I've used several different types of
4 medication for my abdominal migraines from
5 Benadryl to Xanax to Elavil to Imitrex to Reglan,
6 and nothing was even close to being as effective
7 as cannabis.

8 Please add migraine as a qualifying
9 condition as, if you have a migraine you really
10 can't function and there's really nothing else
11 you can do but ride it out and hopefully it ends
12 soon. But, you know, a lot of people that do
13 have migraines also have other metabolic
14 disorders that can really cause severe problems
15 for a patient. So thank you for your time.

16 MS. TEMPLE: Thank you.

17 (Applause.)

18 MS. TEMPLE: And then we have Feliza
19 Castro for migraines.

20 MS. CASTRO: Okay. Another testimony for
21 a patient that we collected. Steven Whitehurst
22 from Chicago. My name is Steven Whitehurst. I
23 am 49 years old. I'm an author and educator, and
24 have been permanently disabled since 1997. I

1 suffer from an illness called bile salt
2 malabsorption, which causes stomach pain,
3 vomiting, daily nausea, discomfort, severe
4 migraines, which at their worst have come eight
5 times a day for at least an hour for years at a
6 time, major depression recur, major depression
7 which is recurrent, and anxiety disorder.

8 These migraines were the most
9 debilitating symptom of all, often preventing me
10 from moving even an inch without worsening the
11 pain. Coupled with anxiety and depression, life
12 was almost not worth living.

13 At one time I lost over 100 pounds from
14 not eating due to the myriad of health problems I
15 dealt with, and was told by a doctor that I was
16 going to die. Eventually I spoke to a physician
17 who suggested medical cannabis for appetite, mood
18 and migraine relief.

19 He was right. Cannabis helps me eat and
20 makes me have a brighter outlook on life. I can
21 stop a migraine before it happens, prevent panic
22 attacks, ease stomach pains and inflammation, and
23 can finally enjoy my life.

24 Illinois is too restrictive when it comes

1 to this often life-saving treatment option. The
2 covered illnesses are inconsistent and exclusive,
3 and access to this medicine is limited to those
4 who can pass a background check. This is an
5 effective medicine and a huge resource of revenue
6 for other states, but cash strapped Illinois
7 still stands idly by while citizens needlessly
8 suffer. By Steven Whitehurst.

9 Okay. So I know that the study The
10 Effect of Medical Marijuana - Migraine Heachache
11 Frequency was mentioned, which is a really good
12 one. Also, the National Center For Biotechnology
13 Information published another really compelling
14 study.

15 More and more studies are emerging that
16 show how both migraine frequency and intensity
17 are significantly reduced by medical cannabis.
18 Patients in California have been sharing their
19 anecdotal success for many years. For some,
20 cannabis is the only treatment option that can
21 stop a migraine in its tracks or help deal with
22 the dizziness, pain and sometimes nausea that
23 comes along with the migraine.

24 Many of our patients with TBI and

1 postconcussion are reporting to us that medical
2 cannabis is actually relieving migraines that
3 they were dealing with often before. So I
4 definitely think that it needs to be added.
5 Thanks again.

6 MS. TEMPLE: Thank you.

7 (Applause.)

8 MS. TEMPLE: And TBI is traumatic brain
9 injury.

10 MS. CASTRO: Yeah.

11 MS. TEMPLE: We had Joel Erickson
12 scheduled to come, but he's not here or scheduled
13 to speak. He's not here. So the next condition
14 -- oh, Nestor. Sorry.

15 MR. RAMIREZ: Discussion on migraine?

16 MS. TEMPLE: Yes.

17 MR. RAMIREZ: I just want to mention a
18 little historical fact. Sir William Osler, who's
19 been called The Father of Modern Medicine, one of
20 the four founding doctors for John Hopkins
21 Hospital has said, or had said at one time
22 because he's dead, that marijuana was the best
23 treatment possible for migraines. And this was
24 in the late 1800's.

1 MS. TEMPLE: Okay. We have neuropathy,
2 which, for which we have had speakers already.
3 So I want to enter into the record that Dr. David
4 Walega, am I saying that right?

5 DR. WALEGA: That's close enough.

6 MS. TEMPLE: Close enough? Okay. That
7 he had spoken extensively on neuropathy as well
8 as Dr. Bush-Joseph. So please refer to their
9 testimony in the records.

10 Okay. Any comments about neuropathy?

11 MS. WEATHERS: Did, okay. I just want
12 to --

13 MS. TEMPLE: Or, are we done? Sorry.
14 Did we finish migraine? Any comments on migraine
15 other than we've heard?

16 MS. WEATHERS: Yeah. We have already
17 past this, but I will say that this is something
18 that I obviously in my role as a neurologist do
19 see and treat frequently. And kind of going back
20 to Dr. Walega's point that any other tool in the
21 tool box for these patients is something that
22 all, all treating neurologists would welcome.

23 It is something that we struggle with,
24 and it's many lost days of work, you know, the

1 impact of quality of life, the lack of
2 productivity. The American Academy of Neurology
3 has very clearly come out and said that opioids
4 should not be used for this, they are not
5 effective. It's not even chronic pain where they
6 might be effective early on and then you're just
7 weighing the side effects versus, the adverse
8 effects versus benefits.

9 There is no benefit. So we have even
10 less medications at our disposal than in other
11 chronic pain conditions, so. I again agree with
12 our previous group.

13 MS. TEMPLE: I have to throw a plug in
14 for acupuncture as well. Again, the work that I
15 do. Good evidence based on migraine data base
16 for tension headaches at least, but I know that's
17 off the subject. It must be mentioned.
18 Osteoarthritis.

19 MR. CHAMPION: I was just going to say --

20 MS. TEMPLE: Oh, yes.

21 MR. CHAMPION: The last thing, a lot of
22 conditions, a lot of conditions really help the
23 migraines. By adding migraines to the group of
24 conditions approved it would cover other

1 conditions as well.

