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Comments: Seeking a Second Opinion: How to Cure Maryland's Medical Marijuana Law

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SEEKING A SECOND OPINION: HOW TO CURE MARYLAND'S MEDICAL MARIJUANA LAW

I. INTRODUCTION

Imagine having a chronic and debilitating medical condition that prevents you from having a functioning work and personal life.[1] Perhaps you deal with non-stop pain, severe nausea, vomiting, seizures, or muscle spasms. Conventional medications have not worked well and have caused incapacitating side effects. You have exhausted your options by going to numerous specialists and by trying experimental treatments that have not yet been proven safe in the long run. Before resigning yourself to accept a lower quality of life, you decide to try marijuana. You know it could help because under a nearby state's law, physicians may recommend marijuana for your exact condition. When you try it, smoking marijuana turns out to ease your symptoms better than anything your doctors have ever prescribed.

A friend ends up knowing someone who maintains a regular supply of marijuana, but at times, the guy is difficult to get in contact with and the quality of his product varies. The last time you stopped by, he told you offhandedly that his apartment was robbed a few weeks ago, so he recently bought a weapon for protection. Tired of your dealer's unreliability, and unwilling to risk your safety, you find a source through a friend of a friend who is willing to mail Canadian marijuana to you at a steep price.

Over the course of a few months, you successfully receive several large shipments of marijuana, and your prognosis is better than it has ever been. However, unexpected knocks on the door make you jump because there is a very real possibility that the law will catch up to you. A month later, that day comes. You are brushing your teeth one morning when you hear a car stop in front of your house and see two police officers getting out.

While sitting in jail waiting for your bail to be set, you recount the humiliation of the police turning your home inside out while neighbors gathered on the sidewalk, craning their necks to get a glimpse of the search inside. After booking you at the station, an officer questioned you about the large amount of marijuana they seized. While you explained your illness and medical history, and that the marijuana was for your personal use, you anticipate that the prosecutor will charge you with possession with intent to distribute. If your boss finds out about your drug arrest, you will lose your job. You begin to brainstorm where you will get the money for your

1. This hypothetical is based in part on the case of William York, *see infra* Part III.B.2, although it is by no means identical to his situation.

defense attorney, who will require payment before agreeing to represent you.

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Marijuana was removed from the United States Pharmacopeia, America's official list of recognized medical drugs, in 1942.[2] Since then, fifteen states and Washington D.C. have assisted patients with various conditions and illnesses in procuring medical marijuana and have given them legal protection for doing so.[3] Additionally, a number of states are currently considering legislative action.[4] As discussion of the topic grows, some media outlets have mistakenly counted Maryland among the medical marijuana states.[5] The confusion originates from Maryland being the only state in the United States with medical marijuana laws that float in limbo.

Maryland does not decriminalize marijuana used by patients for medical use; instead, its law allows courts to grant a lighter sentence at trial for qualifying users.[6] While at first glance, Maryland's treatment might seem defensible under a "better than nothing" view, the reality remains that this law essentially does nothing for Maryland citizens who are already burdened by health conditions.[7]

Maryland residents who use marijuana as medicine currently face similar risks to those in the hypothetical situation above. While Maryland law does address medical marijuana, its recognition of the treatment falls short of actually helping sick individuals. Maryland's current medical marijuana statute exposes patients to the dangers of using an illegal drug and punishes them for doing so, despite their having a compelling reason. This comment will discuss the state of Maryland's current medical marijuana law and will propose that

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2. *See* Matthew W. Grey, Comment, *Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship*, 30 U. RICH. L. REV. 249, 251 (1996).
3. *See infra* Part II.C. The following states have legalized medical marijuana (in chronological order): California, Alaska, Oregon, Washington, Maine, Colorado, Hawaii, Nevada, Montana, Vermont, Rhode Island, New Mexico, Michigan, New Jersey, and Arizona. Additionally, Washington D.C. legalized medical marijuana in 2010.
4. *See infra* Part II.C.
5. *See, e.g.*, Josh Meyer, *A Federal About-Face on Medical Marijuana*, L.A. TIMES, Oct. 20, 2009, *available at* http://articles.latimes.com/2009/oct/20/nation/na-medical-marijuana20?pg=2 (incorrectly listing Maryland as one of fourteen medical marijuana states when only thirteen medical marijuana states existed in October 2009).
6. Maryland courts have rejected the statute as an affirmative defense because the law does not negate the defendant's guilt. *See* Jefferson v. State, 164 Md. App. 330, 340, 883 A.2d 251, 256 (2005).
7. *See infra* Part III.C.

Maryland move beyond a sentence-mitigating provision to a law that embraces marijuana as medicine to certain individuals.

Part II of this comment explains the history of marijuana prohibition, the federal government's treatment of medical marijuana, and how states have reacted to federal law in forming their separate medical marijuana laws.[8] Part III examines Maryland's current medical marijuana statute and cases that have applied it.[9] Part IV addresses the Maryland Legislature's past proposals to amend Maryland's medical marijuana policy and makes recommendations for a new medical marijuana law.[10] Part V concludes that Maryland's present statute addresses the problems of medical marijuana patients ineffectively.[11] This comment will identify a legislative solution for Maryland that is not only sympathetic to the ill and diseased, but also logical and consistent in its application.

II. BACKGROUND

The history of marijuana as a medical drug is rife with controversy because for decades, legislators instead of doctors have made decisions regarding whether marijuana can act as medicine to some people.[12] Congress's outlawing marijuana came at the expense of sick individuals who we now know would benefit from the drug.[13] Instead of treating this substance like other pharmaceuticals (regulated by the Food and Drug Administration and available to qualifying individuals with a doctor's prescription),[14] views reminiscent of "reefer madness" shape medical marijuana policy today. While Congress perceives marijuana as a greater danger than legal substances,[15] the medical community considers alcohol more addictive than marijuana.[16] Moreover, there has never been a recorded incident of death caused by marijuana,[17] compared to the

8. *See infra* Part II.
9. *See infra* Part III.
10. *See infra* Part IV.
11. *See infra* Part V.
12. *See supra* note 2 and accompanying text.
13. *See infra* note 40 and accompanying text.
14. *See generally How Drugs are Developed and Approved*, U.S. FOOD AND DRUG ADMIN., http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/default.htm (last visited Dec. 13, 2010) (discussing the FDA's process of drug development).
15. *See infra* text accompanying note 30.
16. *See infra* note 39 and accompanying text.
17. David W. Rasmussen & Bruce L. Benson, *Rationalizing Drug Policy Under Federalism*, 30 FLA. ST. U. L. REV. 679, 695 (2003).

large number of deaths each year caused by overdose of legal prescription drugs.[18]

A. The Beginnings of Marijuana Prohibition

Law professors Richard Bonnie and Charles Whitebread of the University of Virginia attribute the United States' outlawing of marijuana to a number of factors.[19] The Harrison Act, passed in 1914, regulated opium and cocaine following heightened concern by the medical community that doctors were overprescribing addictive drugs.[20] Professors Bonnie and Whitebread classify the Harrison Act as the beginning of "a shift in public perception of the narcotics addict. With ever-increasing frequency and venom, [the addict] was portrayed in the public media as the criminal 'dope fiend.'"[21] Racial prejudice also contributed to the declining public opinion of marijuana as immigrating Mexicans introduced smoking marijuana to the United States—whose citizens mainly had used marijuana in its processed form: hemp, for rope and cloth.[22] Additionally, the presumption that marijuana was an addictive drug that generated crime, poverty, and mental disease, plus negative discussion of marijuana during the 1925 Geneva Conventions, all led states and the federal government to enact laws that prohibited marijuana except for medical use.[23]

State legislatures feared that marijuana would become a substitute for drugs that the Harrison Act had made more difficult to procure and that marijuana would replace alcohol, which was under prohibition at the time.[24] Furthermore, while "the middle class had successfully frustrated alcohol prohibition because the public opinion process came to reflect its view that the law should not condemn

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18. *See* Written Statement by Leonard J. Paulozzi, M.D., M.P.H., Medical Epidemiologist before Energy and Commerce Comm. and Subcomm. on Oversight and Investigations (Oct. 24, 2007) U.S. DEP'T OF HEALTH AND HUMAN SERVS., http://www.hhs.gov/asl/testify/2007/10/t20071024a.html ("Mortality statistics suggest that [unintentional drug poisoning] deaths are largely due to the misuse and abuse of prescription drugs. Such statistics are backed up by studies of the records of state medical examiners.").
19. Richard J. Bonnie & Charles H. Whitebread, II, *The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition*, 56 VA. L. REV. 971, 975 (1970).
20. *See id.* at 987.
21. *Id.* at 1011.
22. *Id.* at 1011–12.
23. *Id.* at 1011–12, 1026.
24. *Id.* at 1019.

[alcohol] intoxication . . . . marijuana use was primarily a lower class phenomenon" and generally, "there was no voice which could be heard to challenge . . . assumptions" that marijuana was as dangerous as opium or cocaine.[25]

Between 1927 and 1937, most states began regulating the sale and possession of narcotic drugs, including marijuana, by adopting the Uniform Narcotic Drug Act.[26] This model law included marijuana as a "habit-forming drug," but because the status of marijuana as habit-forming was generally disputed, the Act listed it as an optional inclusion that states could reject without affecting the remaining provisions.[27] Despite the states' overwhelming adoption of the Uniform Narcotic Drug Act, the federal government also began regulating marijuana under the Marihuana Tax Act of 1937,[28] attempting to curb use of the drug through heavy taxes.[29]

The more modern theory of marijuana being a stepping-stone to dangerous drugs emerged in the 1950s.[30] Teenage addiction and narcotics violations greatly increased between 1947 and 1951, and Professors Bonnie and Whitebread assert that marijuana was swept ignorantly into public condemnation amidst the hysteria.[31] The federal government predicted that harsh penalties would prove the most effective deterrent, and it extended incarceration sentences to drug users, including those of marijuana.[32] Bonnie and Whitebread contend that the government's inclusion of marijuana within these sentencing provisions set the precedent for the continued public view and treatment of marijuana as a dangerous drug without legitimate reason.[33] Later, the Institute of Medicine clinically disproved the theory of marijuana as "gateway drug"; Drug Czar Barry McCaffrey of the Clinton Administration rejected the findings of this research despite the fact that McCaffrey himself commissioned it from the Institute.[34]

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25. *Id.* at 1027 (emphasis omitted).
26. UNIF. NARCOTIC DRUG ACT § 2, 9B U.L.A. 29 (1932) (amended 1958).
27. Bonnie & Whitebread, *supra* note 19, at 1031–32.
28. Marihuana Tax Act of 1937, Pub. L. No. 75-238, 50 Stat. 551 (1937) (repealed 1970).
29. Bonnie & Whitebread, *supra* note 19, at 1053 (quoting *Signs Bill to Curb Marihuana*, N.Y. TIMES, Aug. 3, 1937, at 4).
30. *See id.* at 1063. Today, opponents more commonly describe marijuana as a "gateway drug" to other narcotics. *See* Eric Blumenson & Eva Nilsen, *No Rational Basis: The Pragmatic Case for Marijuana Law Reform*, 17 VA. J. SOC. POL'Y & L. 43, 56 (2009).
31. Bonnie & Whitebread, *supra* note 19, at 1063–64.
32. *See id.* at 1066–68.
33. *See id.* at 1077.
34. Blumenson & Nilsen, *supra* note 30, at 56; DIV. OF NEUROSCIENCE & BEHAVIORAL HEALTH, INST. OF MED., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 6

B. Modern Federal Treatment of Medical Marijuana

Since Congress implemented its "schedule" system in the Controlled Substances Act of 1970, the federal government has categorized marijuana as a Schedule I drug.[35] Federal law prohibits possessing,[36] manufacturing, distributing, or dispensing a controlled substance, such as those listed under Schedule I.[37]

The Act defines Schedule I drugs as having a high potential for abuse, no currently accepted medical use in the United States, and a lack of accepted safety in using the drug under medical supervision.[38] Regarding marijuana abuse, the American Medical Association stated that between only four and nine percent of marijuana users are substance dependent and that "[a]lthough some marijuana users develop dependence, they appear to be less likely to do so than users of alcohol and nicotine."[39]

Additionally, in 2009, the American Medical Association stated:

> Results of short term controlled trials indicate that smoked cannabis reduces neuropathic pain, improves appetite and caloric intake especially in patients with reduced muscle mass, and may relieve spasticity and pain in patients with multiple sclerosis. However, the patchwork of state-based systems that have been established for "medical marijuana" is woefully inadequate in establishing even rudimentary

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(Janet E. Joy, et al. eds., 1999) ("Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter . . . . [however there] is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.").

35. 21 U.S.C. § 812(c)(Schedule I)(c)(10) (2006). Drugs such as heroin accompany marijuana within Schedule I. *Id.* § 812(c)(Schedule I)(b)(10).

36. *Id.* § 844a(a).

> Any individual who knowingly possesses a controlled substance that is listed in section 841(b)(1)(A) of this title in violation of section 844 of this title in an amount that, as specified by regulation of the Attorney General, is a personal use amount shall be liable to the United States for a civil penalty in an amount not to exceed $10,000 for each such violation.

Id.

37. *Id.* § 841(a)(1). The act also prohibits possessing controlled substances with the intent to manufacture, distribute, or dispense. *Id.*

38. *Id.* § 812(b)(1).

