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

APPEARANCES OF ADVISORY BOARD:

MS. LESLIE MENDOZA TEMPLE
MS. CONNIE MUELLER MOODY
MS. ALLISON WEATHERS
MS. THERESA MILLER
MR. ERIC CHRISTOFF
MR. DAVID McCURDY
MR. MICHAEL FINE
MR. JAMES CHAMPION
MR. NESTOR RAMIREZ
MR. JOHN KNAUS

I N D E X

E X H I B I T S

(None were marked.)

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

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

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

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

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

(Applause.)

We are happy to have your here. I know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

anyways, thank you.

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

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

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

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

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

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

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

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

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

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

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

MS. MOODY: Good morning. I'm Connie

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

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

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

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

(Applause.)

MS. TEMPLE: So we need to actually make

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

MR. RAMIREZ: I make a motion.

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

MR. RAMIREZ: I just made it, so.

MS. TEMPLE: Oh. Did --

MR. CHRISTOFF: Second.

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

(Board responded Aye.)

MS. TEMPLE: Those opposed?

(No response.)

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

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

trauma, chronic pain syndrome, chronic postoperative pain, intractable pain, Irritable Bowel Syndrome, and migraine, neuropathy, osteoarthritis, and post-traumatic stress syndrome.

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

MR. KNAUS: Motion to approve.

MS. WEATHERS: Second.

MS. TEMPLE: Comments from Jim?

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

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

MR. CHAMPION: That is a motion.

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

MS. TEMPLE: Okay.

MS. MOODY: You have a second.

MS. TEMPLE: Either --

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

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

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

MR. FINE: I second.

MS. TEMPLE: Those who approve?

(Board responded aye.)

MS. TEMPLE: Those who oppose?

(No response.)

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

And following that, those presentations,

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

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

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

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

MR. RAMIREZ: Second.

MR. KNAUS: Second.

MS. TEMPLE: All those in favor say aye.
(Board responded aye.)
MS. TEMPLE: Those opposed?
(No response.)
MR. MCCURDY: I just want to say, my only concern is I hope that the petitioners won't fly the coop, you know, now that they know that they've got the request. I move, I would still like to hear from them.
MR. CHAMPION: It becomes a part of public record, and it's always good for review, and when Dr. Shah receives it he receives everyone's testimony. So it's always the more testimony, the better. And I know I appreciate it, and I'm sure everyone on the Board appreciates you coming out today. Thank you.
(Applause.)
MS. TEMPLE: Thank you, James. So we, I remind the speakers that they have three minutes to present their technical evidence. Please speak clearly and slowly for our court reporter. Introduce yourself by your full name and your, if you have an affiliation, an organization, or if you're representing yourself as a patient or as a

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

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

AUDIENCE MEMBER: She's not here.

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

MS. ZALA: Yes.

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

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

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

MS. TEMPLE: We have to use the microphone.

MS. ZALA: Yes. Yes.

MS. TEMPLE: I turned mine off.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. ZALA: Thank you very much.

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

MS. ZALA: Off?

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

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

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

please feel free to provide that to our Chairs.

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

MS. MOODY: You can do that now.

MS. TEMPLE: Thank you very much.

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

MR. CHRISTOFF: Could I just ask a question?

MS. ZALA: Yes, sir.

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

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

MR. CHRISTOFF: Right.

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

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

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

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

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

MS. ZALA: Are you asking me or her?

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

MS. ZALA: Sure.

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

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

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

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

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

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

MS. TEMPLE: Yes, thank you.

MS. ZALA: Thank you so much.

MS. TEMPLE: Okay. Comments from the Board?

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

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

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

MR. CHAMPION: I've been there.

MS. ZALA: It's an awful, terrible

disease.

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

MS. ZALA: I turned it off.

MS. TEMPLE: You did?

MS. ZALA: Yeah.

MS. TEMPLE: Then it's me. Okay. Comments from the Board regarding Diabetes Mellitus Type I?

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

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

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

patients who would benefit. And I think --

MS. TEMPLE: Certifying.

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

MS. TEMPLE: Doctor Weathers?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. TEMPLE: Thank you.

MS. ZALA: Thank you.

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

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

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

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

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

MS. CASTRO: Okay.

MS. MOODY: Thank you.

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

MS. MOODY: Spell your name, please.

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

MS. MOODY: Hold the microphone.

MS. CASTRO: Okay. Is that better?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

she has authorized me to share.

MS. TEMPLE: Thank you very much.

MS. CASTRO: You're very welcome.

MS. TEMPLE: Comments from the Board?

MS. CASTRO: Thank you for having me.

MS. WEATHERS: Will you turn off your mic?

MS. CASTRO: Sure.

MS. TEMPLE: Yes, Theresa.

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

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

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

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

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

MS. WEATHERS: Got it. Thank you.

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

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

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

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

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

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

MS. TEMPLE: Other comments?

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

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

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

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

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

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

(Applause.)

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

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

MR. FINE: Until they're 18.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. KNAUS: Do you prescribe medications --

MS. WEATHERS: Yes.

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

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

MS. WEATHERS: But see --

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

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

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

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

MR. RAMIREZ: Illegal?

MS. TEMPLE: Illegally.

MR. RAMIREZ: Illegal, but on the street?

MS. TEMPLE: Yep. Yep.

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

(Applause.)

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

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

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

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

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

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

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

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

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

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

MR. CHRISTOFF: There were --

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

MR. CHRISTOFF: -- a few reports?

MS. WEATHERS: Yeah.

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

MS. WEATHERS: Yeah. Because --

MR. CHRISTOFF: -- you know --

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

MR. CHRISTOFF: So what is her hemoglobin A1C?

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

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

MS. ZALA: 17.

MR. CHRISTOFF: Oh.

MS. ZALA: Off the charts.

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

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

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

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

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

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

decision made by the Board.

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

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

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

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

So the burden on this group is to provide

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

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

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

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

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

MR. MCCURDY: Move to approve.

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

(Board responded aye.)

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

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

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

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

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

over 18 years of age?

MS. TEMPLE: No, this is for everybody.

MR. RAMIREZ: For everybody.

MS. MOODY: No, for everyone.

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

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

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

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

MR. RAMIREZ: On the current list?

MS. MOODY: On the current list, yes.

MR. RAMIREZ: But otherwise?

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

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

MS. MOODY: Yes.

MR. FINE: -- you know.

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

(Break taken at this time.)

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

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

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

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

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

MS. MOODY: Would you slow down, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. FINE: Oh, I'm sorry.

MS. WEATHERS: Jim.

MR. CHAMPION: Go ahead, you go first.

MR. FINE: I agree from the --

MS. WEATHERS: No, go ahead.

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

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

MS. TEMPLE: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

600 grams of CBD seemed to work best in

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

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

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

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

this.

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

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

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

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

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

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

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

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

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

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

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

MR. MCCURDY: I was going to ask --

MS. WEATHERS: Okay.

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

MS. TEMPLE: No.

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

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

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

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

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

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

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

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

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

MS. WEATHERS: I make a motion to vote.

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

(Applause.)

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

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

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

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

MS. TEMPLE: Yeah.

MR. MCCURDY: If I read it right.

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

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

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

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

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

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

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

comment?

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

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

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

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

MS. WEATHERS: Yeah. Sure.

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

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

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

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

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

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

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

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

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

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

I'd like to see more evidence developed

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

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

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

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

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

MR. FINE: Motion to vote.

MS. MILLER: Second.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. WEATHERS: Move to vote.

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

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

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

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

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

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

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

MR. RAMIREZ: No, you talk.

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

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

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

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

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

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

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

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

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

From the University of Mississippi, which

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

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

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

MS. TEMPLE: Hold on a second. Okay. Sorry. Very, how about just really early?

MR. RAMIREZ: There you go.

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

MR. RAMIREZ: No.

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

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

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

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

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

MS. WEATHERS: Yes.

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

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

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

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

MR. MCCURDY: Okay.

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

MR. MCCURDY: So that's considered infused?

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

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

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

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

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

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

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

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

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

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

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

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

MR. MCCURDY: Was it?

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

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

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

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

MS. MILLER: Exactly.

MS. WEATHERS: -- the rationale.

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

MS. TEMPLE: Nestor.

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

And like Eric said, we use Search Results

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

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

MS. WEATHERS: Motion to vote.

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

MR. RAMIREZ: They die very quickly.

MS. TEMPLE: Okay.

MS. MILLER: I'll second.

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

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

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

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

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

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

MR. RAMIREZ: All lives matter.

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

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

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

We may have some deliberations, some

discussion, but we don't need to vote anymore. They've already been approved.

MR. TAYLOR: All right.

MS. WEATHERS: And I'm sorry, Jared. Just to clarify a point, and I know, Connie, you said that, I thought we had to vote as a group but we don't have to reenter, because I thought once the Director says no it kind of invalidates everything that we did.

MR. MCCURDY: We voted earlier this morning.

MS. MOODY: There was a motion made earlier, and we can check that --

MS. WEATHERS: Okay.

MS. MOODY: -- motion, that the Board was going to approve the entire list of petitions. So we can, we can check that on the transcript if you'd like to. Are we able to read that back?

MS. WEATHERS: Okay. I'm sorry.

MR. FINE: I made a motion before that everything that we had approved, approved previous, at previous hearings, --

MS. WEATHERS: Okay.

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

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

MS. WEATHERS: Okay.

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

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

MR. FINE: We still go down there.

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

MS. TEMPLE: Should we do it again?

MS. WEATHERS: Yes.

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

MS. WEATHERS: We'll do it again.

