risks to the individual and to society."

Another study published in June 15 -- in the June 15, 2009, issue of Chemical Research and Toxicology stated "The smoking of three to four cannabis cigarettes a day is associated with the same degree of damage to the bronchial mucus membranes as twenty or more cigarettes a day."

The research was based on tests that look scientifically at acetylate, a suspected cancer-causing chemical known to effect human DNA that is found in both kinds of smoke.

The study concluded "These results provide evidence for the DNA-damaging potential of cannabis smoke implying that the consumption of cannabis cigarettes may be detrimental to human health with the possibility to initiate cancer development."

There are no -- currently no FDA-approved medications that are smoked. Smoking is a poor delivery system. It is difficult to administer safe regulated dosages of medicines in a smoked form. The harmful chemicals and carcinogens that are by-products of smoking create additional health problems. There is three to five times the level of tar in a marijuana cigarette, for example,

as in a tobacco cigarette.

Morphine has proven to be a medically viable drug, but the FDA does not endorse the smoking of opium or heroin.

Scientists have extracted active ingredients from opium which are sold as pharmaceutical products like morphine, codeine, Hydrocodone, oxycodone. The FDA has not approved smoking marijuana for medical purposes but has approved the active ingredient THC in the form of scientifically regulated Marinol.

Unlike smoked marijuana, which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke, Marinol has been studied and approved by the medical community and the Food and Drug Administration.

The FDA mandates that any drug marketed in the United States must undergo rigorous scientific testing to ensure compliance with the Pure Food and Drug Act.

If this board redefines smoked marijuana as medicine, what agency will fill the role of the FDA to ensure dosage levels and purity of the marijuana? Does the State of Iowa have the

resources to establish such an agency?

On April 20, 2006, the FDA issued an advisory concluding that no sound scientific studies have supported medical use of smoked marijuana for treatment in the United States. And no animal or human data support the safety or efficacy of smoked marijuana for general medical use.

A number of states have passed voter referendum or legislative actions making smoked marijuana available for a variety of medical conditions upon doctor's recommendation. According to the Food and Drug Administration, these measures are inconsistent with efforts to ensure medications undergo rigorous scientific scrutiny of the FDA approval process until they are proven safe and effective under the standards of the FD&C Act.

Experiences in other states which have redefined marijuana as medicine have shown that not only does THC content vary in marijuana, there is no process in place to guarantee that the product remains unadulterated, does not fall into the hands for those which it was not prescribed --

DEBBIE JORGENSON: You have five minutes left.

GARY YOUNG: -- and no protection from secondhand smoke from the public was provided. According to the National Institute on Drug Abuse, marijuana is the most frequently used illicit drug in the United States with over 14 million Americans over the age of 12 reporting past month usage in 2006.

The Harvard School of Public Health conducted three surveys between '93 and '99 examining the drug and alcohol use of 44,265 college students nationwide. According to the Harvard study, factors associated with smoking of marijuana includes spending more time at parties and socializing with friends, spending less time studying, and perceiving religion and community service activities as not important.

Marijuana was also associated with poorer academic performance. Students who use marijuana were less likely than those who did not to study for two hours a day and were more likely to have a grade point average of B or less.

The most consistently reported cognitive defects from chronic marijuana smoking are memory deficits. Physically it's the hippocampus in the brain where the researchers

located the actions that convert information into short-term memory, and perhaps also long-term episodic memory negates the information from memory consolidation as well as coding spatial and temporal relations among stimuli. Researchers also noted a high number of cannabinoid receptors exists in the hippocampus.

Professional -- Professor Samuel Deadwyler from the North Carolina Bowman Gray School of Medicine gave a speech in 1995 in which he said regarding the hippocampus, "In this area when damaged -- it is this area when damaged that renders patients literally incapable of remembering new information for more than a few minutes, and it is undoubtedly critically involved in the well-known memory deficits in Alzheimer's disease."

Long-term exposure to marijuana has dual consequences for the memory. First, repeated exposure to marijuana in animals makes them more and more tolerant of this memory disruptive effect. However, this also means continued use of the drug requires higher and higher doses before the euphoric or high state is achieved. Hence, even though memory is not impaired at the time -- at the same dose as before, it will be impaired just as

much because the individual will take more drugs to obtain the original euphoric state.

