PRIORITY POINTS

STATEMENT OF
ERIC E. STERLING, J.D.
SUBMITTED TO THE
MARYLAND GENERAL ASSEMBLY

IN SUPPORT OF

H.B. 712/S.B. 627
AN ACT CONCERNING PUBLIC HEALTH - MEDICAL MARIJUANA

1. "Physician assessment" should recognize the high cost and often unacceptable side-effects of conventional medication and compare the risks and benefits of conventional medication with risks and benefits of medical marijuana. (p. 10-11)

2. For profit corporations should be allowed to be dispensaries and pharmacies. The current approach will cause expensive litigation. (p. 9-10)

3. Do not restrict this bill only to Maryland residents when so many out-of-state patients seek high quality medical care here. (p. 7)

4. The two-ounce per month limit of medical marijuana is unscientific and arbitrary. The Federal government supplies more than seven ounces per month to its patients. (p. 11-12)

5. Patient cultivation is necessary and reasonable to accomplish standardized dosing. In the transition to full production and distribution by the state, it should be authorized with reasonable limits. (p. 13-14)

6. Create a patient - physician advisory panel to assist the department in administration of the program. (p. 13)

7. Provide for physician training. (p. 1)

8. Maryland State policy since May 19, 2009 is to remove barriers to employment for nonviolent offenders (Chapter 686, H.B. 635). Numerous provisions of this bill are inconsistent with that policy. (pp. 8-9, caregivers, p. 11)

STATEMENT OF

ERIC E. STERLING

SUBMITTED TO
THE MARYLAND HOUSE OF DELEGATES
JUDICIARY COMMITTEE
HEALTH AND GOVERNMENT OPERATIONS COMMITTEE
HON. JOSEPH F. VALLARIO, JR., CHAIR OF JUDICIARY
HON. PETER A. HAMMEN, CHAIR OF HEALTH AND GOVERNMENT OPERATIONS

AND
THE MARYLAND SENATE
JUDICIAL PROCEEDINGS COMMITTEE
HON. BRIAN E. FROSH, CHAIR OF JUDICIAL PROCEEDINGS

IN SUPPORT OF
H.B. 712/S.B. 627
AN ACT CONCERNING
PUBLIC HEALTH - MEDICAL MARIJUANA

Chairman Vallario, Chairman Hammen, Chairman Frosh, Members of the Committees, thank you very much for considering my statement. My name is Eric E. Sterling. I live with my wife and daughter in Chevy Chase, MD in the 18th District.

This statement has four sections:
First, an introduction.
Second, a short review of the historical and sociological background of the use of marijuana both medicinally and socially in order to help frame the current legal and medical context. *This helps explain why the bill is unusual and why it has some of the weaknesses it exhibits.* (pp. 3 - 6).
Third, a detailed look at specific problems of the bill. (pp. 6 - 13).
And fourth, a statement of my qualifications for writing about this issue. (pp. 14)

I. Introduction

I strongly commend Chairman Vallario for his essential work in enacting the Darrell Putman Compassionate Use Act in 2003 in which the General Assembly recognized the medical value of marijuana. That was a breakthrough in Maryland, enacted at a time when there was an intense policy conflict between the White House and the rest of nation regarding the medical use of marijuana. Since then Vermont, Rhode Island, New Mexico, Michigan and New Jersey, have passed laws recognizing the medical value of marijuana, authorizing physicians to recommend cannabis to their

citizens, and protecting citizens from the risk of prosecution when they use cannabis for medical purposes.

In developing different medical marijuana laws, Maryland and the other states have served their role in our federal system of serving as so-called laboratories of democracy, in the common expression of the words of Justice Louis Brandeis ("It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." Dissent, *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (U.S., 1932)).

I commend Delegate Morhaim and Senator Brinkley for their leadership in developing H.B. 712/S.B. 627, and the many co-sponsors who have joined them to improve the medical marijuana law in Maryland. I strongly support the bill.

Weaknesses in medical marijuana law and policy nationwide, as well as in H.B. 712/S.B. 627, are due to deep societal conflicts about marijuana. As we consider the bill and work to advance it through the General Assembly, it may be helpful for Senators and Delegates to review some of the intersecting legal, medical and sociological history around these conflicts.

II. Summary of historical and sociological background of marijuana use and medicine

1. *Marijuana – a drug of abuse for the past century*.

