

DISSEMBLING VOICES?

A Response to Claims By Educating Voices, Inc.

*Prepared by the Illinois Cannabis Patients Association (847 341-0591)
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The Compassionate Use of Medical Cannabis Pilot Program Act is a compassionate bill that is sponsored by Sen. Bill Haine and Rep. Lou Lang. Chief co-sponsors of SB 1381 are Sen. Iris Martinez and Sen. Jeffrey Schoenberg. Chief co-sponsors of HB 2514 are Rep. Angelo Saviano, Rep. Karen A. Yarbrough, Rep. Cynthia Soto, Rep. Deborah Mell, and Rep. Elizabeth Hernandez. Both Republicans and Democrats have sponsored and voted for this legislation, making it a true bipartisan effort.

1. “Marijuana is not an FDA-approved medicine.”

The federal ban on medical use of cannabis was not put in place by the FDA or any medical agency. It was put in place by politicians: Congress and the president.

The federal government has allowed some medical cannabis studies to proceed, but has blocked the type of research needed to develop cannabis as an FDA-approved medicine. The relative lack of large, controlled trials of cannabis is almost entirely due to government obstructionism. The federal government has not only refused to fund medical cannabis research, it has put in place a set of legal and bureaucratic obstacles that have kept the flow of even privately-funded medical cannabis studies to a trickle.

The federal government has a long history of ignoring data that contradicts official dogma on cannabis. When DEA Administrative Law Judge Francis Young ruled in 1988 that cannabis was “one of the safest therapeutically active substances known” and thus must be rescheduled, political appointees overruled him.

In addition, every year, doctors write approximately 65 million prescriptions for drugs not yet approved by the FDA. They are most commonly cough and cold medications, sedatives, and single ingredient narcotics. Some have been on the market for years, since before the current FDA approval system. According to Deborah Autor, associate director of the FDA Office of Compliance, these drugs “are on the market simply because the manufacturers have chosen not to get FDA approval, even though they were required to do so.” Oxycodone hydrochloride, Phenobarbital, and Chloral hydrate are all popular medications prescribed by physicians and dispensed by pharmacies, none of which are FDA approved.

The FDA is the same agency that approved Vioxx, the arthritis drug that later proved to cause heart attacks and strokes, legal claims for which were settled in the billions. Amazingly, the FDA actually re-approved Vioxx two years after its manufacturer voluntarily removed the drug from the market – the FDA simply required more warnings on the label the second time around.

In November of 2007, the FDA issued its own report entitled “FDA Science and Mission at Risk.” The report stated, “science at the FDA is in a precarious position: the Agency

suffers from serious scientific deficiencies and is not positioned to meet current or emerging regulatory responsibilities.”

The bottom line is that cannabis’ classification has been found to be “arbitrary and capricious,” and FDA approval is not necessarily indicative of a drug’s medical efficacy or safety. The public policy question SB 1381 asks is, Is the status quo good for seriously ill patients? Right now, many obtain cannabis from drug dealers and risk arrest because it is the only thing that relieves their pain. Throwing cancer patients in jail is without question bad for their health.

2. “Marijuana has killed people.”

Unlike commonly prescribed medications and even over-the-counter drugs, cannabis has never caused a single medically documented overdose death. In comparison, Tylenol (acetaminophen) has been estimated to kill nearly 500 Americans per year by causing acute liver failure,

Although a claim was made that smoking cannabis illegally in Illinois caused a cancer patient to develop a lethal lung infection, no scientific documentation or studies were referenced to substantiate the claim. If, however, the tragic death were truly related to smoking cannabis, there are several reasons to think that this bill would actually prevent this from happening. It’s important to remember that cannabis need not be smoked. Where used legally according to a doctor’s recommendation, doctors would likely advise that it be vaporized, eaten, or administered as a sublingual spray rather than smoked. As the American College of Physicians has recognized, vaporization allows “the rapid onset of symptom relief without the negative effects from smoking.” Further, the only plausible cause would not be the cannabis itself but a fungus or other contaminate. When cannabis is purchased on the illegal market, one has no idea what it might be laced with. The cartels or others producing it may use dangerous, illegal pesticides or allow mold to grow on it. The best way to avoid this is with a regulated system of state-licensed compassion centers where patients can safely obtain their medicine, rather than procuring it from drug dealers in the criminal marketplace. This is exactly the situation SB 1381 seeks to create.

