Approved: April 2, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on February 11, 2008 in Room 136-N of the Capitol.

Committee members absent: Senator Mark Gilstrap- excused
Senator Nick Jordan- excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the Committee: Mr. Robert Stephan, former Attorney General, Kansas
Ms. Laura Green, Coalition Director,
Kansas Compassionate Care Coalition
Ms. Bette Hulser, Private Citizen, Topeka, Kansas
Dr. Jon Hauxwell, Retired Physician, Stockton, Kansas
Mr. Anthony Buckland, Private Citizen, Mission, Kansas
Dr. Eric Voth, M.D., Chairman,
The Institute on Global Drug Policy
Ms. Jean Holthaus, Director, S.P.I.C.E.
Shawnee Regional Prevention & Recovery Services
representing Safe Street Coalition
Mr. Jeffery Brandau, Special-Agent-in-Charge, KBI
Lt. Michael Life, Junction City Police Department
Mr. Karl Fruendt, President, of Board of Directors,
Kansas Family Partnership
Mr. Chris Schneider, Assistant District Attorney for
Wyandotte County, Kansas City, Kansas
Ms. Debbie Billingsley, Executive Secretary,
Kansas Board of Pharmacy
Ms. Teresa Walters, Executive Director,
Emporians for Drug Awareness
Mr. Don Morin, Director of Government Affairs,
Kansas Medical Society
Ms. Callie Denton Hardle, Kansans Association for Justice

Others in attendance: Please see Guest List

Hearing on SB556 - An act concerning controlled substance; establishing the medical marijuana defense act

Upon calling the meeting to order, The Chair asked Ms. Renae Jefferies, Assistant Revisor, Office of Revisor of Statutes, to give an overview of the bill. Ms. Jefferies stated the bill allows individuals with a written certification from a physician to claim a defense against prosecution for having marijuana, tetrahydrocannabinol or drug paraphernalia to aid in the use of such substances in their control or possession. She covered:

1. the specifics of the written certification,

2. defined debilitating medical conditions,

3. A registry ID card outside of Kansas does not constitute a defense to the possession of marijuana,

4. civil or criminal liability or a disciplinary proceeding and sanctioning a practitioner,

She concluded by stating that if the bill was worked, amendments would need to be made to the act, at the committee's discretion, either to remove tetrahydrocannabinol from the act or to insert it after the word marijuana on page 1, line 30, and page 2, line 14. A copy of her overview is (Attachment 1) attached hereto and incorporated into the Minutes by reference.

As there were no questions of Ms. Jefferies, the Chair called on the first of six proponents to testify, Mr. Robert Stephan, former Attorney General of Kansas, who stated he is not asking the legislature to legalize marijuana but to provide a defense for individuals whose suffering is relieved through the use of marijuana and, by passing this bill, you will send a message to the federal government and the DEA that it must allow appropriate research of the marijuana plant and place marijuana as a Schedule II drug. A copy of his testimony is Attachment 2) attached hereto and incorporated into the Minutes by reference.

Next was Ms. Laura Green, Coalition Director, Kansas Compassionate Care Coalition, who stated that in 1995, SB333, a bill to make the possession of marijuana a felony for a second conviction was amended by the House to include the a medical marijuana defense clause. A copy of her testimony is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

The third conferee was Ms. Bette Hulser, a private citizen from Topeka who offered the story of her son who was diagnosed with Chronic Progressive Multiple Sclerosis at the age of 24. She asks that all Kansans who are sick have the opportunity to relieve their pain in the manner that works for them. A copy of her testimony is (Attachment 4) attached hereto and incorporated into the Minutes by reference.

Dr. Jon Hauxwell was next to testify. He stated that he considers the whole-plant cannabis to be both a drug and a medicine (meaning any substance or combination of substances which, when administered to a human, can influence human physiology and pathology in a beneficial manner.) Dr. Hauxwell went on to offer case studies, drug dependence and safety issues, medication delivery methods, and consistency of dosing. In conclusion, he stated that side effects exist, but the most devastating of the medicinal therapeutic use of cannabis is its legal status, and the potential for life-disrupting legal penalties. A coy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes by reference.

The Chair then called on Mr. Anthony Buckland, private citizen from Mission, Kansas who offered the story of his 16 year old stepdaughter and her fight with an aggressive form of bone cancer (Ostersarcoma of the right pelvic bone.) He stated that if medical marijuana practice was available now, it would replace two of her anti-depression medicines, five of her anti-vomiting medications, replace or reduce the amounts of Oxycodone and Fentanyl for pain, relieve stress, her depression and help her sleep, plus eliminate any additional drugs to counter the side effect of the pain medicine. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes by reference.

Written testimony in support of the bill is as follows:

1. Ms. Susan Hughes-Storm, private citizen from El Dorado;

2. Ms. Rhonda O'Donnell, private citizen, from Rockville, Rhode Island

3. Mr. Paul Armentano, Deputy Director, NORML Foundation, Washington, DC

4. Mr. Michael Byington, Voluntary CEO, Kansas Association for the Blind & Visually Impaired

A copy of their written testimony is (Attachment 7) attached hereto and incorporated into the Minutes by reference.

Chairperson Wagle then called upon the first of seven opponents to testify, Dr. Eric Voth, M.D., Chairman, The Institute on Global Drug Policy, who stated that the major active ingredient in marijuana, THC, is available as a legal medicine, marijuana is impure, containing 488 substances and it is virtually impossible to assure what dose of THC is present with a particular grade. He stated that medical marijuana as set forth in this bill is opposed by the FDA and bypasses the FDA. A copy of his testimony and attachments are (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

The next opponent was Ms. Jean Holthaus, Director, S.P.I.C.E. who read testimony for Mrs. Christi Cain, Project Coordinator, Shawnee Regional Prevention & recovery Services representing Safe Street Coalition,. In FY 2007, marijuana accounted for over 26% of treatment admissions (3,916 Kansas residents) to state-funded treatment organizations. She went on to say that history has shown that legalization increases addiction rates which is demonstrated by the fact that alcohol was the number one problem at admission to state-funded treatment organizations in FY2007. A copy of Mrs. Cain's testimony is (Attachment 9) attached hereto and incorporated into the Minutes by reference.

The third opponent, Mr. Jeff Brandon, Special-Agent-in-Charge, Kansas Bureau of Investigation, said that he would also be testifying for Lt. Michael Life of the Junction City Police Department and President of the Kansas Narcotics Officers Association.

In Mr. Brandon's testimony, he offered marijuana's impact on users influenced by the potency of the THC that marijuana contains. He stated :

- the National Highway Traffic Safety Administration reports marijuana is the second most found drug in crash involved drivers, only alcohol is involved in more accidents;

- the Controlled Substances Act (CSA) placed substances into one of five categories depending on the substances potential for abuse and medical use, Schedule 1 drugs are those that have the highest potential for abuse and have no currently accepted medical use in the United States; and,

- in order for a drug within the CSA to meet the current accepted medical use, it must meet 5 factors, which he listed, but according to the Drug Enforcement Administration, botanical marijuana meets none of these requirements.

He offered information regarding the Compassionate Use Program providing seriously ill patients marijuana. And lastly he concluded the most damage from the passage of this bill would be to tell our young people that marijuana is not dangerous and lower their perception of risk of using the drug. A copy of Mr. Brandon's testimony is (Attachment 10) attached hereto and incorporated into the Minutes as referenced.

-In Lt. Michael Life' s testimony, he stated that as a narcotics officer they are already fighting this very same battle with synthetic opiates such Oxycontin, Delaudid, or other prescription pain medicines and currently have several abusers in his city alone that will drive 240 miles round trip to a popular doctor in another city who will easily prescribe these drugs. He asked the Committee to look at specifics of the bill (part (b)(1) "debilitating medical condition" may include, but not limited to", (B) "Cachexia" and (B) "severe pain" He offered quotes from officers of NORML (National Organization for the Reform of Marijuana Laws (ex. the medicinal use of marijuana is an integral part of the strategy to legalize marijuana). And lastly, he has attached a recent article from a publication where the author of this article is writing from a position of having observed Oregon's Medical Marijuana Act in effect. A copy of his testimony and attachment are (Attachment 11) attached hereto and incorporated into the Minutes as referenced.

Next to testify was Mr. Karl Fruendt, President, Board of Directors, Kansas Family Partnership, Inc. who stated if there were truly a real need for smoked marijuana, the American Medical Association, the American Pediatrics Association, and the many subspecialties in the medical field would be calling for this legislation. Consider the litany of unintended consequences that have occurred as a result in the states that have voted to have ":medical marijuana" as a defense to prosecution. He has also attached to his testimony a list of seven

statewide organizations and 26 local and county individuals, organizations, and coalitions who oppose the use of leaf marijuana as medicine. A copy of his testimony and attachment are (Attachment 12) attached hereto and incorporated into the Minutes as referenced.

The fifth opponent was Mr. Chris Schneider, Assistant District Attorney for Wyandotte County in Kansas City, Kansas, who stated that though this legislation provides a defense to those possessing and using marijuana who have "written certification" from a doctor, there is still no legal way for a person to obtain either marijuana, either in a form ready to be smoked or in a form to be grown. Under both state and federal law it would still be a crime to sell, deliver, or possess with intent to sell or deliver marijuana. A copy of his testimony is (Attachment 13) attached hereto and incorporated into the Minutes as referenced.

Ms. Debbie Billingsley, Executive Secretary, Kansas Board of Pharmacy also spoke in opposition to the bill stating that the Board determined there are safe and effective reliable medicines that do exist that are best for patients and Kansans should be ensured safe medicinal practices through rigorous research and FDA standards prior to any drug being used. Lastly, she has attached to her testimony, a copy of a Resolution for the Committee's review, which the Board unanimously passed opposing the use of leaf marijuana for medicinal purposes. A copy of her testimony and Resolution are (Attachment 14) attached hereto and incorporated into the Minutes as referenced.

The last opponent to testify was Mr. Dan Morin, Director of Government Affairs, Kansas Medical Society who stated that as recently as April 2006, the FDA again declared that marijuana has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and has a lack of accepted safety for use under medical supervision. He went on to say that the FDA has approved a synthetic marijuana-based drug called Marinol that contains THC, which studies have shown to be effective in the treatment of nausea, vomiting, and chronic pain. Lastly, he concluded that even though states can statutorily create a medical use exception for marijuana and its derivatives under their own, state-level substance laws, federal agents, at the same time, can investigate, arrest, and prosecute medical marijuana patients, care givers, and providers in accordance with the CSA. A copy of his testimony is (Attachment 15) attached hereto and incorporated into the Minutes as referenced.

Written testimony in opposition to the bill was also submitted by:

1. Ms. Teresa Walters, Executive Director, Emporians for Drug Awareness

2. Ms. Dorothy Jochem, Prevention Consultant, Regional Prevention Center of the Flint Hills at Emporia, Kansas;

3. Dr. Irving Cohen, Physician, Topeka, Kansas

4. Mr. Ed Klumpp, Chief of Police Topeka, Kansas for Kansas Association of Chief of Police

5. Mr. Ed Klumpp, Chief of Police Topeka, Kansas for Kansas Peace Officers Association

A copy of their testimonies are (Attachment 16) attached hereto and incorporated into the Minutes as referenced..

Neutral written testimony was also offered by Ms. Callie Denton Hardle, Kansas Association for Justice. A copy of her testimony is (Attachment 17) attached hereto and incorporated into the Minutes as referenced.

Committee discussion included questions from Senators Journey, Schmidt, Wagle and Barnett including

- KMS, like many of the other medical Boards and professionals, support medical relief and merits some research, does it provide relief, anticdotially provided

- is it understood that federal administrative judges have ordered the FDA to allow these studies to go forward

but they, according to the judges, unreasonably withheld their approval of this study?

- a 2 ½ page document was handed out entitled "Medical Marijuana: The Fact" from the DEA printed off of the their website (offered by Senator Schmidt) A copy of this document is (Attachment 18)

- in the last 5 years there has been so many more drugs available to cancer patients from Kytrol and Marinol and other pain and nausea relievers, every year something new is coming out that does not have the side effects;

- regarding the case that AG Stephan referred to, there was an expert for the DEA that actually testified the questions relative to the Massachusetts professor was whether or not the government could provide enough marijuana of good enough quality for the Mississippi marijuana farms so there was no reason for Massachusetts to start a marijuana farm;

- when will Marinol become generic?

- in dealing with this in a criminal sense it is a little problematic in how the court process is going to work and rather than making it an affirmative offense, perhaps going a different route where it sets a different threshold and different maximum for the penalty, for example a simple fine, so it does not become a question of fact for a jury or judge to determine

Adjournment

As it was going on Senate session time, the meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for February 12, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: 2-11-08

NAME	REPRESENTING
Christopher L. Schneider	KCDAA / Wy Co District Atty
Richard Samaniego	KCDAA
Stephen Buckland	Living SOUL
Anthony Buckland	Morgan Lindall
Justin Hayden	Hein Law Firm
Jeff Brandau	KBI
Jon Hauxwell	KCCC
Cheryl Rim	KSCCC
Catherine Hepner-Hass	KSCCC
Deb Billingsley	Board of Pharmacy
Heide Meadows	KSCCC
Michelle Peterson	Capitol Strategies
Pat Baker	KCDC
Agnes Bantleth	SRS / AAPS
Jim Vorhees	Witness
Karl A Friendt	Kansas Family Partnership
Michelle Voth	KFP
Todd Fleischer	Ks. Optometric Association
Susan Wolfe	KSCCC

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49 in att.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Feb 11, 2008

49 in all

NAME	REPRESENTING
Debbie L. Wulfkuhle	KSCCC
Laura Green	KSCCC
Cynthia Griggs	KSCCC
Jon Hoffhaus	PARS
Kaii Benner	KFP
Bob Stephan	KCCC
Callie Hartle	KS Assn of Justice
Vistan Moyer	Prieger, Smith
Dan Morin	KS Medical Society

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MEMORANDUM

To: Senate Committee on Health Care Strategies

From: Renae Jefferies, Assistant Revisor

Date: February 11, 2008

Subject: Senate Bill No. 556

SB 556 allows individuals with a written certification from a physician to claim a defense against to prosecution for having marijuana, tetrahydrocannabinol or drug paraphernalia to aid in the use of such substances in their control or possession. The physician providing the written certification must in good standing with and licensed by the Board of Healing Arts to practice medicine and surgery,

The written certification shall state that in the physician's opinion, the individual is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating condition or symptoms associated with the debilitating medical condition or its treatment. The written certification may only be made in the course of a bona fide physician-patient relationship after the physician has completed a full assessment of the qualifying patient's medical history. The certification must also state the qualifying patient's debilitating medical condition.

Debilitating medical condition is defined as including, but not limited to, cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease or the treatment of these conditions. It also includes a chronic or debilitating disease or its treatment that produces one or more of the following: Cachexia or wasting syndrome; severe pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; bladder spasticity or inflamation or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis.

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 1

Tetrahydrocannabinols are synthetic equivalents of the substances contained in the Cannabis plant. See subsection (d) (24) of K.S.A. 65-4105.)

A physician shall not be subject to civil or criminal liability or a disciplinary proceeding for providing a written certification. However, nothing shall prevent a professional licensing board from sanctioning a practitioner for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

A registry identification card or its equivalent issued by another state, district, territory, commonwealth or insular possession of the United States shall not constitute a defense to the possession of marijuana, tetrahydrocannabinols or drug paraphernalia in Kansas.

Should this bill be worked, amendments will need to be made to the act, at the committee's discretion, either to remove tetrahydrocannabinols from the act or to insert it after the word marijuana on page 1, line 30 and page 2, line 14. Additionally, on page 2, in line 17, the word "practitioner" should be changed to physician because only physicians may provide the written certification.

SB 556
Senate Health Care Strategies Committee
February 11, 2008

Testimony of
Robert T. Stephan

Senator Susan Wagle and Members of the Committee:

Some seem surprised that I advocate the legislation that is supportive of medical marijuana. Let me make it clear that I do not advocate the legalization of marijuana or any other controlled substances.

This marks the 25th year since I first publicly supported medical marijuana and the reclassification of marijuana from a Schedule I drug to a Schedule II drug (Class I – no medicinal value – Class II – medicinal value). Twenty five years ago I filed an affidavit with the Congress of the United States setting forth reasons why I believed Congress should support efforts to make marijuana available on a prescription basis to patients undergoing chemotherapy or suffering from glaucoma.

On June 25, 1983 the National Association of Attorneys passed a resolution supporting legislative efforts to make marijuana available on a prescription basis to patients undergoing chemotherapy or suffering from glaucoma.

I find it almost unbelievable that our federal government would continue to let its citizens suffer from various diseases when the properties contained in marijuana would alleviate that suffering. Frankly, I don't know how those in the federal government and the DEA can sleep at night when they choose to ignore mounting evidence that marijuana relieves suffering from many diseases.

It is amazing that those who fight to prevent marijuana from being a Class II drug have no concern about the fact that cocaine, morphine and methamphetamine are classified as Class II drugs.

I know about the nausea that comes with most regimens of chemotherapy. In 1972 I was diagnosed with lymphocytic lymphoma in stage IV. They found lymphoma in the bone marrow, liver, spleen and lymph nodes. My lungs were drained of lymphocytic fluid and my spleen was removed. After a little over a month in the hospital I was sent home with a prognosis of 2 to 4 weeks to live. The chemotherapy started while I was in the hospital and continued for seven years.

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 2

For those who have not endured chemotherapy you hear about nausea, and I can tell you it is not just an upset stomach that can be quieted by chewing pepto bismol tablets. It is horrible and in some instances can cause you to be unable to eat or digest food and possibly become immobile for a time.

While I was undergoing chemotherapy some medicines worked and some did not. The same thing is true today. Opponents of medical marijuana, who say there are plenty of drugs to alleviate suffering, tout the latest drug – Marinol. Shame on them.

Over the past few months I have been talking with a young lady who has stage 4 liver cancer and is undergoing chemotherapy. She is unable to hold down much food and is terribly ill with nausea. One day she was excited because the doctor was going to prescribe Marinol for her which contains THC, a component in the marijuana plant. A week after she started taking Marinol I called her and she could not hold back the tears. She was still so ill she could not hold back vomiting. She has since commenced acupuncture which helps but she is still nauseas. Why would anyone deny this wonderful woman the right to use a drug to relieve her suffering?

For 15 years I visited cancer patients in hospitals in Topeka and Wichita. Some patients said they resorted to marijuana to relieve their nausea. It is not right that they should be subject to incarceration because marijuana was their last resort for relief.

I would be surprised if everyone here thinks the federal government has the answers to all of this country's problems. The states cannot violate federal law, but they do have the right to determine state penalties for violations of law. 12 states have sent a message to the federal government by passing medical marijuana laws. Kansas can add to that message.

DEA Administrative Law Judges have ruled against the DEA position:

- On September 6, 1988, after hearing two years of testimony, the Drug Enforcement Administration's Chief Administrative Law Judge, Francis Young, ruled: "Marijuana, in its natural form, is one of the safest therapeutically active substances known. .... It would be unreasonable, arbitrary, and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance...." The DEA ruled against the decision.

- A petition filed in 2001 by University of Massachusetts agronomy Professor Lyle E. Craker seeking to grow marijuana for research purposes in his greenhouse worked its way through the DEA appeal process and resulted

in a ruling against the agency in 2007. The decision by DEA Administrative Law Judge Mary Ellen Bittner concluded that Craker should be allowed to grow marijuana for use in research. The final decision on the government's marijuana monopoly will be made by the deputy administrator of the DEA.

In 1999, the government's own prestigious Institute of Medicine looked at this issue and published a report titled: "Marijuana and Medicine: Assessing the Science Base." Their conclusions included that, "The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation."

In 1999, the National Academy of Sciences' Institute of Medicine reported, "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. ...."

National Institute of Health medical marijuana panelist Paul Palmberg, M.D., Ph.D., a glaucoma expert, said on February 20, 1997,"I don't think there is any doubt about its effectiveness, at least in some people with glaucoma."

The New England Journal of Medicine (1997) called the federal ban on medical use of marijuana "misguided, heavy-handed and inhumane."

In May 2003, The Lancet Neurology evaluated current knowledge regarding marijuana's active compounds called cannabinoids. The medical journal stated, "Cannabinoids inhibit pain in virtually every experimental pain paradigm...."

If smoking medical marijuana bothers opponents, they should be pleased that extracts are available. For example Sativex, which is a low-temperature vaporization process apparatus which delivers cannabinoids into the human system without incorporating harmful products of combustion.

Health Canada granted regulatory approval for Sativex for the treatment of multiple sclerosis in April 2005.

I realize this is a difficult issue for the legislature because marijuana is illegal under federal law. I am not asking you to legalize marijuana but to provide a defense for individuals whose suffering is relieved through the use of marijuana. By passing this bill you will send a message to the federal government and the DEA that it must allow appropriate research of the marijuana plant and place marijuana as a Schedule II drug.

2-3

SOUTHEAST CLINIC

6155 EAST HARRY WICHITA, KS 67218-3895
TELEPHONE 316-685-2306 FAX 316-685-0891

R. REX LEE, M.D., DABFP

WILLY G. PERIERA M.D.

October 16, 2007

Robert T. Stephan, LLC
Attorney at Law
14243 W. 84th Terrace
Lenexa KS 66215

Dear Bob:

I appreciate your stand and efforts on medical marijuana. Of course this should be legal for patients who would receive help from the effects of this drug. It has been shown to give relief for cancer patients, glaucoma, etc. The expense for this drug would be minimal compared to the expensive drugs we now use.

Kindest Regards,

R Rex Lee, MD

R. Rex Lee, M.D.

Cancer Center of Kansas, P.A.

Shaker R. Dakhil, M.D., F.A.C.P.
Michael W. Cannon, M.D., F.A.C.P.
David B. Johnson, M.D., F.A.C.P.
Dennis F. Moore, Jr., M.D., F.A.C.P.
Bassam I. Mattar, M.D., F.A.C.P.

William H. Jennings, M.D., F.A.C.P.
Thomas K. Schultz, M.D.
Dennis F. Moore, Sr., M.D., F.A.C.P.
Nassim H. Nabbout, M.D.
Pavan S. Reddy, M.D.
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August 27, 2007

Robert Stephan
14243 West 84th Terrace
Lenexa, KS 66215

RE: Medicinal marijuana issue

Dear Bob:

This is concerning my opinion regarding the medicinal marijuana issue. The new drugs for anti-nausea which we have available do work in 85% of the patient population. This leaves 15% of the cancer patient population needing additional treatment for their nausea. The issue of appetite also is significant in that cancer patients have a significant loss of appetite and we do not have a good therapy for that.

As you know, physicians are allowed to prescribe narcotics derived from plants and we do prescribe morphine, Dilaudid, methadone and opium in a significant number of our patients. As you also know, marijuana in a pill form is available to be prescribed by a physician.

Based on all these facts, I do not see why medicinal marijuana would not be legalized. It is an extra weapon to try and comfort the patient as far as nausea and appetite are concerned. Compared to the drugs we are prescribing, it has very little down side.

Thank you very much.

Sincerely yours,

Shaker R. Dakhil, M.D.

SRD/dsb/57545

CLINICAL CARDIOVASCULAR ASSOCIATES
A PROFESSIONAL ASSOCIATION

WILLIAM S. RITTER, M.D., F.A.C.C.
JAY A. JACKSON, M.D., F.A.C.C.
JHULAN MUKHARJI, M.D., F.A.C.C.
JOHN E. PETERSON, M.D., F.A.C.C.
ANTHONY A. ALBRACHT, M.D., F.A.C.C.
ROBERT E. TANENBAUM, M.D., F.A.C.C.
BOB E. GREEN, M.D., F.A.C.C.
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FAX (913) 789-3208

January 16, 2008

Robert T. Stephan
Legal Consultant
Kansas Compassionate Care Coalition

Dear Bob:

I support the medical use of marijuana for pain control in a limited and restricted manner. I feel that only certified physicians should be allowed to prescribe marijuana for pain relief. These physicians would be specially trained and monitored so that no potential abuses occur. The records of these physicians should be routinely reviewed to be sure that proper standards are being achieved.

We appreciate your interest and hard work in pursuing compassionate care.

Sincerely,

William S. Ritter, M.D., F.A.C.C.

WSR/IMT5
D: 01/16/08 T: 01/16/08

2-6

Jan. 20, 2008

Mr Robert Stephan,

My name is Julia Arans and I am writing to you not just as a concerned RN, but also as a person who suffers from chronic pain.

In Sept 2003, I recieved an IM injection to my left hip. Unfortunately, the nurse did not have a great deal of experience in giving injections, and the needle penetrated my sciatic nerve and the medication dissolved the protective mylon sheath surrounding the nerve, leaving the exposed nerve which causes me great pain.

I have been through basically every pain medication as well as being subjected to surgery for placement of a spinal cord stimulator which quickly became ineffective and resulted in another surgery for placement of a morphine pump.

I also take Methadone on top of receiving morphine through my pump, and I still suffer with extreme pain.

There are no other options for me, other than the continuing increase of the rate of morphine that I receive. Not a minute goes by that I do not experience severe pain.

At risk of bringing legal action down upon me,

I am writing you to let you know that by using marijuana strictly for relief of severe, debilitating pain, that after use, it is the only time I am completely pain free for approximately 6 hours at slightly longer.

But considering medicinal marijuana is only legal for cancer and AIDS patients this leaves me and hundreds of thousands of people like myself, without means of relief as prescribed by a medical doctor.

To quote statistics, persons with sciatic nerve damage have a suicide rate of 75%, due to eventually becoming tolerate to all pain medication, leaving us without relief from our pain.

A person can only tolerate so much pain before they reach their threshold of pain tolerance and can no longer continue to exist with such debilitating pain and would rather commit suicide that live one more moment with such horrible pain.

To legalize medicinal maryjuana would be a Godsend to so many like myself, while having a physician working with us to maintain any regulations the government may place on medicinal marijuana.

Please, help legalize maryjuana for patients with chronic pain so that our ~~lives~~ lives can be

easier to deal with for the patients and our families.

Thank you for your time and effort on this battle to make marijuana a legal pain relieving drug that could be an alternate for pain control. After all, it is not known what long term effects I will have from continuous morphine and methadone. I cannot believe that marijuana would be more harmful to my body than morphine or methadone.

Thank you again.

Julia M. Chrans
200 Osborne
Hutchinson, KS 67501

2-11

Testimony to Senate Health Care Strategies Committee
February 11, 2008

S.B. 556 Kansas Medical Marijuana Defense Act

Laura A. Green
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Madam Chair and committee members, it is a great honor for me to present testimony to you today in support of the Kansas Medical Marijuana Defense Act. My name is Laura Green and I am extremely proud to be the Director of the Kansas Compassionate Care Coalition. I founded this organization a year and a half ago with a small group of concerned Kansans who believed in a statement of principle regarding medical marijuana; that statement is

"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to criminal sanctions for using marijuana under the recommendation of their physician."

Since our founding I have traveled all over this state to talk with people from all walks of life about this issue. I've gotten quite an education.

A lot of people have a medical marijuana story. And a don't mean a couple of people – I serious number of people. I've heard hundreds of stories from people all over the state. People who have a friend or an aunt, or a mother, sister, or they themselves used marijuana at one time for a serious illness.

A Staffer right here in the capitol told me their medical marijuana story last week.

In fact, so many people wanted to come here today to tell you their stories that we could have filled 10 hours with their testimony. I included a sampling of their letters them in my written testimony. I hope you will take some time and read them. The are very moving.

Last summer General Bob Stephan joined the coalition and conducted a press conference here in the Capitol. We sent his open letter to Kansans to people across the state and asked them to join our coalition by signing the statement of principles. The response was overwhelming. In the last 6 months hundreds of people have signed on to our statement of principles and sent us letters with their stories.

Now these are not aging hippie baby-boomers from Lawrence, they are law-abiding people, who believe that serious and terminally ill people should be allowed to use marijuana if their physician believes it will help them.

Our coalition includes hundreds of doctors, nurses, RN, LPNs , CNAs and other health care workers. We have lawyers, mayors, newspaper editors, city commissioners (not from Lawrence!), bricklayers, waitresses, and retirees (a lot of retirees) – all kinds of people have signed our statement of principles. I hope you will take a moment to look through the names in my written testimony.

So the bill before you today is not a new bill to the legislature. In 1995, Senate Bill 333 – a bill to make the possession of marijuana a felony for a second conviction – was amended by the House to include a medical marijuana defense clause. The 1995 amended bill passed the House 89-32. The conference committee struck the amendment from the final bill. I've included a list of those who voted in favor of the bill for your review.

SB 333 – at least in the eye of the media – into the 'medical marijuana bill.' In a press clipping from the time, Representative Rochelle Chronister was quoted as saying, "It doesn't open up the issue of marijuana except for people who really, truly can use that drug." The same is true today.

Today's bill does not legalize marijuana, it does not violate federal law, it does not allow cannabis-clubs to open up on every street corner. This bill only allows someone to produce a written statement from their physician about their use of marijuana for a debilitating medical condition in a court of law.

The bill includes a provision which would prevent someone who comes from a state which has legalized medical marijuana from using their out-of-state medical marijuana card in their defense.

This bill is being proposed by Kansans - I grew up right here in Topeka - it is being backed by Kansans – members of the KS Compassionate Care Coalition and it is specifically for Kansans.

The reason so many people from so many backgrounds support the coalition and our statement of principles and this bill is because these people know what our detractors would like everyone to forget, that there are people all over this state, thousands of people, who have used, or who are currently using marijuana for a serious or terminal illness with the support of their physician. Supporters of this bill get it – prosecuting sick people is immoral, and in a just and compassionate society we can not continue to let these vulnerable people be convicted of illegal drug use when they are simply trying to gain relief from pain and suffering with their doctor's support.

I encourage you to ask your friends and neighbors about this issue. I can bet someone will tell you a medical marijuana story, and then you will understand why it is so important to allow these people to tell their story in a courtroom.

I hope you will pass this bill onto the full house for their consideration. Thank you for your time.