For about a century, marijuana has been considered by much of society to be a drug of abuse. The prevailing view for most of that time was that use of marijuana was highly detrimental, its use was a feature of or gateway to deviance of various kinds, and that it was probably dangerous to health, to morals, and the development of healthy, responsible adults. Those views are deeply rooted in our culture.

2. *Marijuana use is widespread.*

Marijuana use has become widespread over the past 40 years. Beginning with the baby boom generation, roughly half of all young adults have used marijuana to various degrees. Many observers recognize this marijuana use as congruent with other risky or rebellious young adult behaviors. Marijuana use can be engaged in as dangerously as driving carelessly, skiing recklessly without a helmet, binge drinking and related behaviors, and promiscuous and unprotected sex that too many young people heedlessly engage in. Marijuana use can also be recognized as congruent with other post adolescent rebellion – staying up late, sleeping late, cutting classes, modifying appearance by means of clothing, hair style, body decoration, or adopting new intellectual or cultural identities, etc.

3. *Protecting youth from marijuana – most of whom who use are not harmed.*

The society's greatest concern with marijuana is to prevent youth from being adversely affected by using marijuana. We see that about half of our youth try

marijuana. And we see a range of patterns of use: from those who engage in a handful of experimental trials, to those who make intense commitments to a "marijuana lifestyle." Yet for almost all of these young people, they emerge into fully functioning and competent adults. Most adults older than their mid twenties who continue to use marijuana integrate it into the structures of their lives without much disruption.

4. *Drug dependence is painful and tragic.*

Justifiably, the nation is greatly concerned about substance abuse. Alcoholism and the dependence on various substances – opiates, stimulants, other depressants and other mood-altering drugs – cause great pain to individuals and their families, absenteeism and lost productivity in the workplace, accidents, death and suicide, and are associated with crimes such as theft and prostitution. The fraction of marijuana users who become dependent is smaller than the fraction of users of opiates, cocaine, alcohol and tobacco, but in absolute terms, there are many such persons. Generally the patterns of marijuana dependence do not seem to be as disabling as addiction to opiates, cocaine and alcohol.

5. *Differentiating types of illegal marijuana distribution.*

Because marijuana use is illegal, large scale production and distribution is a major criminal enterprise that is highly profitable and requires money laundering and protection from theft, often with firearms. At the international trafficking level it is often connected to the traffic in heroin, cocaine, methamphetamine or other drugs, and violence and corruption.

At the consumer level, the illegal distribution of marijuana is socially networked among friends and acquaintances. Depending upon one's enthusiasm for marijuana, one's access to a little capital, and one's willingness to take risks, there are hundreds of thousands of persons who are regularly involved in the informal distribution of marijuana – a few grams; or an eighth, a quarter, a half, or an ounce. Purchasing marijuana by the pound, or a half or quarter pound, enables a network distributor to provide to his or her network quality marijuana for price that is not exorbitant, is conveniently obtained and protects those in the network from purchasing marijuana in dangerous neighborhoods and from strangers with the significant risk of being robbed or "burned" (acquiring a product of inferior quality or that may be counterfeit or dangerously adulterated).

6. *Marijuana's extensive history of medical use.*

Marijuana began to be used in primitive and folk medicine 5000 years ago in China, and later in India. In the mid nineteenth century, Western medicine became aware of the medical value of marijuana. Major pharmaceutical firms distributed medical preparations of Cannabis, and it was a compound prescribed by doctors until it was outlawed by Congress in 1937. The mid-Century demise of medical marijuana use reflected several factors: changing cultural attitudes in science and medicine favoring medicines of a chemical nature vis a vis plant medicines, its stigma as a socially used "drug of abuse," and its restrictions as an illegal drug.

7. *Medical use rediscovered.*

In the late twentieth century, scientific research into drug abuse and neurochemistry, led to the rediscovery of the medical value of marijuana. Scientists discovered biochemical systems in the human body that are triggered or moderated by cannabinoid compounds. Research revealed that cannabinoid compounds play major roles in regulating the body's systems of appetite, muscle control, memory, immune response and pain.

There is not only a public consensus, but a scientific consensus, that marijuana and its constituent compounds have important medical properties. It is also fair to say that the complete nature of these properties remains unknown. Research has been hobbled by the cultural and legal status of marijuana, and by the economics of the pharmaceutical industry that do not favor the expensive development of potential medications that lack patent protection.

