mmp-026

New Jersey Department of Health
Medicinal Marijuana Program
PO 360
Trenton, NJ 08625-0360

MEDICINAL MARIJUANA PETITION
(N.J.A.C. 8:64-5.1 et seq.)

INSTRUCTIONS
This petition form is to be used only for requesting approval of an additional medical condition or treatment thereof as a "debilitating medical condition" pursuant to the New Jersey Compassionate Use Medical Marijuana Act, N.J.S.A. 24:6I-3. Only one condition or treatment may be identified per petition form. For additional conditions or treatments, a separate petition form must be submitted.

NOTE: This Petition form tracks the requirements of N.J.A.C. 8:64-5.3. Note that if a petition does not contain all information required by N.J.A.C. 8:64-5.3, the Department will deny the petition and return it to petitioner without further review. For that reason the Department strongly encourages use of the Petition form.

*This completed petition **must** be postmarked **August 1 through August 31, 2016** and sent by **certified mail** to:*

New Jersey Department of Health
Office of Commissioner - Medicinal Marijuana Program
Attention: Michele Stark
369 South Warren Street
Trenton, NJ 08608

Please complete each section of this petition. If there are any supportive documents attached to this petition, you should reference those documents in the text of the petition. If you need additional space for any item, please use a separate piece of paper, number the item accordingly, and attach it to the petition.

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1. **Petitioner Information**

Name: [redacted]
Street Address: [redacted]
City, State, Zip Code: [redacted]
Telephone Number: [redacted]
Email Address: [redacted]

2. **Identify the medical condition or treatment thereof proposed. Please be specific. Do not submit broad categories (such as "mental illness").**

M15.0 Primary generalized (osteo)arthritis

3. **Do you wish to address the Medical Marijuana Review Panel regarding your petition?**

☒ Yes, in Person
☐ Yes, by Telephone
☐ No

4. **Do you request that your personally identifiable information or health information remain confidential?**

☐ Yes
☒ No

If you answer "Yes" to Question 4, your name, address, phone number, and email, as well as any medical or health information specific to you, will be redacted from the petition before forwarding to the panel for review.

RECEIVED
AUG 31 2016
OFFICE OF THE CHIEF OF STAFF

5. **Describe the extent to which the condition is generally accepted by the medical community and other experts as a valid, existing medical condition.**

I am writing in support of expanding the eligible medical marijuana law to include Osteoarthritis as a permissible condition for its use.
I am a 69 year old male who has been most fortunate in having had the opportunity to live a most active life; I graduated from [redacted] in 1970 with a degree in Business and [redacted] with a Masters in Social Work Administration. I retired some years ago from state service where I held a position in middle management. I am a family man with two daughters (both I am proud to say PhD's). My wife [redacted] is a retired teacher; we have been married 37 years.
I have been active in sports all my life. In high school I was an all-state pitcher in NJ my junior and senior years and had numerous professional teams and colleges expressing interest. I attended [redacted] under a baseball scholarship and spent a summer in the basin league for professional prospects. Unfortunately an injury to my arm ended my professional aspirations. I picked up tennis with my other arm and soon became a USTA 4.5 to 5.0 playing 7 days a week. I lived on an estate with a nationally ranked senior tennis player who had a tennis court in his back yard. I also played in the [redacted] Tennis Club at [redacted] after which I would play 2 hours of basketball on the [redacted] courts. Mondays I played golf in a work league where I shot in the low 80's/ high 70's. On weekends after tennis I'd bike or kayak the Delaware. I was a jock. This all took place up until my 40's then Osteoarthritis (OA) struck. (The full text of my letter, dated 8/6/16, is attached to this Petition.)

According to the Arthritis Foundation:
Sometimes called degenerative joint disease or degenerative arthritis, osteoarthritis (OA) is the most common chronic condition of the joints, affecting approximately 27 million Americans. OA can affect any joint, but it occurs most often in knees, hips, lower back and neck, small joints of the fingers and the bases of the thumb and big toe.
In normal joints, a firm, rubbery material called cartilage covers the end of each bone. Cartilage provides a smooth, gliding surface for joint motion and acts as a cushion between the bones. In OA, the cartilage breaks down, causing pain, swelling and problems moving the joint. As OA worsens over time, bones may break down and develop growths called spurs. Bits of bone or cartilage may chip off and float around in the joint. In the body, an inflammatory process occurs and cytokines (proteins) and enzymes develop that further damage the cartilage. In the final stages of OA, the cartilage wears away and bone rubs against bone leading to joint damage and more pain.
Who's Affected?
Although OA occurs in people of all ages, osteoarthritis is most common in people older than 65. Common risk factors include increasing age, obesity, previous joint injury, overuse of the joint, weak thigh muscles, and genes.

