UNITED STATES DEPARTMENT OF JUSTICE

Drug Enforcement Administration

IN THE MATTER OF

MARIJUANA RESCHEDULING PETITION

Docket No: 86-22

AFFIDAVIT OF TOD H. MIKURIYA, M.D.

Tod H. Mikuriya, being first duly sworn, states as follows:

1) My name is Tod H. Mikuriya. I received my M.D. degree from the Temple University School of Medicine in 1962. My psychiatric residences were at the Oregon State Hospital (1963-1965) and the Mendocino State Hospital (1965 to 1966). I am a Board Eligible Psychiatrist. I am a certified member of the Society for the Treatment of Alcoholism and other Drug Dependicies and the American Medical Society of Alcoholism and other Drug Dependicies. I have been practicing in Berkley, California since 1969. My attached curriculum vitae (attachment A) provides further information about my professional experience.

2) I have studied cannabis and related topics since 1959 during my second year of medical school pharmacology. My contact with the topic was minimal until 1964 when I was made aware of the general presence of cannabis during the second year of my psychiatric residency.

3) In the summer of 1966, I visited Morocco where kif (cannabis) is grown. I visited the Mental Hospital at Berrechid where an oft-quoted article describing the adverse effects of kif

originated. My critique of that study is included as attachment B.

4) During 1966 and 1967, I was employed as the Director of the Drug Addiction Treatment Center (Heroin and Barbiturate Detoxification and Detention Program) at the New Jersey Neuro-Psychiatric Institute, Princeton, New Jersey.

5) For a short period in 1967, I was a full time Consulting Research Psychiatrist at the United States Department of Health, Education and Welfare, National Institute of Mental Health (NIMH), Center for Narcotics and Drug Abuse Studies. In that capacity I was responsible for setting up the first legitimate research program for the study of marijuana.

6) While at NIMH I reviewed the literature available on marijuana including previous government research that had not been disclosed (and to this date has been only partially disclosed). I also reviewed the literature available at the National Library of Medicine where I had the opportunity to study and review the Indian Hemp Drugs Commission Report of 1893-94, a monumental eight volume study that examined the complex questions of the perceived versus actual dangers of cannabis and options for control in British ruled India. The historical section was a rich source of information about the importance of cannabis in American, English, and European medicine which was broadly used for a variety of therapeutic applications prior to the ascendance of synthetic pharmaceuticals. Although cannabis had problems with variable potency and response, in the hands of experienced

clinicians these impediments were effectively addressed. Included with this affidavit is a summary of the report I wrote in 1968.

7) Indeed, cannabis has been used as a medicine for millennia. It was one of the first plants to be used by man for fiber, food, medicine, and in social and religious rituals. Schultes, R.E. and Hofman, A., The Botany and Chemistry of Hallucinogens, 2nd ed., Charles C. Thomas, Springfield, Illinois. Its use in medicine has been reported in the ancient world of the Middle East and Europe, ancient China, in Medieval Arab and European societies, in Europe and the United States throughout the 19th century and into the early 20th century. Mechoclam, R., Cannabinoids as Therapeutic Agents, CRC Press (1986). Many of the documents relating to this historical use are contained in a book I edited entitled Marijuana: Medical Papers. This text has been included as part of the records of these proceedings.

8) With the passage of the Marijuana Tax Act of 1937 the medicinal availability of cannabis functionally ceased. The prohibitionistic rhetoric tainted the literature with emphasis on toxicity and adverse consequences. One can trace the decline by the replacement of therapeutic descriptions by subsequent descriptions of adverse effects in lay and learned journals. The description of cannabis in the 1987 Physicians' Desk Reference bears little resemblance to that in the United States Pharmacopeia before it was removed in 1941. This is not because marijuana has ceased to have medical uses. Indeed, Mechoulam

correctly points out that many of marijuana's historic medical uses have proven true in the last two decades of research. Below is a list of medical uses of cannabis in 19th century medicine and in folklore medicine. Those with an asterisk next to them have received some substantiation in the last two decades.

Analgetic*	Antirheumatic*	Anesthetic
Antiasthmatic*	Antimigraine	Facilitation of childbirth
Anticonvulsive*	Antineuralgic	Stimulation of lactation
Sedative*	Antiparasitic	Alleviation of memory loss
Antidepressive	Reduction of fatigue	Appetite promoter*
Antiallergenic	Antidiarrheal*	Antipyretic*
Hypnotic*	Antibiotic*	

Source: Mechoulam, Cannabinoids as Therapeutic Agents, supra.

No doubt, if positive research on marijuana was not discouraged by current government policies, including the Schedule I classification of cannabis, additional medical uses would become known. Since the recent reintroduction of cannabis to medicinal status with the discovery of antiemetic and ocular normotensive agent there has been minimal iniative to expand the therapeutic applications beyond control of nausea and vomiting in cancer chemotherapy.

9) When I served at NIMH, in my responsibility in setting up the first legitimate research on cannabis, I saw first-hand the government's bias in examining marijuana. The government seemed to only want to justify the total prohibition of cannabis, including its prohibition as a medicine, rather than to honestly research this plant. This political motivation for government research was a principle reason for my leaving NIMH.

