AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

LEGISLATIVE MEMORANDUM

TO:

FROM: CAREN WOODSON, AMERICANS FOR SAFE ACCESS
CAREN@SAFEACCESSNOW.ORG – 202.857.4272

SUBJECT: RE: LEGISLATIVE ANALYSIS OF MARYLAND'S PROPOSED MEDICAL MARIJUANA LEGISLATION (PRIMARY SPONSORS: MORHAIM/ANDERSON/GLENN)

DATE: FEBRUARY 1, 2010

The Maryland Chapters of Americans for Safe Access (ASA) welcome the introduction of legislation designed to address the shortcomings of the Darrel Putnam Compassionate Use Act (2003), Maryland's state medical marijuana law. Maryland residents who use cannabis (marijuana) in accordance with a physician's recommendation should no longer be subjected to arrest and prosecution by state authorities or without a safe, secure way to access medical cannabis. We acknowledge and sincerely appreciate the energy Del. Morhaim has invested in drafting his legislation and respect his commitment to champion reform this year. However, we are concerned that the draft bill includes arbitrary and unnecessary restrictions that will fall short of meeting the legitimate needs of patients, and in some cases force patients back to the underground market potentially jeopardizing both health and safety.

To be clear, ASA unequivocally supports changes to state law to establish comprehensive civil and legal protections for individuals who use or provide cannabis for therapeutic use. This memo is intended to detail a few of our most serious concerns and provide recommendations for policymakers to consider as amendments throughout the legislative process. We look forward to working with Delegates Morhaim, Anderson, Glenn and their colleagues in the Maryland state legislature to ensure that any legislation approved by the Maryland State Legislature is patient-focused and will meet the immediate needs of patients across the whole state.

A few things to keep in mind as legislators move forward on this issue. First, ASA strongly cautions against mirroring state laws that are not yet operational. Instead, policymakers should review states with functional laws, like New Mexico or Rhode Island. Second, policymakers need to understand that while states may provide legal protections and establish programs that support safe and legal access to cannabis for therapeutic use by patients or their care-providers, the threat of federal prosecution still looms and there is no "medical marijuana" defense in federal court. Finally, while the Obama Administration has signaled a new direction on medical marijuana, it's important to remember that the Deputy Attorney General's memo was "intended solely as a guide to the exercise of investigative and prosecutorial discretion." As such, policymakers are strongly advised to enact state laws that help to minimize the risk of prosecution and the consequences of federal sentencing guidelines.

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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 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 their own cannabis strain 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 undoubtedly accompany federal prosecutions of individuals connected with larger marijuana cultivation sites. Under federal statute, a conviction of possession of 250 grams (about 8 ounces) of marijuana or less 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 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 is in cases where individuals were cultivating more than 100 plants, in part because of the significant sentencing guideline enhancement. The Obama Administration's policy is not law, and is subject to change without notice. Restricting patients to a centralized cultivation system potentially jeopardizes their safe access to cannabis for their personal medical use.

- ✓ **RECOMMENDATION**: Registered patients and their designated caregiver(s) ought to have the right 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 Hygene and the Department of Agriculture.

Headquarters
1322 Webster St, Suite 402, Oakland, CA 94612
PHONE: 510.251.1856 **FAX:** 510.251.2036

National Office
1730 M Street NW, Washington DC 20036
PHONE: 202.857.4272 **FAX:** 202.857.4273

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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 joints a day to stimulate appetite and to control the nausea and vomiting associated with the anti-retroviral therapy needs 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 per 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 IND program. 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 possession limitation established by other states with active and operational medical cannabis laws. For perspective, the tables included at the end of this memo detail the cannabis dosage requirements of the four surviving patients currently enrolled in the Federal governments IND Compassionate Use Program and a complete list of medical cannabis state possession and cultivation limits.

- ✓ **RECOMMENDATION**: To fulfill the legitimate needs to 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 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 minorities, and as a result racial minorities are disproportionately represented with felony convictions. 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 submission to the Central Repository for a state and national criminal history check unnecessary.

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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.

Headquarters
1322 Webster St, Suite 402, Oakland, CA 94612
PHONE: 510.251.1856 **FAX:** 510.251.2036

National Office
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The Medical Cannabis Patients' Bill of Rights:

The Medical Cannabis Patients' Bill of Rights was designed to outline the basic rights of critically and chronically ill medical cannabis users, and to urge the federal government to protect these individuals from stigma, arrest and prosecution.

- **I am not a criminal; I am a person living with a medical condition and use cannabis to alleviate my suffering; I am capable of making fundamental decisions about my health.**

- **I have the right to live free of unnecessary suffering, social stigma and interference from the state, and should not have to choose between my personal liberty and my health.**

- **I have the right to produce my own medicine if I am willing and able to do so, or to access it from a safe source without fear of arrest and persecution.**

- **It is the federal government's moral, legal and constitutional obligation to defend these basic and inalienable human rights, and to ensure that no organization or individual unduly interferes with them.**

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Medical Marijuana State Cultivation and Personal Possession Limits

STATE	CULTIVATION PLANT LIMIT	PERSONAL POSSESSION
Alaska	6 marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time	1 ounce **at any one time**
California	6 mature or 12 immature marijuana plants per qualified patient	No more than 8 ounces **at any one time**
Colorado	Not more than 6 marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana	No more than 2 ounces bat **any one time**
Hawaii	3 mature plants and 4 immature plants	3 ounces (one ounce of usable marijuana per mature plant) **at any one time**
Maine	A total of 6 plants, of which no more than three may be mature, flowering plants	2.5 ounces **at any one time**
Michigan	12 marijuana plants and any incidental amount of seeds, stalks, and unusable roots	2.5 ounces **at any one time**
Montana	Up to 6 marijuana plants	1 ounce **at any one time**
Nevada	3 mature plants and 4 immature plants	1 ounce **at any one time**
New Jersey	Not applicable.	2 ounces of usable marijuana *per month*
New Mexico	4 mature plants and 12 seedlings	6 ounces of medical cannabis **at any one time** or more than six ounces of useable medical cannabis if a letter of special need from a physician is provided to the Department of Health
Oregon	18 plants under 12 inches in any direction, with no buds or flowers, and 6 plants over 12 inches high, or 12 inches wide, or in bloom	24 ounces **at any one time**
Rhode Island	12 marijuana plants	2.5 ounces **at any one time**
Vermont	2 mature marijuana plants and 7 immature plants	2 ounces **at any one time**
Washington	A qualifying patient may possess no more marijuana than is necessary for the patient's personal medical use for sixty days. However, the law does not provide a definition of what constitutes a sixty-day supply	A qualifying patient may possess no more marijuana than is necessary for the patient's personal medical use for sixty days. However, the law does not provide a definition of what constitutes a sixty-day supply **at any one time**

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Federal IND Program Monthly Dosage Provisions

Name of Patient	Diagnosis	Marijuana Dosage*	Years in Program (through 12/31/06)	Status (as of 3/20/06)
Douglass, Barbara	Multiple sclerosis	Nine cured ounces (of MJ) per month	15	Still Receives Med MJ
McMahon, George	Nail-patella syndrome	Eight cured ounces (of MJ) per month	16	Still Receives Med MJ
Millet, Corrine	Glaucoma	Four cured ounces (of MJ) per month	17	Deceased
Musikka, Elvy	Glaucoma	Eight cured ounces (of MJ) per month	18	Still Receives Med MJ
Rosenfeld, Irvin	Rare bone disorder	Eleven cured ounces (of MJ) every 3 weeks	24	Still Receives Med MJ

* One cured ounce can equate to about 40 joints (marijuana cigarettes).

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