Contemporary Problems of Drug Abuse - IV. Sunday Morning

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ological effects on the body. I do not see how it can be denied that it is a disease.

DR. SZASZ: No problem. We do not disagree on the last point. Of course, I recognize that a person who is chronically taking heroin or methadone is in a physiologically different state from someone else, but the concept of disease has become like the concept of treatment, a very complicated philosophical and political concept which involves much more than a physiological or biological deviation from some norm. My own book, *The Myth of Mental Illness*, which was published some 15 years ago, deals with this problem.

The concept of disease involves at least two things: (1) a deviation from some norm which traditionally is a biological norm (In that sense, of course, baldness is a disease; syphilis, cancer, etc., have to be deviations from a bodily anatomical physiologic norm.); and (2) in sociologic jargon, the patient role. The patient role can come about in two diametrically opposite ways with diametrically opposite results. We have both voluntary and involuntary patients. They are called by the same name in America — patient — but they have nothing in common. The difference between them is the same as the difference between somebody who goes to West Point because he wants to become a soldier, and a draftee.

The patient role also involves the concept of a right to reject it. Is the Christian Scientist with cancer a patient? No, and if a doctor lays a hand on him, he is liable. I would have no objection to anybody calling addiction a disease, although I do not think it is, if the doctor who touches that patient against his will is just as liable as he would be with the Christian Scientist. Of course, the heroin addict is in a different state. That is why I consider methadone maintenance sponsored by the government a crime — it is the imposition of a disease. It is bad enough if you do it to yourself.

MR. LEVIN: I want to thank Mark Cohen for moderating an extremely stimulating and enlightening panel discussion. I would also like to thank the panelists, Mr. Moss, Dr. Brill, Dr. Szasz, and Professor Kittrie.

IV. SUNDAY MORNING

[The panel discussion was preceded by a presentation of the motion picture *Reefer Madness*]

A. Legislative Process and Social Reform: Marihuana Reconsidered

MR. LEVIN: Ladies and gentlemen, the subject of this morning's panel discussion is Legislative Process and Social Reform: Mari-
huana Reconsidered. We are fortunate to have an attorney who is one of Philadelphia’s foremost defense lawyers in drug abuse cases and is counsel to the Governor of Pennsylvania’s Council on Drug and Alcohol Abuse to preside over this panel. It is my pleasure to introduce Mr. Richard Atkins.

MR. RICHARD ATKINS: We are going to examine the legislative process and the changes in medical, legal, and political thought that led to the development of the marihuana and other associated laws.

I think it is appropriate, before I introduce our first speaker, to give you an example to show that the movie we just saw was typical of the mid and late 1930’s. An article entitled, Marihuana, Assassin of Youth, by Harry J. Anslinger, the U.S. Commissioner of Narcotics, appeared in the February 1938 edition of Reader’s Digest. In the article, Mr. Anslinger described all the people who had killed their mothers, fathers and others while under the influence of marihuana; the mother who complained about her daughter’s death as a result of marihuana addiction; and how people will crawl on the floor and bark like a dog, etc., all as a result of marihuana use.

Even more unbelievable was a book from the late 1930’s called On the Trail of Marihuana, the Weed of Madness by Earle and Robert Rowell, two opponents of liquor and cigarettes, who had, at that time, turned their attention to marihuana. They published what was then considered by many to be the latest authority on marihuana. In the book, they said:

We now know that marihuana (1) destroys the will-power, making a jellyfish of the user — he cannot say no; (2) eliminates the line between right and wrong and substitutes one’s own worst desires or the base suggestions of others as the standard of right. Above all, it leads to crime and fills the victim with an irresistible urge to violence. It incites him to revolting immorality, including rape and murder, and finally it causes insanity as a speciality.

We saw that the subject in the earlier stages of marihuana use could be compared to a coiled rattlesnake, something that may turn dangerous in a split second. In the latter stages, he is completely a madman on the loose. Actually, he is temporarily insane. Although there are no real brain lesions as in insanity, there is an artificial insanity which in all other characteristics resembles the manifestations of genuine insanity. The marihuana addict may run amuck and wreak havoc. There is absolutely no predicting the results but of one thing you can be sure: He is not a safe person to be near under such a condition.

In another section they said:
'Kill, kill,' cries the native of Malay as he dashes down the street with a dagger in his hands, maddened by hashish. Under its influence, the crazed user develops the urge to kill just for the sake of killing. Destruction is the keynote and homicide the polestar guiding him in his maniacal acts. There is born a sadistic lust to kill for murder's own sake. Marihuana is rightly called the killer drug.