- One in two adults will develop symptoms of knee OA during their lives.
- One in four adults will development symptoms of hip OA by age 85.
- One in 12 people 60 years or older have hand OA.

6. **If one or more treatments of the condition, rather than the condition itself, are alleged to be the cause of the patient's suffering, describe the extent to which the treatments causing suffering are generally accepted by the medical community and other experts as valid treatments for the condition.**

With me, my visits to the orthopedic doctor got more frequent, the anti-inflammatory medications change and they get more potent, the stomach gets more upset, the joints get more painful, the limbs get more stiff. It becomes more difficult to walk, to lift my arms, and harder to sleep. I'm becoming less active--no more tennis, no more golf, no more basketball, no more kayaking no more biking. I've become more irritable. My life begins to unravel and all of this is replaced by pain and surgeries. My first surgery was a hip 9 years ago, knee debridement's 6, and 7 years ago, synvisc shots, then knee replacement 5 years ago, right shoulder shots and then, replacement 2 years ago. Left shoulder replacement will be scheduled any day now and left hip could go any time. Cervical spine upper and lower fusion is now on the horizon, L5s1 fusion on deck. I'm a mess inside. I have constant pain 24/7, I take non-steroidal and muscle relaxants daily which result in stomach ulcers, chronic diarrhea, and liver kidney issues. I'm scared to death of having to take the opiates that have been prescribed.

7. **Describe the extent to which the condition itself and/or the treatments thereof cause severe suffering, such as severe and/or chronic pain, severe nausea and/or vomiting or otherwise severely impair the patient's ability to carry on activities of daily living.**

According to the Arthritis Foundation:
Symptoms of osteoarthritis vary, depending on which joints are affected and how severely they are affected. However, the most common symptoms are pain and stiffness, particularly first thing in the morning or after resting. Affected joints may get swollen, especially after extended activity. These symptoms tend to build over time rather than show up suddenly. Some of the common symptoms include:
Sore or stiff joints – particularly the hips, knees, and lower back – after inactivity or overuse.

- Limited range of motion or stiffness that goes away after movement
- Clicking or cracking sound when a joint bends
- Mild swelling around a joint
- Pain that is worse after activity or toward the end of the day

Here are ways OA may affect different parts of the body:

- Hips. Pain is felt in the groin area or buttocks and sometimes on the inside of the knee or thigh.

- Knees. A "grating" or "scraping" sensation occurs when moving the knee.
- Fingers. Bony growths (spurs) at the edge of joints can cause fingers to become swollen, tender and red. There may be pain at the base of the thumb.
- Feet. Pain and tenderness is felt in the large joint at the base of the big toe. There may be swelling in ankles or toes.

OA pain, swelling or stiffness may make it difficult to perform ordinary tasks at work or at home. Simple acts like tucking in bed sheets, opening a box of food, grasping a computer mouse or driving a car can become nearly impossible. When the lower body joints are affected, activities such as walking, climbing stairs and lifting objects may become difficult. When finger and hand joints are affected, osteoarthritis can make it difficult to grasp and hold objects, such as a pencil, or to do delicate tasks, such as needlework.

How OA May Affect Overall Health

The pain, reduced mobility, side effects from medication and other factors associated with osteoarthritis can lead to negative health effects not directly related to the joint disease.

Diabetes and Heart Disease

Knee or hip pain may lead to a sedentary lifestyle that promotes weight gain and possible obesity. Being overweight or obese can lead to the development of diabetes, heart disease and high blood pressure.

Falls

People with osteoarthritis experience as much as 30 percent more falls and have a 20 percent greater risk of facture than those without OA. People with OA have risk factors such as decreased function, muscle weakness and impaired balance that make them more likely to fall. Side effects from medications used for pain relief can also contribute to falls. Narcotic pain relievers can cause people to feel dizzy and unbalanced. OA symptoms can hinder work, social life and family life if steps are not taken to prevent joint damage, manage pain and increase flexibility.

8. Describe the availability of conventional medical therapies other than those that cause suffering to alleviate suffering caused by the condition and/or the treatment thereof.

The therapies described below may well cause suffering in some people (problems with analgesics. etc.), may not be possible for others (maintaining a healthy weight), or may be part of the cause or worsening of OA (exercise).