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Mr. Jim Hix, City Council member, Overland Park, KS, 12839 Lamar Ave, Overland Park
Mr. Frederic E. Goodman, Insurance, 8700 Indian Creek Parkway #280, Overland Park
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Ms. Muriel M Adams, Office Manager, Kansas City Psychiatric Group, 4500 College Blvd, Overland Park
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Mr. William L. Gochis, Retired, 9212 W. 106th Street, Overland Park
Mr. Zachary Wiedner, Student, 6824 West 99th Street, Overland Park
Ms. Daisy DeKnight, 6526 W 89th Street, Overland Park
Mr. Larry L. Ruder, Audiologist, 8708 Woodward, Overland Park
Ms. Betty Crome, R.N., Nurse, 12300 Metcalf Ave., Overland Park
Mr. George Cook,, Chairman, Banker, 7401 W. 135th, Overland Park
Mr. G. Eugene Troehler, Business Development Manager, 15563 Floyd Lane, Overland Park
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Ms. Virginia Stuhr, Retired, 8531 Glenwood, Overland Park
Mr. Ken Gates, Teacher's aide, 8729 Conser, Overland Park
Ms. Kathleen Johnson, Teacher, 12818 Woodson St, Overland Park
Ms. Melissa L. Berglund, Construction, 10880 Cherokee Ln, Ozawkie
Mr. George Bushnell, Electrician, 608 S Agate, Paola
Mr. Kim C. Pasini, CMA, Nurse, 206 W. Kaskaskia Street, Paola
Ms. Mary Christine Joe, R.N., Nurse, 30030 West 274th, Paola
Mr. Dan Dawdy, IT Support Tech, 406 W. Peoria St., Paola
Ms. Debra Griffith, R.N., Nurse, 30609 Bethel Church Rd, Paola
Mr Ryan Asbell, Smoker, 1220 Charleston Dr, Park City
Mr. Shana Zorn, 6500 Kerman, Park City
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Ms. Melinda Soper, College Student, 1708 Chess, Parsons
Ms. Hollie Livingston, Full-time Mother, 2723 Clark, Parsons
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Mr. Billy J. Wilson, Machinist, 17101 Lyon Rd., Parsons
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Ms. Natasha Brown, CMA, Nurse, 1715 Kennedy, Parsons
Ms. Pamela A. Armitage, R.N., Nurse, 621 S. 20th, Parsons
Mr. Ron Myers, LPN, Nurse, 2614 Elm, Parsons
Ms. Susan Jones, R.N., Nurse, 3137 Morton, Parsons
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Mr. Colin Robinson, 4811 Tomahawk Rd, Prairie Villiage
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Mr. Jacob Maddy, 18462 SW Tawakoni, Rose Hill
Mr. Happy Tingley, Mechanic, 220 Brownie, Rosehill
Ms Happy Tingley, 220 E Brownie, Rosehill
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Ms. Linda Kliewer, R.N., 406 Jefferson, Sedgwick
Ms. Tammy Darrough, DON, 712 N Monroe, Sedgwick
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Ms. Kari Hubbel, Cashier, 11410 W. 56th St., Shawnee
Ms. Annie Davidson, 3210 W 71st Terr, Shawnee
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Ms. Jill Vandory, Video Technician, PO Box 75, Tescott
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Mr. Jeremy Graika, Chef, 1555 SW Chelsea Street, Topeka
Ms. Diana D. Davis, disabled, 5311 SW 10th Street, Topeka
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Mr. Jason Jims, Construction, 3301 SE Twilight, Topeka
Mr. Tyson Gibson, Contractor, 3330 Eveningside Dr., Topeka
Mr. Jerry Feagan, Real Estate Developer, 3232 SW Spring Street, Topeka
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Mr. David Johnson, Retired, 7506 SW 25th St, Topeka
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Mr. Kevin Wright, WKW, 856 SW River Valley Rd, Towanda
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Ms. Dawn Stapleton, WKW, 7301 N Hillside, Valley Center
Mr. Jason Hayter, WKW, 210 Sott St, Valley Center
Mr. Randy Roberts, WKW, 7811 Buena, Valley Center
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Ms. Celeste Hornyak, Manager, 355 N. Rock Island, Wichita
Mr. Josh Wychstandt, MPH Student, 230 N Mosley, Wichita
Ms. Abby Sheppard, Healing Arts, 961 Back Bay Blvd,, Wichita
Ms Cynthia Orlando, Homemaker, 361 N Knight, Wichita
Ms. Cheryl Wortman, Nursing Recruiter, 1605 N. Illinois, Wichita

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Mr Ron Salome, Retired, 2034 Park Place, Wichita
Mr. Don Stephan, Director, Stephan Advertising Agency, 807 N. Waco, Wichita
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Ms. Sandra Heath, WKW, 149 Joann, Wichita
Ms. Jori Williams, 2323 W. 14th, Wichita
Ms. Debra Mann, Home Heath, 2925 Shelton, Wichita
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Ms Nicole DeVore, Homemaker, 130 S Greenwich Rd, Wichita
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Ms. c.a. riley, Researcher, 130 S. Greenwich Road, Wichita
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Ms. Brooke Cherry, Therapist, 401 N Harding, Wichita
Mr. Mathew Brown, 121 N Crestway, Wichita
Mr. Craig Crispens, WKW, 11618 W Jewell, Wichita
Ms. Ashley Tull, 11106 Dora, Wichita
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Mr. Teddie G. Barlow, Ajunct Instructor, 133 S Green Street, Wichita
Ms. Amanda Seago, artist, 111 E. Gilbert, Wichita
Mr Terren Brown, Carpenter, 1916 S Broadway, Wichita
Ms. Deborah Winegarner, Retention Manager, Health/Fitness, 428 S. Laura, Wichita
Ms Sherri Brown, Homemaker, 1916 S Broadway, Wichita
Ms Valarie French, Receptionist, 1324 S Market, Wichita
Ms Kaye McKinney, Retail, 1457 S Pattie, Wichita
Mr Quinter Foy, Security guard, 2715 E Pawnee, Wichita
Mr Michael Richards, Truck driver, 619 E Blake, Wichita
Mr. Marek Gregson, Assistant Manager, Warehouse, 428 S Laura, Wichita
Mr. Drake Wolff, 723 S Hillside, Wichita
Mr Jason Satterfield, 350 S Lorraine, Wichita
Ms LaDonna Pickens, 1457 S Pattie, Wichita
Mr. Shane Patrick, Wichita
Mr. Dan Regan, Insurance, 4045 W. Murdock #102, Wichita

Mr. Jerri Shapel, n/k, 1040 Curtis, Wichita
Mr. Brenda Ellsworth, not known, 11709 Lost Creek Ct, Wichita
Mr Harry Prewitt, Welder, 910 N Clara, Wichita
Mr. Andy Wingo, 505 N Tyler Rd, Wichita
Ms. Heather Powell, 505 N Tyler Rd, Wichita
Ms Johanna Kanavy, 450 N Elder, Wichita
Ms Michelle Machado, C.N.A., 1341 S. Main, Wichita
Mr. Bernie Silvers, Cement Mason, 1510 S Water, Wichita
Mr. James Poncin, floor installer, 201 S Oak, Wichita
Mr James McHenry, Food service, 1135 W Munnell, Wichita
Mr Rudolf Pecina, Food service, 1135 W Munnell, Wichita
Ms. Sarita Lirley, L.P.N., 2156 S. Vine, Wichita
Ms. Sheila Simpson, Retired, 2156 S Vine (?), Wichita
Ms. Cynthia Moody, 1506 S Waco, Wichita
Mr. Vincent Rose, 2138 S. Bennett, Wichita
Mr Harlan Lamb, Disabled, 1914 E 10th, Wichita
Mr. Ronnie Keeney, Disabled, 1030 N. Market, Wichita
Mr. Mike Boast, 631 N Topeka, Wichita
Ms. Linda Miller, Bartender, 2520 S. Mosley, Wichita
Terry Horner, Disabled, 3208 S Victoria, Wichita
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Mr. John Badley, WKW, 1302 E MacArthur, Wichita
Mr. Marvin Moore, WKW, 500 E. 50th St S, Wichita
Mr Benjamin Greenwood, Cook, 3302 S Downtain, Wichita
Ms. Kimberly S. Rosner, Hairstylist, 2927 S. St. Paul, Wichita
Ms Angela Solis, Homemaker, 3510 S Osage, Wichita
Mr. Larry Garrelts, outside truck parts sales, 3517 Chitwood, Wichita
Mr Justin Scerini, Painter, 2933 S Edwards, Wichita
Ms. Janice E. Stevens, Nurse Practitioner, Primary Care, 1001 W. Maywood, Wichita
Ms Brianna Duran, Student, 3120 S Fern, Wichita
Mr. Joshua Adair, WKW, 3355 S Glenn, Wichita
Mr. Tony Scheck, WKW, 925 W 29 St S, Wichita
Mr. Brandon Dreher, 217 N. Lorraine, Wichita
Mr Devin Bookout, 3321 S. Gow, Wichita
Mr. Eric Bruce, 2914 S Osage, Wichita
Mr. Richard Reid, 1200 W Carey LN, Wichita
Ms Annie R Hamik, Bartender, 2250 S Oliver, Wichita
Mr Patrick Javorovich, Student, 2142 S Parkwood Lane, Wichita
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Mr. Gordon Bakken, 4323 E Douglas, Wichita
Mr John Brown, Sales, 1657 Hue St (?), Wichita
Ms. Attie Pelnar, Wichita
Ms. Ariel Murillo, Student, 7627 E. 37th St. N., Wichita

Mr. Cade Hamilton, Student, 7627 E. 37th St. N., Wichita
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Mr. Jack Warner, Rancher, 10080 Highway 283, Wright
Ms Jamie Vaughn, Care provider
Ms Donmonique Edmondson, Carpenter
Mr. Ryan Badger, Chef
Ms Judie Hiller, Farmer
Ms. Debbie Douglas, Full-time Mother
Mr. Melissa L. Rodriguez, R.N., Nurse
Mr. Shawn S. Smith, School Custodian
Mr. Bob Crider, store manager
Ms. Ashley Watson, Student
Mr. Justin Cobb, Student
Ms. Angela Homemaker
Mr. Brendon Miller
Mr. Bryan Gleason
Mr. Carl McMechan
Mr. Chris Vieith
Ms. Dawn Randal
Mr. Evan Taylor
Ms. Hallie Harness
Jackie Patterson
Jessica Pageler, 1124 Pomeroy
Ms. Kali Saunders
Ms. Kyra Hollis
Mr. Patrick Kerr
Mr. Stefan Richarc
Mr. Terry Tomlinson
Ms. Tina Jones
Mr. Todd Owen
Mr. Zach Meeter

My name is Keely Denning, I live in Salina, Kansas. I am married with four children who are all adults now.

My oldest son was in Who's Who of High School students, he had perfect vision, and played several sports. He had plans on going into EMS studies, continue study for trauma medicine and become a flight paramedic. All that changed in June 1999, my oldest son had just turned 19 years old, and was diagnosed with a brain tumor. His tumor was removed at the KU Medical Center in Kansas City, the surgery left him fifty percent blind in each eye, paralyzed on his right side, headaches and memory loss. He had a difficult time remembering what he had for dinner. I will never forget the doctor coming out of the surgery telling us that my son's dream of working in the field of emergency medicine was over.

My son walks, however his gate is not even, his right arm shakes. For two years following my son's surgery, he was harassed by people and even the police, who thought he was drunk, one police officer even made the comment to me "Your son is on meth" I asked him what made him come to that conclusion, the officer replied "Because his right arm is shaking and he cannot control it!" I then explained to the officer that my son is a brain tumor survivor, his right arm shakes and is not controlled because it is paralyzed. The officer then felt badly and did give an apology; he said he had a friend who has a five year old daughter with a brain tumor.

My son lived in a deep depression, living on disability and food stamps, not being able to do for himself, then a friend of his introduced him to marijuana, he discovered that marijuana helped him with controlling his shaking; he could reach up with his arm, and grasp the door knob on the door. He cannot turn the knob, but reaching for it was a huge step that he had not been able to do since surgery. He built the confidence to go back to school, and is currently trying to earn his four year degree so he can go onto law school.

This is not a issue of getting "high." The doctors had put my son on all kinds of drugs to control some of his pain, but my son felt like a zombie, he felt strung out, and out of control of himself, so if he wanted to, he can get "high" legally. With the marijuana, he has a lot more control over his life, and is not dealing with the headaches that the stronger drugs could not fully control.

My son has been caught with marijuana, he has served time, he has paid a lot in fines, or should I say, his family has paid a lot out in fines, he has been on probation, and if he is caught again, it will be a felony. Several times in court, charges were dropped, one time a police officer did not show up to testify, another dropped because the officers searched without consent or a warrant to search. One of those charges came because of a broken pipe stem with residue inside. Never has my son ever been caught with a lot of marijuana, only a tiny bit, that is all he ever has at a time.

I have worked for the Saline County Sheriff's office in Juvenile Corrections, I used to believe that medical marijuana was a way for people to use an excuse to get high, but I know different now. I know that it does indeed make a difference on people's lives and how they live. In fact, I lost my job at the department due to my son using marijuana.

Over the years since my son's surgery, I have seen friends suffer with cancer, some have used marijuana to relieve their pain, some have not. They did not use it because it was illegal, but all these friends have since died, and it was a lot harder to see them suffer using pain killers such as oxyconten and dealing with the addiction they get from that legal drug than those who used marijuana and were not addicted to such a powerful pain killer.

I can only hope, and pray, that my son, and others will not have to continue in life worried about being arrested, these people want to be a productive member of society, and not a person with a felony conviction.

Keely Denning
848 S. 9th
Salina, Kansas 67401
785 342-2377

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Kansas Compassionate Care Coalition
Letters Sent through website to Coalition

FNAME: Steve

LNAME: Seckman

OCCUP: Retired

CITY: Augusta

COMMENTS: My wife has MS and has been diagnosed since 1991. She is now confined to a recliner and wheelchair. Her Spasms have gotten much worse in the last month or so and needless to say we have talked about Marijuana as a drug of choice. The Baclofin she takes for spasms has to be at such high levels that it makes her unable to do much of anything she like to do such as knit.
I do understand the dilemma and think it is ridiculous for people who don't understand about the possibilities of using medical marijuana.

Let them walk a mile in our shoes and then say no.

FNAME: Joseph W.

LNAME: Grant

OCCUP: Retired

CITY: Lawrence

COMMENTS: I am a Korean War veteran. I know of many veterans of the Vietnam War and Iraq that are being treated medically with the help of marijuana. It is not right that people in Kansas, including veterans, cannot be treated.

Medical science has made it perfectly clear that theree are many medical benefits to be derived from marijuana.

Make Medical Marijuana legal in Kansas.

Joseph W. Grant

FNAME: Matthew

LNAME: Brown

OCCUP: Disabled

CITY: Wichita

COMMENTS: I have AIDS and glaucoma. I currently use Marinol to control nausea and maintain appetite. I have heard that marijuana can also be remedial in the treatment of glaucoma.

First, about myself. I am a committed Christian and a seminary graduate, so many would surmise that I would be rabidly against any use of marijuana. Most are surprised to find out that I support legislation to provide for medical use of marijuana, and believe that our laws against the use of marijuana are antiquated and harmful.

Currently, Medicare/Medicaid pays for my Marinol at an exorbitant cost to the taxpayer, when, in fact, I could grow a single plant in my backyard which would be more effective and certainly less of a cost to the state. I do not do this because it is illegal, and I respect the laws of the land--even those with which I disagree.

I am only one of many, including cancer patients, AIDS patients, and those suffering from MS, who could benefit by laws allowing for the medical use of marijuana. I cannot understand why those who have a valid need for marijuana must be shackled by laws which have not succeeded in preventing marijuana usage (scofflaws can still buy marijuana with relative ease on the black market), when we have more social problems caused by those who drink to excess (legal) or destroy their health by smoking cigarettes (legal).

I am willing and ready to speak out on this issue.

FNAME: Deborah

LNAME: Winegarner

OCCUP: Health/Fitness

TITLE: Retention Manager

CITY: Wichita

COMMENTS: I was born with orthopedic deformities and survived a cerebral aneurysm in my mid 20's. I have always known, and continue to live in, pain. However, I consider myself a medical miracle and very blessed. Some of the resulting symptoms I experience such as extreme nausea, dizziness, migraines, and glaucoma would be far better served with prescription marijuana than the variety of prescription drugs made available to me that I choose not to take because of adverse side affects. It is my desire to live in a world where compassion and reason determine my medicinal options...if not mine, then my children's and their children's ~

FNAME: Marek

LNAME: Gregson

OCCUP: Warehouse

TITLE: Assistant Manager

CITY: Wichita

COMMENTS: I have Crohn's Disease, and I strongly and sincerely believe in the medicinal qualities of marijuana. I have many friends and family that support medicinal marijuana, can you please send me more pamphlets.

Thank you for changing the way the world has been trained to think.

FNAME: kelly

LNAME: carter

OCCUP: mammographer/radiographer

CITY: derby

COMMENTS: I am an employee in the medical field and see the need for this. I also suffer from debilitating illnesses that cause me much pain with NO cure or relief...yet I am still gainfully employed and do not use the system for support. I am in search of pain relief myself.

Thanks for all you do

FNAME: David

LNAME: Nuss II

OCCUP: Civil Engineer

CITY: Manhattan

COMMENTS: I have a uncle with HIV/AIDS. Some of his only comfort and relief comes from Marijuana. I feel that we as society look at Medical Marijuana from the wrong perspective. All involved in the KSCCC hold a special place near and dear to my heart. Thanks

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FNAME: Anne

LNAME: Bauman

OCCUP: retired

CITY: prairie village

COMMENTS: As compassionate, humane, and concerned human beings, my husband and I wholly support the medical use of marijuana. Godspeed, Robert Stephan.

FNAME: Cass

LNAME: Bruton

TITLE: Former university communications officer (17 years)

CITY: Bogue

COMMENTS: A close relative of mine, a fine, talented person who has had Chron's disease for more than 25 years and who recently had major surgery for that disease, could use your help. Please work hard to legalize medicinal marijuana. I offer myself an advocate for my relative and all others who need medicinal marijuana.

The fact is that reasonable, compassionate people care, and their loved ones are suffering. Please count me in and let me know what I can do to help.

FNAME: Aaron

LNAME: Dennett

OCCUP: Groundskeeper

CITY: McPherson

COMMENTS: I believe what you promote is the best possible remedy for sufferers of M.S.

FNAME: Kathleen

LNAME: Johnson

OCCUP: teacher

COMMENTS: It is unbelievable, in this day and age, that you can legally drink yourself to death but not make your own decision whether or not to consume marijuana for health/comfort reasons. Something is wrong here!!!

FNAME: Angela

OCCUP: Housewife

CITY: Wichita

COMMENTS: This stuff has helped my husband. He is bi polar and when he has it, he is more stable. It should be available.

FNAME: Tim

OCCUP: disabled

CITY: Perry

COMMENTS: I was hit by a drunk driver. Since my disability I have been prescribed medications with side effects I don't like and use of marijuana has been better for me without the horrible side effects.

FNAME: Amanda

LNAME: Guiles

OCCUP: Hotel Night Auditor

CITY: Wichita

COMMENTS: I would love to help this cause in anyway that I can. The legalization of medical marijuana has a personal impact on my life. I've suffered from chronic pain for over eight years now and take 5 different pain pills a day totaling over 30 pills a day.

I also lost my stepfather to pancreatic cancer and am outraged that medical marijuana wasn't an option to relieve his suffering.

Thank you for all that you are doing.

FNAME: Carolyn

LNAME: Howe

OCCUP: Retired

CITY: Wichita

COMMENTS: The Docs at the Cancer Center have been "suggesting" this to their patients for several years!!!!!!!!

3-22

House OKs marijuana use for medicinal purposes

TOPEKA (AP) — The House decided Friday to approve the use of marijuana for people who have cancer, glaucoma or multiple sclerosis.

The bill allows the drug's use when it is prescribed by two doctors. It passed the House, 89-32. It now goes to the Senate for its approval.

The bill also would limit the use of the stimulant ephedrine, which is the only ingredient in the over-the-counter product, Minithins. Minithins is marketed to help people with asthma.

Rep. Jim Garner, D-Coffeyville, called the ephedrine drug "pep tabs" and said it is often abused, especially by children and teenagers.

Marijuana is sometimes prescribed by doctors to relieve symptoms and side effects of cancer treatment, glaucoma and multiple sclerosis.

Rep. Rochelle Chronister, R-Neodesho, said the bill only would provide a defense for someone who is convicted of using marijuana when it is prescribed.

"It doesn't open up the issue of marijuana except for people who really, truly can use that drug," she said.

Garner's proposal would prohibit the sale of any product that is 100 percent ephedrine, unless anyone 18 or older buys it from a pharmacist. He said the product is currently sold at convenience stores where children can easily purchase it.

• Should marijuana use be legalized for medicinal purposes? Answer today's J-W Access question on page 2B.

3-27-95 Lawrence Journal-World

Marijuana bill allows for legal medical use

3-27-95

The Associated Press

TOPEKA, Kan. — Kansans who use marijuana for medical purposes have the Kansas House of Representatives on their side.

It decided Friday to approve use of the drug for people who have cancer, glaucoma or multiple sclerosis.

The bill allows the drug's use when it is prescribed by two doctors. It passed the House, 89-32, and went to the Senate.

Marijuana is sometimes prescribed by doctors to relieve symptoms and side effects of cancer treatment, glaucoma and multiple sclerosis.

State Rep. Rochelle Chronister, R-Neodesha, said the bill only would provide a defense for someone who is convicted of using marijuana when it is prescribed.

"It doesn't open up the issue of marijuana except for people who really, truly can use that drug," she said.

State Rep. John Edmonds, R-Great Bend, voted against the bill because he said it could open up the legal use of marijuana.

1995 SB333

(1) Propylhexedrine (except when part of a compound used for nasal decongestion which is authorized to be sold lawfully over the counter without a prescription under the federal food, drug and cosmetic act, so long as it is used only for such purpose) 8161
(2) Pyrovalerone 1485

(e) Unless specifically excepted or unless listed in another schedule, any product containing as its single ingredient the substance Ephedrine.";

And by renumbering the remaining sections accordingly;

Also on page 4, in line 14, following "21-2511" by inserting ", 65-4113";

On page 1, in the title, in line 11, by striking "marijuana;"; in line 12, by striking all preceding the semicolon and inserting "controlled substances"; in line 13, following "21-2511" by inserting ", 65-4113";

Also, on motion of Rep. Geringer **SB 333** be amended on page 4, in line 2, by striking all following "or"; in line 3, by striking all preceding "as" and inserting "tetrahydrocannabinol"; following line 11, by inserting the following material to read as follows:

"(d) It shall be a defense to a prosecution under subsection (a)(3) that the person in possession or control of marijuana or tetrahydrocannabinol as designated in subsection (d) of K.S.A. 65-4105, and amendments thereto, has been certified to be undergoing treatment for multiple sclerosis or glaucoma or to be undergoing radiation or chemotherapy treatment for cancer by two persons who are licensed to practice medicine and surgery.";

Also on page 4, in line 12, by striking "(d)" and inserting "(e)";

Also, on motion of Rep. Spangler **SB 333** be amended on page 1, following line 16, by inserting the following section:

"Section 1. K.S.A. 1994 Supp. 8-292 is hereby amended to read as follows: 8-292. (a) Except as otherwise provided by law, whenever a statute authorizes the court to place restrictions on a person's driving privileges or whenever a municipal ordinance which prohibits the acts prohibited by such a statute so provides, a district or municipal court may enter an order restricting the person's driving privileges to driving only *a motor vehicle equipped with an ignition interlock device, approved by the division of motor vehicles and obtained, installed and maintained at the person's expense or* under the following circumstances: (1) In going to or returning from the person's place of employment or schooling; (2) in the course of the person's employment; (3) during a medical emergency; (4) in going to and returning from probation or parole meetings, drug or alcohol counseling or any place the person is required to go to attend an alcohol and drug safety action program as provided in K.S.A. 8-1008, and amendments thereto; (5) at such times of the day as may be specified by the order; and (6) to such places as may be specified by the order.

(b) Restrictions imposed pursuant to this section shall be for a period of not less than 90 days nor more than one year, as specified by the court order.

(c) Upon entering an order restricting a person's driving privileges under this section, the court shall require that the person surrender to the court any driver's license in the person's possession. The court shall transmit any such license to the division of vehicles of the department of revenue, together with a copy of the order. Upon its receipt, the division of vehicles shall issue without charge a driver's license which shall indicate on the face of the license that restrictions have been imposed on the person's driving privileges and that a certified copy of the order imposing the restrictions is required to be carried by the person for whom the license was issued any time the person is operating a motor vehicle on the highways of this state. If the person is a nonresident, the court shall transmit a copy of the order to the division. The division shall forward a copy of the order to the motor vehicle administrator of the person's state of residence. The judge shall furnish to any person whose driver's license is surrendered under this section a copy of the order, which for a period of 30 days only shall be recognized as a valid Kansas driver's license pending issuance of the restricted license as provided in this section.

(d) Upon expiration of the period of time for which restrictions are imposed pursuant to this section, the licensee may apply to the division for the return of any license previously surrendered by the licensee. If the license has expired, the person may apply to the division for a new license, which shall be issued by the division upon payment of the proper fee and

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Weiland, Wells
Nays: Adkins
son, Donovan,

3-23

3/28/95, Sen. Emert moves for "nonconcurrance" in House amendments and requests appointment of Conference Committee. House accedes to Conf. Comm. request after motion by Rep. Snowbarger.

4/7/95: Conference Committee report, reflecting omission of med. marijuana section, is adopted.

It is interesting to note that the amended version os SB 333, *with* the med. marijuana language, passed the House 84-32.

SB 333

House Members Voting YEA

"Medical Marijuana Defense Bill" - 1995

Last name	First	Party	Last name	First	Party
Grant	Robert	D	Nichols	Rocky	D
Yoh	Donna	R	Humerickhouse	Joe	R
McKechnie	Ed	D	Lowther	James	R
Howell	Andrew	R	Pugh	Edward	R
Correll	Vernon	D	Glasscock	Kent	R
Tanner	Ralph	R	Larkin	Bruce	D
Garner	Jim	D	Lloyd	Steve	R
Empson	Cindy	R	Geringer	Gerald	R
Chronister	Rochelle	R	Hochhauser	Sheila	D
O'Connor	Kay	R	Weber	Shari	R
Kline	Phil	R	Horst	Deena	R
Allen	Barbara	R	Gossen	Duane	R
Nichols	Brit	R	Beggs	Carol	R
Franklin	Cliff	R	Boston	Garry	R
Tomlinson	Robert	R	Crabb	Delbert	R
Lane	Al	R	Samuelson	Ellen	R
Snowbarger	Dennis	R	Luthi	Ray	D
Gilmore	Phyllis	R	Miller	Robert	R
Adkins	David	D	Pottorff	JoAnne	R
Haulmark	Gary	R	Wells	Joe	
Pettey	Pat	D	Powell	Tony	
Dillon	Herman	D	Helgerson	Henry	
Edlund	Richard	D	Farmer	Mike	
Haley	**David**	**D**	Welshimer	Gwen	
Henderson	Broderick	D	Gilbert	Ruby	
Spangler	Doug	D	Rutledge	Joel	D
Reardon	Bill	D	Ott	Belva	R
Long	Jim	D	Thimesch	Daniel	D
Cox	Ray	R	Sawyer	Tom	D
Dean	George	D	**Wagle**	**Susan**	**R**
Ballou	John	R	Krehbiel	Robert	
Ballard	Barbara	D	Pauls	Janice	D
Sloan	Tom	D	O'Neal	Michael	R
Findley	Troy	D	Alldritt	Richard	D
Flower	Joann	R	Aurand	Clay	R
Hutchins	Becky	R	Dawson	Carol	R
Toelkes	Dixie	D	Wempe	Jack	
Mays	Doug	R	Minor	Melvin	D
Kirk	Nancy	D	Smith	Don	R
Flora	Vaughn	D	Jennison	Robin	

Last name	First	
Mollenkamp	Gary	
McClure	Laura	
Gatlin	Fred	R
Morrison	James	R
Heinemann	David	R
Holmes	Carl	R

3-25

Colorado Department of Public Health and Environment

Medical Marijuana Registry

PHYSICIAN CERTIFICATION

Instructions: Please complete all the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form, and keep a copy in the patient's medical record. The patient will submit this certification along with his or her application for a Medical Marijuana Registry identification card. This does not constitute a prescription for marijuana. You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

PATIENT INFORMATION	
NAME (LAST, FIRST, MI):	DATE OF BIRTH:

PHYSICIAN INFORMATION	
NAME (LAST, FIRST, MI):	TELEPHONE NUMBER:
MAILING ADDRESS:	
CITY, STATE, AND ZIP CODE:	

PHYSICIAN'S STATEMENT

The above-named patient has been diagnosed with and is currently undergoing treatment for the following debilitating medical condition: (Check appropriate boxes.)

1. ☐ Cancer
2. ☐ Glaucoma
3. ☐ HIV or AIDS positive

OR A medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

4. ☐ Cachexia
5. ☐ Severe pain
6. ☐ Severe nausea
7. ☐ Seizures (including those characteristic of epilepsy)
8. ☐ Persistent muscle spasms (including those characteristic of multiple sclerosis)

Comments:

I hereby certify that I, a physician duly licensed to practice medicine in Colorado, am the physician for the above-named patient. It is my conclusion that the applicant might benefit from the medical use of marijuana. This is not a prescription for the use of medical marijuana.