That was the attitude in the mid 1930's. We will try to trace all of the types of influences that went into the laws — the influences of the physicians, the medical societies, the lawyers, the legal societies, and politics.

I think it is very appropriate for us to start with Dr. Lester Grinspoon. Dr. Grinspoon is considered by many to be the foremost medical authority on marihuana in the United States. He is the author of Marihuana Reconsidered and is an Associate Professor of Psychiatry at Harvard Medical School. I think that he certainly needs no further introduction.

DR. LESTER GRINSPOON: Thank you, Dick. I think the program committee has done somewhat of an injustice putting us on after Reefer Madness. That makes it more difficult to present a dull, tedious, serious paper on the subject, but I beg your indulgence.

There now appears to be little doubt that among the commonly used psychoactive drugs, the amphetamines have a formidable potential for harm, psychological, physical and social. It is clear that while they may be used, particularly in small doses over limited periods of time, without creating dependency, their use imposes the risk of severe dependency on many, and outright addiction on some. Animal data indicates that their chronic high-dose use may lead to cell damage in several organs, including the brain. In humans, chronic high-dose use often leads to short- and sometimes long-term psychoses. Even brief episodic exposure to moderate to high doses involves a significant degree of risk with respect to some physical disorders (e.g. cerebral hemorrhage) and psychoses. Furthermore, while it has not been conclusively established, there is a high degree of suspicion that prolonged high-dose use may lead, in some, to a global deterioration of mental functioning. There is, however, no doubt that the amphetamine abuser is more likely to become involved in destructive, often violent and impulsive, antisocial behavior.

There is a curious, albeit not perfect, mirror image relationship between some aspects of cannabis and the amphetamines. Marihuana is not an addicting drug, and there are no serious sequelae upon cessation of chronic use; speed is addicting, and there is a withdrawal
syndrome which often includes severe depression. While there is no convincing evidence that cannabis damages tissue, amphetamines appear to have that capacity; while there are no well documented cases of death from marihuana, it is becoming increasingly clear that speed can indeed kill. Pot is not criminogenic and, in fact, being high on this drug probably diminishes the likelihood that a person may become engaged in violence and crime; just the opposite is the case with amphetamines. Cannabis in very large (usually ingested) doses is capable of producing toxic psychoses and in smaller smoked doses may rarely precipitate functional psychoses in individuals who are already vulnerable to psychoses, that is, people whose psychosis might be precipitated by such events as an alcoholic debauch, an automobile accident, a surgical procedure, or a severe loss. It has been demonstrated that a psychosis which is all but indistinguishable from a schizophrenic reaction can be induced with amphetamines in "normal" subjects in the laboratory and paranoid reactions are not uncommon among speed freaks on the street. Speed quite clearly leads to the use of other psychoactive drugs; cannabis does not.

This is not to say that cannabis is a harmless drug; quite obviously it is not. Some people experience adverse reactions and some of the factors which seem to play a part in that are individual susceptibility, dose (particularly high doses of ingested cannabis), and unfavorable set and settings. However, the risk involved in using marihuana, excluding those which derive from its legal status, are of a different magnitude from those which arise from the psychopharmacologic properties of amphetamines. In fact, the widely believed, largely mythological dangers of cannabis comprise a shoe which more nearly fits the amphetamines. Yet, the astonishing fact is that there has been an enormous concern and near hysterical outcry over the use of marihuana, while attitudes — public, governmental and medical — toward the use of amphetamines have generally ranged from actual enthusiasm to complacency and, only recently, some degree of concern.