2 MS. TEMPLE: We covered the Lyme disease
3 rejection. Okay. Osteoarthritis. Jared Taylor.

4 MR. TAYLOR: Yep.

5 MS. TEMPLE: You get the frequent flyer.

6 MR. TAYLOR: This one's going to be a
7 little bit faster, just to warn you. All right.
8 Good afternoon. Again, thanks to the Advisory
9 Board and Connie and her staff for all that you
10 all have done. I'm really appreciative of that.

11 But since I spoke to you all before in
12 October there has not been a cure discovered for
13 osteoarthritis, OA. OA's the degradation of
14 cartilage in a joint. It's the most common form
15 of arthritis, and it can affect any joint in the
16 body.

17 Commonly affected areas include the
18 hands, the hips, the knees and the spine. My OA
19 is in the facet joints of my spine directly above
20 my --

21 MS. TEMPLE: Slow down.

22 MR. TAYLOR: Sure.

23 MR. FINE: You've got a little more time,
24 so you don't have to be the FedEx guy.

1 MS. TEMPLE: I ask you slow down.

2 MR. TAYLOR: Okay. All right. All
3 right. My OA is in the facet joints of my spine
4 directly above my tailbone. And even with my
5 super cool cushion, it's been a little bit
6 painful here this morning and afternoon.

7 In 2005, the CDC estimated approximately
8 eight percent of Americans had OA, and if these
9 numbers held true today for the State of Illinois
10 approximately 1.1 Illinoisans suffer from OA.
11 That's just my non-academic estimate.

12 So even if 10 percent of these Illinois
13 patients became registered patients, this program
14 would be self-sustaining, which IDPH predicted
15 100 to 150,000 patients with 10 percent of OA
16 patients in Illinois, 110,000, we could make
17 osteoarthritis the saving grace of this cannabis
18 program.

19 OA causes bones to rub against each other
20 after the cartilage is worn down. It's that
21 friction. It's very painful, and OA patients
22 like myself suffer from chronic pain on a daily
23 basis.

24 However, it's going to affect each

1 patient differently. For me, OA makes it painful
2 for me to do yard work, to do chores, painful to
3 sit. I wake up every single morning, this is a
4 hallmark of OA, with pain directly caused by this
5 disease. It affects me in almost every part of
6 my life.

7 Treatments for OA include taking Tylenol,
8 NSAIDS, chronic pain class, other pain management
9 based options. These therapies merely treat the
10 symptoms though of OA. There is no cure.

11 I am reintroducing a 2013 study by the
12 University of Nottingham titled Cannabinoids CB2
13 Receptors Regulate Central Sensitization and Pain
14 Responses Associated with OA of the Knee Joint.

15 In this study it was discovered that the
16 use of cannabis activate CB2 receptors in our
17 brain, and basically these signals are blocked
18 from transferring chronic pain from our brain to
19 the areas.

20 I'm also introducing a March 2016 study
21 titled Effectiveness of NSAIDS for the Treatment
22 of Pain in Knee and Hip Osteoarthritis, a Network
23 Meta Analysis. This study was conducted by Dr.
24 Sven Trelle, and through the study of 55,000+

1 patients discovered that Tylenol has little
2 effect on OA pain. It's a little bit better than
3 a sugar pill. So it really does nothing for us.
4 Rather, NSAIDS, according to the study, were
5 proven to be more effective. But NSAIDS come
6 with a host of risks such as stomach upset and
7 cardiovascular disease.

8 Medical cannabis isn't going to cure my
9 osteoarthritis. I've adapted by taking yoga
10 classes, seeing a pain specialist or
11 rheumatologist, but it's really only going to
12 treat my symptoms.

13 So we've approved this. We've
14 recommended it. But I'm not really realistic
15 that our, your recommendation will be heard. As
16 I said in October, I'm not going to go away, I'm
17 going to come back every time until OA is
18 approved, and I am prepared and willing to pursue
19 any other remedies that are available to me in
20 order to add osteoarthritis to this program.

21 We're not going to go away. We could be
22 the saving grace. Get the number of patients
23 needed to make this program self-sustaining.
24 Thank you.

1 (Applause.)

2 MS. TEMPLE: Nestor.

3 MR. RAMIREZ: For the sake of the record,
4 I think he said 1.1 Illinoisans, but I think he
5 meant 1.1 million.

6 MR. TAYLOR: Yeah, 1.1 million
7 Illinoisans by estimates have OA.

8 MS. TEMPLE: This was a condition we
9 debated early on at our first meeting and I had
10 reservations because it's so common. I mean, I
11 can't imagine, I don't know anyone who doesn't
12 have some form of ache and pain.

13 And we had a good conversation at the
14 first meeting that we need to remember this is
15 for debilitating conditions, that it's going to
16 be something that your physician,
17 patient/physician relationship will ferret out
18 whether other alternatives, other medications and
19 treatment programs have failed, or if this is a
20 better treatment option.

21 Because my initial reaction to
22 osteoarthritis was way too common. But at the
23 same time, that's going to be between
24 doctor/patient, and that it has to be

1 debilitating. You have to remember that these
2 conditions must be at a level of debilitation.
3 There's a conversation that I brought up about
4 why don't we write severe osteoarthritis or put
5 moderate, severe, and start putting qualifiers on
6 it. And then we decided not to go that route.

7 And remember constantly that it's the,
8 all of these conditions have the requirement that
9 they must be debilitating enough to merit their
10 certification. Because I got a lot of flack for
11 the osteoarthritis one from my colleagues. I
12 just want you to know that.

13 Once you explain it that way it works and
14 they're like oh, okay. All right. So the last
15 condition, we're almost done. And we have two
16 speakers. We are at that point where we can
17 decide.

18 MS. WEATHERS: Yes. I would like to make
19 a, I will make a, given how we're doing on time,
20 I'll make a motion that we allow the additional
21 speakers who did not preregister to each have
22 three minutes.