39. COUNCIL ON SCIENTIFIC AFFAIRS, MEDICAL MARIJUANA, AM. MED. ASS'N, (2001), *available at* http://www.ama-assn.org/ama/no-index/about-ama/13625.shtml. Notably, the Controlled Substances Act schedules neither alcohol nor nicotine. 21 U.S.C. § 812.

> safeguards that normally would be applied to the appropriate clinical use of psychoactive substances . . . . To the extent that rescheduling marijuana out of Schedule I will benefit this effort, such a move can be supported.[40]

With drugs classified under Schedule I having "no accepted medical use,"[41] it is incomprehensible to categorize marijuana as such when America's doctors—the logical authority on medicine—state otherwise.[42]

As recently as 2001, the Supreme Court of the United States rejected a challenge to the Controlled Substances Act involving the common law medical necessity defense under *United States v. Oakland Cannabis Buyers*[43]—regardless of the defendant's residing in California, a state that allows marijuana possession and cultivation with the advice of a physician.[44] Moreover, in *Gonzales v. Raich*,[45] the Court held that federal law regarding marijuana preempted that of the states because the Commerce Clause allows Congress to ban the use of cannabis even where individual states allow for its medical use.[46]

The federal government's focus on medical marijuana patients and dispensaries somewhat decreased, however, with the Department of Justice's (DOJ) October 19, 2009 memo.[47] Acting on President Barack Obama's direction, the Deputy Attorney General instructed federal prosecutors to cease pursuing medical marijuana users and dispensaries acting in compliance with state laws, calling action to the contrary "unlikely to be an efficient use of limited federal resources."[48] According to Robert Gibbs, President Obama's chief

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40. COUNCIL ON SCI. & PUB. HEALTH, USE OF MEDICAL MARIJUANA FOR MEDICINAL PURPOSES, AM. MED. ASS'N (2009), http://www.ama-assn.org/ama1/pub/upload/mm/443/csaph-report3-i09.pdf.
41. *See supra* notes 35–38 and accompanying text.
42. *See, e.g., supra* note 40 and accompanying text.
43. 532 U.S. 483, 486 (2001).
44. *See id.*
45. 545 U.S. 1 (2005).
46. U.S. CONST. art. I, § 8; *see also Gonzales*, 545 U.S. at 28–29.
47. MEMORANDUM FROM DAVID W. OGDEN, DEPUTY ATTORNEY GEN., U.S. DEP'T OF JUSTICE, TO SELECTED U.S. ATTORNEYS (Oct. 19, 2009), http://www.justice.gov/opa/documents/medical-marijuana.pdf.
48. United States Attorneys are vested with "plenary authority with regard to federal criminal matters" within their districts. USAM 9-2.001. . . . The prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the Department's efforts against narcotics and

spokesperson, this memo only clarified what "has been administration policy since the beginning of [the Obama] administration in January [2009]."[49] Nevertheless, some federal prosecutors continue to bring controlled dangerous substance (CDS) charges against medical marijuana dispensaries and patients acting legally under state law using various loopholes.[50]

While President Obama and the DOJ memo intend to protect medical marijuana patients and dispensaries acting in accordance with state law,[51] one would assume that the state laws in question would regard marijuana. However, in March 2009, the Drug Enforcement Administration (DEA) raided a San Francisco, California dispensary for marijuana, despite its holding a permit by the California Department of Public Health, because of "alleged financial improprieties related to the payment of sales taxes."[52] What gave the DEA authority to raid and seize the dispensary's marijuana supplies due to tax violations is unclear, but under this logic, a violation of any type of law could expose dispensaries and patients to federal prosecution for marijuana distribution.[53]

Additionally, in July 2010, the Department of Veterans Affairs adopted a department directive allowing veterans who use medical marijuana legally within states that have adopted such laws to

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> dangerous drugs . . . . [However,] pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.

Id. at 1–2.

This is in great contrast to treatment of medical marijuana by the Department of Justice under former President George W. Bush's administration. Solomon Moore, *Dispensers of Marijuana Find Relief in Policy Shift*, N.Y. TIMES, Mar. 20, 2009, at A15, *available at* http://www.nytimes.com/2009/03/20/us/20marijuana.html?scp=7&sq=marijuana%20dispensaries&st=cse.

49. David Stout & Solomon Moore, *U.S. Won't Prosecute in States that Allow Medical Marijuana*, N.Y. TIMES, Oct. 20, 2009, at A1, *available at* http://www.nytimes.com/2009/10/20/us/20cannabis.html.

50. *See, e.g.*, *infra* note 52 and accompanying text.

51. *See supra* notes 47–49 and accompanying text.

52. Rachel Gordon, *DEA Raids Pot Dispensary in SF*, S.F. CHRON. (Mar. 26, 2009, 22:05), http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/03/25/BA5B16N9LR.DTL.

53. *See id.* Additionally, there were (and still might be) some federal cases pending that had been brought prior to the DOJ's memo. In these cases, federal judges' hands were tied with mandatory sentencing requirements. *See* Solomon Moore, *Prison Term for a Seller of Medical Marijuana*, N.Y. TIMES, June 12, 2009, at A18, *available at* http://www.nytimes.com/2009/06/12/us/12pot.html?_r=1.

maintain their benefits.[54] Previously, the Department's policy was to deny veterans access to pain medications if they used illegal drugs.[55] However, with the new written exception, medical marijuana patients may fully disclose their marijuana treatment to their doctors without fear.[56]

Despite the shortcomings within federal law, the United States continues to move toward favorable treatment of medical marijuana; the federal government is at least trying to shift prosecutions and punishments away from legal medical marijuana patients and dispensaries, albeit in ambiguous and inconsistent ways.

Today, over eighty percent of Americans support decriminalizing marijuana for medical use.[57] At this point, it seems irrational for states not to have medical marijuana laws when the majority of Americans support the cause, when the medical community states that marijuana can safely benefit the ill,[58] and when the federal government is no longer vehemently opposed to state laws that conflict with the federal government's treatment of marijuana.[59]

C. The States' Treatment of Medical Marijuana

In addition to the popular consensus, more states than ever are now considering or have adopted medical marijuana laws. The fifteen states that currently protect individuals suffering from chronic or debilitating medical conditions against marijuana prosecution are (in chronological order of adoption): California, Alaska, Oregon, Washington, Maine, Colorado, Hawaii, Nevada, Montana, Vermont, Rhode Island, New Mexico, Michigan, New Jersey, and Arizona.[60]

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54. Dan Frosch, *V.A. Easing Rules for Patients Who Use Medical Marijuana*, N.Y. TIMES, July 24, 2010, at A1, *available at* http://www.nytimes.com/2010/07/24/health/policy/24veterans.html.

55. *Id.*

56. *Id.* However, the new directive does not allow doctors employed by the United States Department of Veterans Affairs to prescribe marijuana because federal law still controls the Department. *Id.*

57. *See* Press Release, ABC News/Wash. Post, High Support for Medical Marijuana (Jan. 18, 2010), *available at* http://abcnews.go.com/images/PollingUnit/1100a3MedicalMarijuana.pdf. Support has increased since 1997 when 69% of Americans supported legalizing medical marijuana. *Id.* In addition, 46% of Americans now support legalizing marijuana for personal use generally (compared to 22% in 1997). *Id.*

58. *See supra* text accompanying note 40.

59. *See supra* text accompanying notes 47–49.

60. *See* Alaska Ballot Measure 8 (1998) (codified as Medical Uses of Marijuana for Persons Suffering from Debilitating Medical Conditions Act, ALASKA STAT. §§ 17.37.010–.080 (2009)); Ariz. Proposition 203 (2010) (to be codified as Arizona

The District of Columbia's medical marijuana law came into effect in 2010[61] twelve years after 69% of D.C. voters approved medical marijuana through Initiative 59 in 1998.[62] Additionally, Louisiana and Virginia have passed laws that allow doctors to "prescribe" marijuana for certain ailments.[63] These two laws, however, are void

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Medical Marijuana Act, ARIZ. REV. STAT. ANN. tit. 28, ch. 28.1); Cal. Proposition 215 (1996) (codified as Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007)); Colo. Ballot Amend. 20 (2000) (codified as Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions, COLO. CONST. art. XVIII, § 14); Hawaii Medical Use of Marijuana, HAW. REV. STAT. ANN. §§ 329-121 to -128 (LexisNexis 2008); Me. Ballot Question 2 (1999) (codified as Maine Medical Marijuana Act, ME. REV. STAT. ANN. tit. 22, § 2383-B(5) (Supp. 2008)); Mich. Proposal 1 (2008) (codified as Michigan Medical Marihuana Act, MICH. COMP. LAWS ANN. §§ 333.26421–26430 (West Supp. 2010)); Montana Medical Marijuana Act, MONT. CODE ANN. §§ 50-46-101 to -210 (2009); Nev. Ballot Question 9 (2000) (codified as Medical Use of Marijuana, NEV. REV. STAT. ANN. §§ 453A.010–.810 (LexisNexis 2009)); New Jersey Compassionate Use Medical Marijuana Act, N.J. STAT. ANN. §§ 24:6I-1 to -16 (West Supp. 2010); Lynn and Erin Compassionate Use Act, N.M. STAT. ANN. §§ 26-2B-1 to -7 (West Supp. 2009); Or. Ballot Measure 67 (1998) (codified as Oregon Medical Marijuana Act, OR. REV. STAT. §§ 475.300–.346 (2009)); Rhode Island Medical Marijuana Act, R.I. GEN. LAWS §§ 21-28.6-1 to -10 (Supp. 2008); Vermont Therapeutic Use of Cannabis, VT. STAT. ANN. tit. 18, §§ 4471–4474d (2009); Wash. Initiative 692 (1998) (codified as Medical Use of Marijuana Act, WASH. REV. CODE ANN. §§ 69.51A.005–.080 (West Supp. 2010)).

61. Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, 57 D.C. Reg. 4798 (June 2010). Previously, Congress had passed the Barr Amendment, a spending restriction, which blocked implementation of the law. Consolidated Appropriations Act of 2000, Pub. L. No. 106-113, § 167(b), 113 Stat. 1501, 1530 (1999). In December 2009, Congress passed an omnibus spending bill that did not include the Barr Amendment. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, 123 Stat. 334 (2009). In May 2010, the D.C. Council unanimously approved implementation of the initiative. Mayor Adrian Fenty signed the measure and sent it to Congress for a thirty-legislative-day review period. The District's "Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010" became law in July 2010 because Congress opted not to intervene. Mayor Fenty and the D.C. Health Department will next establish regulations regarding dispensaries, as the law only legalizes possession of medical marijuana purchased from a D.C. dispensary. *See* Tim Craig, *Medical Marijuana Will Take Time in D.C.*, WASH. POST, July 28, 2010, at B1; D.C. Marijuana Policy Project, *It's Official! Congressional Review Period Expires and D.C. Marijuana Law Takes Effect*, http://www.mpp.org/states/district-of-columbia/ (last updated July 27, 2010).

62. Legalization of Marijuana for Medical Treatment Initiative of 1998, 57 D.C. Reg. 3360 (Apr. 23, 2010).

63. LA. REV. STAT. ANN. § 40:1046 (Supp. 2009); VA. CODE ANN. § 18.2-251.1A (West 2009) ("No person shall be prosecuted under § 18.2-250 or § 18.2-250.1 for the possession of marijuana or tetrahydrocannabinol when that possession occurs pursuant to a valid prescription issued by a medical doctor in the course of his professional practice for treatment of cancer or glaucoma."). In 1996, Arizona's

because physicians may not "prescribe" Schedule I drugs.[64] Conversely, those states in which medical marijuana is legal defer to physicians' recommendations, advice, or professional opinions.[65]

The medical marijuana states allow patients with a wide range of severe, chronic, or debilitating medical conditions to use medical marijuana.[66] All of the medical marijuana states protect patients suffering from muscle spasticity, HIV/AIDS, and cancer.[67] Michigan's law includes the highest number of diverse medical conditions and is the only state to specifically allow for nail patella syndrome.[68]

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voters passed Ballot Proposition 200, an invalid law similar to those of Virginia and Louisiana. However, in 2010, Arizona voters passed a valid medical marijuana law. *See* Ariz. Proposition 203.

64. *See* Gonzales v. Oregon, 546 U.S. 243, 278 (2006) ("[We] interpret[] the word 'prescription' as it appears in 21 U.S.C. § 829, which governs the dispensation of controlled substances other than those on Schedule I (which may not be dispensed at all).").

65. *See* COLO. CONST. art. XVIII, § 14(2)(c); ALASKA STAT. § 17.37.010(c)(1); Ariz. Proposition 203, § 36-2081(18); CAL. HEALTH & SAFETY CODE § 11362.715(a)(2); Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 3(c)(1), 5, 57 D.C. Reg 4798, 4801–4803; HAW. REV. STAT. ANN. § 329-122(a)(2); ME. REV. STAT. ANN. tit. 22, § 2383-B(5)(A)(2); MICH. COMP. LAWS ANN. § 333.26423(1); MONT. CODE ANN. § 50-46-102; NEV. REV. STAT. §§ 453A.010–.810; N.J. STAT. ANN. §§ 24:6I-1 to -16; N.M. STAT. ANN. § 26-2B-3(H); OR. REV. STAT. § 475.309(2)(a); R.I. GEN. LAWS § 21-28.6-2(10); VT. STAT. ANN. tit. 18, § 4471–4473(b)(2)(B); WASH. REV. CODE ANN. § 69.51A.010(5)(a).

