

**SUMMARY**  
STATEMENT OF  
**ERIC E. STERLING, J.D.**  
BEFORE THE  
COUNCIL OF THE DISTRICT OF COLUMBIA  
COMMITTEES ON HEALTH, AND PUBLIC SAFETY AND THE JUDICIARY  
FEBRUARY 23, 2010  
IN SUPPORT OF  
B18-622  
LEGALIZATION OF MARIJUANA FOR MEDICAL TREATMENT  
INITIATIVE AMENDMENT ACT OF 2010

- Washington, D.C. is the Nation's Capital and the center of a multi-jurisdiction metropolitan area. The medical value of marijuana has been recognized by the General Assemblies of the State of Maryland and the Commonwealth of Virginia, and the laws of over 30 other states. Fourteen states now permit doctors to recommend marijuana to their patients to treat a wide variety of medical conditions, and protects those patients from arrest and prosecution. Tens of thousands of residents of other states live and work in the Nation's Capital in government and public service. Tens of thousands of medical patients from around the nation regularly go to D.C. for both routine and highly sophisticated medical care. **D.C. law should permit D.C. physicians to treat their patients from other states without discrimination. D.C. law should permit patients from other states to obtain medical marijuana in D.C. dispensaries with valid recommendations from licensed physicians in any state.**
- Marijuana is not yet a standardized medication enabling standardized dosing. Currently, doctors and patients need to engage in a trial and error process to arrive at the correct dosage levels. **When patients cultivate their own marijuana they can standardize their dosages to that marijuana. This is critical to the proper and effective use of any medication, and patient home cultivation should be allowed under D.C. law.** This cultivation should certainly be permitted immediately and until standardized medical marijuana for the wide variety of conditions for which is it useful is readily available in dispensaries.
- The growing body of scientific evidence demonstrates the wide variety of conditions for which marijuana may have value. **Therefore the definition of patient, and the medical conditions for which marijuana may be recommended, should be broad. To limit the permitted uses of marijuana only to certain "serious" conditions such as HIV/AIDS or cancer improperly discriminates against other medical patients.** The opponents of using marijuana for medical purposes mock patients who use marijuana for having trivial medical conditions. A humane society does not shame patients on the basis of their medicine, nor consign them to pain for political purposes.
- Geographic restrictions on dispensing, cultivating and using marijuana must be reasonable and not arbitrarily overbroad.

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Chairman Catania and Chairman Mendelson, Members of the Committees, thank you very much for permitting me to testify before you today. My name is Eric E. Sterling. I live in Chevy Chase, MD with my wife and daughter. Since 1981, I have worked professionally, on legislation regarding the medical use of marijuana, as counsel to the U.S. House Judiciary Committee and as President of The Criminal Justice Policy Foundation. I am testifying today only on my own behalf.

**I support the bill with amendments to clarify:**

- (1) the authority of D.C. physicians to recommend marijuana, where appropriate, to patients who are residents of other states;**
- (2) that residents of other states who live or work in D.C., or who visit the nation's capital for civic, cultural, medical, educational, athletic, or any other reason may obtain recommendations from D.C. physicians when appropriate, and to obtain marijuana from D.C. dispensaries;**
- (3) that patients may legally cultivate marijuana in their own homes in order to facilitate the standardization of dosage necessary for effective treatment until a sufficiently wide variety of standardized medical marijuana for various conditions is readily available;**
- (4) that any patient who could medically benefit from the use of marijuana in the good faith professional judgement of a licensed physician is able to do so without creating discriminatory classes of patients with arbitrarily or politically favored "serious" diseases;**
- (5) that "proximity" restrictions on cultivating, dispensing or using marijuana for medical purposes not be excessively broad nor more restrictive than such restrictions on businesses that sell alcoholic beverages, firearms, etc.; and**
- (6) that an affirmative defense, such as first recognized in *U.S. v. Randall* (D.C. Super. 1976), be statutorily recognized for patients who are not registered by the Department of Health.**

## **MY QUALIFICATIONS REGARDING CONTROLLED SUBSTANCES LAW AND MEDICAL USE OF MARIJUANA**

Two months ago, I was asked by the National Association of Boards of Pharmacy to be the concluding speaker about the legal use of medical marijuana after a day long symposium in Tucson, AZ. This is only the most recent presentation I have made on the subject. I have also organized programs regarding the medical use of marijuana for the American Bar Association at two Annual Meetings. I analyzed the history of federal policy regarding the medical use of marijuana and the Clinton Administration response to the 1996 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).

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. On the staff of the Subcommittee on Crime, I reviewed almost all of the bills introduced in the House of Representatives to amend the Controlled Substances Act or to govern the operations of the Drug Enforcement Administration. From the 96<sup>th</sup> through the 100<sup>th</sup> 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 was based in Washington until 2002, and is now based in Silver Spring, MD. In the early 1990s, I was a member of the D.C. Mayor's Advisory Committee on Substance Abuse. 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 from around the nation. I am a long-time participant of the Standing Committee on Substance Abuse of the American Bar Association, and past chair of the criminal justice committee of the ABA section of individual rights and responsibilities. My analyses have been published in seven law reviews and academic journals and numerous newspapers and magazines around the nation.

## **MY EXPERIENCE WITH FEDERAL MEDICAL MARIJUANA LEGISLATION**

In 1981, my boss, Rep. William J. Hughes (D-NJ), the chairman of the House Subcommittee on Crime, co-sponsored H.R. 4498 (97<sup>th</sup> Cong. 1<sup>st</sup> sess.), legislation to create a Federal medical marijuana exemption, which he cosponsored in two subsequent Congresses. I staffed him on this issue.

Rep. Hughes had been a District Attorney, a career prosecutor and a tough crime

fighter. He was the author of numerous laws to strengthen the national fight against drug abuse. I staffed him on most of these measures over an eight year period.

Mr. Hughes understood that our national effort to fight drug abuse must not interfere with the ability of doctors to treat their patients. In 1984, our subcommittee developed legislation to give DEA much greater power to investigate the misconduct of doctors and greater powers to revoke their licenses when they engaged in misconduct (P.L. 98-473. sec. 511 & 512). But in doing so, we understood that most physicians can be trusted to use their training and medical licenses appropriately.

### **I AM ALSO FAMILIAR WITH THE MARYLAND MEDICAL MARIJUANA LAW**

I participated in the multi-year debate 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 court's shall provide defendant's 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 conducted four continuing legal education seminars for criminal defense lawyers in Maryland about medical marijuana.

### **ISSUES FOR THE DISTRICT OF COLUMBIA**

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(3) that patients may legally cultivate marijuana in their own homes in order to facilitate the standardization of dosage necessary for effective treatment until a sufficiently wide variety of standardized medical marijuana for various conditions is readily available;

(4) that any patient who could medically benefit from the use of marijuana in the good faith professional judgement of a licensed physician is able to do so without creating discriminatory classes of patients with arbitrarily or politically favored "serious" diseases;

(5) that "proximity" restrictions on cultivating, dispensing or using marijuana for medical purposes not be excessively broad nor more restrictive than such restrictions on businesses that sell alcoholic beverages, firearms, etc.; and

(6) that an affirmative defense, such as first recognized in *U.S. v. Randall* (D.C. Super. 1976), be statutorily recognized for patients who are not registered by the Department of Health.

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