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

MR. CHAMPION: Second.

MS. TEMPLE: All those in favor?

(Board responded aye.)

MS. TEMPLE: Nestor?

MR. RAMIREZ: Aye.

MS. TEMPLE: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. TEMPLE: Pennsylvania.

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

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

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

There is no cure for autism. But if

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. WEATHERS: Please spell your name for me.

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

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

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

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

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

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

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

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

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

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

MS. MOODY: Thank you.

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

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

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

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

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

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

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

MR. KNAUS: In the sativa in a dark

chocolate?

MS. BASOLO-BOND: The sativa.

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

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

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

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

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

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

MS. TEMPLE: So they allow it at school?

MS. BASOLO-BOND: Yes.

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

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

MR. CHAMPION: That's the truth.

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

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

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

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

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

(Applause.)

MS. TEMPLE: Next we have Tina Higens, or Higens.

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

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

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

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

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

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

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

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

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

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

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

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

MS. MOODY: You have 30 seconds.

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

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

Thank you for the time.

(Applause.)

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

MS. HIGENS: Uh-huh.

MS. TEMPLE: Have you tried hemp oil?

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

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

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

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

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

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

MR. CHRISTOFF: That's it?

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

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

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

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

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

MS. DICKERSON: I got skipped.

MS. TEMPLE: Pardon?

MR. RAMIREZ: She said she got skipped.

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

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

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

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

MS. DICKERSON: Is this working?

MS. MOODY: Yes.

MS. TEMPLE: Much better.

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

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

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

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

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

(Audience member proceeded to read.)

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

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

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

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

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

I believe that I should have the right to

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

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

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

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

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

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

MS. MOODY: Thank you for your time.

MS. DICKERSON: Oh, I'm sorry.

MR. MCCURDY: Thank you.

(Applause.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Applause.)

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

MS. DICKERSON: Sure. Yes.

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

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

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

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

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

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

MR. MCCURDY: Thank you.

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

a story that must have been very difficult.

(Applause.)

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

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

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

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

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

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

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

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

only allowing three minutes.

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

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

DR. BUSH-JOSEPH: That would be fine.

MS. TEMPLE: Okay.

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

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

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

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

MS. TEMPLE: Okay.

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

They've had prior injuries, prior

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

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

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

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

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

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

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

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

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

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

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

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

And, certainly, these concerns must be

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

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

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

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

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

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

But I think this is one option, the way

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

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

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

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

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

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

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

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

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

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

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

DR. BUSH-JOSEPH: You know, these patients, unfortunately, they require such high does of opiates --

MR. MCCURDY: To begin with.

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

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

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

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

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

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

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

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

MR. CHRISTOFF: We approved that too.

MS. TEMPLE: We approved that.

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

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

So these patients who are on those

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

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

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

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

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

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

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

So, again, this is, these are all issues

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

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

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

MR. MCCURDY: That would be great.

MS. TEMPLE: Thank you very much.

(Applause.)

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

other conditions, then you'll pass, right?

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

MS. TEMPLE: Okay. Doctor Ramirez.

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

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

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

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

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

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

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

MS. MILLER: Second.

MR. RAMIREZ: Enthusiastic.

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

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

MS. TEMPLE: Oh.

MR. RAMIREZ: I said enthusiastically.

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

MR. RAMIREZ: Approved by acclimation.

MS. TEMPLE: Then a second question was --

MS. WEATHERS: No.

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

Jared Taylor --

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

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

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

MR. TAYLOR: For what?

MS. TEMPLE: Intractable pain.

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

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

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

about chronic pain.

(Lunch break taken at this time.)

MS. TEMPLE: Thank you for being here. We have now the opportunity to officially reopen the meeting. We need a motion and a second to resume proceedings.

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

MR. KNAUS: Second.

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

(Board responded aye.)

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

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

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

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

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

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

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

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

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

DR. WALEGA: -- in about six minutes.

MS. TEMPLE: Okay.

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

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

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

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

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

I'm the President of the Midwest Pain

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

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

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

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

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

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

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

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

In addition, we do a variety of

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

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

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

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

Medical cannabis was used in this group,

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

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

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

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

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

And I've extended my time. Thank you.

MS. MOODY: Thank you.

MS. TEMPLE: Thank you.

DR. WALEGA: Any questions from the Board?

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

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

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

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

MS. TEMPLE: I can speak to that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. WALEGA: Yes.

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

DR. WALEGA: No.

MS. TEMPLE: -- contract?

DR. WALEGA: No.

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

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

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

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

DR. WALEGA: Yeah.

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

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

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

DR. WALEGA: Okay.

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

DR. WALEGA: Sure.

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

DR. WALEGA: Okay.

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

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

MR. KNAUS: Generic.

DR. RAMIREZ: Generic.

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

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

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

MR. KNAUS: Cannabinoid receptors.

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

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

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

I have inadvertently become the voice of

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

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

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

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

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

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

DR. WALEGA: I know Josh very well.

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

DR. WALEGA: My pleasure.

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

DR. WALEGA: Yes.

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

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

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

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

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

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

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

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

And that's primarily due to a lot of

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

MS. TEMPLE: I think Jim Champion has --

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

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

DR. WALEGA: That's excellent.

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

MR. MCCURDY: Thank you so much.

MS. TEMPLE: Thank you very much for your

testimony.

(All Board members thanked Dr. Walega.)

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

(Applause.)

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

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

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

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

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

be more disruptive not to follow your speech. Like keep it the way you have it --

MR. TAYLOR: Okay.

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

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

MS. TEMPLE: All right.

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

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

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

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

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

Approximately 35 percent of Americans have some element of chronic pain, and approximately 50 million Americans are disabled partially or totally due to chronic pain. Chronic pain also is reported more commonly in women.

CPS affects sufferers on a daily basis. Whether sufferers are affected by a depressed mood, poor quality, or non-restorative sleep, being fatigued, a lack or reduction of libido, and experience disability out of proportion with impairment.

Chronic pain also may lead to prolonged physical suffering, marital or family problems, loss of employment, and it may cause adverse

medical reactions and long-term treatments. I myself have experienced chronic pain for the past three years. While I now know that my chronic pain is caused exactly by my osteoarthritis, many patients with CPS don't know what the underlying cause is.

As I can personally attest, chronic pain makes daily life much more difficult. It's hard sometimes to see the proverbial silver lining in dark clouds when one has chronic pain, as chronic pain causes sufferers to have gray skies for many days.

Mundane activities such as going to work, household chores, caring for dependants and other day-to-day activities are difficult with chronic pain. Cannabis is a proven medicine that effectively inhibits pain signals from being transferred from the brain to the point of origin.

Pain is subjective, and what's painful to me might not be painful to you. I do realize that the Advisory Board is proceeding carefully with blanket conditions such as chronic pain, but I do admit that chronic pain is a very broad

condition. However, like I said, I did suffer with chronic pain for nearly three years without having a diagnosis. Other individual patients that have chronic pain are not so lucky to be afforded diagnosis. Because chronic pain syndrome is a disease that affects every facet of a patient's life, it's truly a debilitating condition. Thanks for your time.

(Applause.)

MS. TEMPLE: Our next speaker is Jesse Fosdick. Is Jesse present? Okay. Then we'll move on to, let's see. To enter for the record that Dr. Charles Bush-Joseph has spoken on chronic pain syndrome in his previous testimony.

And then we can move on to Timothy --

MS. MOODY: Could you also enter into the record that Melanie Dillon also submitted a request to present technical evidence. So Melanie Dillon, D-i-l-l-o-n, also submitted information for the intent to present technical evidence, and that is in the Board packets also for you.

MS. WEATHERS: So she was unable to attend?

MS. MOODY: That she was unable to attend, yes.

MS. WEATHERS: Do we need to review that?

MS. TEMPLE: No.

MS. WEATHERS: Okay.

MS. TEMPLE: So our next speaker is Timothy Coughlin. Did I see that once? I don't think, Timothy Coughlin not here?

MS. MOODY: No.

MS. TEMPLE: All right. So moving right along, we, our next topic is chronic postoperative pain, for which Mr. Taylor has already provided his testimony. And also, Dr. Charles Bush-Joseph has provided testimony regarding chronic postoperative pain, a condition that he passed last time.

So the next condition to discuss is intractable pain, and we have Jared Taylor also.

MR. TAYLOR: It's like a frequent flier or something. I thought about, you know, combining them all but I just couldn't do them with six of these. All right. You ready? Okay. My name is Jared Taylor.

We've already approved this, but

intractable pain is actually defined by the Minnesota Department of Public Health as a pain state in which the cause of pain cannot be removed or otherwise treated with the consent of the patient, and which in generally course, an accepted course of medical practice, no relief or cure of the cause of pain is possible, or none has been found after reasonable efforts.

To put it simply, intractable pain is persistent and constant pain, and is happening for an unknown reason. Intractable pain, IP, is different from chronic pain. IP causes a patient to become bedridden or housebound, and can even cause early death.

IP actually causes adverse biological effects on a patient's cardiovascular, hormone and neurological systems. Patients experienced changes in testosterone, estrogen, cortisol and thyroid or pituitary hormones. There is no cure for IP. The common treatments include opioid medications, Methadone, a TENS unit, or an intrathecal pain pump.

Other treatments include muscle relaxants, stimulants, NSAIDs or physical

therapy. And similar to chronic pain treatment for IP is merely throwing a treatment to the wall and seeing what sticks. In December 2015, the State of Minnesota added intractable pain to its list of qualifying conditions.