23 MS. TEMPLE: Okay.

24 MR. RAMIREZ: Second.

1 MS. TEMPLE: I would like -- a second?

2 Okay. Those in favor?

3 (Board responded aye.)

4 Those opposed?

5 (No response.)

6 MS. TEMPLE: Okay. So we will allow
7 further testimony from those who had not signed
8 up. Would you kindly raise your hand if you want
9 to give a testimony so we can get a head count?
10 One, two, three. And you'll get three minutes
11 like the others. So we have three. Okay. We
12 can do that. Okay. For Post Traumatic Stress
13 Syndrome we have Jared Taylor.

14 MR. TAYLOR. All right. I promise this
15 is the last --

16 MR. FINE: He looks so familiar, this
17 guy.

18 MS. TEMPLE: But you don't have to speak
19 faster.

20 MR. TAYLOR: Okay. No, this one's a
21 little bit more of a slower cadence to it. All
22 right. Good afternoon. My name is Jared Taylor.
23 We've already approved Post Traumatic Stress
24 Disorder, but years ago Post Traumatic Stress

1 Disorder used to be known as shell shock, if any
2 of you guys were familiar with that. I actually
3 did a study on this in college, and shell shock
4 was only seen as something that was by Veterans,
5 but we know that Post Traumatic Stress Disorder
6 can cover people that have never even served in
7 the Military.

8 Now, the Mayo Clinic defines PTSD as a
9 mental health condition that's triggered by a
10 terrifying event, either experiencing it or
11 witnessing it. Symptoms of PTSD include
12 flashbacks, nightmares, and severe anxiety, as
13 well as uncontrollable thoughts about the event.

14 PTSD is not limited to members of the
15 Military, although this topic does get heavy
16 exposure in the media. PTSD can affect anyone.
17 And according to the Department of Veterans
18 Affairs, about seven or eight out of every 100
19 people will have PTSD at some point in their
20 life.

21 According to the VA, about Eight Million
22 adults have PTSD during a given year, and about
23 10 out of every 100 women develop PTSD sometime
24 during their lifetime in comparison to roughly

1 four out of every 100 men. So ladies
2 unfortunately had about two and a half times
3 worse occurrence risk of getting PTSD than men.
4 Also according to the VA, 11 out of 2100, out of
5 every 10 Veterans who served in Operations Iraqi
6 Freedom and Enduring Freedom, have Post Traumatic
7 Stress Disorder.

8 As well, approximately 12% of Gulf War
9 and 15% of Vietnam War Veterans experienced PTSD
10 during their lifetime. The VA currently reports
11 that 721,575 Veterans currently reside in the
12 State of Illinois out of a population of
13 12.8 million residents in the State. That's
14 approximately 5% of the population in the State
15 of Illinois.

16 Now, Dr. Rafael Mechoulam, he's an
17 Israeli scientist who first identified
18 Tetrahydrocannabinol, THC, as the psychoactive
19 compound in cannabis. Decades later, Dr.
20 Mechoulam discovered that the human brain's
21 endocannabinoid system in the endogenous
22 neurotransmitter anadamide --

23 MS. TEMPLE: Anadamide.

24 MR. TAYLOR: Okay. Thank you for that.

1 I appreciate that. Doctor Mechoulam believes
2 that the cannabinoid system is integrally related
3 to memory, including memory extinction, which is
4 the normal, healthy process of removing
5 associations from stimuli.

6 Cannabis can therefore help to aid memory
7 extinction by reducing association with an
8 individual's association with stimuli such as
9 loud noises or stress which are trigger things
10 for Post Traumatic Stress Disorders.

11 While PTSD can affect anyone who has
12 experienced a traumatic event, PTSD
13 disproportionately affects our Veterans. Because
14 the debilitating symptoms that PTSD causes, we've
15 already established that you guys are going to
16 approve it, but basically I think the State and
17 its Administration should recognize and respect
18 and honor the service that Illinois Veterans have
19 given to our nation without regards to their own
20 personal safety, and also keep in mind that not
21 only Veterans that have PTSD will benefit from
22 this access to medical cannabis.

23 Thank you for your time.

24 MS. TEMPLE: Thank you.

1 (Applause.)

2 MS. TEMPLE: And we have our last
3 scheduled speaker is Miss Feliza Castro.

4 MS. CASTRO: Thank you. Thanks again.
5 And this is a testimony from a patient, not a
6 Veteran but someone else who wanted me to share
7 her story to the Board and with the rest of you
8 here today.

9 So this is Autumn of Champaign, Illinois.
10 And she says in 2009 I was diagnosed with PTSD
11 after my boyfriend committed suicide. I could
12 not help but blame myself, and I was convinced
13 everyone else knew that it was my fault.

14 I could not eat at all, or I would eat so
15 much I would get sick. I could not sleep for
16 days, and then I would sleep for 18 hours each
17 night. My body was in constant flux, and I
18 couldn't talk to anyone about feeling their pity
19 or judgment.

20 I dove into a deep, dark hole of
21 depression. I couldn't close my eyes without
22 imagining Will. I would have terrible dreams of
23 him dying in every way possible, or I would have
24 dreams that it never happened and wake up

1 sobbing. My doctor diagnosed me with PTSD and
2 started to prescribe a lot of different
3 medications, exacerbating my already debilitating
4 flashbacks and intrusive thoughts. A college
5 freshman at the time, I had to drop out of
6 school.

7 I could no longer muster any motivation
8 to face the world, and moved back to my parents'
9 house where my mom could take care of me like a
10 child again. Sometimes even bathing me. Nothing
11 was right, and I was constantly hiding how
12 triggering the surrounding world could be.

13 I began to read more about how cannabis
14 has helped so many Veterans with PTSD, whose
15 symptoms seemed so much more severe than mine. I
16 started to smoke cannabis and started to feel
17 like myself again. I could sleep on a regular
18 schedule and enjoy my friends for the first time
19 in two years.