10) Similarly the government's preference for synthetic or

single compound drugs, as opposed to natural marijuana is more based on prejudice than any other rationale. Inhaling natural marijuana is in some ways preferable as the patient is better able to control the dose through self-adjustment, i.e. an individual can smoke a half a cigarette but cannot take only one-half a pill. A pill is a fixed dose while a cigarette can be varied to suit the needs of the patient. The inhaled dose is also preferable because the gastrointestinal tract is not involved. The gastrointestinal tract is not reliable because it is slower and provides irregular absorption. Finally, as some of the government's affiants acknowledge, there has not been enough comparative research examining the medical value of the various components of cannabis. Therefore, by choosing only THC the patient will not be getting the variety of cannabis components which provide medical benefit. This is probably a principle reason why studies comparing marijuana and THC have found natural marijuana to be more effective. The federal government approach follows rigid, stereotyped practice modes rather than allowing for an extension of clinical tradition. Doctors and patients should have the freedom to choose the medicine and method of application which suits their needs without rigid restrictions placed on them by the government.

11) In addition to marijuana having historic and current medical uses, it is my belief that marijuana has a low potential for abuse and can be used safely under medical supervision.

12) Since 1967 I have been a psychiatrist in general

private practice, treating substance abusers both as inpatients and outpatients. It has been my personal clinical experience that cannabis abuse compared with other substances of abuse plays a minor or incidental role. When the abuse or misuse of cannabis presents an impediment to recovery, it is of lesser intensity or severity in nature than alcohol or narcotic relapse.

13) Unlike abuse and withdrawal from narcotics or alcohol, cannabis does not produce physical debility, digestive upset, or malnutrition. There may be irritability and minor insomnia for a few days but few other physical or mental withdrawal symptoms.

14) Despite the large numbers of users, the comparative morbidity is seen in few visits to the emergency rooms, psychiatric, and general hospitals. These admissions show cannabis to be a relatively safe and benign substance. Contrary to the descriptions in the 1987 Physicians' Desk Reference which emphasize perceptual distortion and stimulant properties of d 1,9 tethrahdrocannabinol experienced by new users or at high dose, the principal effect chronic users experience is that of mild relaxation similar to properties of minor tranquilizers with antidepressant qualities.

15) The experience of the chronic user is usually a mild initial stimulation of mental activity with a decrease in emotional reactivity. The amount ingested by the inhaled route is easily adjusted because of rapid onset of effect and unpleasantness of perceptual distortion if too much is taken.

16) The quality of decreased emotional reactivity would

appear to be qualitatively different from benzodiazepine minor tranquilizers which appear to aggravate depressive symptoms.

17) It is my clinical opinion that cannabis by virtue of comparative low rates of adverse medical reactions in its current illicit state would not be significantly increased by increased medicinal and therapeutic availability. On the contrary, the increased familiarity of cannabis as a therapeutic tool will afford relief to a wider range of illnesses and diminution of misinformation because of ignorance.

18) One of the most needed extensions of availability of therapeutic cannabis is for pain control. Over the years I have met numerous individuals who suffer from post traumatic or degenerative neuritic pain whose discomfort was best controlled by low doses of smoked cannabis. See enclosed letter and news reports. It is indeed an ethical issue to continue their deprivation from a medication that is useful in relieving pain that has less debilitating side effects than other available agents.

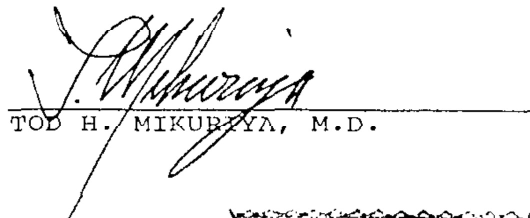
19) Mild sedation and relaxation is also the property of the drug that can be abused. When I have treated cases where cannabis has been used in an abusive fashion the misuse has been through efforts to self-medicate away uncomfortable emotional states. Amelioration of the underlying causes of the emotional discomfort is generally necessary to cease the abusive use of cannabis.

20) The illicit nature of cannabis is often a complicating

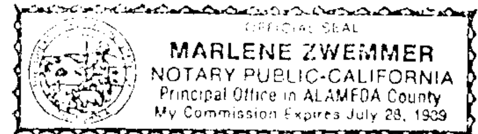
factor in the therapist/patient relationship and aggravate issues of confidentiality and patient rights. Extending the medicinal applications of therapeutic cannabis would facilitate physician/patient relationships, detoxify the issue, as well as provide more effective treatment for disease.

21) In determining whether marijuana should be used for an individual patient, a doctor must weigh its demonstrated medical benefits against its potential adverse effects. This is always a balance in medicine as there are potential adverse effects of virtually all drugs. With regard to marijuana, this balance has been improperly conducted because the "signal" value of allowing marijuana as a medicine is included, i.e. allowing medicinal marijuana will weaken the prohibition of its recreational use. In making signals more important than the traditional balance of cost-benefit the government is committing institutional malpractice. This approach, if applied to other drugs, would result in many useful drugs not being allowed as medicine.

22) As marijuana has been shown to have a number of currently accepted medical uses and as it has a low potential for abuse and can be used safely under medical supervision, I recommend that marijuana be rescheduled to schedule II of the Controlled Substances Act.



TOD H. MIKURIYA, M.D.



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