According to the Arthritis Foundation:

Osteoarthritis is a chronic (long-term) disease. There is no cure, but treatments are available to manage symptoms. Long-term management of the disease will include several factors:

- Managing symptoms, such as pain, stiffness and swelling
- Improving joint mobility and flexibility
- Maintaining a healthy weight
- Getting enough of exercise

Pain and Anti-inflammatory Medications

Medicines for osteoarthritis are available as pills, syrups, creams or lotions, or they are injected into a joint. They include:

- Analgesics. These are pain relievers and include acetaminophen, opioids (narcotics) and an atypical opioid called tramadol.
- Nonsteroidal anti-inflammatory drugs (NSAIDs). These are the most commonly used drugs to ease inflammation and related pain. NSAIDs include aspirin, ibuprofen, naproxen and celecoxib.
- Corticosteroids. Corticosteroids are powerful anti-inflammatory medicines. They are taken by mouth or injected directly into a joint at a doctor's office.
- Hyaluronic acid. Hyaluronic acid occurs naturally in joint fluid, acting as a shock absorber and lubricant. However, the acid appears to break down in people with osteoarthritis. The injections are done in a doctor's office.

Physical and Occupational Therapy

Physical and occupational therapists can provide a range of treatment options for pain management including:

- Ways to properly use joints
- Heat and cold therapies
- Range of motion and flexibility exercises
- Assistive devices

Assistive Devices

Assistive devices can help with function and mobility. These include items, such as like scooters, canes, walkers, splints, shoe orthotics or helpful tools, such as jar openers, long-handled shoe horns or steering wheel grips. Many devices can be found at pharmacies and medical supply stores. But some items, such as custom knee braces and shoe wedges are prescribed by a doctor and are typically fitted by a physical or occupational therapist.

Natural and Alternative Therapies

Many people with OA use natural or alternative therapies to address symptoms and improve their overall well-being. These include nutritional supplements, acupuncture or acupressure, massage, relaxation techniques and hydrotherapy, among others.

Surgery

Joint surgery can repair or replace severely damaged joints, especially hips or knees. A doctor will refer an eligible patient to an orthopaedic surgeon to perform the procedure.

Positive Attitude

Many studies have demonstrated that a positive outlook can boost the immune system and increase a person's ability to handle pain.

9. **Describe the extent to which evidence that is generally accepted among the medical community and other experts supports a finding that the use of marijuana alleviates suffering caused by the condition and/or the treatment thereof.** *[**Note:** You may attach articles published in peer-reviewed scientific journals reporting the results of research on the effects of marijuana on the medical condition or treatment of the condition and supporting why the medical condition should be added to the list of debilitating medical conditions.]*

I've had to turn to getting marijuana illegally so I get relief from the pain of OA and medication side effects. So far marijuana has helped me greatly. It is as effective as the anti-inflammatory drugs and the only side effects are increased appetitie and a positive outlook.

RESEARCH

[1] Swift et al. 2005. Survey of Australians using cannabis for medical purposes. Harm Reduction Journal 4: 2-18.

[2] Ware et al. 2005. The medicinal use of cannabis in the UK: results of a nationwide survey. International Journal of Clinical Practice 59: 291-295.

[3] Mark Wallace, M.D.; et al. 2007. Dose-dependent Effects of Smoked Cannabis on Capsaicin-induced Pain and Hyperalgesia in Healthy Volunteers
Anesthesiology 11 2007, Vol.107, 785-796.

[4] Boehnke KF, Litinas E, Clauw DJ 2016. Medical Cannabis Use Is Associated With Decreased Opiate Medication Use in a Retrospective Cross-Sectional Survey of Patients With Chronic Pain. J Pain. 2016 Jun; 17(6):739-44.

[5] Marcus A. Bachhuber, MD et al. 2014 Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010. JAMA Intern Med. 2014;174(10):1668-1673.

[6] Haroutounian S. et al. 2016. The Effect of Medicinal Cannabis on Pain and Quality of Life Outcomes in Chronic Pain: A Prospective Open-label Study. Clin J Pain. 2016 Feb 17.

[7] Ware et al. 2015. Cannabis for the Management of Pain: Assessment of Safety Study. Journal of Pain.

[8] Lynch ME, Ware MA. 2015 Cannabinoids for the Treatment of Chronic Non-Cancer Pain: An Updated Systematic Review of Randomized Controlled Trials. J Neuroimmune Pharmacol. 2015 Jun;10(2):293-301

[9] Aggarwal SK. 2013 Cannabinergic pain medicine: a concise clinical primer and survey of randomized-controlled trial results. Clin J Pain. 2013 Feb; 29(2):162-71.

[10] Aggarwal SK, et al. 2009. Characteristics of patients with chronic pain accessing treatment with medical cannabis in Washington State. J Opioid Manag 2009 Sep-Oct 5 (5) 257-86.

[11] Bab, I., & Zimmer, A. (2008). Cannabinoid receptors and the regulation of bone mass. British Journal of Pharmacology, 153(2), 182–188.

[12] Baron, E.P. (2015, June). Comprehensive Review of Medicinal Marijuana, Cannabinoids, and Therapeutic Implications in Medicine and Headache: What a Long Strange Trip It's Been... Headache, 55(6), 885-916.