20 I got a job I really like, which allowed
21 me to transition back and to socialize, regaining
22 the outgoing personality that everyone knew
23 before my PTSD diagnosis. I still struggle every
24 day, but I no longer view death as my only exit

1 from this pain. I feel free and independent and
2 like I've regained so much of my life. This is
3 all thanks to cannabis, that at, currently in
4 Illinois, I'm not legally allowed to possess.
5 Cannabis saves so many lives of those with PTSD,
6 and if I hadn't given it a chance I'm certain I
7 would not be sharing this story with you today.

8 MS. TEMPLE: Thank you.

9 (Applause.)

10 MS. TEMPLE: Comments about PTSD?

11 MR. CHAMPION: As the Veterans rep I
12 guess I'm going to say a little bit of something.
13 My numbers are a little bit different than
14 Jared's, but the evidence in support of cannabis
15 as an effective treatment for PTSD is
16 overwhelming. Veteran suicide rates is as high
17 as 22 per day or 8,000 per year. That's more
18 than the people than we lost in the war itself.

19 PTSD affects over 30 percent of all
20 Vietnam, Iraq and Afganistan Veterans. PTSD in
21 all forms should be approved, but we especially
22 owe it to the Veterans of Illinois, so.

23 MS. TEMPLE: Any other comments? This is
24 our last --

1 MR. RAMIREZ: Well, we've got other --

2 MS. TEMPLE: No, we don't have, it's not
3 our last speaker.

4 MR. RAMIREZ: So we've got other
5 speakers?

6 MS. TEMPLE: Right. So if there's, and
7 then the Board can jump in, but we've now opened
8 it up to our spontaneous speakers. Mrs.
9 Champion?

10 MS. CHAMPION: Yeah. And I'll be really
11 quick. I'm Sandy Champaign, and I wanted to
12 address about the 39 conditions. One of the
13 things that we took into account was the idea of
14 palliative care, which is about quality of life,
15 because we don't have a lot of research out
16 there.

17 And many of our representatives did not
18 want to take any research outside of the United
19 States, they wanted something from here. But
20 because we haven't rescheduled, we have this
21 problem.

22 So palliative care was huge in
23 determining what conditions were added. For
24 example, Jim's MS, he was on 59 pills a day.

1 He's down to six. And that clearly makes a huge
2 statement as to why he uses cannabis. So I just
3 wanted to clear that up. I do have a quote from
4 our sponsor because I asked him what he would say
5 if he was asked that question. And he said he
6 listened to tons of people, took our best shot.
7 Some were negotiated.

8 The list is not perfect, but that's why
9 we created the Advisory Board. Thank you.

10 MS. TEMPLE: And your sponsor, you're
11 saying Mr. --

12 MS. CHAMPION: Representative Lou Lane.

13 MR. RAMIREZ: So I just want to say that
14 mine was more of a rhetorical question to say
15 that the excuse for not passing what we've done
16 in the past three meetings has been that it
17 doesn't have enough evidence. And the initial
18 ones didn't have enough evidence either, so it's
19 just like a protocol question.

20 MR. CHAMPION: I agree with you
21 100 percent.

22 MR. RAMIREZ: Yeah. It was not a, not a
23 critique of --

24 MS. CHAMPION: Oh, no, no. But I just

1 wanted to put that on public record that, you
2 know, because a lot of people have asked us that
3 question like what made us decide the 39, not me
4 personally, but we've negotiated a lot of people
5 in here, negotiated those conditions.

6 So a lot of times it was just personal
7 experience. So I just wanted to put that in the
8 record.

9 MR. MCCURDY: It's good to have a
10 historian in the room.

11 MS. CHAMPION: Thank you.

12 MS. TEMPLE: How about our second
13 speaker? The gentleman in the tie. Okay.

14 MR. KURFMAN: I'm trying to laugh on the
15 way up here, maybe I won't be so nervous. My
16 name's David Kurfman. K-u-r-f-m-a-n. I am an
17 approved patient in the Program and I take it for
18 seizures, epilepsy. And I, first off, I just
19 want to say that it's helped me. I've been on it
20 since the dispensary's opened in December last
21 year.

22 And I started out with 2000 milligrams of
23 Depakote. Now I'm down to 250, and I plan on
24 going off of that next week. So now that some of

1 the higher CBD medicine is out like Charles Webb,
2 in particular I take that, which actually they
3 changed the name but, called Sweet Relief. But
4 anyways, I wanted to ask you guys to seriously
5 consider migraines and chronic pain and
6 depression and, basically because I've had all
7 those things and I've been diagnosed with all
8 those conditions.

9 And since this program's approved, or
10 been approved, I've been taking cannabis, and I
11 have to say that it's helped me in all of those
12 areas. I've been on Xanax, I've been on, of
13 course, my Depakote for epilepsy. That's almost
14 gone.

15 I no longer take Xanax. I take Effexor
16 for depression, and I've went way down on it.
17 And I'm just down to 75 milligrams on that.
18 Almost off. My point is that I think these
19 conditions should be approved because they've,
20 cannabis has helped me in those areas.

21 And I think there's overwhelming evidence
22 out there that, from other states that's approved
23 these conditions, why they should be approved,
24 and that they've helped multitudes of people.

1 But I no longer have to take a bunch of
2 medication because I've taken cannabis now for
3 several months, and of course I've been weaning
4 myself down from taking my Depakote and some of
5 the other things with consultation with my
6 doctor.

7 But I have to say it's really, really
8 helped me, and I hope you can approve those other
9 conditions. Okay. Thank you.

10 MS. TEMPLE: Thank you.

11 MR. MCCURDY: Thank you.

12 (Applause.)

13 MS. TEMPLE: Miss Zala is our last
14 speaker.

15 MS. ZALA: Thank you again very much.
16 I'm not going to speak on Meera's behalf. I'm
17 going to actually speak on the dispensary's
18 behalf and a patient consultant that I am for New
19 Age Medical Cannabis Dispensary in Mt. Prospect.

