MEDICINAL MARIJUANA PUBLIC MEETING

DES MOINES, IOWA

TRANSCRIPT OF PROCEEDINGS

AUGUST 19, 2009

Reported by: SueAnn Jones, CSR, RPR

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MEDICINAL MARIJUANA

PUBLIC MEETING

August 19, 2009, 10:10 a.m.

Iowa Historical Building

Des Moines, Iowa

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1 P R O C E E D I N G S
2 LLOYD JESSEN: Good morning and
3 welcome to the first public meeting on medical
4 marijuana. This hearing is being held by the Iowa
5 Board of Pharmacy pursuant to Iowa Code
6 Section 124.201(1). I am Lloyd Jessen, the
7 executive director of the board.
8 With me today are two board members.
9 To my left, Verne Benjamin, a pharmacist and the
10 chairperson of the board from Argyle, Iowa, and to
11 my right, Ann Diehl, a nurse practitioner and
12 public member from Osceola, Iowa. Also present
13 today are board staff, Debbie Jorgenson to my far
14 right and then in the audience Roger Zobel, Dennis
15 Dobesh, Jean Rhodes, Jennifer Tiffany, and Charity
16 Harman. I'm sorry. And also Jim Wolfe.
17 SueAnn Jones of Johnson Reporting
18 Services, Limited is serving as the certified
19 shorthand reporter for this hearing, and she's at
20 my far left.
21 The purpose of this hearing is to
22 receive information from the public. A transcript
23 of all comments that are received at today's
24 hearing will be reviewed by the five board members
25 who are not present today.

3

1 Iowa law imposes upon the board the
2 duty to periodically recommend to the legislature
3 changes in controlled substance schedules. The
4 board views this statutory responsibility with
5 great seriousness, both because of the specificity
6 of Iowa Code Chapter 124 and because marijuana use
7 and the use of drugs in general is a sensitive
8 medical, social, and political issue.
9 Any board recommendation for changes
10 to the controlled substance schedules in Iowa will
11 be preceded by a thoughtful review and analysis of
12 the most helpful and current scientific information
13 available to the board.
14 In making a recommendation to the
15 legislature regarding marijuana, the board will
16 consider the following 12 factors: No. 1,
17 marijuana's actual or relative potential for abuse;
18 No. 2, marijuana's pharmacological effect; No. 3,
19 current scientific knowledge regarding marijuana;
20 No. 4, the history and current pattern of abuse of
21 marijuana; No. 5, the scope, duration, and
22 significance of abuse of marijuana; No. 6, the risk
23 to the public health from moving marijuana from a
24 Schedule I to a different controlled substance
25 schedule; No. 7, the potential of marijuana to

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1 produce psychic or physiological dependence
2 liability; No. 8, whether marijuana is an immediate
3 precursor of a substance on some other controlled
4 substance schedule; No. 9, whether marijuana's
5 potential for abuse or lack thereof is not properly
6 reflected in its inclusion in Schedule I; No. 10,
7 whether marijuana lacks a high potential for abuse;
8 No. 11, whether marijuana has an accepted medical
9 use in treatment in the United States; and No. 12,
10 whether marijuana does not lack accepted safety for
11 use in treatment under medical supervision.
12 This hearing will be held according to
13 the following ground rules and will proceed in the
14 following manner: Both proponents and opponents of
15 medical marijuana will be allowed to speak. All
16 speakers must come to the stage and speak into the
17 microphone. If anyone is unable to make it up onto
18 the stage, we will provide you with a hand-held
19 microphone.
20 Speakers should speak slowly and
21 clearly so their comments can be accurately
22 recorded. Speakers need to identify themselves on
23 the record. They should at a minimum provide their
24 first name. Full names and addresses would be
25 appreciated but will not be required.

1 If speakers are representing an
2 organization or are speaking on behalf of an
3 organization, they should state that before making
4 their comments. Speakers who wish to offer
5 exhibits or written materials to the board need to
6 have them properly identified for the record.
7 Testimony that references an exhibit should
8 identify the exhibit number.
9 Depending on the number of people who
10 wish to speak at today's hearing, time limits will
11 be imposed. In general, each person will be
12 allowed a minimum of five minutes to speak. If
13 feasible, additional time may be allowed. However,
14 the board wants to ensure that every person who
15 wishes to speak receives an opportunity to do so.
16 Speakers will be called according to
17 the order on our sign-up sheet. Some speakers
18 reserved time prior to today's hearing, and they
19 will provide their comments as previously
20 scheduled. Some speakers have also requested
21 additional time. All requests for additional time
22 will be allowed as circumstances permit.
23 The board wishes to remind everyone
24 that this hearing is not an opportunity for debate.
25 We are here today to receive comments concerning