SIGNATURE:	DATE:

3-26

ATTENDING PHYSICIAN'S STATEMENT – NEW APPLICATION
Oregon Medical Marijuana Act Program

Instructions: Please complete all sections of this form in order to comply with the registration requirements of the Oregon Medical Marijuana Act **OR** provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

If you need this document in an alternate format, please call (971) 673-1226

A	PATIENT INFORMATION	
	PATIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
	MAILING ADDRESS:	TELEPHONE #: ( )
	CITY, STATE AND ZIP CODE:	

B	PHYSICIAN INFORMATION	
	PHYSICIAN NAME: (Please print legibly!)	
	MAILING ADDRESS:	TELEPHONE #: ( )
	CITY, STATE AND ZIP CODE:	

C	PHYSICIAN'S STATEMENT
	Debilitating Medical Condition: Check appropriate boxes.
	[ ] 1. Malignant neoplasm (Cancer)
	[ ] 2. Glaucoma
	[ ] 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
	[ ] 4. Agitation due to Alzheimer's Disease
	5. A medical condition or treatment for a medical condition that produces for a specific patient one or more of the following: (check all that apply)
	[ ] a. Cachexia
	[ ] b. Severe pain
	[ ] c. Severe nausea
	[ ] d. Seizures, including but not limited to seizures caused by epilepsy
	[ ] e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis.
	Comments:
	I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with a debilitating medical condition, as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. This is not a prescription for the use of medical marijuana.
	PHYSICIAN'S SIGNATURE: / **DATE:**

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

DHS/OMMP
PO Box 14450
Portland, OR 97293-0450

DHS

Testimony to Committee on Health Care Strategies on Senate Bill No. 556

Bette Hulser
2318 SW Briarwood Plz #107D
Topeka, KS 66611
Phone: 785-267-4512
bettehenry@aol.com

My name is Bette Hulser and I live here in Topeka. I want to thank the committee for the opportunity to testify on behalf of the Kansas Medical Marijuana Defense Act.

My son Michael had the 'American Dream'. A great job as head chef at Georgio's (stolen away from Bennigans), working 10-hour day's 7 days a week, a wife and was expecting a beautiful baby girl. At age 24 he felt he could ask for nothing better and he thanked God every day for his blessings.

Then he started to limp along with some bad migraine headaches. A local chiropractor told him that it was simple his left hip was out of place. After several visits, it was no better and he was literally 'dragging' himself to work. His whole left side was becoming numb and he was having trouble with his balance. Still, he went to work everyday with the hope that it would get better. Then one day he fell in a vat of boiling beans and his wife called me to meet her at the hospital.

When they took off his shoes and socks, the skin came with them. You could literally see all the bones, tendons, etc. And up his leg was blisters the size of goose eggs. He was to undergo intensive plastic surgery. As usual Mike was trying to cheer everyone else by saying "don't cry Mom, I can barely feel it with this hip out of place'." Having some medical knowledge from my father, I knew Mike's condition to be far more serious than that and asked for a neurologist to see him. The tests came back and the prognosis was one of the worst, Mike had Chronic Progressive Multiple Sclerosis. The doctor said soon, very soon he would be in a wheelchair. It was devastating!

One bright spot, little Missy was born. She was a perfect child and Mike adored her! It broke my heart to see that the only way he could hold her was in a sitting position or lying down. It really broke all of our hearts when his wife left with Mike's best friend and he came home to an empty house. We would not see our Missy or know where she was for 5 long years.

Mike moved in with me and it was the first time I have ever seen him cry as an adult! The stress was so great his M.S. really progressed and one night he was rolling and screaming in pain on the floor. Lesions were forming in his brain and causing the worst headache of his life and he was convulsing. After a time, I was praying that God would take us both. I was getting ready to call an ambulance when one of his friends stopped by and asked to see him.

When I told him what was happening he insisted on seeing him and I relented. He went in and I waited and waited and soon Mike's screaming had subsided and he looked relaxed. I asked his friend what in the heck he did. He said I let him smoke some Marijuana. I said WHAT! In my house! I was so 'straight-laced', never been in trouble

and I was in shock! But then it hit me..... This 'outlaw' drug worked the miracle that the fentanyl patch he had on did not even touch!

I knew then that my ignorance of this drugs property needed some investigating. I read everything I could, talked to his physicians and the Director of the Kansas rehab at the time told me 'Bette, it does have it's place in certain diseases'. From that day forward I knew I would never say anything against Mike taking it.

Then came the call Mike had been arrested. The very drug that helped him, he was being put on trial for. Everything he had worked for was taken by the forfeiture laws and sold at a police auction. Then came the hard part, the trial. We were so lucky to get a great lawyer, who now sits on the Supreme Court. He worked hard for Mike and I remember vividly coming out of the court room while trying to make a deal with the prosecutors, red in the face and saying 'those uncompassionate @$#^!'

Mike received probation and time served, we were very grateful. The stress of it all made Mike's M.S. much worse and he could no longer stand. We did not know it at the time, but he would never come out of the wheelchair we rented. He was given a wonderful probation officer that shall always remain a dear friend of this family for later he would put his long career on the line for Mike.

Two years later while still on probation Mike again was arrested and since I had to take out bankruptcy for medical bills, we had no money for an attorney so Mike was appointed one. It didn't take us long to know he was going to 'throw Mike to the wolves'. The sentence was for Mike to be remanded to the custody of the Secretary of corrections for 30 months on count 1 and 28 months on count 2. I was crying for I knew that Mike could not last in prison in his condition.

I thought to myself that this world was a real crazy and horrible place for this to happen to someone so sick and had never hurt anyone in his life! His probation officer jumped up and told the judge he had to apologize to the court as he never gave Mike any U.A.'s because he was aware that Mike still was smoking marijuana and was doing so to ease the pain of his M.S. Judge Conklin was frowning & said Mr. Aitkens you have nothing to apologize to this court for as you were being compassionate!' There was the word I was looking for! The Judge called a recess and asked to speak with me. Asking me to get with my Senator at the time, Alicia Salisbury to pass a compassionate bill for he was tired of putting sick people in jail.

My wonderful Senator went right to work and an amendment to Senate Bill **333** was introduced in 1995 and passed the **House** by a good majority, but, was killed in the **Senate**. I was overwhelmed by the Senators that called and wrote to me stating they hoped I would keep trying as they believed as the Judge, that no chronically or terminally ill should be punished for doing what helps them. Many of us have been long time friends since. Many remembered my father when he was in the House for 2 terms.

When we went back to court Judge Conklin told us that he had received so many calls from Senators and Representatives that he had decided since the bill did not pass that he had made up his mind what he was going to do. Ms. Hamilton jumped up and started to talk and he told everyone he did not want to hear one more word! He then, looked at Mike and then at me and smiled. I felt as if a ton had been lifted off my shoulders! He looked at Mike and said, Mr. Mallonee I am making an order that you will be on

probation for two years and during that time you will not be tested for drugs! You may use marijuana, but just for yourself. Please do not share it with your Mother! Mike's mouth dropped open as mine did! Since then, both the Judge and Mr. Aitkens have received Christmas cards every year from me and shall until I pass from this earth.

Mike's M.S. progressed to the stage that he has been completely bedfast for the last decade and unable to use marijuana. He is in a body, which will not work, and a spirit that is the most awesome I have ever seen.

I have heard people say that there are better drugs, yet, we have yet to find any. We went through Roxanal, Marinol, oxy-contin, Hydrocodone, and fentanyl. Mike takes approximately 35 pills a day. The spasms still are great even while he is on Baclofen, Zanaflex and Flexoril. He has a supra pub cath, a baclofen pump, a stoma by which he gets all feedings and water and is ventilator dependent. He asks for marijuana and I tell him I wish he could use it. He is here now, saying prayers with me every night, his faith is amazing! While we know Mike's time is limited, we are so grateful for every minute he is with us. I am not a chemist; I am just a mother who knows that this worked when all the other FDA approved drugs have not.

Like Mike, I want all Kansans that are sick to have the opportunity to relieve their pain in the manner of what works for them. Not be sent to prison to die, but to go out of this life knowing that someone had the ***compassion*** to stick up for them and they can leave us with the dignity they deserve surrounded by those who love them.

Thank you & God bless!

TESTIMONY OF JON HAUXWELL, MD
BEFORE THE SENATE HEALTH CARE STRATEGIES COMMITTEE
CONCERNING THE KANSAS MEDICAL MARIJUANA DEFENSE ACT

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 5

Mr. Chairman and members of the Committee, I appreciate the opportunity to share with you my perspectives on the Medical Marijuana Defense Act.

I am a retired family physician from Stockton, now living in Hays. For fifteen years I chaired a multidisciplinary chemical dependence recovery team on the Northern Cheyenne Reservation in Montana. I have maintained longstanding interests in clinical pharmacology and medicinal ethnobotany, as well as the management of chronic pain.

HUMAN PHYSIOLOGY AND MEDICINAL CANNABIS

I consider whole-plant cannabis to be both a drug and a medicine. By "medicine," I mean any substance or combination of substances which, when administered to a human, can influence human physiology and pathology in a beneficial manner.

We are just beginning to understand how and why cannabis has medicinal properties. Tiny structures termed "cannabinoid receptors" are widely distributed throughout the body, in such diverse tissues as brain, muscles, heart, and immune system. Nature is thrifty; we may safely assume that this extensive distribution of cannabinoid receptors reflects their versatile role in the regulation of human health.

Nature did not create these with any "intent" of accommodating exogenous medicines; the receptors evolved in tandem with chemicals the body itself makes, termed endocannabinoids. When patients administer cannabis as a medicine, they are simply taking advantage of the body's pre-existing apparatus, much as happens when we use morphine to utilize our system of opiate receptors.

If the therapeutic claims advanced on behalf of cannabis seem suspiciously close to those of a panacea, we must only consider the distribution of those cannabinoid receptors throughout such a host of different tissues. It is apparent that the effects of a given cannabinoid receptor are expressed by virtue of its tissue context. Receptors found in peripheral nerve tissue are likely to influence peripheral nerve function, and the same may be inferred for receptors located in skeletal muscle, bladder wall, brain, blood, bone, intestines, pancreas, and liver. Such versatile effects of limited receptor types on multiple tissue functions are already well known - for example, the alpha and beta adrenergic complexes.

DRUG DEPENDENCE ISSUES

Cannabis has been used medicinally worldwide for thousands of years safely and effectively. But like many other medicines we routinely use, it has abuse potential. Around 9% (depending on one's definitions) of frequent users subsequently develop an addiction syndrome - the persistant obsessive repetition of a behavior despite adverse consequences. This is a far lower percentage than we see in other medicinal or social drugs such as opiates, stimulants, sedatives, alcohol and tobacco, but it still warrants our attention and

concern. Upon stopping use of the substance, heavy cannabis users can experience an abstinence syndrome, commonly termed "withdrawal," although withdrawal from cannabis is itself benign when contrasted with the potentially fatal outcomes seen in withdrawal from drugs like opiates, alcohol, barbiturates, and Valium.

Evidence shows the potential for cannabis dependence is greatest among the young, before and during adolescence. Health care providers must exercise caution prescribing any medicine with abuse potential, especially when the young are receiving treatment.

"EXCUSES" AND REASONS - DRUG ABUSE AND DIVERSION

Professional debunkers on the lecture circuit get a lot of mileage from a favorite catch phrase, "medical *excuse* marijuana." People are just using their cancer or multiple sclerosis as an *excuse* to get high. Never mind that hundreds of thousands of people are getting high without feeling it necessary to offer an excuse at all. When patients use cannabis as medicine, they are at best deluded, and at worse just faking.

Not only is this charge largely inaccurate, it is cruel and monstrously unfair.

Any physician who has prescribed controlled substances knows that there is a subset of the population which will indeed try to obtain prescriptions through deceit. Despite our vigilance, we've all been fooled. But society has made an important decision: we will accept the risk of drug diversion and abuse in order to provide genuine patients with humane treatment and relief of suffering. This has its parallel in jurisprudence - better to free nine guilty men than to execute one innocent one. Or in the case of medicines, we must not allow a small group of abusers to call the shots, to deny treatment to the large group of legitimate patients.

Drug diversion of medical cannabis would not pose the problem we see with, say, Oxy-contin. Marijuana is readily available through an extensive and lucrative black market, and any contribution to the supply from medical sources would be minimal; illicit Oxy, on the other hand, is obtained almost entirely by diversion from medical sources.

Cannabis debunkers often state that medicinal cannabis is just a strategy to poise us on a slippery slope leading to full legalization of marijuana. Now that's just silly. We all know Kansas is not about to legalize marijuana. Ironically, this is one area where workers in the recovery community and blackmarket profiteers agree. Counselors fear that legalization would tempt people who have never tried recreational marijuana to do so; pushers and dealers fear that legal marijuana would put them out of business.

Approving the medical use of controlled substances - opiates, stimulants, sedatives, etc - has not led to their sale in 7-11's. Just because something is abusable doesn't mean that abusers should dictate to real sufferers whether or not they should get relief. And if someone I find generally misguided were to advocate the legalization of drugstore opium, I would still support morphine for medical use.

SAFETY ISSUES

Pharmacologic safety remains a concern, however, as it is for virtually all medicines. Aspirin causes a thousand deaths a year, mainly due to bleeding; thinning the blood is a known, and sometimes sought, action of aspirin. Aspirin is lethal in overdose. Cannabis, by contrast, has no known lethal dosage, and deaths attributable solely to the pharmacologic effects of cannabis are extremely rare if they can be found at all. Our challenge is to identify, understand, and minimize any toxicity associated with cannabis, as we must do with any other medication.

In the laboratory, potentially adverse effects of cannabis have been discovered. For example, interference with immune function has been detected. What has not been shown is that such immune compromise is clinically significant in patients; that is, modest and inconsistent evidence of reduced immune system components' function does not equate with actual compromise of human health, even in AIDS patients. There is evidence that cannabinoids can weaken or even destroy some types of brain cancer, but we don't know yet if that's clinically significant either.

Two types of adverse effects are currently of greatest concern: impairment of mental function, and lung damage.

Unquestionably acute cannabis effects include reduced short-term memory, distractability, reduced vigilance, etc. This would make cannabis, as is the case with Valium, Benadryl, many other medications (and of course alcohol), inappropriate for use during or immediately before driving or operating dangerous machinery. There is little if any evidence of long-term brain damage. In fact, evidence suggests that cannabinoids can exert a neuroprotective effect in the setting of spinal cord injury or stroke, reducing damage resulting from the injury. Some studies have shown no impairment of work performance among long-term users. Because of the phenomenon of "tolerance," the attrition of effect seen with ongoing use of some drugs, activities of daily living such as cooking, dressing, communication, self-care, etc. do not appear to suffer. Tolerance to side effects occurs faster than tolerance to therapeutic effects.

Still, effects of cannabis on cognition are among those that must be weighed in any decision regarding using cannabis as medicine.

The presence in cannabis smoke of carcinogens deserves scrutiny. Unlike tobacco, in which carcinogens are produced by fermentation and curing prior to use, cannabis is simply dried. Carcinogens are produced primarily by combustion itself, in cannabis and in almost any burning plant substance. The presence of carcinogens is of relatively little concern to someone already suffering from terminal lung cancer or end-stage AIDS, but they are worrisome for someone who might profit from using cannabis for years, like an MS patient.

Studies of populations with a high prevalence of cannabis use, such as Rastafarians, have not shown increased rates of lung cancer due to cannabis use alone. A recent retrospective New Zealand study of people who already had lung canceer indicated that volume for volume, cannabis smoke carried a higher risk of lung cancer than tobacco smoke. However, a study on emphysema

showed that when cannabis was smoked in the absence of tobacco use, it did not cause emphysema. But when tobacco was also used, cannabis contributed to emphysema risk, with one cannabis cigarette the equivalent of five tobacco cigarettes. This is noteworthy for two reasons. One is that for emphysema, cannabis risk must be triggered by tobacco or it doesn't occur. Also, testing equal *volumes* of smoke is not the same as testing equal *doses*.

That is, with today's extremely potent cannabis varieties, a patient might actually stop after three or four puffs of cannabis smoke, not inhaling the smoke produced by an entire cigarette. We often hear cannabis compared to tobacco, primarily because both are plants, both can be smoked, and both can lead to chemical dependence; in terms of addiction potential, proven toxicity, and chemical makeup, though, the two are very different. However, some studies simply fail to consider the different usage patterns between the two. While it's true that cannabis smokers inhale smoke more deeply and retain it longer, only the most dedicated chronic users do this more than once or twice a day. The most common dose of smoked tobacco is one cigarette, but today's cannabis is so potent that most cannabis patients, even those who have become tolerant, do not consume more than a few puffs per dose. Some use pipes so they don't "waste" the scarce commodity, and so they don't have to smoke burnt paper.

So cannabis smoke's higher carcinogen concentration, inhaled deeply and held longer but in more limited quantities, might still require concomitant tobacco use to trigger its contribution to cancer risk.

MEDICATION DELIVERY METHODS

Such considerations are of lesser import when we realize that from a medical perspective, cannabis smoking is simply unnecessary. Many drugs are inhaled (though few are burned first!) because this allows a rapid onset of action, and the ability to titrate, or adjust, the dosage very precisely. These same assets can be achieved without combustion of medicinal cannabis, now that low-temperature vaporization apparatus is available.

Furthermore, in many situations cannabis can simply be eaten. The effects take longer to manifest, but they last much longer than inhaled cannabis, reducing the number of doses needed in a day. The proper dose can be determined only after investing several days in an upward titration, beginning with small amounts and gradually increasing until the optimal effect is reached. Today's potent varieties can be pulverized, encapsulated, and swallowed like any other pill.

Debunkers like to display a list of "contaminants" present in some illicit cannabis preparations, micro-organisms and chemicals among them. These contaminants can also be found in many home gardens. We have not seen that the presence of such contaminants has actually been linked to clinical disease among users. An exception might be the presence of an herbicide, Paraquat, which has been sprayed on illicit cannabis crops in eradication attempts.

RELATIVE RISKS

We have seen that there are potential side effects to cannabis use, and these must be considered and managed as they are for any other drugs. In fact, the hazards of cannabis are often much smaller than those of the drugs they supplant or replace. Furthermore, the versatility of those cannabinoid receptors can mean that cannabis can replace several drugs at once - for example, cannabis use can simultaneously reduce or eliminate the use of antinauseants, anti-anxiety drugs, sleep aids, antidepressants, and appetite stimulants in some cancer patients, and might enhance the effects of chemotherapy or radiation by inhibiting the growth of new blood vessels upon which the tumor relies for nourishment.

CONSISTENCY OF DOSING

With any medication, we want assurance that today's dose is identical to yesterday's and tomorrow's. Cannabis reproduces sexually, giving rise to new generations combining both parents' genes. There is as much genetic diversity among cannabis cultivars as there is among dogs. This is not only significant when it comes to consistency of the medicine, but it also means that one variety might have very different effects on one disease versus another. (This is of paramount importance, but widely ignored, during the testing of cannabis' therapeutic potential for specific diseases. More on this later.)

This problem can be addressed quite simply - by cloning, or as we more commonly term it, propagation from cuttings. Once a given variety of cannabis has been determined to be effective for a given condition, the plant can be trimmed and the cuttings grown into genetically identical daughter plants; this is the primary determinant of potency and specificity, provided growing conditions are roughly comparable.

Hypothetical concerns regarding cannabis' safety will be an ongoing issue. Cannabis is the most commonly-used plant-derived recreational drug in the world, and has been for a long time - more than enough time for major hazards to have become visible, a la Vioxx, Bextra, or tobacco. But these uncertainties fully warrant limiting use of cannabis to treatment of disabling or debilitating conditions, as we do drugs actually known to possess serious liabilities.

DATA, RESEARCH, AND THE FDA

Clearly research must continue into the nature of cannabis and its interactions with human physiology. This is no simple matter, at least in this country. It can take years for a researcher to even obtain permission to study cannabis, much less the funding needed to do it. Because of social opprobrium attached to any illegal drug, researchers are reluctant to be associated with legitimate studies of cannabis, fearing it would stigmatize them and jeopardize future research funding. Profit-oriented drug companies have no incentive to try to validate the effectiveness of a medication they can't manufacture, sell, or patent.

Proponents of using medical illness as a defense against possession charges have been accused of wanting to "bypass" or circumvent the FDA.

The FDA, DEA, and NIDA have become entangled in politics, leading to their diversion, among other things, into carrying out the "War on Drugs." As a result of this compromise of its original mission, the FDA has arguably become derelict in its duty. The persistence of widespread unrelieved suffering, and the compelling evidence for cannabis' safety and effectiveness, leave no compassionate choice other than bypassing or preempting the FDA when it specifically comes to cannabis.

However, we do not fail to recognize that savvy but unsavory entrepreneurs continue to endorse a host of bogus nostrums that are neither safe nor effective, ranging from "Natural" remedies to "supplements" which are all marketed in ways that to any sensible person represent therapeutic claims. Recall also the laetrile debacle. If we sanction overriding the FDA on behalf of one unusually promising medicine, we could be mistakenly seen as opening the door for a deluge of worthless or harmful product purveyors to do the same, citing fervent public support as a sufficient justification for foregoing the lengthy FDA-approval process. Pandora's box. Even though we must acknowledge the system's other problems, and must be informed by them, we cannot afford to be intimidated by them; the problems that cannabis can potentially alleviate are real and present, and they demand we act to overcome hurdles both social and political. It is simply not necessary to accept snake oil sales in order to profit from the application of cannabis' uniquely compelling volume of evidence.

National administrations do not want to become vulnerable to charges of being "soft on drugs." Many in the recovery community feel threatened by the prospect of acknowledging that there could conceivably be anything good to be said about any drug they combat daily in their professional roles.

When researchers do succeed in obtaining permission and funding to study cannabis itself, they are limited to a single monopolized strain grown by the National Institute on Drug Abuse (NIDA). This is an inferior, low-potency cultivar, "your grandfather's cannabis." And this product is denied by NIDA even to FDA-approved protocols if NIDA disagrees with them; its bias is apparent in NIDA's name – they are predisposed to consider cannabis only in light of its potential for abuse.

Alternatively, researchers can examine a synthetic version of THC now approved, but little used, as an antinauseant; THC is the most psychoactive of cannabis' 60 or so cannabinoids. Being limited to studying THC in isolation, or to one strain of cannabis, is akin to trying to characterize a Pizza Supreme by a cursory examination of an anchovy fragment.

ISOLATION AND POTENTIATION, THE WHOLE-PLANT ISSUE

Pharmacologists are familiar with the phenomenon of "potentiation." Essentially, two or more drugs used together reinforce, or potentiate, each other's effects, so that their combined effect is greater than the sum of their individual effects: one plus one equals three.

Whole-plant cannabis can have effects differing markedly from one or two of its ingredients used alone. Add to this the enormous genetic variation among cannabis strains - the difference between a St. Bernard and a chihuahua - and it

is no surprise that studies have often failed to discern a therapeutic benefit of one particular cannabis product on a given disease. Cannabis users themselves have long ago learned to distinguish one cultivar from another, based on the net effect of a number of active ingredients. A strain that helps muscle spasticity might not have much effect on pain; one strain may enhance alertness, while another has relaxing or sedating properties.

ANECDOTES AND CONTROLLED STUDIES

Still, we needn't reinvent the wheel, or pretend that we have no information to allow us to make plausible choices in matching the most promising cultivar with an appropriate disease for research purposes.
As the International Journal of Clinical Practice put it, "patients' reports could serve as a valid indicator of target diseases and symptoms for cannabinoid drug development."

Modern science properly looks askance at non-controlled or "anecdotal" reports. Although it was anecdotes that led to the discovery of AIDS, anecdotes, being inherently vulnerable to subjectivity, are granted almost no evidentiary value. Medical scientists are reluctant to support any assertion based primarily on anecdotal evidence.

However, there is a very large volume of such reports when it comes to the therapeutic effects of cannabis, and there is a great deal of consistency among them. Some of the claimed benefits involve the sustained ability to relieve severe symptoms; although any of us are susceptible to the placebo effect, placebo effects on severe symptoms such as chemo-induced nausea or intractable pain tend to attenuate fairly rapidly. Initially a gratifying response does not exclude placebo origin, but a "placebo" that continues to work for months is highly likely to involve a genuine pharmacologic and physiologic phenomenon.

We face an uphill battle convincing politicians, doctors, and researchers to take the enormous volume of experiential data seriously enough to loosen the strictures on cannabis research or on individual cannabis utilization.

TWO CASE STUDIES

I won't try to present a detailed review of all the potential forms of therapeutic response to cannabis; those data are already available from other sources. Let me mention the experiences related to me by a couple of patients, before I list some of the other areas in which both anecdotal and experimental evidence suggest the safe efficacy of cannabis use.

Both of these patients had briefly used marijuana recreationally years before, but had only recently tried it again in a recreational setting. The medical effects of the experience were neither sought nor anticipated, but appeared gratuitously.

One man suffered debilitating back pain which both restricted his mobility and caused a lot of pain even at rest. To his surprise, for nearly a day after he used marijuana, his back pain was markedly reduced, as was his stiffness. He was able to ambulate with much greater ease.

When he mentioned this to me, I explored alternative explanations - maybe he was just distracted from his pain by the psychotropic effects, simply wasn't paying as much attention to it as usual. He assured me that once he noticed what was happening, and paid explicit attention to it, the pain was still far less perceptible than usual; furthermore, the pain decrease persisted for hours after the euphoriant effect had disappeared. I suggested that maybe he found it easier to ambulate because his *fear* of pain normally prevented him from even *trying* to get around much, and that while distracted, he "forgot" to worry about pain, and discovered he had more ambulatory capability that he'd realized. Not so, he said. He has steadfastly refused to be intimidated by pain, or to let it dictate what he can or can't do, and he forces himself to go for walks and do exercises on a regular basis. The difference was that he could do with ease the same things that he usually must force himself to endure out of principle. This does not sound like a simple placebo effect, which requires at the least an expectation of relief.

While his pain decreased substantially, his ability to experience other sensation was not dulled. This is consistent with what we know about the function of cannabinoid receptors along nerve fibers. They depress the reactivity of spinal neurons which conduct pain sensation to the brain, but have no effect on other neurons responsible for non-pain sensation. This contrasts with other pain relievers such as opiates which not only have a pan-suppressant effect on sensation, but can depress the sense of needing to breathe - respiratory drive - leading to respiratory depression and even asphyxiation.

Another patient similarly was not totally unfamiliar with marijuana, but had not used it for years. An old friend came to visit, and convinced her to share some marijuana before walking around the zoo. She had interstitial cystitis, involving pronounced bladder irritability with urgency and incontinence, problems which had not responded to commonly-used "bladder sedatives" or even to surgery. The first thing she did on entering the zoo was get a map and locate all the rest rooms on the grounds, anticipating the usual sequence of sudden dashes to the nearest stall.

To her surprise, she only had to pause once for a bathroom break, and this was only because she felt like she was soon going to need to urinate, as opposed to the usual abrupt overwhelming demand. Although she is accustomed to urinary frequency, she can't avoid it simply by refusing to obsess about it; when it comes, it comes, and it brooks no delays or procrastination.

The effect of cannabis on bladder irritability, spasm, and incontinence has surfaced in more formal studies. This condition is common to many different types of disorder, including multiple sclerosis, inflammatory cystitis, and anatomical distortions such as pelvic relaxation due to multiple childbirth. Related medicines currently available are ineffective for many people, and have the potential to cause serious side effects.

In the case of neither patient could I legally advise them to repeat or continue the use of cannabis despite its seemingly obvious benefits for them as individuals. Instead, I could listen non-judgmentally and empathetically, and note

that I "could understand if you were to resort to cannabis to control this problem." And I could add an exhortation to be wary of legal penalties.

SPECTRUM OF THERAPEUTIC VERSATILITY

Again, there is plausible evidence in both animal and human studies, and unstructured human usage, that many disease states respond favorably to cannabis, without the degree of side-effects found among currently-available alternative surgical and medical therapies. Cannabis constituents might help prevent diabetes, osteoporosis, Alzheimer's, and certain cancers. It can slow progress or alleviate symptoms of fibromyalgia, dystonias, arthritis, intestinal disorders, hypertension, Tourette's Syndrome, ALS (Lou Gehrig's Disease), sleep apnea, AIDS, inanition, and Hepatitis C.

Of particular interest is the effect of cannabis on a specific type of pain – neuropathic pain. A complex, lancinating pain due to diseased nerve trunks and fibers, and often associated with common diseases such as diabetes, or less common ones like multiple sclerosis, neuropathic pain has proved frustrating, resistant to even the strongest pain relievers, the opiates. Anticonvulsant drugs such as gabapentin and pregabalin have been used with some success to treat neuropathic pain, but their side-effects can prove intolerable. The same is true for another class of drugs, the tricyclics.

But as we learn more about the function of cannabinoid receptors in the nervous system, we are coming to understand why cannabis seems to have a unique, and in some cases remarkable, ability to alleviate this challenging disorder.

It is a travesty and a tragedy that patients who have been unable to safely achieve relief or remission using available therapeutic modalities must risk criminal prosecution for attempting to control their diseases using cannabis.

Debunkers put forth the notion that cannabis use, whatever its side-effects, is simply unnecessary – that there are always currently-available alternatives that adequately relieve symptoms without any adverse effects. If you have a friend or relative who has dealt with cancer treatments, or the chemicals used to fight Hepatitis C or multiple sclerosis, you will have noticed that this assertion is bogus. Even today some patients elect to just "die and get it over with," rather than endure the side-effects of chemo- and radiotherapy.

It is common knowledge that the effects of any medical therapy can be "idiosyncratic." A given medicine will work better than another for a given patient, or worse; one person may experience debilitating side-effects from a medicine that someone else tolerates without any problem. There is often no way to predict such idiosyncrasies in advance; only trial and error reveal the best choice, if indeed any such choice is available. The more options available, the better the chances that we can find the drug that is ideal, or least problematic, for a given patient.

THE UPSIDE OF EUPHORIA

I suspect that many opponents' stance on cannabis arises in some part from their concern over therapeutic cannabis' potential to cause concomitant

euphoria - that people will continue to use it because it makes them feel good when it really isn't doing anything to alter their diseases' manifestations. Chemical dependence is always an issue that must be considered, and it is not mere Puritanism reverberating through such attitudes. However, I'm reminded of a statement made by the late Peter McWilliams: "I had forgotten how healing enjoyment can be. Pleasure as therapy. Ease to unravel disease. A deep appreciation of life as an answer to death." We must not trivialize or dismiss the role of a positive outlook, or the responsiveness of the mind-body unit to optimism and to an ability to take pleasure in daily life's variety of sensations and experiences. For many sick people, cannabis enhances these dimensions of their lives.

