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# PSYCHEDELIC MEDICINE AND THE LAW

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Anyone who has ever had the dark cloud of serious illness descend into his or her life knows well the associated mental disease. To be struck with a grave physical illness is to be simultaneously enwrapped in dread, fear, and depression. The effect on the body cannot be separated from the effect on the mind, and the two feedback upon one another in complex patterns that will probably never be fully understood. Here in the West, medical doctors are just beginning to recognize the profound relationship between the mind and the body—a union long acknowledged by healers in other cultures. Eastern healers, for example, have long prescribed meditation with medication, and shamans, curanderas, and medicine people have, for millennia, utilized psychoactive plants and potions as primary healing tools.

Psychedelic medicines, those both ancient and modern, are unique in their ability to reliably access the mind–body interface. They hold out hope for healing where none might otherwise exist (for instance, in the case of cluster headaches as discussed by Halpern and Sewell in this volume). In those horrible cases when all hope has been lost, they may provide the only means of quickly coming to terms with impending death, and reducing emotional and physical suffering.

## DOCTORS V. COPS: WHO SHOULD CONTROL MEDICINE?

As part-and-parcel of our nation's modern drug war policy, government politicians and federal law enforcement agents have stationed themselves in the middle of what was has historically been a private personal decision, perhaps made in conjunction with a physician or pharmacist.

As explained by historian Wallace F. Janssen, in "colonial days, and long afterward, consumers...were their own food and drug inspectors," "there was a striking absence of statutes dealing with drugs," (Janssen 1981, 422–5) and, although there were food inspection laws and standards for weights and measures, "drug laws were virtually non-existent" (Janssen 1975, 671).

Significant drug regulation in the United States did not begin until 1906. In that year, Congress enacted the Pure Food and Drug Act, which was premised on Congress's Commerce Clause powers to regulate interstate commerce and activities that "substantially affect" interstate commerce.[1] The 1906 Act barred misbranded and adulterated foods or drugs from entering interstate commerce, and prohibited false and misleading labeling.[2] Since 1906, there has been a steady march of more and more federal government control over drugs.

In 1909, the Smoking Opium Exclusion Act prohibited the importation, possession, and nonmedical use of opium.[3] Like the 1906 Act, this Act was premised on Congress' power to regulate interstate commerce.

In 1914, Congress used its taxation power to pass the Harrison Narcotics Act, which taxed those who produced, imported, or distributed opiates or cocaine derivatives, and set restrictions on possession.[4]

In 1917, the Senate passed the 18th Amendment, which took effect on January 16, 1920, prohibiting the manufacture, sale, and transportation of "intoxicating liquors." The 18th Amendment was enforced by passage of the National Prohibition Act of 1919[5] (also known as the Volstead Act), which also prohibited the possession of intoxicating liquors, but specifically recognized exceptions for religious use and medical use.[6] Alcohol prohibition was repealed on December 5, 1933, when the 21st Amendment was ratified.

In 1937, Congress passed the Marijuana Tax Act, which taxed any exchange or distribution of marijuana.[7] And, one year later, Congress passed the Food, Drug, and Cosmetic Act of 1938, which among other things required that new drugs be proven safe before marketing.[8]

With the exception of marijuana, it was not until 1965 that federal law directly targeted psychedelic drugs, thus beginning a significant slowdown in psychedelic research. In the previous 16 years (1950–1965), the potential of certain psychedelics to serve as revolutionary medicines was enthusiastically studied, producing over 1,000 published clinical papers documenting psychedelic treatment with 40,000 patients (Grinspoon and Bakalar 1997). In the 1950s and early 1960s, a cancer patient using LSD (lysergic acid diethylamide) as an adjunct to chemotherapy did not fear that his or her hospital bed would be transformed into a jail cot, nor did a doctor feel handcuffed in his or her choice of

treatment options. In 1965, Congress acting under its Commerce Clause powers passed the Drug Abuse Control Amendments, which targeted stimulants and depressants, and for the first time, substances having a "hallucinogenic effect" on the central nervous system. This law was primarily aimed at regulating those who manufactured or dispensed such drugs, specifically exempting from its reach anyone who possessed such drugs for his or her personal use.[9]

It was not until 1968 that the personal possession of LSD became a federal offense. On October 5, 1968, President Lyndon Johnson signed into law an amendment to the 1965 Act,[10] stating, "under this bill the illegal manufacture, sale or distribution of LSD and similar drugs is made a felony, punishable by 5 years in prison and a $10,000 fine. The illegal possession of such a drug is made a misdemeanor punishable by up to 1 year in prison and a $1,000 fine."[11]

