TESTIMONY OF Derek William Rosenzweig
BEFORE THE PENNSYLVANIA SENATE
COMMITTEE ON LAW AND JUSTICE
IN FAVOR OF SB 1182
The RAYMOND SHAFER COMPASSIONATE USE ACT OF 2014

Good morning Chairmen McIlhinney and Ferlo and members of the committee. I am happy to have the opportunity to testify again about this important legislation. I'd like to thank the bill's sponsors, Senators Folmer and Leach, as well as this committee for continuing to work hard on the issue. Since the last hearing, we've made great strides in educating the public and the legislature, and the number of Senate members willing to support this bill has grown considerably. I'm here today to speak on behalf of PhillyNORML, and on behalf of my father.

As I talked about at the last hearing, my father Louis suffers from a condition known as Reflex Sympathetic Dystrophy, aka Complex Regional Pain Syndrome. It's a rare condition that can follow 5% of all nerve injuries, and can be caused by even minor injuries such as a sprain or a fall. RSD is a chronic neurological/neuropathic syndrome characterized by severe burning pain, burning sensations, pathological changes in bone and skin, excessive sweating, tissue swelling and extreme sensitivity to touch. It also affects the internal organs, due to inconsistent blood and oxygen flow. This leaves him in baseline condition of pain, which makes it impossible to take long road trips, such as to Harrisburg to be here with us today.

He deals with it the best he can, and some days it's not quite as bad. Other days, he's in such pain that the only thing to do is take medication, lie down, and hope that it helps a little. It can switch on for almost any reason. One minute he'll be sitting on the couch watching TV, the next he'll have agonizing back/neck pain because he slightly moved his head. This is what's known as "breakthrough pain." Stubbing a toe, something which you or I would get over after a minute or so, would be painful to him for the rest of the day, if not the next. Sunlight, light touch, and excess vibration can exacerbate his condition. The pain and side effects of medication also affect his ability to sleep, and can cause bouts of depression.

Activities like going out to come visit me at my home, going to the theater to see a movie, going to family functions/holiday dinners, going to the ballpark to watch a game... have been out of the question since 2004. Going for a car ride can cause him to be in pain for days. He had to leave my sister's wedding reception before it was halfway over; luckily, he made it through the ceremony. He has one of the worst cases of RSD known to his doctors. Since before his diagnosis, his history of treatment has included the following:

- 4/02 and 5/02, physical therapy;
- 6/02 and 7/02, cervical epidurals;
- 12/02, acupuncture;
- 1/03, nerve root injection. 4/03, carpal tunnel injection;
- 7/22/03, 7/29/03, sympathetic nerve block;
- 8/03, stellate ganglion block;
- 10/03, quantitative sensory testing;
- 11/03 inpatient stay intrapleural catheter with bupivacaine - 3 days;
- 2/04, IV with lidocaine in hickman catheter - 4 days;
- 5/05, 4 day inpatient ketamine IV drip.
- 5/06, psychological help and biofeedback.

At many points during his treatment, the medications he'd been prescribed affected him such ways that it was almost impossible to hold a conversation with him. Memory, speech, and his ability to stay awake were seriously affected, and they caused depression, for which he was prescribed yet more pharmaceuticals. It should be noted that the effects of marijuana are much better tolerated than any of the medications he's been prescribed, which have included:

- Pamelor 10mg, which did not help;
- Neurontin 300mg, which made him spaced out;

- Percodan 5/325, then Percocet 5/325, which made him tired, constipated and only helped a little;
- Paxil 10mg, which didn’t help;
- Fentanyl patch, which didn’t work and caused allergic reaction;
- Oxycontin 10mg; larger dose caused reaction;
- Ultram 50 mg no help;
- Pamelor 10mg and neurontin 300 mg at same time, really made him spaced out;
- Colace for constipation;
- MS Contin (morphine) 15mg, larger dose caused reaction;
- Zanaflex 4mg, made him very tired;
- Lexapro for depression, didn’t help;
- Oxycodone 5mg - am still on, this one helps with pain some, causes constipation;
- Valium 5mg. and miralax for constipation, still on;
- Wellbutrin and Zoloft for depression didn’t help;
- Lyrica 50 mg, which did not work and made him very tired;
- MS Contin (morphine) 15mg, then switched to Opana 40mg

Over the last decade, he tried cannabis a few times, and it did help him without causing any problems. He was more relaxed and his pain was diminished. Unfortunately, given its current illegal status, he won't use it again even though we know it can help. He doesn't want to risk legal penalties, nor penalties that someone helping him obtain medical cannabis would face if caught.