CONCLUSION

There is abundant evidence that in many cases, the administration of cannabis can provide safe and effective relief of a spectrum of human discomfort and disease. Side effects exist, and they must be balanced against the degree of efficacy when a person decides to try, or to continue, using cannabis as a medicinal agent. Currently, among the most devastating side effects of the medicinal therapeutic use of cannabis is its legal status, and the potential for life-disrupting legal penalties.

We need to educate patients about responsible decision-making and proper self-care, about weighing the potential benefits and liabilities of using cannabis as a medication. To punish as criminals those who, with the approval of a licensed physician, elect to use it, does nothing to discourage others' illicit recreational and abusive use. So long as charges relate to simple possession or production of small quantities of cannabis for personal medicinal use, and not to illicit commercial enterprises, a medical defense does not give comfort or assistance to drug dealers, nor does it urge healthy persons to adopt its use. There are already many societal forces at work which unfortunately encourage marijuana experimentation, principally the reports of others' experiences; but medical use as a defense will impact these other factors not at all. Necessitating a medical evaluation and recommendation, as this bill does, precludes the gratuitous and frivolous use of this defense, as it also requires consideration of currently-available therapeutic alternatives to cannabis as a prerequisite to cannabis therapy.

Research needs to continue - indeed, to progress to a higher level - to explore the mechanisms of cannabis' therapeutic actions as well as its liabilities for adverse reactions. But the need is now, and thousands of sufferers for whom existing interventions are either ineffective or intolerable cannot afford to wait for social biases and political infighting to cease their intrusion into the therapeutic alliance among doctors, patients, and medication.

Cannabis is not now, nor is it likely to soon become, the sole or the initial therapeutic option for most of the conditions in which it has already demonstrated its capacity to aid healing. But it should be an option, and those genuine, sincere sufferers who turn to it as a last resort should not be dealt with in the same fashion as career criminals who prey on society through the production and sale

of harmful substances. These patients are sick, not criminal, and we should acknowledge this reality.

Please lend your support to the Medical Marijuana Defense Act.

HIGH LIGHT

Cannabis in painful HIV-associated sensory neuropathy

A randomized placebo-controlled trial

D.I. Abrams, MD; C.A. Jay, MD; S.B. Shade, MPH; H. Vizoso, RN; H. Reda, BA; S. Press, BS; M.E. Kelly, MPH; M.C. Rowbotham, MD; and K.L. Petersen, MD

Abstract—*Objective:* To determine the effect of smoked cannabis on the neuropathic pain of HIV-associated sensory neuropathy and an experimental pain model. *Methods:* Prospective randomized placebo-controlled trial conducted in the inpatient General Clinical Research Center between May 2003 and May 2005 involving adults with painful HIV-associated sensory neuropathy. Patients were randomly assigned to smoke either cannabis (3.56% tetrahydrocannabinol) or identical placebo cigarettes with the cannabinoids extracted three times daily for 5 days. Primary outcome measures included ratings of chronic pain and the percentage achieving >30% reduction in pain intensity. Acute analgesic and anti-hyperalgesic effects of smoked cannabis were assessed using a cutaneous heat stimulation procedure and the heat/capsaicin sensitization model. *Results:* Fifty patients completed the entire trial. Smoked cannabis reduced daily pain by 34% (median reduction; IQR = −71, −16) vs 17% (IQR = −29, 8) with placebo ($p = 0.03$). Greater than 30% reduction in pain was reported by 52% in the cannabis group and by 24% in the placebo group ($p = 0.04$). The first cannabis cigarette reduced chronic pain by a median of 72% vs 15% with placebo ($p < 0.001$). Cannabis reduced experimentally induced hyperalgesia to both brush and von Frey hair stimuli ($p \leq 0.05$) but appeared to have little effect on the painfulness of noxious heat stimulation. No serious adverse events were reported. *Conclusion:* Smoked cannabis was well tolerated and effectively relieved chronic neuropathic pain from HIV-associated sensory neuropathy. The findings are comparable to oral drugs used for chronic neuropathic pain.

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HIV-associated sensory neuropathy (HIV-SN) is the most common peripheral nerve disorder complicating HIV-1 (HIV) infection.[1-3] The dominant symptom in HIV-SN is pain, most often described as "aching," "painful numbness," or "burning." Hyperalgesia and allodynia are common, while weakness is rare and usually confined to the intrinsic foot muscles.

Anticonvulsant drugs have been shown to be effective, specifically lamotrigine and gabapentin, but some patients fail to respond or cannot tolerate these agents.[4,5] Adverse drug-drug interactions with antiretrovirals limit the utility of other antiepileptic drugs used for neuropathic pain, such as carbamazepine.[6] Peptide T, mexiletine, acupuncture, and capsaicin cream were no more effective than placebo in relieving pain from HIV-SN.[7-11] Similarly, tricyclic antidepressants also were no more beneficial than placebo in relieving pain in controlled trials for HIV-SN.[9,10]

Extensive preclinical research has demonstrated analgesic effects of exogenous cannabinoids as well as an endogenous cannabinoid system involved in pain and analgesia.[12,13] The need for a greater variety of effective therapeutic options has led to heightened interest in evaluating smoked cannabis as a treatment for chronic neuropathic pain. Incorporating an experimental pain model into the assessment of smoked cannabis in patients with chronic pain from HIV-SN provides a standardized reference point for each patient's subjective ratings of ongoing chronic pain. The Long Thermal Stimulation procedure tests for acute analgesia by measuring the painfulness of a 1-minute heat stimulus.[14] The heat/capsaicin sensitization model tests for anti-hyperalgesic effects.[15] By simultaneously evaluating acute experimentally induced pain and hyperalgesia and ongoing neuropathic pain, we sought to determine the effect of smoked cannabis on the neuropathic pain of HIV-SN, and to determine if cannabinoids have a more general analgesic and anti-hyperalgesic effect.

Methods. *Study patients.* Patients were adults with HIV infection and symptomatic HIV-SN with an average daily pain score of

From the Community Consortium, Positive Health Program (D.I.A., S.B.S., H.V., M.E.K.), Hematology-Oncology (D.I.A., M.E.K.), and Neurology (C.A.J.), Divisions at San Francisco General Hospital; and Departments of Medicine (D.I.A., S.B.S., H.V., M.E.K.) and Neurology (C.A.J., H.R., S.P., M.C.R., K.L.P.), and the UCSF Pain Clinical Research Center (H.R., S.P., M.C.R., K.L.P.), University of California San Francisco.

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Testimonial
of
Anthony J. Buckland
for
Support of Senate Bill Number 556

February 11, 2008
Committee on Heath Care Strategies

My name is Anthony Buckland, I am an 47 year old unemployed firefighter, former Fire Chief of Mission Township Fire Department and one of the team leaders of Shawnee County Water Rescue concepts used in the last three floods in this area with resulted in not lose of life to victims or rescuers, I worked for Mission Township for the last 8 years as a fire fighter and had a family health insurance plan through my employer during my entire employment. I paid Blue Cross & Blue Shield over $40,000 and never filed a claim. On December 7, 2006 my step-daughter, Morgan Tindall, then 15, was diagnosed with an aggressive form of bone cancer called Osteosarcoma of the right pelvic bone. She has had to endure chemotherapy and radiation therapy since that time and now at the age of 16 faces her death. Within months after the disease was discovered and having never heard a complaint about my work from my 3 bosses I was fired by my township and lost my insurance. Meanwhile Morgan has had to take countless numbers of drugs, drugs for pain, drugs to kill cancer, drugs to hold down the drugs that kill cancer, and more drugs to relieve stress and depression, drugs to help the her body to flush other drugs out of her body, drugs to help her sleep. She is in a vicious cycle of drug use which just can't be avoided, or could it?

If we, you and me had looked at the recent evidence and studies on medical marijuana and using our collective wisdom and knowledge adopted a policy for the use and practice of Medical Marijuana then my step-daughter quality of life would and will be much better, thought nigher you or I can save her life we can by our actions give her some easy of life as she dies. If this medical marijuana practice was available now she could of used medical marijuana to relieve stress, her depression, and as a sleep aid. it would of replaced 2 of her anti-depression medicines, it would of replace the 5 of her anti-vomiting medication she is using. It would replace or reduce the amounts of Oxycodone and Fentanyl she is taking as pain medications, these medication require additional piggy-back drugs to counter the side effect of the pain medicine.

What other benefits are there to adopting medical marijuana laws in the State of Kansas, they are all financial and seem piety to me when I think of my step-daughter needs. Because I lost my job and have no health care plan, Kansas has had to pay for the majority of Morgan's medication over the last year and it has run into the hundreds of thousands of dollars. If medical marijuana was allowed it would of greatly reduced the burden on the State. For example the 5 anti-vomiting medication cost from $35.00 per script, $2000.00 for 18 pills, of which none would be needed if she used medical marijuana.
I ask you and my elected governing body to study the 12 states that have adopted some form of medical marijuana law and follow suite and write one for those people like Morgan Tindall.

Senate Health Care Strategies
Committee
Date: February 11, 2009
Attachment 6

Alaska

State Laws | Leyes Estatales

State Laws
- AK Marijuana Penalties
  Penas Estatales
- AK Medical
- (No DUID law)
- (No tax stamp law)
- (No hemp law)

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Alaska

SUMMARY: Fifty-eight percent of voters approved Ballot Measure #8 on November 3, 1998. The law took effect on March 4, 1999. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*; *chronic pain*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea.* Other conditions are subject to approval by the Alaska Department of Health and Social Services. Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

AMENDMENTS: Yes.

Senate Bill 94, which took effect on June 2, 1999, mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

CONTACT INFORMATION: For more information on Alaska's medical marijuana law, please contact:

Alaskans for Medical Rights
P.O. Box 102320
Anchorage, AK 99510
(907) 277-AKMR (2567)

Application information for the Alaska medical marijuana registry is available by writing or calling:

Alaska Department of Health and Social Services
P.O. Box 110699
Juneau, AK 99811-0699
(907) 465-5423
Attention: Terry Ahrens
terry_ahrens@health.state.ak.us

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Maryland

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- MD Medical
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- MD Hemp Law

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Maryland

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Maryland's legislature passed a medical marijuana affirmative defense law in 2003. This law requires the court to consider a defendant's use of medical marijuana to be a mitigating factor in marijuana-related state prosecution. If the patient, post-arrest, successfully makes the case at trial that his or her use of marijuana is one of medical necessity, then the maximum penalty allowed by law would be a $100 fine.

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Hawaii

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Hawaii

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SUMMARY: Governor Ben Cayetano signed Senate Bill 862 into law on June 14, 2000. The law took effect on December 28, 2000. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*; *chronic pain*; *Crohn's disease*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Hawaii Department of Health. Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

AMENDMENTS: No, although Hawaii has a separate statute allowing patients arrested on marijuana charges to present a "choice of evils" defense arguing that their use of marijuana is medically necessary.

CONTACT INFORMATION: Administrative rules for Hawaii's medical marijuana program are available online from the Drug Policy Forum of Hawaii website at: http://www.dpfhi.org/

Application information for the Hawaii medical marijuana registry is available by writing or calling:

Hawaii Department of Public Safety
919 Ala Moana Boulevard
Honolulu, HI 96814
(808) 594-0150

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Rhode Island

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SUMMARY: The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act took effect immediately upon passage on January 3, 2006. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "written certification" from their physician stating, "In the practitioner's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient." Patients diagnosed with the following illnesses are afforded legal protection under this act: cachexia; cancer; glaucoma; Hepatitis C; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's Disease; or agitation of Alzheimer's Disease. Other conditions are subject to approval by the Rhode Island Department of Health. Patients (and/or their primary caregivers) may legally possess 2.5 ounces of cannabis and/or 12 plants, and their cannabis must be stored in an indoor facility. The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not register with the Department of Health, but have received certification from their physician to use medicinal cannabis, may raise an affirmative defense at trial.

AMENDMENTS: Yes.

In June 2007, the Rhode Island House and Senate enacted legislation eliminating the sunset clause of the The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, making the provisional program permanent

CONTACT INFORMATION: http://www.health.state.ri.us/
Application Forms are available at www.health.ri.gov/hsr/mmp/index.php or by visiting room 104 at the Health Department, 3 Capitol Hill, Providence.

More helpful information can be found here: http://ripatients.org/.

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Maine

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  Penas Estatales
- **ME Medical**
- (No DUID law)
- (No tax stamp law)
- ME Hemp Law

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Maine

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SUMMARY: Sixty-one percent of voters approved Question 2 on November 2, 1999. The law took effect on December 22, 1999. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." Patients diagnosed with the following illnesses are afforded legal protection under this act: *epilepsy and other disorders characterized by seizures*; *glaucoma*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea or vomiting as a result of AIDS or cancer chemotherapy*. Patients (or their primary caregivers) may legally possess no more than one and one-quarter ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession. The law does not establish a state-run patient registry.

AMENDMENTS: Yes. Senate Bill 611, which was signed into law on April 2, 2002, increases the amount of useable marijuana a person may possess from one and one-quarter ounces to two and one-half ounces.

CONTACT INFORMATION: Brochures outlining Maine's medical marijuana law are available from:

www.mainecommonsense.org

Mainers for Medical Rights
P.O Box 746
Gorham, ME 04084
(800) 846-1039

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Vermont

State Laws | Leyes Estatales

State Laws
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  Penas Estatales
- **VT Medical**
- (No DUID law)
- (No tax stamp law)
- VT Hemp Law

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Vermont

SUMMARY: Senate Bill 76 became law without Gov. James Douglas' signature on May 26, 2004. The law takes effect on July 1, 2004. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients diagnosed with a "debilitating medical condition." Patients diagnosed with the following illnesses are afforded legal protection under this act: HIV or AIDS, cancer, and Multiple Sclerosis. Patients (or their primary caregiver) may legally possess no more than two ounces of usable marijuana, and may cultivate no more than three marijuana plants, of which no more than one may be mature. The law establishes a mandatory, confidential state-run registry that issues identification cards to qualifying patients.

AMENDMENTS: Yes.

Senate Bill 7, which took effect on JULY 1, 2007, expands the definition of "debilitating medical condition" to include: "(A) cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms; or (B) a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome; severe pain; severe nausea; or seizures."

The measure also raises the quantity of medical cannabis patients may legally possess under state law from one mature and/or two immature plants to two mature and/or seven immature plants. Senate Bill 7 also amends state law so that licensed physicians in neighboring states can legally recommend cannabis to Vermont patients.

Marijuana Registry
Department of Public Safety
03 South Main Street
Waterbury, Vermont 05671
802-241-5115
www.safeaccessnow.org/article.php?id=2012

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Colorado

State Laws | Leyes Estatales

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- CO Medical
- (No DUID law)
- (No tax stamp law)
- (No hemp law)

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Home > State By State Laws > Colorado (medical)

Colorado

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SUMMARY: Fifty-four percent of voters approved Amendment 20 on November 7, 2000, which amends the state's constitution to recognize the medical use of marijuana. The law took effect on June 1, 2001. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.) Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*; *chronic pain*; *chronic nervous system disorders*; *epilepsy and other disorders characterized by seizures*; *glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Colorado Board of Health. Patients (or their primary caregivers) may legally possess no more than two ounces of usable marijuana, and may cultivate no more than six marijuana plants. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

CONTACT INFORMATION: Application information for the Colorado medical marijuana registry is available online or by writing:

Colorado Department of Public Health and Environment
HSVR-ADM2-A1
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184
http://www.cdphe.state.co.us/hs/medicalmarijuana/fullpacket.pdf

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California

State Laws | Leyes Estatales

State Laws
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- CA Medical
- (No DUID law)
- (No tax stamp law)
- CA Hemp Law

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Home > State By State Laws > California (medical)

California

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SUMMARY: Fifty-six percent of voters approved Proposition 215 on November 5, 1996. The law took effect the following day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act. Conditions typically covered by the law include but are not limited to: *arthritis*; *cachexia*; *cancer*; *chronic pain*; *HIV or AIDS*; *epilepsy*; *migraine*; and *multiple sclerosis*. No set limits regarding the amount of marijuana patients may possess and/or cultivate were provided by this act, though the California Legislature adopted guidelines in 2003.

AMENDMENTS: Yes. Senate Bill 420, which was signed into law in October 2003 and took effect on January 1, 2004, imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess. Under the guidelines, qualified patients and/or their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when such quantities are recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.

Senate Bill 420 also mandates the California Department of State Health Services to establish a voluntary medicinal marijuana patient registry, and issue identification cards to qualified patients. To date, however, no such registry has been established.

Senate Bill 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

CONTACT INFORMATION: For more information on California's medical marijuana law, please contact:

California NORML
2215-R Market Street #278

Oregon

State Laws | Leyes Estatales

State Laws
- OR Marijuana Penalties
  Penas Estatales
- **OR Medical**
- (No DUID law)
- (No tax stamp law)
- (No hemp law)

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Oregon

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SUMMARY: Fifty-five percent of voters approved Measure 67 on November 3, 1998. The law took effect on December 3, 1998. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms. Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*; *chronic pain*; *epilepsy and other disorders characterized by seizures; glaucoma*; *HIV or AIDS*; *multiple sclerosis and other disorders characterized by muscle spasticity*; and *nausea*. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources. Patients (or their primary caregivers) may legally possess no more than three ounces of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

AMENDMENTS: Yes.

House Bill 3052, which took effect on July 21, 1999, mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to *Alzheimer's disease* to the list of debilitating conditions qualifying for legal protection.

In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient; ... is primarily responsible for the care and treatment of the patients; ... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."

Also, Senate Bill 1085, which took effect on January 1, 2006, raises the quantity of cannabis that authorized patients may possess from seven plants (with no more than three mature) and three ounces of cannabis to

Nevada

State Laws | Leyes Estatales

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  Penas Estatales
- NV Medical
- NV Drugged Driving (DUID)
- NV Tax Stamps
- (No hemp law)

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Nevada

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SUMMARY: Sixty-five percent of voters approved Question 9 on November 7, 2000, which amends the states' constitution to recognize the medical use of marijuana. The law took effect on October 1, 2001. The law removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition. Patients diagnosed with the following illnesses are afforded legal protection under this act: *AIDS; cancer; glaucoma*; and *any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain*. Other conditions are subject to approval by the health division of the state Department of Human Resources. Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than seven marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

AMENDMENTS: No.

CONTACT INFORMATION: Application information for the Nevada medical marijuana registry is available by writing or calling:

Nevada Department of Agriculture
P.O. Box 11279
Reno, NV 89510
(775) 688-1180
(Attention: Jennifer Bartlett)

Cannacare, Patients Helping Patients
Cannacare provides a wide range of services patients such as helping patients fill out their paperwork, connecting patients with doctors who sign recommendations for the state, and assisting with legal advice as well as many other types of assistance and advice.
contact@cannacare.org
866-464-5098

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Montana

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- (No tax stamp law)
- MT Hemp Law

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Montana

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SUMMARY: Sixty-two percent of voters approved Initiative 148 on November 2, 2004. The law took effect that same day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physicians authorizing the medical use of marijuana. Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures, including but not limited to seizures caused by epilepsy; or severe or persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis or Crohn's disease.* Patients (or their primary caregivers) may possess no more than six marijuana plants. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

AMENDMENTS: No

www.dphhs.mt.gov/medicalmarijuana/

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Washington

State Laws | Leyes Estatales

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- WA Marijuana Penalties
  Penas Estatales
- WA Medical
- (No DUID law)
- (No tax stamp law)
- (No hemp law)

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Washington

SUMMARY: Fifty-nine percent of voters approved Measure 692 on November 3, 1998. The law took effect on that day. It removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks." Patients diagnosed with the following illnesses are afforded legal protection under this act: *cachexia*; *cancer*; *HIV or AIDS*; *epilepsy*; *glaucoma*; *intractable pain* (defined as pain unrelieved by standard treatment or medications); and *multiple sclerosis*. Other conditions are subject to approval by the Washington Board of Health. Patients (or their primary caregivers) may legally possess or cultivate no more than a 60-day supply of marijuana. The law does not establish a state-run patient registry.

AMENDMENTS: Yes.

Senate Bill 6032, which takes effect on July 22, 2007, mandates the Department of Health to "adopt rules defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients." The Department is instructed to report its findings to the legislature by July 1, 2008.

Patients who possess larger quantities of cannabis than those approved by the Department will continue to receive legal protection under the law if they present evidence indicating that they require such amounts to adequately treat their qualifying medical condition.

Senate Bill 6032 also affirms changes previously recommended by the state's Medical Quality Assurance Commission to expand the state's list of qualifying conditions to include Crohn's disease, hepatitis c, and any "diseases, including anorexia, which results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and/or spasticity, when these symptoms are unrelieved by standard treatments or medications."

The new law also limits the ability of police to seize medicinal cannabis that is "determined ... [to be] possessed lawfully [by an authorized patients] under the ... law."

CONTACT INFORMATION: Fact sheets outlining Washington's medical marijuana law are available from:

Washington State Department of Health
1112 SE Quince St.

Session of 2008

SENATE BILL No. 556

By Committee on Health Care Strategies

2-5

AN ACT concerning controlled substances; establishing the medical marijuana defense act.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) This section shall be known and may be cited as the "medical marijuana defense act".

(b) As used in this section:

(1) "Debilitating medical condition" may include, but is not limited to, one or more of the following:

(A) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease or the treatment of these conditions; or

(B) a chronic or debilitating disease or its treatment that produces one or more of the following: Cachexia or wasting syndrome; severe pain; severe nausea; seizures, including, but not limited to, those characteristic of epilepsy; bladder spasticity or inflammation or severe and persistent muscle spasms, including, but not limited to, those characteristic of multiple sclerosis.

(2) "Written certification" means a document signed by a physician who is also in good standing with the state board of healing arts, stating that in the physician's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition or its treatment. A written certification shall be made only in the course of a bona fide physician-patient relationship after the physician has completed a full assessment of the qualifying patient's medical history. The written certification shall specify the qualifying patient's debilitating medical condition.

(3) "Drug paraphernalia" has the meaning ascribed to it in K.S.A. 65-4150, and amendments thereto.

(4) "Marijuana" has the meaning ascribed to in subsection (o) of K.S.A. 65-4101, and amendments thereto.

(5) "Physician" has the meaning ascribed to it in K.S.A. 65-6112, and amendments thereto.

(6) "Tetrahydrocannabinol" has the meaning ascribed to it in K.S.A. 65-4105, and amendments thereto.

(c) It shall be a defense to prosecution under K.S.A. 65-4152 or 65-4162, and amendments thereto, that the person in possession or control of marijuana or tetrahydrocannabinol or drug paraphernalia to aid in the use of such substances has received written certification as defined in subsection (b).

(d) A physician shall not be subject to criminal or civil liability, denied any right or privilege or be subject to a disciplinary action by the state board of healing arts or by any other business or occupational or professional licensing board or bureau, solely for providing a written certification or for otherwise stating that, in the practitioner's professional opinion, a patient is likely to receive therapeutic benefit from the medical use of marijuana to treat or alleviate the patient's serious or debilitating medical condition, its symptoms or symptoms caused by treatment of such disease, provided that nothing shall prevent a professional licensing board from sanctioning a practitioner for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

(e) A registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth or insular possession of the United States that allows the medical use of marijuana shall not have the same force and effect as a written certification issued by a physician, and shall not constitute a defense to prosecution for possession or control of marijuana or tetrahydrocannabinol or drug paraphernalia in a court of law in Kansas.

(f) The provisions of this section shall be part of and supplemental to the uniform controlled substances act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

SB 556
Kansas Medical Marijuana Defense Act
Written Testimony
Susan Hughes Storm

My name is Susan Hughes Storm. I am 48 years old and live in El Dorado, Kansas. I have Multiple Sclerosis. I was diagnosed with MS 20 years ago when I was working for the USDA ASCS. After being diagnosed with this incurable debilitating disease, I have experienced deteriorating health. I am blessed with a doctor that I have great faith in, Dr. Donna Sweet from the Kansas University School of Medicine, and I have spent considerable time "on the couch" with a therapist studying how the mind can affect my health. So, I try to practice positive thinking, and count my blessings every day.

The first few years after being diagnosed with MS, my doctor and I tried different medications to relieve leg spasms, headaches, and lower back pain. I was accepted as one of the first patients to use Beta Interferon after it was approved by the FDA. Beta Interferon was the first MS drug released by the FDA. Studies had shown it to slow the progression of the disease by 17% and MS patients throughout the United States were eager to try it. I was so excited. The drug is an injection I gave myself every other day. It had terrible side effects and left huge welts on my skin. It cost $1,000 a month. My Insurance paid only half. One of the worst side effects at least for me was the depression. The 300 patients that were in the trial for this drug prior to the FDA releasing it also experienced depression side effects and 5 patients committed suicide. After a few months of trying Beta Interferon, I decided it was not for me. It took almost 12 months to feel like I got the drug completely out of my system and get over the depression.

I discussed using marijuana with my doctor and she said that I should do whatever I can to relieve my chronic pain, but that she could not prescribe marijuana because it is illegal in the state of Kansas. I began to smoke marijuana as a way to help with leg spasms. I found that it helped better than any other resource available with limited negative side effects. I usually smoked in my car in the garage, hiding like a criminal. I had a young daughter who thought marijuana was evil so I hid it from her. I made the mistake of leaving a very small amount in my car. During a routine investigation, a Sherriff's officer found my "stash". The judge told me I would have been OK had I just left it at home. I was given a diversion. I was also labeled a druggy and frowned upon by many in my community. Even my co-workers whom had all said that they would use it if it helped, turned away from me. "Guilt by

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 7

association", I believe that is what one of them said.

So here I am, several years later experiencing more pain than I ever imagined years before. Pain has taken over much of my life. I am limited on what I can do and all I do is try not to focus on pain. You know, that positive thinking thing. My doctor prescribed oxycodone. I tried it but cannot believe this is my only option to find relief from pain. This drug is a controlled substance, no wonder, I call it the loopy pill. I had difficulty functioning on this medication. And I still had pain. Enough pain that I did not think it was worth the side effects and quit taking it.

I have lower back pain that may be more manageable if I go into a wheel chair. I just cannot agree to do that yet . I am afraid that will accelerate my disability, by not forcing me to push myself. I have nerve pain that will shoot up one or the other of my arms that is so painful that at times it makes me cry. I compare it to the pain a wild animal must experience right before they chew off their foot that is caught in a trap.

I visited with my doctor and my pharmacist about the current pain medications available and we just looked at each other. Out of the list, I didn't find one acceptable. Some cause liver damage, others cause seizures. The three of us agreed that there is a need for something better. And although I can not speak for them, we did agree that I should be able to smoke marijuana. These are two women I have immense respect for. Women that spent years working hard to earn their degrees. Women that have dedicated their lives to medicine and the healing of others. So, when I hear others say there are current medications on the market that provide what marijuana does, or that marijuana doesn't have any medical benefits, I question where these people got their information. All I know for sure is what works and doesn't work for me.

I am here today supporting this bill because I believe serious and terminally ill people who use marijuana as medicine should be able to present this bill as evidence to a judge should they be arrested. I hope others will not have to endure the humiliation, cost and loss of reputation that I did. I hope you will support this compassionate act, and vote the bill onto the full Senate for consideration. Thank you for supporting this bill.

Susan Hughes Storm
427 Simpson Rd
El Dorado, Kansas 67042

Testimony to Kansas Senate Health Care Strategies Committee in Support of Kansas Medical Marijuana Defense Act

Rhonda O'Donnell
Rockville, Rhode Island

My name is Rhonda O'Donnell. I am a 45 year old woman who is a happily married mother of two. I am a registered nurse but can no longer work due to progressively worsening disability from multiple sclerosis.

I was an avid advocate for medical marijuana to be legalized in Rhode Island. I'm proud to say that after the RI legislature voted to override the Governor's veto of the bill that was passed to legalize medical marijuana; I was the first one in RI to apply for my medical marijuana ID card. This allows me to use marijuana, with my doctor's recommendation, to help alleviate some of the painful spasms that I suffer due to MS.

It is important to note that 99% of marijuana related arrests are done at the local and state level. When a state is compassionate enough to vote to legalize marijuana for medical purposes, it is PROTECTING it's residents. Federal DEA agents in RI stated that they are not going to arrest sick and dying people for using marijuana for medical purposes to help alleviate their symptoms.

Throughout my advocacy I encountered a wide array of people who would benefit from medical marijuana. Some were already using it, risking the embarrassment of possible arrest and legal consequences while others, like me, wanted to wait until it became legal. Some of the examples about people who benefited were from people who suffer from HIV/AIDS who benefited by regaining an appetite, people with chronic pain, people with cancer undergoing chemotherapy who alleviated their nausea and were able to eat, and people with MS suffering painful spasms.

Two of the examples were about people who died over 25 years ago! One was the mother of a friend of mine who was dying from colon cancer. She was constantly nauseas and retching with dry heaves. Her daughter had just graduated from college, had heard that marijuana helped with nausea and appetite, and suggested it to her mother. Her mother was a straight laced, law abiding woman and at first refused. When she was desperate enough, she relented and tried it. The

marijuana quelled her nausea and restored her appetite. She still died of cancer, but at least some of her suffering was alleviated.

The other example was my father. He died in 1980 from cancer. After I began my advocacy a family member told me that my dad had tried it to help him through the side effects of chemotherapy. It broke my heart to think of my dad, a proud, upstanding member of the community having to sneak having a few hits of a joint to help ease his suffering. He had to worry about being caught and arrested in front of his 4 children.

It makes me wonder - how many other people have had to suffer needlessly during the 25 years since they had to and even for decades before that?

My neurologist once told me that marijuana has a way of crossing the blood/brain barrier in a way that just cannot be duplicated medically at this time. It gets to the nausea and pain centers almost immediately. I literally only have to take 2 hits of marijuana before I begin to feel the immediate relief of pain in my legs.

In RI the bill had the support of the RI Medical Society, the RI State Nurses Association, RI Academy for Family Physicians, United Nurses and Allied Professionals, the RI ACLU, and many individual physicians.

Our legislators passed a medical marijuana bill which our governor vetoed but then they overwhelming voted to override the veto. The first year it was passed they included a one year "sunset clause" so they could see if any problems were encountered within the first year. The following year they voted to make the law permanent since there was only one problem, a man broke the law by having more plants than the law allows so his ID was revoked. Hundreds of people have subsequently been able to protect themselves from local and state arrest by obtaining an ID card.