Hence, though the memory is not impaired, it does take more drugs, which means that the chronic use will eventually produce permanent effect on memory since the hippocampus will adjust its memory storage mechanisms to handle the lower capacity volume of information flow provided by the drugs. This may also be the basis for the well-known memory deficits that are present in chronic marijuana.

Children and young adults in particular depend on their short-term memory since they are learning and receiving new input constantly.

While smoking marijuana may allow patients a temporary feel better, the medical community makes an important distinction between inebriation and the controlled delivery of pure pharmaceutical medicine. The raw leaf form of marijuana contains a complex mixture of concentrations, the majority of which have unknown pharmacological effects.

The American Academy of Ophthalmology stated based on a review by the National Eye

Institute and the Institute of Medicine and on available scientific evidence, "The task force on therapies believes that no scientific evidence has been found that demonstrates increased benefits and/or diminished risks of marijuana use to treat glaucoma compared with a variety -- wide variety of pharmaceutical agents now available."

American Medical Association recommends that marijuana be retained in Schedule I of the Controlled Substances Act and that research should be done to provide THC in a hatch or in a -- the Institute of Medicine also gave a recommendation against it.

The National Multiple Sclerosis Society does not believe that there's any evidence that marijuana or its derivatives provides substantial benefits.

And finally, in closing, I'd like to quote Reverend Scott Imler who was a cofounder of Proposition 215, which is California's medical marijuana law. The reverend stated "We created Proposition 215 so that patients would not have to deal with black market profiteers, but today it is all about the money. Most of the dispensaries operating in California are little more than dope

dealers in storefronts."

I urge the board to make its decision based on scientific evidence and not anecdotal evidence. Thank you for your time.

LLOYD JESSEN: Thank you, Gary. Do we have Audrey Harshbarger? Audrey? Okay. Dr. Alan Koslow.

ALAN KOSLOW: I don't know if you want a copy of my curriculum vitae.

LLOYD JESSEN: Sure.

ALAN KOSLOW: Good afternoon, everybody. The pharmacy board and everybody else here in the audience, I know this is a very important topic for everybody.

I first want to kind of talk about my background, why I'm here and my experience and who I am. I'm a vascular surgery -- surgeon in the community. I also am fairly politically active, as some of you know. I ran for the state legislature.

I -- as a vascular surgeon, probably about 15 or 20 percent of my patients have neuropathic pain. Besides for that, vascular surgeons have within their domain the treatment of several pain syndromes including thoracic outlet syndrome, complex regional pain syndrome or --

yeah, complex regional pain syndrome, and obviously diabetic neuropathy.

Since I had so many patients within my practice who are pain patients, I actually am one of the founding members of the Iowa Pain Institute, and that's an institute that's here in Des Moines that was founded by Dr. Pippin as the founding chairman, and what it is is it's a group of close to 80 or 90 clinicians who deal with pain patients, and we meet once a month, and it's kind of a journal club.

We have -- we invite speakers, but most of the time it's just the members within the group. We present papers, and we review the papers, and then we discuss them. And I've been a founding member and have been going to it on a monthly basis for -- it's now going on -- it was '93 (sic) that we started, so it's now going on six years that it's doing it. I've actually been asked several times to be the chairman, but I have too many other responsibilities and so didn't take that on.

And so even though I'm not a pain doctor, I have a lot of experience with pain. What -- as the last speaker said, I hope that you

deal with this from a scientific basis and not purely from an anecdotal basis, although I am going to be presenting both some anecdotal and some scientific data to you because the anecdotes, I think, are important.

But from a point of view of should a drug be legal versus it being controlled, there are certain criteria that you need to judge. One of the criteria is obviously addiction potential. Another criteria is abuse potential.

Right now for most of the patients who I treat are being treated with a combination of depressants, antidepressants, and are being treated with narcotic pain medication, both of which have a very high diversion rate in the community.

As a matter of fact, each year at the -- at the Iowa Pain Institute, we have one of the undercover drug agents from the State who -- from the FDA who's based here in Des Moines. He comes, and he presents the diversion statistics for the state of Iowa, and it's absolutely staggering.

A significant percentage -- and I don't know the exact percentage, but a significant percentage of pain medications are diverted -- and it's not in the single digits. It's in the

multiple digit percentages -- are diverted to the streets, and these medications have significant -- significant addiction potential and are significantly abused by patients.