20 I'd like to just say that all the
21 conditions that we've spoken about and the 39 all
22 have familiar foundational symptoms, strains,
23 that I work with and that are showing specific
24 relief for specific symptoms are patient to

1 patient, individualized and customized to work
2 with each patient and their lifestyles. That
3 includes all the adversities that come along with
4 being ill. I start my initial consultation by
5 sitting with my patients discussing their needs,
6 their life, their concerns, their goals.

7 And before I dispense any type of
8 cannabis, medical cannabis, I talk about the
9 science and cannabis and how it would affect them
10 on an individual basis.

11 I also start with a high CBD and a low
12 THC or equal part strain. For example, White
13 Harmony, Canna Sue, Harley Sue, which are all CBD
14 and, CBD and THC and all of the other
15 cannabinoids all in one.

16 The White Harmony is an equal one to one
17 ratio, which is great for people who are
18 experiencing MS, for fibromyalgia, for cancer,
19 for HIV. The, for rheumatoid arthritis. I mean,
20 the list is, the symptoms are all the same. The
21 conditions are just different but the symptoms
22 are all there.

23 So what we start is we always start with
24 them with a really, really good CBD base to start

1 building up their system, and then everything
2 else is introduced, slowly, very slowly. To
3 start with their building up of their system of
4 CBD, that is an anti-inflammatory, antioxidant,
5 and antispasmodic effects. THC can then be
6 systematically induced, introduced, based on
7 comfort level and tolerance.

8 The training I have received in cannabis
9 education ranges from thousands of hours
10 dedicated to education and in terpening, which is
11 the science and art of studying terpenoid
12 profiles of the cannabis plant, which means that
13 I'm able to help my patients distinguish which
14 strain will affect them in a certain way based on
15 smell or essentially, aromatherapy, quality of
16 bud structure, land raise, and anecdotal
17 testimony globally.

18 So when we go into our patients, we are
19 not just dispensing medical cannabis freely. We
20 are talking to our patients and we are discussing
21 with them. We are understanding their needs and
22 we're helping them succeed and successfully
23 surpass the discomforts of their illness.

24 Thank you very much once again for

1 allowing us to speak.

2 MS. TEMPLE: Thank you.

3 (Applause.)

4 MS. TEMPLE: It's nice to have a
5 dispensary point of view, so that was very
6 helpful. Any other? Otherwise --

7 MR. FRIEDMAN: I wasn't planning on but
8 I, you know what, I think it's interesting. I
9 think it's --

10 MS. TEMPLE: They're making --

11 MR. FRIEDMAN: Whose idea to really --

12 MR. FINE: Talk into the --

13 MR. FRIEDMAN: Oh, I'm sorry. I'm sorry.

14 MS. TEMPLE: Yeah.

15 MR. FRIEDMAN: Joseph Friedman.

16 F-r-i-e-d-m-a-n. And I'm being forced to be up
17 here. But thank you, Michael. I appreciate the
18 opportunity. From the dispensary standpoint, and
19 I think this is where the rubber meets the road.
20 You know, we have patients coming in every day.
21 Some of them are familiar with cannabis.

22 Those kinds of patients have higher
23 tolerances, and so we consider the dosing
24 differently than those that come in that have

1 never touched it or haven't touched it since they
2 smoked a joint in the seventies. One of the
3 things that I'm very proud of is we have
4 healthcare professionals in our dispensary, and I
5 consider what we do very important from the
6 standpoint of communication, not only with the
7 patient but also many times with the physician.

8 The physician writes the certification
9 and then a lot of them don't know what happens at
10 that point. So I'm trying to take this a step
11 further where we're communicating with their
12 doctors and we're letting them know what we're
13 doing, and then we're also monitoring outcomes.

14 We're not expecting a whole lot to happen
15 with the first visit. We give them
16 recommendations. And then it's two weeks later
17 or a month later when they come back where we
18 talk about what they, what's helped them, what
19 hasn't helped them. And then we also, if
20 necessary, speak with the doctor, get on a
21 conference call when they have their doctor
22 visit.

23 So it's this triangle of care that I
24 think is very important. Something that I sort

1 of grew up with as a pharmacist where there was
2 all this kind of, this type of communication.
3 And I consider what we're doing healthcare, very
4 healthcare wise.

5 So, you know, Michael's, he comes in and,
6 you know, we just have, it's friendly but it's
7 also very professional and it's very helpful, and
8 we learn from patients like Michael as much as
9 patients like Michael learn from us.

10 So it's really a great communication.
11 Thank you.

12 MR. FINE: Thanks, Joe.

13 MS. TEMPLE: Yes.

14 (Applause.)

15 MR. RAMIREZ: I hate to be crass and
16 materialistic, but since I assume that marijuana
17 is not covered by any insurance or by Public Aid,
18 what is the cost, approximately, for somebody
19 that's using it for treatment?

20 MS. ZALA: I can answer that for you. We
21 are very comparable to, let me, let me retract
22 that. The black market dictates the cost,
23 unfortunately. When we look at the amount that
24 is being regulated in dispensaries, there is a

1 specific cost for an eighth of bud versus oil, or
2 a gram of bud versus a gram of oil. It ranges.
3 It ranges between, you know, a dispensary that is
4 a cultivator and a dispensary that is a
5 dispensary. So we are in the middle, and we are
6 often trying our very, very best to accommodate
7 patients because it is expensive.

8 And it is expensive and it's very hard
9 for them to pay for it, as well as being on all
10 these other medications. Their whole life
11 depends on this therapy. So now that, you know,
12 the prices are starting to kind of level out a
13 little bit, but really we're trying very hard to
14 accommodate our patients as best we can with
15 hardship programs, disability programs, Veteran
16 programs.

17 I believe our dispensary gives 20 percent
18 off for Veterans, 10 percent off for disability,
19 and we work with them for hardships. So we are
20 always trying our very best to accommodate our
21 patients.