I urge you to please consider protecting the residents of Kansas by passing a medical marijuana law. Medical decisions should be made by doctors, not legislators. Please be compassionate and vote for a medical marijuana bill to protect patients and help them ease some of their suffering.

Sincerely,
Rhonda O'Donnell
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WRITTEN TESTIMONY IN SUPPORT OF SB 556: A BILL TO ESTABLISH "DEFENSE TO PROSECUTION" FOR MEDICAL MARIJUANA PATIENTS IN KANSAS, BEFORE THE SENATE COMMITTEE ON HEALTH CARE STRATEGIES

By Paul Armentano
Deputy Director
NORML | NORML Foundation
Washington, DC
paul@norml.org

February 11, 2008

I applaud the members of the Kansas Committee on Health Care Strategies for holding this hearing regarding SB 556, which seeks to allow for a "defense to prosecution" for select medical marijuana patients who possess a written authorization from a state-licensed physician.

Specifically, this bill would allow state judges and juries to consider a patient's use of medical cannabis as a mitigating factor at trial. This common sense and humane proposal will ensure patients charged with minor marijuana offenses will be able to present evidence at trial regarding their therapeutic use of cannabis to treat a serious medical condition. This bill would not alter existing laws prohibiting the possession and use of marijuana for recreational purposes.

I have examined the science surrounding the medicinal use of cannabis and its active compounds (known as cannabinoids) for fourteen years. During this time, I have published more than 500 articles and white papers on the subject in numerous journals, anthologies, and college textbooks.

I also have work experience as a consultant for London's biotechnology firm GW Pharmaceuticals (http://www.gwpharm.com) – the only company legally licensed in the world to cultivate medical cannabis and perform clinical trials on various preparations of oral spray cannabis extracts. These extracts are legally available by prescription in Canada as well as on a limited basis in Spain and the United Kingdom under the trade name Sativex. Clinical trials assessing the efficacy of Sativex on cancer pain are ongoing in North America under the guidance Dr. Russel K. Portenoy, Chairman of the Department of Pain Medicine and Palliative Care at Beth Israel Medical Center in New York City.

Most recently, I authored the booklet, *Emerging Clinical Applications for Cannabis and Cannabinoids: A Review of the Recent Scientific Literature* (2008, NORML Foundation), which critically reviews the efficacy of cannabis or cannabinoids in the treatment of 17 clinical indications, including HIV, Alzheimer's disease, cancer, fibromyalgia, multiple sclerosis, osteoporosis, rheumatoid arthritis, and Tourette's syndrome.

I profiled these conditions because patients from around the nation write me inquiring about the use cannabis therapy to treat these debilitating illnesses. Many of them seek guidance not only for themselves, but also for their physicians, so they can begin to engage in an open dialogue regarding their medicinal use of marijuana.

While researching this book, I discovered that many of the conditions profiled in it – such as HIV and multiple sclerosis – could be successfully moderated by cannabis therapy. In several cases, cannabinoids may halt the progression of these diseases in a more efficacious manner than available pharmaceuticals. In virtually all cases, my report is the most thorough and comprehensive review of the recent scientific literature regarding the therapeutic use of cannabis and cannabinoids. An online edition of this booklet is available for review by members of the Committee at: http://www.norml.org//index.cfm?Group_ID=7002.

While writing this booklet, I reviewed more than 150 clinical and preclinical studies assessing the therapeutic value of cannabis and its active compounds. The findings of many of these studies have significant public policy implications.

For example, 2006 paper published by the National Institutes of Health (NIH) and the National Institute on Alcohol Abuse and Alcoholism concludes that cannabinoids "hold therapeutic promise in a wide range of disparate diseases and pathological conditions, ranging from mood and anxiety disorders, movement disorders such as Parkinson's and Huntington's disease, neuropathic pain, multiple sclerosis and spinal cord injury, to cancer, atherosclerosis, myocardial infarction, stroke, hypertension, glaucoma, obesity/metabolic syndrome, and osteoporosis."[1]

Though impressive, this list of clinical conditions that may be improved by cannabis is far from exhaustive. For instance, investigators at The Scripps Research Institute in California in 2006 reported that THC inhibits the enzyme responsible for the aggregation of amyloid plaque — the primary marker for Alzheimer's disease — in a manner "considerably superior" to approved Alzheimer's drugs such as donepezil and tacrine.

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[1] Pacher et al. 2006. The endocannabinoid system as an emerging target of pharmacotherapy. *Pharmacological Reviews* 58: 389-462.

"Our results provide a mechanism whereby the THC molecule can directly impact Alzheimer's disease pathology," researchers concluded. "THC and its analogues may provide an improved therapeutic [option] for Alzheimer's disease [by]... simultaneously treating both the symptoms and the progression of [the] disease."[2]

Following the publication of this study, investigators writing in the *British Journal of Pharmacology*, stated, "[C]annabinoids offer a multi-faceted approach for the treatment of Alzheimer's disease by providing neuroprotection and reducing neuroinflammation, whilst simultaneously supporting the brain's intrinsic repair mechanisms by augmenting neurotrophin expression and enhancing neurogenesis. ... Manipulation of the cannabinoid pathway offers a pharmacological approach for the treatment of AD that may be efficacious than current treatment regimens."[3]

Recent scientific studies also indicate that cannabis can effectively and safely treat symptoms of HIV as well as the side effects of various antiretroviral medications. Last February, investigators at San Francisco General Hospital and the University of California's Pain Clinical Research Center assessed the efficacy of inhaled cannabis as a treatment for HIV-associated sensory neuropathy. Writing in the journal *Neurology*, researchers reported that patients who smoked low-grade cannabis three times daily experienced, on average, a 34 percent reduction in pain.[4]

Investigators at Columbia University also published clinical trial data in 2007 reporting that HIV/AIDS patients who inhaled cannabis four times daily experienced "substantial ... increases in food intake ... with little evidence of discomfort and no impairment of cognitive performance." They concluded, "Smoked marijuana ... has a clear medical benefit in HIV-positive [subjects]."[5] As a result, many experts now believe that "marijuana represents another treatment option in [the] health management" of patients with HIV/AIDS.[6]

Recent clinical and preclinical studies also suggest that cannabinoids may inhibit the progression of multiple sclerosis. Writing in the journal *Brain*, investigators at the

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[2] Eubanks et al. 2006. A molecular link between the active component of marijuana and Alzheimer's disease pathology. *Molecular Pharmaceutics* 3: 773-777.

[3] Campbell and Gowran. 2007. Alzheimer's disease; taking the edge off with cannabinoids? *British Journal of Pharmacology* 152: 655-662.

[4] Abrams et al. 2007. Cannabis in painful HIV-associated sensory neuropathy: a randomized placebo-controlled trial. *Neurology* 68: 515-521.

[5] Haney et al. 2007. Dronabinol and marijuana in HIV-positive marijuana smokers: caloric intake, mood, and sleep. *Journal of Acquired Immune Deficiency Syndromes* 45: 545-554.

[6] Fogarty et al. 2007. Marijuana as therapy for people living with HIV/AIDS: social and health aspects *AIDS Care* 19: 295-301.

University College of London's Institute of Neurology recently reported, "[C]annabis may also slow the neurodegenerative processes that ultimately lead to chronic disability in multiple sclerosis and probably other disease."[7]

Clinical data reported in 2006 from an extended open-label study of 167 multiple sclerosis patients found that use of whole plant cannabinoid extracts relieved symptoms of pain, spasticity, and bladder incontinence for an extended period of treatment (mean duration of study participants was 434 days) without requiring subjects to increase their dose. [8]

Results from a separate two-year open label extension trial in 2007 also reported that the administration of cannabinoids was associated with long-term reductions in neuropathic pain in select MS patients. On average, patients in the study required fewer daily doses of the drug and reported lower median pain scores the longer they took it.[9] These results would be unlikely in patients suffering from a progressive disease like MS unless the cannabinoid therapy was halting its progression.

Finally, a growing body of scientific evidence now indicates that compounds in cannabis may actually halt the proliferation of various forms of cancer, including brain cancer, prostate cancer, breast cancer, lung cancer, skin cancer, pancreatic cancer, and lymphoma.[10]

It is unconscionable to think that under current state law, a patients who uses cannabis to effectively treat these and other serious, potentially lethal disease faces up to 10 years in jail for simply possessing or growing a plant that can alleviate their suffering. Passage of SB 556 would help to protect select patients so that they would no longer have to.

State law already allows for the medical use of many controlled substances, such as cocaine and morphine, which can be abused in a non-medical setting. Likewise, Kansas law should also properly differentiate between medicinal cannabis and other controlled substances. Please support SB 556 and help protect Kansas' patient community.

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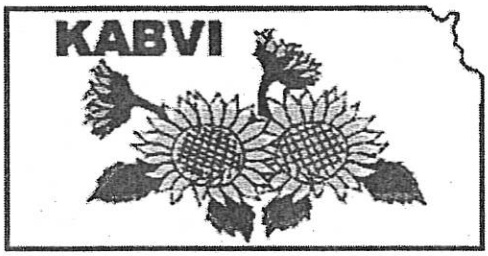
[7] Pryce et al. 2003. Cannabinoids inhibit neurodegeneration in models of Multiple Sclerosis. *Brain* 126: 2191-2202.

[8] Wade et al. 2006. Long-term use of a cannabis-based medicine in the treatment of spasticity and other symptoms of multiple sclerosis. *Multiple Sclerosis* 12: 639-645.

[9] Rog et al. 2007. Oromucosal delta-9-tetrahydrocannabinol/cannabidiol for neuropathic pain associated with multiple sclerosis: an uncontrolled, open-label, 2-year extension trial. *Clinical Therapeutics* 29: 2068-2079.

[10] Sarfarez et al. 2008. Cannabinoids for cancer treatment: progress and promise. *Cancer Research* 68: 339-342,



Kansas Association for the Blind And Visually Impaired

AFFIRMATIVE TESTIMONY: SENATE BILL 536

DELIVERED FEBRUARY 11, 2008

Committee on Health Care Strategies

Let us begin by explaining who we are and why we are appearing concerning this legislation. The Kansas Association for the Blind and Visually Impaired, Inc. (KABVI) is an all volunteer, consumer advocacy group made up of Kansans who are blind and visually impaired and advocates who are interested in issues relating to blindness and visual impairment. We were founded in Kansas in 1920. We have been an affiliate of the American Council of the Blind, a national advocacy group of people who are blind and visually impaired, sense 1961.

Like most individual Kansans, we are generally a conservative body. Our only interest has been to support issues that will bring the best possible quality of life about for blind and low vision Kansans. Our mission ever sense our incorporation nearly 88 years ago has been to make every blind or visually impaired Kansan a contributing and self-supporting citizen.

We have many members and associates who have lost vision due to glaucoma. Although leading causes of blindness change from study to study, glaucoma is almost always shown to be among the top three causes of blindness. It is well clinically documented that use of cannabis, in many cases, is effective in reducing glaucoma pressure, thereby assisting in retaining vision and reducing glaucoma pain.

Many of the traditional topical medications used in the treatment of glaucoma have side effects that cause severe pain as well, and in some patients, effective pressure control medications cause severe nausea, headaches, heart damage, and other completely unacceptable side effects.

We are not going to tell you that our Organization has hundreds of members or associates who would benefit from and use cannabis in controlling glaucoma pain and pressure should this Legislation be enacted. The numbers realistically are probably more in single digits. We are aware from the descriptions of many glaucoma sufferers, however, how very severe the pain and suffering of glaucoma can be when this illness and its related pressures can not be controlled by traditional means. We submit that if enactment of this

Legislation can save the vision, or reduce the pain and suffering of even one Kansan, who suffers from glaucoma, and who has not been able to effectively control pressures, or tolerate current traditional treatment methods, adoption of this legislation is worth while. There is no public harm, and potentially tremendous public benefit.

We are attaching a resolution on this subject, adopted by our membership at our fall, 2007 Annual Meeting. Thank you.

FOR ADDITIONAL INFORMATION, contact:
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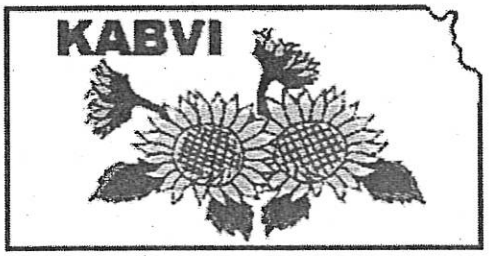

Kansas Association for the Blind And Visually Impaired

RESOLUTION 03-07

WHEREAS, there is a compelling body of scientifically conducted medical research documenting that cannabis has therapeutic impacts in lowering glaucoma pain and pressure, and that cannabis can therefore assist glaucoma sufferers in retaining vision, and also reducing pain and discomfort caused by glaucoma; and

WHEREAS the National academy of Science: Institute of Medicine has reviewed relevant research and concluded that there are some circumstances in which use of cannabis is a legitimate medical treatment, and

WHEREAS, the American Council of the Blind (ACB) has been on record as supporting the medical use of cannabis as an option for treatment of glaucoma subsequent to ACB's adoption of Resolution 85-20 in 1985, and

WHEREAS the Kansas Compassionate Care Coalition will be introducing legislation in the 2008 session of the Kansas Legislature which would permit use of cannabis for medical purposes, when prescribed and monitored by licensed physicians in Kansas, and

WHEREAS former Kansas Attorney General, Robert T. Stephan, has sent a letter to the Kansas Association for the Blind and Visually Impaired (KABVI) expressing his support for use of cannabis for medical purposes in Kansas, when prescribed and monitored by a Kansas physician, and has asked KABVI to support legislation to permit this practice.

NOW THEREFORE BE IT RESOLVED by KABVI, in convention assembled this 19th day of October, 2007, that this organization directs its officers, staff, and Legislative Committee to support, and offer affirmative testimony, concerning Legislation addressing use of cannabis for medical purposes that is supported by the Kansas Compassionate Care Coalition and by former Attorney General Stephan.

Testimony to Senate Health Care Strategies committee.
February 11, 2008
Eric A. Voth, M.D., Chairman
The Institute on Global Drug Policy

Senator Wagle, members of the committee:

I am a practicing Internal medicine and addiction medicine specialist. I also serve as the chairman of the Institute on Global Drug Policy and am Editor in Chief of the Journal on Global Drug Policy and Practice. I have worked internationally for close to 30 years against drug abuse and more recently against the medical excuse marijuana movement.

I oppose SB 556 from several standpoints. SB 556 creates a defense to possession which in effect is a "get out of jail free card" for individuals who are able to convince a physician that they should possess marijuana. **Medical excuse marijuana as set forth in this bill is opposed by the FDA, it bypasses the FDA, and it creates marijuana by popular vote.** It is a dangerous precedent that has been a disaster in other states. Please see the attached formal position of the FDA. The Kansas Medical Society, Kansas State Board of Healing Arts, Kansas Board of Pharmacy, Kansas Nurses Association, and a large coalition of drug prevention and treatment professionals all oppose marijuana as a medicine.

The advocates of marijuana are making the outlandish claims with anedoctal or no evidence that marijuana should be used for the nausea of cancer chemotherapy and AIDS wasting, muscle spasms, chronic pain, glaucoma, anxiety, alcoholism, drug addiction, depression, and menstrual cramps. It is inconceivable to allow the smoking of any medical substance as a delivery system. While the major active ingredient in marijuana, THC is available as a legal medicine, marijuana is a poor excuse for a medicine. It is impure- containing 488 substances, and it is virtually impossible to assure what dose of THC is present with a particular grade. Marijuana samples range from 2% THC to around 30% THC.

There is no effective process for assuring purity or lack of contaminants. Marijuana smoke is very similar to tobacco smoke but contains higher amounts of cancer causing agents. Marijuana has recently been found to have a very narrow therapeutic window, and thus, the THC has actually increased pain in some patients and increased depression in some patients. Since liberalization of marijuana laws in England, cannabis related psychosis has skyrocketed. Marijuana causes trouble with memory, concentration, and driving performance. It is also addictive which could be an issue for younger, less debilitated patients.

Furthermore, despite the contentions of marijuana advocates, there is no evidence in the medical literature of a significant group of patients who have truly failed all other therapies, that would clearly benefit from marijuana.

Finally, throughout the country and here in Kansas the medical excuse movement is driven by advocates of marijuana legalization. This current bill was proposed by the Kansans for Compassionate Care which is a spin-off of the Drug Policy Forum of Kansas. Despite their protestations and denials, their intent is clear. It is to soften drug policy and to make marijuana more accessible. They are doing this on the backs of the sick and suffering and taking advantage of patients with chronic illnesses.

I urge you to vote against the progression of this bill.

Institute on Global Drug Policy

Dear Senator Wagle:
Recently, the Kansas Medical Society, Kansas State Nurses Association, Kansas State Board of Healing Arts, and the Kansas State Board of Pharmacy have taken positions opposing the use of marijuana as a medicine. I hope that you will not allow such a flawed concept to progress.

It is most important to understand that legislative actions giving access to marijuana seriously jeopardize consumer protection. Our processes for bringing medicine to the public have been established so that science, not emotion, prevails. Medicine needs come through the FDA to assure safety and efficacy. The FDA opposes medical excuse marijuana and such legislative actions. More importantly, the recent legislative initiatives create medicine by popular vote.

What other drug would even be considered appropriate to deliver by smoking. Marijuana is not a safe drug, and is far from clearly effective. The active ingredients of marijuana are already available to the public by medical prescription. There is no advantage to smoking marijuana over available medications.

Allowing such legislation to become law is riding a wave of emotion and mob psychology that has been carefully crafted, financed, and driven by the marijuana lobby. They have declared that medical excuse marijuana is the battlefield to gain the overall legalization of pot. It is no different than the disinformation campaign that the tobacco lobby fought for years to manipulate the public.

While advocates may have their own opinions, they may not create their own facts. I have worked in opposition to the medical marijuana movement for close to 30 years, and the advocates strategy remains the same; play to emotion, overstate the benefits of marijuana, use the medical excuse to get the camel's nose under the tent and then push for more legal access to pot.

Some of the most consistently identified problems with marijuana are the effect on memory, concentration, and coordination. Studies have found that not only does marijuana have this effect acutely, but some effects have been identified even after 2 years of abstinence. The effects on driving skills and coordination are extremely serious, and marijuana is regularly implicated in trauma. Marijuana also has effects on the lungs, and has been found to damage lung immunity. Marijuana has serious effects on the fetus which has been documented not only at birth, but have also been seen in the children who used during pregnancy.

Supporting medical excuse marijuana either reflects serious ignorance of the medical literature, or malignant misrepresentation of it. Medicine and policy makers need to let cool heads prevail and stop this circus of medicine by popular vote which is dangerous and which plays in to the pot legalization lobby.

For a detailed scientific discussion of the medical excuse issue see www.globaldrugpolicy.org

Sincerely,

Eric A. Voth, M.D., FACP
Chairman, The Institute on Global Drug Policy
Topeka
Office phone: 785-354-0525

8-3

MEDICAL EXCUSE MARIJUANA
SUMMARY POINTS
ERIC A. VOTH M.D., FACP
Chairman- The Institute on Global Drug Policy

1. Modern medicine does not condone smoking medications or potions. We follow a process through the FDA to assure that medications are safe and effective. Marijuana has never passed the safety and efficacy tests by the FDA and thus jeopardizes consumer protection. The FDA opposes medical excuse marijuana. Medicine by popular vote is a dangerous precedent. Some treatments are thought to be useful but turn out to be ineffective or dangerous when submitted to rigorous scientific study.
2. Crude marijuana in any form does not constitute a medicine. The medical excuse is a Trojan horse propagated by the pro-marijuana lobby to ultimately legalize marijuana.
3. In states that have tried to have highly regulated restrictive statues allowing smoked marijuana for terminal or extremely ill patients, and the marijuana lobby liberalizes the rules later.
4. Few legitimate medical groups are supportive of the availability of crude marijuana as a medicine even though they may support research on individual cannabinoids.
5. THC is available as a medicine in a pure oral preparation. THC suppositories have been tested and found effective for appetite stimulation. Nasal sprays and aerosols are being developed of pure THC. Other substances exist, such as digoxin from foxglove plant or Taxol from the ewe tree, which have medicinal properties but which must be purified or synthesized to constitute medicine.
6. Many difficult logistical questions are not answered such as: Who would pay for the marijuana? Should the government have to shoulder that load or the patient. What type of marijuana would be legal? What concentration of THC would be allowed? Would it only be standard government marijuana or any marijuana. Who is responsible for assuring purity and lack of contamination?
7. The medical marijuana defense bogs down courts prosecuting drug cases. Virtually anyone could contend medical uses for bogus medical ailments. Protection is also being sought for those who deal marijuana for supposed medical applications.
8. Vehicular trauma and related DUI problems could increase if significant increases in marijuana use occurred. Further, the medical marijuana defense could easily be used to cover such offenses.
9. Open acceptance of marijuana for medical uses interfere with enforcing drug screening because of alleged medicinal applications.
10. The United States Court of Appeals has set forth a decision which strikes down crude marijuana as a medicine.

KANSAS MEDICAL SOCIETY
KMS

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Statement of the Kansas Medical Society
on the use of marijuana for medical purposes

October 13, 2007

The Kansas Medical Society believes patients are best served by medical treatment options which are proven to be safe and effective by the U.S. Food and Drug Administration (FDA). The FDA has not yet approved smoked marijuana for any condition or disease indication, and until such time as it receives that approval, KMS opposes the use of smoked marijuana for medical purposes. KMS does believe well-designed clinical research studies should be conducted on the potential therapeutic value of synthetic and plant-derived, non-smoked cannabinoids for pain relief, control of nausea and vomiting, and other conditions.

KANSAS

BOARD OF PHARMACY
DEBRA L. BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Kansas State Board of Pharmacy
Board Meeting
December 17, 2007

Subject: Availability of Leaf Marijuana for Medicinal Purposes

Resolution of the Board Approved: December 17, 2007

Whereas, the federal controlled substance act and the Kansas controlled substance act has scheduled marijuana as a Schedule I illegal drug and do not make medical necessity or acceptance an exception to its illegal use and distribution; and

Whereas, the Department of Health and Human Services, including the United States Food and Drug Administration have concluded that no scientific studies support medical use of marijuana for treatment in the United States; and

Whereas, all Kansans should be ensured safe medicinal practices through rigorous research and FDA standards; and

Whereas, there are safe and effective reliable medications that exist that are best for patients that provide compassionate symptom management; and

Whereas, marijuana is a frequently used illegal drug and has a high potential for abuse and abuse may lead to severe psychological or physical dependence; and

Whereas, laws that allow the use of marijuana raise serious regulatory challenges for state regulatory boards;

There, be it hereby

Resolved, That the Kansas State Board of Pharmacy opposes the smoking of marijuana (leaf marijuana) for medicinal applications unless first approved by the United States Food and Drug Administration.

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KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-02

Subject: **Use of Marijuana**
Date: **February 12, 2005**

WHEREAS, the United States Supreme Court has ruled (May 14, 2001) that the controlled Substances Act may not be violated by the sale of marijuana for medicinal purposes;

WHEREAS, the Supreme Court further opined that there is no medical necessity exception to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana;

WHEREAS, the recommendation of crude (smoked) marijuana for cancer chemotherapy, glaucoma, wasting in AIDS, depression, menstrual cramps, pain, and miscellaneous ailments (by Grinspoon 1993) are anecdotal and contain no controls, and no independent medical evaluation for efficacy or toxicity; and

WHEREAS, the best evidence of the effects of crude (smoked) marijuana indicate medical dependence, the gateway phenomenon, respiratory problems, spontaneous abortions, congenital mental impairment, reduction of immune response, and impairment of performance in operating aircraft or automobiles.

THEREFORE, BE IT RESOLVED that the Kansas Board of Healing Arts finds that medical uses of marijuana should be those, and only those, approved by the federal Food and Drug Administration; and

BE IT FURTHER RESOLVED that the Kansas Board of Healing Arts forward this resolution to the Federation of State Medical Boards requesting that it formulate model regulations incorporating the Kansas initiative.

Ray N. Conley DC

Ray N. Conley, D.C.
Board President

KSNA
KANSAS STATE NURSES ASSOCIATION

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Caring Hearts, Healing Hands

Susan Bumsted, M.N., R.N.
President

The Voice And Vision Of Nursing In Kansas

Terri Roberts, J.D., R.N.
Executive Director

2007 Resolution

Providing Patients Safe Access to Therapeutic Marijuana/Cannabis

Whereas, KSNA consistently advocates for compassionate and safe health care for all Kansans; and;
Whereas, current research does not offer sound evidence to support the medicinal use of smoked marijuana as an intervention in the management of symptoms associated with chronic/terminal disease processes (e.g., pain, anorexia, nausea); and
Whereas, the Food and Drug Administration (FDA) does not support the use of smoked marijuana for medical purposes; and
Whereas, all Kansans should be ensured of safe medicinal practices through rigorous research and FDA standards;

Be it resolved that the Kansas State Nurses Association:

Recognize the need for evidence-based practice surrounding the use of marijuana/cannabis as it relates to compassionate care of individuals who are refractory to other evidence-based methods of symptom management, and;

Support research through controlled investigational trials on the chemical components of marijuana, their therapeutic efficacy, associated toxicities, and alternative methods to smoked marijuana.

Adopted October 5, 2007.

FDA Statement

FOR IMMEDIATE RELEASE Statement April 20, 2006 Media Inquiries: FDA Press Office, 301-827-6242 Consumer Inquiries: 888-INFO-FDA

Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine

Claims have been advanced asserting smoked marijuana has a value in treating various medical conditions. Some have argued that herbal marijuana is a safe and effective medication and that it should be made available to people who suffer from a number of ailments upon a doctor's recommendation, even though it is not an approved drug.

Marijuana is listed in schedule I of the Controlled Substances Act (CSA), the most restrictive schedule. The Drug Enforcement Administration (DEA), which administers the CSA, continues to support that placement and FDA concurred because marijuana met the three criteria for placement in Schedule I under 21 U.S.C. 812(b)(1) (e.g., marijuana has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and has a lack of accepted safety for use under medical supervision). Furthermore, there is currently sound evidence that smoked marijuana is harmful. A past evaluation by several Department of Health and Human Services (HHS) agencies, including the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Drug Abuse (NIDA), concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use. There are alternative FDA-approved medications in existence for treatment of many of the proposed uses of smoked marijuana.

FDA is the sole Federal agency that approves drug products as safe and effective for intended indications. The Federal Food, Drug, and Cosmetic (FD&C) Act requires that new drugs be shown to be safe and effective for their intended use before being marketed in this country. FDA's drug approval process requires well-controlled clinical trials that provide the necessary scientific data upon which FDA makes its approval and labeling decisions. If a drug product is to be marketed, disciplined, systematic, scientifically conducted trials are the best means to obtain data to ensure that drug is safe and effective when used as indicated. Efforts that seek to bypass the FDA drug approval process would not serve the interests of public health because they might expose patients to unsafe and ineffective drug products. FDA has not approved smoked marijuana for any condition or disease indication.

A growing number of states have passed voter referenda (or legislative actions) making smoked marijuana available for a variety of medical conditions upon a doctor's recommendation. These measures are inconsistent with efforts to ensure that medications undergo the rigorous scientific scrutiny of the FDA approval process and are proven safe and effective under the standards of the FD&C Act. Accordingly, FDA, as the federal agency responsible for reviewing the safety and efficacy of drugs, DEA as the federal agency charged with enforcing the CSA, and the Office of National Drug Control Policy, as the federal coordinator of drug control policy, do not support the use of smoked marijuana for medical purposes.

VOTH EA, SCHWARTZ RH. Medicinal applications of Delta-9-tetrahydrocannabinol ANNALS OF INTERNAL MEDICINE1997;126:791-98
Examination of 6000 articles in the medical literature regarding marijuana and medicinal uses. Conclusion: The evidence does not support the reclassification of crude marijuana as a prescribable medicine. Other safe and effective medicines are available to patients, and there is nothing to gain from the use of smoked marijuana.

Schwartz RH, Voth EA, Sheridan MJ. Marijuana to Prevent Nausea and Vomiting in Cancer Patients: A Survey of Clinical Oncologists. Southern Medical Journal 1997: 90;167-172
1500 oncologists surveyed, **98%** had used Zofran or Kytril,
51% of respondents had prescribed Marinol for patients. 22% of these only used once or twice.
Only 12% of respondents had ever recommended smoking marijuana , and only **1%**
Had recommended more frequently than 5 times per year
28% of respondents favored rescheduling, **50% of those supported legalization**
48% opposed rescheduling
only 9% would prescribe more than 10 times annually if available to prescribe
10% changed their original support for marijuana as a medicine when presented with information on the media hype and marijuana movment.

Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors. Marijuana and Medicine: Assessing the Science Base Division of Neuroscience and Behavioral Health, Institute of Medicine. National Academy Press, Washington, D.C. 1999. Internet address www.nap.edu

RECOMMENDATIONS

Recommendation 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.

Recommendation 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

Recommendation 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence perceived medical benefits, should be evaluated in clinical trials.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

Recommendation 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.

Recommendation 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, non-smoked cannabinoid delivery systems.