But let's talk about the patients that I have that are using the medication therapeutically and using it appropriately. I just had a patient in my office an hour and a half ago who at the age of 14 came down with juvenile onset diabetes, and he's been a severely brittle diabetic. He's now in his 30s, and he's developing severe peripheral -- actually, he developed about six years ago severe peripheral neuropathy that I'm seeing him for.

He basically wants to keep working. He's -- he's very upset that he can't, but because of the -- because of the effects of the antidepressants and the narcotics that he's on, what he's finding is he's not able to concentrate enough to work.

Now, he's not one who has ever tried it because he's a very law-abiding citizen. Well, last week I published an op ed in the Iowa Bystander which I'll also when I submit my written testimony, I'll submit a copy of that with it.

And in that op ed, because of that op ed, I ended up getting about 20 e-mails from people who were medical marijuana users, either legally or illegally. There was one that stands out in my mind particularly, and I'll give you a copy of that e-mail with it.

It's an Iowan whose family all lives in Iowa. When medical marijuana became legal in California -- he was completely disabled because of his -- because of his medical condition. When he went -- when medical marijuana became legal, he went to California, and he started using medical marijuana.

He got completely off almost all of his medications. He got to the point where he could work productively, and he's now productively employed, almost completely off his medications, and he is -- and the problem is he can't even come back to visit his family here in Iowa because he can't be off the marijuana, and he doesn't want to go back onto the medications.

When I treat a patient clinically with pain medications who have neuropathies -- and this is specifically neuropathies. It's not other pain because I treat lots of patients with postoperative

pain. I treat lots of patients with other types of pain, but specifically neuropathic pain, when I treat them with this, what I tell them is this pain medication is not going to help your pain. What it's going to do is it's going to basically sedate you enough so that you can tolerate the pain -- so you can tolerate the pain.

And so what we're trying to achieve with the antidepressants and with the pain medications and neuropathic pain, which a very large problem in this -- in the diabetic patient population and also post-traumatic patients who have complex regional pain syndrome or reflex sympathetic dystrophy, what we're trying to accomplish is just to get them so that they can either basically sleep or rest.

But what we do by accomplishing that is we make them nonfunctional. We make them that they're so sedated from the pain medication that they are totally nonfunctional.

Now, just -- and I'm sure a lot of people have given you these statistics, but I just real quickly want to reiterate them. In the United States in 1994, 1995 -- and I use those years, you'll see why, for a specific reason -- there were

roughly 140,000 people who died from alcohol-related causes. About half were from the direct medical effects of the alcohol, and about half were from -- from traffic fatalities, either as a driver or as a victim.

That same year there were about 440,000 people who died from tobacco-related diseases. The reason I use that year is because it compares to Great Britain because that's not good statistics in the United States, but Great Britain keeps very good statistics.

In a two-year period, 1993 to 1994, there were only five people they could identify -- and Great Britain is one-quarter the size of the United States -- so in a two-year period only five people they could identify that had a marijuana-related death, and all five of those were from asphyxiation from throwing up and choking on your vomit. But still, it's a much, much smaller number. It's -- from looking at that, it's a much, much safer medication.

Now, by the way, I at one time was a fellow, and one of my -- one of my major professors was with the Food and Drug Administration, so for a three-year period when I was in -- at the National

Institute of Health, for a three-year period when I was in Washington, I spent two and a half days a week at the Food and Drug Administration and got very involved in -- very knowledgeable about their practices, at least back then.

What I -- what I -- you know, what I learned was that what you need to do is you need to show that a drug is safe and effective. And that's the basis for it.

The problem is that it's a drug company who is then -- who is then proposing this drug, and they are going to be selling the drug. With marijuana, because there's no drug company that is going to be selling it, it has no proponent that goes to the FDA to do this.

Because of the 1937 law, it does not fit under DSHEA, which is the law that our own senator, Senator Harkin, passed, you know, that said that -- that the FDA cannot say no to a nutriceutical, to a natural substance, or it would be able to be accomplished under it.

It basically is -- it's one of the safest, most effective medications that we have for a lot of these conditions.

Now, I'd specifically like to -- by

the way, in terms of the papers, would you like me to give you -- is one copy of each enough or would you --

LLOYD JESSEN: Sure.

ALAN KOSLOW: In terms of the papers -- oh, one other thing. I was speaking with -- in my personal patients -- actually, two points before I go to the papers.