While the personal possession of LSD was federally prohibited in 1968, it took two more years before federal drug control policy was consolidated with the enactment of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[12] Title II of the 1970 Act is popularly known as the Controlled Substances Act. In the Controlled Substances Act, Congress established a five-schedule scheme for regulating various substances. Schedule I includes the most tightly controlled drugs. Under federal law, to be placed in Schedule I a drug must be unsafe for use even under medical supervision, have a high potential for abuse, and have no currently accepted medical use. On the other end of the schedule spectrum is Schedule V, which contains those substances thought to have a low potential for abuse, relatively slight potential for physical or psychological dependence, and a currently accepted medical use.[13]

In 1970, Congress initially allocated various substances to particular schedules, but then authorized the Attorney General to schedule, transfer between schedules, or remove a substance from a schedule.[14] When enacted in 1970, Schedule I was populated with 17 psychedelic substances, denoted as "hallucinogens."[15] The list currently includes 34 substances.[16] With the primary exception of ketamine, nearly every psychedelic substance currently controlled under federal law has been placed in Schedule I, thereby legislating that they have "no accepted medical use" and are "unsafe even under medical supervision." Because physicians are prohibited from prescribing Schedule I substances, it is all but impossible for medical doctors and psychiatrists to utilize these potentially beneficial substances in treating their patients. Indeed, merely possessing a drug placed in Schedule I is a federal crime punishable by imprisonment and fines.

Dr. Thomas Szasz, professor emeritus of psychiatry at the State University of New York, Syracuse, has forcefully argued that since 1938, when federal prescription laws were first enacted,[17] physicians have been "parentified" and now act as "agents of the therapeutic state" (Szasz 1992).[18] As described by Dr. Szasz, under the 1938 law:

> [g]overnment bureaucrats became the final arbiters of what counted as a therapeutic drug and as legitimate medical treatment in general. As a result, the patient lost his

> right to drugs traditionally available in the free market; the doctor lost his freedom to medicate his patient as he saw fit, subject only to his patient's consent; and the medical profession lost its integrity as an organization independent of the political vagaries of politics.[19]

Regardless of whether one agrees with Dr. Szasz that prescription requirements are an affront to the autonomy of patients and doctors, it is impossible to dispute that in 2006 law enforcement agents, rather than medical professionals (or patients), often had more of a say in the treatment options available for some seriously ill and suffering patients.

Under federal law, ultimate authority over the scheduling of drugs (and hence over the determination of which drugs doctors can prescribe and which they cannot) is vested not in a medical organization but rather in the Attorney General of the United States. In 1973, shortly after the DEA (Drug Enforcement Administration) was created by President Nixon, the Attorney General delegated his scheduling powers to the Administrator of the DEA.[20] In making the required findings for scheduling any given drug, federal law requires that the Administrator consider the following eight factors:

1. The drug's actual or relative potential for abuse;
2. Scientific evidence of the drug's pharmacological effect, if known;
3. The state of current scientific knowledge regarding the drug or other substance;
4. The drug's history and current pattern of abuse;
5. The scope, duration, and significance of abuse;
6. What, if any, risk there is to the public health;
7. The drug's psychic or psychological dependence liability; and
8. Whether the drug is an immediate precursor of another controlled substance.[21]

The DEA is a law enforcement agency, not a medical body. In its thirty-year history, the DEA has been led by former police officers, military officers, and prosecutors with no training or experience in medicine. Yet, because the DEA is the federal agency that determines whether to place a drug in Schedule I, it is the DEA that ultimately holds the control over which drugs can or cannot be prescribed by physicians. Under federal law, the DEA Administrator's scheduling power is theoretically checked by the Secretary of HHS (Health and Human Services), who must approve the Administrator's intention to schedule a particular drug. In practice, however, the Secretary's "check" is likely to be a rubber stamp, approving whatever the Administrator recommends. For example, in the *Grinspoon* case (discussed, *post*), the U.S. Court of Appeals for the First Circuit criticized the HHS Secretary for just such a rubber stamp approval with respect to MDMA (methylenedioxymethamphetamine), commenting:

> The record...reveals that the HHS performed in a less than admirable fashion in making its recommendation to the Administrator. The record indicates that HHS failed to look beyond its files upon receiving the Administrator's...request for a scientific and medical evaluation; neglected to consult any organization of medical professionals or even the FDA's own panel of experts, the Drug Abuse Advisory Committee; and simply rubber stamped the Administrator's conclusion by adopting the...analysis already performed by the DEA.[22]

