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Statement of Eric E. Sterling before the Maryland House of Delegates Judiciary Committee Hon. Joseph F. Vallario, Jr., Chair, in Support of H.B. 702: An Act Concerning the Darrell Putman Medical Research Act March 4, 2003

Statement In Support of H.B. 702

Eric E. Sterling

We ought to agree, as a matter of principle, that sick people should never fear arrest or imprisonment from their decision to use a medication recommended by their physician. We ought to assure that the law never threatens to punish bona fide patients for their choice of medication upon the recommendation of their licensed physician.

We ought to agree that there is medical value to the use of marijuana if the most distinguished and impartial panel of medical experts in the country makes such a determination after an extensive review of all of the scientific literature. This was a conclusion of the Institute of Medicine of the National Academy of Sciences in its 1999 report, *Marijuana and Medicine*: *Assessing the Science Base*. We ought to agree that this is a fact that sick persons and their physicians may reasonably rely upon in making decisions about medication.

We ought to agree that the Maryland General Assembly is fully competent to legislate regulatory controls on the medical use of controlled dangerous substances such as cocaine, morphine – and marijuana – that will not handicap the law enforcement agencies in investigating and prosecuting illegal manufacture, distribution and use of such drugs.

We ought to agree that the State of Maryland has the constitutional power to legislate to regulate commerce within the State, to regulate health care delivery within the State, and to govern its law enforcement agencies and courts independently of the federal laws unless the field is pre-empted by the U.S. Constitution and an Act of Congress. We can agree that Congress has not pre-empted the field of controlled dangerous substances.

We ought to agree that competent attorneys, including the Office of Maryland's Attorney General, have found that the Supreme Court's opinion in the Oakland Cannabis Club case does not block Maryland from carrying out the purposes of H.B. 702.

Statement

Mr. Chairman, Members of the Committee, thank you very much for permitting me to testify before you today. My name is Eric E. Sterling. I live with my wife and daughter in the 18th Legislative District of Maryland. I am President of the Criminal Justice Policy Foundation headquartered in

Silver Spring, Maryland. I am testifying today on behalf of the Marijuana Policy Project, Inc. of Washington, D.C.

My Qualifications

From 1979 to 1989 I served as counsel to the U.S. House of Representatives Committee on the Judiciary, principally responsible for Federal Controlled Substances Law. On the staff of the Subcommittee on Criminal Justice, and then for eight years on the staff of the Subcommittee on Crime, I reviewed almost all of the bills introduced in the House of Representatives to amend the Controlled Substances Act, or to govern the operations of the Drug Enforcement Administration. From the 96th through the 100th Congress, I directly participated in the drafting of most of the bills enacted with respect to illegal drugs. I was also responsible for Federal laws regarding gun control, organized crime, money laundering, pornography, arson, and other issues. I played a major role in drafting the Comprehensive Crime Control Act of 1984, the Firearms Owners Protection Act of 1986, the Anti-Drug Abuse Act of 1986, and the Anti-Drug Abuse Act of 1988. I have been commended by the U.S. Bureau of Alcohol, Tobacco and Firearms, and the U.S. Postal Inspection Service for my assistance to their law enforcement missions.

Since 1989, I have been the President of the Criminal Justice Policy Foundation, now based in Silver Spring, MD. I work on a wide variety of criminal justice issues, and drug policy matters. I am regularly consulted by Members of Congress and state legislators from around the nation. I am a section liaison to the Standing Committee on Substance Abuse of the American Bar Association, and past chair of the criminal justice committee of the ABA section of individual rights and responsibilities. My analyses have been published in law reviews and other journals around the nation.

I analyzed the federal response to the California medical use of marijuana law in my article, "Drug Policy: A Smorgasbord of Conundrums Spiced by Emotions Around University Law Review 597, 622-645 (Spring 1997).