I was speaking with one of the infectious disease doctors who practiced early on in the '80s and '90s, and he told me two things. He told me, one, in his experience, when they compared Marinol with smoked marijuana that the AIDS patients that he has treated do not have anywhere near the benefit and not able to get a normal appetite with the marijuana as compared with the Marinol, and one of the papers specifically looked at that that I'll be referencing.

Secondly, my own experience for my patients who have illegally -- and I obviously can't say which patients they are because of confidentiality, but in my patients who have confided in me -- and a couple dozen over 20 years have confided in me. It's probably -- it's probably 10 times that who have actually done it --

have confided in me that they've used medical marijuana and that they were significantly able to decrease their use.

Now, again, I agree that that is anecdotal, but it is very powerful anecdotes when you see -- when you're looking in the patient's eyes and you see the suffering that they have when they're on regular pain medication, and they're begging you for something to relieve the medication, and all you can say is "We can sedate you enough so that you don't care that you're -- that you're in pain." And that's basically the current state of treatment with a lot of the neuropathic pains.

There was a study that was done that basically showed -- this was a study done in patients who were HIV and with anti-retroviral therapy, and it was by Bouke, et al. Actually, Bouke de Jong, et al., and it was from 2005 and basically showed that patients on smoking marijuana were much better able to adhere to their -- to their pharmaceutical regimen.

Again, this is the -- this is pretty much the same thing that -- in patients with Hepatitis C -- this is by Sylvester, et al. from

2005, and this basically showed that patients were much better able to tolerate their antiviral medications against Hepatitis C.

There's another paper by Haney, et al. from 2007 that again clearly shows that it's effective in patients who -- in order for them to be able to tolerate it.

Now I'm going to get into some of the neuropathic papers, and there was a paper by Ellis in 2008 that showed that what they did was they did a cannabis crossover study in which -- versus placebo, and they basically showed that neuropathic pain was able to be controlled in these patients with HIV peripheral neuropathy. I fortunately have not treated any HIV patients with peripheral neuropathy.

But there's another study -- actually, I'm sorry. This is two of the same. And I'm just listing these studies now for the record because I know you all have copies of them rather than going into all the micro details of them.

But I think one of the best studies was a study that actually looked at state-run clinical trials, and this is a paper by Musty and Rossi, published in 2001. And they basically

looked at six -- I believe it was six states. They looked at at least six states, and in every single state, they compared Marinol with -- with smoked marijuana, and they found that the Marinol did not have the effect, and one -- in Texas, which was the worst state -- and I am cherry-picking, giving you the worst, obviously -- there was 40 percent improvement in symptoms on the patients who were taking Marinol, and there was a 90 percent improvement in symptoms that were smoking marijuana.

Now, obviously, there's a lot of variability because what I understand from people who tell me who do smoke marijuana, there's a big difference in the effect that you have.

By the way, I just want to talk about that. There was a study, and I'll get it and make sure that you have it, in which -- in which they looked at the -- the LD50 of marijuana, and they found that it was 10,000 times higher than the dose that -- this was in rats that they did it. They found it was 10,000 times higher than the dose that you would need to get higher -- to get high. Not higher. To get high.

And so the safety profile, most of the

narcotics that we prescribe have an LD50 that's in the range of 5 to 20 times higher than the dose that people are taking. So we're talking 10,000 times higher for an LD50. You're talking about a very, very safe drug that's out there.

This is another one on Hepatitis C. I told them not to call me during this time. It's my office. Patients -- patients do not wait.

The -- the -- and this is another one in which they were able to tolerate the medications much better. There was actually a study that came out, and I don't have the actual study, but I saw it on the news feed just this week from -- I believe it was the University of Texas, and it was a three-level study. It was a very large study. It just got published this week, and I'll be getting the data for you, the actual study for you.

And in this -- in this study from the news feed, what I gathered from it was they basically found that most of the pain receptors in -- and they were doing this in rats, but then they translated it to humans, and they did a test with an electric shock on the arms to see if it worked, and they were cannabinoid receptors in the spine, and they developed a cannabinoid blocker so

that the cannabinoid receptors will not -- will not block the pain.

And what they found was that they found that the cannabinoid blocker was effective in -- it was with the cannabinoid blocker that the rats and the human subjects both suffered as much pain as when they did not use the cannabinoid blocker.

So obviously, one of the main receptors in the spinal column is a cannabinoid-driven receptor and not a narcotic-driven receptor. So if you're going to treat a patient, you treat them with the simplest medication that you can that blocks the simplest most peripheral receptor that you can, and that's why cannabinoids are so much safer than -- than narcotic medications.