8. *Marijuana is a symbolic weapon in our cultural battles.*

For more than 40 years, marijuana has been a powerful symbol in the nation's social and political struggles. In September 1969, a month after Woodstock, one of the greatest country singers, Merle Haggard, released *Okie from Muskogee*, which begins, "We don't smoke marijuana in Muskogee." Although issued as a light-hearted spoof, the song was embraced by social conservatives outraged at war protest and social unrest. Woodstock, a music festival, and *Okie from Muskogee* highlight the cultural poles regarding marijuana use. Ironically, if the stereotypical association is marijuana and liberal, in the conflict between liberals and conservatives about federal power *vis a vis* state power, the leading conservative justices in the U.S. Supreme Court supported state power to regulate medical marijuana (i.e., Chief Justice Rehnquist, Associate Justices Thomas and O'Connor, in dissents in *Gonzales v. Raich,* 545 U.S. 1, 2005).

9. *Law enforcement sees the drugs and crime connection daily, and the evil of drug abuse.*

Every day police and prosecutors see thieves, prostitutes, drug addicts, illegal drug dealers – and among them all, marijuana users. Every day they confront the most anti-social members of our society, and illegal drug use is one of the features of the outlaw life-style. Correctly, they see addiction as one of the major drivers of the degradation and dishonesty that plague out society.

The U.S. Drug Enforcement Administration was founded in 1973 with the mission to zealously combat drug abuse by focusing on the supply. Since its founding, DEA Special Agents have fought around the world against producers, distributors, and illegal users of drugs. In their eyes, drugs are evils that must be suppressed and the survival of society depends upon them to protect youth from using drugs. Fighting marijuana has been a central part of DEA's mission since its founding.

10. *Agency resistance to the medical use of marijuana.*

DEA views with contempt those who think marijuana may have medical value. A petition to modify marijuana's status under the Controlled Substances Act to permit its

medical use was filed in 1972 before the creation of DEA. A review of DEA's administrative consideration of "medical marijuana" since then reveals an unbroken pattern of obstruction, delay and rejection.

Due both to DEA's rooted objections, its restrictions on research into marijuana's medical use, and the economics of drug development, marijuana has not been approved as a safe and effective medication for any purpose by the Food and Drug Administration.

11. *Widespread medical use of marijuana.*

About 18 million American adults have been diagnosed with cancer. The CDC estimates that over 1 million Americans have been diagnosed with AIDS, about a half million are living with HIV/AIDS. The medications used to fight cancer and HIV/AIDS are famous for the nausea they cause. Marijuana is perhaps best known medically for fighting nausea and stimulating appetite.

Thus millions of patients (and their loved ones) have confronted the horrid side effects of the cancer and HIV/AIDS medications with medical marijuana and the medical value of marijuana is confirmed in the general public. The effectiveness of marijuana in treating a variety of conditions, its low toxicity, its quite tolerable side effects, and its widespread availability and use illegally has exposed tens of millions of Americans to its medical potential.

Fourteen states have legalized the medical use of marijuana under state law, but these laws are clumsily constructed to work around the hostility of the federal agencies to the use of marijuana for medical purposes, and the popular, legal and political need to minimize the criminal traffic in marijuana for social purposes.

Thus the challenge of finishing a bill such as H.B. 712/S.B. 627 is to construct a system for producing and distributing marijuana for medical patients that meets the needs of the patients, that does not do violence to the regulation of the practice of medicine and pharmacy, that minimizes the risk of diversion of such marijuana to the general public for social use, and which does not directly conflict with the federal Controlled Substances Act that regulates the production and distribution of controlled substances generally.

III. Drafting problems with H.B. 712/S.B. 627, as introduced

The text of H.B. 712/S.B. 627, as introduced, raises a number of problems which I discuss below in chronological order by section. My qualifications to comment on these matters, as former Counsel to the U.S. House of Representatives Committee on the Judiciary (1979-1989) responsible for drug laws, including the medical use of marijuana, and otherwise, are detailed at the end.

1. Section 13-3001. Definitions.

A. The definition of **"authorized grower"** refers in paragraph (2) to a "registration permit." To avoid confusion with registrations issued under the federal Controlled Substances Act (21 U.S.C. 801 et seq.), specifically sections 21 U.S.C. 822, 823 and 824, I suggest referring to registration permit **under this subtitle**, as the bill does in referring to "dispensing centers" in subsection (E).