Once the DEA Administrator has placed a substance in Schedule I, the drug is not available as medicine and possession of it for any reason except as authorized by federal agencies for research is a federal crime. Because of the extremist nature of the war on drugs, there is no federal exception for seriously sick or dying people. This, of course, includes medical use of marijuana. While increasing numbers of states are exempting medical users of marijuana from the state's marijuana prohibitions, these exemptions are limited to prosecutions that take place in *state* courts, not in *federal* court (and are limited to marijuana). In 2005, the U.S. Supreme Court made clear that even if a medical user of marijuana never crosses a state border, and obtains and uses his or her marijuana completely within a state with a medical protection, the federal government retains the power to prosecute that person for violating the *federal* marijuana prohibition.[23]

As things currently stand, the urgent therapeutic needs of such patients are forced to take back seat to the government's concerns about recreational drug use by healthy persons. Hence, a terminal cancer patient using marijuana, LSD, or MDMA, or psilocybian mushrooms, to aid his or her preparation for death, is treated no differently under federal law than a wild-eyed user of crack cocaine. In fact, crack cocaine (a.k.a., cocaine base) is acknowledged to have accepted medicinal applications and has been placed in Schedule II, whereas all medical properties of the psychedelic substances are denied.[24]

## THE POLITICS OF MEDICINE: THE SCHEDULING OF MDMA

"The first casualty of war is truth" wrote the Greek playwright and poet Aeschylus around 500 BC. In the war on drugs, Aeschylus' proposition is surely realized. Drugs that patients and medical professionals have found beneficial are decreed to have "no accepted medical use" by the nation's top drug cop—the Administrator of the DEA—and are declared off-limits for use in treatment of any kind. This ugly politicized process is clearly illustrated by the history surrounding the scheduling of the drug MDMA.

First synthesized by the Merck pharmaceutical firm in 1912, but never marketed by the company, MDMA resurfaced in the early 1970s. With its short duration and unique characteristic for reliably heightening the capacity for introspection and self-acceptance, coupled with the easing of communication anxieties, MDMA soon caught the ear of psychotherapists who quietly began using the drug as an adjunct to therapy.

One such psychiatrist was Dr. George Greer. Colleagues of Dr. Greer discovered that MDMA facilitated the therapeutic process (see Chapter 7 by Greer and Tolbert in this volume). After spending a few months researching the laws and regulations, Dr. Greer concluded that if he manufactured the MDMA himself, and had peer review and informed consent, he could legally administer MDMA to his patients. He proceeded to synthesize a batch of MDMA with the assistance of Dr. Alexander Shulgin, Ph.D., and administered it to about 80 people over a five-year period (Greer and Tolbert 1990).

Although none of the patients to whom Dr. Greer administered MDMA suffered from disabling psychiatric conditions (Dr. Greer excluded such patients for safety reasons), well over 90% reported benefits that they considered significant. These included improvement of communication and intimacy during the sessions with spouses, and a general decrease in psychological problems afterward. Interpersonal relationships, self-esteem, and mood also generally improved. Many patients reported that these improvements in their lives lasted from weeks to years, even after only one or two sessions utilizing MDMA.

At the same time that Dr. Greer and a growing number of other psychotherapists were finding MDMA useful as an adjunct to therapy, recreational use of the drug was growing. In 1981, an underground manufacturer of MDMA gave it the marketing moniker "ecstasy," and its recreational use ballooned. Word of MDMA soon reached the DEA, which, in 1982, opened a file on the drug.

In the July 27, 1984, issue of the *Federal Register,* the DEA announced that it was moving to add MDMA to the list of Schedule I substances. The notice stated that MDMA had no legitimate medical use or manufacturer in the United States, was responsible for an undisclosed number of trips to emergency rooms, and had a high potential for abuse.[25]

Dr. Greer and other psychiatrists who were successfully using MDMA in therapy were alarmed when they learned of the DEA's intention to place MDMA in Schedule I. Dr. Greer and fifteen other medical professionals wrote the DEA explaining that in their professional experiences, MDMA had proven to be a tremendous aid to therapy, and could be used safely under medical supervision. Placing MDMA in Schedule I would make it all but impossible for anyone—medical professionals included—to use the substance in therapy. Not one person wrote to support the DEA's intention to place MDMA in Schedule I.

As a result of the doctors' letters, the DEA was forced to hold hearings on the matter of MDMA's proposed scheduling. Nine days of hearings were held in three cities during 1985. At the hearings, thirty-three witnesses testified and ninety-five exhibits were received into evidence. Psychiatrists testified that the drug was an invaluable therapeutic adjunct that was safe when used under professional supervision. Witnesses for the DEA countered that the psychiatrists were basing their testimony on nothing but anecdotes—that no controlled scientific studies existed to support their claims.

