

Peter Angelini  
North Haven, CT

## Testimony Submission for HB 5389

March 7<sup>th</sup>, 2012

Chairman Eric Coleman, Chairman Gerald Fox, Ranking Member John Kissel, Ranking Member John Hetherington and other distinguished Members of the Judiciary Committee.

Thank you for the opportunity to submit testimony in favor of **HB 5389 AN ACT CONCERNING THE PALLIATIVE USE OF MARIJUANA.**

I became involved supporting palliative use of marijuana several years ago after hearing deeply painful stories from families suffering. Not just suffering from ailments, but also suffering from prescription medication. Prescription medication prescribed by doctors to relieve pain; however instead of relieving their pain the medication created new problems with horrific side-effects. Watching and talking with families who since turned to marijuana for help, the almost immediate reversal of symptoms is simply put—a miracle. Lives changed overnight. Although marijuana doesn't completely cure most of these serious ailments, it lets the person tolerate the symptoms more manageably than any prescription pill could ever; it lets them enjoy their life.

The claim (and crackdown) from our Federal Government that marijuana has no palliative use (as declared by scheduling status) is hypocritical. Our Federal Government has been supplying palliative marijuana to eight (four of whom are still alive) federal marijuana patients since 1976. Regulated by the National Institute on Drug Abuse, this federal medical marijuana program is, perhaps, the most self-sustaining of any in the country. States that have such programs in place rely on the patients to grow or legally obtain from a dispensary. Under the federal program, the pot is grown by the government, packaged, and mailed out in metal tins with white labels—delivered directly to patient doorsteps. The four patients still receiving monthly shipments of perfectly rolled joints from the Federal Government have estimated they've received 584 pounds over the years, a street value of more than \$500,000.

The American Medical Association results of short term controlled trials indicate that smoked cannabis reduces neuropathic pain, improves appetite and caloric intake especially in patients with reduced muscle mass, and may relieve spasticity and pain in patients with multiple sclerosis. AMA urges that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

During the early 1980s, Kaiser Permanente studied over 65,000 patients with a ten-year follow-up. About half of these patients, admitted to having tried marijuana. One hundred eighty-two tobacco related cancers were found but no effects of marijuana use on the risk of cancer. Tashkin's (2005) research at UCLA-MC showed increased redness, swelling, and white blood cell count in regular marijuana users. Furthermore, because marijuana smoke is very similar to cigarette smoke, it seems quite likely that long term effects may be the same. Doll et al. (2005) conducted a 50 year follow-up study of 40,000 volunteers and showed that half of all regular cigarette smokers eventually die of lung, mouth, throat, larynx, pancreatic or bladder cancer or asthma or emphysemas (Doll, 2005) but no effects of marijuana use on the risk of cancer.

Some studies indicate that when pot with a higher THC content is smoked users take smaller drags and don't hold it in as long (*Matthias et al. 1997*). Experienced users know how to adjust their smoking to attain a certain high. It may be that smoking joints with higher THC content results in less tar intake. Water pipes and filters reduce the tar before it reaches the lungs. Vaporizers bypass inhaling smoke all together. The body ingests only a vapor of THC; providing a harmless entry in to the body. (*Donald Abrams, M.D. University of California*) Eating marijuana is another harmless entry in to the body. Some state dispensaries and collectives sell lollipops, drinks, and pastries. Home bakers like to make marijuana butter and use it to bake brownies and other foods. This THC delivery method is less reliable than smoking and vaporizing. Smoking and vaporizing produces a rapid and more controllable high and seems to go directly to the cannabinoid receptors in the brain within seconds.

Many multiple sclerosis patients attest that marijuana quells their uncontrollable tremors better than barbiturates and reduces the pain caused by their degenerative condition better than opiates. Research confirmed that symptomatic muscle spasms were reduced by marijuana in clinical measurements of MS patients' symptoms. (*Ellenberer Journal of Clinical Pharmacology, 1981*) In 1987, researchers from the UCLA School of Medicine studied 13 MS patients receiving THC in clinical trials. They concluded, "These positive findings in a treatment failure population suggest a role for THC in the treatment of spasticity in multiple sclerosis." (*Ungerleider, Andrysiak, Fairbanks, Ellison, and Myers, "Delta-9 THC in the treatment of spasticity associated with multiple sclerosis." Advisory on Alcohol and Substance Abuse, Vol. 7, No. 1, pp. 39-50, 1987*)

There are many more different ailments that the palliative use of marijuana can succeed in aiding. Without creating a 15-page testimony I will just name the ones I have read studies associated with them. Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, Posttraumatic Stress Disorder, HIV/AIDS, depression, Huntington's disease, dystonia, reflex sympathetic dystrophy, colorectal cancer, migraines, atherosclerosis, nausea, bi-polar disorder, Amyotrophic Lateral Sclerosis, skin tumors, Tourette syndrome, psoriasis, insomnia, opioid dependence, inflammatory bowel disease, leukemia, premenstrual syndrome, and Methicillin-Resistant Staphylococcus Aureus (MRSA).

State laws allowing for the legal use of medical marijuana by qualified patients do not increase teen marijuana use, and if anything decrease teen use or have no effect at all, according to data published online in the journal *Annals of Epidemiology*. "Difference-in-differences estimates suggested that passing palliative marijuana laws decreased past-month use among adolescents and had no discernible effect on the perceived riskiness of monthly use," McGill University researchers Sam Harper, Erin C. Strumpf and Jay S. Kaufman reported. "[These] estimates suggest that reported adolescent marijuana use may actually decrease following the passing of medical marijuana laws"

It is well established that alcohol increases accident risk. Evidence of marijuana's culpability in on-road driving accidents is much less convincing. Although cannabis intoxication has been shown to mildly impair psychomotor skills, this impairment does not appear to be severe or long lasting. In driving simulator tests, this impairment is typically manifested by subjects decreasing their driving speed and requiring greater time to respond to emergency situations. Nevertheless, this impairment does not appear to play a significant role in on-road traffic accidents. A 2002 review of seven separate studies involving 7,934 drivers reported, "Crash culpability studies have failed to demonstrate that drivers with cannabinoids in the blood are significantly more likely than drug-free drivers to be culpable in road crashes." This result is likely because subject under the influence of marijuana are aware of their

impairment and compensate for it accordingly, such as by slowing down and by focusing their attention when they know a response will be required. This reaction is just the opposite of that exhibited by drivers under the influence of alcohol, who tend to drive in a more risky manner proportional to their intoxication. Today, a large body of research exists exploring the impact of marijuana on psychomotor skills and actual driving performance. This research consists of driving simulator studies, on-road performance studies, crash culpability studies, and summary reviews of the existing evidence. To date, the result of this research is fairly consistent: Marijuana has a measurable yet relatively mild effect on psychomotor skills, yet it does not appear to play a significant role in vehicle crashes, particularly when compared to alcohol.

As more states choose to pass legislation for the legalization and regulation of the palliative use of marijuana, more is learned and more mistakes are corrected. The legislation that is proposed is thoughtfully well written. The bill uses the best examples of what each state has to offer combined. Connecticut last year in a Quinnipiac University poll voted **79%** in favor of passing a medical marijuana program. Connecticut can create the best model to date to regulate safe access to patients that are suffering each and every minute every day. It is unjust to deny safe, legal access to those of who desperately are seeking a way to legally tolerate their ailments and live their lives to the fullest. It's overwhelmingly undeniable that this legislation is critically important to pass.

Thank you for your thoughtful consideration of this testimony. I would be happy to provide more information or research studies if requested.

Thank you,  
Peter Angelini