It is also important to remember that banning medical cannabis *has* killed people. Patients such as Robin Prosser of Montana have taken their lives due to lack of access to their medicine. And at least one patient, quadriplegic Jonathan Magbie of Washington D.C., died in a jail that was unable or unwilling to care for his medical needs after being sentenced for possession of a small amount of the cannabis that gave him relief.

3. “Marijuana grown in locked facilities poses grave concerns.”

SB 1381 requires cannabis be grown in an enclosed, locked facility so that those who are not authorized by the state to participate in the program do not have access to it. Requiring marijuana to be grown in a locked location also keeps it out of the view of the public, thereby decreasing the chance of theft. In the end, locking medicine up is a good idea because it helps ensure that those who do not need it are not using it.

The concerns about problems related to wiring and electricity are unfounded. Patients and caregivers will only be allowed to grow a total of seven plants, which would not require a dangerous amount of wiring or lighting in their homes. In states with similar limits, such as Vermont, there has not been a single report of a problem due to electricity used for patients' medical cannabis.

4. "Where will the first seed come from?"

In addition to protecting seriously ill patients from living in fear of arrest, another benefit of SB 1381 is that patients will no longer have to support a dangerous criminal market where the cannabis they purchase may be financing the operations of deadly cartels. Patients will be able to shift to obtaining their medicine from well-regulated non-profit dispensaries or will be able to cultivate their own medicine.

Patients will be allowed to give away cannabis to one another or to the dispensaries to get it started. Patients and dispensaries would also be allowed to purchase start-up seeds from patients and providers from any of the other medical cannabis states, including Michigan.

At least one state-legal medical cannabis provider has already expressed interest in providing the first seeds for Illinois' patients. In addition, this concern is largely illusory. In reality, it is very easy to find medical cannabis seeds online. Illinois patients are already using cannabis to treat medical conditions that would be covered under SB 1381, so obtaining seeds is really not an issue at all. The real issue is whether they should be criminals for preserving their health.

5. "Medical cannabis organizations threaten children, families, and neighborhoods."

State-licensed and tightly regulated compassion centers that assist patients by providing them with a safe, reliable source of medicine are no more of a threat to Illinois citizens than the local pharmacy. In fact, many residents and community leaders have reported improvements in neighborhoods with regulated dispensaries.

Claims that San Francisco saw crime increase in areas with dispensaries in 2006 should be taken with a grain of salt. In California, there is no statewide licensing or regulation of dispensaries and San Francisco did not begin regulating dispensaries until after 2006. The situation in San Francisco in 2006 was very different than the situation today, and nothing like the situation contemplated by a tightly crafted bill like SB 1381 and HB 2514.

Barbara Kiley, who administers Oakland's dispensary regulation ordinance, notes that "The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc. ... since the ordinance passed."

Likewise, Santa Rosa Mayor Jane Bender said that since the city began regulating dispensaries, "The city attorney says there have been no complaints either from citizens

nor from neighboring businesses." Similarly, Tulare's Planning and Building director, Mark Keilty, said dispensaries had had "no effect [on local business], or at least no one has complained."

Former Santa Cruz mayor and current Councilmember Mike Rotkin said that his city's dispensary "provides a legal (under State law) service for people in medical need. Because it is well-run and well-regulated and located in an area acceptable to the City, it gets cooperation from the local police ... It is no longer a controversial issue in our city. ... The immediately neighboring businesses have been uniformly supportive or neutral. There have been no complaints either about establishing it or running it."

City Councilmember Kriss Worthington of Berkeley said the dispensary there has "been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

6. "More than one person can grow marijuana for a patient, which would allow cardholders to possess 4 ounces and 14 plants."

SB 1381 defines an adequate supply as the amount the patient and caregiver are allowed to "collectively" possess. The amount will be determined based on input from a committee that includes law enforcement and botanists. Until then, SB 1381 says a registered patient can only possess six cannabis plants (only three of which may be mature female plants that produce usable cannabis) and 2 ounces of usable cannabis.

7. "Marijuana dispensaries would only be required to meet 'minimum oversight requirements,' and provide 'minimum record-keeping' and 'minimum security.'"

This is a misrepresentation of what the bill proposes and the quoted portions are taken completely out of context. What SB 1381 actually says is that the Department of Health "shall promulgate rules governing the manner in which it shall consider applications for and renewals of registration certificates for medical cannabis organizations, including rules governing: (1) The form and content of registration and renewal applications; (2) Minimum oversight requirements for medical cannabis organizations; (3) Minimum record-keeping requirements for medical cannabis organizations; (4) Minimum security requirements for medical cannabis organizations; and (5) Procedures for suspending or terminating the registration of medical cannabis organizations that violate the provisions of this Section or the rules promulgated pursuant to this subsection."