My Experience with Federal Medical Marijuana Legislation

In three Congresses in the 1980s, my boss, Rep. William J. Hughes (D-NJ), the chairman of the House Subcommittee on Crime, was a co-sponsor of legislation to create a Federal medical marijuana exemption. Rep. Hughes had been a career prosecutor and a tough crime fighter. He was the author of numerous laws to strengthen the national fight against drug abuse. He wrote the Federal forfeiture laws in 1984 and 1986 that enable the government to seize the proceeds and tools of drug traffickers. He wrote the mandatory minimum sentences enacted in 1986. He wrote the Federal money laundering statute in 1986. He wrote the ban on designer drugs. The Federal criminal code is filled with the tough anti-crime provisions he sponsored and shepherded through the House of Representatives.

Congressman Hughes became familiar with the medical literature regarding the use of marijuana. He was satisfied that marijuana had medical value, and that for some medical patients, it provided relief when other medications – often considered superior medications – did not.

Mr. Hughes understood that our national effort to fight drug abuse must not interfere with the ability of doctors to treat their patients. In 1984, we gave DEA much greater powers to investigate the misconduct of doctors and greater powers to revoke their licenses when they engaged in misconduct (P.L. 98-473. sec. 511 & 512). But in doing so, we understood that most physicians can be trusted to use their training and medical licenses appropriately.

Mr. Hughes also understood an important point: *making a drug available for use in medicine does not send a signal to youth that the drug is safe to use socially*. Every drug education program makes the point that there are medicines that are recommended by doctors and should be taken only when prescribed by doctors. If not taken as directed,

Mr. Hughes knew that well-trained police and prosecutors routinely distinguish between legitimate medical cases and those cases in which prescription drugs are used illegally.

Overview of H.B. 702

H.B. 702 will provide vitally needed medical and legal relief to many residents of Maryland. It will not handicap the State's ability to investigate and prosecute violations of the controlled dangerous substances law. It will not create a legal conflict with the federal government although there is in obvious policy difference.

H.B. 702 Does Not Create a State – Federal Legal Conflict

Enactment of H.B. 702 will not put the State of Maryland in a legal conflict with the Federal government. **The States of Oregon, Hawaii and Alaska have operated programs identifying medical patients who qualify for the use of marijuana, and exempted such patients from the risk of prosecution since May 2001 without any interference from the federal government**. Those programs are very similar to the one proposed in H.B. 702.

The U.S. Supreme Court's medical marijuana ruling in May 2001 (*U.S. v. Oakland Cannabis Buyers' Cooperative*, 522 U.S. 483; 121 S.Ct. 1711; 149 L.Ed. 2d 722; U.S. LEXIS 3518; 69 U.S.L.W. 4316) has been misread by many persons. Many people looked at newspaper headlines and mistakenly concluded that the Court struck down California's medical use of marijuana law. The holding of the Supreme Court was that Federal courts had no authority to create a common law defense of medical necessity to a marijuana distribution prosecution for the ad hoc organizations in California that were distributing marijuana to medical patients. The defense of necessity had been created by several courts to enable an individual who is using marijuana to avoid going blind, for example, to be found not guilty of marijuana possession or cultivation because it would be unreasonable to require them to go blind and obey the law. (*U.S. v. Randall*, 104 Washington Daily Law Reporter 2249, D.C. Superior Ct 1976; *State v. Musikka*, Case No. Dec. 28, 1988, rep'ted in 14 F.L.W. 2, Jan. 27, 1989). In the *Oakland* case, the buyers' clubs could not claim they had a necessity to distribute marijuana in violation of the federal law.

Some people like to say that the Supreme Court SAID there is no medical use for marijuana. Actually the Court simply noted that this is what the federal Controlled Substances Act says. It is a correct statement of federal law, but the court was not examining any medical or scientific evidence in making that statement.

There is a medical use for marijuana that was very clearly set forth in the report of the Institute of Medicine of the National Academy of Sciences in *Marijuana and Medicine: Assessing the Science Base* (*1999: National Academy Press*).