To attempt to understand how attitudes toward these two classes of psychoactive agents became so divergent and so divorced from their actual relative potentials for harm, it may be instructive to review some aspects of what may be referred to as the social histories of these two drugs. Cannabis has an ancient history as a medicinal agent; its first recorded use is to be found in the Herbal, an ancient equivalent of the United States Pharmacopoeia, written about 400 to 500 B.C. (It is often, and probably erroneously, dated at 2737 B.C.). But its entry into Western medicine occurred in 1839 when W. B. O'Shaughnessy, a 30-year-old assistant surgeon and professor of chemistry in the
Medical College of Calcutta, reported on his experiments in treating patients with rabies, rheumatism, epilepsy, and tetanus with tincture of hemp. He found it to be an effective analgesic and to have impressive anticonvulsant and muscle relaxing properties. Stimulated by O'Shaughnessy's report, a number of Western physicians proceeded to explore the clinical possibilities of cannabis, and, within the next few decades, scores of papers on the medical usefulness of cannabis were to be found in the medical literature. Before long, it was fairly widely used in the United States in the treatment of a variety of ailments, many of which were symptomatically benefited, particularly by its analgesic and soporific effects. Several major limitations on its usefulness were imposed by the facts that it was not soluble in water and, therefore, could not be given parenterally, and that cannabis indica (the alcoholic tincture of cannabis, the form in which it was dispensed as a medicine) was notoriously unstable and, physicians therefore, could never be certain of dosage. Its uses as an analgesic began to be superseded by the opiates which were being used increasingly in the United States in the second half of the 19th century. When the hypodermic syringe was introduced from England in 1856 that use was accelerated, for the water-soluble opiates could be conveniently administered parenterally with predictable and rapid relief of pain. In fact, their use for the relief of pain became so widespread during the Civil War that opiate addiction became known as the "soldier's disease." With the development of synthetic analgesics such as aspirin, and synthetic hypnotics such as chloral hydrate and barbiturates, physicians lost interest in cannabis indica for its analgesic and hypnotic properties, for it was far less stable and, primarily for that reason, less reliable than the synthetics. Thus, in the early decades of the 20th century its use as a medicine declined rapidly and its death knell was sounded with the passage of the 1937 Marihuana Tax Act.29

Curiously, during the heyday of its use, in America, as a medicine, there was only a very narrow appreciation of the fact that cannabis could be used as an intoxicant. Those who were aware of this property were largely intellectual and literary-minded readers of those writers of the French Romantic movement who together comprised the mid-nineteenth century Le Club des Haschischins. The two most important, where cannabis is concerned, were Theophile Gautier and Charles Baudelaire. Their effusive accounts were very influential, even though Gautier was describing the toxic psychosis induced by the very large doses of hashish he ingested, and even though there is considerable question as to whether what Baudelaire wrote about

as hashish experiences were not, in fact, more truly Thomas De Quincey influenced accounts of the effects of chronic use of laudanum (a mixture of opium and alcohol) on his very fertile and highly imaginative mind. The American counterpart to these authors was Fitz Hugh Ludlow, whose book The Hasheesh Eater: Being Passages from the Life of a Pythagorean was published in 1857. While, as with Baudelaire, there is some question as to how uncontaminated with De Quincey the descriptions provided by Ludlow are, there can be no doubt, that his book was a success and excited the interest of intellectuals although apparently not to the point where large numbers of them were turning on with cannabis. One way in which Ludlow differed from his European colleagues was that while they generally used hashish as the source of the drug, his was generally obtained from his “friendly apothecary” in the form of “Tilden’s Extract” or some other brand of cannabis indica.

The writings of Fitz Hugh Ludlow were distinctive in that they provided one of the few connections in the American public mind (and a narrow segment of it at that) between cannabis the medicine and cannabis the intoxicant. Furthermore, to the extent that general knowledge of the relationship between the medicine and the euphoriant existed at all, it had all but vanished during the half century that passed before cannabis in a different form (what we now know as marihuana, grass, dope, pot — the dried leaves and flowering tops of the Cannabis sativa plant) began to come into this country from below the southern border.

A good deal of mystery surrounds the story of the “reefer’s” debut in the United States. It is generally assumed that in the early decades of this century the custom of smoking the weed in cigarette form traveled with groups of itinerant Mexican workers across the Texas border into the southwestern and southern states. In 1910 the reefer began attracting some slight attention in New Orleans. By 1926, according to R. P. Walton, who studies the problem “on location,” the city was wet with the habit. Supplies of marihuana came occasionally from Texas and more often by boat from Havana, Tampico, and Vera Cruz. Using New Orleans as a distributing center for the intoxicant, enterprising sailors became traffickers. The dried plant leaves were shipped from New Orleans up the Mississippi to various river ports and thence cross-country to large cities. It is said that by 1930 there was not one major American city which did not have a few marihuana smokers among its ranks.