66. *See* COLO. CONST. art. XVIII, § 14(a); ALASKA STAT. § 17.37.070(4); Ariz. Proposition 203, § 36-2801(3); CAL. HEALTH & SAFETY CODE § 11362.7(h); Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 2(17)–(18), HAW. REV. STAT. ANN. § 329-121; ME. REV. STAT. ANN. tit. 22, § 2383-B(5)(A)(1); MICH. COMP. LAWS ANN. § 333.26423(a); MONT. CODE ANN. § 50-46-102(2); NEV. REV. STAT. ANN. § 453A.050; N.J. STAT. ANN. § 24:6I-3; N.M. STAT. ANN. § 26-2B-3(B); OR. REV. STAT. § 475.302(3); R.I. GEN. LAWS § 21-28.6-3(1); VT. STAT. ANN. tit. 18, § 4472(2); WASH. REV. CODE ANN. § 69.51A.005(4).

67. *See* COLO. CONST. art. XVIII, § 14(A); ALASKA STAT. § 17.37.070(4); Ariz. Proposition 203, § 36-2801(3); CAL. HEALTH & SAFETY CODE § 11362.7(h); Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 2(17)–(18); HAW. REV. STAT. ANN. § 329-121; ME. REV. STAT. ANN. tit. 22, § 2383-B(5)(A)(1); MICH. COMP. LAWS ANN. § 333.26423(a); MONT. CODE ANN. § 50-46-102(2); NEV. REV. STAT. ANN. § 453A.050; N.J. STAT. ANN. § 24:6I-3; N.M. STAT. ANN. § 26-2B-3(B); OR. REV. STAT. § 475.302(3); R.I. GEN. LAWS § 21-28.6-3(1); VT. STAT. ANN. tit. 18, § 4472(2); WASH. REV. CODE ANN. § 69.51A.005(4).

68. MICH. COMP. LAWS ANN. § 333.26423(a). "Nail patella syndrome is an inherited condition characterized by abnormalities of the nails, knee, elbows, and pelvis. Other areas of the body may also be affected, particularly the eyes and kidneys." *Nail Patella Syndrome*, GENETIC & RARE DISEASES INFO. CTR., NAT'L INST. OF HEALTH, http://rarediseases.info.nih.gov/GARD/Disease.aspx?PageID=4&DiseaseID=7160 (last visited Dec. 13, 2010).

Table 1: Protected Conditions Under State Medical Marijuana Laws[69]																
Medical condition	AK	AZ	CA	CO	DC	HI	ME	MI	MT	NV	NJ	NM	OR	RI	VT	WA
Agitation of Alzheimer's disease		X						X					X	X		
Anorexia			X													
Arthritis			X													
Cachexia/ Muscular dystrophy	X	X	X	X		X	X	X	X	X	X		X	X	X	
Cancer	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Crohn's disease/ IBD		X				X		X	X		X			X		
Chronic nervous system disorders											X					X
Chronic pain	X	X	X	X		X		X	X	X	X		X	X	X	X
Epilepsy/Seizures	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Glaucoma	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
Hepatitis C		X						X						X		
HIV/AIDS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hospice/ Terminal patients											X	X				
Lou Gehrig's disease/ALS		X						X			X					
Migraine			X													
Muscle spasms/ Multiple sclerosis	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nail patella syndrome								X								
Nausea/Vomiting	X	X	X	X		X	X	X	X	X	X		X	X	X	
Conditions protected	8	12	11	8	4[70]	9	7	13	9	8	12	6	9	11	7	7

69. See COLO. CONST. art. XVIII, § 14(A); ALASKA STAT. § 17.37.070(4); Ariz. Proposition 203, § 36-2801(3); CAL. HEALTH & SAFETY CODE § 11362.7(h); Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, § 2(17)–(18); HAW. REV. STAT. ANN. § 329-121; ME. REV. STAT. ANN. TIT. 22, § 2383-B(5)(A)(1); MICH. COMP. LAWS ANN. § 333.26423(a); MONT. CODE ANN. § 50-46-102(2); NEV. REV. STAT. ANN. § 453A.050; N.J. STAT. ANN. § 24:6I-3; N.M. STAT. ANN. § 26-2B-3(B); OR. REV. STAT. § 475.302(3); R.I. GEN. LAWS § 21-28.6-3(1); VT. STAT. ANN. tit. 18, § 4472(2); WASH. REV. CODE ANN. § 69.51A.005(4)..

70. Washington D.C.'s law also provides for patients that have "[a]ny other condition, as determined by rulemaking, that is: (i) [c]hronic or long-lasting; (ii) [d]ebilitating or interferes with the basic functions of life; and (iii) [a] serious medical condition for which the use of medical marijuana is beneficial: (I) [t]hat cannot be effectively treated by any ordinary medical or surgical measure; or (II) [f]or which there is scientific evidence that the use of medical marijuana is likely to be significantly less addictive than the ordinary medical treatment for that condition." Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 2(17).

Only six of the fifteen state laws were adopted via legislation, while voters approved and enacted the rest in election years.[71] The medical marijuana states allow patients to possess various amounts ranging from one ounce (Nevada), up to twenty-four ounces (Oregon), or simply "no more than is necessary for the patient's personal, medical use," so long as that amount does not exceed a sixty-day supply (Washington).[72] Patients may grow their own marijuana under all of the medical marijuana laws except for New Jersey and Washington, D.C.[73] Alaska and Colorado, for example, allow patients to possess six plants, three of which can be mature, while Oregon allows patients to possess up to eighteen seedlings and six mature plants.[74]

Patient registries are another key feature. Registries are particularly important because they give medical marijuana patients protection before they are ever arrested, eliminating the time and costs of arrest, detainment, and defending a criminal lawsuit.[75] All of the medical marijuana states have patient registries except Washington.[76] Most of the states have official patient identification cards to facilitate patients' purchasing marijuana and to present to

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71. *See* Alaska Ballot Measure 8 (1998); Ariz. Proposition 203; Cal. Proposition 215 (1996); Colo. Ballot Amend. 20 (2000); D.C. Initiative 59 (1998); HAW. REV. STAT. ANN. §§ 329-121 to -128; Me. Ballot Question 2 (1999); Mich. Proposal 1 (2008); MONT. CODE ANN. §§ 50-46-101 to -210; Nev. Ballot Question 9 (2000); N.J. STAT. ANN. §§ 24:6I-1 to -16; N.M. STAT. ANN. §§ 26-2B-1 to -7; Or. Ballot Measure 67 (1998); R.I. GEN. LAWS § 21-28.6-2; VT. STAT. ANN. tit. 18 §§ 4471–4474d; Wash. Initiative 692 (1998).

72. *See* NEV. REV. STAT. § 453A.200; OR. REV. STAT. § 475.320 (2009); VT. STAT. ANN. tit. 18, § 4472; WASH. REV. CODE § 69.51A.040(2)(b).

73. *See* Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010; N.J. STAT. ANN. §§ 24:6I-1 to -16. Arizona will allow medical marijuana patients to grow their own marijuana if a dispensary is located more than twenty-five miles away from the patient's home. *See* Ariz. Proposition 203, § 36-2804.02(A)(3)(f).

74. *See* COLO. CONST. art. XVIII, § 14(4)(a); ALASKA STAT. § 17.37.040(4) (2009); OR. REV. STAT. § 475.320(3)–(4)(a).

75. *See infra* Part III.C.2; *see also infra* note 180 and accompanying text (discussing the costs of representation for a drug-related criminal defense).

76. *See* COLO. CONST. art. XVIII, § 14(1)(g); ALASKA STAT. § 17.37.010; Ariz. Proposition 203, § 36-2804.02; CAL. HEALTH & SAFETY CODE § 11362.71(a)(1) (West 2007); Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 3(c)(1)(A); HAW. REV. STAT. ANN. § 329-123; ME. REV. STAT. ANN. tit. 22, § 2425 (Supp. 2008); MICH. COMP. LAWS ANN. § 333.26426 (West Supp. 2010); MONT. CODE ANN. §§ 50-46-101 to -210; NEV. REV. STAT. § 453A.210; N.J. STAT. ANN. §§ 24:21–22; N.M. STAT. ANN. § 26-2B-7.B; OR. REV. STAT. § 475.309; R.I. GEN. LAWS § 21-28.6-6; VT. STAT. ANN. tit. 18 § 4473.

law enforcement in the event of a dispute.[77] Many states also provide harsh penalties in the event of fraud.[78]

While most of the patient registries have yearly administrative costs ranging from $25 (Hawaii) to over $150 (Nevada), Washington D.C. will base its costs on a sliding scale.[79] Additionally, California has separate prices for the financially needy and for Medicaid recipients.[80] Some medical marijuana states honor other states' patient identification cards[81] and others establish an affirmative defense of medical necessity for medical marijuana arrestees not enrolled in the state registry.[82]

Arizona, California, Colorado, Maine, New Jersey, New Mexico, Rhode Island, and Washington D.C. have (or will establish) government-sanctioned medical marijuana dispensaries.[83]

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77. *See* COLO. CONST. art. XVIII, § 14(3); ALASKA STAT. § 17.37.010; Ariz. Proposition 203, § 36-2804.02–06; CAL. HEALTH & SAFETY CODE § 11362.71; Legalization of Marijuana for Medical Treatment Initiative Amendment Act, sec. 2, § 3(c)(1), (5); HAW. REV. STAT. ANN. § 329-123; ME. REV. STAT. ANN. tit. 22, § 2425; MICH. COMP. LAWS ANN. § 333.26426; MONT. CODE ANN. §§ 50-46-101 to -210 (2009); NEV. REV. STAT. § 453A.210; N.J. STAT ANN. §§ 24:6I-1 to -16; N.M. STAT. ANN. § 26-2B-7.B; OR. REV. STAT. § 475.309; R.I. GEN. LAWS § 21-28.6-6; VT. STAT. ANN. tit. 18 § 4473; *see also supra* note 60.

78. *See* COLO. CONST. art. XVIII, § 14(3); CAL. HEALTH & SAFETY CODE § 11362.71; Legalization of Marijuana for Medical Treatment Initiative Amendment Act, sec. 2, § 3(c)(1), (5); HAW. REV. STAT. ANN. § 329-123; ME. REV. STAT. ANN. tit. 22, § 2383-B5 (Supp. 2008); MICH. COMP. LAWS ANN. § 333.26426 (West Supp. 2010); MONT. CODE ANN. §§ 50-46-101 to -210 (2009); NEV. REV. STAT. § 453A.210; N.J. STAT. ANN. §§ 24:6I-1 to -16; N.M. STAT. ANN. § 26-2B-7.B; OR. REV. STAT. § 475.309; R.I. GEN. LAWS § 21-28.6-6; VT. STAT. ANN. tit. 18 § 4473.

79. Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 2(9); HAW. REV. STAT. ANN. § 329-123; NEV. REV. STAT. ANN. § 453A.740. Additionally, Arizona's Proposition 203 authorizes but does not require the Arizona Department of Health Services to establish a sliding scale for fees based on the patient's household income. *See* Ariz. Proposition 203, § 36-2803(A)(5)(e).

80. *See* CAL. HEALTH & SAFETY CODE § 11362.5.

81. *See* Ariz. Proposition 203, § 36-2804.03(C); ME. REV. STAT. ANN. tit. 22, § 2423-D; MICH. COMP. LAWS ANN. § 333.26426(j); MONT. CODE ANN. §§ 50-46-201(8); R.I. GEN. LAWS § 21-28.6-4. However, Arizona's proposition does not permit visiting patients to obtain marijuana from Arizona's dispensaries. Ariz. Proposition 203 § 36-2804.03(C).

82. *See* Ariz. Proposition 203 § 36-2812(B); COLO. CONST. art. XVIII, § 14; MONT. CODE ANN. §§ 50-46-206; NEV. REV. STAT. ANN. § 453A.310; OR. REV. STAT. § 475.319; R.I. GEN. LAWS § 21-28.6-8(b).

83. *See* COLO. CONST. art. XVIII, § 14; Ariz. Proposition 203 § 36-2803(A)(4), 36-2804, 36-2806; CAL. HEALTH & SAFETY CODE § 11362.5; Legalization of Marijuana for Medical Treatment Initiative Amendment Act of 2010, sec. 2, § 2(9); ME. REV. STAT. ANN. tit. 22, § 2383-B; N.J. STAT. ANN. §§ 24:6I-7; N.M. STAT. ANN. § 26-2B-4; R.I.

Dispensaries provide legal marijuana access to patients who do not want to grow the plant, which can require a substantial investment of time and capital.[84] However, dispensaries are not a mere convenience to patients, they can also be a source of economic boon. California's dispensaries take in $2 billion every year, increasing the state's tax revenue by $100 million annually.[85]

States that have not yet enacted medical marijuana laws but that are considering (or have recently considered) doing so include: Alabama,[86] Delaware,[87] Illinois,[88] Massachusetts,[89] Missouri,[90] New

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GEN. LAWS § 21-28.6-4; *see also* Clarke Canfield, *Maine Fifth State to Allow Pot Dispensaries*, BANGOR DAILY NEWS, Nov. 4, 2009, http://www.bangordailynews.com/detail/128197.html?print=1. Nevada's law requires the Nevada School of Medicine to seek federal permission to establish a state-run medical marijuana distribution program "aggressively." *See* NEV. REV. STAT. ANN. § 453A.6.

