

AMERICANS FOR SAFE ACCESS

PUBLIC COMMENT ~ MARYLAND'S PROPOSED MEDICAL MARIJUANA LEGISLATION

PRIMARY CONCERNS AND RECOMMENDATIONS

1. *Restriction on Patients' Personal Cultivation [13-3002]*

Restricting patients to a centralized cultivation system limits personal choice and freedom, jeopardizes access in rural areas, subjects cultivators to lengthy Federal sentencing guidelines, and inflates prices. Of course, not all patients have a green thumb or the time and space to cultivate their own cannabis. To enhance personal choice and freedom to make their own decisions regarding medical treatment, patients need both centralized and localized cultivation.

Cannabis is not a complicated pharmaceutical product; it is a plant that, like a tomato plant, will thrive with appropriate care. While the proper cultivation of cannabis may require some time, resource, and skill, for the most part cannabis is relatively easy to grow. In fact, patients and their caregivers have been cultivating cannabis on their own with relative success for thousands of years.

Personal cultivation allows knowledgeable patients to select cannabis strains that meet their needs and encourages self-sufficiency for long-term, chronic-need patients. Moreover, personal cultivation guarantees reliable, affordable, and consistent access to cannabis for patients in rural communities or locales without a dispensing center nearby.

Few individuals will risk the lengthy sentencing guidelines that may accompany Federal prosecution of individuals connected with larger marijuana cultivation sites. Under Federal statute, a conviction for possession of 250 grams (about 8 ounces) of marijuana or fewer carries with it a sentencing range of 0-6 months. However, a defendant convicted under the same statute for possession of 30,000 kilograms (about 1,000 ounces) or more, has a range of 15-25 years.

Restricting patients to a centralized supply that will be limited to "authorized

growers” who are willing to risk Federal prosecution, can navigate the licensing provisions, and cover the initial costs of production will ultimately burden patients at the point of purchase in the form of higher prices. Personal cultivation ensures prices will be kept low by providing a definitive source of competition to a few centralized suppliers.

In the eight years since ASA began tracking Federal raid activity in states with medical cannabis laws, we have rarely recorded an arrest of a patient or their caregiver where fewer than 100 plants were present. Instead, where the ire of the Federal government has been sparked has been in cases where individuals were cultivating more than 100 plants, in part because of the significant sentencing guideline enhancement. Restricting patients to a centralized cultivation system potentially jeopardizes safe access to cannabis for therapeutic use.

RECOMMENDATION: ASA recommends registered patients and their designated caregiver(s) be granted the option to cultivate a small, personal amount of cannabis individually or in small groups so long as they comport with reasonable standards and restrictions set by the Department of Health and Mental Hygiene and the Department of Agriculture.

2. *Arbitrary 2-ounce per 30-day Possession Limit [13-3006 (A)(1) and (2)]*

Licensed and trained physicians, not elected legislatures, have traditionally been the arbiters that decide how much of a particular medication is right for an individual patient. When in doubt, physicians are instructed to follow a set of established guidelines to determine appropriate patient need. For many patients, 2-ounces (about 57 grams) per 30-days may be more than enough to address their symptoms and provide relief. However, for other patients, 2-ounces every 30-days may not be enough to address their legitimate need, especially if tolerance develops over time.

The administration of medical care is done best when treatment and care is tailored for individual needs, not based on a one-size fits all policy. Legislators should trust and respect the authority of physicians to make appropriate dosage recommendations, or at the very least permit enough leeway for patients who may need more than 2-ounces in a 30-day period.

An individual living with HIV/AIDS who requires approximately five 1-gram cannabis cigarettes a day to stimulate appetite and to control the nausea and vomiting associated with the anti-retroviral therapy requires about 150-grams (or about 5

ounces) in a 30-day period. Under the provisions of this bill, this individual would be at some point relegated to the underground market or forced to go without access to the medicine recommended by his or her physician.