Minnesota's medical cannabis program was passed in 2014, and Minnesota patients with IP will have access to medical cannabis in August of this year. As I'm sure you are all aware, Illinois has had our Medical Cannabis Pilot Program longer than the State of Minnesota. And for some, I don't know whatever reason, but things are getting done in Minnesota much faster here than in the State of Illinois.

I lived in the State of Minnesota for three years. It's a great state, but we really here in the State of Illinois are the powerhouse of the Midwest and we need to be making head gains rather than the North Star state.

Getting back to this, Minnesota Commissioner of Health, Dr. Ed Ehlinger, stated upon the passage of intractable pain that the relative scarcity from evidence to add IP made this a difficult decision. However, given the

strong medical focus of Minnesota's Medical Cannabis Program, and the compelling testimony of hundreds of Minnesotans, it became clear that the right compassionate choice was to add intractable pain to the Program's list of qualifying conditions.

This gives new options for clinicians and new hope for suffering patients. That's what he said. Like I said to you, Minnesota's Medical Cannabis Program is younger than Illinois, and really Minnesota took the advice of its Advisory Board and its Commissioner of Health and the advice of its citizens.

MR. FINE: Wow, what a concept.

MR. TAYLOR: And they actually thought about the compassion of people suffering with intractable pain. We've already approved this, but as I mentioned to you, as a person who suffers from chronic pain caused by osteoarthritis, I know what it's like to have pain and not know the cause.

And it really sucks, to be honest with you, to not know what's causing the pain. And intractable pain is a lot worse than chronic

pain. Thanks for your time.

MS. TEMPLE: I have a question, Jared. Who was the person that made that quote from Minnesota?

MR. TAYLOR: Yeah. The Minnesota Commissioner of Health, Dr. Ed Ehlinger.

MS. TEMPLE: Okay.

MR. TAYLOR: Very similar to the State of Illinois, there's also an Advisory Board that reports to this Director of Health that apparently --

MR. FINE: So what do you think the difference is, just out of curiosity.

MR. TAYLOR: From Minnesota to Illinois? A couple hundred miles, but --

MR. FINE: Yeah.

MR. TAYLOR: To be honest, it's, in theory there should be no difference. There is an Advisory Board, there is a person that makes that decision. And as Dr. Ehlinger from Minnesota stated, he focused on the relatively scarce evidence presented by technical evidence, but took into account the compassion of this program, of their program, and listened to the

patients --

MR. FINE: The what?

MR. TAYLOR: The compassion.

MR. FINE: Oh, okay. Thanks.

MR. TAYLOR: The compassion of the program. So I hope that IDPH will also follow in Minnesota's tracks of allowing compassionate treatment of cannabis for those that suffer from intractable pain. Thank you.

MR. FINE: Thank you.

(Applause.)

MS. WEATHERS: I certainly, I share the frustration of the Board members, of our Board members and many of the audience, and I know we've discussed this to have our recommendations kind of repeatedly not be approved. However, I would like to be careful and again not deflate the, kind of that decision with all the work the IDPH does.

I think they've, I'm sitting next to Connie so I will give you credit. I think they've done kind of just an incredible amount of work on behalf of this Act and the patients and getting those that are approved moving through,

getting this program started. And I think, you know, there's a lot of people who really, who are involved in the IDPH who really do care, who are compassionate advocates, tireless advocates for the patients, and I think that needs to be recognized.

I think we are, we are a critical part of it but we are a small part, and I think the lack of movement for this aspect shouldn't cast a shadow over all the accomplishments of all the people that worked so hard on behalf of this Act.

MR. FINE: Here, here.

MR. MCCURDY: That's true.

MS. MILLER: Can I just coattail on that? I just want to say too, building on that, I think it's important too, we're all adults, and to remain and maintain a level of professionalism and adult-like mannerisms with that.

MS. TEMPLE: Also to acknowledge again, the hard work of the IDPH in particular with very limited resources, a lot of passion goes into this. And the fact that my patients are getting their cannabis cards and going to the dispensaries and getting quality product is huge.

And so I hope that that, for the record, how it's going down in my view as a clinician has been excellent. So, yes, I definitely want to also give credit to Connie Moody, who has worked tirelessly. And it hasn't been perfect, it's not going to be when you don't have a lot of help. And so thank you very much.

MS. MOODY: Thank you.

(Applause.)

MR. KNAUS: Can I ask a question?

MS. TEMPLE: Yes.

MR. KNAUS: Is there a predictable outcome of things that we've approved or recommended and then have gotten to the point?

MS. TEMPLE: Predictable outcome, if we go on the track record, is that the likelihood of what we passed today getting passed again is probably pretty slim if the same set of criteria and decision makers are at the helm.

MR. KNAUS: Is it possible that the people making those decisions should be here at the hearing?

MS. TEMPLE: Okay. So --

MR. FINE: We have --

MS. TEMPLE: Yes. I would like to call attention to Mr. Wright here who is from the Governor's Office. Thank you for coming. So we do have representation there. We would have, you know, we would like to see more folks coming to hear this.

But in the meeting that Michael Fine, and Jim Champion and I had with Dr. Shah, the evidence base is what his hugest hang-up was about all of the conditions we've talked about. It's the evidence base, the black and white.

And we did stress that compassion is a very important part of this ruling, but he was quite focused on the evidence base, and nothing has really met the level of his criteria to move forward with these conditions.

MR. BACHTELL: It's subject to the clinical information that was brought forth by the physicians with the, right with the additional list of clinical studies.

MR. FINE: Just come up here and speak up.

MS. TEMPLE: I guess informally we're going to have a little chat.

MR. BACHTELL: I didn't mean to disrupt anything.

MS. TEMPLE: Then go ahead and state your name.

MR. BACHTELL: Sure. Charles Bachtell. Last name is B-a-c-h-t-e-l-l. I think one distinguishing factor between previously approved conditions and the ones that are going to be approved today would be the additional clinical information that was presented in written form by the physicians that appeared. So I hope that's a distinguishing factor.

MS. TEMPLE: Every bit of extra testimony, evidence, it all counts and it should be reevaluated with fresh eyes. Nestor?

MR. RAMIREZ: Just as a point of curiosity, the original 39, what kind of evidence base did they have and who came up with that list?

MR. FINE: None. The Legislature passed it.

MR. RAMIREZ: Oh.

MS. TEMPLE: I actually did a little literature review. I cherry picked one

condition, I won't say what it is, but it had much less evidence base.

MS. ZALA: We had, we had a lot of advocates and a lot of sick people come in, and that's how the conditions were chosen. They were based on their relief that they found with cannabis, what their doctors felt and so forth.

It wasn't just somebody made up a group of list of conditions and said well, let's pass this. A lot of people had personal compassion and --

MR. RAMIREZ: That's what we have today, and we had in January, and we had in June.

MS. ZALA: That's why they call it the Compassionate Medical Cannabis Program.

MR. CHAMPION: That's exactly what we brought up to Dr. Shah that the 39 conditions that currently exist on our program have about the same amount of research and studies as the ones being presented to the Board, and that didn't seem to matter.

MS. TEMPLE: So just to keep everything back under control, back to the format, because we still have several testimonies to go through.

Let's, we're going to again reevaluate the opportunity for members of the public to come up and give their commentary at the end just based on train schedules and travel schedules.

So any other, I can't think of any other comments regarding this. And I'm sure the theme will come up again. The next topic is Irritable Bowel Syndrome, and we have Jared Taylor.

MR. TAYLOR: All right. So in my prior testimony, I just want to make very clear, I'm very happy with Connie and all the people who are part of her team. My frustration doesn't lie with the Advisory Board or the people that really have done the work.

My frustration kind of lies where what happens to these conditions after they're kind of passed up the loop. So that's where my frustrations lie. So my apologies for not making that clear.

According to the Mayo Clinic, Irritable Bowel Syndrome, IBS, is a common disorder that affects the large intestine. IBS commonly causes cramping, abdominal pain, bloating, gas, diarrhea, and constipation, and it affects

between 25 and 45 million Americans, and it's estimated to affect one in 10 people worldwide. It's a chronic condition that will require long-term management. There's no known cause of IBS, and in a normal functioning adult, a person's intestines contract or relax in a coordinated rhythm as food is moved from the stomach through the intestinal tract to the rectum.

With IBS, the contractions may be longer and last longer causing gas, bloating and diarrhea. It's also possible that contractions may be weaker, which will slow food passage.

These poorly coordinated signals between the brain and the intestines can make the body overreact to normal changes in the digestive process. The overreaction can cause pain, diarrhea or constipation.

While many people have signs and symptoms of IBS, there are four distinct groups of people who have a higher risk of IBS; those under the age of 45, females who are twice as likely to have the condition, those with a family history of IBS, and those who have a mental health

problem such as anxiety, depression, and personality disorders. Since it's not clear as to what causes IBS, treatment options focus on the relief of symptoms. Dietary changes that have alleviated symptoms of individuals with IBS who had eliminated high gas foods, such as broccoli, cabbage and cauliflower.

There are currently two medications that are currently approved for IBS, Alosetron and Amentiza. Alosetron to relax the colon to slow the movement of waste. It can only be prescribed by doctors enrolled in a special program and is not approved for the use of, by men.

Its effectiveness in men is not proven, and its side effects, well, actually, Amentiza works by increasing fluid secretion in the small intestine to help with the passage of stool. Its effectiveness in men is not proven, and its side effects include nausea, diarrhea, and abdominal pain, which are the symptoms of IBS that this medication is trying to prevent.

In 2004 the University of Naples conducted a study titled Cannabinoids and Intestinal Motility - Welcome to CB2 Receptors.