1 the medical use of marijuana. As part of this
2 process, I and/or the board members may have
3 questions for the speakers.
4 Please be aware that we are not here
5 to receive comments regarding the legalization of
6 marijuana for recreational use. Speakers are also
7 reminded to avoid repetitious or irrelevant
8 comments. Speakers should be as short and concise
9 as possible.
10 In addition to receiving oral comments
11 at today's hearing, the board welcomes and
12 encourages written comments. Any comments or other
13 information received at today's hearing will be
14 public information and may be referred to or
15 referenced in reports or recommendations issued by
16 the board to the Iowa legislature.
17 This hearing will be in session until
18 7 p.m. this evening. We will take a lunch break
19 from noon to 1 p.m. We will also take two
20 15-minute breaks during the afternoon.
21 Are there any questions from anyone?
22 Yes.
23 UNIDENTIFIED MALE: The information I
24 received suggested that it was a minimum of ten
25 minutes, so I prepared ten minutes of -- of speech.

1 LLOYD JESSEN: We will try to
2 accommodate that. We had announced five to ten
3 minutes, and so we'll try to accommodate that.
4 UNIDENTIFIED MALE: Thank you.
5 GEOFF GREENWOOD: For members of the
6 media and also for the reporter, could you ask the
7 speakers to spell their names?
8 LLOYD JESSEN: Yes, we will. Oh, yes.
9 UNIDENTIFIED FEMALE: Could you speak
10 closer to the mic? I'm hearing impaired. I didn't
11 get half what you said. Thank you.
12 LLOYD JESSEN: Okay. Our next public
13 hearing will be held from 10 a.m. to 7 p.m. on
14 Wednesday, September 2 in Reunion Hall at the Music
15 Man Square in Mason City, Iowa.
16 We will now begin with our first
17 speaker who is Dr. Joe McSherry.
18 JOE McSHERRY: Honorable Chair Vernon
19 Benjamin and members of the board, present and
20 absent, and Director Jessen, thank you for the
21 opportunity to address this group.
22 I am Joe McSherry, M-c-S-h-e-r-r-y. I
23 didn't copy my CV to you, but I was born in
24 Washington, D.C. in 1943, graduated in physics from
25 Harvard in 1965 with an M.D. and a Ph.D. from

1 Baylor College of Medicine in 1971.
2 Did lots of doctoring and research
3 things, but most importantly for this group, in
4 2002, I participated in a study committee that was
5 created by the legislature -- and cleverly, they
6 did not include any legislators -- to consider the
7 problem of medical marijuana because the
8 legislature didn't know what to do about it.
9 And the committee was relatively
10 balanced. We had a person from the AG's office and
11 a person from the state's attorney's,
12 representative of the police chief's organization,
13 and a judge as well as two doctors appointed by the
14 medical society -- I was one of them -- and
15 patients and some patient advocate groups.
16 And we took testimony and heard lots
17 of stuff from the people who wrote the Institute of
18 Medicine report which I'm going to recommend to you
19 at least several times from 1999, but it is a great
20 way to get up to a base line.
21 There were 13 conclusions of this
22 committee, I would say, and two of them were agreed
23 to by everyone. The law-enforcement people
24 couldn't get around our recommendations regarding
25 how to circumvent the federal law. There seemed to

1 be some sort of inconsistency from their point of
2 view, but they did agree that marijuana is a
3 medicine and that it's misclassified as a
4 Schedule I drug at the federal level because it has
5 accepted value, and Marinol is an example, which is
6 a Schedule III drug, both here and at the federal
7 level. It's not exceptionally prone to abuse and
8 not remarkably toxic.
9 The meat of why I'm here, though, is
10 why would you approve marijuana given that you have
11 Marinol already? The usual concern of people is
12 Marinol is a combination sesame oil and THC, and
13 there are two reasons why it's not a useful
14 medicine for the most part.
15 One is it only has THC in it, and GW
16 Pharmaceuticals that makes an oral mucosal medicine
17 called Sativex did a great deal of research, and
18 just straight THC is not the right way to provide
19 the benefits of cannabis. There are many -- there
20 are 60, 70 cannabinoids in cannabis. Most of them
21 are not psychoactive. THC is very psychoactive and
22 really limits the use of Marinol or for anything
23 for any of those benefits from cannabis.
24 Cannabidiol, on the other hand, is not
25 psychoactive, actually counteracts a lot of the