22 MR. FRIEDMAN: And you made a great
23 comment about, you know, what's happening from
24 the standpoint of third party reimbursement. One

1 of the things that we're working on is
2 accreditation. We're hoping that accreditation,
3 and this is going to take us probably through the
4 end of 2016 to become accredited. Down the road
5 we're hoping that accredited dispensaries will be
6 able to adjudicate claims for medical cannabis.

7 In fact, I was talking to a
8 representative from United Healthcare the other
9 day and he's talking to his executives because
10 there's a lot of, there's a groundswell of
11 information and interest going on from the
12 standpoint of insurance coverage for this.

13 And as soon as it comes off of Schedule
14 I, I think those possibilities will come to
15 fruition.

16 MR. RAMIREZ: I understand the comments,
17 but still to paraphrase The Tonight Show, how
18 high was it, Mr. Carson. Give me a number so --

19 MS. ZALA: The prices for an eighth are
20 between, I would say between, for our dispensary,
21 between \$60.00 and \$65.00. For a gram is between
22 \$19.00 to \$22.00. But I can tell you that we
23 have sales all the time, so we are always once
24 again trying very hard to make sure that our

1 patients get what they need.

2 AUDIENCE MEMBER: So it's about 360 to
3 440 an ounce. But it depends on the patient and
4 what they need too.

5 MR. CHAMPION: It's cheaper if you buy an
6 ounce too.

7 MS. ZALA: Absolutely.

8 MR. MCCURDY: Based on the State data, I
9 want to say that the average patient spent about
10 \$420.00 in the month of March?

11 MS. ZALA: Correct.

12 AUDIENCE MEMBER: I was going to say, I
13 spent, I spent personally as a normal patient
14 without being a, getting any discounts, which not
15 all of the dispensaries give.

16 MS. ZALA: Right.

17 AUDIENCE MEMBER: Mine doesn't. Mine
18 only, mine does do a discount program where you
19 can, for every \$50.00 you spend you get a punch
20 card and you fill out the punches and then you
21 get free \$50.00 off the next purchase or
22 whatever. That takes time.

23 I generally spend between four and five
24 hundred dollars.

1 MS. TEMPLE: In a month or?

2 AUDIENCE MEMBER: In a month.

3 MS. TEMPLE: Okay.

4 AUDIENCE MEMBER: So it's ungodly
5 expensive to me, but it's helping me and I want
6 to get off of all this medicine. The other thing
7 I would say is now that some of this newer
8 medicine's coming out, the oils and the
9 concentrates, which for somebody like me with
10 epilepsy, I need higher CBD medicine that doesn't
11 get you high, the THC.

12 And it's more expensive. I mean, you're
13 talking \$80.00 for a syringe of a little oil,
14 what they have out so far. And that doesn't last
15 very long for me. I mean, just to be honest with
16 you, it might be five days. Four to five days.

17 MS. TEMPLE: Do we have figures from
18 industry about how much, how much has been netted
19 in sales so far?

20 MS. CHAMPION: There is, yeah, there is
21 actually --

22 MS. ZALA: Actually, yeah. I think Joel
23 Erickson would know, would be a really good
24 person to ask.

1 MS. TEMPLE: So a bigger question I have,
2 since we have the Director right here in the
3 audience, this Pilot Act ends what,
4 December 31st, 2017; is that right? Or January
5 1, 2018?

6 MS. CHAMPION: December 31st.

7 MS. TEMPLE: New Years Eve.

8 MS. CHAMPION: Somewhere between the
9 clock striking 12:00.

10 MS. TEMPLE: Okay. What kind of data is
11 needed to, and what, who says okay, this is no
12 longer a Pilot Act, we make this the law? Okay.
13 That's, you know, I'm sure lots of people here
14 are on pins and needles that this program could
15 go away, which would be terrible.

16 MS. CHAMPION: One of the things that
17 I'm, is said often, is a lot of people talk about
18 greed and about the industry is in it for money,
19 and this and that, and I don't agree with that.

20 What I agree with is that patients need
21 the industry and the industry needs the patients.
22 And without each other we're not going to
23 succeed. And that's why we have this Board
24 because we need to add conditions to get more

1 patients and help more patients have a quality of
2 life. It's not even about quantity of life, it's
3 about quality of life many times. And just the
4 fact that we're paying out of pocket rather than
5 going to the insurance companies means a lot.

6 Jim can get all the drugs he wants for
7 free through the VA, and they're more than
8 willing to give him methadone and morphine and
9 anything he would possibly want to get stoned,
10 but it's not about that for us, it's about his
11 quality of life. So we pay.

12 MS. TEMPLE: So I'm just curious to know,
13 you know, is it financial data and safety data?
14 Are people diverting this? I mean, I would like
15 to know how is it being studied so that when it's
16 December 2017 when it's time to decide what
17 happens. That's the part where the process to me
18 is unclear.

19 And I'm sure it, you know, goes to the
20 Governor's Office but, you know, I think we're
21 doing what we need to do as a Board.

22 MS. MOODY: Right. It will take action
23 by the Legislature and then the Governor to sign
24 the Bill if the Legislature chooses to do that,

1 and appease or extend the pilot date, or, do away
2 with the pilot and move it. So those are some of
3 the options that the General Assembly have.

4 MS. CHAMPION: We will need the veto
5 majority and the Governor's award to extend the
6 program. We will need veto majority, which we're
7 prepared to use.

8 MR. RAMIREZ: But other than the
9 Department of Public Health, supposedly the
10 Department of Agriculture and the Department of
11 Tax Revenue are supposed to be picking up some of
12 this information, is supposed to be generating
13 some of this data. Because they're co,
14 co-sponsors of the project, or whatever you want
15 to call it.

16 MS. MOODY: So there are multiple
17 agencies involved in the program. The Illinois
18 Department of Public Health works with the
19 Patient Registry Program. The Department of
20 Financial and Professional Regulation, they are
21 responsible for authorizing and licensing the
22 medical cannabis dispensaries.

23 The Department of Agriculture is
24 involved. They license the cultivation centers

1 where the medical cannabis is grown. The
2 Secretary of State, they're responsible for
3 collecting the tax revenue. The Illinois State
4 Police is involved as a consultant.