84. *See generally* JORGE CERVANTES, MARIJUANA HORTICULTURE: THE INDOOR/OUTDOOR MEDICAL GROWER'S BIBLE, (2006) (describing the process and necessary equipment to grow marijuana). Dispensaries greatly benefit patients as they negate the knowledge and labor required to produce usable marijuana. In fact, the process is complicated enough that entrepreneurs have founded marijuana growing "colleges" to educate aspiring professional growers. Tamar Levin, *At This School, Everyone Majors in Marijuana*, N.Y. TIMES, Nov. 29, 2009, at A1, *available at* http://www.nytimes.com/2009/11/29/education/29marijuana.html. Growers also face the risk of being raided by the federal government and receiving the harsher penalties that accompany being labeled a distributor. *See* 21 U.S.C. § 841(b) (Supp. 2010); *Federal Trafficking Penalties — Marijuana*, U.S. DEP'T OF JUSTICE, http://www.justice.gov/dea/agency/penalties.htm (last visited Dec. 13, 2010).

85. Dan Mitchell, *Legitimizing Marijuana*, N.Y. TIMES, May 31, 2008, at C5, *available at* http://www.nytimes.com/2008/05/31/technology/31online.html?_r=1. This is especially notable for California, which ran a deficit of over $6 billion from 2009 to 2010, and projected a $14.4 billion deficit for 2010 to 2011. LEGISLATIVE ANALYST'S OFFICE, THE 2010–11 BUDGET: CALIFORNIA'S FISCAL OUTLOOK (2009), *available at* http://www.lao.ca.gov/2009/bud/fiscal_outlook/fiscal_outlook_111809.aspx.

86. Alabama Representative Patricia Todd introduced House Bill 207 in January 2010. *See* H.R. 207, 2010 Leg., Reg. Sess. (Ala. 2010), *available at* http://alisondb.legislature.state.al.us/acas/acaslogin.asp (follow "Bills" hyperlink; then "By Sponsor"; then select "Todd" and follow "Get Bills"; then select "HB207" and follow "View").

87. Delaware Senator Margaret Rose Henry introduced Senate Bill 94 in May 2009. At the hearing before the Health and Social Services Committee, patients and advocates offered testimony in support, and the Committee approved the bill. The bill was reintroduced to the Senate with Amendments in June 2009. *See* S. 94, 145th Gen. Assemb., Reg. Sess. (Del. 2009), *available at* http://legis.delaware.gov/LIS/LIS145.nsf/vwlegislation/SB+94?Opendocument.

88. The Illinois Senate passed Senate Bill 1381 in May 2009. House Bill 2514 failed to pass by seven votes, but House sponsor Lou Lang asked for "postponed consideration" of the bill, meaning that it could be called again in January 2010. *See* S. 1381, 96th Assemb. (Ill. 2009), *available at*

York,[91] North Carolina,[92] Ohio,[93] Pennsylvania,[94] South Dakota,[95] and Wisconsin.[96]

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http://www.ilga.gov/legislation/BillStatus.asp?DocTypeID=SB&DocNum=1381&GAID=10&SessionID=76&LegID=42617.

89. Massachusetts' Joint Committee on Public Health held a hearing on House Bill 2160, in May 2009. *See* H.R. 2160, 185th Gen. Court, Reg. Sess. (Mass. 2009), *available at* http://www.mass.gov/legis/bills/house/186/ht02/ht02160.htm.

90. Missouri Representative Kate Meiners introduced House Bill 1670 in January 2010. *See* H.R. 1670, 95th Gen. Assemb., 2d Reg. Sess. (Mo. 2010), *available at* http://www.house.mo.gov/billtracking/bills101/biltxt/intro/HB1670I.htm.

91. New York Assembly Health Committee Chair Richard Gottfried and Senate Health Committee Chair Tom Duane sponsor New York's twin bills, Assembly Bill 9016 and Senate Bill 4041-B. Because Senate Republicans oppose allowing patients to grow small amounts of marijuana, the bills would create state-registered and regulated entities to dispense medical marijuana to qualified patients. *See* Assemb. 9016, 2009 State Assemb., Reg. Sess. (N.Y. 2009), *available at* http://assembly.state.ny.us/leg/?bn=A09016 &sh=t; S. 4041-B, 2009 Leg., Reg. Sess. (N.Y. 2009), *available at* http://open.nysenate.gov/openleg/api/html/ bill/S4041B.

92. North Carolina Representatives Earl Jones, Pricey Harrison, and Nick Mackey sponsor House Bill 1380, which was introduced in April 2009. Unfortunately, the Legislature adjourned before the bill was voted on. H.R. 1380, 2009 Gen. Assemb., Reg. Sess. (N.C. 2009-2010), *available at* http://www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2009&BillID=HB1380. The Committee on Health heard testimony from patients and medical professionals in June 2009. *See* N.C. GENERAL ASSEMBLY, *NCGA Calendars*, http://www.ncleg.net/Calendars/PastCalendars/House/2009/06-17-2009 House cal.pdf (last visited Dec. 13, 2010).

93. Ohio Representative Kenny Yuko introduced House Bill 478 in April 2010, which was then referred to the House Health Committee. *See* GENERAL ASSEMBLY OF THE STATE OF OHIO, *Status Report of Legislation 128th General Assembly-House Bills*, http://lsc.state.oh.us/coderev/hou128.nsf/House+Bill+Number/0478?OpenDocument (last visited Dec. 13, 2010).

94. Pennsylvania Representative Mark Cohen introduced House Bill 1393 in April 2009. This bill would protect patients using medical marijuana with their doctors' recommendations from arrest and prosecution. *See* H.R. 1393, 2009 Gen. Assemb., Reg. Sess. (Pa. 2009), *available at* http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2009&sessInd=0&billBody=H&billTyp=B&billNbr=1393&pn=1714. Pennsylvania Senator Daylin Leach introduced Senate Bill 1350 in May 2010, which was referred to the Public Health and Welfare Committee. *See* S. 1350, 2010 Gen. Assemb., Reg. Sess. (Pa. 2010), *available at* http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2009&sind=0&body=S&type=B&BN=1350.

95. In May 2009, South Dakota Secretary of State, Chris Nelson, certified the South Dakota Safe Access Act to appear on the ballot for the November 2010 South Dakota general election as Initiated Measure 13. Unfortunately, 63% of voters rejected this measure. *See* S.D. SAFE ACCESS ACT, *Initiative Petition*, http://medicalmarijuana.procon.org/sourcefiles/SDSafeAccessAct2010.pdf (last visited Dec. 13, 2010).

While their treatment of medical marijuana differs, the fifteen medical marijuana states (and some legislators in the states that are considering laws) have acknowledged the shift in popular and medical opinion.[97] Marijuana effectively treats many ailments,[98] and these states and politicians recognize the farce in applying criminal charges to individuals who are only trying to better their quality of life through effective symptom management.

III. MARYLAND'S MEDICAL MARIJUANA LAW

A. The Darrell–Putman Compassionate Use Act

As originally proposed, the 2003 Darrell–Putman Compassionate Use Act[99] would have given residents with chronic or debilitating medical conditions reliable access to effective medical treatment without the interference of state law enforcement.[100] Recognizing that at the time (2003), eight other states had successful medical marijuana programs,[101] Maryland Senator Paula Hollinger introduced

96. Wisconsin's Assembly and Senate Committees on Public Health heard testimony for Assembly Bill 554 and Senate Bill 368 in December 2009. However, the bills did not receive a committee vote before the regular session adjourned. WIS. STATE LEGISLATURE, *History of Assembly Bill 554*, http://www.legis.state.wi.us/2009/data/AB554hst.html; WIS. STATE LEGISLATURE, *History of Senate Bill 368*, http://www.legis.state.wi.us /2009/data/SB368hst.html (last visited Dec. 13, 2010).

97. *See supra* notes 40, 57 and accompanying text.

98. *See supra* note 40 and accompanying text.

99. Darrell–Putman Compassionate Use Act, MD. CODE ANN., CRIM. LAW §§ 5-601 to -610 (LexisNexis 2009).

100. *See* H.D. 702, 2003 Leg., 417th Sess. (Md. 2003), *available at* http://mlis.state.md.us/pdf-documents/2003rs/bills/hb/hb0702t.pdf ("It is the intent of the General Assembly to ensure that . . . seriously ill individuals who engage in the medical use of marijuana on their physicians' advice are not arrested and incarcerated for using marijuana for medical purposes.").

101. California, Alaska, Oregon, Washington, Maine, Colorado, Hawaii, and Nevada (in that order) had successfully established medical marijuana programs by 2003. *See* Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions, COLO. CONST. art. XVIII, § 14; Medical Uses of Marijuana for Persons Suffering from Debilitating Medical Conditions Act, ALASKA STAT. §§ 17.37.010–.070 (LexisNexis 2009); Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE §§ 11362.5–.9 (West 2010); Haw. Medical Use of Marijuana, HAW. REV. STAT. ANN. §329-121 to -128 (2010); Maine Medical Marijuana Act of 1998, ME. REV. STAT. ANN. tit. 22, § 2383-B (Supp. 2008); NEV. REV. STAT. §§ 453A.010–.810 (2010); Oregon Medical Marijuana Act, OR. REV. STAT. §§ 475.300–.346 (2009); Washington State Medical Use of Marijuana Act, WASH. REV. CODE. §§ 69.51A.005–.80 (West 2010).

Senate Bill 502,[102] and Delegates Dan Morhaim and Al Redmer introduced House Bill 702.[103] The bills proposed creating a medical marijuana program that would allow qualifying patients and their caregivers to apply for exemption from criminal prosecution for possessing limited amounts of marijuana.[104] The bill was also to establish an identification card program for patients and caregivers to avoid arrest,[105] a medical marijuana research program,[106] and provisions prohibiting arrest or prosecution for being in the presence or vicinity of medical marijuana.[107] The Maryland General Assembly failed to pass the Darrell–Putman Compassionate Use Act in its original form.[108] The Assembly's 90 Day Report[109] stated that House Bill 702 was amended (gutting all of the above provisions) to make compromises "[i]n partial recognition of both the illegality of marijuana and the value of marijuana for medical purposes."[110] Then-Governor Robert Ehrlich signed the amended Darrell–Putman Compassionate Use Act into law in May 2003,[111] against the wishes of President George W. Bush.[112]

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102. S. 502, 2003 Leg., 417th Sess. (Md. 2003), *available at* http://mlis.state.md.us/pdf-documents/2003rs/bills/sb/sb0502t.pdf.

103. H.D. 702, 2003 Leg., 417th Sess. (Md. 2003), *available at* http://mlis.state.md.us/pdf-documents/2003rs/bills/hb/hb0702t.pdf.

104. *See* Md. H.D. 702 § 5-610 (C)(1), (3); Md. S. 502 § 5-610 (C)(1), (3). Caregivers would most likely be buying or growing marijuana for debilitated patients and could possess marijuana for their registered patient's use. The bill would allow qualifying patients and caregivers to possess an amount of marijuana "reasonably necessary to ensure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a participating patient's debilitating medical condition" but not more than three mature marijuana plants, four immature plants, and up to one ounce of usable marijuana for each mature plant. Md. H.D. 702 § 5-610(A)(2); Md. S. 502 § 5-610(A)(2).

105. 2003 Md. Laws 3019. Section 5-610(C)(1) protects those with program participation cards from arrest so long as the amount of marijuana in their possession does not exceed "an adequate supply." *Id.*

106. *See id.* at 3014.

107. *See id.* at 3020.

108. *See generally id.* at 3012–23.

109. MD. DEP'T OF LEGISLATIVE SERVS., THE 90 DAY REPORT: A REVIEW OF THE 2003 LEGISLATIVE SESSION, 417th Sess. (2003), *available at* http://mlis.state.md.us /2003rs/90-day-report/index.htm.

110. *Id.* at E-3.

111. H.R 702, 2003 Leg., 417th Sess. (Md. 2003), *available at* http://mlis.state.md.us/2003rs/billfile/hb0702.htm.

112. Lori Montgomery, *A Medical Marijuana Break: Use to Remain Illegal, but Patients' Penalties Cut*, WASH. POST, May 23, 2003, at B4.

As adopted, the relevant section of the Darrell–Putman Compassionate Use Act reads:

> In a prosecution for the use or possession of marijuana, the defendant may introduce and the court shall consider as a mitigating factor any evidence of medical necessity.[113]
>
> [I]f the court finds that the person used or possessed marijuana because of medical necessity, on conviction of a violation of this section, the maximum penalty that the court may impose on the person is a fine not exceeding $100.[114]

As enacted, Darrell–Putman only barely resembles House Bill 702. Gone are the proposed research program, the identification cards, and most importantly, the fact that the State would no longer prosecute medical users for buying or possessing marijuana. Maryland's current law fails to assist medical marijuana users until it comes to determining an individual's punishment (a $100 fine)—and also fails to stop the State from searching, arresting, detaining, or convicting that individual.