In Pennsylvania, the current penalty for possessing even 30 grams of cannabis (slightly over one ounce) is 30 days in jail and a $500 fine; possession of over 30 grams carries a 1 year incarceration and a $5,000 fine. Subsequent convictions can lead to doubled penalties. The penalty for growing cannabis is a felony conviction; depending on the number of plants, the mandatory minimum sentence is 1 or 3 years in jail, as well as a maximum $5,000 or $15,000 fine. No patient should have to choose between facing such penalties for attempting to treat their condition, and forgoing effective treatment.

In addition to the potential legal consequences, his pain management physician would stop treatment if my dad tested positive for cannabis in a drug test. Cannabis metabolites can be detected in the bloodstream for up to 30 days if it is used regularly. Pain management physicians are forced to drug test their patients because they can't be seen as enabling "drug addicts." It's a policy that pain management physicians have in place to protect themselves. Since these doctors prescribe a LOT of opiate based drugs to their patients, drugs which are highly addictive and abused, pain doctors must make well sure their patients aren't using chronic pain as an excuse to 'do drugs'. They can't be seen by the government as enabling addiction, or they could lose their DEA license to prescribe these medications. It's a catch-22 that blocks my dad and many other chronic pain patients from a treatment option that can improve their quality of life.

My dad, and others who suffer from this insane corruption of the human nervous system, would gain a palliative benefit and higher quality of life by using marijuana as a regular part of their medical regimen. My dad's tried talking to his neurologist about medical marijuana, but he won't discuss it since it's illegal. I guess in his mind he doesn't think there's any point. Due to the policies that pain management physicians must follow, he won't even try talking with his pain management physician about it - and he's not alone in that regard. Many chronic pain patients remain silent or are booted by their PMPs for medical cannabis use.

There is good scientific evidence which shows that marijuana is not only useful for chronic pain, but that it is even better suited for treating chronic (especially neuropathic) pain than opiate based medications. A study entitled "Effects of Vaporized Marijuana on Neuropathic Pain" attempted to determine if participants would report a 30% or greater reduction in pain intensity, and concluded:

> "Ten of the 38 subjects (26%) who were exposed to placebo had a 30% reduction in pain intensity as compared to 21 of the 37 exposed to the low dose (57%) and 22 of the 36 receiving the medium dose (61%) of cannabis."

This study tested the conditions Neuropathic Pain, Reflex Sympathetic Dystrophy, Peripheral Neuropathy, Post-herpetic Neuralgia, Spinal Cord Injury, and Multiple Sclerosis. Besides the clinical research, which concluded that:

> "Psychoactive effects were minimal and well tolerated, and neuropsychological effects were of limited duration and readily reversible within 1 to 2 hours. Vaporized cannabis, even at low doses, may present an effective option for patients with treatment-resistant neuropathic pain."

Numerous anecdotal reports have also shown that RSD and chronic pain patients do better with medical cannabis than without it. A 30% reduction in pain intensity might not sound like much, but it can enable my father to reduce the use of some of his other narcotic medications in the long term, and hence their side effects. My father deserves the best possible treatment for his condition, and passing SB1182 would give his doctors the freedom to provide written certification for medical marijuana. He, and other patients who suffer from chronic or neuropathic pain, could then use it without fear of going to jail or pain management physician's drug testing policies.

I feel the need at this time to reiterate something important. Marijuana is currently listed as a Schedule I drug under Pennsylvania law by the Controlled Substance, Drug, Device and Cosmetic Act. To be placed in Schedule I, a substance must meet three criteria: **a high potential for abuse**; AND **no currently accepted medical use in the United States**, AND **a lack of accepted safety for use under medical supervision**. Time, science, and medicine have shown us that marijuana is safe to use. Twenty-two states, plus Washington DC, have followed scientific research and medical evidence and concluded that marijuana is an effective medicine. Patients in the United States use marijuana safely for medical use; this has become self evident. Its placement in Schedule I is unrealistic, and if SB1182 is passed into law, Pennsylvania will finally recognize this important fact.

So what makes a good medical marijuana law? In more general terms, the primary issue to address in a medical marijuana law is ending penalties for any patient who is in possession of cannabis. It should not matter if they are plants being cultivated; cannabis plant matter that's ready to be consumed aka 'usable cannabis'; concentrates like hashish, oils, topical creams, etc.; or cannabis-infused edibles such as brownies, gummy bears, hard candies, or soft-drinks. It should not matter how or where the patient obtained it. The bottom line is that patients should no longer be subject to arrest, fines, or asset forfeiture.