This study found that cannabinoids, which are found in cannabis, inhibit gastric and intestinal motility through the activation of enteric CB1 receptors. In plain English, the use of cannabis slows down the digestive process for those with IBS by activating receptors in the intestine.

IBS, like I said, has no cure. Modern medicine doesn't have an explanation for its occurrence. The symptoms that this disease causes are painful and inconvenient for those affected with IBS.

Cannabis is a proven medicine that can better help to regulate the digestive process for those with IBS, and is effective to manage the pain that IBS causes. Thank you for your time.

(Applause.)

MS. TEMPLE: I don't see Tina Higens here anymore. Tina.

MS. HIGENS: I'm hiding back here.

MS. TEMPLE: Okay.

MS. HIGENS: Hi. My name is Tina Higens. The last name is spelled H-i-g-e-n-s. First, I'm just going to talk about my personal experience. I'm a qualifying medical patient under the

diagnoses of interstitial cystitis and fibromyalgia. But today I want to speak to you about how medical cannabis is helping me with my IBS as well. I've seen a dramatic decrease in IBS flares since becoming a medical cannabis patient.

I no longer need to locate where the bathroom is as soon as I enter a store or a public area, knowing that at any time I may only have a few minutes to run to and to avoid an embarrassing accident.

This has dramatically improved my quality of life. This allows me to be more comfortable going out and enjoying time with my family and friends. Cannabis helps combat the painful and awful debilitating cramping that accompanies many GI disorders, because cannabinoids relax the smooth muscle of the intestines.

In fact, the smooth muscle relaxing properties of cannabinoids are well established that preparations of guinea pig intestines are routinely used as an in vitro screening tool to test the potency and function of synthetic cannabinoids. Research on a variety of rodents

has shown that endogenous cannabinoids play crucial, neuromodulatory roles in controlling the operation of the gastrointestinal symptoms. With synthetic and natural cannabinoids acting powerfully to control GI motility and inflammation, cannabinoid receptors compromise G protein coupled receptors that are predominantly in enteric central CBV1R and immune cells CB2R.

These digestive tracts contain endogenous cannabinoids and cannabinoid CB1 receptors can be found in mucosal nerves. But basically it really helps what I would call intestinal, like, it's almost like a seizure.

Your GI system just cannot stop having these horrific contractions. You can get very sick. You can be sweating. You feel like you're going to pass out. And since using medical cannabis for my qualifying conditions, I've noticed that it has just had a dramatic decrease of Irritable Bowel Syndrome, which I've been suffering for for over half my life.

So I really would like to see this as a qualifying condition to be, you know, added. Thank you for your time.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: Comments from the Board? Or we move on to Miss Feliza Castro on Irritable Bowel Syndrome.

MS. CASTRO: Hi. Thanks again for having me. I'm going to read two testimonies from two separate patients that turned these testimonies into The Healing Clinic. One was from Pamela Santos of Chicago, Illinois.

She says: My name is Pamela J. Santos, and I have been suffering with irritable bowel syndrome for many years with severe cramping and constipation and diarrhea, which has made me pass out many times alone in the house, even causing me to fracture my arm.

I've done so much research on medical cannabis for pain management. I have been a nurse all of my life, now currently on SSD due to severe osteoarthritis, IBS, panic disorder, anxiety, depression, migraines and insomnia.

I know that cannabis would be a more natural, less harmful option for me than taking so many of the pills I am taking now. I have dry

mouth and dry eye syndrome caused by all of the prescription drugs I have had to take for these conditions, while I could be using just one plant that would not cause such adverse reactions.

Please consider how cannabis can help make life easier for people like me, and all the rest of the poor people that are suffering in this state due to our restrictive cannabis program. We all desperately need your help.

And then I have a second testimony from an Ian Oraveck from Chicago, Illinois as well. And he says: Four years ago I started presenting symptoms of Irritable Bowel Syndrome, and was shortly after diagnosed with IBS.

IBS has drastically changed my life. It complicates simple, everyday errands, and prevents me from being able to perform timely tasks required at work. My doctor prescribed me Dicyclomine and multiple probiotics, which mildly helped my symptoms but did not prevent them all together.

If I was having a bad IBS day, none of the medicine prescribed would help calm my stomach. I did some research online and found

that marijuana has been shown to help with IBS and can calm the stomach. I finally gave it a chance and never looked back. Almost instantly my stomach was settled and the pain and bloating started to subside. The most surprising thing was that I no longer felt the urge to have to consistently use the bathroom.

At my worst, I used to find myself on the toilet in pain between 10 to 15 times every single day. Cannabis is the most effective medicine I have used in relieving my IBS symptoms. Since I have been using the natural medicine I have never felt better.

I am no longer having to look out for a bathroom when I'm out doing errands, and I can now be a much more efficient and effective employee at my company. There have been some published studies about the benefits of cannabinoids for gastrointestinal problems.

One was published by the British Journal of Pharmacology in 2008. It says the body produces its own cannabinoid molecules, called endocannabinoids, which we have shown increase the permeability during inflammation, the

permeability of the epithelium during inflammation, implying that overproduction may be detrimental. However, we were able to actually reverse this process using plant-derived cannabinoids, which appear to allow that epithelial cells to form tighter bonds with each other and restore the membrane barrier. Thank you.

MS. TEMPLE: Our next speaker is Amanda Wilson. She's not here. Neither comments about Irritable Bowel Syndrome have passed at least twice in our petition meeting. I know we talk about it a lot, especially after lunch. Perfect.

It's interesting about the research on leaky gut, as we would call it, but I think it's interesting that many of our patients, particularly Miss Higens who's had interstitial cystitis and fibromyalgia with the IBS would see these syndromes and that there may be an entity called endocannabinoid deficiency syndrome, which is something that, it is a bit of a wastebasket term for every condition that we can't seem to fit basically, but I find it intriguing that the research that we see out there is looking at the

endocannabinoid system specifically in the gut pain receptors behavior and such. So more needs to be done but, you know, we've already passed IBS. So, okay. And now the third. Okay. Let's see. We've got next up migraine with Jared Taylor.

MR. TAYLOR: Okay. All right.

MR. FINE: Change your shirt or something or put a hat on, sunglasses.

MR. TAYLOR: Well, I came all the way down from the suburbs. You know, I wanted to make the best use of my time, so.

MS. TEMPLE: Perfect.

MR. FINE: Awesome.

MR. TAYLOR: All right. So good afternoon, everyone. According to the Mayo Clinic, a migraine headache can cause intense throbbing or a pulsing sensation in one area of the head, and it's commonly accompanied by nausea, vomiting and extreme sensitivity to light and sound.

Migraine attacks can cause significant pain for hours to days, and be so severe that all a patient thinks about is finding a dark, quiet

place to lie down. Migraines might be caused by changes in the brainstem and genetics, or environmental factors may play a role. Triggers for migraines include foods, food additives, drinks such as alcohol, wine specifically, stress, change of weather, and certain medications.

Risk factors for migraines include family history, age (the majority of the patients experience migraines during adolescence), sex (women are more than three times as likely to have migraines than men), and hormonal changes.

Migraines have no cure, but medications such as aspirin, NSAIDS, acetaminophen, also known as Tylenol, ergons and triptans are also used to treat migraines. While I did not formally submit this study into evidence, a January 2016 study tilted Effects of Medical Marijuana on Migraine Headache Frequency in an Adult Population, discovered that medical cannabis helped with migraines.

From the 121 participants, researchers saw a decrease of 10.4 migraines per month, to roughly 4.6 migraines per month. 40 percent of

the 121 participants experienced positive effects, and roughly 85 percent reported having fewer migraines per month. Migraines may be treated with cannabis by the activation of CB2 receptors.

That's also what the study had found, not my personal opinion. I've seen friends and people that I care about experience migraines, and I know that migraines are not pleasant.

Even though medical cannabis is not a cure for migraines, individuals should be able to choose what medication works best to treat their condition. Thank you for your time.

(Applause.)

MS. TEMPLE: Thank you. Tina Higens.

MS. HIGENS: Tina Higens. Last name is spelled H-i-g-e-n-s. Once again, thank you for giving me this opportunity to speak. As I told you before, I'm a qualifying patient for medical cannabis for fibromyalgia and interstitial cystitis.

I have severe migraines of all different types, but the ones that are most troublesome and potentially life threatening for me are my

abdominal migraines. This is because I have a metabolic disorder called mitochondrial disease. I would vomit violently with the abdominal migraines. I would often vomit 10 to 12 times in an hour for up to 12 hours. The vomiting would not subside even while I was retching up bile.

I would need to go to the ER to get hydrous dextrose, Reglan, and sometimes all different types of medications because I would become severely dehydrated, and with the mitochondrial disorder that can cause, you know, a metabolic crisis.

Most months I would need to go to the ER probably at least one time a month. I would often have to drag my children out of bed at 3:00 a.m. to go to the hospital. This process was very upsetting to my sons, and they would cry asking family if I was going to be okay.

Since becoming a medical cannabis patient in December I have not needed to go to the ER once. This has had a huge impact on my life, as I would live in fear that another episode would be coming soon.

The last episode I had was on Christmas

Eve. As soon as I feel an episode coming on, I can medicate with cannabis and it aborts the episode. I've used several different types of medication for my abdominal migraines from Benadryl to Xanax to Elavil to Imitrex to Reglan, and nothing was even close to being as effective as cannabis.

Please add migraine as a qualifying condition as, if you have a migraine you really can't function and there's really nothing else you can do but ride it out and hopefully it ends soon. But, you know, a lot of people that do have migraines also have other metabolic disorders that can really cause severe problems for a patient. So thank you for your time.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: And then we have Feliza Castro for migraines.