Recommendation 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

* failure of all approved medications to provide relief has been documented;

* the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;

* such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness;

* and involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

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TABLE I

COMPARATIVE ANALYSIS OF MAINSTREAM SMOKE FROM MARIHUANA AND TOBACCO REFERENCE CIGARETTE.
(Average weight : 1.110 mg; Length : 85 mm)

Measurements	Marihuana Cigarette	Tobacco Cigarette
Gas phase		
Carbon monoxide, vol.%	3.99	4.58
Carbon dioxide, vol.%	8.27	9.38
Ammonia, µg	228	199
HCN, µg	532	498
Cyanogen $(CN)_2$, µg	19	20
Isoprene, µg	83	310
Acetaldehyde, µg	1,200	980
Acetone, µg	443	578
Acrolein, µg	92	85
Acetonitrile, µg	132	123
Benzene, µg	76	67
Toluene, µg	112	108
Vinyl chloride, ng*	5.4	12.4
Dimethylnitrosamine, ng*	75	84
Methylethylnitrosamine, ng*	27	30
Particulate phase		
Total particulate matter, dry, mg	22.7	39
Phenol, µg	76.8	138.5
O-Cresol, µg	17.9	24
m- and *p*- Cresol, µg	54.4	65
Dimethylphenol, µg	6.8	14.4
Catechol, µg	188	328
Cannabidiol, µg	190	-
Delta-9-tetrahydrocannabinol, µg	820	-
Cannabinol, µg	400	-
Nicotine, µg	-	2,850
N-Nitrosonornicotine, ng*	-	390
Naphthalene, µg	3	1.2
1-Methylnaphthalene, µg	6.1	3.65
2-Methylnaphthalene, µg	3.6	1.4
Benz(*a*)anthracene, ng*	75	43
Benzo(*a*)pyrene, ng*	31	21.1

* indicates known carcinogens.

From Marihuana and Health, National Academy of Sciences, Institute of Medicine Report, Washington, D.C., 1982.

Progression of Medical Excuse Marijuana Legislative proposals:

Once they get a "medical" marijuana law passed, they will come back in a year or two and seek to get another bill passed to expand "medical" marijuana in several ways:

1. THEY WILL SEEK TO EXPAND THE NUMBER OF MARIJUANA PLANTS THAT "PATIENTS" AND "CAREGIVERS" CAN POSSESS.

Vermont

In Vermont they tried to go from one plant to six mature marijuana plants and 18 immature plants, and from two to four ounces of marijuana that can be possessed..

How much pot can 6 plants produce? The typical marijuana plant produces 1 to 5 pounds of smokeable materials (leaves and buds). Maybe more if grown indoors under the right conditions. The 6 plants permitted by the bill can thus produce a minimum of 6 to 30 pounds of marijuana per year.

How many joints are in 6 to 30 pounds of pot? The typical marijuana cigarette (joint) weighs a gram. There are 28.35 grams in an ounce. Thus 1 ounce of pot will make approximately 28.35 joints. There are 16 ounces in a pound - thus 1pound of marijuana is approximately 454 joints (16 x 28.35).

The plants can produce 1 to 5 pounds. Thus, at a minimum, the 6 plants will produce approximately 2,724 joints (6 x 454). If the plants can produce up to 5 pounds each this is 30 pounds of marijuana or 13,620 joints.

The Vermont bill would permit the possession of 2,724 to 13,620 joints per person who has "mature" plants. They can also then possess 18 "immature plants." This is three times as much. What happens when the 18 plants "mature."

Maine

The expansion bill will permit "medical" marijuana patients to possess up to 12 marijuana plants. The old law permits 6 plants.

Rhode Island

In Rhode Island they expanded the number of plants a caregiver can have to 24 plants.

2. THEY WILL SEEK TO LIMIT LAW ENFORCEMENT.

Maine

The Maine expansion bill prohibits a law enforcement officer from cooperating with federal authorities in investigating, searching, arresting or prosecuting patients eligible to

receive marijuana for medical use or their care givers or registered dispensaries for "medical" marijuana. Any officer who does this can be fired. This is a "get out of jail free" card for abusers of the system.

Vermont

In Vermont they sought to remove the program from the Department of Public Safety to the Department of Health.

3. THEY WILL SEEK TO EXPAND THE "CONDITIONS" FOR WHICH MARIJUANA CAN BE USED.

Vermont

In Vermont the expansion bill added on vague "conditions"such as "a life-threatening, progressive, and debilitating disease or medical condition or its treatment that produces severe, persistent, and intractable symptoms such as: cachexia or wasting syndrome; severe pain; severe nausea; or seizures.

This is very subjective standard and was not backed up by scientific data. By not mentioning specific diseases, they allowed unethical doctors to be very subjective in deciding if someone "needs" marijuana for pain, nausea or seizures.

Maine

An expansion bill sought to expand the conditions that "medical" marijuana can be used for to include Crohn's disease and Alzheimer's disease.

Washington

The expansion bill in the State of Washington sought to add the following illnesses that medical marijuana can be used for: Crohn's disease, Hepatitis C; or diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity.

General comment

There is no scientific research regarding marijuana and its effectiveness and, its risks, benefits, dosages, interactions with other drugs, and impact on pre-existing conditions for all the above conditions. Studies on marijuana do not exist that show the quantity of dose, frequency of administration, duration of administration, time of administration, in relation to time of meals, time of onset of symptoms, or other time factors, route or method of administration of marijuana for all the medical conditions in these bills. These studies are a requirement before a drug can be used for medicine.

4. THEY WILL SEEK TO EXPAND THE NUMBER OF "CAREGIVERS" THAT CAN GIVE MARIJUANA TO "PATIENTS."

Rhode Island

In Rhode Island they sought to permit persons with felony drug convictions to be "care givers." The original law did not permit this.

Washington

The State of Washington expansion bill provides that medical marijuana providers will include anyone who has been designated in writing by a patient to serve as a designated provider. The providers will be able to engage in marijuana production and they can create a "sixty-day supply.

Maine

The Maine expansion bill allows anyone who can prescribe medication to recommend marijuana. This will increase opportunities for abuse. The Maine bill will also permit "medical" marijuana dispensaries.

5. THEY WILL SEEK TO LOWER COSTS FOR "PATIENTS."

In Vermont they tried to go from $100 for an approval to use marijuana to $50.

6. THEY WILL SEEK TO LOWER THE STANDARDS FOR OBTAINING "MEDICAL" MARIJUANA.

In the State of Washington expansion bill doctors will no longer have to weigh the risks of medical marijuana against the benefits before giving it to a patient.

FYI ARTICLE IN THE OREGONIAN WWW.OREGONLIVE.COM

Don't make a bad marijuana law worse

Monday, February 04, 2008

Ten years ago, when Oregon voters approved the state's landmark Medical Marijuana Act, they did so with assurances that only a handful of very ill people needed it -- perhaps 500 a year, supporters said at the time.

That turned out to be a false promise, as critics warned at the time. They appear to have correctly predicted that the new law would open the door for wider use of pot in Oregon by creating new legal defenses for the possession, use, cultivation and delivery of marijuana.

Statistics strongly suggest this. Today, nearly 16,000 Oregonians hold patient cards entitling them to use marijuana. Nearly 8,000 hold "caregiver cards" so they can possess it, and about 4,000 have permits to grow the plant, resulting in at least 19 tons of marijuana growing legally at any given time.

Not surprisingly, the rate of marijuana use by adult Oregonians is 50 percent higher than the national rate. Voters in 1998 may have thought they were showing compassion for a small number of terminally ill cancer patients who needed marijuana to alleviate their symptoms, but the law is clearly being abused in a big way.

This abuse is showing up in the workplace, where the Oregon drug test failure rate is 50 percent higher than the national rate. And the most prevalent reason for testing failure? Marijuana use -- 71 percent of all positive tests in Oregon, compared with 53 percent nationally.

The 2007 Legislature had a chance to address the workplace issue but fell short. A bill to make it easier for Oregon employers to enforce drug-free workplace policies, even against employees with valid medical marijuana cards, passed in the Senate but faltered in the House.

That was a sensible bill and deserves a second chance in the special session that begins today. Instead, however, the House Business and Labor Committee has put forth a much narrower bill that would give employers the option to regulate medical pot users in only the most dangerous of jobs.

This is a bad bill that will make Oregon's flawed law worse, not better. By giving employers discretion on accommodating medical marijuana use only by workers doing "hazardous duties," the bill would create a huge uncovered class of workers who would win the implicit right to accommodation at work -- something the original act explicitly did not grant.

In other words, this new bill is a Trojan horse. It would exempt such dangerous jobs as mining, logging and blasting, while creating the right to special accommodation for everyone else who might have marijuana cards, including surgeons, bus drivers, nannies and editorial writers.

Legislators should spike this bill. Instead, they should pass Senate Bill 465, clarifying the right of employers to enforce drug-free workplace policies.

And while they're at it, they should fund a Justice Department study of what increasingly appears to be widespread abuse of a well-intentioned medical marijuana law gone bad

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Testimony in Opposition of SB 556 before the Senate Committee on Health Care Strategies

Cristi Cain, Certified Prevention Professional, Shawnee Regional Prevention and Recovery Services
February 11, 2008

Chairperson Wagle and Members of the Committee,

I appear today on behalf of Shawnee Regional Prevention and Recovery Services and the Safe Streets Coalition of Topeka-Shawnee County. I am a Certified Prevention Professional and have worked in substance abuse prevention for 12 years. I currently serve as the State Coordinator for the Kansas Methamphetamine Prevention Project and work at the state and local level with the Kansas Alliance for Drug Endangered Children.

Medical marijuana is the pro-legalization movement's way of gaining a foothold in our state. The Food and Drug Administration, Drug Enforcement Administration, and the Office of National Drug Control Policy all oppose the use of smoked marijuana for medical purposes. Is it legitimate to prescribe a drug with over 400 carcinogens as a medical treatment?

As a prevention professional, one of my main concerns about medical marijuana is the message it sends to our youth. The message is that it is legal in some cases and it may have benefits. This is the wrong message. Shawnee County has one of the highest youth marijuana usage rates in the state with 45.8% of high school seniors having tried it at least once in their lifetime and 22.6% of high school seniors having used within the past 30 days. This is much higher than the state level of 36.7% and 16.6% respectively. Additionally, 59.4% of high school seniors in Shawnee County reported that one of their best friends had used marijuana within the past year. Every day in the United States, 3,577 youth try marijuana for the first time and 586,454 teens used marijuana. As a representative of the Safe Streets Coalition, I would like to report that significant progress has been made in addressing crime and safety issues in the community with a push to make Topeka the Safest Capital City (population 100,000 and above). Now is not the time to adopt legislation that will cause increased problems in our community.

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 9

In FY 2007, marijuana accounted for over 26% of treatment admissions (3,916 Kansas residents) to state-funded treatment organizations. If marijuana becomes legalized and normalized in Kansas what will happen to those numbers? Does Kansas have the treatment capacity to handle more marijuana addiction? History has shown that legalization increases addiction rates which is demonstrated by the fact that alcohol was the number one problem at admission to state-funded treatment organizations in FY2007.

Last year, I appeared before the Kansas Legislature testifying in favor of changes to the drug paraphernalia statute. Thank you for passing the legislation. It has made a huge difference in Kansas communities to the point where in some cases, 100% of stores have removed paraphernalia, including paraphernalia used for smoking marijuana. This statute was a huge step forward for communities to address marijuana and other drugs. I believe SB 556 is a huge step backwards and I urge you not to pass this legislation.

On a personal note, my family was devastated two years ago when my dad was diagnosed with Stage 4 cancer. He has suffered many debilitating symptoms as a result of the cancer and treatment. If my dad asked me if medical marijuana would provide him comfort, I would, without hesitation, tell him that marijuana has no medical value and there are many better, more effective treatment options. My heart goes out to patients and families who have conditions that they think will be relieved by marijuana. Medical marijuana is not the answer and has no place in healthy communities. Please help keep Kansas communities healthy and safe.

Kansas Bureau of Investigation

Robert E. Blecha
Director

Stephen N. Six
Attorney General

Testimony in Opposition of SB 556
Before the Health Care Strategies Committee
Jeffery Brandau, Special-Agent-in-Charge
Kansas Bureau of Investigation
February 11, 2008

Chairperson Wagle and Members of the Committee:

I am Jeffery Brandau and I am the Special-Agent-in-Charge of the Topeka Regional Special Operations Division of the Kansas Bureau of Investigation. I have been in law enforcement since 1982, and I have been the State of Kansas marijuana eradication coordinator since 1995. In 26 years of law enforcement I have seen first hand the damage that marijuana causes to individuals' lives and families. It is the most abused illegal drug in the United States and in Kansas.

I am here today representing the Kansas Bureau of Investigation and the Kansas Narcotics Officers Association and voicing our strong opposition to SB 556. Marijuana is derived from the hemp plant Cannabis Sativa. By drying the flowers and leaves of the plant and then shredding them, this makes up what we know as marijuana. Marijuana is most often ingested by smoking, but can be used as an ingredient in cooking or in a brewed tea. There are hundreds of variety of Cannabis Sativa each with differing compounds and potency of the main psychoactive (mind altering) ingredient delta-9-tetrahydrocannabinol or THC. In fact over 400 different chemical compounds are found in Cannabis Sativa.

Marijuana's impact on users is influenced by the potency of the THC that the marijuana contains. Higher THC can make psychotic and other reactions to marijuana such as: anxiety, agitation, delusions, amnesia, confusion and hallucinations more likely. Higher THC also increases the users risk for becoming dependent on the drug. THC content is affected by the strain of the plant and the method used to grow the plant; either indoors or outdoor growing.

Smoked marijuana enters the bloodstream in the lungs and reaches the brain in seconds, producing a powerful rush of pleasure. This intense high can fade within a few minutes taking the user down to more normal levels. Scientists believe that abuse is created when individuals attempt to repeat the drugs use to recreate this rush of pleasure. Use of marijuana has many dangers, not only addiction, but in change in heart rates by increasing the rate 20 to 100%, coordination needed for safe driving of machinery and

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 10

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vehicles, the ability of the mind to think clearly and comprehend, and a greater likely hood of anxiety and panic attacks. The National Highway Traffic Safety Administration (NHTSA) reports marijuana is the second most found drug in crash involved drivers, only alcohol is involved in more accidents.

The Comprehensive Drug Abuse Prevention and Control Act of 1970 in Title II is the Controlled Substances Act or CSA. The CSA placed substances into one of 5 categories depending on the substances potential for abuse and medical use. Schedule I drugs are those that have the highest potential for abuse and have **no currently accepted medical use in the United State.**

The Food and Drug Administration (FDA) approves drugs for over the counter or prescription. Currently the FDA has one approved cannabis-based drug approved for use and is called Marinol the trade name for a synthetic THC known as dronabinol. First approved as a schedule II drug it has since been moved to schedule III to make it more available to patients.

There have been attempts to reschedule marijuana but all have failed. In order for a drug within the CSA to meet the current accepted medical use it must meet 5 factors:

1) The drug's chemistry must be known and reproducible
2) There must be adequate safety studies
3) There must be adequate and well controlled studies to prove efficacy
4) The drug must be accepted by qualified experts and
5) The scientific evidence must be widely available

According to the Drug Enforcement Administration botanical marijuana meets none of these requirements.

The last attempt to reschedule marijuana was in 1995 and the investigation lasted until 2001. The Department of Health and Human Services (HHS) conducted the investigation and concluded that marijuana has a high potential for abuse and no currently accepted medical use.

In 1976 the FDA began to use marijuana in the Compassionate Use Program for seriously ill patients. Marijuana was provided to patients when marijuana was alleged to have a positive effect. Patients received government grown marijuana to treat a variety of symptoms. This ceased in 1991 when the National Institute of Health (NIH) concluded that marijuana was not the best treatment for any of the patients that were receiving it.

The most damage from passage of a SB 556 would be to tell our young people that marijuana is not dangerous and lower their perception of risk of using the drug. Of the 12 States with medical marijuana programs, 5 states (Alaska, Maine, Vermont, Montana, and Rhode Island) are represented in the top 10 states with the lowest perception of risk in using marijuana among individuals 12-17 years of age.

I have attached a lengthy study by the KBI on this issue of marijuana and medical use. Kansas has a compassionate and caring population. There is not one person in this room today that wouldn't do what they could to help alleviate the pain and suffering, many in our population endure from terrible diseases, that this bill would hope to help. The bottom line is that extensive studies have not proven the claim it helps in any way and the harm it would do to the society as a whole, makes this bill not in the best interest of the State.

Thank you and I would be happy to answer any questions you may have.

A Report

On

Medical Use of Marijuana In Kansas

Presented by:

The Kansas Bureau of Investigation
1620 SW Tyler
Topeka, Kansas 66612
(785) 296-8200

10-4

"Drugs like marijuana, heroin and cocaine are not dangerous because they are illegal;
They are illegal because they are dangerous."
~Joseph A. Califano, Jr., National Center for Addiction and Substance Abuse at Columbia University

Marijuana is the most commonly used illicit drug[1] in the United States and the most predominantly abused drug in Kansas[2]. In 2006, 60.5 percent of all reported drug offenses in Kansas involved the use, possession or sale of marijuana. In addition, more persons seek treatment for marijuana than any other drug in the state.[3] It is well known that marijuana is viewed as a gateway drug that can lead to abuse of other serious drugs like cocaine, methamphetamine, etc.

It is difficult to understand why anyone would want to legalize a drug that is so powerfully addictive, mind-altering and oftentimes leads to other illicit drug use, but advocates of drug legalization have been working since the 60s and 70s to reform drug policies. Organizations such as the National Organization for the Reform of Marijuana Laws (NORML) and the Drug Policy Foundation have little medical expertise and are very vocal about their support to legalize various illicit drugs. Pro-drug advocate Eric Sterling admits "It's the leaky bucket strategy. Legalize it in one area and sooner or later it will trickle down into the others."[4]

Pro-marijuana advocates have tried but, so far, have not been able to enact medical marijuana legislation in Kansas. In 1998, Senate Concurrent Resolution 1605 was brought before the State Legislature. The resolution sought to have the Kansas Department of Commerce and Housing form a task force to investigate and research the viability of nonpsychoactive industrial hemp as an alternative crop. The formation of such a task force sounded harmless enough but the bill was the first step toward their suspected agenda of legalizing marijuana. Fortunately, that bill did not receive much attention.

It's now ten years later and legalization proponents are actively pursuing their goal. Just recently, former Kansas Attorney General Robert "Bob" Stephan announced his support to help change the state law so that Kansas physicians can recommend the use of medical marijuana to their patients.[5]

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[1] DEA Briefs and Background, Drugs and Drug Abuse, Drug Descriptions, Marijuana, http://www.usdoj.gov/dea/concern/marijuana.html (January 7 2008)
[2] KBI, Incident Based Reporting, January 4 2007
[3] SRS Division of Health Care Policy, Policy Evaluation Research and Training, December 2007
[4] Testimony of Sandra S. Bennett, Director, Northwest Center for Health & Safety, President, Drug Watch International, The Drug Decriminalization Movement in America, June 13, 1999, p. 3
[5] University Daily Kansan, Former Attorney General Bob Stephan Advocates Medicinal Marijuana, August 22 2007, http://www.kansan.com/stories/2007/aug/22/marijuana (January 7 2008)

10-5

This paper offers points on the use of marijuana as a medicine and why the passage of such a law would simply be bad policy for Kansans.

Overview

I. Marijuana

Marijuana is a dry, shredded green/brown mix of flowers, stems, seeds, and leaves of the hemp plant Cannabis sativa. It is usually smoked as a cigarette (commonly referred to as joint), or in a pipe or bong (water-type pipe). It also is smoked in blunts (cigars that have been emptied of tobacco and refilled with marijuana), oftentimes in combination with another drug. It can also be mixed in food or brewed as a tea. In a more concentrated form it is called hashish and, as a sticky black liquid, it is called hash oil. Marijuana smoke has a distinctive odor; it resembles an almost sweet-and-sour smell. There are numerous street terms for marijuana including pot, herb, weed, grass and hash, as well as terms derived from trademarked varieties of cannabis, such as Bubble Gum, Northern Lights, Fruity Juice, Afghani #1, in addition to a number of Skunk varieties.[6]

II. How Marijuana Works

The marijuana plant contains more than 400 different chemical compounds, 66 of which – the cannabinoids – are unique to the plant. Its main psychoactive (mind-altering) ingredient is THC (delta-9-tetrahydrocannabinol).[7]

When a person smokes marijuana, THC passes from the lungs into the bloodstream, which carries the chemical to the brain and other organs. THC attaches cannabinoid to receptors on nerve cells in the brain and influences the activity of those cells. The number of receptors that cannabinoids attach to varies in the different regions of the brain; they are particularly abundant in the parts of the brain that influence coordinated movement like learning, memory, higher cognitive functions, pleasure, and sensory and time perception.[8]

Marijuana's impact on the user is influenced by the strength or potency of the THC it contains. Higher THC can make psychotic and other reactions to marijuana (anxiety, agitation, delusions, amnesia, confusion and hallucinations) more likely; marijuana with higher THC content can also increase users' risk of developing dependence on the drug.[9]

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[6] National Institute on Drug Abuse, National Institutes of Health, US Department of Health and Human Services, NIDA InfoFacts: Marijuana, http://www.drugabuse.gov/PDF/InfoFacts/Marijuana06.pdf, (January 9 2008)

[7] National Center on Addiction and Substance Abuse, Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette?, April 2004, p. 7

[8] National Center on Addiction and Substance Abuse, Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette?, April 2004, p. 7

[9] National Center on Addiction and Substance Abuse, Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette?, April 2004, p. 7

THC levels are affected by a great many factors, including plant type, weather, soil and time of harvest. Kansas has large areas of rich fertile soil and a climate that permits the necessary weather conditions for the growing of prime marijuana crops. Hydroponics grows (indoors) are also popular with illegal growers. This system basically involves growing plants without soil. Plant nutrients and water are mixed together and distributed to the roots by way of a pump or alternative method.

III. Marijuana's Health Risks

Marijuana is a health problem not only for adults but puts our youth at risk for a full range of health and developmental problems.

Among all ages, the specific illicit drugs that had the highest levels of past year dependence or abuse in 2006 were marijuana (4.2 million), followed by cocaine (1.7 million) and pain relievers (1.6 million).[10]

Smoking a drug or injecting it into a vein increases its addictive potential. Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. This intense "high" can fade within a few minutes, taking the abuser down to more normal levels. Scientists believe that this low feeling drives individuals to repeated drug abuse in an attempt to recapture the high pleasurable state.[11]

Regular marijuana smokers display many of the respiratory problems of tobacco smokers, including daily cough and phlegm, symptoms of chronic bronchitis, more frequent chest colds and damage to lung tissue.[12]

Marijuana use causes a 20 percent to 100 percent increase in heart rate, starting during the ten minutes or so it takes to smoke a marijuana cigarette and lasting two to three hours, as well as increases in cardiac output (the volume of blood pumped by the heart per minute). Cardiac function is altered for some hours after marijuana use.[13]

Long-term marijuana use causes temporary cognitive defects, particularly with respect to attention and memory, lasting as long as a few days after smoking marijuana.[14]

Women who smoke marijuana during pregnancy often have children with low birth weights, and researchers have observed that "there is evidence that infants exposed in

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[10] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2006 National Survey on Drug Use and Health, http://oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf (January 10 2008)
[11] National Institute on Drug Abuse, National Institutes of Health, US Department of Health and Human Services, Drugs, Brains, and Behavior: The Science of Addiction, p. 9
[12] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 10
[13] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 11
[14] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 10

utero to cannabis [may] have behavioral and developmental effects during the first few months after birth.[15]

Marijuana has adverse effects on the skills needed for safe driving. The short-term effects of marijuana use can include difficulty in thinking and problem solving, loss of coordination, increased heart rate, greater likelihood of anxiety and panic attacks.[16] The National Highway Traffic Safety Administration (NHTSA) reports marijuana is the second most frequently found drug (after alcohol) in crash-involved drivers.[17]

Adults with a past year major depressive episode who reported past month binge alcohol or illicit drug use were more likely to report suicidal thoughts and suicide attempts than their counterparts with a past year episode who had not engaged in past month binge drinking or illicit drug use. Illicit drugs were involved in an estimated 28.4 percent (30,109 visits) of the drug-related suicide attempts treated in the emergency department. The most frequently reported illicit drug was cocaine (13,620 visits) followed by marijuana (8,490 visits).[18]

Legislation

IV. Marihuana Tax Act of 1937

The Marihuana Tax Act of 1937 imposed registration and reporting requirements and a tax on growers, sellers and buyers of marijuana. The act did not prohibit marijuana outright but its affect was the same. Because marijuana was not included in the Harrison Narcotics Act in 1914, the Marihuana Tax Act was the federal government's first attempt to regulate marijuana. The American Medical Association (AMA) opposed it but the Marihuana Tax Act was approved causing all medicinal products containing marijuana to be withdrawn from the market.[19]

V. Controlled Substances Act

All substances -- legal and illegal -- are placed into one of five schedules under the Controlled Substances Act (CSA) which is enforced by the Drug Enforcement Administration (DEA). This placement is based upon the substance's medical use, potential for abuse and safety or dependence liability. Marijuana is currently a Schedule I drug, the highest level of all. Drugs falling within this category have a high potential

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[15] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 11

[16] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 11

[17] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 11

[18] Office of Applied Studies, SAMHSA, Suicidal Thoughts, Suicide Attempts, Major Depressive Episode and Substance Use Among Adults, 2006, p. 6

[19] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 5

for abuse, they have no currently accepted medical use in treatment in the United States and there is a lack of accepted safety for their use under medical supervision.[20]

The Food and Drug Administration (FDA) is responsible for approving drugs, over-the-counter and prescription drug labeling and drug manufacturing standards.[21] Currently, Marinol is the only cannabis-based drug approved by the FDA for use in the US. Made by Unimed, Marinol is the trade name for dronabinol, a synthetic form of THC. Marketed as a capsule, it was originally placed in CSA's Schedule II category but has since been moved to III to make it more widely available to patients.[22] Rescheduling of a drug can be done administratively or it can be done by an act of Congress.

There have been attempts to reschedule marijuana but so far they have failed. In order for a drug to meet the CSA standard of having a "currently accepted medical use in treatment in the US, it must meet a five-factor test:

1) The drug's chemistry must be known and reproducible;
2) there must be adequate safety studies;
3) there must be adequate and well-controlled studies proving efficacy;
4) the drug must be accepted by qualified experts, and
5) the scientific evidence must be widely available.

According to DEA, botanical marijuana meets none of these requirements.[23]

The last attempt to reschedule marijuana was made to DEA in 1995. DEA asked the Department of Health and Human Services (HHS) for a scientific and medical evaluation of the abuse potential of marijuana and a scheduling recommendation. HHS concluded that marijuana has a high potential for abuse, no currently accepted medical use in treatment in the US and a lack of accepted safety for use under medical provision. HHS recommended that marijuana remain a Schedule I drug. DEA denied the petition by way of letter on March 20, 2001.[24]

The CSA does not distinguish between the medical and recreational use of marijuana. Federal law supersedes state law; therefore, federal agents are able to investigate, arrest and prosecute persons using marijuana for medicinal purposes, even in those states that have medical marijuana laws.

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[20] US Department of Justice, Drug Enforcement Administration, Speaking Out Against Drug Legalization, October 1995, p. 20

[21] US Food and Drug Administration, US Department of Health and Human Services, What FDA Regulates, http://www.fda.gov/comments/regs.html (January 9 2008)

[22] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 8

[23] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 24

[24] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 11

Federal and state penalties for possessing or selling marijuana vary depending on the amount and whether it's a first or second offense.

VI. Compassionate Use Program

The Compassionate Use Program, launched in 1976, was administered as part of an existing program to provide seriously ill patients with promising medicines prior to their approval by the FDA. Patients received government-grown marijuana to treat a variety of symptoms and were later joined by hundreds of patients in state-run experimental treatment programs. Marijuana was obtained by physicians who submitted a lengthy application to the FDA, after which the DEA conducted inspections to assure that the drug would not be diverted from its intended use. In 1991, the Public Health Service closed the Compassionate Use program for smoked marijuana after a National Institutes of Health (NIH) review concluded that marijuana was not the best treatment for any of the patients who were receiving it.[25]

VII. Other Federal Legislation

There have been other attempts at the federal level to approve marijuana as a medicine, recognize its medicinal value, and reschedule it to make it more accessible but as of this date, none have been approved. An overview of these legislative attempts as well as other case law can be reviewed in the Congressional Research Service Report for Congress, "Medical Marijuana: Review and Analysis of Federal and State Policies, http://www.medicalmarijuanaprocon.org/pdf/CRS2007.pdf.

VIII. State Medical Marijuana Laws

Currently, 12 states have enacted laws which allow the use of cannabis for medical purposes:[26]

California	Approved through voter initiative.
Oregon	Approved through voter initiative.
Alaska	Approved through voter initiative.
Washington	Approved through voter initiative.
Maine	Approved through voter initiative.
Hawaii	Approved through state legislative initiative.
Colorado	Approved through voter initiative.
Nevada	Approved through voter initiative.
Vermont	Approved through state legislative initiative.
Montana	Approved through voter initiative.
Rhode Island	Approved through state legislative initiative.
New Mexico	Approved through state legislative initiative.

[25] The National Academies Press, Marijuana as Medicine? The Science Beyond Controversy (2000), http://books.nap.edu/openbook.php?record_id=9586&page=160 (January 14 2008)

[26] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 17

should not and cannot make that decision. Medicine is based on science and smoked marijuana has not been proved by science to be safe and effective.