So the bottom line, to summarize my testimony, is that I have personal experience from patients who -- who without marijuana were -- were basically forced to be disabled on the pain medication. Ones who confided with me with marijuana were able to function and be productive members of society, that marijuana is one of the safest pharmaceuticals that there is on the market,

that smoked marijuana is much more effective than oral marijuana, and this is -- these last two points are both a scientific finding, not this.

There's a lot of paranoia because we feel that there's a criminal element out there that is dealing with marijuana. There's purely a criminal element out there because of prohibition.

In the 1920s there was a criminal element with alcohol, and that criminal element disappeared when the prohibition against alcohol was removed.

And so I really strongly ask the pharmacy board to -- to -- to acknowledge that marijuana is a safe, effective -- smoked marijuana is a safe, effective therapeutic agent that should be -- that should be in the pharmacopeia of physicians so that we can adequately treat our patients so that they can become functional and viable members of society.

I'll be happy to answer any questions that the board has.

LLOYD JESSEN: Thank you, Doctor. Questions? Dr. Koslow, do you have an opinion as to what's the best way to distribute medical marijuana if a state does approve it?

ALAN KOSLOW: Well, I can think of basically two ways, that one is through our established pharmacies, and the other is through licensed shops that purely deal in medical marijuana as California has.

I see those -- and the third way is to allow patients to get a permit to grow a certain amount of marijuana in their -- if they need chronic treatment with it, get a permit to grow a certain amount of marijuana in their own home. Those are logically the only three ways I see.

I'm not giving any value judgments on one or the other. I'm just saying logically if you were to say what are the possible ways, those are the only three logical ways I can see.

LLOYD JESSEN: Thank you. Do we have Audrey Harshbarger? Audrey? All right. Jacqueline Patterson?

UNIDENTIFIED FEMALE: Could you call maybe the next names so that they could be closer to the front so -- I'm mean -- just a recommendation.

LLOYD JESSEN: Sure. The next person after Jacqueline would be Gary Bellitt.

UNIDENTIFIED MALE: What number is

that?

LLOYD JESSEN: Pardon?

UNIDENTIFIED MALE: What number is that?

LLOYD JESSEN: You don't have a number? The people who --

UNIDENTIFIED MALE: I do have a number. I'm just No. 8. I'm just curious, where are we at?

LLOYD JESSEN: Oh, right now we're taking people who had pre -- preregistered with us.

UNIDENTIFIED MALE: Yeah, I did this morning.

LLOYD JESSEN: Yes. There were some people who registered before today.

UNIDENTIFIED MALE: Oh, I understand.

LLOYD JESSEN: Let's see. We'll have one, two, three, four. Four people speak before we get to Speaker No. 4 so that -- if that gives you an idea.

UNIDENTIFIED MALE: Could I ask a question?

LLOYD JESSEN: Sure.

UNIDENTIFIED MALE: I am Speaker No. 4, and I was told I would either testify at

1:10 or before, and so I'm just curious of why we are so far behind.

UNIDENTIFIED MALE: Because we were given times. We were given times.

DEBBIE JORGENSON: The times when you checked in up front were just estimate times. It had been posted several weeks ago that if you want to set up and schedule a time, you could contact me, and the people who have been calling up by name have actual times that they have signed up. Everyone else is being worked in between the speakers as we've had breaks.

LLOYD JESSEN: And we ran a little bit late for lunch. We apologize for that but it was beyond our control. So yes.

UNIDENTIFIED FEMALE: I'm Speaker No. 5. And I traded with someone because I have a doctor's appointment at 3 o'clock.

LLOYD JESSEN: Okay.

UNIDENTIFIED FEMALE: So I would like to be able to get to my doctor's.

LLOYD JESSEN: And you're No. 5?

UNIDENTIFIED FEMALE: Yes.

LLOYD JESSEN: I think we'll be able to work that in. So again, we apologize if you're

not getting the time you thought you would get. We're trying to make this as fair as we can.

JACQUELINE PATTERSON: I will try to keep it short.

LLOYD JESSEN: Go ahead, Jacqueline.

JACQUELINE PATTERSON: I'm -- I moved to -- I moved to Iowa following a really brutal rape when I was -- it was right after I turned 19.

