

Drug Policy Alliance

Point-by-Point Response to Governor M. Jodi Rell's Veto Message for HB 6715

21 June 2007

Governor M. Jodi Rell's veto message for HB 6715—sent to Secretary of State Susan Bysiewicz on 19 June 2007—was riddled with inaccuracies and distortions. The Drug Policy Alliance provides this point-by-point rebuttal of the claims made by Governor Rell in her veto message regarding marijuana and its medical use.

RELL ARGUMENT # 1:

“I would note that smoked marijuana as medicine has been rejected by the American Medical Association, the National Multiple Sclerosis Society, the American Glaucoma Society, the American Academy of Ophthalmology and the American Cancer Society. Our own Connecticut State Medical Society has also rejected the use of smoked marijuana for medical purposes.”

DPA RESPONSE # 1:

Smoked marijuana is not the only method of delivery, and very few of the medical and scientific organizations listed by Governor Rell have actually rejected “smoked marijuana as medicine.”

In fact, organizations such as the *American Medical Association (AMA)* have never released any statement rejecting “smoked marijuana as medicine.” The AMA has stated, “The AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana.”¹ This AMA statement does not constitute an outright rejection of “smoked marijuana as medicine.” *The American Academy of Ophthalmology (AAO)* asserts that National Eye Institute (NEI) sponsored studies have demonstrated that some derivatives of marijuana did result in the lowering of IOP when administered orally, intravenously, or by smoking, but not when topically applied to the eye.² *The National Multiple Sclerosis Society (NMSS)* states “Research is continuing to determine if there is a possible role for marijuana or its derivatives in the treatment of

¹American Medical Association - Council on Scientific Affairs, "Medical Marijuana (A-01) Full Text." [American Medical Association](http://www.ama-assn.org/ama/pub/category/print/13625.html). June 2001. American Medical Association. 24 Jun 2007

<<http://www.ama-assn.org/ama/pub/category/print/13625.html>>.

²Schwab et al. "Marijuana in the Treatment of Glaucoma." [American Academy of Ophthalmology](http://www.eyecareamerica.org/eyecare/treatment/alternative-therapies/marijuana-glaucoma.cfm). May 2003. American Academy of Ophthalmology. 24 Jun 2007 <<http://www.eyecareamerica.org/eyecare/treatment/alternative-therapies/marijuana-glaucoma.cfm>>.

MS.”³ This also does not constitute a rejection of “smoked marijuana as medicine.” Finally, the *Connecticut State Medical Society* has taken no official position on medical marijuana.

Numerous national and international organizations in the fields of medicine and science have spoken out in favor of the medical use of marijuana. Organizations such as the American Nurses Association, National Academy of Sciences - Institute of Medicine, National Association of Attorneys General, National Association of People with AIDS, American Academy of Family Physicians, American Public Health Association, American Society of Addiction Medicine, Federation of American Scientists, Lymphoma Foundation of America and the Yale School of Public Health have all released firm statements of support for the use of doctor-recommended medical marijuana for seriously ill patients with debilitating medical conditions.

Smoking is not the only means through which a patient can receive palliative benefits from marijuana. There have been many medical research studies conducted on the means through which medical marijuana can be delivered; some delivery methods significantly reduce potential smoke-related harm, including ingestion (eating). One of the most promising delivery systems is called *vaporization*. A study published in the *Harm Reduction Journal* found that, “(V)aporizers heat cannabis to release active cannabinoids, but remain cool enough to avoid the smoke and toxins associated with combustion. Vaporized cannabis should create fewer respiratory symptoms than smoked cannabis.”⁴ Data from this study revealed that the use of a vaporizer predicted fewer respiratory symptoms even when age, sex, cigarette smoking, and amount of cannabis used were taken into account. The data concludes that the “safety of cannabis can increase with the use of a vaporizer.”⁵ In a recent study in the *Journal of Pharmaceutical Sciences* evaluated the performance of the Volcano vaporizer in terms of reproducible delivery of THC; the results showed that the Volcano was a “safe and effective cannabinoid delivery system.”⁶ In addition the study found that the “final pulmonary uptake of THC is comparable to the smoking of cannabis, while avoiding the respiratory disadvantages of smoking.”⁷

With regard to the toxicity of medical marijuana, the US Drug Enforcement Agency's Administrative Law Judge, Francis Young concluded: "In strict medical terms marijuana is far safer than many foods we commonly consume. For example, eating 10 raw potatoes can result in a toxic response. By comparison, it is physically

³ National Multiple Sclerosis Society, "Marijuana (Cannabis)." *National Multiple Sclerosis Society*. 18 Sept. 2006. 24 Jun 2007 <http://www.nationalmssociety.org/site/PageServer?pagename=HOM_LIB_sourcebook_marijuana>.