1 effects of THC, and is a part of the Sativex
2 medication. And there are -- there is research in
3 recent years on various other cannabinoids which
4 also have medical value without remarkable
5 toxicity.
6 So the absence of -- or only using the
7 most toxic element in the marijuana is one reason
8 Marinol is not a perfect drug. It's only useful
9 for those who take the medicine orally and take THC
10 only.
11 The other significant factor is that
12 it's taken orally, and when you inhale a drug, you
13 get almost instant blood levels, and that's
14 important for a lot of the people who use
15 marijuana; for instance, for pain. And there's a
16 little graphic which I've given to the group here,
17 but basically when you treat pain, you treat a base
18 line level of pain, and you usually use opiates and
19 long-acting substances for that.
20 But people also have break-through
21 pain which is characterized as something that lasts
22 30 minutes to an hour. And if you try to treat
23 that with things like Percodan and it comes on
24 suddenly and you can't anticipate it, the Percodan
25 kicks in after the pain has already gone away, and

1 you get the side effects of the Percodan.
2 The pharmaceutical industry has tried
3 to treat this with Fentanyl fizzies and lollipops,
4 little things that go in through their mouth. It
5 still takes 20 minutes to get any kind of relief.
6 If they develop -- and I think they're working on
7 an inhalational form of Fentanyl that's going to be
8 almost as fast as heroin with all of the side
9 effects and risks of abuse of very rapid onset
10 drugs which are highly addictive.
11 Marijuana goes in very rapidly, but in
12 terms of its addictive potential, it's not the same
13 order of magnitude.
14 And another case where this is
15 similarly important, to people with nausea. And
16 again, when you hear patients testify, you'll hear
17 that when they're sick and throwing up, they can't
18 take medicine at that particular point, and on the
19 other hand, you can inhale cannabis and get the THC
20 value, which has been well studied. It works as a
21 5-HT3 blocker as well as working in the central
22 nervous system with cannabinoid receptors which
23 reduce the nausea component.
24 The 5-HT3 blockers is what the
25 pharmaceutical industry uses to control vomiting.

1 Being able to inhale that is a great advantage for
2 people who take drugs which makes them very ill or
3 have other responsibilities.
4 On the third page, I also have
5 included for you some graphs, and these are in
6 the -- I left Mr. Jessen with the -- the references
7 that I brought for this, but when you take THC
8 orally, only 6 percent of it gets into the blood.
9 And how much gets into the blood is highly
10 unpredictable.
11 The top graph on that page shows a
12 large rise. It's a solid line. That's an inactive
13 metabolite of THC. The dashed line is an active
14 metabolite, and the dotted line down there barely
15 getting off ground zero on the left-hand side of
16 blood levels on the bottom is time.
17 The THC very rarely gets absorbed,
18 which is why in studies people often find that
19 patients who are complaining of toxicity don't have
20 measurable levels in their blood. If you're going
21 to take it at bedtime and you're going to sleep
22 through any intoxication you get, it's a
23 potentially very useful way of delivering the
24 medicine.
25 If you look at the next graph down,

1 though, when you inhale it, the THC level is the
2 dotted line that goes way up on the blood level
3 side and comes down again within a half an hour.
4 The solid black line again is the metabolites,
5 which are inactive, and the dashed line, there's
6 not very much of that, but that's the active
7 metabolite.
8 So when you inhale it, it goes in.
9 It's redistributed in the body so that the effects
10 of the cannabis or the THC, I should say, last for
11 a couple of hours. But the -- the ability to get
12 it in very quickly is very important to people with
13 nausea, break-through pain, and things like that.
14 On the next page I have another --
15 these are graphs swiped out of those articles of a
16 study of when doctors give medicine, we like to
17 give 325 milligrams of aspirin or something we know
18 what we're doing. We know it's the right dose. It
19 should take care of people.
20 And when you inhale things, you don't
21 really know how much goes in or how much stays
22 unless you do a lot of complicated measurements,
23 and so it happens that tobacco was found 40 years
24 ago. People who smoked smoked to get a level of
25 nicotine, so if you want to sell more cigarettes,

1 you sell low tar and nicotine cigarettes because
2 then you sell more cigarettes. If you wanted to
3 cut down on smoking, you'd give everybody Camels.
4 The similar situation exists with
5 smoking cannabis. No matter what you buy on the
6 street, illegal market, from the pharmacy, or
7 wherever else, you'll inhale to get an effect. And
8 so this is a study that was done with NIDA-approved
9 THC cigarettes of three different strengths, one
10 1.7 percent THC, which is kind of like modified
11 grope (phonetical), 3.4 percent THC cigarette,
12 which is probably standard Mexican-grade stuff, and
13 I don't know what they call these things nowadays,
14 but the 6.8 percent stuff is probably like Acapulco
15 gold.
16 In the left-hand column, the vertical
17 axis is carbon monoxide. And the -- there is also
18 the open squares. The closed squares is the smoked
19 variety. They cut each of these cigarettes in
20 half, and one day they didn't smoke the cigarette,
21 and the other day they did through a vaporization
22 system, which is a much preferable system.
23 But the lowest doses, they get a lot
24 of carbon monoxide basically from smoking, and they
25 still get quite a bit of the 3.4 percent dose and