This means the department will determine the requirements for security and oversight that must be met; it does not mean that that floor will be low. The requirement for the compassion centers says they must, "implement *appropriate* security measures to deter and prevent unauthorized entrance into areas containing cannabis." The bill's safeguards also include background checks and state registration for all employees.

8. “Marijuana is a dangerous drug.”

Cannabis is less dangerous than most of the narcotics that patients who need this law are currently being prescribed. Cannabis has never caused a lethal overdose, unlike OxyContin, Tylenol, and even water. Tylenol kills about 500 people per year. While all medications have side effects, cannabis' are far less dangerous than death. Vioxx, which was approved by the FDA, is estimated to have caused between 26,000 and 55,000 needless deaths before it was taken off the market.

Even the DEA's own Administrative Law Judge, the Honorable Francis Young, stated in 1988 that cannabis "is one of the safest therapeutically active substances known to man." He went on to say, "The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."

Some opponents of SB 1381 have cited that “there were 33,854 admissions for marijuana treatment in Illinois” in 2006; however, the Office of National Drug Control Policy reports about half that number. It reports 16,137 admissions for cannabis in 2006, and the Substance Abuse & Mental Health Services Administration reports 17,201 admissions in 2006 (based on data collected through January of this year). Moreover, the available data suggests that many of these admission referrals take place as a condition of probation, and that acceptance of treatment is part of a plea agreement in which individuals enter treatment in order to avoid incarceration rather than because they are dependent on cannabis.

In its report on cannabis as medicine, the Institute of Medicine noted that "few marijuana users develop dependence," and that "they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs."

9. “Marijuana is a gateway drug.”

The federal government's own official advisor on scientific matters, the National Academy of Sciences' Institute of Medicine, has found “no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.” RAND Corporation, one of the world's most respected think tanks, has firmly refuted the gateway theory as it relates to the claim that cannabis leads to the use of harder drugs: “The gateway theory has little evidence to support it despite copious research.”

The claim about cannabis being a gateway makes little sense in the case of people using cannabis for medical purposes rather than for psychoactive effects. In the case of medical cannabis, seriously ill patient often want to *stop* using highly addictive and intoxicating medicines. As the prestigious American College of Physicians said in its February 2008 statement supporting cannabis' medical value, “Marijuana has not been

proven to be the cause or even the most serious predictor of serious drug abuse. It is also important to note that the data on marijuana's role in illicit drug use progression only pertains to its non-medical use."

10. "Marijuana's potency is significantly higher today."

THC is essentially nontoxic, and no research has demonstrated greater risks of addiction or health problems from higher THC levels. As an Australian government report noted, much of the research showing cannabis to have minimal health risks has been done on users consuming very high levels of THC, indicating that a high level of THC isn't necessarily a bad thing. Moreover, users of higher-potency cannabis require smaller doses, thereby reducing the overall intake of cannabis, whether it is via inhalation (smoked or vaporized) or oral administration (ingested or sprayed sublingually).

In addition, a pill that is 100% pure synthetic THC, Marinol, is already legal for medical use in the United States. Therefore, all natural medical cannabis is *less* potent than the pill that is legally available for medical use. Among the many reasons that the pill is not an adequate substitute for many patients is that it is frequently too intoxicating, because it is pure THC and patients are unable to use a smaller dosage, as they can when they use a vaporizer to administer natural cannabis rather than a pill. At least one of cannabis' other therapeutic cannabinoids, cannabidiol, actually moderates the psychoactive effects of THC.

11. "The American Medical Association, American Cancer Society, American Academy of Pediatrics, National Multiple Sclerosis Society, and the British Medical Association all advise against medical marijuana."

This is a misleading and incomplete statement. The American Medical Association actually supports more research into medical cannabis. They also support the development of "a smoke-free inhaled delivery system," which is exactly what a vaporizer is. The American Cancer Society "supports the right of individuals with cancer to decide what treatment is best for them." The National Multiple Sclerosis Society supports more research and acknowledges that some multiple sclerosis patients do find relief using cannabis. In 1997, the British Medical Association stated, "Present evidence indicates that [cannabinoids, marijuana's active components] are remarkably safe drugs, with a side-effects profile superior to many drugs used for the same indications." In 2004, The American Academy of Pediatrics issued a policy statement that "supports rigorous scientific research regarding the use of cannabinoids for the relief of symptoms not currently ameliorated by existing legal drug formulations."