The next issue to address is giving patients and medical practitioners the peace of mind and freedom to fully discuss and choose marijuana as a treatment option. The bottom line for medical professionals is the patient's quality of life. If the patient's doctor, nurse, psychiatrist, or dentist believes cannabis will help, they should be free to discuss and recommend it without the risk of arrest or penalty from the State Medical Board. My father should not have to fear simply asking his pain management physician or neurologist about cannabis as a medicine!

The next issue is making sure patients can easily obtain their medicine, and provide options and alternatives for patient satisfaction. Marijuana is easy to grow with minimal training - numerous books and online resources exist which provide expert advice. It's relatively inexpensive once the garden or grow area is initially set up, especially compared to purchasing it regularly. Patients must always have the right to grow their own cannabis for medical use - in fact, of the 22 states which have already legalized medical marijuana, all of them except 9 - New Jersey, Delaware, Connecticut, Massachusetts, Illinois, New Hampshire, Maryland, and Minnesota - allow patients to grow their own. It should be noted that patients in Delaware, Connecticut, Illinois, New Hampshire, Maryland, and Minnesota are still waiting for their dispensary programs to be implemented - and therefore have no legal way to obtain their medical cannabis. The most successful medical marijuana programs allow home cultivation from the start.

Many patients will likely opt to grow their own, but they should not be expected to. Most simply won't want to, or even be physically able to, therefore a mechanism needs to be present to ensure these patients have consistent and safe access to various strains of cannabis they might need. The existing mechanisms patients use in PA is either grow it themselves with no legal protection, or turn to the black market. Nobody knows how many of the estimated 1,992,000 cannabis consumers in PA use it for medical reasons, with no guidance from a medical professional. In Pennsylvania, cannabis bought through the

black market has inconsistent quality and availability, and one can almost never be certain of where it comes from. None of it is tested, and it is expensive - it's worth more than its weight in gold.

The price of marijuana varies based on many things, including but not limited to quality, proximity in the supply chain to the grower, how much the dealer likes or dislikes you, and many other factors. Regardless, the price is artificially hiked up due to the risk of imprisonment and fines, and high demand. Typically, people purchase cannabis for personal use measured in grams or multiples of eighths of an ounce. A gram of cannabis in PA can cost anywhere from $10 - $30, and is enough for a joint or two. An eighth ounce (3.5g) can run from $20 - $70; quarters (7.0g) go between $40 and $140. For the worst quality imaginable, a full ounce may only run $100; but for well grown and carefully tended buds of a really good strain, one might pay over $500. That's assuming the dealer actually knows the true strain they're selling, and is not just making it up so they can charge more. To make matters worse, many dealers even short their customers by not providing the correct weight, or by selling product which is not properly dried. Regardless, people really like good cannabis, and they pay top dollar for it. It's completely an seller's market - opaque and unregulated. This clearly is not the right solution.

The classic answer in states which have already legalized medical cannabis is a dispensary or compassion center which legally sells clones and seeds for growers, usable cannabis, concentrates, edibles, and paraphernalia. Quality will rise significantly - patients in these states never have to hear the term "schwag" again. The choice of available strains will grow with each harvest, as will competition by cannabis farmers to create better, more stable, and more effective strains for specific ailments. Commercial growers and compassion centers will be licensed and regulated by the state, and a system will be in place to handle customer complaints. Combined with competition and the system being transparent, it will help ensure that patients get what they expect and don't get ripped off.

Another option that should be available is co-operative gardens, where a group of patients have their medicine grown and distributed collectively in one location. Typically, a plot of plants of their requested strain(s) are grown for each patient, and the garden is run/tended by a small group of people (patients, caregivers, volunteers, etc). Community-driven medical cannabis collectives can be very successful, especially for low-income patients who cannot grow their own, nor afford prices at compassion centers. Nationwide, we are seeing a trend of marijuana prices going down both in the black market and in dispensaries, but it's hard to say what the overall cost of medical marijuana will be in PA once our program is up and running. Typically they start out near black market prices, since that's what most people are used to paying, and fluctuate as the market grows and evolves. Prices at the register should end up being noticeably lower due to allowing farmers to grow as much as they need to, and because the state would not tax it, but it doesn't help that insurance is not required to cover it. We won't see a reduction to its more natural cheap price point until the Federal prohibition ends and the marijuana industry scales up with to fit a national economy, just like other highly-valued commodities. When that happens, and interstate commerce of available supply becomes allowed, we may also see insurance companies cover medical marijuana in their policies.