Shortly before the first hearing date, then-President Reagan appointed a new Administrator of the DEA. The appointee, John Lawn, had a long history as an

upper-level special agent in the FBI but, like all other DEA administrators to date, absolutely no medical training or experience. In a remarkably unabashed affront to the hearing process that was already underway, the new Administrator, acting under emergency scheduling powers, unilaterally decreed that effective July 1, 1985, MDMA would be a Schedule I drug. The emergency scheduling provision allows the Attorney General to act without holding a hearing by asserting that there is an "imminent hazard to the public safety."[26] Administrator Lawn stated that notwithstanding the ongoing hearing on the issue of MDMA's appropriate status, emergency scheduling was "necessary to avoid an imminent hazard to the public safety." In particular, Administrator Lawn offered the following reasons for his decision to invoke the emergency scheduling provision:

> Unapproved, so-called therapeutic use of MDMA continues in many sections of the country. Clandestine production, distribution and abuse of MDMA is occurring nationwide and appears to be escalating. The open promotion of MDMA as a legal euphoriant through fliers, circulars and promotional parties has recently surfaced in some areas. DEA agents estimate that 30,000 dosage units of MDMA are distributed each month in one Texas city. Drug abuse treatment programs have reported that they are seeing individuals seeking treatment who have taken multiple doses of MDMA. ...Of immediate concern to DEA in terms of hazard to public safety is a very recent research finding which suggests that MDMA has neurotoxic properties. A paper entitled "Hallucinogenic Amphetamine Selectively Destroys Brain Serotonin Nerve Terminals: Neurochemical and Anatomical Evidence" by G. Ricaurte, G. Bryan, L. Straus, L. Seiden and C. Schuster [(Ricaurte, 1985)], describes studies which show that single or multiple doses of MDA selectively destroy serotonergic nerve terminals in the rat brain....Experts have concluded that because of the neurotoxic effects of closely related structural analogs of MDMA (MDA, amphetamine and methamphetamine) and because both MDA and MDMA cause the release of endogenous serotonin, it is likely that MDMA will produce similar nuerotoxic [*sic*] effects to those of MDA.[27]

In a subsequent case, the federal convictions of several defendants for distributing and conspiring to distribute MDMA were reversed by the Ninth Circuit Court of Appeals, which found that Administrator Lawn overstepped his powers. The court held that the Attorney General never properly delegated to the DEA Administrator the *emergency power* to temporarily schedule controlled substances.[28]

Over the next ten months, however, the facts about MDMA were heard by Judge Francis Young, who presided over the hearings. After receiving and considering all the evidence admitted during the hearings, Judge Young issued his findings and recommendation on May 22, 1986. In a comprehensive opinion, Judge Young found that MDMA did *not meet a single one of the three criteria necessary for placement in Schedule I.* Judge Young reported that MDMA had a safe and accepted medical use in the United States under medical supervision. Furthermore, he found that the evidence failed to establish that MDMA had a

high potential for abuse. Based on his thorough examination of the evidence, Judge Young recommended that MDMA be placed in Schedule III, which would allow doctors to use it in therapy and prescribe it, while still keeping it unavailable to the public at large.

Administrator Lawn refused to accept Judge Young's recommendation. In Administrator Lawn's opinion, because MDMA was not an FDA-approved drug, it *ipso facto* lacked both any currently accepted medical use in treatment and an accepted safety for use under medical supervision. Administrator Lawn also averred that Judge Young gave too much weight to the testimony and evidence of doctors and patients, and not enough consideration to studies on rats, or the lack of FDA approval. In a flat rejection of Judge Young's recommendation, Administrator Lawn decreed that effective November 13, 1986, MDMA would be permanently placed in Schedule I, not Schedule III.[29]

The medical community fired back. Lester Grinspoon, an associate professor of Psychiatry at Harvard Medical School, sued the DEA, seeking to invalidate MDMA's Schedule I status.[30] The federal circuit court that heard the case succinctly summarized the competing arguments: "The [DEA] Administrator reads 'accepted [medical use]' to mean that *the FDA* must have approved the drug for interstate marketing. Dr. Grinspoon, on the other hand, prefers to interpret "accepted" as meaning that the *medical community* generally agrees that the drug has a medical use and can be used safely under medical supervision."[31]

Calling Administrator Lawn's argument "strained" and "unpersuasive," the federal court rejected Lawn's argument and sided with Dr. Grinspoon.[32] The court vacated MDMA's Schedule I status and remanded the case to the DEA for reconsideration—prohibiting Administrator Lawn from making the lack of FDA approval the basis for his decision.[33] Forced to do so by the federal circuit court's ruling, the DEA on January 27, 1988, deleted MDMA from Schedule I, pending the Administrator Lawn's reconsideration of the evidence and Judge Young's recommendation.