1 considerably less at 6.8 percent THC content.
2 So the fact that the pot you get today
3 if you're lucky is not the pot your grandfather got
4 or father got actually is the wrong way of putting
5 it because the stronger the cannabis, the less
6 you'll smoke, the less you'll get the polycyclic
7 hydrocarbons, the less you'll get the carbon
8 monoxide.
9 On the right-hand column is the
10 subjective levels these people achieved with a
11 vertical line being their visual analog scale of
12 how intoxicated or high or whatever they were, and
13 it's apparent that they all, no matter which kind
14 of cigarette you get, you go up to about a 70 on
15 that scale rating.
16 Again, I don't recommend smoking. I
17 don't recommend smoking over vaporization
18 particularly, and this was done with a vaporizer
19 that was made by a German medical equipment
20 manufacturer, and I see their name all the time in
21 the operating room where I work a lot because they
22 make the monitors in that room.
23 But I would also briefly address the
24 downside risks. And for the patients, there are
25 none. Basically, I've included in there a couple

1 of review articles on cancer in the last year or so
2 that go through all the different ways that the
3 cannabinoids actually cause cancer cells to die,
4 and neighboring healthy cells are unaffected.
5 I could -- I could -- they would
6 probably be a lot higher if I brought all the
7 articles that have accumulated since 2002 when I
8 started paying attention to these things.
9 And for people with neurogenative
10 diseases, again, this is another area that's
11 growing rapidly in terms of research that's
12 available in humans. There's lots of rat research,
13 and again, I would say the Institute of Medicine
14 report, terrific way to find out where animal
15 research is at, where human research was at in
16 1999, and there has been a lot of progress. But
17 that's -- the base line there is not to be ignored.
18 And they were the people who
19 recommended or told us that there were medical uses
20 back then in 2002. And the only downside was
21 smoking.
22 MS patients, people with inflammatory
23 disease, it's a terrific anti-inflammatory. It
24 works directly on the immune system through the
25 cannabinoid-2 receptor and turns down inflammation

1 without impairing the cell's response to bacteria,
2 and so it doesn't promote infection. It doesn't,
3 of course, cause all the body changes that steroids
4 do when you have multiple sclerosis and is -- you
5 know, for diseases like Crohn's disease treats the
6 symptoms because it reduces bowel spasms no matter
7 what they're caused by, and it also treats
8 inflammation, which is the underlying cause of the
9 disease.
10 One of the things that everybody who's
11 concerned about this brings up at this point, so
12 what is the message we're going to send to the kids
13 if you legalize or say it's okay for medicine? And
14 I have put in a couple of studies which study
15 states and neighboring states before and after it's
16 permitted as a medicine in those states that it has
17 been permitted, and in both of those studies, there
18 is no increase in the use among kids. In fact,
19 there's generally a decrease.
20 I also tried to address your questions
21 more specifically, and I don't know how I'm doing
22 on time? Have I got another minute or two?
23 DEBBIE JORGENSON: Got seven more
24 minutes.
25 JOE McSHERRY: Oh, excellent. The

1 first thing is its actual relative or potential for
2 abuse, and I have a little trouble understanding
3 exactly what abuse is in your definition, and I'm
4 sure you have a good one. I looked up things like
5 violence and self-harm, which are two things which
6 you might worry about. Certainly patients who are
7 taking it are not prone to violence. It's not
8 associated with increased violence. And it's also
9 not associated with increased injuries.
10 There are other aspects of abuse which
11 I'm sure you're interested in, and again, that's --
12 I don't have to do everything.
13 The pharmacological effects are much
14 too long to talk about at this point. They are in
15 some of the articles that I've given you, and if
16 you'd like, I'd certainly be delighted to send
17 more.
18 The current status of the scientific
19 knowledge, again, I would suggest that the board
20 really needs its own copy of the IOM report. I
21 would be glad to have brought it, but the
22 government charges money for it even though we paid
23 for it when it was done, and it's a book. It's got
24 five chapters, deals with patients, deals with
25 animal research, deals with social consequences,