⁴ Barnwell, Sara, Earleywine, Mitch. "Decreased respiratory symptoms in cannabis users who vaporize." *Harm Reduction Journal* (2007) 4:11.

⁵ Barnwell, Sara, Earleywine, Mitch. "Decreased respiratory symptoms in cannabis users who vaporize." *Harm Reduction Journal* (2007) 4:11.

⁶ A. Hazekamp et al. "Evaluation of a Vaporizing Device (Volcano) for the Pulmonary Administration of Tetrahydrocannabinol," *Journal of Pharmaceutical Sciences* 95, no. 6 (June 2006): 1308-1317.

⁷ A. Hazekamp et al. "Evaluation of a Vaporizing Device (Volcano) for the Pulmonary Administration of Tetrahydrocannabinol," *Journal of Pharmaceutical Sciences* 95, no. 6 (June 2006): 1308-1317.

impossible to eat enough marijuana to induce death. Marijuana in its natural form is one of the safest therapeutically active substances known to man."⁸

Respected researchers and organizations in science and medicine have firmly established that smoked marijuana is *not* the only method by which the benefits of marijuana can be delivered, and many respected state and national organizations have made firm statements in support of allowing doctors to recommend marijuana for medical purposes.

RELL ARGUMENT # 2:

“Indeed there are no studies or clinical trials that establish the appropriate quantity to be administered to relieve pain, the optimal frequency and duration of administration, or the most effective method of administration for medical conditions specified in the bill.”

DPA RESPONSE # 2:

As with any recommended medication, a physician must determine the appropriate dosage for each patient, taking into account various factors that make each patient unique. Especially with pain management, there is no “one size fits all.” Even so, several studies and clinical trials have studied quantity, duration of administration and effective delivery methods of marijuana for medical use.

A recent study by the University of Washington School of Medicine, the Cyber Anthropology Institute, and the University of California at San Francisco outlines reasonable guidelines for dosing of medical cannabis, based on known pharmacology.⁹ And in a 2007 double-blind placebo study on neuropathic pain in HIV/AIDS patients, patients were randomly assigned to smoke either cannabis (3.56% tetrahydrocannabinol) or identical placebo cigarettes with the cannabinoids extracted three times daily for 5 days. The study showed that smoked cannabis reduced daily pain by 34%. The first cannabis cigarette reduced chronic pain by an average of 72%. No serious adverse events were reported.¹⁰

In the July 2006 issue of *Current Medical Research and Opinion*, investigators at Germany's University of Heidelberg evaluated the analgesic effects of oral THC in nine patients with fibromyalgia over a 3-month period. Subjects in the trial were administered daily doses of 2.5 to 15 mg of THC, but received no other pain medication during the trial. Among those participants who completed the trial, all reported a significant reduction in daily recorded pain and electronically induced pain.¹¹⁻¹²

In 2004, a German research team at the Hannover Medical School reported successful treatment of musician's dystonia in a 38-year-old professional pianist following

⁸ US Department of Justice, Drug Enforcement Agency, "In the Matter of Marijuana Rescheduling Petition," [Docket #86-22], (September 6, 1988): 57.

⁹ GT Carter, P Weydt, M Kyashna-Tocha, DI Abrams. "Medicinal cannabis: Rational guidelines for dosing." *IDrugs* (2004): 7: 464 - 470.

¹⁰ Abrams DI, Jay CA, Shade SB, Vizoso H, Reda H, Press S, Kelly ME, Rowbotham MC, Petersen KL. "Cannabis in painful HIV-associated sensoryneuropathy: A randomized placebo-controlled trial." *Neurology* (2007): 68: 515-521.

¹¹ Schley et al. "Delta-9-THC based monotherapy in fibromyalgia patients on experimentally induced pain, axon reflex flare, and pain relief." *Current Medical Research and Opinion* (2006): 22: 1269-1276.