MS. CASTRO: Okay. Another testimony for a patient that we collected. Steven Whitehurst from Chicago. My name is Steven Whitehurst. I am 49 years old. I'm an author and educator, and have been permanently disabled since 1997. I

suffer from an illness called bile salt malabsorption, which causes stomach pain, vomiting, daily nausea, discomfort, severe migraines, which at their worst have come eight times a day for at least an hour for years at a time, major depression recur, major depression which is recurrent, and anxiety disorder.

These migraines were the most debilitating symptom of all, often preventing me from moving even an inch without worsening the pain. Coupled with anxiety and depression, life was almost not worth living.

At one time I lost over 100 pounds from not eating due to the myriad of health problems I dealt with, and was told by a doctor that I was going to die. Eventually I spoke to a physician who suggested medical cannabis for appetite, mood and migraine relief.

He was right. Cannabis helps me eat and makes me have a brighter outlook on life. I can stop a migraine before it happens, prevent panic attacks, ease stomach pains and inflammation, and can finally enjoy my life.

Illinois is too restrictive when it comes

to this often life-saving treatment option. The covered illnesses are inconsistent and exclusive, and access to this medicine is limited to those who can pass a background check. This is an effective medicine and a huge resource of revenue for other states, but cash strapped Illinois still stands idly by while citizens needlessly suffer. By Steven Whitehurst.

Okay. So I know that the study The Effect of Medical Marijuana - Migraine Heachache Frequency was mentioned, which is a really good one. Also, the National Center For Biotechnology Information published another really compelling study.

More and more studies are emerging that show how both migraine frequency and intensity are significantly reduced by medical cannabis. Patients in California have been sharing their anecdotal success for many years. For some, cannabis is the only treatment option that can stop a migraine in its tracks or help deal with the dizziness, pain and sometimes nausea that comes along with the migraine.

Many of our patients with TBI and

postconcussion are reporting to us that medical cannabis is actually relieving migraines that they were dealing with often before. So I definitely think that it needs to be added. Thanks again.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: And TBI is traumatic brain injury.

MS. CASTRO: Yeah.

MS. TEMPLE: We had Joel Erickson scheduled to come, but he's not here or scheduled to speak. He's not here. So the next condition -- oh, Nestor. Sorry.

MR. RAMIREZ: Discussion on migraine?

MS. TEMPLE: Yes.

MR. RAMIREZ: I just want to mention a little historical fact. Sir William Osler, who's been called The Father of Modern Medicine, one of the four founding doctors for John Hopkins Hospital has said, or had said at one time because he's dead, that marijuana was the best treatment possible for migraines. And this was in the late 1800's.

MS. TEMPLE: Okay. We have neuropathy, which, for which we have had speakers already. So I want to enter into the record that Dr. David Walega, am I saying that right?

DR. WALEGA: That's close enough.

MS. TEMPLE: Close enough? Okay. That he had spoken extensively on neuropathy as well as Dr. Bush-Joseph. So please refer to their testimony in the records.

Okay. Any comments about neuropathy?

MS. WEATHERS: Did, okay. I just want to --

MS. TEMPLE: Or, are we done? Sorry. Did we finish migraine? Any comments on migraine other than we've heard?

MS. WEATHERS: Yeah. We have already past this, but I will say that this is something that I obviously in my role as a neurologist do see and treat frequently. And kind of going back to Dr. Walega's point that any other tool in the tool box for these patients is something that all, all treating neurologists would welcome.

It is something that we struggle with, and it's many lost days of work, you know, the

impact of quality of life, the lack of productivity. The American Academy of Neurology has very clearly come out and said that opioids should not be used for this, they are not effective. It's not even chronic pain where they might be effective early on and then you're just weighing the side effects versus, the adverse effects versus benefits.

There is no benefit. So we have even less medications at our disposal than in other chronic pain conditions, so. I again agree with our previous group.

MS. TEMPLE: I have to throw a plug in for acupuncture as well. Again, the work that I do. Good evidence based on migraine data base for tension headaches at least, but I know that's off the subject. It must be mentioned. Osteoarthritis.

MR. CHAMPION: I was just going to say --

MS. TEMPLE: Oh, yes.

MR. CHAMPION: The last thing, a lot of conditions, a lot of conditions really help the migraines. By adding migraines to the group of conditions approved it would cover other

conditions as well.

MS. TEMPLE: We covered the Lyme disease rejection. Okay. Osteoarthritis. Jared Taylor.

MR. TAYLOR: Yep.

MS. TEMPLE: You get the frequent flyer.

MR. TAYLOR: This one's going to be a little bit faster, just to warn you. All right. Good afternoon. Again, thanks to the Advisory Board and Connie and her staff for all that you all have done. I'm really appreciative of that.

But since I spoke to you all before in October there has not been a cure discovered for osteoarthritis, OA. OA's the degradation of cartilage in a joint. It's the most common form of arthritis, and it can affect any joint in the body.

Commonly affected areas include the hands, the hips, the knees and the spine. My OA is in the facet joints of my spine directly above my --

MS. TEMPLE: Slow down.

MR. TAYLOR: Sure.

MR. FINE: You've got a little more time, so you don't have to be the FedEx guy.

MS. TEMPLE: I ask you slow down.

MR. TAYLOR: Okay. All right. All right. My OA is in the facet joints of my spine directly above my tailbone. And even with my super cool cushion, it's been a little bit painful here this morning and afternoon.

In 2005, the CDC estimated approximately eight percent of Americans had OA, and if these numbers held true today for the State of Illinois approximately 1.1 Illinoisans suffer from OA. That's just my non-academic estimate.

So even if 10 percent of these Illinois patients became registered patients, this program would be self-sustaining, which IDPH predicted 100 to 150,000 patients with 10 percent of OA patients in Illinois, 110,000, we could make osteoarthritis the saving grace of this cannabis program.

OA causes bones to rub against each other after the cartilage is worn down. It's that friction. It's very painful, and OA patients like myself suffer from chronic pain on a daily basis.

However, it's going to affect each

patient differently. For me, OA makes it painful for me to do yard work, to do chores, painful to sit. I wake up every single morning, this is a hallmark of OA, with pain directly caused by this disease. It affects me in almost every part of my life.

Treatments for OA include taking Tylenol, NSAIDS, chronic pain class, other pain management based options. These therapies merely treat the symptoms though of OA. There is no cure.

I am reintroducing a 2013 study by the University of Nottingham titled Cannabinoids CB2 Receptors Regulate Central Sensitization and Pain Responses Associated with OA of the Knee Joint.

In this study it was discovered that the use of cannabis activate CB2 receptors in our brain, and basically these signals are blocked from transferring chronic pain from our brain to the areas.

I'm also introducing a March 2016 study titled Effectiveness of NSAIDS for the Treatment of Pain in Knee and Hip Osteoarthritis, a Network Meta Analysis. This study was conducted by Dr. Sven Trelle, and through the study of 55,000+

patients discovered that Tylenol has little effect on OA pain. It's a little bit better than a sugar pill. So it really does nothing for us. Rather, NSAIDS, according to the study, were proven to be more effective. But NSAIDS come with a host of risks such as stomach upset and cardiovascular disease.

Medical cannabis isn't going to cure my osteoarthritis. I've adapted by taking yoga classes, seeing a pain specialist or rheumatologist, but it's really only going to treat my symptoms.

So we've approved this. We've recommended it. But I'm not really realistic that our, your recommendation will be heard. As I said in October, I'm not going to go away, I'm going to come back every time until OA is approved, and I am prepared and willing to pursue any other remedies that are available to me in order to add osteoarthritis to this program.

We're not going to go away. We could be the saving grace. Get the number of patients needed to make this program self-sustaining. Thank you.

(Applause.)

MS. TEMPLE: Nestor.

MR. RAMIREZ: For the sake of the record, I think he said 1.1 Illinoisans, but I think he meant 1.1 million.

MR. TAYLOR: Yeah, 1.1 million Illinoisans by estimates have OA.

MS. TEMPLE: This was a condition we debated early on at our first meeting and I had reservations because it's so common. I mean, I can't imagine, I don't know anyone who doesn't have some form of ache and pain.

And we had a good conversation at the first meeting that we need to remember this is for debilitating conditions, that it's going to be something that your physician, patient/physician relationship will ferret out whether other alternatives, other medications and treatment programs have failed, or if this is a better treatment option.

Because my initial reaction to osteoarthritis was way too common. But at the same time, that's going to be between doctor/patient, and that it has to be

debilitating. You have to remember that these conditions must be at a level of debilitation. There's a conversation that I brought up about why don't we write severe osteoarthritis or put moderate, severe, and start putting qualifiers on it. And then we decided not to go that route.

And remember constantly that it's the, all of these conditions have the requirement that they must be debilitating enough to merit their certification. Because I got a lot of flack for the osteoarthritis one from my colleagues. I just want you to know that.

Once you explain it that way it works and they're like oh, okay. All right. So the last condition, we're almost done. And we have two speakers. We are at that point where we can decide.

MS. WEATHERS: Yes. I would like to make a, I will make a, given how we're doing on time, I'll make a motion that we allow the additional speakers who did not preregister to each have three minutes.

MS. TEMPLE: Okay.

MR. RAMIREZ: Second.

MS. TEMPLE: I would like -- a second? Okay. Those in favor?

(Board responded aye.)

Those opposed?

(No response.)