[13] Burston, J., et al., (2013). Cannabinoid CB2 Receptors Regulate Central Sensitization and Pain Responses Associated with Osteoarthritis of the Knee Joint. PLoS ONE, 8(11), e80440.

[14] Idris, A.I., et al., (2009, August). Cannabinoid receptor type 1 protects against age-related osteoporosis by regulating osteoblast and adipocyte differentiation in marrow stromal cells. Cell Metabolism, 10(2), 139-47.

[15] La Porta, et al., (2014, February). Involvement of the endocannabinoid system in osteoarthritis pain. The European Journal of Neuroscience, 39(3), 485-500.

[16] Malfait, A. M., et al., (2000). The nonpsychoactive cannabis constituent cannabidiol is an oral anti-arthritic therapeutic in murine collagen-induced arthritis. Proceedings of the National Academy of Sciences of the United States of America, 97(17), 9561–9566.

[17] Ofek, O., et al., (2006). Peripheral cannabinoid receptor, CB2, regulates bone mass. Proceedings of the National Academy of Sciences of the United States of America, 103(3), 696–701.http://doi.org/10.1073/pnas.0504187103

[18] Schuelert, N., and McDougall, J.J. (2008, January). Cannabinoid-mediated antinociception is enhanced in rat osteoarthritic knees. Arthritis and Rheumatism, 58(1), 145-53.

[19] Sumariwalla, P.F., et al., (2004, March). A novel synthetic, nonpsychoactive cannabinoid acid (HU-320) with antiinflammatory properties in murine collagen-induced arthritis. Arthritis and Rheumatism, 50(3), 985-98.

[20] Woodhams, S.G., et al., (2015). The role of the endocannabinoid system in pain. Handbook of Experimental Pharmacology, 227, 119-43.

10. Attach letters of support from physicians or other licensed health care professionals knowledgeable about the condition. List below the number of letters attached and identify the authors.

1. Kenneth R. Wolski, RN, MPA

I certify, under penalty of perjury, that I am 18 years of age or older; that the information provided in this petition is true and accurate to the best of my knowledge; and that the attached documents are authentic.

Si[redacted]	Date August 23, 2016

Mr.Ken Wolski RN MPA August 6, 2016

Executive Director

Coalition for Medical Marijuana New Jersey Inc.

Dear Mr. Wolski,

I am writing in support of expanding the eligible medical marijuana law to include osteoarthritis as a permissible condition for its use.

I am a 69 year old male who has been most fortunate in having had the opportunity to live a most active life; I graduated from [redacted] in 1970 with a degree in Business and [redacted] with a Masters in Social Work Administration. I retired some years ago from state service where I held a position in middle management. I am a family man with two daughters (both I am proud to say PhD's). My wife [redacted] is a retired teacher; we have been married 37 years.

I have been active in sports all my life. In high school I was an all-state pitcher in NJ my junior and senior years and had numerous professional teams and colleges expressing interest. I attended [redacted] under a baseball scholarship and spent a summer in the basin league for professional prospects. Unfortunately an injury to my arm ended my professional aspirations. I picked up tennis with my other arm and soon became a USTA4.5 to 5 playing 7 days a week. I lived on an estate with a nationally ranked senior tennis player who had a tennis court in his back yard. I also played in the [redacted] Tennis Club at [redacted] after which I would play 2 hours of basketball on the [redacted] courts. Mondays I played golf in a work league where I shot in the low 80's/ high 70's. On weekends after tennis I'd bike or kayak the Delaware. I was a jock. This all took place up until my 40's then Osteoarthritis (OA) struck. Actually it began earlier; at first little pains, as a jock you play in pain that's what you do because it's second nature, you play hurt. Hell, take an aspirin, let's go. But slowly, ever so slowly, and all over, the joints let you know. The orthopedic doctor visits get more frequent, the anti-inflammatory medications change and they get more potent, the stomach gets more upset, the joints get more painful, the limbs get more stiff. It becomes more difficult to walk, to lift your arms, and harder to sleep. You're becoming less active, no more tennis, no more golf, no more basketball, no more kayaking no more biking. You become more irritable, your life begins to unravel and all of this is replaced by pain and surgeries. My first surgery was a hip 9 years ago, knee debridement's 6, and 7 years ago, synvis shots, then knee replacement 5 years ago, right shoulder shots and then, replacement 2 years ago. Left shoulder replacement will be scheduled any day now and left hip could go any time. Cervical spine upper and lower fusion is now on the horizon, L5s1 fusion on deck. I'm a mess inside. I have constant pain 24/7, I take non-steroidal and muscle relaxants daily which result in stomach ulcers, chronic diarrhea, and liver kidney issues. I've had to turn to getting pot illegally so I get relief from the pain of OA and medication side effects and I'm scared to death of having to take the opiates that have been prescribed. So far pot has helped greatly. It is as effective as the anti-inflammatory and the only side effects of pot are Twinkies, and Tasty Cakes.

