



# LAW ENFORCEMENT AGAINST PROHIBITION

121 Mystic Avenue, Medford, Massachusetts 02155 - Tele: 781.393.6985 Fax: 781.393.2964 info@leap.cc www.leap.cc

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Hearing of the Criminal Law Subcommittee of the  
Committee for Courts of Justice of the  
Virginia House of Delegates  
Richmond, Virginia  
H. Morgan Griffith, Chairman  
January 27, 2010

Statement of  
**Eric E. Sterling, J.D.**  
on behalf of

**LAW ENFORCEMENT AGAINST PROHIBITION (LEAP)**  
in support of  
**House Bill No. 1136**  
**Medical Use of Marijuana**

Mr. Chairman and distinguished Members of the Subcommittee, thank you very much for the opportunity to present the views of Law Enforcement Against Prohibition (LEAP) in support of H.B. 1136, introduced by the highly distinguished, Delegate Harvey B. Morgan.

LEAP is an association of current and former law enforcement officers, prosecutors, judges and criminal justice professionals at every level of government who are speaking out about the failure of our drug policy, and I serve on the Advisory Board. LEAP has 544 members in Virginia.

For nine years during the Reagan Administration, I was counsel to the Subcommittee on Crime of the U.S. House Judiciary Committee. I oversaw federal law enforcement and helped develop legislation regarding drugs, pornography, organized crime, money laundering, and other issues. More recently, I am a part-time professor teaching Criminal Justice and Sociology at George Washington University in Washington, DC. I am the President of the Criminal Justice Policy Foundation in Silver Spring, MD.

In 1981, my boss, the Chairman of the House Crime Subcommittee, Rep. William J. Hughes (NJ), cosponsored the medical marijuana bill (H.R. 4498, 97<sup>th</sup> Cong.) introduced by four senior Republican Representatives: Hamilton Fish (NY), Millicent Fenwick (NJ), Stewart McKinney (CT), and Newt Gingrich (GA), and I was assigned to study the issue for him. I have followed this issue ever since. I've written about the legal and political issues involved in the medical use of marijuana in my 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). I have testified before the Maryland General Assembly numerous times on this issue. Most recently, in December 2009 I was invited by the National Association of Boards of Pharmacy to speak to their annual day-long symposium regarding the medical use of marijuana.

There is a growing consensus among scientists that marijuana has medical value. There are hundreds of laboratory studies involving cells and laboratory animals demonstrating a variety of potential useful medical activity from Cannabis and its constituent compounds. This was affirmed by the prestigious Institute of Medicine in its 1999 report, *Marijuana and Medicine: Assessing the Science Base*. Since then, there has been a great deal of additional research.

There are two pharmaceutical problems: First, marijuana is not yet standardized so that dosing remains hit or miss. Second, marijuana is not yet being manufactured in the U.S. to pharmaceutical standards of purity, although it has been produced as a pure, standardized medication in The Netherlands since 2003 by the Bedrocan BV under a license from the Ministry of Health, Welfare and Sport.

The primary legal obstacle is that the federal regulatory agencies oppose the changes primarily for political reasons and even block additional research. In 1988, the DEA's Administrative Law Judge, Francis Young -- after extensive hearings held around the country, at which doctors and patients on one side, and DEA's lawyers and expert witnesses on the other, presented their evidence -- concluded that marijuana had medical value. But the presidentially-appointed, Senate-confirmed Administrator disregarded his proposed findings of fact, and substituted an opinion that conformed to the White House political line asserting that marijuana had no medical value and could not be used safely under medical supervision.

More recently, the June 2001 application to DEA of plant scientist, Dr. Lyle Craker of the University of Massachusetts at Amherst, for a registration to cultivate scientifically useful strains of Cannabis to support privately funded research that meets the standards of the FDA and other appropriate agencies, since it was first filed, has been ignored, "lost," delayed, and, most recently, eight days before the G.W. Bush administration left office, rejected by DEA -- 23 months after the Administrative Law Judge ruled in his favor. This pattern is typical of law enforcement resistance to scientific research or legal acceptance of the medical use of marijuana.