And I came up here because of the community -- because of the community values I had seen while -- while traveling with friends. I had a -- I had a one-year-old son who was asleep in -- who was asleep in the next -- next -- in the next -- in the next -- in the next -- in the next room.

During the -- during the -- during the -- during the attack, I was so afraid for him because there was nothing I could do to -- to save him, so that's -- that's the reason I moved here, was to keep him safe.

In the -- in the -- in the two weeks following the attack, cannabis was crucial to my -- to my existence. It really allowed me the emotional distance that I needed to deal with the trauma that I had just -- that I had just gone

through.

But it is not legal here, and it wasn't legal in Kansas City, so I quit -- so once I thought that I was ready to move on, I quit -- I quit smoking cannabis. I began attending school at North Iowa Area Community College in 1998, and I was -- I -- I was quite determined to find a -- to find a causation of rape and to eradicate the -- and to eradicate the problem so that no woman would have to suffer what I went through.

I know now it's not quite that -- I know now it's not quite that simple, but in -- but in addition to being a valuable -- a valuable tool for post-traumatic stress sufferers, cannabis can also help violent offenders modify their behavior by -- by biologically reducing stress.

By now you guys have all heard me stutter. I've got cerebral palsy which -- which manifests itself most visibly in my -- in my -- in my stutter. I was made -- I was made fun of by -- by my peers all throughout school.

I was -- I was -- I was banned from taking -- from taking classes even in college at the University of Northern Iowa. I was told that I could not speak in class because -- because it

takes me too long.

And I used cannabis briefly while I was in high school, and I noticed that it helped me, but it wasn't worth the legal risks, especially being a juvenile. So I quit using it until I met -- until I met my husband who is a post-traumatic stress survivor whose life was so inarguably enhanced by cannabis that I could no longer deny its medical -- its medical value.

We had two children at the time, and I decided that I could not teach my children to -- to break a law that they were not going to try to fix, and I -- I began lobbying for the rights of medical cannabis patients in Missouri, Kansas, and Iowa.

In October of 2007, I was arrested here for medical cannabis -- for medical cannabis -- for medical cannabis possession. It actually says that on my -- on my -- on my conviction.

I was living in Missouri at the time and had just received a Section 8 voucher that -- that was -- that was -- that was -- that was -- that was voided unless I moved out to California because I was arrested for medical cannabis. We spent three -- I've lived in California now for two

and -- and a half years.

I'm -- I'm the president of my children's school site council, and I've -- I can -- I can speak well enough to be -- to be understood and really get things -- and really get things -- and really get things done.

I know that you guys have questions like how do we keep medical cannabis away -- away from children and those who may abuse it? And who will be responsible for control of this controversial -- of this controversial plant, and is medical cannabis truly -- truly necessary? Yes, it is, and I think that the -- that the most beneficial way to legitimize therapeutic -- therapeutic -- therapeutic -- therapeutic cannabis is -- is -- is to charge the Department of Social Services and a research university such as the University of Iowa jointly with the task of creating -- of creating a -- of creating a cultivation and dispensary model.

I think that though there are many corrupt medical cannabis dispensaries in California, there are a few that have developed really wonderful models. A physician that you guys heard from mentioned the Harborside Health Center.

He said that they -- that they test their medicine.

They also offer complimentary patient services such as -- such as -- such as yoga and -- and hypnotherapy, and you can -- and they would be more than happy to share their model with you.

DEBBIE JORGENSON: Thank you.

JACQUELINE PATTERSON: Thank you.

LLOYD JESSEN: Thank you, Jacqueline. Speaker No. 4.

RICHARD STEWART: My name is Richard Stewart, S-t-e-w-a-r-t. I'm from Cedar Rapids. I don't have any medical or scientific information to present today. All I have is a story. It's not a story about me. It's a story about my son.

I would prefer and perhaps you would prefer that my son were able to tell his own story, but I think by the time I'm done, you'll understand why we thought perhaps I should tell it.

Usually when I tell this story, even in the privacy of my own home -- for instance, last night when I was practicing -- I cry. Since I don't want to cry in front of you, I have very cleverly inserted some jokes in my testimony. I know you've been asked not to applaud, but if you could just laugh at my jokes, I'd greatly

appreciate it. Thank you. Some of you don't appear to be able to recognize my jokes, however, so let me just say when it's -- this is a joke. Okay? And that gives you permission to laugh.