It is debatable whether smoking marijuana is more harmful than smoking cigarettes as research is not conclusive. It is impossible to make precise comparisons between the damage to one's health caused by smoking marijuana versus the damage caused by smoking tobacco. Since an estimated 70 percent of marijuana users also smoke tobacco, it is difficult to conduct epidemiologically studies that isolate the effects of marijuana smoking. Marijuana joints have been shown to deliver at least four times as much tar to the lungs as tobacco cigarettes of equivalent weight.[29]

In January 1997, the Director of the Office of National Drug Control Policy commissioned the Institute of Medicine (IOM) of the National Academy of Sciences to review the scientific evidence on the potential health benefits and risks of marijuana and its constituent cannabinoids. The IOM's report, "Marijuana and Medicine: Assessing the Science Base," was released in March 1999. It analyzed all existing studies of the therapeutic value of cannabis as well as took into account information received from public hearings and consultations held around the country with biomedical and social scientists and concerned citizens. In general, the report emphasized the need for well-formulated, scientific research into the therapeutic effects of marijuana and its cannabinoid components on patients with specific disease conditions. To this end, the report recommended that clinical trials be conducted with the goal of developing safe delivery systems.[30]

Eric A. Voth, M.D., Cotton O'Neil, Topeka, Kansas, states IOM findings are consistent with previous evaluations by the AMA and NIH.[31] Voth opposes the smoking of marijuana for recreational or medicinal use, saying it would expose the person to hundreds of other toxic substances, as well as putting the person at risk for bacterial infections and respiratory disease.[32] However, Voth said there are other drugs on the market more effective for treatment of the nausea associated with chemotherapy and with fewer side effects than THC. THC's side effects include disphoria, panic, hallucinations, changes in reality perception and also difficulty with coordination, driving skills and memory.[33] According to Voth, "Crude marijuana in any form does not constitute a medicine."[34]

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[29] The National Academy of Sciences, Marijuana as Medicine?: The Science Beyond the Controversy, p. 39

[30] Mark Eddy, Specialist in Social Legislation, Domestic Social Policy Division, May 15, 2007, Congressional Research Service Report for Congress, Medical Marijuana: Review and Analysis of Federal and State Policies, p. 10

[31] Eric A. Voth, M.D., FACP, Chairman, International Drug Strategy Institute, Commentary on Institute of Medicine Marijuana Study, September 26, 1999

[32] Topeka Capital-Journal, Topeka Doctor Says Marijuana Not Medicine, April 10, 1999

[33] Topeka Capital-Journal, Topeka Doctor Says Marijuana Not Medicine, April 10, 1999

[34] Eric A. Voth, M.D., FACP, Chairman, International Drug Strategy Institute, Commentary on Institute of Medicine Marijuana Study, September 26, 1999

According to Edward T. Creagan, M.D., an oncologist at Mayo Clinic, Rochester, Minnesota, THC has not proven to be an especially effective anti-nausea agent. "A major clinical trial was launched at Mayo several years ago, assessing in a controlled fashion the effects of pure THC, in tablet form, for nausea due to chemotherapy," Dr. Creagan says. "The study results were overwhelmingly against THC. Patients felt detached and spacey and it simply wasn't that effective. Doctors are concerned about the lack of proven value for this drug."[35]

Alan J. Wright, M.D., an infectious disease specialist who treats patients with AIDS at Mayo Clinic states "The reality is, we just don't have a big need for marijuana in our HIV patients. We have other medications that are just as good, usually even better, in treating wasting in AIDS patients. I haven't had a single patient who I thought would have benefited significantly by using marijuana."[36] Decreases in AIDS incidence and in the number of AIDS deaths, first noted in 1996, have been attributed to the affect of new treatments which prevent or delay the onset of AIDS and premature death among HIV-infected persons and result in an increase in the number of persons living with HIV and AIDS.[37]

X. Public Opinion

It is unclear how many people or patients have an interest in the passage of medical marijuana legislation or would benefit from it. It is not believed that any polls or surveys have been conducted in the state of Kansas.

Considering what action has taken place in other states, though, it is probable that public opinion is favorable to the passage of medical marijuana laws. In fact, according to an October 2002 Time/CNN poll, the vast majority of Americans (80 percent) believe adults should be allowed to use marijuana for medicinal purposes.[38]

But most people are not informed on all the issues connected to the medical marijuana debate, nor have they been educated on the costs or risks involved. Pro-advocates are able to push their agenda by appealing to voters' sense of compassion for the sick and dying.

The remainder of this document will offer additional information and data that will show why a medical marijuana law would do more harm than good in Kansas.

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[35] Mayo Clinic, Medical Marijuana: The Jury's Still Out, September 27, 1999, http://www.mayohealth.org/mayo/9605/htm/marijuan.htm, (January 14 2008)
[36] Mayo Clinic, Medical Marijuana: The Jury's Still Out, September 27, 1999, http://www.mayohealth.org/mayo/9605/htm/marijuan.htm, (January 14 2008)
[37] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2007, p. 435
[38] Pamela Paul, American Demographics, Medical Opinion – Legalization of Medical Marijuana, June 1, 2003

Dangers of Legalizing Marijuana

XI. Risk and Prevention

Americans, only four percent of the world's population, consume two thirds of the world's illegal drugs.[39]

According to the 2006 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), among past year marijuana users aged 12 or older, 12.3 percent used marijuana on 300 or more days within the past 12 months. This translates into 3.1 million using marijuana on a daily or almost daily basis over a 12-month period, similar to the estimate in 2005. Among past month marijuana users aged 12 or older, 34.4 percent (5.1 million) used the drug on 20 or more days in the past month.[40]

Of the twelve states that have medical marijuana programs, five (Alaska, Maine, Vermont, Montana, and Rhode Island) are rated in the top 10 states with the lowest perception of risk in using marijuana once a month among persons aged 12-17.[41]

How dangerous is marijuana use to our youth? A youth who experiments with marijuana before the age of 17 is 85 times more likely to experiment with harder drugs, including cocaine, in his or her lifetime. And, according to the Center for Disease Control, adolescents who smoke marijuana are twice as likely to attempt suicide, twice as likely to carry a weapon and three times as likely to have sex (and far more likely to do so without a condom) than those who do not.[42]

Research shows that there is a correlation between teenage drug abuse, delinquency, school dropout rates, teen pregnancy and violence. Adolescents who are involved in any of the above are more likely to engage in one or more of the other problem behaviors.[43]

Also, there are various factors that can increase the chances of addiction in a person. These include home and family life (parents or family members who use drugs or engage in criminal behavior), friends who use, school (poor grades, poor social skills), age at which a person begins to use drugs and method of administration.

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[39] The National Center on Addiction and Substance Abuse at Columbia University, Califano Calls for Fundamental Shift in Attitudes and Policies about Substance Abuse and Addiction, http://www.casacolumbia.org/absolutenm/templates/PressReleases.aspx?articleid=487&zoneid=65 (January 10 2008)

[40] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2006 National Survey on Drug Use and Health, http://oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf (January 10 2008)

[41] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2006 National Survey on Drug Use and Health, http://oas.samhsa.gov/2k5state/ageTabs.htm#Tab4 (January 11 2008)

[42] Community Anti-Drug Coalitions of America, Say It Straight: Our Health, Our Youth and Marijuana, January 29, 1997, p. 30

[43] Kansas Alcohol and Drug Abuse Services, Directions, 1996

CASA conducted a special analysis of data from the 2001 US Centers for Disease Control and Prevention Youth Risk Behavior Survey of 11,000 9th through 12th graders and isolated teen use of these gateway drugs from other problem behaviors such as fighting, drunk driving, carrying a weapon and attempting suicide. The conclusion: among teens aged 12 to 17 with no other problem behaviors, those who used marijuana at least once in the past 30 days are 13 times likelier than those teens who have not used marijuana in the past 30 days (33.5 percent vs. 4.4 percent) to use another drug like cocaine, heroin, methamphetamines, LSD or Ecstasy, and almost 26 times likelier than those teens who have never used marijuana (33.5 percent vs. 1.3 percent) to use another drug like cocaine, heroin, methamphetamines, LSD or Ecstasy.[44]

According to the 2006 NSDUH:[45]

- The percentages of youths reporting binge alcohol use and use of cigarettes and marijuana in the past month were lower among those who perceived great risk in using these substances than among those who did not perceive great risk.
- There were no changes in the perceived risk of marijuana, cocaine or heroin between 2005 and 2006 among youths aged 12 to 17. However, between 2002 and 2006, there were increases in the perceived risk of smoking marijuana once a month (from 32.4 to 34.7 percent) and smoking marijuana once or twice a week (from 51.5 to 54.2 percent). *(Perceived risk is measured by NSDUH as the percentage reporting that there is great risk in the substance use behavior.)*
- About half (50.1 percent) of youths aged 12 to 17 reported in 2006 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some.
- A majority of youths (90.4 percent) in 2006 reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice. Current marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.6 vs. 26.5 percent).
- Marijuana was the most commonly used illicit drug (14.8 million past month users). Among persons aged 12 or older, the rate of past month marijuana use was the same in 2006 (6 percent) as in 2005.
- Among young adults aged 26 or older, 6.1 percent reported current illicit drug use in 2006. In this age group, 4.2 percent used marijuana and 2.2 percent used prescription-type drugs nonmedically.
- In 2006, there were 2.1 million persons who had used marijuana for the first time within the past 12 months; this averages to approximately 6,000 initiates per day. This estimate was about the same as the number in 2005 (2.1 million), 2004 (2.1 million), 2003 (2.0 million) and 2002 (2.2 million).
- Most (63.3 percent) of the 2.1 million recent marijuana initiates were younger than age 18 when they first used. Among youths aged 12 to 17, an estimated 4.7

[44] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 15

[45] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2006 National Survey on Drug Use and Health, http://oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf (January 10 2008)

10-14

percent had used marijuana for the first time within the past year, similar to the rate in 2005.

Drug use in the home has far-reaching effects when considering the inmate population:

While growing up, 42 percent of drug dependent or abusing state prisoners received public assistance, 45 percent lived in single-parent homes, and 41 percent had a substance abusing parent. By comparison to federal inmates, 31 percent of other inmates received public assistance, 39 percent lived in single-parent homes and 24 percent had a substance-abusing parent.[46]

Over half of jail inmates grew up in either a single-parent household or with a guardian, such as grandparents, another relative or a nonrelative. Jail inmates who lived with a mother only dropped from 43 percent to 39 percent between 1996 and 2002. In 2002, 31 percent of jail inmates said they grew up in households where a parent or guardian abused alcohol or drugs, unchanged since 1996. Nearly 9 percent lived with parents who abused both alcohol and drugs.[47]

The association between the use of marijuana and other drugs is well-established: most current cocaine and heroin users have already used marijuana and the people who use marijuana are at higher risk for using other illegal drugs.[48]

The key to preventing drug abuse is education and it needs to start with our youth. The good news is, drug abuse is starting to drop.

In 2005, the Monitoring the Future (MTF) survey recorded an overall 19.1 percent decrease in the current use of illegal drugs between 2001 and 2005. Between 2001 and 2005, marijuana use dropped in all three categories: lifetime (13 percent); past year (15 percent) and 30-day use (19 percent). Current marijuana use decreased 28 percent among 8th graders (from 9.2 percent to 6.6 percent) and 23 percent among 10th graders from (19.8 percent to 15.2 percent).[49]

While drug abuse is dropping in some areas, we can't afford to let up pressure now; it is still an invasive problem in our communities.

XII. Costs

Proponents argue that areas such as education and health care would benefit from the taxes raised by legalizing marijuana. In all likelihood, though, there would be an increase

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[46] US Department of Justice, Bureau of Justice Statistics, Drug Use and Dependence, State and Federal Prisoners, 2004, October 2006, p. 8

[47] US Department of Justice, Bureau of Justice Statistics, Profile of Jail Inmates, 2002, July 2004, p. 10

[48] The National Center on Addiction and Substance Abuse at Columbia University, Non-Medical Marijuana II: Rite of Passage or Russian Roulette? April 2004, p. 15

[49] Drug Enforcement Administration, The DEA Position on Marijuana, May 2006, http://www.usdoj.gov/dea/marijuana_position.html (January 9 2008)

in other costs associated with corrections, treatment, police protection, productivity losses related to work absences, accidents, etc. At this time, there is no way to determine what increases there will be and how much they will cost.

It might be simpler to think of it this way: Legalized gambling has not put illegal gambling out of business. In fact, legalized gambling has produced a whole new group of people who cannot control their need to gamble.[50]

One thing is certain, health care costs continue to increase yearly and legalizing marijuana would have a direct affect to those costs.

The Office of National Drug Control Policy reports that between 1992 and 2002 the overall economic cost of drug abuse to society increased at a rate of 5.9 percent annually.[51] By 2002, the economic cost of drug abuse was $180.8 billion nationally.[52]

Costs related to health care rose from $10.7 billion in 1992 to $15.8 billion in 2002. Overall the health care costs related to drug abuse increased 2.9 percent annually over this six-year period.[53]

In 2005, the US spent 16 percent (up from 14 percent in 2000) of its Gross Domestic Product (GDP) on health care, a greater share than any other developed country for which data are collected by the Organisation of Economic Co-operation and Development.[54]

Medicaid and private insurance pay the largest shares of mental health expenditures, whereas the largest share of substance abuse expenditures come from other state and local government funds (excluding Medicaid expenditures).[55]

In 2006, among persons who received their last or current substance use treatment at a specialty facility in the past year, 42.1 percent reported using their "own savings or earnings" as a source of payment for their most recent specialty treatment. In addition, 37.4 percent reported using private health insurance, 26.9 percent reported using Medicaid, 21.4 percent reported using public assistance other than Medicaid, 20.9 percent reported using Medicare, and 16.3 percent reported relying on family members. (Note that persons could report more than one source of payment.)[56]

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[50] US Department of Justice, Drug Enforcement Agency, Speaking Out Against Drug Legalization, October 1995, p. 18

[51] Office of National Drug Control Policy, Economic Costs of Drug Abuse in the United States 1992-2002, December 2004, IV-1

[52] Office of National Drug Control Policy, Economic Costs of Drug Abuse in the United States 1992-2002, December 2004, IV-1

[53] Office of National Drug Control Policy, Economic Costs of Drug Abuse in the United States 1992-2002, December 2004, IV-2

[54] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2007, p. 26

[55] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2007, p. 28

Closing

XIII. Further Research Needed

The movement to legalize marijuana for medicinal purposes can largely be attributed to the well-financed and coordinated efforts of a very few, high profile people residing in other parts of the nation. But make no mistake – their true agenda is more about profit than it is about compassion for the sick and dying.

The biggest argument for not legalizing marijuana is that there simply has not been enough research conducted. It is our responsibility to protect our citizens until all of the questions have been asked and the appropriate answers have been received. Federal agencies like the American Medical Association, American Glaucoma Society, American Academy of Ophthalmology, International Federation of Multiple Sclerosis Societies and American Cancer Society all say that marijuana is not a safe and effective medicine.[57]

It would be irresponsible of us to implement a piece of legislation without considering other affects. For instance, alcohol is legal but driving under the influence isn't. Will stricter legislation follow suit? What about legalization of other drugs? How will the passage of such legislation interfere with law enforcement investigations of marijuana-related crimes? Will legal marijuana be administered to everyone or will an age-limit be proposed? Is there any criteria documenting that the patient has tried other medications to treat his or her ailment? How do we address social issues that stem from it? What affect will the law have on health care costs and other costs to society and who will pay for them? How do we control abuse by those who are restricted from using it, i.e. patients vs. nonpatients? How will a black market for cheaper drugs be controlled? Who will distribute and sell the medicinal marijuana – the government or private companies? What about testing for certain professions like child care providers, teachers and law enforcement? What about quality controls to make sure drugs are safe? This we know -- too many questions remain.

Finally, Kansas has much to be proud of as an agricultural state but if the legalization proponents' true agenda is realized, is marijuana the crop for which it wants to be recognized?

The best way to keep kids and adults from using drugs is to send clear and consistent messages about the dangers of using them. We have provided several convincing reasons why legalizing marijuana should be considered a dangerous piece of legislation. The passage of such an initiative would send a loud message that as a state, we are becoming

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[56] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2006 National Survey on Drug Use and Health, http://oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf (January 10 2008)

[57] Community Anti-Drug Coalitions of America, Say It Straight: Our Health, Our Youth, and Marijuana, January 29, 1997, p. 7

more tolerant of drugs. And whenever public attitude becomes more tolerant of drugs, substance abuse rises.

10-18

WRITTEN TESTIMONY TO THE HEALTH CARE STRATEGIES COMMITTEE

IN OPPOSITION OF SB556

Presented by Lt. Michael D. Life
On behalf of the
Kansas Narcotics Officers Association

February 11, 2008

Health Care Strategies Committee
Senator Susan Wagle, Committee Chair

Senator Wagle and Committee Members,

This testimony is in **opposition** of SB556

Senator Wagle and Members of the Committee,

I am Lt. Mike Life of the Junction City Police Department. I have been a police officer for 22 years. For 14 of those years, I have been worked exclusively in narcotic investigations. I am the supervisor of a multi-agency, county wide drug task force and the current president of the Kansas Narcotics Officers Association. I am writing this testimony on behalf of the Kansas Narcotics Officers Association. We are strongly opposed to the passing of SB556.

Marijuana is NOT medicine. There is a well-financed and organized pro-drug legalization lobby whose strategic ploy is to appeal to your compassion for sick people in order to convince you that smoking marijuana is not only safe, but also an effective medicine. This is simply an excuse to open the doors for anybody that can convince a doctor that they have no appetite, back pain, or some other malady which can not be easily diagnosed, and need marijuana in order to ease their pain. This tactic has already been deployed in other states. I implore you not to fall into the same trap.

As a narcotics officer I can tell you we are already fighting this very same battle with synthetic opiates such as Oxycontin, Delaudid, or other prescription pain medicines. Those individuals who were addicted to heroin have now switched to these types of prescription drugs because they can find a doctor and can convince them that they have back pain and then get a prescription. Once a compassionate doctor is found, that doctor's name is spread to other abusers and they will flock to him or her. We currently have several abusers in my city alone that will drive 240 miles round trip to a popular doctor in another city who will easily prescribe these drugs. They all know this doctor's name and we find the prescription bottles with that doctor's name on them everywhere. Once they get the drug, it is then crushed and injected or snorted to get high, or sold on the black market for a profit.

I do not blame the doctors. I want a doctor who is caring and compassionate. But by that very nature, they are taken advantage of by skilled drug abusers who know how to appeal to this compassion by being able to fake their symptoms. These same abusers will frequent various doctors complaining of the same ailment and get multiple prescriptions for the same symptoms. We have conducted investigations involving these abusers going to various pharmacies in the surrounding towns and cities getting these prescriptions filled so that their doctors do not get suspicious.

I can tell you that we have I-70 running through Junction City and have met several of the "medical" marijuana users from other states. They have received their marijuana under these very same types of excuses and run the gambit from back pain to no appetite. Let's unmask this attempt and call this bill exactly what it is, legalized marijuana!

I urge you to look closely at how the bill is written. See part "(b)(1) "Debilitating medical condition" may include, ***but is not limited to***, one or more of the following:" Talk about the proverbial Pandora's Box. A doctor can prescribe this medical marijuana for virtually anything, without limitation.

See part "(B) a chronic or debilitating disease or its treatment that produces one of more of the following: ***Cachexia***..." The definition of Cachexia is "Weight loss, wasting of muscle, loss of appetite, and general debility that can occur during a chronic disease". There we have the loss of appetite excuse.

"(B).....***severe pain***". There we have the back pain excuse. This bill is intentionally written to deceive you into feeling sorry for genuinely sick people and into opening the door for all the "California" excuses. We all want genuinely sick people to get the medicine they need. Marijuana is NOT medicine.

Pro-legalization organizations such as NORML (National Organization for the Reform of Marijuana Laws) have admitted that their strategy to legalize marijuana begins with legitimizing smoking marijuana as a medicine. Let me quote from a paper titled Use of Marijuana as a "Medicine" written by the Narcotic Educational Foundation of America. "As reported in HIGH TIMES magazine, the Director of NORML expressly stated that the medicinal use of marijuana is an integral part of the strategy to legalize marijuana. Tony Serra, a criminal defense attorney associated with the pro-legalization groups, stated that medicinal marijuana is the "chink in the administration's armor that will lead to society's seeing pot's mystical effects of peace, sisterhood, and brotherhood." He is also the one who said "if you kill a cop, I'll pay to take the case." And "my sustenance is drugs and murder." A former Director of NORML, Keith Stroup, told an Emory University audience that NORML would be using the issue of medicinal marijuana as a red herring to give marijuana a good name. The Director of NORML, Dick Cowan, is quoted, "The key is medical access. Because once you have hundreds of thousands of people using marijuana under medical supervision, the whole scam is going to be brought up....then we will get medical, then we will get full legalization."

Is there any doubt about the motive of this movement? All while playing this cruel hoax on people with legitimate illnesses. Marijuana is NOT medicine. Marijuana is NOT FDA approved. It is made up of over 400 chemicals which are largely unstudied and appear in uncontrolled strengths, and when smoked, marijuana has 4 times the level of tar that a tobacco cigarette has. The harmful chemicals and carcinogens that are byproducts of smoking marijuana create entirely new health problems.

Prescribing marijuana as a "medicine" is like prescribing methamphetamine for weight loss, or tobacco cigarettes as an appetite suppressant, or heroin as a pain reliever. I believe there are thousands of studies available that show smoking marijuana has harmful physical and psychological effects. There are plenty of FDA approved drugs available which make the excuse of smoking marijuana as "medicine" a complete sham. Besides, what kind of message are you sending to young kids by legalizing marijuana for medical reasons? It legitimizes the use of marijuana and if its "safe" and legal for some people, why not them?

As you examine SB556, I urge you to think about what message you would be sending to children if you were to say that marijuana is "medicine". I personally do not want any children I know thinking that smoking marijuana is anything but a bad decision. I urge you to think about people in the work place smoking their marijuana "medicine". Do you want your taxi driver, your tax preparer, your pilot, your fireman, your police officer, your DOCTOR smoking their marijuana "medicine?" I sure don't. I am not an alarmist, but simply a person whose job puts them in a position to have already seen this scheme at work.

I have attached a recent article from a publication called The Oregonian. The author of this article is writing from a position of having observed Oregon's Medical Marijuana Act in effect. See the attached article.

In closing, I ask you to research and carefully examine this issue. I am confident that you will then reject SB556 as bad legislation for Kansas. On behalf of over 600 law enforcement officers and prosecutors who are members of the Kansas Narcotics Officers Association I pray that you reject SB556. I sincerely regret that I was unable to present this testimony in person due to a previous scheduling conflict, but I want to thank you for your time and attention in reading this testimony.

Respectfully submitted,
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ARTICLE IN THE OREGONIAN WWW.OREGONLIVE.COM

The Oregonian

Don't make a bad marijuana law worse

Monday, February 04, 2008

Ten years ago, when Oregon voters approved the state's landmark Medical Marijuana Act, they did so with assurances that only a handful of very ill people needed it -- perhaps 500 a year, supporters said at the time.

That turned out to be a false promise, as critics warned at the time. They appear to have correctly predicted that the new law would open the door for wider use of pot in Oregon by creating new legal defenses for the possession, use, cultivation and delivery of marijuana.

Statistics strongly suggest this. Today, nearly 16,000 Oregonians hold patient cards entitling them to use marijuana. Nearly 8,000 hold "caregiver cards" so they can possess it, and about 4,000 have permits to grow the plant, resulting in at least 19 tons of marijuana growing legally at any given time.

Not surprisingly, the rate of marijuana use by adult Oregonians is 50 percent higher than the national rate. Voters in 1998 may have thought they were showing compassion for a small number of terminally ill cancer patients who needed marijuana to alleviate their symptoms, but the law is clearly being abused in a big way.

This abuse is showing up in the workplace, where the Oregon drug test failure rate is 50 percent higher than the national rate. And the most prevalent reason for testing failure? Marijuana use -- 71 percent of all positive tests in Oregon, compared with 53 percent nationally.

The 2007 Legislature had a chance to address the workplace issue but fell short. A bill to make it easier for Oregon employers to enforce drug-free workplace policies, even against employees with valid medical marijuana cards, passed in the Senate but faltered in the House.

That was a sensible bill and deserves a second chance in the special session that begins today. Instead, however, the House Business and Labor Committee has put forth a much narrower bill that would give employers the option to regulate medical pot users in only the most dangerous of jobs.

This is a bad bill that will make Oregon's flawed law worse, not better. By giving employers discretion on accommodating medical marijuana use only by workers doing "hazardous duties," the bill would create a huge uncovered class of workers who would win the implicit right to accommodation at work -- something the original act explicitly did not grant.

In other words, this new bill is a Trojan horse. It would exempt such dangerous jobs as mining, logging and blasting, while creating the right to special accommodation for everyone else who might have marijuana cards, including surgeons, bus drivers, nannies and editorial writers.

Legislators should spike this bill. Instead, they should pass Senate Bill 465, clarifying the right of employers to enforce drug-free workplace policies.

And while they're at it, they should fund a Justice Department study of what increasingly appears to be widespread abuse of a well-intentioned medical marijuana law gone bad

Member
Community Anti-Drug
Coalitions of America
(CADCA)

KANSAS family PARTNERSHIP, INC.

Kansas Partner
National Family Partnership

....building partnerships to raise drug-free successful youth

Testimony to the Senate Committee on Health Care Strategies

February 11, 2008
Karl Fruendt, President, Board of Directors, Kansas Family Partnership, Inc.

Dear Senator Wagle, Members of the Committee, Ladies and Gentlemen:

I come before you today as a concerned Kansan, a single father of four, community volunteer and Board President of the Kansas Family Partnership. I come to urge you to oppose Senate Bill 556 and to not advance it out of this committee.

Across the country, efforts have been made to legalize marijuana for "medical purposes". If there were truly a real need for smoked marijuana, the American Medical Association, the American Pediatrics Association, and the many subspecialties in the medical field would be calling for this legislation. If smoking marijuana was good medicine, these specialists would be crying out for the need for marijuana for their patients. This is not the case nationally nor in the state of Kansas. I would hope that this legislative body would not be swayed by anecdotal stories about this perceived need. I would hope that science and research would rule your decisions. I also hope that this body will consider the litany of unintended consequences that have occurred as a result in the states that have voted to have "medical marijuana as a defense" to prosecution.

I ask you to consider what will greater access to marijuana do? Will we have pharmacies in Kansas that provide pot? Will we have street corner pot shops like California? Will we be able to get marijuana from a vending machine as they now have in California? **Will communities need to create moratoria to undo a morass caused by pot dispensaries?** Is Kansas willing to go against the recommendation of the Federal Drug Administration and basically say "Your rules for what is considered a safe medicine don't apply in Kansas?" How do we as parents tell our kids that marijuana is harmful as the research shows? Will they believe us if it is legal for some, but not for others?

One of our greatest concerns is with young people. In virtually every student group we meet, young people use the medical excuse discussion as justification for marijuana use. It reduces the perception of harm and reduces important preventative community norms. Remember, even the leaders of the marijuana movement see the medical excuse as a way to get the "camel's nose under the tent" with marijuana.

Attached to my testimony is a list of seven statewide organizations and 26 local and county individuals, organizations and coalitions who oppose the use of leaf marijuana as a medicine. This list includes representatives from the medical community, pharmacists, nurses, law enforcement, schools, health departments, substance abuse prevention and treatment facilities, business owners, pharmacists, judges and community coalitions. Please join with the more than 4,000 concerned Kansans this list represents in saying no to medical excuse marijuana by voting no to SB 556. Thank you.

Respectfully submitted,

Karl Fruendt, President, Board of Directors
Kansas Family Partnership, Inc.

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 12

5942 SW 29th Street Topeka, Kansas 66614 (785)266-6161 1-(800)206-7231 fax (785)266-6149
Email: KsFamPart@kansasfamily.com www.kansasfamily.com

Resolutions Signed Against the Availability of Leaf Marijuana for Medicinal Purposes

Organizations

Statewide Organizations

Kansas Board of Healing Arts
Kansas Family Partnership, Inc.
Kansas Medical Society
Kansas Narcotics Officers Association
Kansas State Board of Pharmacy
Kansas State Nurses Association
Regional Prevention Center Directors Association of Kansas

Community and County Organizations

Central Kansas Foundation
Chase County Drug Free Action Team, Inc.
Cheyenne County Kids Making a Connection Coalition
Communities in Schools of Harvey County
Community Partnership for Prevention & Education
DCCCA, Inc.
Decatur County Interagency Team
District Court of Phillips County
Ronald Eisenbarth, NCAC II, Owner/Manager
Emporians for Drug Awareness
Graham County Communities That Care Coalition
Harvey County Drug-Free Youth Coalition
Logan County Community Action Team
Natoma FADD
Norton County Council on Alcohol/Drugs
Phillipsburg High School
Phillipsburg Elementary School
Prevention and Recovery Services
Rooks County Communities That Care
Rooks County Health Department
Safe Streets Coalition
Smith County Health Department
Smith County Drug & Alcohol Council
Thomas County Coalition
Topeka-Shawnee County Alcohol
Trego County Juvenile Justice Authority

Remarks of Christopher L. Schneider, Assistant Wyandotte County District Attorney, and representative of the Kansas County and District Attorneys Association Concerning S.B. 556

Before the Committee on Health Care Strategies of the Kansas Senate February 11, 2008

Madam Chairman and members of the committee:

As a representative of the Wyandotte County District Attorney's office and the Kansas County and District Attorney's Association, I appear before the committee in opposition to S.B. 556. There are multiple grounds for our opposition to this legislation.

This bill purports to provide an affirmative defense to a state criminal charge of possessing an illegal substance--marijuana. However, possession of marijuana would remain illegal under both state and, more importantly, federal law. This bill would provide a false sense of security to those who receive "written certification" from a physician authorizing their possession and use of marijuana and the paraphernalia necessary to its use. These persons would, *inter alia*, still be subject to federal prosecution, they would still be subject to arrest and investigation for violations of the uniform controlled substances act, and they would be subject to being fired from their jobs for failing drug tests.

Though this legislation provides a defense to those possessing and using marijuana who have "written certification" from a doctor, there is still no legal way for a person to obtain either marijuana, either in a form ready to be smoked or in a form to be grown. Under both state and federal law it would still be a crime to sell, deliver, or possess with intent to sell or deliver marijuana. It would still be a crime under state law to cultivate marijuana.

Because there would still be no legal way in which to obtain marijuana if this legislation were to be enacted, all of the social ills that accompany drug trafficking would continue to exist, if not be exacerbated. Our law defines Sale of Marijuana as an inherently dangerous crime. Because of the close connection between marijuana, significant amounts of money, and guns, the potential for bad things happening to innocent people would remain. Just last week one of my colleagues argued a homicide case across the street in the Kansas Supreme Court where a marijuana seller was murdered in a drug transaction that went bad. A couple of months ago another homicide which was the result of a marijuana deal gone bad occurred at a car wash in Kansas City.

In addition, subsection (b)(1) is problematic because it is too broad. Reasonable people,

based on scientific research, can disagree as to whether marijuana is a useful treatment for any or all of the conditions specified. The problem is inclusion of the wording " but is not limited to" in the definition of "debilitating medical condition". This would conceivably allow a person to argue that any physical or psychological condition is appropriate to be treated with marijuana.