None of these organizations calls for patients to be hauled off to jail for using the medicine their doctor believes will help. On the contrary, when they were interviewed about a bill similar to SB 1381, the spokespersons for the American Medical Association and the American Cancer Society said that patients afflicted with cancer and other painful medical conditions should not be prosecuted for trying to alleviate their suffering. That is exactly what this bill would prevent.

State-level support for allowing medical marijuana includes more than 1,000 Illinois physicians, 1,000 Illinois nurses, former prosecutors, the Illinois Nurses Association, the AIDS Foundation of Chicago, and the Test Positive Action Network. National support includes the American Bar Association, the American Nurses Association, the American Public Health Association, the American Academy of HIV Medicine, and the Leukemia & Lymphoma Society. Even two former U.S. Surgeons General – Joycelyn Elders and Jesse L. Steinfeld – recognize cannabis as a legitimate, beneficial medicine.

12. “It is difficult to legislate medicine.”

The fact that something is difficult to do is no reason to ignore the problem. It is legislators’ job to address the problems faced by citizens of this state. Currently, Illinois’ laws criminalize cannabis use by terminally and seriously ill patients who have not found relief from other medications and whose doctors recommend medical cannabis. It’s time for compassionate legislators to change that.

In 2002, then Republican leader Frank Watson helped pass legislation creating Illinois’ pharmaceutical assistance program that helps participants pay for approved medications used to treat heart and blood-pressure conditions, diabetes, arthritis, Parkinson’s disease, Alzheimer’s disease, cancer, glaucoma, and lung and smoking-related illnesses. This session, there are dozens of bills that address medical issues involving everything from acupuncture (Sen. Koehler), nursing (Sen. Crotty), naturopathic medicine (Sen. Collins), the monitoring of controlled substances (Sen. Luechtefeld), HPV prevention (Rep. Jakobsson), students with diabetes (Rep. Cross), senior citizens with MS (Sen. Holmes), and contraception (Rep. Feigenholtz).

13. “Hepatitis patients should not use marijuana daily.”

This statement oversimplifies and distorts relevant research on medical cannabis and hepatitis C. In some cases, medical cannabis may be indicated, and in some it should not be used. This is precisely the sort of clinical judgment doctors are trained to make, and SB 1381 allows physicians and patients to determine whether the benefits of using cannabis outweighs the risks for any given patient.

A 2006 study of 71 patients to determine the impact of cannabis use during interferon/ribavirin treatment for the hepatitis C virus (HCV) compared to non-users and found that cannabis users had three times the rate of sustained virological response, meaning that HCV could not be detected six months after they completed treatment (in essence, the patients were cured of the deadly infection). Interferon causes significant side effects, and the patients using cannabis stayed on their HCV treatment for an average of five weeks longer than those not using cannabis. The researchers stated, “[T]he use of cannabis during HCV treatment can improve adherence by increasing the duration of time that patients remain on therapy; this translates to reduced rates of post-treatment virological relapse.”

The study cited by Educating Voices involves established, chronic HCV infection, and — unlike the 2006 study — was not a study of patients receiving treatment designed to

eliminate the virus. It does appear that patients with an established, chronic hepatitis C infection should avoid daily cannabis use, but the best way to avoid HCV-related liver damage is to be cured of the infection. The evidence strongly suggests that short-term, occasional use during treatment to relieve drug side effects can increase the chances of success.

In the 2006 study, subjects who used cannabis less than every other day were as likely to adhere to their medication as those who used cannabis every other day or more frequently. Thus, it seems that hepatitis C patients need not use cannabis daily to improve their adherence to interferon. Though there is no evidence that short-term use during treatment is harmful, avoidance of daily use seems to mitigate any concerns.

14. “People with multiple sclerosis who smoke marijuana are more likely to have emotional and memory problems.”

As the National Multiple Sclerosis Society notes in relation to looking into cannabis’ cognitive effects, “to keep this in perspective, it must be remembered that many existing drugs used in MS have effects on cognition.” It also noted that “the trials with cannabinoids have not found significant adverse cognitive effects.”

All medications produce some side effects. Unlike cannabis, many of those possible side effects include the risk of death from overdose. For some patients, such as Julie Falco of Chicago, other MS medications’ side effects are as bad as the disease itself — and can lead patients to consider taking their own lives.