5 We also work with the Secretary of
6 State's Office because when a medical cannabis
7 patient is approved to participate in the
8 Program, there's a notation on that patient's
9 driver's license record also.

10 So there are multiple agencies that are
11 involved in the oversight. As you know, there's
12 an annual report that the Department of Public
13 Health is authorized to submit annually to the
14 General Assembly and the Office of the Governor.
15 And as the program continues to be implemented,
16 that annual report will include additional
17 information from each of those agencies.

18 Our first two annual reports have been a
19 little bit sparse because, as you know, when that
20 report was written it's on a fiscal-year basis,
21 and at the end of June of 2015 we had not yet
22 approved, or issued a registration card for a
23 single medical cannabis patient, and dispensaries
24 were not yet open either. So that is some of the

1 documentation that will be shared. I'm sure that
2 the General Assembly will ask for that
3 information. I know that our Directors of each
4 of the agencies are watching that information.

5 I'm sure that the Office of the Governor
6 is going to be looking to the agencies to share
7 that kind of information also.

8 MS. CHAMPION: Can I say one positive
9 thing though that, because I think that would
10 help. I guess it was last year or sometime I was
11 asked, and I'm sure a lot of people in this room
12 were asked, what can we do to make the program
13 better.

14 And that was through the agencies and the
15 Governor's Office and stuff. So that, I know I,
16 sometimes I sound negative, but I'm not always
17 negative. I'm actually an optimist.

18 And I don't think the program's going to
19 die. I don't think the Governor's going to kill
20 the program. I know a lot of people have, you
21 know, their opinions about that, including
22 myself, but I don't think the Program's going to
23 die.

24 But I do think it's going to take all of

1 us together because that, it takes a village,
2 it's going to take a huge village to make sure
3 that this is sustainable.

4 MR. KNAUS: Okay. Could I ask, was there
5 something about the 39 approved conditions that,
6 an element that gave them approval beyond what
7 this committee has looked at very carefully and
8 made recommendations as to other conditions?

9 MS. CHAMPION: Can you repeat that,
10 because I'm not sure I understand?

11 MR. KNAUS: It seems like if 39 things
12 were approved for this, that this committee has
13 looked at other things that they have looked at
14 very carefully, and some people said yes, some
15 people said no. It seems like somebody would
16 appreciate that effort and proceed on with
17 approval instead of non-approval.

18 MS. CHAMPION: Right. I completely agree
19 with you, and that's why we called it the
20 compassionate use of medical marijuana, medical
21 cannabis. Because when the program was passed it
22 was based on compassion.

23 It was based, again, on quality of life,
24 based on what research we could possibly find.

1 So our hope was when we put the Advisory Board
2 into that Bill was that we would add conditions.
3 That was our hope. And do you guys know how many
4 conditions have been rejected so far?

5 MR. FINE: 19 so far.

6 MS. CHAMPION: So we're going into almost
7 a year now and we've had every single condition
8 rejected.

9 MR. FINE: Summarily rejected without
10 explanation.

11 MS. CHAMPION: Right.

12 MR. FINE: And then there has been some
13 time.

14 MS. CHAMPION: Right. So we, right. So,
15 but, you know, we don't have a reason for that
16 because we did not put it in the law that Dr.
17 Shah would have to give a reason for that. That
18 will change in the next one because we want to
19 know why. We want to know why because if we
20 don't know why we can't improve on what we're
21 doing.

22 MS. TEMPLE: Might I add then that per
23 Dr. Shah the reason they were summarily rejected
24 is not for no reason, it's because the level of

1 scientific evidence did not pass muster.

2 MS. CHAMPION: Right. But, again, when
3 we --

4 MS. TEMPLE: On like blankets, which --

5 MS. CHAMPION: But, and that's --

6 MS. TEMPLE: -- of which --

7 MS. CHAMPION: -- was not supposed to be
8 happening because we're supposed to be using,
9 balancing --

10 MS. TEMPLE: Compassionate.

11 MS. CHAMPION: -- compassionate with the
12 scientific. And so we don't know why. But I
13 want to remain optimistic and positive that we
14 just keep doing what, we have patients keep
15 coming. I know it's a hardship, but we can't
16 give up. We can't let them think we're giving
17 up, because if we give up then we might as
18 well --

19 MS. TEMPLE: So are there other comments?
20 We're actually running ahead of time. This was
21 supposed to end at 3:00, it's 2:30.

22 MS. WEATHERS: A couple things. So my
23 question, comment and question, my understanding
24 too was that there was a statement made after our

1 initial meeting, the Advisory Board and
2 rejection. Not only the IDP Director's
3 statement, as well as the Governor's Office,
4 saying that part of the rationale was that
5 because this was a limited Pilot Program, the
6 decision was made to keep it as a kind of a
7 contained pilot and not expand that past that by
8 adding conditions that would be an expansion to
9 the Pilot Program.

10 MR. RAMIREZ: That was the first
11 rejection.

12 MS. TEMPLE: That was the very first
13 rejection.

14 MS. WEATHERS: That was the first
15 rejection.

16 MR. FINE: And time too.

17 MS. WEATHERS: And time that we haven't
18 even started, so how could we add before we've
19 even started? Now that we have, I don't know if
20 that will change, but I was wondering, I know
21 Mr. Wright is in the room.

22 Was there any comments that you can add
23 or understanding, shed light on, for the Board
24 and for the, kind of the questions that we

1 raised?

2 MR. WRIGHT: Sure. Yeah.

3 MR. WRIGHT: My name is Joseph Wright.

4 W-r-i-g-h-t. I'm the Director of the Illinois
5 Medical Cannabis Pilot Program. And would you
6 state your question one more time again just so I
7 can make sure I got it?