1 and deals with the health values and then finally
2 concludes that probably the pharmaceutical industry
3 won't ever make it.
4 In the history and current pattern of
5 abuse of marijuana, I suggest the Shafer report
6 because it was another government-funded report
7 which is wildly underread and dealt with the abuse
8 part, and it didn't agree with Dr. -- President
9 Nixon's view at the time, and it was discarded.
10 But it brings you up to date in 1972. Abuse hasn't
11 changed that much. Large number of people still
12 use it and such.
13 The risk to public health, again, I
14 don't think it affects kids. I'm not sure what the
15 other risks would be. The potential for it to
16 produce psychic or physiologic dependence, I did
17 snap out one table from the Institute of Medicine
18 report, and that's the table that's included there.
19 It goes -- shows tobacco is used by about
20 76 percent of the population; alcohol, 92 percent
21 and so on in the left column.
22 In the right column, of those who have
23 ever used these drugs, it shows what percentage
24 became dependent. And again, with tobacco, about a
25 third of the people who use it become dependent;

1 with alcohol and cocaine, about a sixth; heroin,
2 about a quarter; and with anxiolytics and
3 marijuana, less than 10 percent.
4 So in terms of its risk of abuse, it's
5 lower than a lot of the drugs that you have to
6 schedule here.
7 I also put in an article on the
8 withdrawal syndromes. I have lots -- there are
9 other articles that have been on the withdrawal
10 syndromes. Essentially, it's about four days of
11 being more irritable. It's the same as tobacco in
12 many regards. Being more irritable, maybe trouble
13 with sleep. In the case of marijuana, they also
14 lose some weight when they stop taking it.
15 On whether it's an immediate precursor
16 of a substance or other controlled substance
17 schedule, I was a little puzzled by that because I
18 think of a precursor as something that's chemically
19 transformed into something else, and marijuana, of
20 course, is a plant, so I looked up your definition.
21 I included that. Wasn't very helpful.
22 In your Schedule I, I pointed out what
23 you have there, which is anything that has to do
24 with THC is bad. Schedule II, I was somewhat
25 puzzled in that it says "unless specifically

1 accepted or listed in another schedule, it's" -- I
2 have to get my other glasses on, but -- where are
3 they? I don't get them on. But at some point in
4 that, it does allow that the Board of Pharmacy can
5 actually put things on Schedule II that are
6 marijuana, marijuana when used for medicinal
7 purposes pursuant to the rules of the board. Is
8 that your board?
9 LLOYD JESSEN: It is.
10 JOE McSHERRY: Anyway, I would just in
11 terms of whether you have to get an act of Congress
12 or whatever to do this, the state legislature, I
13 wasn't sure.
14 And so I don't find any of the other
15 drugs -- and I will say on Schedule I there are
16 things I've never heard of and have no idea what
17 they are, but I don't think there are any
18 derivatives other than what you've listed in these
19 other schedules, and I'd be delighted to address
20 any questions.
21 LLOYD JESSEN: Thank you. Thank you,
22 Dr. McSherry. I do have a few questions. The
23 Institute of Medicine study you refer to, is that
24 the one dated 1999?
25 JOE McSHERRY: That is.

1 LLOYD JESSEN: We've already received
2 a copy of that.
3 JOE McSHERRY: Excellent, excellent.
4 It's good reading. Gets you to sleep at night.
5 LLOYD JESSEN: In your opinion, do you
6 think we have current scientific evidence that
7 supports the medical use of marijuana?
8 JOE McSHERRY: Absolutely.
9 LLOYD JESSEN: And in your opinion, do
10 you feel the benefits outweigh the risks?
11 JOE McSHERRY: Yes. But that's based
12 on the things that we've talked about here.
13 LLOYD JESSEN: Correct. Okay. Thank
14 you very much, Dr. McSherry, for your time.
15 JOE McSHERRY: Thank you.
16 LLOYD JESSEN: We'll now proceed with
17 our first -- our second speaker, and she's
18 identified, I think, with Speaker No. 1.
19 I'd also like to ask if anyone has a
20 cell phone, if they could please turn it to
21 vibrate, that would help with the noise level.
22 Thank you.
23 LINDA LEE O'NEEL: Sorry about the
24 phone. My name is Linda Lee O'Neel. I'm from
25 Creston, Iowa. My last name is spelled O'N-e-e-l

1 like the fish.
2 My abilities are not as profuse as the
3 doctor here. What I want to do is show you the
4 literature that I have cited. The most recent
5 document was from a May 15, 2009, Denver Post
6 article on an experiment that was done by a --
7 let's see here. Dr. Julie L. Ryan of the
8 University of Rochester tested more than 600 breast
9 cancer patients undergoing chemo treatments across
10 the country. Some were given ginger root; others a
11 placebo.
12 The ginger root takers rated their
13 nausea severity 45 percent less. The placebo, no
14 change. And it should be noted the ginger was
15 given before the chemo treatments.
16 The patients receiving ginger
17 expressed less nausea for four days after
18 chemotherapy. Doses of .5 gram and 1 gram were the
19 most effective, reducing nausea by 40 percent
20 compared with the patients taking the placebo. One
21 gram of ginger is equivalent to about one teaspoon.
22 Now, the article stressed that the
23 ginger used was grated ginger root, not any ginger
24 ale or ginger-type flavored substances, and so it
25 would provide a nonmedicine alternative to medical