Cannabis has been shown to alleviate many serious MS symptoms, including neuropathic pain and spasms. As the National Multiple Sclerosis Society notes, “it now appears that cannabinoids may reduce neuronal damage and thereby could limit disease progression.” In a long-term follow-up of a clinical trial of a cannabis-based oral spray not available in the U.S., the spray demonstrated long-term relief of spasticity, pain, and bladder issues related to multiple sclerosis “without unacceptable adverse effects.”

The federal government itself has provided medical cannabis to a handful of patients for decades, all but a few of whom have passed away. One of the patients who received federal cannabis for multiple sclerosis was among the four subjects of the only study of long-term recipients of federal cannabis. The study found that cannabis helped alleviate her spasticity, tremor, gait, and depression. Her physician reported that cannabis “seems to have a positive effect on her mental status overall.” The researchers found that her “[m]emory functions ... appear to be normal in the sense that once she acquires information, she seems to hold it quite effectively.”

The decision of whether to include cannabis in a multiple sclerosis patient’s treatment plan should be made by the physician and his or her patient without Illinois’ criminal penalties standing in the way.

15. “Marijuana is clinically useless in ophthalmology.”

Glaucoma patient James Bingenheimer of Belvidere, whose eyesight has been saved with the help of cannabis, would disagree. He has been arrested for possessing small amounts of cannabis for medical use twice, but maintains that “if I have to choose between going blind and going to jail, I’ll go to jail again.”

In 1999, the Institute of Medicine stated that “In a number of studies of healthy adults and glaucoma pressure, IOP (intra-ocular pressure) was reduced by an average of 25% after smoking a cannabis cigarette that contained approximately 2% THC — a reduction as good as that observed with most other medications available today.”

Glaucoma is the second leading cause of blindness in the United States. It damages the optic nerve, which is responsible for carrying images from the eye to the brain. High pressure within the eye is one of the main risk factors for this optic nerve damage. There currently is no cure for glaucoma. Cannabis helps relieve the pressure within the eye, thus preventing damage. Although other drugs are considered first-line glaucoma treatments, some patients and physicians have found cannabis useful when conventional drugs fail. If other drugs were uniformly successful, then why is glaucoma still a leading cause of blindness? One of the three patients who still receive medical cannabis from the federal government – Elvy Musikka – is a glaucoma patient; he also successfully argued in a Florida court case that cannabis was medically necessary to maintain her vision.

16. “Seven plants can produce 16,464 joints.”

Opponents offer no data nor cite any studies to support this outrageous claim. According to data from a study by the DEA, the average usable cannabis yield under ideal conditions per female plant per year is 4 ounces. It should be noted that due to genetics male plants account for half of all plants but produce no usable medicine, and Illinois patients would only be allowed to grow six plants at any given time, only three of which could be mature females producing medicine. For the sake of argument, even if all six plants were females producing medicine, patients would only be able to produce 24 ounces of usable cannabis in a year, which is approximately 2 ounces per month.

Because SB 1381 has been amended so that only three plants will be able to produce medicine at any given time, patients will only be able to produce about 1 ounce per month, or 12 ounces per year. This is a paltry amount that will ensure many patients will need to obtain additional medicine from a state licensed compassion center.

The federal government sends approximately 8 ounces of cannabis to the three surviving federal patients each month in the form of 300 pre-rolled cannabis cigarettes. Using the average weight of these cigarettes ($0.734 \pm 0.05g$), that would work out to no more than 456 joints per year for three female plants grown in ideal conditions.

Seriously ill patients with no expertise in botany will not be producing 36 times as many joints as the federal government’s trained and experienced cultivators have managed to produce under ideal conditions.

Opponents claims are also at odds with an objective state review of how much medical cannabis patients need. The Washington State Department of Health was charged with objectively determining what would constitute an adequate 60-day supply of cannabis for patients. After consulting with experts, patients, and law enforcement it determined that 15 plants at any stage of growth would produce an adequate 60-day supply. This is more than five times the number of medicine producing plants SB 1381 would allow.

17. “People will be able to grow marijuana in their homes.”

Illinoisans are allowed to have numerous potentially lethal possessions. Unlike most prescription drugs, cannabis has never caused a lethal overdose. Drugs like morphine, Oxycontin, and Vicodin are not required to be kept in an enclosed locked facility like SB 1381 requires cannabis plants to be. Guns are also not required to be kept under lock and key.

Opponents are concerned that allowing cancer patients or their caregivers to have cannabis plants in their home will cause young people to try to start invading neighbors’ homes looking for cannabis. Seriously ill patients are allowed to possess prescription drugs that can cause fatal overdoses. Why can’t they be trusted with a plant that the DEA’s own chief judge called “one of the safest therapeutically active substances known”?