B. Paragraph (6) of the definition of **"debilitating medical condition,"** refers to "any other condition that is severe and resistant to conventional medicine." Does "resistant" include intolerable side effects? **Perhaps the problem of unacceptable side effects of a conventional medicine should be explicitly included**.

C. The definition of "qualifying patient" limits patients to residents of Maryland. While this restriction might have made sense when there were only a few states with medical marijuana laws, it no longer does. Johns Hopkins University Medical Center is only one of numerous Maryland medical facilities that attract patients from around the nation. Many of those patients will come from states which also permit the medical use of marijuana. **Restricting the class of qualifying patients only to Maryland residents no longer makes sense.**

2. Section 13-3002. Authorized Growers.

A. Subsection (B) which requires that minimum proposals be for $100,000 is unclear. Does this mean that the grower has to offer to cultivate a minimum of $100,000 worth of marijuana? If so, priced in what manner?

B. Paragraph (C)(3) should be rewritten to read, "Submit the marijuana to pharmacological testing to ensure:"

C. **Criminal history check requirement.** The requirement that employees names be submitted for a criminal history check in sections 13-3002(D) (and 13-3003(C)(5)) is awkwardly structured and does not create a duty upon the permitted grower or dispenser to not employ a person with a disqualifying conviction.

To be clear, the language should explicitly state, **"No authorized grower, dispensing center, or pharmacy may employ, or use the services of a volunteer, any person who has not been determined by a criminal history check to have not been convicted of the disqualifying offenses. Before any person may be hired, the authorized grower, dispensing center, or pharmacy shall submit the name of any prospective employees and volunteers to a criminal history check."**

Framing the obligation this way in sections 13-3002 and 13-3003 would make explicit the continuing obligation of the authorized grower, dispensing center, or pharmacy to submit all employees and volunteers to criminal history checks.

D. **Disqualifications due to criminal conviction.**

In general, this disqualification is now contrary to the policy of the state. On May 19, 2009, Governor O'Malley signed H.B. 635, now Chapter 686, which provides,

> *It is the policy of the State to encourage the employment of nonviolent ex-offenders and remove barriers to their ability to demonstrate fitness for occupational licenses or certifications required by the State.* (Criminal Procedure 1-209 (C)).

Six state departments, including the Department of Health and Mental Hygiene, the Department of Public Safety and Correctional Services, and the Department of Agriculture are given direction to determine

. . ."**(3) whether the applicant's previous conviction has any impact on the applicant's fitness or ability to perform the duties and responsibilities authorized by the license or certificate;**

(4) the age of the applicant at the time of the conviction and the amount of time that has elapsed since the conviction; . . .

(6) other information provided by the applicant or on the applicant's behalf with regard to the applicant's rehabilitation and good conduct; and

(7) the legitimate interest of the department in protecting property and the safety and welfare of specific individuals or the general public."
(Criminal Procedure section 1-209(E)).

What convictions are evidence that a person is unfit for employment in a marijuana growing establishment? Why would a conviction for having grown marijuana outside the law be a disqualification from growing marijuana under law? Those who break the law by growing marijuana do not do so because it is the easiest crime they can engage in for remuneration! This is an offense that typically reflects a zeal to grow marijuana.

An inference that such persons are likely to be zealous in meeting the legal requirements to avoid adulteration and contamination and assuring safety and distribution to the proper individuals *is as reasonable* as an inference that such persons are likely to be dishonest, careless or lawless in the cultivation of marijuana for medical purposes.

A conviction that might be reasonable to presume a disqualification from employment handling a valuable crop would be a somewhat recent conviction demonstrating fraud or embezzlement, i.e. crimes that involve dishonesty or breach of trust.

A drug conviction as a bar to employment as a grower is only justified on the same basis as a drug conviction bars working with controlled substances as a pharmacist, nurse or physician (i.e. working with unsupervised access to an addictive

drug) if addiction were a factor in the crime. In fact, drug convictions are extremely plentiful, and they are not evidence of addiction. On the other hand, an addicted person who has a conviction quite possibly has been to treatment and is in recovery. A blanket prohibition is contrary to the policy the state adopted last year, and unwarrantedly maintains the stigma of addiction, for what may be a long-ago surmounted problem.

The General Assembly, if it is to follow the policy it enacted last year, should not make this bar to employment a lifetime ban.