The next issue for a successful medical marijuana program is product testing. Marijuana sold at a compassion center needs to be tested for quality, cannabinoid content, and mold or other contaminants. This also applies to co-operative gardens. The American Herbal Products Association (AHPA) has a great set of cannabis guidelines for cultivation, dispensing, and testing facilities that the Health department can utilize when drafting regulations. Marijuana grown by patients for themselves must not require testing, but testing facilities should provide cheaper or subsidized services for patients who do want it tested.

The final issue is to allow scientific and medical research to be conducted on marijuana. This includes animal studies, work on cell cultures, and human clinical trials using whole-plant cannabis as well as individual preparations of its cannabinoids and terpenes. This will push the frontier of knowledge and can be used to refine available strains to be better suited for treating specific conditions, much like how oil extractions using the Charlotte's Web strain have been shown to be more effective for epileptic patients. In California, when the state legislature decided to regulate cannabis dispensaries, they also included language to create the Center for Medicinal Cannabis Research (CMCR). The purpose of the Center is to coordinate rigorous scientific studies to assess the safety and efficacy of cannabis and cannabis compounds for treating medical conditions. The funding of the CMCR is the result of SB 847, signed into law by Governor Gray Davis. The legislation calls for a three year program overseeing objective, high quality medical research that will "enhance understanding of the efficacy and adverse effects of marijuana

as a pharmacological agent." As a result, California is at the forefront of medical cannabis research in the USA today. There is no reason why Pennsylvania can't be right up there with them, and I urge the Senate to draft and pass a separate bill to create such an institution after SB1182 becomes law.

Some amendments have been proposed to make the bill more workable. We have not seen the exact language of these amendments, so it's hard for us to analyze the situation completely. From what we've been told, the changes are mainly administrative, in order to save taxpayers money and reduce government bloat. Having a dedicated department to deal with all aspects of the program may have been the preferred option, but splitting up the duties among the existing departments will suffice. Our main concern is effective communication between the departments in order to implement the program quickly and without undue hindrance. If the core of the bill stays the same, PhillyNORML will of course continue to support it.

Recently, Governor Corbett proposed a program to allow certain children with certain types of epilepsy to take part in a pilot program at select local hospitals. While anything we can do to help the children is a positive step forward, it simply doesn't go far enough. We know medical marijuana can be legalized, implemented, and regulated successfully. We know medical marijuana doesn't cause the types of hyped up outcomes feared by the media and those with a vested interest in keeping this useful medication out of the hands of patients and doctors. The legislature should spend their limited time on the best possible legislation, in order to help the most people. Under the Governor's proposal, patients like my father would be left in the cold. A real medical marijuana law is simply a better solution which can be done without reinventing the wheel.

Since Rep. Mark Cohen first introduced a medical marijuana bill in 2009, Pennsylvania's legislature has had four public hearings where excellent testimony was given and submitted by dozens of patients, advocates, and medical professionals. All of this testimony is publicly available on the PA Legislative website, and in video form on YouTube. SB1182 does a great job of learning from the mistakes and successes of the twenty-two states that have already charted this well traversed territory. It's the strongest bill to come out of all of that hard work, and it should be what both the Senate and House send to Governor Corbett. It is the hope of both myself and PhillyNORML that this committee will schedule a voting hearing soon so the Senate can pass it. I thank you for your time and consideration.

Sincerely,

Dated: June 9, 2014

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Addendum:

Examples of cannabis collectives in California:

- "The Green Cross" - http://www.thegreencross.org/
- "Berkeley Patients Group" - http://www.berkeleypatientsgroup.com/
- California NORML Collective Listing -
    - http://listing.canorml.org/medical-marijuana-collectives-in-california/

According to the latest SAMHSA data, in 2012, 20.2% of respondents aged 15 or older used marijuana. Pennsylvania has a population of approximately 9,861,456 citizens aged 15 or older. Without weighing for the same age distribution, and applying the 20.2% figure to Pennsylvania, approximately 1,992,014 citizens aged 15 or older used marijuana in 2012.
http://www.infoplease.com/us/census/data/pennsylvania/demographic.html
http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect1peTabs1to46-2012.htm#Tab1.12A