The Supreme Court did not address a key question because it was not addressed by the court below. That question is **whether the federal law applies to medical use of marijuana that takes place only in one state**. This point is important because H.B. 702 would regulate matters that take place wholly within Maryland and which do not constitute "commerce among the states." If the matter is not within the commerce power of the U.S. Congress under article I, section 8 of the U.S. Constitution, there is no power for DEA to regulate or enforce it. If the matter is outside the power of the Congress to regulate, then it is not possible, as a legal matter, for there to be a conflict between state and federal law. There are cases pending in California in which this question is being considered (*Raich v. Ashcroft*, No. C-02-4872 MJJ, U.S.D.C. N.D. Cal.).

It is critically important that the General Assembly of the State of Maryland recognize that H.B. 702 regulates activities that take place wholly within the state and which do not constitute "commerce among the states." Three years ago the U.S. Supreme Court struck down part of the federal Violence Against Women Act of 1994 because it exceeded Congress' power under the Constitution (*U.S. v. Morrison*,*et al*. No. 99-5, May 15, 2001). If a matter is not under the power of Congress to "

Article I, Section 8 of the U.S. Constitution in this area, then there can be no conflict between federal law and State law. The three categories of commerce power are: (1) the channels of interstate commerce; (2) instrumentalities of interstate commerce, or persons or things in interstate commerce; or (3) those activities having a substantial relation to interstate commerce, i.e. those activities that substantially affect interstate commerce.

The activities of the medical patients authorized by H.B. 702 are not significant enough to have a substantial relation to interstate commerce.

Maryland Must Not Allow Federal Policy to "Commandeer" its Legislature, Law Enforcement Officers or Licensed Physicians

The Supreme Court has struck down two federal regulatory policies that attempt to direct states to address problems in certain ways (*New York v. United States*, 505 U.S. 144 (1992) and *Printz v. United States*, 521 U.S. 898 (1997)). Judge Alex Kozinski noted that, "much as the federal government may prefer that California keep medical marijuana illegal, it cannot force the state to do so." And the federal government cannot use its licensing of physicians' controlled substances prescribing power to force a state to keep the medical use of marijuana illegal (*Conant v. Walters*, No. 00-17222, 9th Cir. (2002), *concurring* slip op. 29-30).

How Will H.B. 702 Affect Doctors?

Some doctors are worried that if they recommend the use of marijuana under this bill, they would be violating the law or risk losing their Federal license to prescribe controlled substances. That won't happen. This issue was settled in the case of*Conant v. Walters*, No. 00-17222, U.S. Court of Appeals for the Ninth Circuit, Oct. 29, 2002. A permanent injunction barring the U.S. from taking action against doctors who recommend the use of marijuana to their patients was upheld. The Ninth Circuit relied upon the Supreme Court's precedents protecting the speech of physicians: *Thompson v. Western* (2002);*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992); *Rust v. Sullivan*, 500 U.S. 173, 200 (1991).

It is well established that "direct control of medical practice in the states is beyond the power of the federal government" (*Linder v. United States*, 268 U.S. 5, 18 (1925).

A recommendation by a physician to a patient to use marijuana for a medical purpose should be treated by the police like a prescription to obtain controlled dangerous substances such as narcotic pain relievers (which, incidentally, are addictive and can be lethal). When appropriately stopped and searched by a police officer, a patient who possesses prescribed narcotic pain relievers who shows the prescription bottle with label, is not subject to arrest for such narcotic possession. A patient with a Maryland identification card or a copy of the recommendation from their physician would not be subject to arrest. The Supreme Court of California ruled unanimously on July 18, 2002 that under their medical marijuana law, "the possession and cultivation of marijuana is no more criminal -- so long as its conditions are satisfied -- than the possession and acquisition of any prescription drug with a physician"s prescription." (*People v. Mower*, No. S094490, Cal. Supreme Court, July 18, 2002).