Remarkably, in a perfunctory final rule decreed less than a month later, Administrator Lawn claimed that he had reconsidered the evidence and once again concluded that MDMA belonged in Schedule I.[34] In his published ruling, Administrator Lawn paradoxically gave greater weight to the *absence* of certain evidence than to the actual evidence admitted during the hearing. Evidence that psychiatrists had administered MDMA to approximately 200 patients with positive effects was summarily dismissed by Administrator Lawn, as "merely anecdotal," simply because it was not published. According to Administrator Lawn: [t]he published literature contains no references to the clinical use of MDMA nor animal studies to indicate such a clinical use. Recognized texts, reference books and pharmacopoeia contain no references to the therapeutic use of MDMA. The two unpublished studies supporting the therapeutic use of MDMA which were presented during the hearings, do not contain any data which can be assessed by scientific review to draw a conclusion that MDMA has a therapeutic use.[35]

Thirty days later (on March 23, 1998), in spite of clear evidence showing MDMA's promise in treating mentally suffering people, MDMA became a Schedule I "hallucinogen." Possession of the drug, for any reason except for authorized research studies, remains a federal offense.

## CRIMINALIZING THE SICK

As the laws stand today, patients who use psychedelic medicines face the constantly looming threat that their medical problems will be compounded by legal problems. For many patients, the fear and social stigma engendered by the fact that psychedelic treatment makes them federal criminals is too much to bear, and they reluctantly forgo potentially beneficial treatment. For those who decide to go forward with psychedelic treatment despite its outlawed status, the treatment's medical benefits can be compromised by the incumbent stress inherent in the patient's suddenly precarious legal status.

For other patients, the dire need for relief from suffering, or the fact that death may loom near, can make the federal law nothing but a nuisance—outrageous nonetheless—but not something that will deter them. The testimony of an AIDS patient during the battle for an exemption that would allow terminally ill patients to use unapproved (but unscheduled) drugs speaks to the situation currently confronting seriously suffering or terminally ill patients who seek to use Schedule I psychedelic medications:

> [It's like being] in a disabled airplane, speeding downward out of control... [seeing] a parachute hanging on the cabin wall, one small moment of hope... [trying] to strap it on when a government employee reaches out and tears it off [your] back, admonishing, "You can't use that! It doesn't have a Federal Aviation Administration sticker on it. We don't know if it will work." (Delaney 1989)

Who would not snatch the parachute under such circumstances?

### Physicians' Roles in Psychedelic Medicine Use

A medical doctor or psychologist convinced that treatment or therapy with a particular Schedule I psychedelic drug may benefit a patient confronts a number of difficult issues. Can a doctor or psychologist discuss treatment of a patient with an illegal psychedelic? What role, if any, can a doctor play if a patient is determined to use an illegal psychedelic for its physical and/or mental healing properties?

The answer to the first question is easy. Discussing of the healing potentials of a legal or illegal psychedelic substance with a patient is protected by the First Amendment.[36] The only exception is for speech that instructs a patient where or how to obtain an outlawed psychedelic, or somehow involves the doctor in a conspiracy with the patient to obtain the drug. Short of those limits, a doctor is well

within the law to speak openly about the pros and cons of alternative treatment methods, including a patient's medical use of a particular outlawed psychedelic. Again, so long as the doctor does not provide information on how or where to obtain an outlawed drug, the First Amendment bars the government from dictating the content of a doctor's conversion with a patient. As a result, a doctor commits no crime by recommending particular books for the patient to read, or by conducting a search of Medline® or similar electronic databases for information on a psychedelic and then providing the fruits of his or her research to the patient.

If a patient decides to avail him or herself to a psychedelic in an attempt at physical or mental healing, the medical professional must be careful with respect to his or her role. A physician who provides a Schedule I psychedelic to a patient—even as part of a thoughtful treatment plan—is treated no better than a street corner crack dealer. Both the doctor and the crack dealer are distributing an outlawed drug in violation of federal and state law. The crime of distribution does not require multiple sales, or any sales at all. Simply giving away the drug can be sufficient for conviction.