B. Maryland Cases Regarding Medical Marijuana

The limited number of trials that have used section 5-601(c)(3) sentencing demonstrates the stringency of the statute's requirements.[115] Maryland's intermediate appellate court has seen only one case involving the statute,[116] and this author found only four Maryland cases that had used section 5-601(c)(3) at trial since the Act's adoption in 2003.[117]

1. *State v. Delli*

Six months after Governor Robert Ehrlich signed the Darrell–Putman Compassionate Use Act into law, Maryland saw the first

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113. MD. CODE ANN., CRIM. LAW § 5-601(c)(3)(i)–(ii) (LexisNexis Supp. 2009).

114. *Id.*

115. *See id.*

116. Jefferson v. State, 164 Md. App. 330, 333, 883 A.2d 251, 252 (2005).

117. Maryland's trial courts do not report opinions, and the state does not index trial records by topic. Therefore, the author relied upon information from newspaper articles, individuals from drug policy reform non-profit organizations, such as the Marijuana Policy Project and the National Organization for the Reform of Marijuana Laws (NORML), as well as Maryland attorney Alex Foster, Esq., who has firsthand experience representing these defendants, in gathering cases that had used the sentence mitigation provision. To these entities' knowledge, these four cases are the only existing Maryland cases that have employed section 5-601(c)(3) sentencing.

application of its new statute.[118] The State arrested and charged thirty-two-year-old Jodi Delli with possessing marijuana and CDS paraphernalia[119] after neighbors reported smelling marijuana to the police.[120] While her medical condition is not clear from the public record, Ms. Delli claimed medical necessity and presented a letter from her doctor stating that smoking marijuana had more effectively relieved Ms. Delli's pain than prescription drugs.[121] Ms. Delli pled guilty to marijuana possession before the Circuit Court of Maryland for Frederick County and received the section 5-601(c)(3) sentence of a $100 fine, all of which the court suspended.[122]

2. *State v. York*

More than five years passed before another Maryland defendant received a section 5-601(c)(3) mitigated sentence. *State v. York*,[123] a case in Montgomery County, involved a fifty-six-year-old man with extreme gastrointestinal problems.[124] Mr. York had exhausted his medical options and found that marijuana was the best treatment for his severe nausea and cyclic vomiting.[125] While the Montgomery County Police Department was conducting routine mail investigations, officers observed a suspicious package.[126] A dog

118. *See supra* note 114 and accompanying text; *see also infra* notes 119–22 and accompanying text.

119. *Circuit Court of Maryland, Case Information: State v. Delli*, MD. JUDICIARY CASE SEARCH, http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp (click terms and conditions box; click continue; select Frederick County Circuit Court in the "Court" query; enter 10K04034273 in the "Case Number" query; then click "Get Case") (last updated Oct. 12, 2010) (Case No. 10K04034273, Md. Cir. Ct. Frederick Cnty. filed Jan. 14, 2004). The police arrested Ms. Delli on November 12, 2003. *Id.*

120. *Woman Gets Probation in Medicinal Marijuana Case*, WTOP.COM (Mar. 31, 2005, 6:32 AM), http://www.wtopnews.com/index.php?sid=187418&nid=25.

121. *Id.*

122. *Circuit Court of Maryland, Case Information: State v. Delli*, MD. JUDICIARY CASE SEARCH, *supra* note 119.

123. *Circuit Court of Maryland, Case Information: State v. York*, MD. JUDICIARY CASE SEARCH, http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp (click terms and conditions box; click continue; select Montgomery County Circuit Court in the "Court" query; enter 6D00206387 in the "Case Number" query; then click "Get Case") (last updated Oct. 9, 2008) (Case No. 6D00206387, Md. Cir. Ct. Montgomery Cnty. filed Jan. 8, 2008).

124. Memorandum in Aid of Sentencing at 1–2, State v. York, No. 111489 (Md. Cir. Ct. Montgomery Cnty. Aug. 27, 2009).

125. *Id.* at 5.

126. Statement of Probable Cause at 1, State v. York, Local Incident No. 6D00206387 (Md. Cir. Ct. Montgomery Cnty. Feb. 8, 2008.

trained to smell drugs alerted the officers that there were drugs inside the package, which contained twenty-two vials of marijuana.[127] The officers visited the recipient's address and asked Mr. York if he was expecting a package.[128] Mr. York replied that he was, accepted the package, and went back inside.[129] After a struggle, the officers arrested Mr. York and obtained a search warrant for his home.[130] They located marijuana and drug paraphernalia, including items that indicated that Mr. York was growing marijuana.[131]

The State charged Mr. York with several CDS violations: possession, possession with intent to distribute, and possession of CDS production equipment.[132] The District Court of Maryland for Montgomery County convicted Mr. York of possessing marijuana, sentenced him to supervised probation for nine months and twenty-five hours of community service, and instructed Mr. York to submit to alcohol and drug testing when required to do so.[133] The fines, costs, and fees of Mr. York's trial totaled over $1,300, not including his attorney's fees.[134]

Mr. York appealed his case to the Circuit Court for Montgomery County.[135] At his June 2009 trial, he asserted the medical necessity statute and presented medical records and two doctors' notes at his sentencing hearing, which stated that he suffered from cyclic

127. *Id.*

128. *Id.*

129. *Id.* at 1–2.

130. *Id.*.

131. *Id.* at 2.

132. Charge Summary at 1, State v. York, No. 6D00206387 (Md. Cir. Ct. Montgomery Cnty. Feb. 8, 2008). The maximum penalties for these charges are as follows: CDS possession (marijuana)—up to one year incarceration, and/or $1,000 fine; CDS possession with intention to distribute—felony, up to five years incarceration and/or $15,000 fine; CDS production equipment—felony, up to five years incarceration and/or a $15,000 fine. *Id.*

133. Defendant Trial Summary at 1, State v. York, No. 6D00206387 (Md. Dist. Ct. Oct. 7, 2008); Defendant Probation Summary, State v. York, No. 6D00206387 (Md. Dist. Ct. Oct. 7, 2008).

134. *Id.*; *see also infra* note 180 and accompanying text (discussing prices of representation for drug charges).

135. *Circuit Court of Maryland, Case Information: State v. York*, MD. JUDICIARY CASE SEARCH, http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp (click terms and conditions box; click continue; select Montgomery County Circuit Court in the "Court" query; enter 111489C in the "Case Number" query; then click "Get Case") (last updated Jan. 27, 2010) (Case No. 111489C, Md. Cir. Ct. Montgomery Cnty. filed Oct. 22, 2008).

vomiting syndrome.[136] Mr. York's condition involved extreme nausea and vomiting that could last for hours or days and was not effectively treatable with other medication.[137] Mr. York also spoke of the difficulties of buying illegal, unregulated marijuana, stating "I've been robbed a couple of times. The quality of the cannabis is suspect."[138] The circuit court affirmed Mr. York's conviction, but reduced his sentence under section 5-601(c)(3) to a $100 fine plus costs, without probation, community service, or subsequent drug testing.[139]

3. *State v. Gesumwa*

On the same day in 2009 as Mr. York's trial and in the same court, Winnie Gesumwa raised section 5-601(c)(3) as a defense in her marijuana case.[140] Montgomery County police arrested Ms. Gesumwa after a neighbor reported smelling marijuana.[141] Ms. Gesumwa's purse contained seventeen small plastic bags filled with marijuana.[142] The State charged Ms. Gesumwa with marijuana possession, possession with the intent to distribute, and with possession of CDS paraphernalia.[143] The district court forwarded the case to the Circuit Court for Montgomery County, where Ms. Gesumwa was convicted.[144]

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136. Dan Morse, *Medical Marijuana Finds a Mellow Audience in Md.: In State That's Shown Leniency, Advocates Push Legislation for Some Cases*, WASH. POST, Sept. 3, 2009, at A1, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/09/02/AR2009090203878.html.

137. *Id.*

138. *Id.*

139. Criminal Sentencing, State v. York, No. 111489C (Md. Cir. Ct. Montgomery Cnty. Aug. 27, 2009).

140. Morse, *supra* note 136, at A1.

141. *See* Statement of Probable Cause at 1, State v. Gesumwa, No. 2D00225332 (Md. Dist. Ct. Feb. 25, 2009).

142. *Id.* at 2.

143. Charge Summary, State v. Gesumwa, No. 2D00225332 (Md. Dist. Ct. Montgomery Cnty. Feb. 25, 2009).

144. *District Court of Maryland, Case Information: State v. Gesumwa*, MD. JUDICIARY CASE SEARCH, http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp (click terms and conditions box; click continue; select Frederick County Circuit Court in the "Court" query; enter 2D00225332 in the "Case Number" query; then click "Get Case") (last updated Apr. 6, 2009) (Case No. 2D00225332, Md. Dist. Ct. Montgomery Cnty. filed Feb. 25, 2009); *Circuit Court of Maryland, Case Information: State v. Gesumwa*, MD. JUDICIARY CASE SEARCH, http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp (click terms and conditions box; click continue; select Frederick County Circuit Court in the "Court"

Before that court, Ms. Gesumwa, a native of Kenya and a Canadian citizen, presented testimony that she began suffering from grand mal seizures and convulsions when she was three years old.[145] After being diagnosed with epilepsy at age twelve, her doctors prescribed the epilepsy medication Depakote.[146] The drug's side effects caused Ms. Gesumwa to experience sudden weight changes, migraines, and nausea.[147] Ms. Gesumwa subsequently found that marijuana effectively controlled her epilepsy without side effects, and explained that to reduce her risk of being caught, she bought marijuana less often but in large quantities.[148] At a disposition hearing, the circuit court found Ms. Gesumwa guilty of CDS possession, but using section 5-601(c)(3), sentenced her to the $100 fine (which the court suspended), and waived the costs.[149]

4. *State v. Steagall*

In August 2009, police arrested twenty-year-old James Steagall while he was sitting in a vehicle after an officer saw a marijuana cigarette being hand-rolled.[150] The officer searched the occupants of the vehicle and found a small bag of marijuana in Mr. Steagall's sock.[151] The State charged Mr. Steagall with possessing marijuana.[152] At his December 2009 trial, Mr. Steagall pled guilty and presented a letter from his psychiatrist stating that Mr. Steagall suffered from bipolar disorder and that the psychiatrist prescribed Mr. Steagall several medications to treat this condition.[153] The psychiatrist also wrote in the letter that Mr. Steagall had previously stated that only marijuana successfully calmed his severe anxieties.[154] While the psychiatrist's letter did not affirmatively endorse marijuana use, Mr.

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query; enter 112669C in the "Case Number" query; then click "Get Case") (last updated Oct. 16, 2009) (Case No. 112669C, Md. Cir. Ct. Montgomery Cnty. filed Apr. 2, 2009).

145. Morse, *supra* note 136, at A1.

146. *Id.*

147. *Id.*

148. *Id.*

149. Criminal Plea Hearing, State v. Gesumwa, No. 2D00225332 (Md. Dist. Ct. Montgomery Cnty. Aug. 27, 2009).

150. Statement of Probable Cause, State v. Steagall, No. 0T00066430 (Md. Dist. Ct. Howard Cnty. Aug. 5, 2009).

151. *Id.* at 1–2.

152. *Id.* at 2.

153. Telephone Interview with Alex Foster, Attorney, Alex Foster, LLC (Feb. 23, 2010). Alex Foster, Esq. represented John Steagall in *State v. Steagall* and Winnie Gesumwa in *State v. Gesumwa*. *See id.*

154. *Id.*

Steagall argued that section 5-601(c)(3) sentencing was appropriate in his case.[155] The district court agreed that Mr. Steagall's using marijuana to treat bipolar disorder satisfied medical necessity and sentenced him to a $100 fine, plus court costs.[156]

C. Problems with Section 5-601(c)(3) and Its Application

While the Maryland legislature drafted section 5-601(c)(3) as a compromise between federal laws and relief for sick individuals,[157] the statute suffers from several fundamental issues. First, Maryland provides no standards regarding to whom the law applies because the legislature did not define (and the courts have not defined) "medical necessity."[158] Second, patients using medical marijuana and their caregivers remain vulnerable to repeated arrests and convictions.[159] Third, the statute fails to provide medical marijuana patients a safe means of access to the drug.[160] In combination, these problems render Maryland's medical marijuana law an inadequate solution to a serious problem.

1. To Whom Should the Law Apply?

Maryland's law does not sufficiently protect people with chronic or debilitating medical conditions because neither judges, attorneys, nor patients know a uniform standard that the court will use in applying the statute. The trial courts of Maryland have decided this handful of cases on an ad-hoc basis that might rest solely on the judge's sympathy toward the defendant. *State v. Steagall*[161] is especially distinctive as the defendant had bipolar disorder, a malady left untouched by all of the fifteen medical marijuana states.[162] While bipolar disorder is certainly serious and deserving of effective treatment—and this author would argue that the court decided *State v. Steagall*[163] correctly because the disorder is indeed debilitating to some sufferers—the majority of states do not address mental

155. *Id.*
156. Defendant Trial Summary, State v. Steagall, No. 0T00066430 (Md. Dist. Ct. Howard Cnty. Dec. 11, 2009).
157. *See supra* notes 110–11 and accompanying text.
158. *See infra* Part III.C.1.
159. *See infra* Part III.C.2.
160. *See infra* Part III.C.3.
161. *See supra* Part III.B.4.
162. *See supra* Table 1.
163. *See supra* Part III.B.4.

illness.[164] While some Maryland judges would consider bipolar disorder "evidence of medical necessity," it is likely that many other judges would not.[165] The legislature should affirmatively decide what illnesses Maryland's law covers instead of leaving the decision to individual trial court judges who set no binding legal precedent for other judges to follow. Courts cannot apply section 5-601(c)(3) consistently and predictably absent a list of qualifying diseases and conditions.