H.B. 702 is Consistent with the Purposes of Maryland's Controlled Dangerous Substances Law

Drawing distinctions between the appropriate and inappropriate use of drugs is what the Controlled Dangerous Substances Act is all about. The findings and declarations of the General Assembly are quite articulate on this point:

" . . . . many of the substances included in this subheading have a*useful and legitimate medical purpose and are necessary* to maintain the health and general welfare of the people . . . however . . . illegal manufacture, distribution, possession, and administration of controlled dangerous substances have a substantial and detrimental effect on the health and general welfare of the people . . . It is the purpose of

controlling the manufacture, distribution, possession, and administration of controlled dangerous substances and related paraphernalia in order to *insure their availability for legitimate medical* and scientific purposes, but to *prevent their abuse* . . . . " Article 27, Section 276(a) of the Code of Maryland (emphasis added).

Drugs recognized by Maryland law (and federal law) as having "useful and legitimate medical purpose and [that] are necessary" include cocaine, a wide variety of powerful opiate and synthetic narcotics, and stimulant and depressant drugs that have a high potential for abuse. These drugs are used both legally and illegally. In the instance of cocaine, the extent of illegal use of the drug probably exceeds its legal use.

This bill, H.B. 702, brings Maryland's law into conformity with the weight of scientific opinion – marijuana has medical benefit. One of the things I learned in a decade of working on the Federal regulation of controlled substances is that two people can have very different responses to a given drug. For example, for most of us, aspirin in its usual dosage is sufficient to relieve a headache. For some people it doesn't work at all. This does not mean that aspirin is not a good drug. And it doesn't mean that another drug which does relieve the headache pain for the person who gets no relief from aspirin is a better drug. *Physicians have learned that having many drugs available for a single condition can be a great benefit for the individuals who don't respond to the most common or the most safe drugs available for that condition*.

It is the nature of the law itself (and the responsibility of agents of the law) to make distinctions between sometimes similar circumstances, to separate the lawful from the unlawful. H.B. 702 does an outstanding job of clearly setting forth the circumstances that reasonably describe what ought to be lawful use of marijuana in Maryland. It does so in a manner that will be enforceable by the police and state's attorneys, and with more than adequate clarity for the courts to rule with confidence in separating the lawful from the unlawful.

H.B. 702 Creates Controls that are Much More Demanding than the Current Law Controls for Cocaine and Similar Dangerous Drugs

There are many examples in H.B. 702 where it is much more precise and demanding in controlling the dispensing and distribution of marijuana compared to cocaine and other hard drugs regulated under the Controlled Dangerous Substances chapter of Article 27. In every instance *H.B. 702 is much more demanding* than current law in governing the prescribing and use of highly addictive, often lethal drugs.

First, H.B. 702 details the nature of a bona-fide physician-patient relationship far more explicitly than the general requirement found elsewhere in Article 27 for other controlled dangerous substances. Section 288 of Article 27 requires in very general fashion that any prescribing be "in the course of his regular professional duties, and in conformance with. . .the standards of his particular profession."

H.B. 702 requires, in addition to that general requirement, a "written certification," including a statement of the "physician's professional opinion," after a "full assessment" of the "patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship" that the patient has a "debilitating medical condition" and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks" for the patient. Nothing in the current law requires anything like this specificity of relationship, examination and consultation as a prelude to issuing a prescription for powerful and addictive controlled dangerous substances.

Second, the definition of "physician" in H.B. 702 is more precise than the definition of "practitioner" in section 277(t) or the definition of "physician" in sec. 277(t)(1)(a). Art. 27 sec. 277(t) very generally grants to "practitioners" authority to "distribute, dispense, conduct research with respect to or administer a controlled dangerous substance *in the course of professional practice or research in this state*." A "physician" under current law means "any

person authorized by law to practice medicine in this State." Art. 27 sec. 277(t)(1)(a).

In H.B. 702, a "physician" is "an individual who has a license to practice medicine,*and is licensed to prescribe drugs*, under title 14 of the Health Occupations article." (Emphasis added.) This is a narrower and more specific definition.