Good Luck,

[redacted]

Trenton, NJ 08618

August 22, 2016

Medicinal Marijuana Program
P.O. Box 360
Trenton, NJ 08625-0360

Re: Adding Osteoarthritis (OA) as a qualifying condition for marijuana therapy

To Whom It May Concern:

I have practiced as a Registered Nurse (RN) since 1976, and I am currently licensed to practice in New Jersey (# and Pennsylvania (#). See my attached resume for a summary of my education, professional experience, and interests.

My interest in medical marijuana began in 1993 when I attended my first conference—of many--on the emerging science of the Endocannabinoid System. The conference took place in Amsterdam and there I met an American expatriate named told me he had glaucoma and no medication was effective in controlling his disease. His eyesight was continually deteriorating. Several of his family members had already gone blind from glaucoma. When he was in his 30s he tried marijuana for the first time. He noticed an almost immediate improvement in his vision. He discussed this with his ophthalmologist who recommended that he continue to use marijuana. was a farmer in Kentucky, so he grew marijuana on his farm. The government found it growing there. They arrested him, tried him and convicted him, despite his doctor's testimony at his trial. spent a year in prison, part of that time in maximum security. While he was in prison, the government seized his farm and his home for growing that marijuana. His eyesight deteriorated in prison. When he was released from prison, he fled America, never to return. This was one of the worst cases of social injustice I had ever encountered. This man had to leave America to find the freedom to save his eyesight. I vowed I would try to stop this injustice from happening to other people.

I began to research the issue. The more I studied, the more I realized that what happened to was just the tip of the iceberg. Legitimate patients who were using marijuana on the recommendation of their physicians were being prosecuted throughout the country. In 2001 I began work on a resolution in support of medical marijuana that I presented to the New Jersey State Nurses Association (NJSNA). The resolution was approved by the NJSNA on March 20, 2002. The American Nurses Association adopted a similar resolution in 2004, updated in 2008 (see attached).

In 2002 I met who was pushing his wife in her wheelchair around the country. The were publicly demonstrating that marijuana was the only thing that relieved muscle spasticity that resulted from her multiple sclerosis. I proposed that and I should work together to form a coalition of people and organizations in New Jersey that

supported medical marijuana. [redacted] agreed and thus was formed the Coalition for Medical Marijuana—New Jersey (CMMNJ).

CMMNJ was instrumental in getting the New Jersey Compassionate Use Medical Marijuana Act (CUMMA) introduced into the Senate Health Committee on January 11, 2005, and signed into law on January 18, 2010. The mission of CMMNJ, an all-volunteer 501 (c)(3) nonprofit educational organization and public charity is, "To bring about safe and legal access to medical marijuana for New Jersey patients who are under the care of licensed physicians and nurse practitioners."

CMMNJ believes that medical marijuana should be available to any patient who can benefit from it, including patients like [redacted], who endures chronic pain from severe Osteoarthritis (OA).

Chronic pain is often considered the fifth vital sign, to be monitored routinely along with temperature, pulse rate, respiratory rate, and blood pressure. In fact, chronic pain from any cause was included as a qualifying condition in the original version of the CUMMA, and this version was approved by the New Jersey Senate in February 2009. However, before CUMMA became law, chronic pain was only allowed as a qualifying condition for marijuana therapy in cases of cancer or HIV/AIDS. There is no scientific or medical justification for limiting marijuana therapy to just two of the numerous conditions and diseases-- including Osteoarthritis--that cause chronic pain. It appears that the current limitation on chronic pain as a qualifying condition for marijuana therapy was done solely to limit the scope of the state's Medicinal Marijuana Program (MMP). I would challenge the MMP panel members to justify how marijuana can be recognized as a safe and effective form of therapy for chronic pain in the cases of cancer and HIV/AIDS but not for all other causes of chronic pain, including severe OA.