My son, Cane Lennon Richardson, was born on June 13, 1981. It was not a Friday. Shortly after birth, Cane began having seizures. He was rushed to neonatal intensive care where he spent the first ten days of his life. I stayed with him in the hospital the entire time, and his mother stayed at home taking care of the older three children.

Cane's seizures were so mild, all I ever saw was a very slight twitching of the little finger on his left hand. When Cane was discharged, he was on Tegretol. Tegretol is a brand name for carbamazepine, a word I never learned to pronounce.

Within one month his mother secretly weaned Cane from Tegretol. When she revealed this information to Cane's doctor and to me, he said "Well, I would never be brave enough to try that. But if he hasn't had any Tegretol for two weeks, there's no reason to put him on it now."

For the next 12 or 13 years, Cane was entirely seizure-free. Then one night when he was

12 or 13 years old, Cane had a violent seizure; a grand mal, although I believe that nomenclature is now politically incorrect.

He was discovered by one of his brothers and rushed to the hospital. By this time, Cane's mother and I were divorced, so I was not present. Some sort of strong medication was required to bring him out of the seizure. The doctor recommended putting Cane back on Tegretol. But his mother did not agree. Seeing the seizure as a rare and perhaps unique event, the doctor agreed this might be the case.

Almost a year later Cane had his second seizure. This time he was with me. It occurred in the middle of the night right after I had gone to bed, and I consider myself lucky to have heard the noise that he made during the seizure.

We rushed him to the hospital. Sitting in the waiting room, thinking everything was now under control, I heard the emergency-room doctor say "Open that freaking cabinet. We're losing him." Except she did not use the word "freaking."

You can imagine the terror that struck

me upon hearing those words. The cabinet was the one containing controlled substances. Not marijuana, of course, but apparently there are certain prescription drugs considered so threatening -- to whom, I do not know -- they must be kept under lock and key, even if it means losing patients.

Let me repeat that. Medicine, dangerous medicine, used by doctors to save lives. Fortunately, the cabinet was unlocked, and thanks to the dangerous medicine, Cane survived. Again, Cane's mother refused to allow him to take Tegretol. She did agree that if there was one more seizure, she would relent.

Almost one year to the day, Cane had his third life-threatening seizure and was rushed to the hospital to be saved. This time his mother approved Tegretol for his epilepsy.

I never know quite how to describe Cane. A parent always has a hard time admitting their children are below average. Let me just say this. In standardized tests, Cane's older sister consistently scores in the top 5 percent. Cane consistently scores in the bottom 5 percent.

Of course, Cane has many positive

attributes not shared with his sister. He's an excellent bowler. He can run without eliciting laughter, and he has a sense of rhythm. And in this case, exactly like his sister, Cane is a very hard and cheerful worker.

Nevertheless, I think you will know what I mean when I say Cane needs more help finding his way in the world than his sister does. Not help from the government -- we have no interest in Senator Harkin turning him into a disabled person -- but help from his friends and family. Fortunately, Cane makes friends easily, and he has a lot of family.

After graduation from high school, it took Cane more than a few months to find a good job. A friend eventually helped him get hired at a concrete factory. It is hard, dirty work, but it is a Teamster shop, and the pay is excellent.

Cane worked in that factory for about five years. He was a hard worker, greatly appreciated by his bosses. He was a solid member of the working class, although perhaps a bit thriftier than average. He accumulated over $20,000 in his IRA. He owned his own house, and other than his mortgage, he had zero debt.

Unfortunately, Tegretol has some serious side effects. A common one is drowsiness. Cane frequently sleeps 12 hours at a stretch, something he never did before he started taking Tegretol.

Just yesterday Cane told me that he slept 12 straight hours on Monday this week. Frequently -- excuse me. Typically Tegretol also decreases a person's alcohol tolerance. It is painful for me to watch Cane drink alcohol. He quickly turns into a happy drunk, spouting nonsense in a very loud voice, unlike me who quickly turns into a happy drunk spouting wisdom in a very loud voice.

Cane himself does not enjoy these two side effects. He would like to wake up before half the day is gone. He would like to share a couple of beers with his coworkers without turning into a slobbering drunk.

Cane has also smoked marijuana before, as did roughly half the students in his high school class, and thanks primarily to his mother and certainly not to me, he is aware that marijuana might control his epilepsy. I will present the board with three medical studies which suggest

exactly that.

Of course, Cane cannot speak to his doctor about marijuana for fear of arrest, so the bulk of his medical advice comes from his marijuana-smoking friends who appear underqualified for this important task.