These points are relevant as well to Section 13-3004(E)(6) regarding the disqualification of a person from being a primary caregiver. The lifetime nature of this ban fails to recognize the extent of recovery from substance abuse, and is continuation of an unwarranted stigma upon such persons.

E. **Exception for "conduct that is legal under this subsection** In Section 13-3002 (D) and Section 13-3003(C)(5), (and Section 13-3004(E)(6) with different language), the exception to the exclusion from employment by authorized growers of persons with certain criminal convictions is laudable, and consistent with state policy.

As drafted it is unclear and the manner for determining that a federal conviction was "for conduct that is legal under this subtitle" is problematic. Considering that the federal courts in prosecutions for marijuana cultivation or distribution have refused to admit evidence of state law or medical use, how would probative evidence of lawfulness under this subtitle be obtained? What would be the burden of proof, and upon what party would the burden of going forward lie?

I suggest the following language as a way to identify a process which would resolve these questions definitively on a case by case basis:

"Any prospective employee, volunteer or care giver who has a drug conviction who submits sufficient evidence that demonstrates to the Department's satisfaction that the conduct constituting the conviction would have been legal under this subtitle shall, upon the payment of a fee of [$100.00], be eligible to receive, and the Department shall issue, a certificate of employability under this subtitle."

3. Section 13-3003. Pharmacies and Dispensing Centers

A. **Profit-making corporations?** Subsection 13-3003(G) provides that patients may **reimburse** pharmacies or dispensing centers *"for reasonable costs associated with the production of marijuana for the cardholder."* The implications of this language are highly problematic.

Subsection 13-3003(A)(1)(I) establishes "a registration program to authorize ***entities*** to distribute marijuana for medical purposes." Subsection 13-3003(A)(2)(I) says

that a pharmacy may register to distribute medical marijuana. Most pharmacies are owned and operated by corporations. These clauses seem to contemplate authorizing corporations. Does language regarding reimbursement for reasonable costs in subsection (G) contemplate that these corporations may only be non-profit corporations? Does that make sense?

Does the General Assembly contemplate that incorporated pharmacies, organized to make a profit, would be *entities* that would seek authorization to distribute medical marijuana, but **not in order to make a profit in that part of their enterprise**? How does the General Assembly contemplate allocating rent, salaries, and other overhead between the for-profit enterprise of selling opiates, tranquilizers, and other medications, and the not-for-profit enterprise of "distribution" medical marijuana for "reimbursement"?

What authority does Subsection 13-3003(G) give to the Department to police "reimbursements"? What penalties does an authorized medical marijuana distributor face if the "reimbursement" it charges (or requests) exceeds reasonable costs? Is the payment of dividends to the corporate owners/investors a reasonable cost? Is there any class of business now operating in Maryland that is required to use this revenue model of "reimbursement" for reasonable costs?

This almost unique restriction on profit-making is fraught with potential conflict and invites enormously expensive litigation for the state and obstruction of the program.

4. Section 13-3004. Identification cards and written certifications.

A. **Content of physician assessment.**

Clause 13-3004(A)(2)(II) specifies the medical conclusions a physician must make preliminary to issuing a written certification. Significantly, not only must the physician find a "debilitating medical condition" defined in subsection 13-3001(D), but the physician must determine that "***recognized*** drugs or treatments would not be ***effective***" for the condition. This language does not require that the physician conduct a series of clinical experiments upon the patient to determine that a universe of "recognized drugs" were not effective, fortunately. However, the term "recognized drugs" is novel and fails to provide adequate guidance to a physician about what drugs included. "Recognized drugs" is not a term recognized by the Merriam-Webster dictionary or medical dictionary search engines. http://www.merriam-webster.com/medical/recognized%20drugs An obvious, unanswered question is, "recognized by whom?" Elsewhere in the bill, the term "conventional medicine" is used (Section 13-3001(D)(6)). Are these concepts different, or the same?

Second, this language does not explicitly acknowledge that the side-effects that may accompany "effective" medications may be so intensely unpleasant that the patient will not comply with the medication regime.

Third, the language disregards the potential **extremely high expense** that results from the use of some so-called “recognized” drugs. **Implicit in this language is a presumption that the patient can afford to pay for any so-called “recognized effective drug,” or that the patient’s insurance carrier will reimburse the patient adequately for such medication. This is a wholly unwarranted presumption.** Medical marijuana may be a much less expensive alternative medication, but this language does not permit a physician to consider the relative costs of treatment to be a factor in assessing a patient’s medical condition.