The issue is personal for me, as well as professional, because [redacted]

There is no cure for OA, and some of the strategies to control the painful symptoms are either not possible for many who suffer from this disease, or the strategies themselves are the cause of additional suffering. The Arthritis Foundation recommends that OA sufferers maintain a healthy weight, but, given America's Obesity Epidemic, this is simply not possible for many people in this country. Non-steroidal anti-inflammatory drugs may well cause gastrointestinal problems. Or take, for example, analgesic therapy. Acetaminophen, an over-the-counter (OTC) pain reliever, is the leading cause of liver failure in the U.S. There is currently an opioid addiction crisis in this country due to the overreliance on prescription opioids to manage painful symptoms. If patients are not satisfied with the dosage of analgesics prescribed by their doctors, they will often seek extra-legal relief, like that offered by street drugs like heroin, or illegally-obtained prescription analgesics like oxycodone or fentanyl. Others self-medicate with alcohol, which, in combination with opioids, can lead to a fatal overdose. The opioid crisis has led to

deaths by overdose at an alarming rate, surpassing the rate of death by all other accidents among young U.S. adults. Marijuana, by contrast, is a much safer alternative. There has never been a single death attributed to a marijuana overdose. Indeed, in states with robust medical marijuana programs that include home cultivation, there is a 25% reduction in opiate overdose death rates.

My thirteen years of experience as executive director of CMMNJ has put me in touch with numerous patients both in New Jersey and throughout the country who have personally experienced the therapeutic benefits of marijuana therapy for OA (among numerous other conditions.) Patients consistently report that marijuana is more easily tolerated than OTC and prescription analgesics, and that they use fewer pharmaceutical drugs when they incorporate marijuana into their therapeutic regimen. Marijuana acts synergistically with analgesics and it provides a pleasant, temporary euphoric feeling. The side effects of marijuana are easily managed by nearly all patients who use it in the proper setting and with the proper mind set.

Moreover, many patients report that the use of marijuana puts them in a more therapeutic "mood" where they are removed from the typical cares of the day, and they are more attuned to issues of physical and spiritual well-being. For example, many patients think they are "too busy" to take an Epsom salts bath. However, after using marijuana, patients suddenly find that they have the time and the inclination to engage in the therapeutic benefits of hydrotherapy.

Marijuana therapy can be used in oral (and rectal) doses for prolonged symptom management. Inhaled forms of marijuana, via vaporization or smoking, can be used for quick-acting management of breakthrough pain.

I am sorry to report that there is a lack of enthusiasm from physicians in the state for marijuana therapy for any condition. Only a few hundred doctors have joined New Jersey's MMP Physician Registry in the six years since the CUMMA has passed into law, out of a total of about 30,000 physicians in the state. I attended every committee hearing on medical marijuana while the legislature debated this issue between 2005 and 2010 and physician testimony in support of medical marijuana was notable for its absence. In fact, the Medical Society of New Jersey (which several of the current panel members belong to) opposed the state's CUMMA law, and they still have not come out in support of it. It was the compelling testimony of New Jersey patients, and their nurses, that convinced the legislators to pass CUMMA.

When I testified at the Pennsylvania legislative committee hearings on the issue, I heard Charles Cutler, MD, of the Pennsylvania Medical Society report on March 24, 2015 in his statement in opposition to Senate Bill 3 (which eventually passed and legalized marijuana for medical use in Pennsylvania). Dr. Cutler said, "There are no state medical societies that have endorsed the use of medical marijuana," despite the fact that now 25 states and the District of Columbia have medical marijuana laws. It seems that the state medical societies are as intransigent in their opposition to medical marijuana as is the federal government. The federal government has been insisting for the last 46 years that marijuana is a Schedule I drug that has, "No accepted medical uses in the U.S." Requiring letters of support from physicians for adding conditions like OA to the state's MMP seems like a requirement that is nearly impossible to achieve. It is nearly as impossible to achieve as are the large scale double-blind placebo controlled clinical trials that many opponents of marijuana therapy insist on, knowing full well that the federal government

has an "inadequate supply" of marijuana to conduct these trials, even as it lacks the political will to allow these trials to proceed.

The worst and most enduring adverse effect of marijuana is an arrest. Draconian penalties for cultivation of marijuana, like those endured by the American expatriate [redacted], still apply here in New Jersey. Patients are naturally reluctant to publicly reveal their use of marijuana for OA and other unauthorized conditions because they fear the heavy hand of the criminal justice system. The MMP panel is empowered to protect OA patients, who are mostly elderly, and I pray that you do so.

Sincerely,

Kenneth R. Wolski, RN, MPA
Executive Director
Coalition for Medical Marijuana--New Jersey, Inc.

www.cmmnj.org

Attachments:

Resume of Kenneth R. Wolski, RN, MPA

New Jersey State Nurses Association, "Resolution Concerning Therapeutic Marijuana," 2002.

American Nurses Association, "Position Statement in Support of Patients' Safe Access to Therapeutic Marijuana," 2008.

Kenneth R. Wolski, RN, MPA
Trenton, NJ 08618

Professional Employment

Registered Nurse (RN) since 1976, licensed to practice in New Jersey (#) and Pennsylvania (#).