In its early American years the reefer did not cause a great deal of consternation. However, as it became more popular among Mexican-
Americans and a favorite of Blacks, particularly jazz musicians in urban centers, and awareness of this use among these minority groups became more widespread, marihuana use began to arouse concern. In Louisiana, the *New Orleans Item* pointed a critical finger at the "moota" and hostilely claimed that the habit seemed to be most widespread among groups of foreign extraction. Clearly, the early fury aroused by marihuana can largely be attributed to the fact that it was introduced by Spanish speaking people and Blacks and that it was, therefore, considered an alien and un-American drug which was a particularly dangerous and degenerate intoxicant. Reflections of this increasingly widespread attitude were occasionally to be found even in the medical literature. In 1931, the *New Orleans Medical and Surgical Journal* stated that:

\begin{quote}
The debasing and baneful influence of hashish and opium is not restricted to individuals but has manifested itself in nations and races as well. The dominant race and most enlightened countries are alcoholic, whilst the races and nations addicted to hemp and opium, some of which once attained to heights of culture and civilization have deteriorated both mentally and physically.
\end{quote}

In 1930, less than 2 years before the Benzedrine inhaler first became available to the public, the Federal Bureau of Narcotics was founded. The bureau under the leadership of its first director, H. J. Anslinger, undertook an "educational program" which must be some sort of landmark for its success in converting the general lack of concern with and ignorance about marihuana to widespread alarm and misinformation. In the year of the bureau's founding, only 16 states had laws prohibiting the use of marihuana. By 1937, the year it succeeded in getting the congress to adopt the Marihuana Tax Act, nearly every state had adopted legislation outlawing marihuana. The lay press, with the help of the bureau, contributed to the campaign with its frequent publication of alarmist stories of violent behavior, usually of a sexual nature, which they asserted all but invariably resulted from use of the weed. By 1950 the bureau, which had theretofore denied that the use of marihuana led to the use of opiates, embraced the so-called "stepping-stone hypothesis" which was to become the major argument against liberalization of the marihuana laws. A number of articles appeared in the early 1950's in support of that contention. The authors of the articles offered no supporting data; apparently they realized that the mass media audience had been sufficiently propagandized to accept the "stepping stone" theory as self-
evident. Had they presented what little data was available — for example, the rise in cannabis use was simultaneous with a leveling off or even a declining rate of opiate addiction over the preceding twenty years — they would have done little to support their claims.

At about the same time the American Medical Association was undergoing a remarkable shift in attitude toward cannabis. Prior to the passage of the 1937 Marihuana Tax Act, the American medical establishment had been quite interested in, and knowledgeable about, cannabis as a medicine, and had been sensible about its capacity for abuse. The change in attitude was symbolized by the fact that the only seriously dissident voice heard during the hearings before the House Ways and Means Committee which preceded passage of the act was that of Dr. W. C. Woodward, Legislative Counsel for the American Medical Association. While he acknowledged a limited medical use for cannabis, he attempted to persuade the congressmen to initiate less restrictive legislation because of the possibility “that future investigators may show that there are substantial uses for cannabis.” Dr. Woodward then went on to attack the evidence proffered by the Treasury Department on the “marihuana problem,” particularly the claim that it was addicting, that it led to crime, and that its use was widespread among children. With the completion of his initial statement, the committee began questioning Dr. Woodward in a most hostile fashion concerning his educational background, his relationship to the American Medical Association, and his views on the medical legislation of the previous 15 years. Mr. Dingell chided Dr. Woodward: “The medical profession should be doing its utmost to aid in the suppression of this curse that is eating the very vitals of the Nation . . . . Are you not simply piqued because you were not consulted in the drafting of the bill?” Dr. Woodward was told that he was trying to throw obstacles in the federal government’s way and, of course, none of his testimony was harkened to.

The House hearings were concluded without any substantial changes in the proposed bill, and the Senate hearings were conducted in a similar way. The bill became law on October 1, 1937, and, in its wake, many state laws, just as punitive and hastily conceived, were legislated. While its clinical use was already declining somewhat in the earlier part of this century, primarily because of the introduction of synthetic hypnotics and analgesics, the difficulties imposed on its use by the Tax Act completed the medical demise of cannabis, and it was removed from the United States Pharmacopoeia and National Formulary in 1941. While, as previously mentioned, there had never been much of a public consciousness of the relationship between can-
nabis the medicine and marihuana the weed-like intoxicant that Blacks and Spanish-speaking people used, the dropping of cannabis from the listings of legitimate medicines set the stage for the ignorance of doctors and for the change in their attitudes toward cannabis over the next 30 years. In protesting the impending 1937 Marihuana Tax Act legislation, members of the Committee of Legislative Activities of the American Medical Association, wrote “Cannabis at the present time is slightly used for medicinal purposes, but it would seem worthwhile to maintain its status as a medicinal agent for such purposes as it now has. There is a possibility that a restudy of the drug by modern means may show other advantages to be derived from its medicinal use.” Thirty years later a Journal of the American Medical Association position paper, written by men who have apparently had little, if any, experience with the use of cannabis drugs and apparently as little familiarity with the medical literature asserted: “Cannabis (marihuana) has no known use in medical practice in most countries of the world, including the United States.”