Undeniably, there are risks and benefits from the use of “recognized” drugs. For a physician to fail to present those risks and benefits to the patient in order to draw effective comparisons with the risks and benefits of marijuana use fails to provide proper advice to patients. To fail to require physicians to present the risk-benefit profiles of “recognized” drugs fails to protect patients.

If the General Assembly wishes to address these concerns in the context of the physician’s statement that “the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient,” that intent needs to be clearer. The latter language implies only the health risks from using marijuana, and not the risks (and benefits, or limits thereof) in the use of the “recognized” drugs.

B. **Exclusion of primary caregivers with drug or felony convictions.**
The concern to minimize the risk that marijuana will be diverted from proper medical channels to social use is reasonable. Is the exclusion from serving as a primary caregiver due to a drug or felony conviction too broadly drafted? See the discussion on this issue above.

5. Section 13-3005. Protection from penalties

This bill does not amend, nor does this section exclude from, Title 5 of the Criminal Law – Controlled Dangerous Substances, that prohibits the possession of marijuana. How do the protections of this bill apply to the Controlled Dangerous Substances law?

6. Section 13-3006 Dispensing Requirements

A. **Arbitrary and unreasonable two-ounce limit on marijuana.**

This section limits the quantity of marijuana that a patient may be authorized by his or her physician to no more than two-ounces per 30-day period because it provides that a patient may only register at a single dispensing center or pharmacy, and the physician may not authorize the dispensing of more than two-ounces in a 30-day period.

This quantity is designed to minimize the risk of diversion and perhaps the risk of overdose or misuse of marijuana by patients. **Unfortunately, this quantity is utterly**

arbitrary and unreasonable.

The federal government provides more than 7 ounces of usable marijuana every month to the medical marijuana patients in the federal Compassionate Investigational New Drug program in the form of 300 pre-rolled marijuana cigarettes.

Before an all-patient limitation on quantity can be reasonably set, at least two facts must be known. First, what is the reasonable maximum dosage, by weight, of THC (or other cannabinoids) that is required to treat the medical condition that demands the highest dosage of THC? Second, what is the potency of the marijuana (percentage of the marijuana that is recoverable THC and other cannabinoids) that will be available at the dispensing center? A computation then yields the maximum amount of marijuana necessary to provide the proper dosage for the most severe case. But neither of these fundamental, preliminary facts is known.

As Donald Abrams, M.D., points out at the website, www.medicalmarijuana.procon.org, the potency varies, and therefore the quantity of marijuana to provide a dose varies. http://medicalmarijuana.procon.org/viewanswers.asp?questionID=000334 (Dr. Abrams is chief of the hematology-oncology division at San Francisco General Hospital and Professor of Clinical Medicine at the University of California, San Francisco.)

One cannot reasonably compute the weight of marijuana that a patient will need without knowing the dosage in mg of THC the patient will need, and the potency of the marijuana. Section 13-3002, in referring to proposals and cultivation of medical marijuana, **says nothing about the range of potency of the medical marijuana that is to be grown.**

The arbitrary nature of this quantity limit is unwittingly revealed by section 13-3010(C)(2) which asks the Secretary to report in October 2012 “whether the maximum amount of medical marijuana [two-ounces per 30-days] allowed under this subtitle is sufficient to meet the needs of qualifying patients.”

It is the case that a number of other states have selected two ounce per month limits. But those limits are arbitrary and unreasonable, too. To go along with an unreasonable, unjustifiable, unscientific quantity limit because some political compromise in some state legislature resulted in such an arbitrary limit is the worst kind of me-too policymaking!

With no scientific basis for setting a two-ounce per month limit, the General Assembly is creating a system that has a high probability of generating non-compliance!

B. **Lack of requirement that physicians be trained**.

Several provisions of H.B. 712/S.B. 627 require that physicians make determinations based upon knowledge that is highly specialized and not part of the curriculum of most medical education programs.

Section 13-3006(B)(3), for example, requires physicians to make determinations regarding "undue risk of diversion." This is not a medical question. There is nothing in the regular course of medical education that qualifies a physician to make such a determination. Either this requirement should be omitted, or provision should be made to provide such training.

7. Section 13-3007 Secretary to monitor dispensation of marijuana.

This section provides little guidance to the Secretary on the nature of the monitoring that the General Assembly desires. Is the monitoring simply what is required to obtain the data for the reporting to the General Assembly set forth in section 13-3010(A)?