Opponents also claim that “off-campus housing could become a mecca of marijuana grow operations.” Problems like this have not been reported in the 13 states that have a medical cannabis law, nor have opponents offered any facts to suggest that this would happen in Illinois.

The root of this concern seems to be a concern that SB 1381 would increase recreational cannabis use by young people. But data has shown this concern is unfounded. In the 11 medical cannabis states that have before-and-after data, all have reported overall decreases in teen cannabis use — exceeding 50% in some age groups. Further, SB 1381 provides additional penalties for anyone who would sell medical cannabis.

18. “Property owners can not refuse to lease an apartment or house to a patient or caregiver and the owner of a commercial property can not refuse to lease to a dispensary on the basis that the tenants will be growing marijuana on the property.”

SB 1381 says that a patient or caregiver cannot be denied a lease “solely for his or her *status*” as a registered patient or a caregiver. It does not say a landlord has to allow any particular conduct. The bill also specifically states that schools, employers, and landlords may refuse to enroll, employ, lease to, or otherwise penalize a patient if “failing to do so would put the school, employer, or landlord in violation of federal law or cause it to lose a federal contract or funding.”

19. “Marijuana could be recommended for pain.”

Many Illinois patients suffer from serious, debilitating, intractable pain for which they are prescribed dangerous and addictive narcotics. Studies have shown that marijuana is effective in treating severe pain, including neuropathic pain, a nerve pain commonly seen in amputees and persons with multiple sclerosis or HIV/AIDS. It is notoriously resistant to treatment with conventional pain drugs, including opiates. Preclinical research, case studies, and anecdotal reports suggest that cannabis may allow reduced opioid doses.

Furthermore, SB 1381 has been amended so that pain is now only a qualifying condition if it is intractable, severe, debilitating, and the patient has not responded to other reasonable medical efforts for a reasonable amount of time.

In 2008, a study entitled “A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain” appeared in the *Journal of Pain*. This study investigated the efficacy of smoked cannabis in patients suffering from neuropathic pain related to a variety of conditions, including multiple sclerosis, spinal cord injury, diabetes, and complex regional pain syndrome. Researchers concluded, “This study adds to a growing body of evidence that cannabis may be effective at ameliorating neuropathic pain, and may be an alternative for patients who do not respond to, or cannot tolerate, other drugs.”

In 2007, a clinical trial involving HIV/AIDS patients suffering from HIV-associated sensory neuropathy was reported on in the scientific journal *Neurology* under the title “Cannabis in Painful HIV-Associated Sensory Neuropathy: a Randomized Placebo-Controlled Trial.” It reported that there are presently no FDA-approved treatments for this indication. Dr. Abrams and his colleagues tested the efficacy of smoked cannabis on both HIV neuropathy and laboratory-induced pain. Cannabis produced an average 34% reduction in pain and was well tolerated.

20. “The bill recognizes marijuana registry cards from other states, creating a major loophole.”

As is the case in most of the newer medical cannabis states, patients who are visiting from another state, such as Michigan, and have a state medical cannabis ID card or similar documentation would not be subject to arrest during a visit of no more than 30 days. It would also permit new residents who moved from a medical cannabis state where they were registered 30 days to get an Illinois-issued medical cannabis ID card. This provision is important because many patients travel to other states, including for medical care. In addition, many people facing serious illnesses want to move to be nearer to their family members.

21. “A mixed message about the harmful effects of marijuana will go out to our youth.”

This is a common complaint often heard from opponents of compassionate medical

cannabis laws, but it has yet to be substantiated. In fact, available data suggests just the opposite – medical cannabis laws are actually associated with decreases in youth cannabis use: All 11 of the medical cannabis states that have produced before-and-after data have reported overall decreases in teen cannabis use — exceeding 50% in some age groups.

22. “The bill could provide cover for marijuana trafficking.”

On the contrary, the bill would provide for increased penalties for any person who sells cannabis to someone who is not allowed to use it under state law. Each individual caregiver can only assist a single patient, and each compassion center will be strictly regulated and subject to inspections and strict regulations.

Even though most of the other medical cannabis states do not have penalty enhancement for diverted cannabis, those with more carefully crafted laws have not seen problems. In the states that keep such records, only zero to three medical cannabis cards have been revoked for misconduct. Seriously ill people are not looking to sell their medicine — they are looking for relief.