This remarkable transformation of attitude toward cannabis is illustrated in the changing editorial policy of the American Medical Association. In September 1942, the American Journal of Psychiatry published a paper by Drs. S. Allentuck and K. M. Bowman entitled The Psychiatric Aspects of Marihuana Intoxication in which they asserted, among other things, that habituation to cannabis is not as strong as to tobacco or alcohol. Their report grew out of the studies they had carried out under the auspices of the La Guardia committee. The Journal of the American Medical Association subsequently published (in December 1942) a reasoned, informative editorial on their work which was described as “a careful study.” In reviewing the major findings of the study, the editorial proceeded to mention some possible therapeutic uses that might be made of the drug’s properties. Those mentioned were the treatment of depression, the treatment of loss of appetite, and the possible treatment of addicts to opiate derivatives. However, following the Journal’s publication of letters from H. J. Anslinger (January 1943) and R. J. Bouquet, Expert on the Narcotics Commission of the League of Nations (April 1944), both of which denounced the La Guardia Report, the American Medical Association made an extraordinary about-face and joined the Federal Bureau of Narcotics in the denunciation of the report. The switch was heralded by an editorial which appeared in the Journal of the American Medical Association in April 1945:

For many years medical scientists have considered cannabis a dangerous drug. Nevertheless, a book called “Marihuana Prob-
lems” by the New York City Mayor’s Committee on Marihuana submits an analysis by seventeen doctors of tests on 77 prisoners and, on this narrow and thoroughly unscientific foundation, draws sweeping and inadequate conclusions which minimize the harmfulness of marihuana. Already the book has done harm. . . . The book states unqualifiedly to the public that the use of this narcotic does not lead to physical, mental or moral degeneration and that permanent deleterious effects from its continued use were not observed on 77 prisoners. This statement has already done great damage to the cause of law enforcement. Public officials will do well to disregard this unscientific, uncritical study, and continue to regard marihuana as a menace wherever it is purveyed.

With this editorial the Journal of the American Medical Association, in the words of A. S. deRopp,

abandoned its customary restraint and voiced its editorial wrath in scolding tones. So fierce was the editorial that one might suppose that the learned members of the mayor’s committee . . . had formed some unhallowed league with the “tea-pad” proprietors to undermine the city’s health by deliberately misrepresenting the facts about marihuana.

Over the past 25 years the American Medical Association has been steadfast in maintaining a position on marihuana closely allied to that of the Federal Bureau of Narcotics. A great deal of misinformation and fear-generating mythology has come to surround this drug, and, judging by the published statements of the Council on Mental Health of the American Medical Association, the medical community has been both a victim and an agent of this unfortunate process. This position is reflected in the editorial policy of the Journal of the American Medical Association which apparently “disregards” as “unscientific” and “uncritical” any study that does not demonstrate marihuana to be “a menace wherever it is purveyed.” Thus the Journal has over recent years, with respect to cannabis, departed from the policy of accepting papers solely on the basis of criteria of medical importance and scientific soundness; clearly it has consistently accepted papers, one which from a scientific point of view have been of questionable worth but which tend to confirm the American Medical Association’s view of marihuana as a great menace, and rejected those, regardless of scientific merit, which presented data and results which contradicted this view.

Thus the medical establishment’s view of cannabis has over the course of little more than a century come full turn. The same drug that had excited physicians’ interest in 1839 and become a respected
and much used therapeutic tool during the remaining decades of the 19th century had increasingly, from the 1940's on, come to be regarded by American medicine with the same bias, fear and ignorance as by the Federal Bureau of Narcotics. By the 1960's the American Medical Association had completely denied the medical heritage and potential of cannabis and its only interest in it appeared to be in providing quasi-scientific underpinnings to some of the now widely held myths.