8 MS. WEATHERS: Sure. I was just, it was
9 kind of open ended, but given the questions that
10 have been raised, especially during this open
11 period, about the willingness of the Director and
12 the Governor to add more conditions, especially,
13 I know that some of the concern, let me take a
14 step back and rephrase.

15 I know that some of the concerns from the
16 rationale given for the rejections after our
17 initial meeting was that the program, nobody had
18 even got their cards yet and the program hadn't
19 even started, and how can we expand when we
20 haven't yet begun.

21 I wanted to know if that rationale, given
22 that we now do have data since November, if
23 there's a feeling that that rationale is still in
24 place, or if you feel that there was kind of any

1 opportunity for further conditions to be added,
2 and the viewpoint from your standpoint from the
3 Governor's Office?

4 MR. WRIGHT: Sure. Well, the first thing
5 I do want to clarify though is that the
6 Governor's Office gave a statement at various
7 points along the way in terms of events that
8 happened. So there was a Bill that was passed to
9 extend it as well as add PTSD.

10 There was the first recommendation of the
11 Board. So some of the messaging, while the end
12 result may be the same, with some different
13 things and about different, you know, items. In
14 terms of whether or not additional time is still
15 needed, I would say that the position is probably
16 still the same.

17 But the Governor's Office has already
18 said as much, that they're willing to work with
19 the Legislature on an extension of the program.
20 That's already in the public domain.

21 In terms of when and how that happens and
22 how long that extension is, that will have to be
23 hammered out between the Legislature and the
24 Governor. In terms of additional conditions, you

1 know, I don't have a particular satisfying answer
2 for you how long. It's going to take a little
3 bit more thought, and I don't have a crystal ball
4 to when or how conditions will be added.

5 But, you know, there's two methods, as
6 you all know. One is this Board, another is
7 through the Legislature. So we'll see what
8 happens with that. But, unfortunately, I don't
9 have a definitive timeline for you on when that
10 can happen.

11 MS. TEMPLE: Okay. So on that note, I
12 would say we're going to just keep doing what the
13 Board was tasked to do, which is to provide a
14 balanced and fair look at the science and
15 patients and compassion, and really vet these
16 conditions as thoughtfully as we have.

17 And I really appreciate how much work
18 you've all put in. This is a volunteer Board.
19 You've taken Clinic off, you've taken time off of
20 your jobs. We've donated this time, including
21 the time that, just to prepare for this meeting.

22 I want to thank you, IDPH, for all of
23 their hard, hard work on making, in making this
24 Pilot Program a success as it is so far. And

1 that patience is key in all of this, and so we
2 keep trying. Our next meeting will be sometime
3 in the fall, and the venue is to be determined.
4 It will be announced on the State's website.

5 We may hear similar conditions again, I
6 believe the six-month period of time where our
7 recommendations from today, which we probably
8 should read for the record as to what was
9 approved and not approved, are going to be
10 decided upon by the Governor.

11 If you want to you can go ahead and sit
12 down. And then we will hear in six months
13 whether the conditions that we talked about today
14 would be approved or disapproved.

15 MR. MCCURDY: They get six months after
16 the time the petition period closes?

17 MR. FINE: Yes.

18 MS. TEMPLE: Is that right?

19 MR. FINE: Yes.

20 MS. MOODY: Right. So that would be
21 January 31st.

22 MR. MCCURDY: So January next year.

23 MS. MOODY: So 180 days after that.

24 MS. TEMPLE: Got it. So January 31st we

1 will hear the decision on today's --

2 MR. MCCURDY: No.

3 MS. MOODY: No.

4 MS. TEMPLE: No?

5 MR. MCCURDY: In July.

6 MS. MOODY: Yeah.

7 MR. MCCURDY: End of July.

8 MS. MOODY: So January 31st was the
9 closing date of the petition, open petition
10 period. And then from that date --

11 MS. TEMPLE: Okay.

12 MS. MOODY: -- the Board and the
13 Department have 180 days to render a final
14 recommendation.

15 MR. MCCURDY: So we're midway there.
16 We're midway there.

17 MS. TEMPLE: So two months from now?

18 MS. CHAMPION: Something like that.

19 MS. TEMPLE: Three months. Nestor.

20 MR. RAMIREZ: So I want to make a
21 personal comment. I want to thank personally
22 each and every person involved in this whole
23 project for their courage, their persistence,
24 their perseverance, their support of the

1 patients. Everything that you do for this
2 project is helping, and we've got to keep moving
3 forward. We don't even want to go backwards at
4 all at any time.

5 (Applause.)

6 MR. MCCURDY: I want to make one other
7 comment, and it's related I think maybe to
8 something Sandy said, and I may have
9 misunderstood you. But the legislation itself
10 actually did make a provision for the Advisory
11 Board. The Advisory Board was a result of the
12 Department's deciding on a process. And so we
13 actually owe the existence of the very Board
14 itself to the Department in the first place.
15 So --

16 MR. CHAMPION: Well, that was part of the
17 Bill as well, that it was, they put together the
18 rules for what would happen.

19 MR. MCCURDY: Right, right. But there
20 wasn't a Board in the legislation. The Board was
21 created because of (inaudible) the Department
22 made. Interestingly enough, yeah.

23 MS. TEMPLE: Let's not forget thanking
24 the patients and the advocates who really make

1 this. So we're ahead of schedule. It's 2:37, so
2 I think we did pretty well covering everything.
3 Thank you, Board.

4 MR. FINE: Motion to adjourn.

5 MS. TEMPLE: Motion to adjourn.

6 MR. RAMIREZ: Second.

7 MS. WEATHERS: Second.

8 MS. TEMPLE: All those in favor say aye.

9 (Board responded aye.)

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11 (Hearing end time: 2:37 p.m.)

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CERTIFICATE OF REPORTER

I, KATHY L. JOHNSON, a Certified
Shorthand Reporter within and for the State of
Illinois, do hereby certify that the hearing
aforementioned was held on the time and in the
place previously described.

IN WITNESS WHEREOF, I have hereunto set
my hand and seal.

Kathy L. Johnson

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