¹² Armentano, Paul. "Emerging Clinical Applications for Cannabis and Cannabinoids: A Review of the Recent Scientific Literature." *NORML Foundation* (2007):, 27-29.

administration of 5 mg of THC in a placebo-controlled single-dose trial.¹³ Investigators reported “clear improvement of motor control” in the subject’s affected hand, and noted, “[Two] hours after THC intake, the patient was able to play technically demanding literature, which had not been possible before treatment.” Prior to cannabinoid treatment, the subject had been unresponsive to standard medications and was no longer performing publicly. “The results provide evidence that ... THC intake ... significantly improves [symptoms of] ... focal dystonia,” investigators concluded.¹⁴

A 2007 study by the State University of New York at Albany and the University of Southern California suggests that the “safety of cannabis can increase with the use of a vaporizer.”¹⁵ Another 2007 study found that “vaporization of marijuana does not result in exposure to combustion gases, and therefore is expected to be much safer... ”¹⁶

Contrary to Governor Rell’s assertion, several studies have been conducted on the quantity, duration of administration and effective delivery of medical marijuana. And the final party to determine appropriate dosage levels for medical marijuana would in effect be the patient’s physician.

RELL ARGUMENT # 3:

“I am also concerned that the bill would send the wrong message to our youth. I believe that we undermine our own efforts to teach children about the dangers of illegal drugs when we say ‘...except in this case’.”

DPA RESPONSE # 3:

According to available government data – youth usage rates in states that have legalized medical marijuana have stayed the same or decreased, making this claim specious at best, or at worst, petty fear-mongering.

In fact, a recent study of trends in teen marijuana use in states with medical marijuana laws found that every state has actually experienced an overall decline in youth marijuana use since their respective laws were enacted.¹⁷ According to the California Student Survey, since the passage of medical marijuana legislation in California, marijuana use among eleventh graders dropped by 21%; use among ninth graders dropped 44%; and use among seventh graders dropped 34%.¹⁸ These findings strongly indicate that medical marijuana laws actually contribute to a decrease in marijuana use amongst young people.

¹³ Jabusch et al. “Delta-9-tetrahydrocannabinol improves motor control in a patient with musician’s dystonia.” . [Movement Disorders](#) (2004):19: 990-991.

¹⁴ Armentano, Paul. “Emerging Clinical Applications for Cannabis and Cannabinoids: A Review of the Recent Scientific Literature.” [NORML Foundation](#) (2007):, 25-26.

¹⁵ Barnwell, Sara, Earlywine, Mitch. “Decreased respiratory symptoms in cannabis users who vaporize.” [Harm Reduction Journal](#) (2007): 4:11.

¹⁶ D. Abrams et al. “Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study,” [Clinical Pharmacology & Therapeutics](#) (E-pub ahead of print).

¹⁷ Earlywine, Mitch and O’Keefe, Karen, “Marijuana Use by Young People: The Impact of State Medical Marijuana Laws.” [Marijuana Policy Project](#) (2007).

¹⁸ California State Attorney General, “10th Biennial California Student Survey Highlights,” [State of California, Department of Justice](#). (2004).

Additionally, as with any legally prescribed medication, the message to young people is precisely as Governor Rell describes it: do not use this drug except in this case—when a doctor tells you to do so. In this instance, how would marijuana be any different?

Arguments that effective medical marijuana laws send a “wrong message” to youth are unfounded in the existing data. By vetoing HB 6715, Governor Rell has effectively sent Connecticut resident, including its young people, a clear message: politics trumps compassion and reason. As a result, seriously ill and dying people will continue to be criminalized for relieving their pain and suffering.

RELL ARGUMENT # 4:

“I do not want to give false hope to the people this bill intends to benefit, nor do I wish to place them in legal jeopardy by encouraging them to purchase, plant or grow, marijuana in violation of federal law.”

DPA RESPONSE # 4:

Connecticut state law, not the federal law, is putting patients in legal jeopardy for palliative use. Over 99% of all marijuana arrests take place under the state, not federal, level.¹⁹

Under state and federal law, states can remove criminal penalties for to cultivate, possess, transport, administer and use medical marijuana under the recommendation of a physician. The Supreme Court of the United States affirmed this ability in *Gonzales v. Raich*, while also affirming that federal officials retain authority to enforce federal drug laws against medical marijuana patients and their caregivers notwithstanding state law.²⁰ But because the overwhelming majority of arrests for marijuana are made by state, not federal, officials, the removal of state penalties for medical use become exceedingly important.

In Connecticut, patients, their caregivers and their families have the most to fear from state prosecution, not federal prosecution, for the palliative use of marijuana. In states with effective medical marijuana laws there are currently no known cases of a patient or caregiver being arrested by federal officials if that patient or caregiver is following the guidelines under state law.

RELL ARGUMENT # 5:

“I am troubled by the fact that, in essence, this bill forces law abiding citizens to seek out drug dealers to make their marijuana purchases.”