I currently volunteer full time as Executive Director of the Coalition for Medical Marijuana—New Jersey, Inc. (CMMNJ). I co-founded this non-profit, 501(c)(3) educational organization and public charity in 2003. I volunteered part-time at CMMNJ until my retirement from the State of New Jersey in August 2006.

Prior to 2006, I was employed full time with the State of New Jersey at Trenton Psychiatric Hospital for four years, and at various institutions in the Department of Corrections (DOC) for 22 years. At the State, I was a Graduate Nurse, Head Nurse, Supervisor of Nurses, Quality Assurance Coordinator, and Health Services Manager.

In addition, I worked for seven years in Acute Care Facilities (Mercer Medical Center and Thomas Jefferson University Hospital) as an Intensive Care Unit/Cardiac Care Unit (ICU/CCU) Nurse. I also worked as a Public Health Nurse for the City of Trenton.

Education

February, 1990 to January, 1992	Rutgers University Newark/Princeton, New Jersey Executive Masters Degree in Public Administration (MPA)
September, 1974 to June, 1976	Mercer County Community College West Windsor, New Jersey Associate in Applied Science (Nursing), Cum Laude
September, 1969 to June, 1971	Rutgers University New Brunswick, New Jersey Bachelor of Arts (BA) in Philosophy, Cum Laude

Organizations and Interests

I am a member of the American Nurses Association, and both the New Jersey and the Pennsylvania State Nurses Associations.

I received the Governor's Certificate of Appreciation for "improving government in New Jersey" in 2005 for developing a telemedicine program that both improved inmate health care and reduced expenses at the DOC.

CMMNJ was instrumental in passing the New Jersey Compassionate Use Medical Marijuana Act into law in January 2010. I lecture for CMEs & CEUs on the issue.

I am a founding Board member of the American Cannabis Nurses Association.

I am on the Board of Advisors of Patients Out of Time. I have attended the following medical marijuana conferences organized by Patients Out of Time (http://www.medicalcannabis.com/clinical-conferences/):

2004 Charlottesville, VA;
2006 Santa Barbara, CA;
2008 Pacific Grove, CA;
2010 Warwick, RI;
2012 Tucson, AZ;
2014 Portland, OR;
2015 West Palm Beach, FL;
2016 Baltimore, MD.

New Jersey State Nurses Association
Resolution Concerning Therapeutic Marijuana

Summary: A number of New Jersey residents would benefit from access to therapeutic marijuana as a form of treatment for their health problems.

Whereas: Marijuana has been used medicinally for centuries, and marijuana was widely prescribed by physicians in the United States until 1937, and;

Whereas: Marijuana has been reported to be effective in: a) reducing intraocular pressure in glaucoma, b) reducing nausea and vomiting associated with chemotherapy, c) stimulating the appetite for patients living with AIDS (acquired immunodeficiency syndrome) and suffering from the wasting syndrome, d) controlling spasticity associated with spinal cord injury and multiple sclerosis, and;

Whereas: Patients not helped by conventional medications and treatments may find relief from their suffering with the use of marijuana, and;

Whereas: The relative safety of marijuana has been established and the benefits associated with medical marijuana use would outweigh any potential adverse effects, and;

Whereas: Nurses have a fundamental responsibility to promote health, to prevent illness, to restore health and to alleviate suffering, and;

Whereas: Thirty-three states have passed legislation recognizing marijuana's therapeutic value, and eight states have removed criminal penalties for use, possession and cultivation of marijuana for medical reasons, and;

Whereas: Ten State Nurses Associations, the American Nurses Association, the American Medical Association, the American Public Health Association and various other health-related associations have favorable positions on medical marijuana education and/or use, therefore,

Be it resolved that The New Jersey State Nurses Association:

1. Recognizes the therapeutic value and safety of medically recommended marijuana; and,
2. Recognizes the effect of second hand smoke on those in the immediate therapeutic environment; and,
3. Supports legal access to medically recommended marijuana for patients

in New Jersey who are under the care of a licensed health care provider; and,

4. Urges the Governor of New Jersey and the New Jersey State Legislature to move expeditiously to make medical marijuana legally available to New Jersey residents who can benefit from it.

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Submitted by: Kenneth R. Wolski, RN
Date Submitted: January 16, 2002
Date Approved: March 20, 2002

Position Statement

In Support of Patients' Safe Access to Therapeutic Marijuana

Effective Date: December 12, 2008
Status: Revised Position Statement
Originated By: Congress on Nursing Practice and Economics
Adopted By: ANA Board of Directors

Purpose: The purpose of this statement is to reiterate the American Nurses Association (ANA) support for patients having safe access to therapeutic marijuana.