Maryland's definition of medical necessity remains vague because the only appellate court with the opportunity to discuss medical necessity in relation to medical marijuana use declined to define it. In *Jefferson v. State*,[166] Maryland charged the defendant with possession of marijuana and drug paraphernalia.[167] While Jefferson did not claim to suffer from any medical condition, he argued at trial and on appeal that by enacting the Darrell–Putman Compassionate Use Act, the Maryland General Assembly recognized that marijuana "has at least some accepted medical use," and that by not rescheduling marijuana, the current classification was "'arbitrary and unreasonable.'"[168] Looking to the legislature's intent, the Maryland Court of Special Appeals rejected this argument because medical marijuana, even when used for medical necessity, remained illegal under the Act.[169]

The court completely avoided the question of to whom section 5-601(c)(3) applied by stating in *Jefferson*:

> It is not necessary to determine the meaning of "medical necessity" to resolve this case [because Jefferson does not seek sentence mitigation]. Other [states], however, have considered "medical necessity" when it has been raised as a defense in possession of marijuana cases . . . requir[ing] that harm be imminent and that there [be] no legal alternatives to its use."[170]

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164. *See supra* Table 1. Michigan, Oregon, and Rhode Island extend medical marijuana coverage to patients with Alzheimer's disease. California protects medical marijuana patients suffering from anorexia. *See supra* Table 1.

165. *See supra* text accompanying note 117.

166. 164 Md. App. 330, 883 A.2d 251 (2005).

167. *Id.* at 332, 883 A.2d at 252.

168. *Id.* at 333, 883 A.2d at 252 (quoting appellant).

169. *Id.* at 335–36, 883 A.2d at 254.

170. *Id.* (emphasis omitted) (referring to cases in Idaho, Florida, and federal court). Maryland's highest court, the Court of Appeals, considered the common law defense of necessity in a case involving trespass upon an abortion clinic's property. Sigma

While the Court of Special Appeals did not adopt the other jurisdictions' definition of medical necessity, Maryland defense attorneys have nothing else to employ as a model when structuring their legal arguments (Mr. York's attorney actually used this exact language in his Memorandum in Aid of Sentencing in *State v. York*).[171] However, the medical necessity standard is unsuitable for medical marijuana use because marijuana does not usually rescue a sick person from imminent harm in the same way, for example, that a late-term abortion, otherwise illegal under state law, might be medically necessary to save the life of the mother.[172] Physicians usually recommend medical marijuana to prevent or suppress pain, muscle spasticity, nausea, and to encourage weight gain, as well as a few other uses.[173] Using marijuana to address these medical issues would not prevent "imminent harm," but these debilitating, life-impacting maladies still deserve redress. Medical necessity is not an appropriate standard for medical marijuana; many conditions for which a physician might validly recommend marijuana would simply not meet its requirements.

While the General Assembly clearly recognized the injustice in forcing people to choose between their health and a year of incarceration, a $1,000 fine, or both,[174] Maryland's current law still gives patients nothing upon which to rely. The Court of Special Appeals has stated that the statute does not absolve the defendant of

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Reprod. Health Ctr. v. State, 297 Md. 660, 467 A.2d 483 (1983). The court rejected the defendant's argument that "sav[ing] the life of unborn fetuses" and "protect[ing] the health and well-being" of abortion-seeking mothers justified the trespass. *Id.* at 663, 467 A.2d at 484. In examining the common law standard, the court referred to a hornbook stating that the defense of necessity arises "'[i]f a choice exists but only between two evils, one of which is the commission of a prohibited act, and the emergency was not created by the wrongful act of any other person.'" *Id.* at 677, 467 A.2d at 491 (quoting ROLLIN M. PERKINS, CRIMINAL LAW 956–61 (2d ed. 1969)). Additionally, in 1970, the Court of Special Appeals held that the defense of necessity did not apply to charges of heroin possession because "in a prosecution for an offense not requiring intent [such as CDS possession] . . . necessity is not available, at least where the defendant could have avoided the emergency by taking advance precautions." Frasher v. State, 8 Md. App. 439, 448–49, 260 A.2d 656, 662 (1970).

171. *See* Memorandum in Aid of Sentencing at 2, State v. York, No. 111489 (Md. Cir. Ct. Montgomery Cnty. Aug. 31, 2009). *See generally supra* Part III.B.2 (discussing *State v. York*).

172. *See* Stenberg v. Carhart, 530 U.S. 914 (2000).

173. *See supra* Table 1.

174. *See supra* note 104.

guilt,[175] and it has taken a hands-off approach to establishing to whom the law should apply.[176] These mixed messages are the heart of the problem within section 5-601(c)(3) and its application. Maryland comforts the ailing with one hand while arresting them with the other, and then refuses to identify who is eligible for section 5-601(c)(3) sentencing in the first place.

2. Exposure to Arrest and Conviction

Section 5-601(c)(3) leaves medical marijuana patients vulnerable to arrest and conviction and does not place a limit on repeat arrests and convictions despite a previous judicial finding of medical necessity. At first glance, a $100 fine under section 5-601(c)(3) sentencing seems negligible, but just getting to that fine is expensive. A flat rate for legal services in cases like those discussed above can cost around $1,000 to $1,500, not taking into account that two of those cases were heard on appeal at the circuit court level, probably doubling or tripling the attorney's original fee for representation.[177]

Additionally, if they continue to use marijuana, the above defendants, who the courts determined were all worthy of section 5-601(c)(3) sentencing,[178] all remain vulnerable to arrest and re-conviction despite the courts' and their doctors' beliefs that medical need existed for their using marijuana. Indeed, the statute sets no affirmative limit as to how many times the State may convict a medical user.[179]

However, even if the police never arrest these four individuals again, their convictions remain inequitable. Beyond the $100 fine, the consequences of a CDS conviction are vast.[180] Criminal background checks are ubiquitous when it comes to applying for a

175. Jefferson v. State, 164 Md. App. 330, 340, 883 A.2d 251, 256 (2005) ("The [Darrell–Putman Compassionate Use] Act does not create a statutory [affirmative] defense . . . .").

176. *See supra* text accompanying notes 166–73.

177. Telephone interview with James E. Farmer, Associate, Farmer & Pyles, P.A. (Jan. 11, 2010). James E. Farmer, Esq. is a criminal defense attorney who works primarily in southern Maryland and routinely represents defendants in marijuana possession cases. *See id.*

178. *See supra* Part III.B.1–4.

179. *See* MD. CODE ANN., CRIM. LAW § 5-601(c) (LexisNexis 2002 & Supp. 2009).

180. *See* Karen Aho, *What Illegal Drug Use Can Cost You*, MSN MONEY (Sept. 4, 2008), http://articles.moneycentral.msn.com/CollegeAndFamily/Advice/WhatIllegalDrugUseCanCostYou.aspx?page=1&f=255&MSPPError=-2147217396; *see also* ROBIN LEVI & JUDITH APPEL, DRUG POLICY ALLIANCE, COLLATERAL CONSEQUENCES: DENIAL OF BASIC SOCIAL SERVICES BASED UPON DRUG USE (2003), *available at* http://www.drugpolicy.org/docUploads/Postincarceration_abuses_memo.pdf.

job, renting an apartment, adopting a child,[181] or even signing up for an online dating website.[182] Additionally, the Higher Education Act[183] renders students convicted of a drug offense ineligible for further financial aid or work–study for a number of years or, upon a third offense, indefinitely.[184] The Denial of Federal Benefits Program[185] allows judges to deny those with drug convictions federal grants, contracts, and licenses,[186] and the Welfare Reform Act[187] gives states the option to ban drug offenders for life from receipt of food stamps and cash assistance.[188] Some property owners draft leases that enable eviction upon a tenant's illegal drug use on the premises.[189] Noncitizens convicted of drug offenses are even subject to deportation from the United States.[190] While Maryland attempts to be lenient to medical marijuana patients in sentencing, it overlooks the fact that a drug conviction still affects the defendant's life in countless other ways.

Finally, an arrest itself can become dangerous when dealing with law enforcement that crosses lines of safety and common sense. As paramilitary style police divisions become more popular, police departments have been heavily criticized for no-knock raids.[191] Some raids have occurred on the wrong house and others have involved excessive force; inhabitants of a house being raided might also

181. Aho, *supra* note 180.

182. *See Safer Dating Guidelines*, TRUE, http://www.true.com/magazine/safer dating_prosecute.htm?svw=global (last visited Dec. 13, 2010). The online dating service TRUE, for example, distinguishes its product by screening its members for felony and sexual offense convictions before allowing communications between members. *See id.*

183. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 8021(c), 120 Stat. 4 (codified as amended in scattered sections of 20 U.S.C.).

184. 20 U.S.C. § 1091(r) (2006).

185. 21 U.S.C. § 862 (2006).

186. *Id.* § 862(b)(1)(A)–(B), (d)(1)(A).

187. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C.).

188. 21 U.S.C. § 862a.

189. Aho, *supra* note 180.

190. 8 U.S.C. §§ 1227(a)(2)(B), 1182(a)(2)(C) (2006). Over 11,000 noncitizens have been deported for a marijuana possession conviction. *Forced Apart (by the Numbers)*, HUMAN RIGHTS WATCH (Apr. 15, 2009), http://www.hrw.org/sites/default/files/related_material/forced_apart_charts_final.pdf.

191. *See* William Booth, *Exploding Number of SWAT Teams Sets Off Alarms: Critics See Growing Role of Heavily Armed Police Units as 'Militarization' of Law Enforcement*, WASH. POST, June 17, 1997, at A1; Radley Balko, *No SWAT*, SLATE (Apr. 6, 2006), http://www.slate.com/id/2139458.

misconstrue the raid as a break-in and mistakenly respond to the police with force.[192] In Mr. York's situation, where he possessed large amounts of marijuana,[193] the police easily could have chosen to involve a SWAT team. A patient registry would prevent medical marijuana patients from encountering some of the risks of drug raids by notifying law enforcement that these individuals possess marijuana legally.

Section 5-601(c)(3) falls short of protecting medical marijuana patients despite the relief defendants may feel initially by avoiding jail or burdensome fines. However, it is not only unfair to make patients go through the arrest and trial process just so the State can collect a $100 fine, it is an inefficient use of Maryland's police and court resources. Both citizens and the government would benefit from a patient registry and identification system that would clearly distinguish medical marijuana patients from other, illegal drug users. That section 5-601(c)(3) sentencing is essentially a slap on the wrist indicates that the Legislature does not view medical marijuana patients as a serious addition to Maryland crime. One should question, then, why the State bothers investigating, arresting, and prosecuting medical marijuana patients in the first place.

3. Safe Access to Marijuana as Medicine

The correlation between Baltimore's violence and the fact that Maryland has one of the country's biggest drug problems cannot be ignored.[194] The streets are certainly not the ideal place for the ill to find medicine. In 2009, Baltimore was America's tenth most dangerous city,[195] and Baltimore is plagued by its booming "informal

192. Balko, *supra* note 191. The Howard County Police Department's SWAT team entered a home unannounced in January 2008. The couple's dog charged the police, who shot and killed the dog. The police arrested the couple and found marijuana and paraphernalia on a visitor in their home who admitted to owning the drugs. The search warrant was facially defective, however, as the people it identified were not even associated with the address. It was not until the couple filed an excessive force complaint against the police department that the police charged them with marijuana possession. *Couple Files Lawsuit After Raid on Home*, WBAL (July 27, 2009), http://www.wbaltv.com/news/20193414/detail.html.

193. *See supra* Part III.B.2.

194. *See infra* Table 2 and note 201.

195. Zack O'Malley Greenburg, *In Pictures: America's Most Dangerous Cities*, FORBES.COM (Apr. 23, 2009), http://www.forbes.com/2009/04/23/most-dangerous-cities-lifestyle-real-estate-dangerous-american-cities_slide_7.html. The Baltimore metropolitan area had 791 violent crimes per 100,000 people in 2008. *Id.* Violent crimes include murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault. *Id.*

economy," estimated to be just below $1 billion.[196] This translates to drug revenue occupying almost the same amount of space on a pie chart as revenue from all of Baltimore's hotels and restaurants.[197] Per capita, Maryland is ranked second nationally in drug abuse violations,[198] and in raw numbers, Maryland is seventh in drug abuse violations, surpassing many states that are significantly larger and more populous.[199] It is no secret that Baltimore is home to violent gangs that feed off drug dealing.[200]

196. Edward Ericson, Jr., *Shadow Players: Drilling Down into Baltimore's Billion-Dollar "Informal Economy,"* CITY PAPER (Baltimore), Jan. 28, 2009, at 12, *available at* http://www.citypaper.com/news/story.asp?id=17425. The "informal economy" relates to unregulated economic activity in general, not just marijuana sales. *See* SOC. COMPACT, INC., BALTIMORE NEIGHBORHOOD MARKET DRILLDOWN: CATALYZING BUSINESS INVESTMENT IN INNER-CITY NEIGHBORHOODS 17 (Oct. 2008).