1 marijuana.
2 This was also -- there's evidence that
3 when other amounts in different types of ginger
4 like ginger ale and ginger cookies and stuff were
5 used that it was hard on the stomach, so just as
6 aspirin is hard on the stomach if you don't take it
7 in the right amounts, so can this drug too be.
8 It's ginger that you find in the grocery store,
9 that weird little ginger root. You grate it. You
10 make tea out of it, and you take the tea before you
11 take your chemotherapy. And that is the latest
12 article that I have.
13 The earlier articles that I had, one
14 was the Lancet article that appeared in 1963 that
15 Parade magazine picked up on. Parade used to be
16 the insert in the newspapers. It's now replaced by
17 USA Today. And it picked up on the idea of medical
18 marijuana, and we've been hashing medical marijuana
19 ever since.
20 There is one article in here that I
21 have. I took my finger out of it, and it said that
22 the marijuana acted on the brain and the dopamine
23 aspects of the brain in the same way as other drugs
24 did and making it just as much addictive as any
25 other drug.

1 This here is -- "The release of
2 anandamide is followed by rapid uptake into the
3 plasma and hydrolysis by fatty-acid amidohydrolase.
4 The psychoactive cannabinoids increase the activity
5 of dopaminergic neurons in the ventral tegmental
6 area of the mesolimbic pathway. Since these
7 dopaminergic circuits are known to play a pivotal
8 role in mediating the refining -- or reinforcing
9 effects of most drugs of abuse, the enhanced
10 dopaminergic drive elicited by the cannabinoids is
11 thought to underlie the reinforcing and abuse
12 properties of marijuana. Thus, cannabinoids share
13 a final common neuronal action with other major
14 drugs of abuse such as morphine, ethanol, and
15 nicotine in producing facilitation of the
16 mesolimbic dopamine system."
17 This is in -- P-r-o-g is the
18 abbreviation, Neurobiological, 1999, July edition
19 on pages 315 to 348. And it was Effective
20 Cannabinoids on the Brain.
21 I had prepared an organized response
22 to positive marijuana because I do not believe that
23 after having seen my friends get high and become.
24 less person than what they were, I know that there
25 are times when the -- the brain is less affected by

1 marijuana than at other times.
2 One of the articles that I did have,
3 here talked about the brain cells that were there
4 and getting ready to divide and how marijuana
5 inhibited this ability for them to divide, and it
6 also talked about the effect of THC on the
7 cancer-fighting cells of the body. THC in any form
8 was known to stop the cancer-fighting cells'
9 ability to stick to the cancer cell to destroy it.
10 It would just slide right off. I have the
11 documents here.
12 And I've been given my four-minute
13 notice. So I will put in writing to submit to the
14 board if you would please give me the address that
15 I can write this in a coherent form.
16 LLOYD JESSEN: Yes. We'll provide you
17 with that.
18 LINDA LEE O'NEEL: Thank you.
19 LLOYD JESSEN: I have a question,
20 please. Are you in favor of medical marijuana or
21 opposed to it?
22 LINDA LEE O'NEEL: I think the facts
23 that I've brought forth would cause any normal
24 person to be opposed to it.
25 LLOYD JESSEN: All right. Thank you.

1 We're a little bit ahead of schedule. The next
2 scheduled speaker would be Kate Gainer from the
3 Iowa Pharmacy Association. Kate, are you okay
4 going now?
5 KATE GAINER: Yeah.
6 LLOYD JESSEN: Okay.
7 KATE GAINER: My name is Kate Gainer,
8 vice president of professional affairs for the Iowa
9 Pharmacy Association.
10 Thank you for the opportunity to state
11 the position of the Iowa Pharmacy Association on
12 this subject of legalization of marijuana for
13 medical purposes.
14 The Iowa Pharmacy Association is the
15 professional state society representing nearly
16 1,000 pharmacists, 700 pharmacies, as well as
17 pharmacy technicians and pharmacy students.
18 The mission of IPA is to advance
19 patient safety and patient health for all Iowans
20 through pharmaceutical care. IPA supports
21 evidence-based medicine. Evidence-based medicine
22 as defined in the 2009 users guide to the medical
23 literature is the conscientious, explicit, and
24 judicious use of current best evidence in making
25 decisions about the care of individual patients.

