AMERICANS FOR SAFE ACCESS

PUBLIC COMMENT ~ WASHINGTON, DC'S EMERGENCY AND THIRD PROPOSED RULEMAKING TO IMPLEMENT THE LEGALIZATION OF MARIJUANA FOR MEDICAL TREATMENT INITIATIVE OF 1999

Americans for Safe Access ("ASA") appreciates the opportunity to submit these comments regarding the above-referenced notice of proposed rulemaking. ASA would like to commend the Office of the Mayor and the Department of Health for moving forward on the implementation of DC's law to authorize the use of cannabis for medical purposes. Also, we would like to offer our sincere appreciation to Councilman Catania and the entire DC Council for their important contributions to this process.

While ASA takes issue with several provisions included in the law and these proposed rules, we promise to continue our attempts to engage in a constructive dialogue with the Office of the Mayor and the Department of Health to ensure that this program both serves the interests and meets the legitimate therapeutic needs of individuals who might benefit from the use of cannabis.

ASA respectfully submits regarding the proposed rule that:

1. Forcing medical cannabis patients to designate only one dispensary from which they may get their medicine is inappropriate and unwarranted [Chapter 2, §200.4].

ASA is in the unique position to speak to the types of issues that arise from this type of limitation. We have seen many problems come from limiting patients to only one designated dispensary, including the inability of patients to determine which dispensary carries the strains of medicine they need, issues of consistency and availability are also of concern.

Not all dispensaries will carry the correct medicine for each patient. A patient must be free to acquire the strain and form of medical cannabis that works best for his or her particular debilitating condition.

Patients are also required to choose one dispensary to serve their medical needs

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when they first register as a patient without knowing anything about the reliability of the dispensary or its ability to consistently provide adequate medicine, including the particular strains a patient might be seeking.

If a patient needs to switch dispensaries in order to get the best medicine available to treat his or her condition, it will cost both the patient and the caregiver $90.00 to get new identification cards noting the change in dispensaries. Forcing patients to pay $90.00 just for the opportunity to seek out the best medicine to treat their condition is an undue burden to place on patients.

In addition to the issues related to reliability, consistency, and integrity of the dispensary, other issues arise when a patient is limited to use only one dispensary. Patients may be subjected to unnecessary stress and inconvenience if their designated dispensary has temporary stocking issues. Medical cannabis exists in a legal grey area, which means that at any given time, the supply of medical cannabis may be shut down to a dispensary, and patients who are legally bound to only one dispensary will find themselves with unforeseen and immediate cessation of supply of medication. With the extreme quantity restrictions in the District of Columbia, there exists no way to plan ahead for the possibility of such an eventuality. If a cultivation site or the dispensary itself is shut down by law enforcement, thousands of patients will be without medication. These patients will have shifted their treatment plans to accommodate the newly-adopted program and will be stuck with inadequate treatment until either stop-gap measures are taken or they are able to re-adjust their treatment plans with their physicians. Until changes to the law occur allowing patients to cultivate their own medication, the limitation to only one dispensary puts them in a vulnerable position.

2. The restrictions on registered caregivers are unnecessary [Chapter 6, §601.1(e)].

ASA is deeply troubled by the restrictions placed on those who seek to be a caregiver for a qualified patient. As stated by the rules, any person who has been convicted of possession or sale of a controlled substance before the effective date of this Act is barred from being a caregiver. This means that anyone who was arrested for and convicted of using medical cannabis before this Act was passed is automatically prevented from assisting other registered patients, including those previously forced to live as a criminal in the District when they were simply trying to find relief from a debilitating condition. The people who may be best-suited to assist patients with the procurement, preparation, and use of their medicine are

those with experience; prior to the passage and implementation of the Act, those with experience were, categorically, criminals. In addition, most localities include these types of restrictions to protect patients from criminals who run large-scale enterprises only to defraud those they are giving care to. In the District of Columbia, each caregiver is only limited to serve one patient, thereby preventing this type of fraud and allowing patients the security of knowing their caregiver. As drafted, this limitation only serves to hinder safe access and does nothing to protect patients or the general public.

3. The amount of cannabis that both patients and cultivation centers are allowed to possess at any one time must be raised in order to best meet the needs of patients [Chapter 3, §300.9 and Chapter 51, §5704].

Two ounces every 30 days for patients is not an adequate supply for many, particularly if the patient chooses to medicate through a method other than smoking the cannabis. A very large number of patients choose to ingest their medicine in alternative routes of administration, many of which require large quantities of medicine in order to achieve the same levels of relief. Even patients who do choose to smoke cannabis have often reported using as much as an ounce a week for moderate illness, therefore severely limiting the relief available under the current draft of rules. Each cultivation center is allowed no more than 95 living plants at any one time. This means that at maximum combined number of plants at District cultivation centers is 950 at any one time. With the number of patients already predicted to register with the District's medical cannabis program, this will simply not be enough to cover the medical needs of all registered patients.

4. Patient representation on the selection panel must be guaranteed [Chapter 54, §5402].

The regulations provide for a committee of five members appointed by the mayor including one representative from each of the following: the Department of

Health, the Metropolitan Police Department, the Office of the Attorney General, the Department of Consumer and Regulatory Affairs (DCRA), and a consumer representative or patient advocate.

This committee is charged with evaluating, rating, and scoring each application for a new cultivation center or dispensary.

ASA believes that those engaged in the program deserve a strong voice on the Committee. We suggest that the Committee require at least two qualified patients.

Except for the few concerns raised herein, we acknowledge the solid effort and we appreciate the time and resources the Office of the Mayor and the Department have dedicated to this important issue. When you (or your designated agents) have any questions or concerns about the comments provided or about any other questions concerning the medical marijuana programs, please contact our Washington, D.C. office directly at 202-857-4272.