197. *See* 2007 Economic Census: Accommodations & Food Services, U.S. CENSUS BUREAU (June 18, 2010), http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=D&-ds_name=EC0772A1&-_Lang=en (click "Filter Rows: by geography"; select "economic place"; select "Maryland"; add "Baltimore City"; click "Show Result").

198. *See infra* Table 2 and note 201. In total drug abuse violations, California is first, followed by Florida, Texas, New York, Pennsylvania, New Jersey, and then Maryland. *See infra* note 202.

199. *See infra* Table 2 and note 202.

200. *See* Detective Edward Burns, *Gang- and Drug-Related Homicide: Baltimore's Successful Enforcement Strategy*, NAT'L CRIM. JUST. REFERENCE SERVICE (July 2003), http://www.ncjrs.gov/html/bja/gang/pfv.html ("In Baltimore, the [efforts of gangs are] directed toward distributing narcotics or providing support services for the drug trade, which may include murder for hire. . . . Baltimore gangs control drug distribution from street-level consumption to bulk wholesale.").

Table 2: 2009 Arrests[201]					
State	Estimated population	Total crime	Drug abuse violations[202]	Drug abuse violations per 100,000 people	Drug abuse violations as % of total crime
Illinois[203]	3,006,374	157,242	43,536	1,448.12	27.69%
Maryland	5,674,380	283,407	51,629	909.86	18.22%
Florida	18,514,171	1,049,817	146,056	788.89	13.91%
California	36,772,788	1,474,004	251,740	684.58	17.08%
New York[204]	10,719,319	347,436	60,543	564.80	17.43%
U.S. Average	258,354,142	11,782,558	1,451,1264	511.21	12.32%

Because the effects of marijuana wear off after one to three hours,[205] medical marijuana patients who want to control their symptoms continuously will consume large amounts of the drug. Therefore, medical marijuana patients are going to be buying either

201. These statistics were adapted from data published by the Federal Bureau of Investigation. *See Crime in the United States, 2009: Table 69, Arrests by State,* FED. BUREAU OF INVESTIGATION (Sept. 2010), http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2009. The states in this table are only representative of the "top five" states in drug abuse violations as percentage of total crime, not the top five in every listed category.

202. Drug abuse violations include "[t]he unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of[:] . . . opium or cocaine and their derivatives (morphine, heroin, codeine); marijuana; . . . manufactured narcotics that can cause true addiction (demerol, methadone); and dangerous non-narcotic drugs (barbiturates, benzedrine)." FED. BUREAU OF INVESTIGATION, CRIME IN THE UNITED STATES, 2009, OFFENSE DEFINITIONS (Sept. 2010), http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2009.

203. Illinois' numbers are probably higher because only Chicago and Rockford reported arrest data in accordance with Uniform Crime and Reporting guidelines. *See* FED. BUREAU OF INVESTIGATION, CRIME IN THE UNITED STATES, 2009, METHODOLOGY, ARREST DATA CONSIDERATIONS (Sept. 2010), http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2009.

204. New York's numbers are probably higher because New York City did not provide arrest data. *See id.*

205. NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. 05-3859, RESEARCH REPORT SERIES: MARIJUANA ABUSE 3 (July 2005), *available at* http://www.nida.nih.gov/researchreports/marijuana/Marijuana3.html.

large quantities of marijuana or small amounts on a frequent basis.[206] Moreover, drug dealers are notoriously unreliable, creating the need to have several suppliers as options for some medical marijuana patients. However, this remains a network that an individual interested in their safety would not want to foster.[207]

Additionally, when buying street drugs, there is always the question of quality and safety.[208] In the last few years, the DEA has seized marijuana containing pool chlorine, MDMA (ecstasy), and morphine.[209] Medical marijuana patients need access to marijuana that does not originate from individuals who are unreliable at best and dangerous at worst.[210] They also need the drug itself to be transparent in content. Maryland could accomplish this by allowing patients and their caretakers to grow marijuana themselves or by establishing dispensaries where patients could buy marijuana safely in its usable form.

The other, and probably most concerning danger to medical marijuana patients comes from the law itself in the forms of arrest and incarceration. Some may assume that police focus on "hard" drugs and on drug dealers, but the numbers indicate otherwise. In southern states like Maryland, the vast majority (83.6%) of CDS arrests are for possession, not for selling drugs.[211] A slim majority (50.2%) of all possession arrests in the South are for marijuana, not for "hard" drugs.[212] In contrast, marijuana dealers comprise only 4.3% of all CDS manufacturing and sales arrests.[213] Medical marijuana patients should not be perceived as safe from the law under the assumption that police focus on drug dealers and on those who use hard drugs.

206. *See, e.g., supra* text accompanying notes 148, 151.
207. *See supra* text accompanying note 200.
208. *See, e.g., supra* text accompanying note 138.
209. *See* Drug Enforcement Admin., U.S. DEP'T OF JUSTICE, *Microgram Bulletin* No. 12 (Dec. 2006), *available at* http://www.justice.gov/dea/programs/forensics ci/microgram/bulletins_index.html (follow Dec. 2006; May 2008; and Feb. 2009 hyperlinks).
210. *See supra* note 200 and accompanying text.
211. *Crime in the United States, 2008: Arrests for Drug Abuse Violations: Percent Distribution by Region,* FED. BUREAU OF INVESTIGATION (Sept. 2009), http://www.fbi.gov/ucr/cius2008/arrests/index.html.
212. *Id.*
213. *Id.*

Table 3: CDS Arrests by Region 2008[214]				
Region	CDS Arrests for Sales/Mfg.	CDS Arrests for Possession	Marijuana Sales/Mfg. Arrests as Percentage of All CDS Sales/Mfg. Arrests	Marijuana Possession Arrests as Percentage of All CDS Possession Arrests
West	16.1%	83.9%	5.4%	33.2%
South (MD)	16.4%	83.6%	4.3%	50.2%
Midwest	19.3%	80.7%	8.2%	51.9%
Northeast	22.1%	77.9%	5.9%	46.5%
All Regions	17.7%	82.3%	5.5%	44.3%

Arrest and defending a criminal trial are burdensome and far-reaching events by themselves.[215] However, because attorneys rarely raise section 5-601(c)(3),[216] individuals with legitimate medical reasons may still face traditional marijuana possession sentencing instead of the $100 fine.[217] Alternatively, because the statute is discretionary and so poorly written, some judges may find that a defendant's medical condition is an appropriate one for section 5-601(c)(3) sentencing while other judges may disagree. Those convicted of marijuana possession in Maryland can serve up to one year of incarceration,[218] and if convicted of CDS possession with intent to distribute, up to five years,[219] which may be the case for patients that buy large quantities of marijuana.[220]

Nationally, state courts sentence sixty-three percent of defendants to incarceration whose most serious conviction offense is drug possession[221] for an average length of twelve months.[222] Of those

214. *Id.*
215. *See supra* Part III.C.2.
216. *See supra* Part III.B.
217. The defendants discussed *supra* in Part III.B, who were all found guilty of possessing marijuana, could have faced traditional marijuana sentencing had the presiding judges found their medical conditions insufficient to satisfy section 5-601(c)(3) sentencing.
218. MD. CODE ANN., CRIM. LAW § 5-601(c)(2) (LexisNexis 2002).
219. *Id.* § 5-607(a). Maryland mandates a minimum sentence of two years for repeat offenders of section (a). *Id.* § 5-607(b)(1).
220. *See supra* note 148 and accompanying text.
221. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, tbl.1.2, FELONY SENTENCES IN STATE COURTS, 2006 STATISTICAL TABLES (2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/fssc06st.pdf.
222. *Id.* at tbl.1.3.

convicted of drug trafficking (sales, distribution, and manufacturing), sixty-seven percent receive incarceration sentences.[223] Maryland taxpayers pay about $25,000 per inmate for each year of jail time.[224]

American correctional facilities are rife with violence, abuse, rape, disease, and illness, and are without external monitoring or oversight, further detracting from the safety of these facilities.[225] Medical care in penal institutions is negligible due to small budgets and overwhelming inmate-to-doctor ratios.[226] Incarceration is not a risk medical marijuana patients should have to face in the event that they do not receive section 5-601(c)(3) sentencing.

Maryland does not provide its afflicted residents with any means of safely accessing marijuana for medical purposes. Instead, the law exposes them to the dangers of buying marijuana of uncertain quality and content from drug dealers, and to the consequences of arrest and incarceration.[227] While it is obvious that the 2003 General Assembly intentionally omitted legal access to the drug, Maryland must move forward in protecting the ill from these dangers and provide a safe way for patients to possess and procure marijuana for medical purposes.

IV. MAKING IMPROVEMENTS TO MARYLAND'S LAW

A. 2009: House Bill 1339

In February 2009, Maryland took its first step since 2003 toward establishing a logical and compassionate medical marijuana policy. Delegate Henry Heller introduced House Bill 1339, which proposed forming the Task Force to Study Issues Relating to Medical Marijuana in Maryland.[228] Under the bill, the task force was to study whether purchasing marijuana on recommendation of a health care provider should be legal in Maryland; whether the current law, section 5-601(c)(3), was effective, fair, and equitably applied across all jurisdictions in the state; and whether section 5-601(c)(3) gives

223. *Id.* at tbl.1.2.

224. Dan Rodricks, *Sometimes, Jail Time Is Just Useless*, BALT. SUN, Mar. 3, 2009, at 2, *available at* http://articles.baltimoresun.com/2009-03-03/news/0903020059_1_hiring-ex-offenders-prison-i-hear/2.

225. *See* JOHN J. GIBBONS & NICHOLAS DE B. KATZENBACH, VERA INST. OF JUSTICE, CONFRONTING CONFINEMENT 21 (2006), *available at* http://www.prisoncommission.org/pdfs/Confronting_Confinement.pdf.

226. *See id.* at 13.

227. *See supra* Part III.C.2.

228. H.D. 1339, 2009 Leg., 426th Sess. (Md. 2009), *available at* http://www.mlis.state.md.us/2009rs/bills/hb/hb1339f.pdf.

residents using medical marijuana a false sense of legality or reliance.[229] The bill also proposed that the task force study how and where Maryland patients could legally procure "good quality" marijuana.[230] Last, the task force was to evaluate having Johns Hopkins University School of Medicine and University of Maryland School of Medicine establish research programs devoted to the medical and social issues surrounding medical marijuana.[231] The bill dictated that after the studies, the task force would recommend whether repealing the current statute (or, assumedly, improving it) was appropriate.[232]

However, because House Bill 1339 required money from the Maryland Department of Health and Mental Hygiene (DHMH) to staff the task force,[233] the bill died in Committee with the General Assembly citing the state's "fiscal difficulties" and constrained agency budgets.[234]

B. 2010: House Bill 712 and Senate Bill 627

On February 4, 2010, Delegate Dan Morhaim introduced House Bill 712,[235] Maryland's next attempt at improved medical marijuana legislation. The next day, Senators David Brinkley and Jamie Raskin introduced the identical Senate Bill 627.[236] While 2009's House Bill 1339 only proposed research to determine whether future action regarding medical marijuana was appropriate,[237] the 2010 bills proposed taking substantial measures to protect medical marijuana patients immediately.[238]

House Bill 712 and Senate Bill 627 would have allowed Maryland physicians to recommend marijuana to patients suffering from

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229. *Id.* § 1(f)(1)–(2).
230. *Id.* § 1(f)(4).
231. *Id.* § 1(f)(5).
232. *Id.* § 1(g).
233. *Id.* § 1(d).
234. H.D. 1339, 2009 Leg., 426th Sess. (Md. 2009) (Fiscal and Policy Note), *available at* http://mlis.state.md.us/2009rs/fnotes/bil_0009/hb1339.pdf.
235. H.D. 712, 2010 Leg., 427th Sess. (Md. 2010), *available at* http://mlis.state.md.us/2010rs/bills/hb/hb0712f.pdf.
236. S. 627, 2010 Leg., 427th Sess. (Md. 2010), *available at* http://mlis.state.md.us/2010rs/billfile/SB0627.htm; WELCOME TO THE MARYLAND GENERAL ASSEMBLY, http://mlis.state.md.us/#gena (last visited Dec. 13, 2010).
237. *See supra* Part IV.A.
238. H.D. 712, 2010 Leg., 427th Sess. (Md. 2010), *available at* http://mlis.state.md.us/2010rs/bills/hb/hb0712f.pdf; S. 627, 2010 Leg., 427th Sess. (Md. 2010), *available at* http://mlis.state.md.us/2010rs/bills/sb/sb0627t.pdf.

chronic or debilitating medical conditions.[239] The bills specifically included conditions that display cachexia,[240] severe or chronic pain, severe nausea, seizures, or muscle spasms.[241] However, the bills would also have allowed for medical discretion by stating that doctors may recommend marijuana to a patient with "any other condition that is severe and resistant to conventional medicine."[242] The recommending physician was to provide a written certification stating that

> In the physician's professional opinion, after having completed a full assessment of the patient's medical history and current medical condition, the patient has a debilitating medical condition for which recognized drugs or treatments would not be effective; and [t]he potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient.[243]

This certification was more specific than, but also very similar to, most other medical marijuana states' physician certifications.[244]

Patients could have obtained physician recommendations[245] providing for thirty-day supplies of marijuana not to exceed two

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239. Md. H.D. 712 § 13-3004; Md. S. 627 § 13-3004.