Amphetamine, on the other hand, came into being as a medicine and has for most of its short history enjoyed the unequivocal enthusiasm of the pharmaceutical industry and the medical profession. Only in the past several years has the medical establishment begun to be concerned about the consequences of its romance with the amphetamines. Let us briefly review the history of this class of psychoactive agents in the United States.

In 1887, the German pharmacologist, L. Edeleano, first synthesized the drug which would eventually become famous as “Benzedrine,” but he was uninterested in exploring its pharmacological properties and put this extraordinary stimulant back on the shelf. Not until 1910, did G. Barger and Sir H. H. Dale investigate the effects on experimental animals of this and a series of closely related chemical compounds, which they called “sympathomimetic amines.” However, no one in America or England grasped the implications of their findings for another 17 years, when Gordon Alles who was looking for a synthetic amine substitute for ephedrine concluded that the most effective such substitute was the original amphetamine synthesized by Edeleano. Because of his willingness to use himself as a human guinea pig, Alles not only discovered, very quickly, that amphetamine was active whether inhaled or taken orally, but also found that “Benzedrine” was surpassed by its dextro isomer (later known as Dexedrine) in its ability to alleviate fatigue, increase or intensify his alertness, and make him feel euphorically confident even when it kept him awake long into the night.

When F. P. Nabenhauer, the chief chemist at the drug house of Smith, Kline & French, found out about Alles' work he began to experiment with various commercial applications of amphetamine in conjunction with his firm's patented inhaling device. Realizing what a potential bonanza this “new” class of synthetic “ephedrine substitute” represented, the executives at Smith, Kline & French persuaded Alles to sell them all his patent rights, and in 1932 their “Benzedrine” inhaler was first made available to the public by non-prescription, over-the-counter sale in drug stores across the country. The American Medical Association issued a mild parenthetical warning note in which
it cautioned that "continued over-dosage" might cause "restlessness and sleeplessness," but, at the same time, assured physicians that "no serious reactions have been observed." In late 1937, the American Medical Association approved the new drug in tablet form, recognizing it as an acceptable therapeutic medication for the treatment of narcolepsy and postencephalitic parkinsonism. The American Medical Association further stated that "Benzedrine" was "useful" in the treatment of "certain depressive psychopathic conditions," and even that persons "under the strict supervision of a physician" could take amphetamine in order to capture "a sense of increased energy or capacity for work, or a feeling of exhilaration."

Complementing the enthusiastic over-prescribing of amphetamines by physicians is the fact that since the 1930's there have been ways in which the public could procure these euphoriants with little or no assistance or interference from organized medicine, the Food and Drug Administration, or any state or federal drug abuse control authorities. First, of course, there were the inhalers. Although Smith, Kline & French held the patent on the "Benzedrine" inhaler until 1950, other drug companies quickly realized that they could sell their own imitations without fear of patent-infringement suit, because "Benzedrine" was only one of an almost unlimited variety of equally stimulating, euphorogenic, and toxic amphetamine congeners. By the end of World War II, there were at least seven different inhalers on the market containing large amounts of these drugs, and all of them could be purchased at drug or grocery stores without a prescription. All of these products were very easy to break open, and the number of different techniques of ingestion was limited only by the ingenuity of the abusers. Although dissolving the fillers in alcohol or coffee produced the desired effects, a much stronger kick could be obtained by chewing these bits of cotton, or simply swallowing them whole.

While the inhalers introduced millions of young people to the amphetamines, most users found that it was just as easy to procure the pills. In the first three years after "Benzedrine" was introduced in tablet form, sales rose to over 50 million units. The outbreak of World War II gave perhaps the greatest impetus to date to both the legal, medically authorized use and the illegal, black market abuse of these drugs. When German Panzer troops invaded Poland, obliterated Warsaw, and turned west to rush through Belgium and France, they were taking large doses of methamphetamine to eliminate fatigue and maintain physical endurance. But the German Army was by no means the only large-scale consumer of amphetamines during World
War II; Japanese warriors and factory workers used as much or more. Nor was use of these stimulants limited to the Axis powers. According to British war statistics, 72 million standard dose amphetamine tablets were distributed to the British Armed Forces alone. Although the United States Armed Forces did not authorize the issue of amphetamines on a regular basis until the Korean “conflict,” “Benzedrine” was used extensively by Army Air Corps personnel stationed in England, and it was an open secret that many pilots were engaged in a mammoth bootlegging operation. Amphetamines were also easily obtainable from military medical officers and aides. If only 10 per cent of the American fighting men ever used amphetamines during this war, over 1.5 million men returned to the country in 1945 with some first-hand knowledge of the effects of these drugs. Indeed, in recent years, the Armed Forces have constituted a veritable breeding ground for the abuse of all kinds of drugs, and especially the amphetamines.