Third, H.B. 702 specifically limits the medical conditions for which marijuana may be lawfully provided. Art. 27, sec. 285, regarding prescriptions for cocaine, morphine, methamphetamine and other controlled dangerous substances, contains no limitation regarding the medical conditions for which prescriptions for such drugs may be issued.

Fourth, H.B. 702 is much more specific than the statute governing cocaine and other drugs, regarding the writing that a physician must prepare. Section 285 of the current law merely requires a "written prescription by the practitioner" (or oral prescription in the case of schedule III and IV drugs) with no definition of prescription and no requirement of any specific findings by the physician. The detailed "written certification" required by H.B. 702 is spelled out above.

Fifth, H.B. 702, unlike the law regarding cocaine and other drugs, explicitly defines the quantity of marijuana that may be lawfully possessed, and explicitly terminates the protection of the Act if the quantity of marijuana possessed exceeds the adequate supply for the course of treatment projected by the physician.

Sixth, H.B. 702 is specific about the liabilities and responsibilities of family members and other care givers in their conduct with respect to marijuana. The law governing the other dangerous controlled substances is silent regarding the lawfulness of a person or parent obtaining the prescribed medication, such as powerful narcotics for the relief of pain, for their spouse, parent or child.

Seventh, to provide the clearest guidance to law enforcement officers in the continued enforcement of the laws against marijuana, H.B. 702 provides for the issuance of "registry identification cards" by the state to qualifying patients.

H.B. 702 Has Additional Protections against Fraud

The bill is very explicit in prohibiting potential areas of abuse or evasion such as making fraudulent representations to a police officer that one has a lawful medical use exception to the marijuana law. It specifically prohibits the possession, use or distribution of marijuana by qualifying patients for non-permitted purposes.

This bill does not give an unqualified person room to concoct a defense after an arrest. It is only operative when a physician has been consulted in the course of a bona fide physician-patient relationship, and the physician has made a specific diagnosis regarding a handful of debilitating medical conditions, and then made specific findings for the patient regarding the relative risks and benefits of using marijuana. It is hard to see how the protections of this bill could be applied by a person who upon arrest for marijuana possession or cultivation suddenly claims to be a medical marijuana patient.

H.B. 702 Provides Protections to the Public More Extensive than Current Law

Unlike current law, H.B. 702 specifically prohibits drug use in a manner dangerous to the public, such using marijuana in public or on public transportation, or driving or operating heavy machinery.

Maryland Authority to Regulate Medical Marijuana under the Controlled Substances Act

The states are not excluded from regulating drugs and the practice of medicine. Section 708 of the federal Controlled Substances Act (hereafter CSA) (21 U.S.C. 903), "Application of State Law," provides that "No provision of this subchapter [the Controlled Substances Act] shall be construed as indicating an intent on the part of the Congress to occupy the filed in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a *positive* conflict between that

so that the two cannot consistently stand together." (Emphasis added).

Controlled Substances Act Prescribing Provisions

There is no provision in the CSA that explicitly prohibits physicians from recommending marijuana for their patients. Section 309 of the CSA (21 U.S.C. 829), relating to prescriptions, is silent regarding prescriptions for Schedule I substances. The CSA provides for the registration of manufacturers and distributors of Schedule I substances (21 U.S.C. 823(a) and (b)) which is evidence that Congress intended the Schedule I substances would be manufactured, distributed, and used. Section 303(f) of the CSA (21 U.S.C. 823(f)) provides that practitioners may conduct research with Schedule I substances. In fact, the United States has been providing marijuana to as many as 25 medical patients since 1978 in what is called a research program.

A careful reading of all of the offenses of the CSA (21 U.S.C. sections 841-863) reveals than none prohibit a physician from recommending a Schedule I substance.

No provision of H.B. 702 is in "positive conflict" with a provision of the CSA. H.B. 702 does not interfere with federal administration of the CSA.