A doctor who *assists* a patient in obtaining a Schedule I substance also commits a crime: namely, aiding and abetting the unlawful possession of a controlled substance. In most jurisdictions, this crime is punished just as harshly as if the doctor, him or herself, were the person who acquired and possessed the outlawed drug. Aiding and abetting is not only accomplished by physically procuring a Schedule I drug for a patient; the crime can also be committed by nothing more than speech. It is unlawful aiding and abetting, for example, if a physician tells a patient the name of a person who sells a Schedule I psychedelic, or arranges a meeting between the patient and a supplier of the drug. The First Amendment's protections for speech do *not* protect these sorts of actions.

With these legal concerns in mind, a physician who is asked by a patient for assistance in obtaining a Schedule I psychedelic is well-advised to explain to the patient that even if the doctor is sympathetic to the patient's plight, and believes that psychedelic therapy could well be of benefit, the physician will not provide *any* assistance in obtaining such a drug. On this point, the physician should not waver.

What is the potential criminal liability, as opposed to civil liability, of a medical professional who is present when a patient self-medicates with a Schedule I medication? As should be clear from the discussion above, a doctor commits a crime if he or she procures an outlawed psychedelic for a patient, stores an outlawed psychedelic, or gives an outlawed psychedelic to a patient. But, beyond such a clear violation of the law, criminal liability for a doctor falls into a gray area. For example, imagine a patient who arrives at a psychologist's office for a therapy session and ingests a psychedelic prior to entering the office. An isolated incident of this sort presents little worry of criminal liability for the psychologist. The psychologist would be ill-advised, however, to build an entire practice around such a scenario, or to promote such services. Most states have laws that prohibit so-called "drug houses," premises where "drug activity" occurs. In 1986,

Congress passed the "Crack House Statute,"[37] which was intended to "outlaw operation of houses or buildings, so called 'crack houses,' where 'crack,' cocaine and other drugs are manufactured of used."[38] In 2001, however, federal prosecutors indicted a promoter of rave dance parties and two venue managers, alleging that the men knew that attendees of the raves would be using MDMA during the all-night events.[39] The case was settled with a negotiated plea, which required the managers to pay a fine of $100,000 and placed them on five years probation.[40]

Another imaginable scenario is one in which a patient, independent of the professional's direct assistance, ingests MDMA, or some psychedelic medicine, and then calls the psychologist for advice or counseling. A psychologist in such a situation commits no criminal conduct by speaking with the patient over the phone, or by making a house call. Likewise, a psychologist who is merely present at an event where people have used a psychedelic medicine, violates no criminal law by providing medical assistance or counseling to those who seek his or her assistance or guidance.

### The Medical Necessity Defense

For patients who decide to violate the criminal laws outlawing possession of Schedule I psychedelics, arrest is always a possibility. Plainly, an arrest for criminal drug possession, with its likely attendant jail time prior to bail, and the ongoing anxiety associated with defending oneself against criminal charges will add an immense amount of stress to any patient's life. Fortunately, in many states, a seriously ill patient who has been charged with possessing a small amount of an outlawed psychedelic medication will likely be treated relatively leniently by a court. There are few criminal defendants more sympathetic than an otherwise law-abiding citizen who has been struck with a serious or terminal illness.

The goal at any trial involving a medical user of a Schedule I psychedelic is twofold: (1) to obtain an acquittal based on a "medical necessity defense"; or, failing that (2) to educate the judge with respect to the medical use of the outlawed psychedelic and to the defendant's serious medical condition. The hope is that even in the event of conviction a fully informed judge will be lenient in imposing a sentence.

The general defense of "necessity" to charges of criminal conduct is centuries old. As a British court succinctly explained in a case decided in 1551, "where the words of [a law] are broken to avoid greater inconvenience, or through necessity, or by compulsion," the law has not been broken.[41] In essence, the necessity defense protects a person who has been forced to chose between the lesser of two evils, and in doing so was compelled to break the law. For social policy reasons, if the harm that is likely to result from compliance with a law is greater than that which will result from violating the law, a person is, by virtue of the legal defense of necessity, justified in breaking the law. Paradigmatic examples are a prisoner escaping from a burning jail, or a person who steals food from a cabin

after being lost in the woods for a week. However, some states bar necessity defenses to criminal acts. Consequently, a patient who is considering a medical defense in the event that he or she is arrested for medical use of a psychedelic is well advised to research the law of his or her state or consult with an attorney to learn whether such a defense is viable.