Some patients have adverse reactions to smoking cannabis and prefer to cook with their cannabis. Unfortunately, cooking with cannabis often requires much more than 2-ounces, especially where patients might be cooking batch recipes (like cookies or brownies) or base products (like butter or oil).

Instead of setting an arbitrary limitation for a 30-day period, policymakers might consider the research the United States government has generated during its experience in producing and providing medical marijuana to qualified patients who have been enrolled, over the past 30 years, in clinical trials involving smoked cannabis under the Compassionate Investigational New Drug program (IND). Data from the program has demonstrated that about six pounds of cannabis per year is a safe and effective dosage to alleviate chronic health problems.

Alternatively, perhaps policymakers could look to the cultivation and possession limitations established by other states with active and operational medical cannabis laws. For perspective, this memo is appended with documents that detail the cannabis dosage requirements of the four surviving patients currently enrolled in the Federal government's IND Compassionate Use Program and a complete list of medical cannabis state possession and cultivation limits.

RECOMMENDATION: To fulfill the legitimate needs of patients, ASA recommends that patients be restricted to possession of no more than 8 ounces at any given time. This limitation is comparable to the standard of care established by the Federal government.

3. *Restricting Patients and Caregivers to a Single Dispensing Center [13-3006 (E)]*

The foundation of any competitive and free-market is the ability of individuals to shop around; a healthy and competitive market ensures prices will be kept low

while enhancing the quality of the product and/or delivery of service. Imagine the reduction of service, lack of choice, and price gouging that would ensue if elected legislatures restricted people to a single pharmacy or grocery store in order to access necessary goods and services.

Individual patients and their caregivers need to have the ability to visit multiple dispensing centers in order to find the right mix of service and affordable medicine. Restricting patients to a single dispensary may violate their rights to freely associate. Moreover, supplies of herbal medicine can be unpredictable and highly variable. It is entirely possible that a dispensing center may lack the appropriate medicine or have none at all when a patient is in need.

RECOMMENDATION: To ensure market competition, ASA recommends eliminating this provision altogether.

4. *Restrictions on Felony and Previous Drug Convictions [13-3001 (I)(1)(II); 13-3002 (A)(3)(I-II); 13-3003 (C)(5)(I-II); 13-3004 (D)(6)(I-II)*

For decades, state and Federal drug laws have denied the legitimate use and distribution of cannabis for therapeutic purposes. As such, medical cannabis patients, their care providers and cultivators have been participating in a systematic act of civil disobedience. It should come as no surprise that the individuals with the greatest expertise on the cultivation, use, and distribution of cannabis probably have felony convictions in their criminal backgrounds, particularly previous drug convictions.

Patients should not have to pay the price for the past criminal behavior of a designated primary caregiver, knowledgeable grower, or experienced provider. Likewise, individuals who have completed their court-imposed debts to society should not be subject to employment or licensure discrimination, especially when their criminal behavior does not specifically jeopardize the health or safety of registered patients.

U.S. criminal justice policies have been fueled by historical bias against racial mi-

norities and as a result, racial minorities are disproportionately represented in felony conviction statistics. Discrimination against convicted felons, particularly those with previous drug convictions, will have real economic consequences for minority communities.

RECOMMENDATION: ASA recommends the elimination of all provisions that restrict or prohibit convicted felons from serving as designated caregivers and participating in the cultivation or distribution of cannabis so long as these individuals have completed their court-imposed sentences and are in compliance with all other provisions of the law. This recommendation would make fingerprinting requirements and submissions to the Central Repository for a state and national criminal history check unnecessary.

5. *Enhance Reporting Protections [13-3010 (C)]*

Given the restrictions on access and personal cultivation provided in the legislation, requiring a report every two years to describe whether the needs of the registered patient community are being adequately met might be too long to accurately reflect the needs of patients in the program for short time periods.

RECOMMENDATION: ASA recommends the Department establish a medical cannabis advisory board which is required to convene twice a year and conduct public hearings to evaluate the provisions included in this subsection among other provisions of the law to determine whether the law adequately meets the needs of patients.