Of course, using marijuana to treat his epilepsy also has a negative side effect. Cane is subject to arrest and incarceration. One year ago Cane had a minor workplace accident, completely unrelated to his work. He was helping move a Pepsi vending machine.

He was not injured in any way, but because he experienced temporary back pain, one of his coworkers insisted he go to the hospital to make sure workers' compensation covered it. At the hospital his urine tested positive for marijuana. Cane was immediately fired from his job with no support whatsoever from his union, which is happy to do their part to fight the war on drugs.

One thing is certain. Cane had not smoked marijuana before going to work or at work. Cane has never smoked marijuana on the job or gone to work under the influence of marijuana. His was a day job requiring him to begin heavy labor at

seven in the morning. Getting stoned was the last thing on his mind.

And every one of Cane's extremely rare but life-threatening seizures has been while he was sleeping, never while he was awake. Whatever medicine Cane uses to control his seizures, it is most important that it be effective during his sleeping hours.

Unfortunately for Cane, urine will test positive for marijuana for up to 30 days. Clever people know how to avoid this problem, but Cane is not clever. He is just an epileptic who is dissatisfied with his current medication and would like to try something that might work better for him.

Unfortunately again, Cane cannot get the help of qualified medical professionals to see if marijuana will work better for him. He is forced to run his own experiments. Furthermore, he is forced to buy marijuana of uncertain quality at inflated prices from criminals, and in fact, he is forced to be a criminal himself.

One year after losing his job, my son Cane is still unemployed. He could no longer make his mortgage payments and was forced to sell his

house at a deep loss. His IRA is decimated. That might not be fair. Mine is too, but he has been spending his down.

He was arrested after a daytime drinking incident, not while driving, and is serving a suspended sentence. He is essentially homeless, sleeping on the couch in my garage or at his mother's house every night. He is depressed and severely lacking in self-confidence. Does this surprise you?

If Cane were allowed to use medical marijuana legally -- I'm wrapping up -- the end of the story would be much happier. Medical marijuana may or it may not work to control his epilepsy. He and his doctor could figure that out.

His union would not have allowed him to be fired. He would still have a house, and he would still be proud of his participation in this wonderful society.

I had the opportunity to tour a little bit of the museum during the lunch break, and I saw a poster in the World War I room which I will quote. It says "Must children die and mothers plead in vain? Buy more liberty bonds."

So let me paraphrase that 90 years

later. Must children be fired and be arrested and fathers plead in vain? Legalize medical marijuana.

LLOYD JESSEN: Thank you very much. Next, Audrey Harshbarger.

GARY BELLITT: Excuse me.

LLOYD JESSEN: Yes.

GARY BELLITT: I was scheduled at 1:40. You said I would be after the young lady, and I'm not sure why. I'm pressed for time myself.

LLOYD JESSEN: Okay. Audrey, do you have --

AUDREY HARSHBARGER: No, I don't mind.

LLOYD JESSEN: You have a little extra time? Okay. Since we're a little off track, we will see who has a pressing time concern. I know you do. And --

GARY BELLITT: Yeah. My name is on the list for 1:40. I'm sorry. I don't know how I got missed.

LLOYD JESSEN: Okay. You're Gary?

GARY BELLITT: Yes. Thank you.

LLOYD JESSEN: Please go ahead.

GARY BELLITT: I hadn't planned to present scientific evidence since I am a patient. However, a friend of mine forwarded these to me,

and this first article, I will be referring to.

Good afternoon. I don't need a microphone. Members of the board, citizens of the state of Iowa, I stand before you today as living proof that medical -- of the medical benefits that marijuana can provide.

Over 20 years ago I was -- I tested positive for HIV, the virus that causes AIDS. At that time there were no proven medications to combat the virus, and I was resigned to the fact that I would eventually succumb to the disease.

Soon drugs to help the progression of the disease were developed, but they came at a price. They had severe side effects, including nausea, diarrhea, headaches, muscle cramps, fatigue, anxiety, and worst of all, insomnia.

Where was the rigorous testing for these drugs that allowed them to come onto market before they knew everything that they would do to my body? I know this is not a debate, so I'll stop with my rebuttal at that point.

Soon I tried to take these drugs as prescribed, but the sides effects were too much. I tried everything to alleviate the side effects. I tried Tylenol for the headaches and muscle cramps,