It is important for the General Assembly to understand the actual operation of the medical marijuana program. But the purpose of the statistical report required by section 13-3010(A) is unclear.

How will any of that data actually help the General Assembly determine if the program is meeting the needs of the patients, if it is not too burdensome to physicians, that it is not resulting in diversion, or if it is not too expensive to the patients or to the taxpayers? None of the data sought by the section enable either the Secretary or the General Assembly to answer those important questions.

8. Missing elements:

A. **Patient - Physician Advisory Panel**

At a minimum, the bill should provide for the creation of a patients and physicians advisory panel to assist the Secretary and the General Assembly in understanding and monitoring the program on a real-time basis. Such a panel would be able to provide on a formal basis an avenue for the Secretary to address the biennial reporting requirements of section 13-3010 (C).

B. **Patient Cultivation**

During the transition from enactment until the dispensing centers are operating in all parts of the state, patients should be permitted to cultivate marijuana in their own homes. One of the most significant challenges that exists in this area is determining proper dosage. Currently the marijuana that patients are purchasing from illegal sources

is not tested for potency. This makes it impossible for patients to determine the proper dosing except by trial and error. For patients who are able to cultivate their own plants, they can standardize their dosing to a known supply. Standardized, knowledgeable dosing is important for the effective medical management of disease and conditions.

To not permit patient cultivation provides no protection for patients who are now using medical marijuana, nor protection until the regime contemplated by H.B. 712/S.B. 627 can be implemented.

IV. MY QUALIFICATIONS REGARDING MEDICAL USE OF MARIJUANA

NATIONAL:

Most recently, in December 2009, the National Association of Boards of Pharmacy recognized my expertise in this field by asking me to be the concluding speaker at its day-long symposium in Tucson, AZ about the legal use of medical marijuana.

In 2007, I moderated a forum on medical marijuana for the New York City Bar Association featuring Assemblyman Richard N. Gottfried, Chair of the New York State Assembly Health Committee, Edward H. Jurith, General Counsel, Office of National Drug Control Policy, The White House, and Professor Susan Herman, Brooklyn Law School.

I have organized two programs regarding the medical use of marijuana for American Bar Association Annual Meetings.

In 1997, I analyzed the history of federal policy regarding the medical use of marijuana and the Clinton Administration response to the California medical marijuana law in a law review article, "Drug Policy: A Smorgasbord of Conundrums Spiced by Emotions Around Children and Violence" in 31 VALPARAISO UNIVERSITY LAW REVIEW 597, 622-645 (Spring 1997).

MARYLAND:

I participated in the multi-year deliberations in Maryland that resulted in the 2003 medical marijuana law. The General Assembly recognized the value of medical marijuana but was concerned about the risk of conflict with federal law. The approach it took was to provide that possession of marijuana for medical purposes had a nominal $100 fine, and provided that courts shall provide defendants the opportunity to argue that their possession of marijuana was for a medical necessity.

After the enactment of the Maryland medical marijuana law in 2003, I was the featured lecturer at four continuing legal education seminars for Maryland criminal defense lawyers about medical marijuana. I am the author of the *Maryland Medical Marijuana Criminal Defense Manual* (October 15, 2004, 30 pp.)

FEDERAL:

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. In 1981, my boss, Rep. William J. Hughes (D-NJ), the chairman of the House Subcommittee on Crime, co-sponsored H.R. 4498 (97th Cong. 1st sess.), legislation to create a Federal medical marijuana exemption, which he cosponsored in two subsequent Congresses. I staffed him on this issue, monitoring closely the litigation before the DEA Administrative Law Judge that culminated in the Sep. 5, 1988 ruling that marijuana was safe and had medical value.

OTHER DRUG AND CRIMINAL JUSTICE ISSUES:

As counsel to the House Subcommittee on Crime, I reviewed almost all of the bills introduced in the U.S. 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, which is based in Silver Spring, MD. In addition I am an adjunct professor of sociology at George Washington University, and have taught at American University, as well as lecturing at law schools and universities around the nation.

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. I am a long-time participant on the Standing Committee on Substance Abuse of the American Bar Association. My analyses have been published in law reviews at the law schools of University of Maryland, Villanova University, Temple University as well as other law schools and in academic journals and numerous newspapers and magazines around the nation.

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March 9, 2010