MS. TEMPLE: Okay. So we will allow further testimony from those who had not signed up. Would you kindly raise your hand if you want to give a testimony so we can get a head count? One, two, three. And you'll get three minutes like the others. So we have three. Okay. We can do that. Okay. For Post Traumatic Stress Syndrome we have Jared Taylor.

MR. TAYLOR. All right. I promise this is the last --

MR. FINE: He looks so familiar, this guy.

MS. TEMPLE: But you don't have to speak faster.

MR. TAYLOR: Okay. No, this one's a little bit more of a slower cadence to it. All right. Good afternoon. My name is Jared Taylor. We've already approved Post Traumatic Stress Disorder, but years ago Post Traumatic Stress

Disorder used to be known as shell shock, if any of you guys were familiar with that. I actually did a study on this in college, and shell shock was only seen as something that was by Veterans, but we know that Post Traumatic Stress Disorder can cover people that have never even served in the Military.

Now, the Mayo Clinic defines PTSD as a mental health condition that's triggered by a terrifying event, either experiencing it or witnessing it. Symptoms of PTSD include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.

PTSD is not limited to members of the Military, although this topic does get heavy exposure in the media. PTSD can affect anyone. And according to the Department of Veterans Affairs, about seven or eight out of every 100 people will have PTSD at some point in their life.

According to the VA, about Eight Million adults have PTSD during a given year, and about 10 out of every 100 women develop PTSD sometime during their lifetime in comparison to roughly

four out of every 100 men. So ladies unfortunately had about two and a half times worse occurrence risk of getting PTSD than men. Also according to the VA, 11 out of 2100, out of every 10 Veterans who served in Operations Iraqi Freedom and Enduring Freedom, have Post Traumatic Stress Disorder.

As well, approximately 12% of Gulf War and 15% of Vietnam War Veterans experienced PTSD during their lifetime. The VA currently reports that 721,575 Veterans currently reside in the State of Illinois out of a population of 12.8 million residents in the State. That's approximately 5% of the population in the State of Illinois.

Now, Dr. Rafael Mechoulam, he's an Israeli scientist who first identified Tetrahydrocannabinol, THC, as the psychoactive compound in cannabis. Decades later, Dr. Mechoulam discovered that the human brain's endocannabinoid system in the endogenous neurotransmitter anadamide --

MS. TEMPLE: Anadamide.

MR. TAYLOR: Okay. Thank you for that.

I appreciate that. Doctor Mechoulam believes that the cannabinoid system is integrally related to memory, including memory extinction, which is the normal, healthy process of removing associations from stimuli.

Cannabis can therefore help to aid memory extinction by reducing association with an individual's association with stimuli such as loud noises or stress which are trigger things for Post Traumatic Stress Disorders.

While PTSD can affect anyone who has experienced a traumatic event, PTSD disproportionately affects our Veterans. Because the debilitating symptoms that PTSD causes, we've already established that you guys are going to approve it, but basically I think the State and its Administration should recognize and respect and honor the service that Illinois Veterans have given to our nation without regards to their own personal safety, and also keep in mind that not only Veterans that have PTSD will benefit from this access to medical cannabis.

Thank you for your time.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: And we have our last scheduled speaker is Miss Feliza Castro.

MS. CASTRO: Thank you. Thanks again. And this is a testimony from a patient, not a Veteran but someone else who wanted me to share her story to the Board and with the rest of you here today.

So this is Autumn of Champaign, Illinois. And she says in 2009 I was diagnosed with PTSD after my boyfriend committed suicide. I could not help but blame myself, and I was convinced everyone else knew that it was my fault.

I could not eat at all, or I would eat so much I would get sick. I could not sleep for days, and then I would sleep for 18 hours each night. My body was in constant flux, and I couldn't talk to anyone about feeling their pity or judgment.

I dove into a deep, dark hole of depression. I couldn't close my eyes without imagining Will. I would have terrible dreams of him dying in every way possible, or I would have dreams that it never happened and wake up

sobbing. My doctor diagnosed me with PTSD and started to prescribe a lot of different medications, exacerbating my already debilitating flashbacks and intrusive thoughts. A college freshman at the time, I had to drop out of school.

I could no longer muster any motivation to face the world, and moved back to my parents' house where my mom could take care of me like a child again. Sometimes even bathing me. Nothing was right, and I was constantly hiding how triggering the surrounding world could be.

I began to read more about how cannabis has helped so many Veterans with PTSD, whose symptoms seemed so much more severe than mine. I started to smoke cannabis and started to feel like myself again. I could sleep on a regular schedule and enjoy my friends for the first time in two years.

I got a job I really like, which allowed me to transition back and to socialize, regaining the outgoing personality that everyone knew before my PTSD diagnosis. I still struggle every day, but I no longer view death as my only exit

from this pain. I feel free and independent and like I've regained so much of my life. This is all thanks to cannabis, that at, currently in Illinois, I'm not legally allowed to possess. Cannabis saves so many lives of those with PTSD, and if I hadn't given it a chance I'm certain I would not be sharing this story with you today.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: Comments about PTSD?

MR. CHAMPION: As the Veterans rep I guess I'm going to say a little bit of something. My numbers are a little bit different than Jared's, but the evidence in support of cannabis as an effective treatment for PTSD is overwhelming. Veteran suicide rates is as high as 22 per day or 8,000 per year. That's more than the people than we lost in the war itself.

PTSD affects over 30 percent of all Vietnam, Iraq and Afganistan Veterans. PTSD in all forms should be approved, but we especially owe it to the Veterans of Illinois, so.

MS. TEMPLE: Any other comments? This is our last --

MR. RAMIREZ: Well, we've got other --

MS. TEMPLE: No, we don't have, it's not our last speaker.

MR. RAMIREZ: So we've got other speakers?

MS. TEMPLE: Right. So if there's, and then the Board can jump in, but we've now opened it up to our spontaneous speakers. Mrs. Champion?

MS. CHAMPION: Yeah. And I'll be really quick. I'm Sandy Champaign, and I wanted to address about the 39 conditions. One of the things that we took into account was the idea of palliative care, which is about quality of life, because we don't have a lot of research out there.

And many of our representatives did not want to take any research outside of the United States, they wanted something from here. But because we haven't rescheduled, we have this problem.

So palliative care was huge in determining what conditions were added. For example, Jim's MS, he was on 59 pills a day.

He's down to six. And that clearly makes a huge statement as to why he uses cannabis. So I just wanted to clear that up. I do have a quote from our sponsor because I asked him what he would say if he was asked that question. And he said he listened to tons of people, took our best shot. Some were negotiated.

The list is not perfect, but that's why we created the Advisory Board. Thank you.

MS. TEMPLE: And your sponsor, you're saying Mr. --

MS. CHAMPION: Representative Lou Lane.

MR. RAMIREZ: So I just want to say that mine was more of a rhetorical question to say that the excuse for not passing what we've done in the past three meetings has been that it doesn't have enough evidence. And the initial ones didn't have enough evidence either, so it's just like a protocol question.

MR. CHAMPION: I agree with you 100 percent.

MR. RAMIREZ: Yeah. It was not a, not a critique of --

MS. CHAMPION: Oh, no, no. But I just

wanted to put that on public record that, you know, because a lot of people have asked us that question like what made us decide the 39, not me personally, but we've negotiated a lot of people in here, negotiated those conditions.

So a lot of times it was just personal experience. So I just wanted to put that in the record.

MR. MCCURDY: It's good to have a historian in the room.

MS. CHAMPION: Thank you.

MS. TEMPLE: How about our second speaker? The gentleman in the tie. Okay.

MR. KURFMAN: I'm trying to laugh on the way up here, maybe I won't be so nervous. My name's David Kurfman. K-u-r-f-m-a-n. I am an approved patient in the Program and I take it for seizures, epilepsy. And I, first off, I just want to say that it's helped me. I've been on it since the dispensary's opened in December last year.

And I started out with 2000 milligrams of Depakote. Now I'm down to 250, and I plan on going off of that next week. So now that some of

the higher CBD medicine is out like Charles Webb, in particular I take that, which actually they changed the name but, called Sweet Relief. But anyways, I wanted to ask you guys to seriously consider migraines and chronic pain and depression and, basically because I've had all those things and I've been diagnosed with all those conditions.

And since this program's approved, or been approved, I've been taking cannabis, and I have to say that it's helped me in all of those areas. I've been on Xanax, I've been on, of course, my Depakote for epilepsy. That's almost gone.

I no longer take Xanax. I take Effexor for depression, and I've went way down on it. And I'm just down to 75 milligrams on that. Almost off. My point is that I think these conditions should be approved because they've, cannabis has helped me in those areas.

And I think there's overwhelming evidence out there that, from other states that's approved these conditions, why they should be approved, and that they've helped multitudes of people.

But I no longer have to take a bunch of medication because I've taken cannabis now for several months, and of course I've been weaning myself down from taking my Depakote and some of the other things with consultation with my doctor.

But I have to say it's really, really helped me, and I hope you can approve those other conditions. Okay. Thank you.

MS. TEMPLE: Thank you.

MR. MCCURDY: Thank you.

(Applause.)

MS. TEMPLE: Miss Zala is our last speaker.

MS. ZALA: Thank you again very much. I'm not going to speak on Meera's behalf. I'm going to actually speak on the dispensary's behalf and a patient consultant that I am for New Age Medical Cannabis Dispensary in Mt. Prospect.

I'd like to just say that all the conditions that we've spoken about and the 39 all have familiar foundational symptoms, strains, that I work with and that are showing specific relief for specific symptoms are patient to

patient, individualized and customized to work with each patient and their lifestyles. That includes all the adversities that come along with being ill. I start my initial consultation by sitting with my patients discussing their needs, their life, their concerns, their goals.