In general, the political opposition to the medical use of marijuana relies upon three arguments:

*It will lead to more teenage marijuana use, it is a step on a slippery slope that will lead to the legalization of drugs, and it will undermine the ability of law enforcement to enforce the drug laws.* Here is my analysis of those three arguments:

#### **OPPOSITION CLAIM NUMBER (1): LEGAL USE OF MARIJUANA FOR MEDICAL PURPOSES WILL LEAD TO MORE TEENAGE MARIJUANA USE.**

We all want to know whether H.B. 1136, or an even more comprehensive law, might lead to increased marijuana use by young people. 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 in research and treatment, and teenage marijuana use continued downward. From 1981 through 1987, federal 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 first Bush Administration decided to close the small, then-14-year-old “compassionate use” federal program that provides marijuana, grown under federal contract, for medical use to select patients, 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 about the rise, there were four major 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, or that the surviving patients under the “compassionate use” program were using marijuana for medical purposes.

It is noteworthy that teenage marijuana use resumed its decline after passage of the medical marijuana initiative in California in November 1996 (where the initiative received 1 million more votes than successful candidate Bill Clinton). The White House ONDCP Director, Gen. Barry McCaffrey, sought special data in the annual National Household Survey on Drug Abuse on teenage marijuana use in California. 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 in recent years, the Bush Administration proudly and repeatedly noted that, even though state after state enacted comprehensive medical marijuana laws, teenage marijuana use has gone down.

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

Today, marijuana is perceived by youth primarily as a “party” drug. But with a changed law and proper social marketing, that image could change. Medical marijuana could be a major driver to discourage social use of marijuana by teenagers, if we let it. 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 infirm and elderly people and people vomiting from cancer chemotherapy, with persons who are crippled by multiple sclerosis, and with people who are dying from AIDS and cancer. Imagine the effects on the popularity of marijuana smoking among adolescents after several years of such advertising.

Thinking of adolescents, why do the opponents of medical marijuana violate the rules of decorum in the House of Delegates to mock and insult those who offer such bills? Why do they make sneering, adolescent jokes about the mental state of those who support bills such as H.B.

1136? They make these juvenile attacks because they do not have confidence in their arguments, and they lack the facts to justify their objections. Sadly, they attract the attention of adolescents by engaging in such behavior.

**OPPOSITION CLAIM NUMBER (2): PASSAGE OF A MEDICAL MARIJUANA BILL IS A STEP ON A SLIPPERY SLOPE THAT WILL LEAD TO THE LEGALIZATION OF MARIJUANA AND OTHER DRUGS.**

There are significant fiscal, public safety, and public health reasons for legislatures to study the taxing and genuine regulation of marijuana for adults to use socially. Those reasons are similar to those for increasing the taxes on alcohol and tobacco. Those reasons have nothing to do with the medical use under the direction of a physician. And, there are significant public safety and public health arguments in favor of establishing legal and pharmaceutical controls for the non-medical use of heroin or cocaine, but they are irrelevant to the argument whether marijuana may be used by medical patients pursuant to their physician's prescription or recommendation.

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?

It is unlikely. 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 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 has never been an argument for legalizing cocaine for social purposes. Such an argument would be ludicrous.

How would this step to "legalization" actually happen? If the House of Delegates were to vote to permit the medical use of marijuana under a physician's direction or prescription, would this be your "gateway" or "stepping stone" to voting to legalize all marijuana use, or the recreational use of heroin and cocaine? Of course not. The proposition is laughable. You, of all people, know very well that legislators don't become "addicted" to some kind of voting pattern by casting a vote. The fear that a vote for a medical marijuana bill *will then lead a legislature* to legalize drugs for social or recreational purposes is delusional.