1 Evidence-based clinical practice
2 requires integration of individual clinical
3 expertise and patient preferences with the best
4 available external clinical evidence from
5 systematic research and consideration of available
6 resources.
7 The Iowa Pharmacy Association will
8 support the science on the issue of marijuana
9 legalization for medical purposes. IPA is hopeful
10 the Board of Pharmacy will hear comprehensive
11 testimony from experts on the science of medical
12 marijuana.
13 For any prescription medication used
14 in the treatment and prevention of sickness and
15 disease, IPA supports distribution under the
16 control of the Iowa Boards of Medicine and
17 Pharmacy.
18 For medication used in our state, IPA
19 supports prescribing by Iowa licensed prescribers
20 and dispensing along with medication management by
21 an Iowa licensed pharmacist.
22 The Iowa Pharmacy Association house of
23 delegates adopted policy in 1997 relating to the
24 issue of legalizing marijuana for medical purposes.
25 I'll read that policy.

1 IPA supports the experimental use of
2 marijuana for medical purposes subject to
3 distribution controls by the Iowa Board of
4 Pharmacy. IPA endorses utilization of the Board of
5 Pharmacy as the governmental agency responsible for
6 ensuring adequate control measures concerning
7 experimental studies involving marijuana for
8 medical purposes. IPA opposes legalization of
9 marijuana for recreational purposes. Thank you.
10 LLOYD JESSEN: Thank you, Kate. Do we
11 have the person who's been identified as our
12 Speaker No. 3? Yes.
13 ROBERT MANKE: Morning, folks. My
14 name is Robert Manke, M-a-n-k-e, and I'm a medical
15 marijuana user here in the state of Iowa.
16 Board of Pharmacy members -- Board of
17 Pharmacy members, I'm here because I need your
18 help. I don't represent anybody professionally. I
19 represent myself. I've been in three severe
20 traffic accidents. You want to see what a miracle
21 looks like? This is what a miracle looks like.
22 See me hold my arms up? It's incredible. I'm
23 amazed I'm not in a wheelchair.
24 I have a broken spine. I have two
25 Harrington rods, six fused joints in my back. I

1 had four blown disks in my cervical spine and two
2 jellied locations in my brain as evidenced by CT
3 scans.
4 I know what pain is like. That doctor
5 came up and talked about Fentanyl fizzies. Yeah,
6 what I know they're like too. I take morphine. I
7 take Percocets. I take -- God, what else? I'm on
8 methadones right now.
9 I have severe nausea, folks. I know
10 what it's like to crawl around on the bathroom
11 floor like an animal in the morning vomiting with
12 my head in the stool, and I need your help.
13 I'm not here because I want to get
14 high. I'm here because I want to stop being sick,
15 and I want to stop being persecuted, and I need
16 your help. This isn't fun to get up here. This is
17 scary. I'm trembling right now.
18 Our laws need to be changed. They
19 need to respect the truth. We need your scientific
20 evaluation, but we also need you to hear people
21 like me very badly. You need to hear that I'm an
22 Iowan, and I was born here in Iowa. My wife was
23 born here Iowa. All our kids are born here in
24 Iowa. All our parents, mom and dad, parents born
25 here in Iowa. My grandparents were in the first

1 federal census of the state of Iowa. I'm what Iowa
2 looks like, folks, and I need this law changed. I
3 need this terrorism to stop.
4 In 19 -- excuse me -- in 2007 I was
5 arrested for growing three Mexican pot plants in my
6 closet. I didn't do that because I want to be a
7 rebel. I do that because I want to stop puking.
8 I find from my own personal experience
9 something you need to hear. In the morning I can't
10 take a Compazine suppository. Oh yeah, I'm on that
11 too. I'm also on Phenergan. I can't take
12 suppositories because I have a hypercholesterol
13 anemia condition, and my blood cholesterol is over
14 900. I take the biggest dose of Tricor you can
15 cram in a human body, and it produces tremendous
16 constipation. I can't get a suppository in there,
17 folks, just to be blunt. We're talking medical
18 stuff here.
19 But what I can get in me on the for
20 real is marijuana. I can smoke cannabis, and I'm
21 telling you, if I got good cannabis, strong
22 cannabis, and I smoke about two pokes of that, my
23 nausea is reduced by 50 percent in, like, five
24 seconds.
25 What do you want me to do? Take

1 injections? I don't want shots. I don't want to
2 be a junkie.
3 I want to talk about my migraines for
4 just a moment. My migraines just utterly crush me.
5 Break-through pain, I can write you a book on
6 break-through pain. I can. That's why I get the
7 physics.
8 And they do -- they do exactly like
9 that doctor, that first speaker, said. They don't
10 kick in for about 20 minutes. You know what
11 20 minutes of a really bad migraine is like? I
12 doubt it. And I'm telling you right now, I'm a
13 very serious Christian, and it's about hell on
14 earth.
15 You get so sick and have blinding
16 flashes and vomit and just -- just wallow on the
17 floor and wish you were dead. And it only helps
18 the littlest tiny bit that I'm not at fault in
19 those traffic accidents, folks. It only helps the
20 smallest amount.
21 I need something that works. I need
22 some serious, serious consideration by this board
23 on cannabis. I'm not looking to get high on dope.
24 If I want to get high on dope, I do just exactly
25 like I tell Senator Grassley. I just reach over