Statement of ANA position: Marijuana (cannabis) has been used medicinally for centuries. It has been shown to be effective in treating a wide range of symptoms in a variety of conditions. Therefore, the American Nurses Association supports:

1. The education of registered nurses and other health care practitioners regarding appropriate evidence-based therapeutic use of marijuana including those non-smoked forms of delta-9-tetrahydrocannabinol (THC) that have proven to be therapeutically efficacious
2. Protection from criminal or civil penalties for patients using medical marijuana as permitted under state laws
3. Exemption from criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for health care practitioners who prescribe, dispense or administer medical marijuana in accordance with state law.
4. Reclassification of marijuana's status from a Schedule I controlled substance into a less restrictive category.
5. Confirmation of the therapeutic efficacy of medical marijuana.

History/Previous Position Statements: Marijuana has been smoked for its medicinal properties for centuries. The American Nurses Association has supported providing patients with safe access

to therapeutic marijuana for over a decade. The ANA House of Delegates has gone on record as supporting nurses' "ethical obligation to be advocates for access to healthcare for all" including patients in need of "marijuana/cannabis for therapeutic use" (ANA, 2003). In addition, in 1996, ANA's Congress on Nursing Practice (the forerunner of today's ANA Congress on Nursing Practice and Economics) advocated support for:

- the education for RNs regarding current, evidence based therapeutic uses of cannabis, and
- the investigation of therapeutic efficacy of cannabis in controlled trials (ANA, 1996).

Preclinical, clinical, and anecdotal reports suggest numerous potential medical uses for marijuana. Although the indications for some conditions (e.g., HIV wasting and chemotherapy-induced nausea and vomiting) have been well documented, less information is available about other potential medical uses (ACP, 2008).

Until 1937, cannabis was widely prescribed in the United States. *The Marihuana Tax Act of 1937* began the prohibition of its use (Galliher & Walker, 1977) and the Controlled Substances Act of 1970 completely prohibited all therapeutic medicinal use of marijuana/cannabis by making it a Schedule I drug (Public Law 91-513). There is a growing body of evidence that marijuana has a significant margin of safety when used under a practitioner's supervision when all of the patient's medications can be considered in the therapeutic regimen (Steinborn, 2001; IOM, 1999). A number of professional associations including the American College of Physicians (ACP) and the American Public Health Association have noted marijuana's therapeutic properties for a number of conditions. Marijuana is seen as efficacious in:

- Reducing nausea and vomiting associated with chemotherapy
- Stimulating the appetite of patients coping with the wasting syndrome associated with HIV/AIDS and cancer
- Short-term relief of the intraocular pressure associated with glaucoma
- Decreasing spasticity, pain, and tremor in some patients with multiple sclerosis (MS), spinal cord injuries, or other trauma
- Decreasing suffering from chronic pain (ACP, 2008; APHA, 1995).

Additional research is called for to confirm marijuana's therapeutic properties and to determine standard and optimal doses and routes of delivery. Unfortunately, research expansion has been

hindered by a complicated federal approval process, limited availability of research-grade marijuana, and the debate over legalization. Marijuana's categorization as a Schedule I controlled substance raises significant concerns for researchers, health care practitioners, and patients (ACP, 2008).

While voters have approved the use of marijuana in a number of states, there are several where the administration and legislative bodies have refused to accept regulations or codify provider behaviors. Further, the FDA, the DEA and the federal government have issued warnings to the providers in those states, identifying the federal consequences of distributing or prescribing medical marijuana. Therefore, families and patients who gain access to or use marijuana/cannabis as adjunct therapy for symptom relief are still at risk for breaking the law (Wall, 2001).

According to a number of U.S. Department of Health and Human Services agencies, including the Food and Drug Administration (FDA) and the National Institute of Drug Abuse (NIDA), there is no evidence supporting medical use of marijuana for treatment in the United States (FDA, 2006). In June 2005, the U.S. Supreme Court ruled 6 to 3 that the federal government has the power to arrest and prosecute patients and their suppliers even if the marijuana use is permitted under state law, because of its authority under the federal Controlled Substances Act to regulate interstate commerce in illegal drugs (Okie, 2005). Those positions are in conflict with the IOM report which noted that "for patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, scientific studies support medical use of marijuana for treatment in the United States." The IOM also determined that in comparison with other drugs (both legal and illicit), including alcohol, tobacco, and cocaine, "dependence among marijuana users is relatively rare and dependence appears to be less severe than dependence on other drugs." (IOM, 1999). Clearly there is a disconnect between federal agencies and the scientific and healthcare communities as to the value of medical marijuana, which hinders ongoing research and precludes patients having safe access to therapeutic marijuana.

Summary: The evidence demonstrates a connection between therapeutic use of marijuana and symptom relief. The American Nurses Association actively supports patients' rights to legally and

safely utilize marijuana for symptom management and health care practitioners' efforts to promote quality of life for patients needing such therapy.

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