The *medical* necessity defense is a particularized type of necessity defense, one in which the defendant asserts that the harm done by using an illegal drug was less than would have resulted by obeying the law and foregoing the ostensibly illegal treatment. More specifically, a patient who possesses a Schedule I psychedelic exclusively to treat his or her own serious illness must establish the following elements in order to present the medical necessity defense to a jury:

1. the patent's illness is not a fabrication and his or her suffering is severe;
2. lawful medical treatment was tried and found ineffective;
3. treatment with the particular Schedule I psychedelic reduces the patient's severe suffering and does not disproportionately cause other harm to the patient, to other people, or to the State's interest in otherwise controlling drugs.[42]

A physician can play a central role in assisting a patient in preparing a medical necessity defense. Indeed, aside from the patient's own testimony at trial concerning his or her illness and how the use of the Schedule I psychedelic helped to alleviate suffering, testimony by the patient's physician or therapist is likely to be the most important and compelling testimony presented at the trial.

Preparation for a medical necessity defense should begin long before any arrest. The doctor's files should describe the severity of the patient's suffering and the course of conventional treatment that was tried and found inadequate. Any legal medication that might possibly be a "substitute" for a Schedule I medicine should be tried, and any unsatisfactory results documented in detail.

In the event that a patient is arrested and the medical professional is called upon to testify at trial, the professional should explain to the jury the patient's extreme medical situation and difficult course of treatment. Next, the professional should testify to the unique benefit derived (actual or potential) by the patient's use of the psychedelic. This explanation should be based on at least three considerations: (1) the patient's self-report to the physician of the treatment's benefits; (2) the physician's examination of the patient, which corroborates the patient's apparent benefit from using the drug; and (3) the scientific, historic, and anthropological literature speaking to the medical use of the drug. Finally, the doctor may wish to testify that were it possible to legally prescribe the psychedelic medication for the patient, the doctor would do so given the unique needs of the patient and the lack of alternative conventional medications.

## PRISONS OR HOSPITALS? THE FUTURE OF PSYCHEDELIC MEDICINE

Americans have respect for medical professionals and deep compassion for sick, diseased, or dying patients. A carefully restricted medical accommodation would reduce needless suffering and stress, while maintaining an otherwise strict drug control policy. Yet, the current laws, which outlaw *any* use of Schedule I psychedelic substances (with the exception of a few states, which have permitted the use of medical marijuana), place police concerns above medical needs. To a large extent this may be due to a silence from professional medical organizations and patient advocacy groups, both of which have made little effort to seek a legislative accommodation that would permit the lawful use of Schedule I psychedelic medicines under certain circumstances and under the supervision of a medical professional.

A statutory exemption permits members of the Native American Church to use peyote (a Schedule I psychedelic substance) in their religious ceremonies.[43] This has not led to abuse, nor has it resulted in members of the general public obtaining peyote for recreational use. There is no rational reason why a similar exemption, but restricted to *medical* use of Schedule I psychedelic medications, under the supervision of a medical doctor, could not be enacted to accommodate seriously ill or dying patients whose health or life may depend upon the potential healing evoked by a psychedelic medicine. Currently, limited amounts of almost all the Schedule I psychedelic medicines are being manufactured by pharmaceutical companies under federal authorization,[44] and a strenuous procedure already exists for tracking and regulating the manufacture and distribution of pharmaceutically manufactured controlled substances, including those in Schedule I.[45] Permitting seriously ill or terminal patients to lawfully use a Schedule I psychedelic substances when their doctors believe it is the last best hope would require only a slight modification of the law. The problem, of course, is not one of practicality, but rather one of politics.

With the recent wave of state laws permitting the medical use of marijuana, perhaps the political tide is turning. A truce in the drug war may not yet be possible, but more and more people agree that the wounded should be removed from the battlefield. Hopefully, the politicians will start listening.

## NOTES

1. For a discussion of Congress' powers to legislate under the commerce clause, see *United States v. Lopez* (1995) 514 U.S. 549 [131 L. Ed. 2d 626, 115 S. Ct. 1624]; *Gonzales v. Raich* (2005) 545 U.S. 1 [125 S.Ct. 2195, 162 L.Ed.2d 1].