Small Likelihood that the Federal Government would Initiate a Legal Conflict with Maryland over this Legislation

Other than to strongly object to this legislation, it is highly unlikely that the Federal government will take any steps to block the implementation of this bill should it be enacted. Indeed, while running for President, George W. Bush characterized the "medical marijuana issue" as a "states rights issue." It is also highly unlikely that the Federal government will prosecute Maryland residents who are qualified to seek the benefit of this bill and comply with its provisions.

It is highly unlikely that the United States Attorney would devote his precious resources to prosecuting medical patients and doctors who comply with the requirements of this bill. In FY 2001, there were fewer than 200 Maryland, about one-third of all federal criminal cases. Yet there were over 10,000 state prosecutions for drug offenses, statewide. The heroin, PCP and cocaine problems in Maryland are terribly acute. The danger that legitimate medical patients will be lured, by passage of this bill, into facing federal criminal charges, is close to zero if they follow the provisions of the bill.

Three final points: will this bill lead to more teenage marijuana use, will it lead to the legalization of drugs, and will it undermine law enforcement?

Will this Bill Lead to More Teenage Marijuana Use?

We all want to know whether this measure will lead to increased marijuana use by young people. There are several reasons to believe that it is highly unlikely.

First, our actual historical experience suggests it will not. Many state laws providing for the medical use of marijuana were passed in the period 1978 to 1981. Teenage marijuana use started to decline in 1979. From 1976 to 1986, the National Institute of Drug Abuse shipped over 160,000 marijuana cigarettes for human use, and teenage marijuana use continued downward. Legislation to provide for medical marijuana was considered in Congress, and teenage marijuana use continued to decline. In 1987 and 1988 there were numerous public hearings in several cities over the question of medical marijuana, and in September 1988, the DEA Administrative Law Judge ruled that marijuana was safe and effective as a medicine and should be available for medical purposes, and teenage marijuana use continued to decline.

In 1991 the Bush Administration decided to close the small, 14-year old "compassionate use" program providing marijuana for medical use, in order to stop "sending the wrong message" to teenagers. However, that year, teenage marijuana use started to rise after a dozen years of decline.

Teenage marijuana use rose dramatically between 1991 and 1996 when the federal medical marijuana program was closed to new patients. In the finger-pointing in Congress

scapegoats: President Clinton was blamed for failing to give enough anti-drug speeches; Hollywood was blamed for glamorizing drugs; "baby-boomer" parents were blamed for being insufficiently strict about drugs; and advocates of "drug legalization" were blamed for "promoting" drug use. In this casting of blame, no one claimed, nor offered any evidence, that the increase in teenage marijuana use was due to the public debate around the medical use of marijuana.

After passage of the medical marijuana resolutions in California and Arizona in 1996, the White House ONDCP Director, Gen. Barry McCaffrey, sought special data in the National Household Survey on Drug Abuse on teenage marijuana use in those two states. The data demonstrated that teenage marijuana use in California remained substantially lower than the national average – 6.6% used in the past month in California compared to 9.6% nationwide. *And beginning at this point, with national media and Internet attention to the medical use of marijuana at its greatest level ever, teenage marijuana use began to decline again*.

The data regarding youthful initiation into marijuana use has never revealed that kids start smoking marijuana because it has medical uses.

Indeed, the right kind of public education around the medical use of marijuana could be a powerful deterrent to teenage marijuana use. Imagine television advertising that associates marijuana use with people vomiting from cancer chemotherapy, associating marijuana use with persons who are crippled by multiple sclerosis, and associating marijuana with people who are dying from AIDS and cancer. None of these are positive associations. Associate the use of marijuana with persons struggling to live. Imagine the effects on the popularity of marijuana smoking among teenagers after several years of such advertising. Today, marijuana is perceived primarily as a party drug. But with a changed law and proper social marketing, that image could change.

(2) Will Passage of this Bill Lead to the

Second, will legalizing the use of marijuana for medical purposes lead to the legalization of marijuana for recreational or social purposes, or other drug legalization, as some opponents suggest?