And before I dispense any type of cannabis, medical cannabis, I talk about the science and cannabis and how it would affect them on an individual basis.

I also start with a high CBD and a low THC or equal part strain. For example, White Harmony, Canna Sue, Harley Sue, which are all CBD and, CBD and THC and all of the other cannabinoids all in one.

The White Harmony is an equal one to one ratio, which is great for people who are experiencing MS, for fibromyalgia, for cancer, for HIV. The, for rheumatoid arthritis. I mean, the list is, the symptoms are all the same. The conditions are just different but the symptoms are all there.

So what we start is we always start with them with a really, really good CBD base to start

building up their system, and then everything else is introduced, slowly, very slowly. To start with their building up of their system of CBD, that is an anti-inflammatory, antioxidant, and antispasmodic effects. THC can then be systematically induced, introduced, based on comfort level and tolerance.

The training I have received in cannabis education ranges from thousands of hours dedicated to education and in terpening, which is the science and art of studying terpenoid profiles of the cannabis plant, which means that I'm able to help my patients distinguish which strain will affect them in a certain way based on smell or essentially, aromatherapy, quality of bud structure, land raise, and anecdotal testimony globally.

So when we go into our patients, we are not just dispensing medical cannabis freely. We are talking to our patients and we are discussing with them. We are understanding their needs and we're helping them succeed and successfully surpass the discomforts of their illness.

Thank you very much once again for

allowing us to speak.

MS. TEMPLE: Thank you.

(Applause.)

MS. TEMPLE: It's nice to have a dispensary point of view, so that was very helpful. Any other? Otherwise --

MR. FRIEDMAN: I wasn't planning on but I, you know what, I think it's interesting. I think it's --

MS. TEMPLE: They're making --

MR. FRIEDMAN: Whose idea to really --

MR. FINE: Talk into the --

MR. FRIEDMAN: Oh, I'm sorry. I'm sorry.

MS. TEMPLE: Yeah.

MR. FRIEDMAN: Joseph Friedman. F-r-i-e-d-m-a-n. And I'm being forced to be up here. But thank you, Michael. I appreciate the opportunity. From the dispensary standpoint, and I think this is where the rubber meets the road. You know, we have patients coming in every day. Some of them are familiar with cannabis.

Those kinds of patients have higher tolerances, and so we consider the dosing differently than those that come in that have

never touched it or haven't touched it since they smoked a joint in the seventies. One of the things that I'm very proud of is we have healthcare professionals in our dispensary, and I consider what we do very important from the standpoint of communication, not only with the patient but also many times with the physician.

The physician writes the certification and then a lot of them don't know what happens at that point. So I'm trying to take this a step further where we're communicating with their doctors and we're letting them know what we're doing, and then we're also monitoring outcomes.

We're not expecting a whole lot to happen with the first visit. We give them recommendations. And then it's two weeks later or a month later when they come back where we talk about what they, what's helped them, what hasn't helped them. And then we also, if necessary, speak with the doctor, get on a conference call when they have their doctor visit.

So it's this triangle of care that I think is very important. Something that I sort

of grew up with as a pharmacist where there was all this kind of, this type of communication. And I consider what we're doing healthcare, very healthcare wise.

So, you know, Michael's, he comes in and, you know, we just have, it's friendly but it's also very professional and it's very helpful, and we learn from patients like Michael as much as patients like Michael learn from us.

So it's really a great communication. Thank you.

MR. FINE: Thanks, Joe.

MS. TEMPLE: Yes.

(Applause.)

MR. RAMIREZ: I hate to be crass and materialistic, but since I assume that marijuana is not covered by any insurance or by Public Aid, what is the cost, approximately, for somebody that's using it for treatment?

MS. ZALA: I can answer that for you. We are very comparable to, let me, let me retract that. The black market dictates the cost, unfortunately. When we look at the amount that is being regulated in dispensaries, there is a

specific cost for an eighth of bud versus oil, or a gram of bud versus a gram of oil. It ranges. It ranges between, you know, a dispensary that is a cultivator and a dispensary that is a dispensary. So we are in the middle, and we are often trying our very, very best to accommodate patients because it is expensive.

And it is expensive and it's very hard for them to pay for it, as well as being on all these other medications. Their whole life depends on this therapy. So now that, you know, the prices are starting to kind of level out a little bit, but really we're trying very hard to accommodate our patients as best we can with hardship programs, disability programs, Veteran programs.

I believe our dispensary gives 20 percent off for Veterans, 10 percent off for disability, and we work with them for hardships. So we are always trying our very best to accommodate our patients.

MR. FRIEDMAN: And you made a great comment about, you know, what's happening from the standpoint of third party reimbursement. One

of the things that we're working on is accreditation. We're hoping that accreditation, and this is going to take us probably through the end of 2016 to become accredited. Down the road we're hoping that accredited dispensaries will be able to adjudicate claims for medical cannabis.

In fact, I was talking to a representative from United Healthcare the other day and he's talking to his executives because there's a lot of, there's a groundswell of information and interest going on from the standpoint of insurance coverage for this.

And as soon as it comes off of Schedule I, I think those possibilities will come to fruition.

MR. RAMIREZ: I understand the comments, but still to paraphrase The Tonight Show, how high was it, Mr. Carson. Give me a number so --

MS. ZALA: The prices for an eighth are between, I would say between, for our dispensary, between $60.00 and $65.00. For a gram is between $19.00 to $22.00. But I can tell you that we have sales all the time, so we are always once again trying very hard to make sure that our

patients get what they need.

AUDIENCE MEMBER: So it's about 360 to 440 an ounce. But it depends on the patient and what they need too.

MR. CHAMPION: It's cheaper if you buy an ounce too.

MS. ZALA: Absolutely.

MR. MCCURDY: Based on the State data, I want to say that the average patient spent about $420.00 in the month of March?

MS. ZALA: Correct.

AUDIENCE MEMBER: I was going to say, I spent, I spent personally as a normal patient without being a, getting any discounts, which not all of the dispensaries give.

MS. ZALA: Right.

AUDIENCE MEMBER: Mine doesn't. Mine only, mine does do a discount program where you can, for every $50.00 you spend you get a punch card and you fill out the punches and then you get free $50.00 off the next purchase or whatever. That takes time.

I generally spend between four and five hundred dollars.

MS. TEMPLE: In a month or?

AUDIENCE MEMBER: In a month.

MS. TEMPLE: Okay.

AUDIENCE MEMBER: So it's ungodly expensive to me, but it's helping me and I want to get off of all this medicine. The other thing I would say is now that some of this newer medicine's coming out, the oils and the concentrates, which for somebody like me with epilepsy, I need higher CBD medicine that doesn't get you high, the THC.

And it's more expensive. I mean, you're talking $80.00 for a syringe of a little oil, what they have out so far. And that doesn't last very long for me. I mean, just to be honest with you, it might be five days. Four to five days.

MS. TEMPLE: Do we have figures from industry about how much, how much has been netted in sales so far?

MS. CHAMPION: There is, yeah, there is actually --

MS. ZALA: Actually, yeah. I think Joel Erickson would know, would be a really good person to ask.

MS. TEMPLE: So a bigger question I have, since we have the Director right here in the audience, this Pilot Act ends what, December 31st, 2017; is that right? Or January 1, 2018?

MS. CHAMPION: December 31st.

MS. TEMPLE: New Years Eve.

MS. CHAMPION: Somewhere between the clock striking 12:00.

MS. TEMPLE: Okay. What kind of data is needed to, and what, who says okay, this is no longer a Pilot Act, we make this the law? Okay. That's, you know, I'm sure lots of people here are on pins and needles that this program could go away, which would be terrible.

MS. CHAMPION: One of the things that I'm, is said often, is a lot of people talk about greed and about the industry is in it for money, and this and that, and I don't agree with that.

What I agree with is that patients need the industry and the industry needs the patients. And without each other we're not going to succeed. And that's why we have this Board because we need to add conditions to get more

patients and help more patients have a quality of life. It's not even about quantity of life, it's about quality of life many times. And just the fact that we're paying out of pocket rather than going to the insurance companies means a lot.

Jim can get all the drugs he wants for free through the VA, and they're more than willing to give him methadone and morphine and anything he would possibly want to get stoned, but it's not about that for us, it's about his quality of life. So we pay.

MS. TEMPLE: So I'm just curious to know, you know, is it financial data and safety data? Are people diverting this? I mean, I would like to know how is it being studied so that when it's December 2017 when it's time to decide what happens. That's the part where the process to me is unclear.

And I'm sure it, you know, goes to the Governor's Office but, you know, I think we're doing what we need to do as a Board.

MS. MOODY: Right. It will take action by the Legislature and then the Governor to sign the Bill if the Legislature chooses to do that,

and appease or extend the pilot date, or, do away with the pilot and move it. So those are some of the options that the General Assembly have.

MS. CHAMPION: We will need the veto majority and the Governor's award to extend the program. We will need veto majority, which we're prepared to use.

MR. RAMIREZ: But other than the Department of Public Health, supposedly the Department of Agriculture and the Department of Tax Revenue are supposed to be picking up some of this information, is supposed to be generating some of this data. Because they're co, co-sponsors of the project, or whatever you want to call it.

MS. MOODY: So there are multiple agencies involved in the program. The Illinois Department of Public Health works with the Patient Registry Program. The Department of Financial and Professional Regulation, they are responsible for authorizing and licensing the medical cannabis dispensaries.