DPA RESPONSE # 5:

HB 6715 does not force law abiding citizens to seek out drug dealers. Law abiding citizens are already seeking out marijuana for relief of debilitating pain and suffering. The bill would ensure that state-sanctioned patients could possess, use, and grow doctor-recommended medical marijuana without fear of state

¹⁹ Carroll, Chuck “Medical Pot User Vows to Fight On,” *Mercury News*, 6 June 2005.

²⁰ *Gonzales v. Raich* (2005) 352 F. 3d 1222.

prosecution. State sanctioned patients would also not be subject to any civil penalty for the palliative use of marijuana, or denied any right or privilege. By allowing patients to grow up to four plants, HB 6715 actually provides a mechanism for patients to obtain marijuana without entering the illicit market.

Representative Penny Bacchiochi (R-Somers), the bill's primary sponsor, has publicly recounted her story of being a caregiver for her cancer-stricken husband. Rep. Bacchiochi's husband found relief through using marijuana, and she risked arrest in order to obtain the marijuana for him. This law would have protected Rep. Bacchiochi and her husband from arrest and prosecution. Currently, laws that effectively remove state-level criminal penalties for growing and/or possessing medical marijuana are in place in twelve states--Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont and Washington. These states have enacted reforms that have had the practical effect of eliminating patient arrest and prosecution under state law. "Drug dealers" are neither mentioned nor protected under HB 6715. Because of Governor Rell's veto, patients and caregivers will continue to be forced into illicit markets to obtain marijuana for palliative use.

RELL ARGUMENT # 6:

"... there is no mechanism for assessing the effectiveness of the use of marijuana in relieving pain and other symptoms."

DPA COUNTERARGUMENT # 6:

HB 6715 included an important monitoring "mechanism" that would assess the effectiveness of the use of marijuana in relieving pain and other symptoms—a practicing physician.

Under HB 6715, a physician's written certification - based upon the physician's professional opinion after having completed a full assessment of the qualifying patient's medical history and current medical condition- is required for a patient to obtain a valid medical marijuana identification card from the State of Connecticut. That certification is good for only one year. The bill further state that, "(n)ot later than ten days after the expiration of such period, or at any time before the expiration of such period should the qualifying patient no longer wish to possess marijuana for palliative use, the qualifying patient or the primary caregiver shall destroy all marijuana plants and usable marijuana possessed by the qualifying patient and the primary caregiver for palliative use."²¹ This monitoring mechanism ensures that those who qualify for medical marijuana will be required to be re-assessed by their physician for eligibility on an annual basis.

RELL ARGUMENT # 7:

"The medical profession, as well as public and private biotechnology researchers, have made great strides in both pharmacologic and non- pharmacologic modalities for pain

²¹Connecticut General Assembly. (January Session, 2007) *AN ACT CONCERNING THE PALLIATIVE USE OF MARIJUANA, Substitute Bill No. 6715*. Retrieved June 25, 2007, from <<http://www.cga.ct.gov/2007/ACT/Pa/pdf/2007PA-00137-R00HB-06715-PA.pdf>>.

management and they continue their search to find effective pain-relieving drugs. And yet, for those suffering from unrelenting pain, these scientific advances are hardly sufficient.”

DPA AGREES WITH GOVERNOR RELL ON THIS POINT.

Governor Rell is exactly right. Current pain management technologies are sufficient for some, but not all, people. HB 6715 would provide doctors with yet another tool they can employ to relieve pain and suffering in their patients.

Medical research has provided an abundance of conclusive evidence to support the palliative use of medical marijuana. The medicinal value of marijuana is documented in rigorous research studies around the globe, including studies by the congressionally chartered Institute of Medicine (IOM), funded by the U.S. government. The IOM’s 1999 report on medical marijuana found “a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation.”²² The study further found that “for patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication.”²³ A 2006 study on the endocannabinoid system as a target of pharmacotherapy found “modulating the activity of the endocannabinoid system turned out to hold therapeutic promise in a wide range of disparate diseases and pathological conditions, ranging from mood and anxiety disorders, movement disorders such as Parkinson’s and Huntington’s disease, neuropathic pain, multiple sclerosis and spinal cord injury, to cancer, atherosclerosis, myocardial infarction, stroke, hypertension, glaucoma, obesity/metabolic syndrome, and osteoporosis, to name just a few.”²⁴