When the General Assembly votes to permit the medical use of marijuana under a physician's direction, is this a "gateway" or "stepping stone" for legislators to go down the road to vote legalize all marijuana use, or the recreational use of heroin and cocaine? Of course not. The proposition is laughable. Legislators don't become addicted to some kind of voting pattern by casting a vote.

In reality, legalizing medical use of marijuana is extremely unlikely to lead to the legalization of marijuana generally. The public completely understands the difference between medical and non-medical use, and so do you. When polled on the two questions, the public overwhelmingly supports medical use of marijuana, and overwhelmingly opposes legalization of marijuana for social purposes. Legalizing marijuana for medical purposes conceptually puts marijuana in the same kind of status as cocaine, morphine and other addictive drugs. The fact that cocaine is legally used in medicine is no argument for legalizing cocaine for social purposes. Such an argument is ludicrous.

The fear that bills of this kind will lead to legalizing drugs for social or recreational purposes is not grounded in political or social reality. The opposite is true. To the extent that the drug control regime looks well-managed, compassionate and effective, the less likely it is that it will be thrown over.

The longer legislators oppose allowing the legal use of marijuana by sick people, the more discredit they bring upon the drug laws in general. They certainly are well-intentioned, but they appear heartless to those who sympathize with the seriously ill who get no relief from conventional medications. The longer they resist, the more reasonable sound the complaints of drug legalizers about the irrationality of the drug laws.

To argue that you will be more likely to vote to legalize drugs if you vote for this measure is an insult to your intelligence, your

(3) Will this Bill Undermine Law Enforcement?

Third, and most importantly, creating a legal scheme for the use of marijuana in medicine poses no threat to the enforcement of the drug laws.

Maryland doctors prescribe, and patients use and possess, powerful narcotics like Dilaudid®, Percodan®, powerful stimulants like Ritalin®, habit-forming tranquilizers and mood-elevating drugs like Valium®. The local police departments, the Maryland State Police and the DEA are fully able to investigate and prosecute the illegal trafficking, misprescribing, and misuse of those drugs.

Policing the non-medical use of such drugs is not more difficult for law enforcement than investigating cases against "street drugs" such as heroin – indeed they are often easier because of the existence of the required paper trail.

Federal drug laws will be unaffected by H.B. 702. DEA, FBI, ATF, IRS, Customs, etc. will continue to investigate and prosecute drug cases that merit Federal attention without any limitation. Any marijuana cases meriting Federal or state investigation and prosecution can proceed without limitation by H.B. 702.

Investigations of large-scale trafficking in drugs – the top priority of law enforcement – will in no way be affected by the small-scale use by and distribution of marijuana to some very ill persons who have a bona fide physician-patient relationship and written documentation.

Any medical patient who is distributing marijuana improperly will be subject to prosecution under the terms of the bill. The power to investigate such offenses is not limited by the bill.

Providing patients with "Registry Identification Cards" will make legitimate patients easily verifiable, and identifying violators easy too.. When a person is apprehended with pills – whether in a prescription bottle or not – the police may make an arrest and undertake the a preliminary investigation before they learn whether the person's possession of the drugs is lawful

Open-air drug trafficking prosecutions will continue under H.B. 702. None of the disturbing and violence-prone open-air drug markets will escape investigation or prosecution because of H.B. 702. The bill permits controlled and regulated distribution of marijuana only.

I commend Delegate Morhaim, and the many other co-sponsors of this necessary and well-crafted bill. People are suffering, and marijuana provides relief to some of those people after all the other drugs they have tried have failed. This bill is a very well-written measure that is workable and effectively overcomes the legal obstacles. It deserves to pass, and I think the people of Maryland will be proud of their legislature for doing so.

Eric Sterling is the Executive Director of the Criminal Justice Policy Foundation in Washington, D.C. He was counsel to the House Judiciary Committee from 1979 to 1989.