For another thing, the slippery slope argument is not a disagreement with the merits of whether cannabis can be useful for some patients for the relief of their conditions. If one has sound scientific arguments that marijuana has no medical value, one need not retreat to this argument. The slippery slope argument is, in a sense, a concession that the argument for the medical use of marijuana on scientific grounds is persuasive. Why raise a tangential argument if the central argument is available? In logic, the slippery slope argument is a classic fallacy, and identified as such in texts on logic and rhetoric. To oppose a proposition on the ground that its adoption will lead to another proposition – and always the other is presumed to be worse – requires that the first proposition have some inherent power to affect the second.

Where do we hear this argument now? How often was it said last fall that if Congress were to enact public option health insurance it is the step onto the slippery slope to socialism. It is asserted that, notwithstanding the disastrous consequences of the public option, the public would want still more of it. That is a good example of the slippery slope objection, and how illogical it is.

But let's assume that the opponents of social use of marijuana really believe that legalized medical marijuana will lead to legalizing social use of marijuana. What might this really mean? Perhaps it means that if the public becomes aware that persons using marijuana for medical purposes are *without terrible, harmful side effects*, the public will conclude that marijuana is just not the dangerous drug many law enforcement opponents have been saying it is. When Americans become aware of various neighbors and colleagues who are using marijuana medically, and who are not being hurt by that use, a majority of Americans might conclude that marijuana is not more dangerous than alcohol or tobacco. And many Americans might then conclude that society is not likely to be seriously harmed if marijuana were legal for social purposes.

However, if marijuana is actually as dangerous and likely to be misused as other law enforcement witnesses typically insist, then the case against legalization of marijuana for social purposes will actually be strengthened as the tragedies of patients harmed by medical marijuana become apparent to us. If that were to happen, there will not be a slippery slope at all.

This is a bipartisan issue. As Montana was re-electing George W. Bush in 2004, it was adopting a medical marijuana law. And in November 2008, as Barack Obama carried Michigan with 57 percent, medical marijuana received 63 percent of the vote.

### **OPPOSITION CLAIM NUMBER (3): A MEDICAL MARIJUANA LAW WILL UNDERMINE EFFECTIVE LAW ENFORCEMENT**

Perhaps most importantly for all of us, creating a legal scheme for the use of marijuana in medicine poses no threat to the effective enforcement of the drug laws.

Virginia 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 Virginia State Police and the DEA are fully able to investigate and prosecute the illegal trafficking, misprescribing, and misuse of those drugs – to the extent that they are not now distracted by initiating much easier to make marijuana cases

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.

Investigations of criminals who in engage in large-scale trafficking in illegal drugs who engage in the extensive violence, bribery and corruption, and tax evasion that are inextricably associated with prohibition and “black markets” – investigations which are an important priority of well-managed police departments -- will in no way be interfered with by the small-scale

medical distribution of marijuana to ill persons who have a bona fide physician-patient relationship and written documentation.

## **CONCLUSION**

Because of marijuana's status under federal law, it cannot be prescribed by physicians at this time, and enactment of this bill is not going to result in marijuana being shipped to Virginia pharmacies to fill any prescriptions that Virginia physicians may write. This bill is a very elegant bill in that it makes Virginia ready to meet the medical needs of its citizens *when* the federal law regarding medical marijuana changes. This bill does not create any conflict with federal law or challenge the Supremacy clause in Article VI of the U.S. Constitution.

Passage of this bill would encourage the Virginia delegation in the U.S. Congress to push to change federal law so that Virginians may have the benefit of medications that their physicians have concluded would relieve painful or disabling symptoms and increase their well-being.

LEAP commends Delegate Morgan and the other patrons of the legislation, and urges the Subcommittee and Committee to favorably report H.B. 1136

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Eric E. Sterling, J.D., The Criminal Justice Policy Foundation,  
8730 Georgia Ave., Suite 400, Silver Spring, MD 20910 301-589-6020  
[www.cjpf.org](http://www.cjpf.org)