Subsection (b)(2) allows any physician to certify, in writing, that marijuana is likely to be beneficial to a patient in treating a "debilitating medical condition". Though the vast majority of physicians would not abuse this authority, there will be a small number whose practices would become known as legal "smoke shops". One need only look at the current case of *United States v. Steven Schneider* (no relation, at least as far as I know!), currently pending in federal court in Wichita, to see how a medical professional can abuse his or her privilege to write prescriptions for substances commonly accepted as having medicinal value, to see what can take place. There is a greater danger of this with marijuana because its use would be allowed, but not via a prescription, under this bill. Thus there would be not paper trail as to authorization or usage of the marijuana as exists with a prescription. It would further appear to be beyond the monitoring envisioned by S.B. 491, Senator Vicki Schmidt's bill to create a prescription monitoring system in Kansas.

From a public policy perspective, these problems would make marijuana more readily available to those who seek to abuse it, which would only compound the social ills our communities face as a result of drug use.

KANSAS

KANSAS BOARD OF PHARMACY
DEBRA BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Testimony concerning SB 556: Medical Marijuana Defense Act
Senate Health Care Strategies
Presented by Debra Billingsley
On behalf of
The Kansas State Board of Pharmacy
February 11, 2008

Chairperson Wagle, Members of the Committee:

My name is Debra Billingsley, and I am the Executive Secretary for the Kansas State Board of Pharmacy. Our Board is created by statute and is comprised of six members, each of whom is appointed by the Governor. Of the six, five are licensed pharmacists and one is a member of the general public. They are charged with protecting the health, safety and welfare of the citizens of Kansas and to educate and promote an understanding of pharmacy practices in Kansas.

The Board of Pharmacy reviewed the issue related to the availability of leaf marijuana for medicinal purposes at their December 17, 2007 Board Meeting. The Department of HHS, including the FDA has previously concluded that no sound scientific studies support medical use of marijuana for treatment in the United States. Accordingly, the FDA and DEA do not support the use of smoked marijuana for medical purposes. The Board determined that there are safe and effective reliable medicines that do exist that are best for patients. Kansans should be ensured safe medicinal practices through rigorous research and FDA standards prior to any drug being used. Until the FDA approves the medicinal applications of leaf marijuana the Board of Pharmacy would oppose its use in this manner.

The Board unanimously passed a Resolution opposing the use of leaf marijuana for medicinal purposes and I have attached a copy of that Resolution for your review.

Thank you very much for permitting me to testify and I will be happy to yield to questions.

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 14

LANDON STATE OFFICE BUILDING, 900 SW JACKSON ST, ROOM 560, TOPEKA, KS 66612-1231
Voice 785-296-4056 Fax 785-296-8420 http://www.accesskansas.org/pharmacy/

KANSAS

BOARD OF PHARMACY
DEBRA L. BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Kansas State Board of Pharmacy
Board Meeting
December 17, 2007

Subject: Availability of Leaf Marijuana for Medicinal Purposes

Resolution of the Board Approved: December 17, 2007

Whereas, the federal controlled substance act and the Kansas controlled substance act has scheduled marijuana as a Schedule I illegal drug and do not make medical necessity or acceptance an exception to its illegal use and distribution; and

Whereas, the Department of Health and Human Services, including the United States Food and Drug Administration have concluded that no scientific studies support medical use of marijuana for treatment in the United States; and

Whereas, all Kansans should be ensured safe medicinal practices through rigorous research and FDA standards; and

Whereas, there are safe and effective reliable medications that exist that are best for patients that provide compassionate symptom management; and

Whereas, marijuana is a frequently used illegal drug and has a high potential for abuse and abuse may lead to severe psychological or physical dependence; and

Whereas, laws that allow the use of marijuana raise serious regulatory challenges for state regulatory boards;

There, be it hereby

Resolved, That the Kansas State Board of Pharmacy opposes the use of leaf marijuana for medicinal applications unless first approved by the United States Food and Drug Administration.

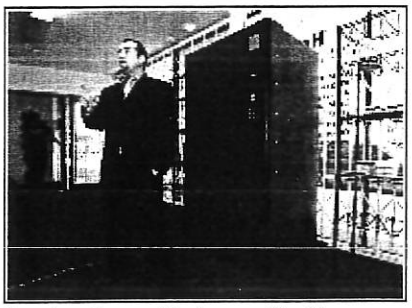
LANDON STATE OFFICE BUILDING, 900 SW JACKSON STREET, ROOM 560, TOPEKA, KS 66612-1231
Phone 785-296-4056 Fax 785-296-8420 www.kansas.gov/pharmacy pharmacy@pharmacy.ks.gov

npr

February 8, 2008

Vending Machines Dispense Pot in LA

from **The Associated Press**



Los Angeles medical-cannabis dispensary owner Vincent Mehdizadeh poses with his new Marijuana vending machine installed at the Herbal Nutrition Center in Los Angeles, Tuesday, Jan. 29, 2008. The black, armored machine is bolted to the floor dispenses medical-cannabis to patients who provide a doctor's prescription and special identification card and their fingerprints. Associated Press © 2008

LOS ANGELES January 30, 2008, 08:47 am ET · The city that popularized the fast food drive-thru has a new innovation: 24-hour medical marijuana vending machines.

Patients suffering from chronic pain, loss of appetite and other ailments that marijuana is said to alleviate can get their pot with a dose of convenience at the Herbal Nutrition Center, where a large machine will dole out the drug around the clock.

"Convenient access, lower prices, safety, anonymity," inventor and owner Vincent Mehdizadeh said, extolling the benefits of the machine.

But federal drug agents say the invention may need unplugging.

"Somebody owns (it), it's on a property and somebody fills it," said DEA Special Agent Jose Martinez. "Once we find out where it's at, we'll look into it and see if they're violating laws."

At least three dispensaries in the city, including two belonging to Mehdizadeh, have installed vending machines to distribute the drug to people who carry cards authorizing marijuana use.

Mehdizadeh said he spent seven months to develop and patent the black, armored box, which he calls the "PVM," or prescription vending machine.

A sliding fence protects the tinted windows of his dispensary, barely distinguishing it from a busy thoroughfare of strip malls, automobile dealers and furniture shops. A box resembling a large refrigerator stands inside the nearly empty shop, near a few shelves stocked with vitamins and herbs.

A guard in a black T-shirt emblazoned with the word "Security" on the front stands at the door. A poster of Bob Marley decorates a back room.

The computerized machine requires fingerprint identification and a prepaid card with a magnetic stripe. Once the card and fingerprint are verified, a bright green envelope with the pot drops down a slot.

Mehdizadeh says any user approved for medical marijuana and registered in a computer database at his dispensaries can pre-purchase the drug and then use the machine to pick up.

The process provides convenience and privacy for users who may otherwise feel uncomfortable about buying marijuana, Mehdizadeh said.

At the Timothy Leary Medical Dispensary in the San Fernando Valley, the vending machine is accessible only during business hours. An employee there said the machine was introduced about five months ago, and provides speedy service.

14-3

"It helps a lot of patients who are in a lot of pain and don't want to wait around to get help," Robert Schwartz said. "It's been working out great."

Mehdizadeh said he sought the advice of doctors, and decided to limit the amount of marijuana per user to an ounce per week. Each purchase from the machine yields 1/8th or 2/8th of an ounce. By eliminating a vendor behind the counter, he said, the machine offers users lower drug prices. The 1/8th ounce packet would cost about $40 — $20 lower than the average price at other dispensaries.

A spokesman for a marijuana advocacy group said the machine also benefits dispensary owners.

"It limits the number of workers in the store in the event of a raid, and it'll make it harder for theft," said Nathan Sands, of The Compassionate Coalition.

Marijuana use is illegal under federal law, which does not recognize the medical marijuana laws in California and 11 other states.

The Drug Enforcement Agency and other federal agencies have been actively shutting down major medical marijuana dispensaries throughout the state over the last two years and charging their operators with felony distribution charges.

Mehdizadeh said the Herbal Nutrition Center was the target of a federal raid in December. He said no arrests were made and no charges have been filed against him.

Kris Hermes, a spokesman for advocacy group Americans for Safe Access, said the machine might benefit those who already know how much and what strain of marijuana they're looking for. But he said others will want to see and smell the drug before they buy it.

A man who said he has been authorized to use medical marijuana as part of his anger management therapy said the vending machine's security measures would at least protect against illicit use of the drug.

"You have kids that want to get high and that's not what marijuana is for," Robert Miko said. "It's to medicate."

14-4

KANSAS MEDICAL SOCIETY
KMS

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www.KMSonline.org

To: Senate Committee on Health Care Strategies

From: Dan Morin
Director of Government Affairs

Date: February 11, 2008

Subject: SB 556; An act concerning controlled substances; establishing the medical marijuana defense act

The Kansas Medical Society appreciates the opportunity to submit the following comments in opposition to SB 556, which would allow for the medical use of marijuana with written certification from a licensed Kansas physician.

The Kansas Medical Society believes patients are best served by medical treatment options, which are proven to be safe and effective by the U.S. Food and Drug Administration (FDA). Marijuana is currently a Schedule I drug, the most restrictive of 5 categories. Schedule I substances, by definition, have a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety standards for use of the drug. Other Schedule I substances include heroin, LSD, mescaline, and peyote. Drugs of abuse with recognized medical uses — such as opium, cocaine, and amphetamine — are assigned to Schedules II through V, depending on their potential for abuse. As recently as April 2006, the Food and Drug Administration (FDA) again declared that marijuana has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and has a lack of accepted safety for use under medical supervision.

We are hesitant to support efforts to circumvent the protections provided by the FDA to ensure that the medicines people use are safe and will accomplish what they are intended to do. Until such time as it receives FDA approval, KMS opposes the use of smoked marijuana for medical purposes. KMS does believe well designed clinical research studies should be conducted on the potential therapeutic value of synthetic and plant-derived, non-smoked cannabinoids for pain relief, control of nausea and vomiting, and other conditions. The FDA has approved a synthetic marijuana-based drug called Marinol that contains THC, the active ingredient in marijuana. Studies show Marinol to be effective in the treatment of nausea, vomiting and chronic pain.

In addition, a September 2007 Congressional Research Service Report states, "the federal Controlled Substances Act (CSA), which placed marijuana as a Schedule I drug, is not preempted by state medical marijuana laws, nor are state medical marijuana laws preempted by the CSA. States can statutorily create a medical use exception for marijuana and its derivatives

under their own, state-level controlled substance laws. At the same time, federal agents can investigate, arrest, and prosecute medical marijuana patients, caregivers, and providers in accordance with the Controlled Substances Act, even in those states where medical marijuana programs operate in accordance with state law." In addition to our primary, patient-care related concerns expressed above, this is another reason we would not support legislation which potentially places our members at risk for federal criminal prosecution.

Thank you for the opportunity to offer these comments.

Emporians for Drug Awareness, Inc.
Working for a Safer Community

PO Box 2015 Emporia KS 66801

620.341.2450 voice
620.341.2331 fax

February 7, 2008

Honorable Susan Wagle, Chair, and
Distinguished Members of the Health Strategies Committee:

Marijuana is currently a Schedule I drug under the Controlled Substances Act. The Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) both support that designation as marijuana meets the three criteria for placement in Schedule I: (1) marijuana has a high potential for abuse; (2) marijuana has no currently accepted medical use in treatment in the United States; and, (3) marijuana has a lack of accepted safety for use under medical supervision.

In addition, numerous scientific studies conducted by credible agencies such as the FDA, Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Drug Abuse (NIDA) have concluded that there is no data, either animal or human, to support the safety or effectiveness of marijuana for general medical use. More importantly, alternative medications that are FDA-approved are already in existence for treatment of many of the proposed uses of smoked marijuana.

No one wants to deny a person with a debilitating illness some relief, but putting these same people at risk because of the lack of appropriate dosages, quality control, interactions with other drugs, and the effect crude marijuana might have on pre-existing conditions makes it more of a health risk than a benefit. This is merely a method of playing on our emotions and sympathy for our fellow human beings who are suffering by those who want to be able to have the ability to use marijuana at will.

I am confident that our lawmakers and the vast majority of their constituents from across the state realize the negligence legislation such as medical excuse marijuana represents.

Respectfully,

Teresa Walters

Teresa Walters, Certified Prevention Specialist
Executive Director

Senate Health Care Strategies
Committee
Date: February 11, 2008
Attachment 16

THE REGIONAL PREVENTION CENTER

Strengthening Individuals, Families & Communities

February 7, 2008

Senate Health Care Strategies Committee
Kansas State Capitol
300 SW 10th St.
Topeka, Kansas 66612

Honorable Chair Senator Wagle and Distinguished Members of the Health Care Strategies Committee:

I am writing this letter to you in opposition of the medical marijuana bill number 556. Marijuana users are trying to get their foot in the door to legalization of marijuana with this bill. I firmly believe that if this bill is passed that it will only be a matter of time until this very dangerous substance is entirely legalized.

It's a common misconception that young adults are in favor of marijuana legalization. I am 21 years old and I couldn't be more against the idea of legalization of marijuana or any other drug in any form of legalization. I went into the prevention field because I know the dangers that illicit drugs are capable of and I want to stop that from happening.

The Drug Enforcement Agency (DEA) is trusted to enforce the controlled substance laws and regulations of the United States. According to their research marijuana is an addictive drug that carries many harmful short-term and long-term problems. The DEA reports that there are over 400 chemicals in one marijuana cigarette and that it deposits four times more tar into the lungs than one filtered tobacco cigarette. The tar and chemicals that are being deposited into the body of marijuana users could potentially cause cancer and that is one of the diseases that patients are asking relief from. There are many other drugs that are approved by the DEA that help suppress pain and are much safer for the body than marijuana. Marijuana will do more harm than good in bodies that are already suffering from low immune systems.

Marijuana is a gateway drug to other body altering substances such as heroin and cocaine. The doctors that prescribe this addictive gateway drug to patients are in effect responsible for leading their patients to other more harmful drugs. Rehab professionals are going to have the responsibility of weaning these patients off of the prescribed drug when the patient is healed of their disease.

This bill affects more people then just the doctors that will prescribe this drug and the patients that will use it. Parents would be sending a mixed message to their children by using marijuana and then telling their children that they aren't allowed to use it. I believe that juvenile delinquency rates will rise if this bill is passed. If the support for this bill goes any further the residents and the state of Kansas as a whole will suffer greatly.

Sincerely,

Dorothy Jochem

Dorothy Jochem
Prevention Consultant
Regional Prevention Center of the Flint Hills
1000 Lincoln
Emporia, KS 66801

From: "Irv Cohen" <icohen-vfa@kumc.edu>
To: <wagle@senate.state.ks.us>
Date: 2/11/2008 10:31 AM
Subject: Oppose MJ medical purpose bill

Dear Senator Wagle;

I urge you to reject bill for the supposed medical use of smoked marijuana. This is based on misinformation by those attempting to legalize this drug. Ask physicians and you will learn that it is possible and perfectly legal to give patients a pill form of marijuana, if a medical need exists. The first, Marinol (generic - Dronabinol) has been available for some time. A newer competitor Cesamet (generic - Nabilone) recently entered the market after FDA approval.

The MJ lobby has mounted a well-funded campaign preying upon victims of disease to sway public opinion. Any licensed physician could have prescribed a perfectly legal form of potent THC to these people, subject to the normal DEA safeguards for controlled drugs. No new legislation is needed for this.

Smoked marijuana presents a public health hazard three ways:
1) It could be used for questionable purposes, rather than the legitimate purposes that the pill form is prescribed for.
2) It is far more carcinogenic than tobacco smoke. No such danger exists for the legal pill form.
3) It interferes with law-enforcement efforts in the control of illegal drugs, efforts intended to protect our children.

Your meeting today is busy, so I am electing to submit this by email for distribution to your committee. Since I am possibly the only physician in NE Ks who is both residency-trained and Board-Certified in the medical discipline of Public Health & Preventive Medicine, please feel free to contact me for input on appropriate issues. Your assistant, Margaret, has my contact information.

Sincerely,

Irving Cohen, MD, MPH
Fellow of the American College of Preventive Medicine
Fellow of the American Society of Addiction Medicine
Author of "Addiciton: The High-Low Trap" (Health Press 1995)

The following is a letter printed in the Topeka Capital Journal Aug 30, 2007

Legal help available

Providing cancer sufferers misleading information for political gain has no place in Kansas. The Capital-Journal recently carried articles about a group claiming to want to help cancer sufferers by legalizing marijuana for supposed medical purposes in Kansas. In fact, physicians in all states are able to prescribe the active ingredient of marijuana in the form of a capsule called Marinol (generic name dronabinol) for patients suffering from cancer or AIDS.

This capsule contains delta-9-THC, the chief active ingredient in marijuana, but in a pure and consistent form. Complete prescribing information can be found in the Physicians Desk Reference or at www.marinol.com.

This drug has been legally available for about two decades and was approved by the FDA precisely because of the claims that the delta-9-THC found in marijuana had value for these patients, especially those suffering from nausea.

Despite this easy availability for those with a legitimate medical need, a well-funded national lobbying effort to legalize smoked marijuana continues, supposedly to benefit these cancer sufferers.

Why don't these lobbyists also mention that marijuana smoke gives off far more cancer-causing tar than tobacco smoke? Are these cancer victims being used as pawns by a group that wants to legalize marijuana for all? What are the chances that the tobacco companies are funding this drive to create a new product market?

IRVING A. COHEN, M.D., Topeka

TESTIMONY TO THE SENATE HEALTH CARE STRATEGIES COMMITTEE IN OPPOSITION OF SB 556

Presented by Ed Klumpp

February 11, 2008

This testimony is in opposition to the provisions of SB556 proposing a medical defense to possession of marijuana. The Kansas Association of Chiefs of Police oppose this attempt to legalize marijuana and encourage you to oppose it also. There are many reasons.

First, we do not believe there is significant medical need for marijuana. There are other alternatives already pharmaceutically available for the listed ailments.

Second, if there is an identifiable medical need, then the proper system is to allow pharmacies to supply it, not the corner drug dealer. This also requires the physician to use the acceptable practice of prescribing medications well established and controlled by law along with professional oversight. A simple letter or form signed by a physician will easily be acquired from a handful of rogue physicians or by illegally generating a document appearing to be from a physician. Kansas is currently looking at a significant investment to control prescription drug abuse. Imagine the scope of the problem if we start allowing non-prescription access to controlled substances.

Ten years ago Oregon went down this same path. Today they estimate marijuana usage is up 50% in that state. There were supposed to be about 500 people in the state marijuana use would medically assist. It has turned into 16,000 in the state holding the medical card to possess marijuana. In fact, last year I had a personal encounter with the Oregon medical marijuana situation. I was in Oregon for the funeral of a family member. Some of my family asked if I would mind giving a ride to another person who was a family friend. I stopped at his house and as he approached the car he was obviously not normal in his reactions and appearance. As soon as he opened the door I knew why. The smell of marijuana nearly floored me. Another person in the car, who knew I was a retired law enforcement officer, tried to make light of it by saying something to him about the "stench." The person high on marijuana looked at him, gave a wink, and said, "Well, it's medicinal of course." I later asked some other people that knew him what his medical condition was. I was told he didn't have a medical condition and

Kansas Association of Chiefs of Police • P.O. Box 780603 • Wichita, Kansas 67278-0603 • (316) 733-7300 • Fax: (316) 733-7301 • kacp@cox.net

ARTICLE IN THE OREGONIAN WWW.OREGONLIVE.COM

The Oregonian

Don't make a bad marijuana law worse

Monday, February 04, 2008

Ten years ago, when Oregon voters approved the state's landmark Medical Marijuana Act, they did so with assurances that only a handful of very ill people needed it -- perhaps 500 a year, supporters said at the time.

That turned out to be a false promise, as critics warned at the time. They appear to have correctly predicted that the new law would open the door for wider use of pot in Oregon by creating new legal defenses for the possession, use, cultivation and delivery of marijuana.

Statistics strongly suggest this. Today, nearly 16,000 Oregonians hold patient cards entitling them to use marijuana. Nearly 8,000 hold "caregiver cards" so they can possess it, and about 4,000 have permits to grow the plant, resulting in at least 19 tons of marijuana growing legally at any given time.

Not surprisingly, the rate of marijuana use by adult Oregonians is 50 percent higher than the national rate. Voters in 1998 may have thought they were showing compassion for a small number of terminally ill cancer patients who needed marijuana to alleviate their symptoms, but the law is clearly being abused in a big way.

This abuse is showing up in the workplace, where the Oregon drug test failure rate is 50 percent higher than the national rate. And the most prevalent reason for testing failure? Marijuana use -- 71 percent of all positive tests in Oregon, compared with 53 percent nationally.

The 2007 Legislature had a chance to address the workplace issue but fell short. A bill to make it easier for Oregon employers to enforce drug-free workplace policies, even against employees with valid medical marijuana cards, passed in the Senate but faltered in the House.

That was a sensible bill and deserves a second chance in the special session that begins today. Instead, however, the House Business and Labor Committee has put forth a much narrower bill that would give employers the option to regulate medical pot users in only the most dangerous of jobs.

This is a bad bill that will make Oregon's flawed law worse, not better. By giving employers discretion on accommodating medical marijuana use only by workers doing "hazardous duties," the bill would create a huge uncovered class of workers who would win the implicit right to accommodation at work -- something the original act explicitly did not grant.

In other words, this new bill is a Trojan horse. It would exempt such dangerous jobs as mining, logging and blasting, while creating the right to special accommodation for everyone else who might have marijuana cards, including surgeons, bus drivers, nannies and editorial writers.

Legislators should spike this bill. Instead, they should pass Senate Bill 465, clarifying the right of employers to enforce drug-free workplace policies.

And while they're at it, they should fund a Justice Department study of what increasingly appears to be widespread abuse of a well-intentioned medical marijuana law gone bad

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TESTIMONY TO THE SENATE HEALTH CARE STRATEGIES COMMITTEE IN OPPOSITION OF SB 556
Presented by Ed Klumpp

February 11, 2008

This testimony is in opposition to the provisions of SB556 proposing a medical defense to possession of marijuana. The Kansas Peace Officers Association opposes the legalization of marijuana and other controlled drugs in any form other than as a prescription authorized under existing laws and controls.

This bill seems to have many avenues to use as an excuse to have a letter in your hand saying it is okay to use marijuana. Although we are not medical experts, we question several of those listed needs. It is our belief other remedies and medicines are currently legal to address most if not all of the ailments listed.

Officers in other states having this type of exemption from the law tell us it simply doesn't work and under this type of plan marijuana becomes virtually an open market with little ability to control it, even when the medical excuse letter does not exist.

The odor of marijuana will no longer be of use to investigate since the odor could be from the legal use of marijuana. Spotting the marijuana on a person, in a vehicle, or in a building will not lead to an investigation without somehow knowing the person doesn't have a letter of excuse. The enforcement problems this creates are numerous. A fact many advocates to legalize the controlled substance are well aware of and hope to avoid by a law such as proposed in SB556.

Appropriate Kansas statutes relating to marijuana already exist today. They don't need changed. We strongly urge you to not recommend SB 556 to be passed.

Ed Klumpp
Legislative Committee Chair

In Unity There Is Strength

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KANSAS ASSOCIATION FOR JUSTICE

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Your rights. Our mission.

To: Senator Susan Wagle, Chairperson
Members of the Senate Health Care Strategies Committee

From: Callie Denton Hartle

Date: February 11, 2008

Re: SB 556 Concerning controlled substances; establishing the medical marijuana defense act--**NEUTRAL**

The Kansas Association for Justice is a statewide nonprofit organization of attorneys who serve Kansans seeking justice. Our association's position on SB 556 is neutral, and we offer the committee an observation and recommendation for a clarifying amendment.

KsAJ has no position on the use of, or public policy pertaining to, medical marijuana. However, SB 556 as currently drafted eliminates civil remedies and criminal penalties against a practitioner that fails to properly evaluate a patient's medical condition or otherwise violates the standard of care for evaluating medical conditions, in treating a patient with medical marijuana. (The bill permits the Board of Healing Arts to sanction such practitioner for violations or deviations from the standard of care relating to evaluating medical conditions.)

Licensees are required to properly evaluate a patient's medical condition in all cases, and are subject to civil, criminal, and disciplinary actions for failure to do so. We believe that the loophole in the bill is an oversight, and suggest its correction since we are not aware of any public policy rationale for distinguishing evaluation of patients for medical marijuana from evaluation of patients for other conditions or treatments. The same civil, criminal, and disciplinary remedies should be available for failure to properly evaluate a patient's medical condition or violating the standard of care for evaluating medical

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conditions.

To correct this oversight, KsAJ suggests the attached balloon amendment.

Thank you for allowing us to present our observations and recommend a clarifying amendment.

(6) "Tetrahydrocannabinol" has the meaning ascribed to it in K.S.A. 65-4105, and amendments thereto.

(c) It shall be a defense to prosecution under K.S.A. 65-4152 or 65-4162, and amendments thereto, that the person in possession or control of marijuana or tetrahydrocannabinol or drug paraphernalia to aid in the use of such substances has received written certification as defined in subsection (b).

(d) A physician shall not be subject to criminal or civil liability, denied any right or privilege or be subject to a disciplinary action by the state board of healing arts or by any other business or occupational or professional licensing board or bureau, solely for providing a written certification or for otherwise stating that, in the practitioner's professional opinion, a patient is likely to receive therapeutic benefit from the medical use of marijuana to treat or alleviate the patient's serious or debilitating medical condition, its symptoms or symptoms caused by treatment of such disease, provided that nothing shall prevent a professional licensing board from sanctioning a practitioner for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

in this subsection

limit the criminal or civil liability of a practitioner, or

,

(e) A registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth or insular possession of the United States that allows the medical use of marijuana shall not have the same force and effect as a written certification issued by a physician, and shall not constitute a defense to prosecution for possession or control of marijuana or tetrahydrocannabinol or drug paraphernalia in a court of law in Kansas.

(f) The provisions of this section shall be part of and supplemental to the uniform controlled substances act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

...provided that nothing in this subsection shall limit the criminal or civil liability of a practitioner, or prevent a professional licensing board from sanctioning a practitioner, for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

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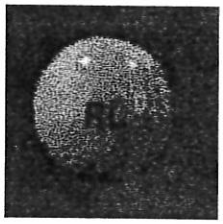

"Medical" Marijuana - The Facts

- Medical marijuana already exists. It's called Marinol.

- A pharmaceutical product, Marinol, is widely available through prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch. The active ingredient of Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients.

- Unlike smoked marijuana--which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke-Marinol has been studied and approved by the medical community and the Food and Drug Administration (FDA), the nation's watchdog over unsafe and harmful food and drug products. Since the passage of the 1906 Pure Food and Drug Act, any drug that is marketed in the United States must undergo rigorous scientific testing. The approval process mandated by this act ensures that claims of safety and therapeutic value are supported by clinical evidence and keeps unsafe, ineffective and dangerous drugs off the market.

- There are no FDA-approved medications that are smoked. For one thing, smoking is generally a poor way to deliver medicine. It is difficult to administer safe, regulated dosages of medicines in smoked form. Secondly, the harmful chemicals and carcinogens that are byproducts of smoking create entirely new health problems. There are four times the level of tar in a marijuana cigarette, for example, than in a tobacco cigarette.

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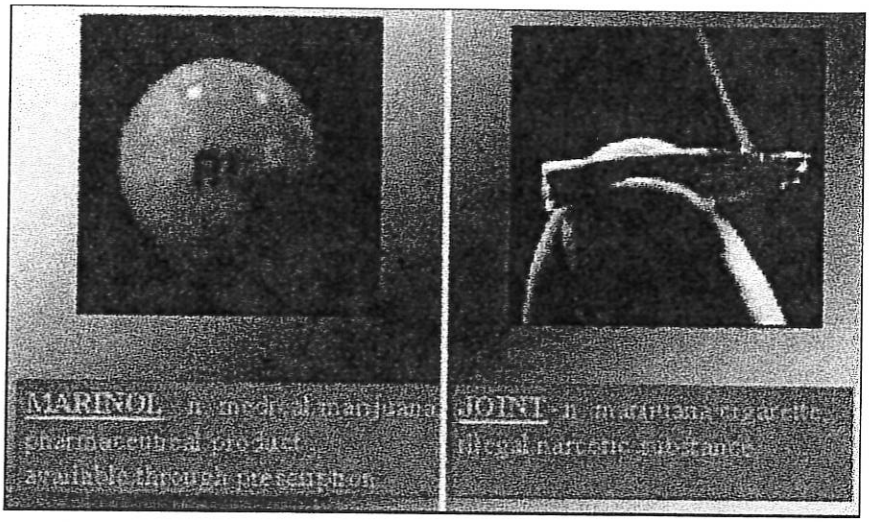

- Morphine, for example, has proven to be a medically valuable drug, but the FDA does not endorse the smoking of opium or heroin. Instead, scientists have extracted active ingredients from opium, which are sold as pharmaceutical products like morphine, codeine, hydrocodone or oxycodone. In a similar vein, the FDA has not approved smoking marijuana for medicinal purposes, but has approved the active ingredient-THC-in the form of scientifically regulated Marinol.

- The DEA helped facilitate the research on Marinol. The National Cancer Institute approached the DEA in the early 1980s regarding their study of THC's in relieving nausea and vomiting. As a result, the DEA facilitated the registration and provided regulatory support and guidance for the study.

- The DEA recognizes the importance of listening to science. That's why the DEA has registered seven research initiatives to continue researching the effects of smoked marijuana as medicine. For example, under one program established by the State of California, researchers are studying the potential use of marijuana and its ingredients on conditions such as multiple sclerosis and pain. At this time, however, neither the medical community nor the scientific community has found sufficient data to conclude that smoked marijuana is the best approach to dealing with these important medical issues.

- The most comprehensive, scientifically rigorous review of studies

of smoked marijuana was conducted by the Institute of Medicine, an organization chartered by the National Academy of Sciences. In a report released in 1999, the Institute did not recommend the use of smoked marijuana, but did conclude that active ingredients in marijuana could be isolated and developed into a variety of pharmaceuticals, such as Marinol.

- In the meantime, the DEA is working with pain management groups, such as Last Acts, to make sure that those who need access to safe, effective pain medication can get the best medication available.

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