240. Also called "wasting syndrome," weight loss and muscle atrophy characterize cachexia, which often accompanies cancer and AIDS. *Community Oncology and Prevention Trials*, NAT'L INST. OF HEALTH PROJECT REP. http://projectreporter.nih.gov/project_info_description.cfm?aid=7479572&icde=5555381 (last visited Dec. 13, 2010).

241. Md. H.D. 712 § 13-3001(D)(1)–(5); Md. S. 627 § 13-3001(D)(1)–(5).

242. Md. H.D. 712 § 13-3001(D)(6); Md. S. 627 § 13-3001(D)(6). The bills did not elaborate on the meaning of "resistant to conventional medicine," which could have become a source of ambiguity. *See* Md. H.D. 712; Md. S. 627.

243. Md. H.D. 712 § 13-3004(A)(2)(II)(1)–(2); Md. S. 627 § 13-3004(A)(2)(II)(1)–(2).

244. For example, Hawaii, Rhode Island, and Washington all use similar language requiring physicians to assert that the medical use of marijuana would outweigh its health risks. *See* Medical Use of Marijuana, HAW. REV. STAT. ANN. § 329-121 (LexisNexis 2008 & Supp. 2009) ("[I]n the physician's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient."); Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, R.I. GEN. LAWS § 21-28.6-4 (Supp. 2008) ("[I]n the practitioner's professional opinion, the potential benefits of the medical marijuana would likely outweigh the health risks for a patient."); WASH. REV. CODE. ANN. § 69.51A.010(5)(a) (West 2007) ("[I]n the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for a particular qualifying patient.").

ounces,[246] an amount relatively on point with other medical marijuana states' usable marijuana limits.[247]

The bills would have established a patient registry system with identification cards featuring a photo of the registrant.[248] Qualifying patients and their caregivers would have applied to the DHMH and renewed their identification cards yearly.[249] Caregivers would have to pass a criminal background check and could only care for one medical marijuana patient at a time, as designated on the patient's registration application.[250] The bills also would have employed unusual security measures such as requiring that the recommending physician have an ongoing responsibility for treatment of the patient's debilitating condition and forbidding physician treatment "limited to authorization for the patient to use medical marijuana or consultation for that purpose."[251]

The 2010 medical marijuana bills would not have allowed patients to grow their own marijuana, but instead provided for authorized growers.[252] The bills mandated that growers and their employees submit to background checks and excluded any person with a previous drug or felony conviction from working with marijuana.[253] DHMH and the Maryland Department of Agriculture would also

245. Physicians will not be able to "prescribe" marijuana until the federal government declassifies marijuana from Schedule I as physicians may not prescribe illegal drugs. *See supra* note 64 and accompanying text.

246. Md. H.D. 712; Md. S. 627. Section 13-3006(A)(1) specifically states amounts "may not exceed 2 ounces." Md. H.D. 712; Md. S. 627.

247. *See supra* note 74 and accompanying text.

248. Md. H.D. 712 § 13-3004(A)(1), (F)(1)(IV); Md. S. 627, § 13-3004(A)(1), (F)(1)(IV).

249. Md. H.D. 712 § 13-3004(H); Md. S. 627, § 13-3004(H).

250. Md. H.D. 712 § 13-3001(I)(1)(II)–(IV); Md. S. 627, § 13-3001(I)(1)(II)–(IV). The bills did not specify why caregivers could care for only one patient at a time, and this restriction could have greatly impacted the livelihood of those employed as medical attendants. *See* Md. H.D. 712; Md. S. 627.

251. Md. H.D. 712 § 13-3004(A)(2)(I)(2)–(3); S. 627 § 13-3004(A)(2)(I)(2)–(3). The definitional section of the bills described this as a "bona fide physician–patient relationship." Md. H.D. 712 § 13-3001(C); S. 627 § 13-3001(C). Maryland would not have been the only medical marijuana state to require a bona fide physician–patient relationship, however most other states do not attempt to prohibit physician shopping to the extent Maryland did. *See, e.g.*, COLO. CONST. art. XVII, § 14(2)(a)(II); ALASKA STAT. § 17.37.070(2) (2008); HAW. REV. STAT. ANN. § 329-126(3) (LexisNexis 2008); MONT. CODE ANN. § 50-46-102(II) (2009); R.I. GEN. LAWS § 1-21-28.6-3(14) (Supp. 2008). Vermont's statute does approach the Maryland bills' stringency by stating that a bona fide physician–patient relationship must exist for at least six months before the physician can recommend medical marijuana. VT. STAT. ANN. tit. 18, § 4472(1).

252. Md. H.D. 712 § 13-3002(A); Md. S. 627 § 13-3002(A).

253. Md. H.D. 712, § 13-3003(C)(1), (5); Md. S. 627 § 13-3003(C)(1), (5).

have instituted security and quality control measures upon medical marijuana growers to maintain the integrity of the program as well as the product.[254] Pharmacies and dispensaries would ultimately have sold the drug in its usable form, and the bills stated that DHMH would have reported any excessive prices to the governor annually.[255]

The bills also installed measures protective of both patient and the public. The bills would have forbidden patients from operating motor vehicles while under the influence of medical marijuana or smoking the drug in public areas.[256] Names of individuals participating in the medical marijuana program would have remained confidential (i.e., not of public record) and the bills would have precluded law enforcement from treating application for, or possession of, a registry identification card as probable cause to search the individual's person or property.[257] As a final precaution, the bills proscribed law enforcement from arresting or prosecuting non-patients for being in the vicinity or presence of a patient's medical marijuana.[258]

Despite their safeguards, the 2010 medical marijuana bills did not become law.[259] While Senate Bill 627 overwhelmingly passed 35 to 12 votes,[260] House Bill 712 died in session.[261] However, that even one Maryland legislative chamber passed a medical marijuana bill was a huge step forward. House Bill 1339 of 2009 proposed hardly any change from Darrell–Putman compared to the 2010 bills, yet still failed to receive a majority vote.[262] In comparison, Senate Bill 627 of 2010 represents the state's most robust medical marijuana legislation ever introduced and still managed to garner more support than that of a previous, less radical bill. The 2010 bill reflects the progression of Maryland's viewpoint on medical marijuana, and the momentum of Senate Bill 627 will hopefully propel Maryland's medical marijuana policy into a rational, compassionate one in the near future.

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254. Md. H.D. 712, § 13-3002(C)(2)–(3); Md. S. 627 § 13-3002(C)(2)–(3).
255. Md. H.D. 712, §§ 13-3003(A)(2), 13-3010(C)(3); Md. S. 627 §§ 13-3003(A)(2), 13-3010(C)(3).
256. Md. H.D. 712, § 13-3008; Md. S. 627 § 13-3008.
257. Md. H.D. 712, § 13-3005(B); Md. S. 627 § 13-3005(B).
258. Md. H.D. 712, § 13-3005(C); Md. S. 627 § 13-3005(C).
259. *MPP Plays Key Role in Major Progress on Medical Marijuana in 2010,* MARIJUANA POLICY PROJECT (Apr. 22, 2010), http://www.mpp.org/states/Maryland.
260. See MD. GEN. ASSEMB., Bill Info—2010 Regular Session—SB 627, http://mlis.state.md.us/2010rs/billfile/sb0627.htm (last visited Dec. 22, 2010).
261. MARIJUANA POLICY PROJECT, *supra* note 259.
262. *See supra* Part IV.A.

C. Recommendations for New Medical Marijuana Policy

While House Bill 712 and Senate Bill 627 took many steps toward a fair and logical medical marijuana policy, problems remain. Because the bills would not have repealed section 5-601(c)(3),[263] one must assume that an arrestee with an appropriate medical condition who had not registered their medical use of marijuana could have raised section 5-601(c)(3) to mitigate his or her sentencing.[264] While a conviction with sentencing mitigation is certainly not ideal for various reasons,[265] keeping some type of defense protects unregistered patients from incarceration and fines.[266] Ideally, Maryland should pass a new version of section 5-601(c)(3) that acts as an affirmative defense (completely absolving the defending patient of guilt) instead of retaining the conviction and providing a mitigated sentence.

Second, if Maryland's legislators propose new bills, they should reexamine turning Maryland into one of the few medical marijuana states that do not allow patients to grow their own marijuana.[267] As previously discussed, dispensaries give patients options in procuring marijuana other than the labor-intensive process of growing it themselves.[268] However, choice for each individual in that matter remains key. The 2010 Maryland bills carefully explained that they would not mandate health insurance companies to cover the costs of medical marijuana,[269] and while price checks were installed in the legislation—inexact as they were[270]—buying marijuana from dispensaries could remain cost prohibitive for some individuals. Sick individuals especially might face financial barriers as some may be unable to work due to their condition and others may already be overburdened by the costs of other medical treatments. Giving sick individuals and their caretakers the choice to grow their own marijuana might result in a lower cost than any retailer could provide. Maryland should give its residents options.

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263. Darrell–Putman Compassionate Use Act, MD. CODE ANN., CRIM. LAW § 5-601(c)(3)(i)–(ii) (LexisNexis 2003). *See also supra* Parts III.A, III.C.

264. *See supra* Part III.A.

265. *See supra* Part III.C.2.

266. *See supra* notes 216–17 and accompanying text.

267. *See supra* note 73.

268. *See supra* note 84 and accompanying text.

269. *Compare* H.D. 712, 2010 Leg., 427th Sess. § 13-3009 (Md. 2010), *available at* http://mlis.state.md.us/2010rs/bills/hb/hb0712f.pdf, *with* S. 627, 2010 Leg., 427th Sess. § 13-3009 (Md. 2010), *available at* http://mlis.state.md.us/2010rs/bills/sb/sb0627t.pdf.

270. *See supra* notes 254–55 and accompanying text.

Finally, that the 2010 bills prohibited patients from consulting physicians to attain a medical marijuana recommendation[271] could have proven to be unnecessarily restrictive to patients. Patients need to have input in their treatment, and this interest should outweigh the State's interest in trying to prevent physician shopping. There is no guarantee that a patient's current physician will recommend marijuana to him or her, despite that patient's having an appropriate medical condition under the law. If that patient must then switch physicians, perhaps because the doctor is personally opposed to marijuana use, the patient should not have to abide by an arbitrary restriction on finding another doctor. Additionally, allowing patients to choose a certain doctor based on the doctor's pursuit of unconventional treatment is of great import if the patient sees this as his best option. Indeed, the distinction between going physician shopping and seeking a second opinion can sometimes be non-existent.

Physician recommendations of marijuana should rely upon an individual physician's medical opinion, just as any other treatment would. Instead of forcing patients to veil their intentions, Maryland should encourage open communication between doctor and patient. Maryland's medical marijuana law should not discourage seeking a line of treatment because of the connotation the drug carries, and the misguided assumption that recreational marijuana use trumps all, especially when the treatment is a safe, effective, and natural substance.[272]

The proposed bills before the 2010 General Assembly certainly would have been a great triumph for Maryland medical marijuana patients and their doctors. However, Maryland legislators should strive to make marijuana accessible to patients of all income levels, and put patients' treatment completely in the hands of doctors, free of unnecessary political meddling. Ultimately, the legislature should afford marijuana the reasonable treatment that other effective medications receive because the medical community views marijuana as that exactly: an effective medication.[273]

V. CONCLUSION

Maryland must make medical marijuana legislation a priority. The American Medical Association has stated that marijuana has

271. *See supra* note 251 and accompanying text.

272. *See supra* text accompanying notes 18, 40–41.

273. *See supra* text accompanying note 40.

legitimate and effective medical uses for a host of diseases and conditions,[274] and fifteen medical marijuana states have successful, compassionate, and logical medical marijuana laws.[275] While Maryland's proposed bills in the last two years have been steps in the right direction, many issues still require redress.[276] Maryland should set a law that clearly discerns to whom it applies by listing a broad range of debilitating symptoms and conditions to give doctors medical flexibility in choosing the best treatment for each patient.[277] Maryland needs a new medical marijuana defense—one that prevents patients' arrests and convictions.[278] For reasons of cost and convenience, medical marijuana patients need choice in how they procure their medicine, whether it is from a pharmacy or their own garden.[279] Maryland should implement a patient registry with identification cards to prevent patients' wrongful arrests.[280] Last, the state should not restrict patients in their choice of physician or how long they must wait after first seeing a doctor before asking about marijuana-based treatment.[281]

Ideally, instead of Congress, doctors and the FDA would make decisions about using marijuana as medicine. However, while waiting for the federal government to solve these problems on a national level, Maryland must end unreasonable medical marijuana treatment where it has control—at the state level. Leaving people with conditions such as cancer, HIV/AIDS, glaucoma, multiple sclerosis, and epilepsy to choose between an effective medication and complying with the law at the expense of their own wellbeing is unfair and irrational. Asking people with life-ending conditions to wait for legislative acceptance and budgetary adjustments[282] is even more senseless. Maryland must act now, and must get rid of its ineffective and uncompassionate statute.

274. *See supra* text accompanying note 40.
275. *See supra* Part II.C.
276. *See supra* Part IV.B–C.
277. *See supra* Part III.C.1.
278. *See supra* Parts III.C.2, IV.C.
279. *See supra* Part IV.C.
280. *See supra* Part II.C.
281. *See supra* Part II.C.
282. *See supra* text accompanying note 233–34.

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