The Department of Agriculture is involved. They license the cultivation centers

where the medical cannabis is grown. The Secretary of State, they're responsible for collecting the tax revenue. The Illinois State Police is involved as a consultant.

We also work with the Secretary of State's Office because when a medical cannabis patient is approved to participate in the Program, there's a notation on that patient's driver's license record also.

So there are multiple agencies that are involved in the oversight. As you know, there's an annual report that the Department of Public Health is authorized to submit annually to the General Assembly and the Office of the Governor. And as the program continues to be implemented, that annual report will include additional information from each of those agencies.

Our first two annual reports have been a little bit sparse because, as you know, when that report was written it's on a fiscal-year basis, and at the end of June of 2015 we had not yet approved, or issued a registration card for a single medical cannabis patient, and dispensaries were not yet open either. So that is some of the

documentation that will be shared. I'm sure that the General Assembly will ask for that information. I know that our Directors of each of the agencies are watching that information.

I'm sure that the Office of the Governor is going to be looking to the agencies to share that kind of information also.

MS. CHAMPION: Can I say one positive thing though that, because I think that would help. I guess it was last year or sometime I was asked, and I'm sure a lot of people in this room were asked, what can we do to make the program better.

And that was through the agencies and the Governor's Office and stuff. So that, I know I, sometimes I sound negative, but I'm not always negative. I'm actually an optimist.

And I don't think the program's going to die. I don't think the Governor's going to kill the program. I know a lot of people have, you know, their opinions about that, including myself, but I don't think the Program's going to die.

But I do think it's going to take all of

us together because that, it takes a village, it's going to take a huge village to make sure that this is sustainable.

MR. KNAUS: Okay. Could I ask, was there something about the 39 approved conditions that, an element that gave them approval beyond what this committee has looked at very carefully and made recommendations as to other conditions?

MS. CHAMPION: Can you repeat that, because I'm not sure I understand?

MR. KNAUS: It seems like if 39 things were approved for this, that this committee has looked at other things that they have looked at very carefully, and some people said yes, some people said no. It seems like somebody would appreciate that effort and proceed on with approval instead of non-approval.

MS. CHAMPION: Right. I completely agree with you, and that's why we called it the compassionate use of medical marijuana, medical cannabis. Because when the program was passed it was based on compassion.

It was based, again, on quality of life, based on what research we could possibly find.

So our hope was when we put the Advisory Board into that Bill was that we would add conditions. That was our hope. And do you guys know how many conditions have been rejected so far?

MR. FINE: 19 so far.

MS. CHAMPION: So we're going into almost a year now and we've had every single condition rejected.

MR. FINE: Summarily rejected without explanation.

MS. CHAMPION: Right.

MR. FINE: And then there has been some time.

MS. CHAMPION: Right. So we, right. So, but, you know, we don't have a reason for that because we did not put it in the law that Dr. Shah would have to give a reason for that. That will change in the next one because we want to know why. We want to know why because if we don't know why we can't improve on what we're doing.

MS. TEMPLE: Might I add then that per Dr. Shah the reason they were summarily rejected is not for no reason, it's because the level of

scientific evidence did not pass muster.

MS. CHAMPION: Right. But, again, when we --

MS. TEMPLE: On like blankets, which --

MS. CHAMPION: But, and that's --

MS. TEMPLE: -- of which --

MS. CHAMPION: -- was not supposed to be happening because we're supposed to be using, balancing --

MS. TEMPLE: Compassionate.

MS. CHAMPION: -- compassionate with the scientific. And so we don't know why. But I want to remain optimistic and positive that we just keep doing what, we have patients keep coming. I know it's a hardship, but we can't give up. We can't let them think we're giving up, because if we give up then we might as well --

MS. TEMPLE: So are there other comments? We're actually running ahead of time. This was supposed to end at 3:00, it's 2:30.

MS. WEATHERS: A couple things. So my question, comment and question, my understanding too was that there was a statement made after our

initial meeting, the Advisory Board and rejection. Not only the IDP Director's statement, as well as the Governor's Office, saying that part of the rationale was that because this was a limited Pilot Program, the decision was made to keep it as a kind of a contained pilot and not expand that past that by adding conditions that would be an expansion to the Pilot Program.

MR. RAMIREZ: That was the first rejection.

MS. TEMPLE: That was the very first rejection.

MS. WEATHERS: That was the first rejection.

MR. FINE: And time too.

MS. WEATHERS: And time that we haven't even started, so how could we add before we've even started? Now that we have, I don't know if that will change, but I was wondering, I know Mr. Wright is in the room.

Was there any comments that you can add or understanding, shed light on, for the Board and for the, kind of the questions that we

raised?

MR. WRIGHT: Sure. Yeah.

MR. WRIGHT: My name is Joseph Wright. W-r-i-g-h-t. I'm the Director of the Illinois Medical Cannabis Pilot Program. And would you state your question one more time again just so I can make sure I got it?

MS. WEATHERS: Sure. I was just, it was kind of open ended, but given the questions that have been raised, especially during this open period, about the willingness of the Director and the Governor to add more conditions, especially, I know that some of the concern, let me take a step back and rephrase.

I know that some of the concerns from the rationale given for the rejections after our initial meeting was that the program, nobody had even got their cards yet and the program hadn't even started, and how can we expand when we haven't yet begun.

I wanted to know if that rationale, given that we now do have data since November, if there's a feeling that that rationale is still in place, or if you feel that there was kind of any

opportunity for further conditions to be added, and the viewpoint from your standpoint from the Governor's Office?

MR. WRIGHT: Sure. Well, the first thing I do want to clarify though is that the Governor's Office gave a statement at various points along the way in terms of events that happened. So there was a Bill that was passed to extend it as well as add PTSD.

There was the first recommendation of the Board. So some of the messaging, while the end result may be the same, with some different things and about different, you know, items. In terms of whether or not additional time is still needed, I would say that the position is probably still the same.

But the Governor's Office has already said as much, that they're willing to work with the Legislature on an extension of the program. That's already in the public domain.

In terms of when and how that happens and how long that extension is, that will have to be hammered out between the Legislature and the Governor. In terms of additional conditions, you

know, I don't have a particular satisfying answer for you how long. It's going to take a little bit more thought, and I don't have a crystal ball to when or how conditions will be added.

But, you know, there's two methods, as you all know. One is this Board, another is through the Legislature. So we'll see what happens with that. But, unfortunately, I don't have a definitive timeline for you on when that can happen.

MS. TEMPLE: Okay. So on that note, I would say we're going to just keep doing what the Board was tasked to do, which is to provide a balanced and fair look at the science and patients and compassion, and really vet these conditions as thoughtfully as we have.

And I really appreciate how much work you've all put in. This is a volunteer Board. You've taken Clinic off, you've taken time off of your jobs. We've donated this time, including the time that, just to prepare for this meeting.

I want to thank you, IDPH, for all of their hard, hard work on making, in making this Pilot Program a success as it is so far. And

that patience is key in all of this, and so we keep trying. Our next meeting will be sometime in the fall, and the venue is to be determined. It will be announced on the State's website.

We may hear similar conditions again, I believe the six-month period of time where our recommendations from today, which we probably should read for the record as to what was approved and not approved, are going to be decided upon by the Governor.

If you want to you can go ahead and sit down. And then we will hear in six months whether the conditions that we talked about today would be approved or disapproved.

MR. MCCURDY: They get six months after the time the petition period closes?

MR. FINE: Yes.

MS. TEMPLE: Is that right?

MR. FINE: Yes.

MS. MOODY: Right. So that would be January 31st.

MR. MCCURDY: So January next year.

MS. MOODY: So 180 days after that.

MS. TEMPLE: Got it. So January 31st we

will hear the decision on today's --

MR. MCCURDY: No.

MS. MOODY: No.

MS. TEMPLE: No?

MR. MCCURDY: In July.

MS. MOODY: Yeah.

MR. MCCURDY: End of July.

MS. MOODY: So January 31st was the closing date of the petition, open petition period. And then from that date --

MS. TEMPLE: Okay.

MS. MOODY: -- the Board and the Department have 180 days to render a final recommendation.

MR. MCCURDY: So we're midway there. We're midway there.

MS. TEMPLE: So two months from now?

MS. CHAMPION: Something like that.

MS. TEMPLE: Three months. Nestor.

MR. RAMIREZ: So I want to make a personal comment. I want to thank personally each and every person involved in this whole project for their courage, their persistence, their perseverance, their support of the

patients. Everything that you do for this project is helping, and we've got to keep moving forward. We don't even want to go backwards at all at any time.

(Applause.)

MR. MCCURDY: I want to make one other comment, and it's related I think maybe to something Sandy said, and I may have misunderstood you. But the legislation itself actually did make a provision for the Advisory Board. The Advisory Board was a result of the Department's deciding on a process. And so we actually owe the existence of the very Board itself to the Department in the first place. So --

MR. CHAMPION: Well, that was part of the Bill as well, that it was, they put together the rules for what would happen.

MR. MCCURDY: Right, right. But there wasn't a Board in the legislation. The Board was created because of (inaudible) the Department made. Interestingly enough, yeah.

MS. TEMPLE: Let's not forget thanking the patients and the advocates who really make

this. So we're ahead of schedule. It's 2:37, so I think we did pretty well covering everything. Thank you, Board.

MR. FINE: Motion to adjourn.

MS. TEMPLE: Motion to adjourn.

MR. RAMIREZ: Second.

MS. WEATHERS: Second.

MS. TEMPLE: All those in favor say aye.

(Board responded aye.)

(Hearing end time: 2:37 p.m.)

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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