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1 the tableside and grab a bottle of morphine, which
2 I hate, by the way. You want to go to sleep for
3 about three days and wake up about two hours a day,
4 go get your morphine. I hate that stuff.
5 What the doctor told you about these
6 delays and, you know, for the onset of the
7 medication to kick in, marijuana, smoked marijuana,
8 has an -- has a delay of seconds.
9 I have never in my life -- I've been
10 smoking cannabis off and on since 1972. First it
11 was recreational, but since these traffic
12 accidents, I promise you, it's very different. I
13 have never seen pink elephants. I do not
14 hallucinate ever. I've never seen anybody else do
15 it either.
16 I have no sensations of a desire to
17 harm myself or anybody else. In fact, I've seen
18 people who would smoke cannabis that were violent
19 out on the construction sites. I'm a professional
20 construction worker, among other things. And it
21 calmed down those violent urges in those people,
22 and they would go back to work. And they'd be
23 straightened out a bunch.
24 This stuff is not what you have had it
25 misrepresented to you to be like. It is not an

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1 addictive drug. And I've heard statements about
2 10 percent or something. No, it's not. Zero.
3 Marijuana doesn't addict people. It doesn't do it.
4 I can't read that, honey. Okay.
5 DEBBIE JORGENSON: You have five
6 minutes left.
7 ROBERT MANKE: Okay. I'll see if I
8 can -- I've got to take these off for just a
9 moment. I want to affirm that stronger cannabis
10 lets me have fewer coughs and better control of my
11 nausea. I affirm that there is no withdrawal from
12 cannabis ever. For me it doesn't exist. But try
13 and tell me that with morphine or Percocet or, God
14 help me, Fentanyl, which is many, many times as
15 addictive and powerful as morphine. Smoked pot
16 helps me stay off of narcotics.
17 I want to talk about severe
18 constipation just a bit again. These narcotic
19 drugs that I take cause severe constipation. Pot
20 doesn't do that. It enables me to take a lot fewer
21 narcotic drugs, but I can't take it because I'm
22 going to get arrested.
23 I'm not interested in hurting anybody.
24 I need some help. Right now the FDA-approved drugs
25 that I take are chlorpromazine maleate, Compazine,

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1 and Phenergan, and I'm telling you right now, not
2 only do they have quite a long delay before they
3 kick in, they don't work as well as cannabis.
4 Cannabis is a more effective drug.
5 I want to talk about pain control for
6 severe migraine. It works. It's real. I've sent
7 a lot of letters to Senator Grassley. Talk about
8 frustrating effort. That guy doesn't exactly like
9 people like me.
10 Who's going to represent me, pharmacy
11 members? If it isn't you, who's going to represent
12 me? Because I need your help. I'm not up here to
13 get high. I'm up here to help you understand that
14 there really are people like me out here. We're
15 Iowans and marijuana helps us. I don't even like
16 to call it marijuana. It's cannabis.
17 I've done a lot of reading on the
18 pharmaceutical derivatives of this, the sesame oil
19 with the THC, and I personally -- personally
20 believe that they're probably right when they say,
21 like the doctor did, that what's in the plant is
22 far more complex, contains far more different kinds
23 of pharmaceutically active molecules than what
24 these stripped-down versions that are being sold to
25 the public provide.

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1 There's a lot we don't understand yet.
2 I believe that. But at the same time, cannabis has
3 been so studied over and over and over.
4 I want to present you with one
5 statistic too. 100 people a year die from potato
6 overdose because potatoes have sialic acid in them
7 and can kill you.
8 There are multiple offers of rewards
9 for thousands and thousands of dollars for one
10 authentic case of cannabis overdose death, and to
11 date they are unclaimed, and I don't think they
12 ever will be claimed. How can they? Cannabis
13 doesn't kill anybody. It doesn't do it. You
14 don't see pink elephants off of it. It doesn't
15 kill anybody.
16 What do you want? What does it take
17 to get something legal to help somebody like me?
18 I'm tired of being reduced by people like Senator
19 Grassley to being an anecdote. I am an Iowan. I
20 am not an anecdote. Thank you for your time.
21 LLOYD JESSEN: Thank you. Thank you.
22 ROBERT MANKE: Was there questions you
23 need?
24 LLOYD JESSEN: Any questions from
25 board members? No. Thank you, though.