2. Pure Food and Drug Act, Pub. L. No. 59-384, 34 Stat. 768 (repealed 1938).

3. Opium Smoking Act, Pub. L. No. 221, 60th Cong., 35 Stat. 614 (February 9, 1909).

4. Harrison Narcotics Act, c. 1, 38 Stat. 785 (December 17, 1914).
5. National Prohibition Act, ch. 85, 41 Stat. 305.
6. *Id.*, Title II, §§ 6 and 7.
7. Marijuana Tax Act 1937, Pub. L. No. 238, 75th Cong. (1937).
8. Food Drug and Cosmetic Act of 1938, Pub. L. No. 75-717, 52 Stat. 1040 (1938), as amended 21 U.S.C. §§ 301 *et. seq.*
9. Drug Control Abuse Amendments of 1965, Pub. L. No. 89-74, § 2, 79 Stat. 226 (1965).
10. Drug Abuse Control Amendments of 1968, Pub. L. No. 90-639, 82 Stat. 1361 (1968).
11. "Statement by the President Upon Signing Bill Relating to Traffic in or Possession of Drugs Such as LSD," (October 25th, 1968) Online at http://www.presidency.ucsb.edu/ws/index.php?pid=29206.
12. 21 U.S.C. § 801 *et. seq.*
13. 21 U.S.C. § 812.
14. 21 U.S.C. § 811(a).
15. As initially enacted, subdivision (c) of Schedule I (21 U.S.C. § 812) stated: Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

1. 3, 4-Methylenedioxy amphetamine.
2. 5-Methoxy-3, 4-methylenedioxy amphetamine.
3. 3, 4, 5-Trimethoxy amphetamine.
4. Bufotenine.
5. Diethyltryptamine.
6. Dimethyltryptamine.
7. 4-Methyl-2, 5-dimethoxyamphetamine.
8. Ibogaine.
9. Lysergic acid diethylamide.
10. Marihuana.
11. Mescaline.
12. Peyote.
13. *N*-Ethyl-3-piperidyl benzilate.
14. *N*-Methyl-3-piperidyl benzilate.
15. Psilocybin.
16. Psilocyn.
17. Tetrahydrocannabinols.

16. 21 CFR § 1308.11, subd. (d) (May, 2006).
17. Federal Food, Drug and Cosmetic Act of 1938, see endnote 2, *supra.*

18. For an excellent discussion of the early federal laws controlling drugs, see P. Temin, "The Origin of Compulsory Drug Prescriptions," *Jnl. of Law and Econ.* 22 (1):91–105 (April 1979).

19. *Id.* at p. 52.

20. 28 CFR 0.100(b) (1986).

21. 21 U.S.C. § 811 (c).

22. *Grinspoon v. DEA* (1st Cir. 1987) 828 F.2d 881, 897.

23. *Gonzales v Raich* (2005) 162 L.Ed.2d 1 [125 S.Ct. 2195].

24. See 21 U.S.C. § 812(c)(II)(a)(4).

25. 49 Fed. Reg. 30210-30212, July 27, 1984.

26. 21 U.S.C. Sec. 811 (h).

27. 50 Fed. Reg. 23118-23119, May 31, 1985.

28. [*U.S. v. Emerson* (9th Cir. 1988) 846 F.2d 541; accord, *U.S. v. Spain* (10th Cir. 1987) 825 F.2d 1426, 1429.]

29. *Ibid.*

30. *Grinspoon v. DEA, supra,* 828 F.2d 881.

31. *Id.* at p. 886.

32. *Ibid.*

33. *Id.* at p. 891.

34. 53 Fed. Reg. 5156-5159 (February 22, 1988).

35. *Ibid.*

36. *Conant v. Walters* (2002) 309 F.3d 62.

37. 21 U.S.C. § 856.

38. 132 Cong. Rec. 26, 474 (1986) (excerpt of Senate Amendment No. 3034 to H.R. 5484).

39. *McClure v. Ashcroft* (2003) 335 F.3d 404.

40. *Id.*

41. *Reninger v. Fagossa* (1551) 1 Plowd. 1, 19, 75 Eng. Rep. 1, 29-30.

42. See, for example, *Idaho v. Hastings* (Idaho 1990) 801 P.2d 563 [outlining elements of a necessity defense in a medical marijuana case]; Benjamin Reeve, *Necessity: A Recognized Defense,* 21 NEW ENG. L. REV. 779, 781 (1986).

43. 21 C.F.R. § 1307.31; 21 C.F.R. § 16(c) (1967).

44. Under the 2005 controlled substance production quotas, specified pharmaceutical companies are authorized to manufacture: 17g of MDMA, 15g of MDA, 2g of psilocybin, 7g of psilocin, and a whopping 61g of LSD. (See "Controlled Substances: Revised Aggregate Production Quotas for 2005" 70 *Fed. Reg.* 68087-68089.) (Nov. 9, 2005); 21 U.S.C. § 826.

45. See 21 U.S.C. §§ 821–829.

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