A 2007 double-blind placebo study from the University of California at San Francisco on neuropathic pain in HIV/AIDS patients found that marijuana provided relief for chronic neuropathic pain from HIV-associated sensory neuropathy. The findings were comparable to oral drugs used for chronic neuropathic pain.²⁵ With regard to multiple sclerosis, recent clinical data from an extended study of multiple sclerosis patients reported that the use of whole plant cannabinoid extracts could relieve symptoms of pain, spasticity, and bladder incontinence for an extended period of treatment without requiring subjects to increase their dose.²⁶

In the case of amyotrophic lateral sclerosis (ALS) - also known as Lou Gehrig’s Disease – recent preclinical findings indicate that cannabinoids can delay ALS progression, lending support to anecdotal reports by patients that cannabinoids may be efficacious in

²² Benson, John Jr., Joy, Janet, and Watson, Stanley Jr., Eds. “Marijuana and Medicine: Assessing the Science Base.” Division of Neuroscience and Behavioral Health – Institute of Medicine (1999).

²³ Benson, John Jr., Joy, Janet, and Watson, Stanley Jr., Eds. “Marijuana and Medicine: Assessing the Science Base.” Division of Neuroscience and Behavioral Health – Institute of Medicine (1999).

²⁴ Bátkai, Sándor, Kunos, George and Pacher, Pal. “The Endocannabinoid System as an Emerging Target of Pharmacotherapy.” National Institutes of Health -Laboratory of Physiologic Studies (2006).

²⁵ Abrams DI, Jay CA, Shade SB, Vizoso H, Reda H, Press S, Kelly ME, Rowbotham MC, Petersen KL. “Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial.” Neurology (2007): 68: 515-521.

²⁶ Wade et al. “2006. Long term use of a cannabis-based medicine in the treatment of spasticity and other symptoms of multiple sclerosis.” Multiple Sclerosis (2006): 12: 639-645.

moderating the disease's development and in alleviating certain ALS-related symptoms such as pain, appetite loss, depression and drooling.^{27.28.29} Clinical and preclinical trials have shown that both naturally occurring and endogenous cannabinoids hold analgesic qualities,^{30.31} particularly in the treatment of cancer pain³² and neuropathic pain,³³ both of which are poorly treated by conventional opioids. As a result, some experts have suggested that cannabinoid agonists would be applicable for the treatment of chronic pain conditions unresponsive to opioid analgesics.^{34.35}

There is a large body of medical research supporting the palliative use of marijuana, especially for pain relief. For Governor Rell to acknowledge that current pain management technologies are insufficient and then veto a bill that would expand pain management options in Connecticut is simply unconscionable.

In summary, the key points made by Governor Rell in her veto message are specious, not supported by science, inaccurate, and disingenuous. Given the enormous support for HB 6715 within Connecticut, both in the public and in the General Assembly, Governor Rell's veto, accompanied by a message full of distortions, exemplifies the Governor's choice of political posturing and rhetoric over compassion, science and justice. In this light, the Governor's veto was not a rejection of medical marijuana, but a rejection of Connecticut's patients and families in need of relief.

²⁷ Amtmann et al. "Survey of cannabis use in patients with amyotrophic lateral sclerosis." The American Journal of Hospice and Palliative Care (2004) 21: 95-104.

²⁸ Carter and Rosen. "Marijuana in the management of amyotrophic lateral sclerosis." The American journal of Hospice and Palliative Care (2001) 18: 264 – 70.

²⁹ Armentano, Paul. "Emerging Clinical Applications for Cannabis and Cannabinoids: A Review of the Recent Scientific Literature." NORML Foundation (2007), 18-19.

³⁰ Burns and Ineck. "Cannabinoid analgesia as a potential new therapeutic option in the treatment of chronic pain." The Annals of Pharmacotherapy (2006) 40: 251-260.

³¹ Secko, David. "Analgesia through endogenous cannabinoids." CMAJ (2005) 173.:

³² Radbruch and Elsner. "Emerging analgesics in cancer pain management." Expert Opinion on Emerging Drugs (2005): 10: 151-171.

³³ Notcutt et al. "Initial experiences with medicinal extracts of cannabis for chronic pain: Results from 34 'N of 1' studies." Anaesthesia (2004) 59: 440.

³⁴ Ethan Russo, Ethan. "Clinical Endocannabinoid deficiency (CECD): Can this concept explain therapeutic benefits of cannabis in migraine, fibromyalgia, irritable bowel syndrome, and other treatment-resistant conditions?" Neuroendocrinology Letters (2004): 25: 31-39.

³⁵ Armentano, Paul. "Emerging Clinical Applications for Cannabis and Cannabinoids: A Review of the Recent Scientific Literature." NORML Foundation (2007):. 27-29.