In recent years amphetamine prescriptions have accounted for between 6 to 10 per cent of all prescriptions for any drugs, including non-pharmaceuticals like penicillin, and a group of researchers in California have recently reported that at least one out of every five adults admits to long-term or habitual use of amphetamines. By 1946, Smith, Kline & French had been so successful in its amphetamine promotion campaign that a paper by W. R. Bett listed 39 generally accepted “clinical uses” for the drug, including treatments of schizophrenia, morphine and codeine addictions, “nicotinism” (tobacco smoking), heart block, head injuries, infantile cerebral palsy, irradiation sickness, and hypotension. Bett, who further recommended the drug for ailments like sea sickness, persisted hiccups, and even “caffeine mania,” was only one of a huge number of physicians who regarded amphetamines as “versatile remedies” which were second only to a few other extraordinary drugs like aspirin in terms of the scope, efficacy, and safety of their effects.

Today, even though the Food and Drug Administration officially recognizes only “short-term appetite reduction,” narcolepsy, some types of parkinsonism, and certain “behavioral” disorders in hyperkinetic young children as valid “therapeutic indications” for the amphetamines, the federal agency has no real power to limit the drug industry’s advertising claims, and amphetamines continue to be prescribed by many physicians for nearly as many different reasons as Bett mentioned.

By 1958 the annual legal United States production of amphetamines had risen to 75,000 pounds, or 3.5 billion tablets — enough to supply every man, woman, and child with about 20 standard (5 mg)
doses. Less than 10 years later, the drug industry admitted it was pouring out 160,000 pounds — about 8 billion amphetamine tablets — per year, or enough for 35 to 50 pills for every living American. By 1970 reported legal amphetamine production had risen to over 10 billion tablets and in 1971 it rose again to over 12 billion.

While the national media, particularly in the late 1930's and early 1940's, were giving amphetamine a tremendous amount of publicity, even referring to the new drug as “poisonous,” this did nothing to discourage use. Quite to the contrary, the numerous references to these “brain,” “pep,” and “superman” pills in popular press “news” stories and feature articles, even when ostensibly phrased as warnings, acted mainly to arouse the curiosity and interest of the American people. But the most important factor was the quick and amazingly enthusiastic reception accorded these inhalers and pills by the medical profession. The American Medical Association was especially influential in reinforcing the general impression that this was indeed a new wonder drug.

Public attitudes toward the amphetamines were initially, and for many years, either positive, neutral, or merely humorous, and the people who used them did not, in the tremendous majority of cases, fit into any traditional stereotypes of “dope fiends.” As long as the medical community was willing to accept the manufacturers’ claims, no one was going to question why in 1932 practically any new psychoactive “medicine” could be marketed without any proof of either safety or efficacy. Nor did the American Medical Association, the Food and Drug Administration, or the Federal Bureau of Narcotics have any legal or sub-legal authority to deny a drug company the right to sell practically any chemical not specifically forbidden by the Harrison Act of 1914.31 All the Food and Drug Administration could do was recommend appropriate therapeutic indications; it had absolutely no power to limit or warn against consumer purchasing of drugs for which prescriptions were not required. Furthermore, the amphetamines clearly demonstrated the ease with which drug manufacturers could expand claims for their products and advertise their usefulness in an unlimited range of areas. Some drug firms obtained patents for their amphetamine congeners and combinations on the basis of these drugs’ alleged “antidepressant” actions, and then expanded their advertising claims to include the “treatment” of conditions as disparate as obesity, alcoholism, enuresis, and so on; others took different tacks, starting from the claim that their product was “uniquely effective” in the treatment of obesity, but employing the same basic tactics.

Thus in the mid 1930's, while marihuana was beginning to be brought to the public's attention through vilification, as a menace capable of wreaking great havoc, amphetamine was introduced and then promoted as perhaps the earliest technology-derived exemplar of better living through chemistry. Marihuana, having long since lost what little public awareness it once had as a medicine, was now identified with Spanish-speaking and black people. In view of the widespread bigotry and the attitudes towards and beliefs about these minority peoples which then existed, the mythology which grew up around marihuana is not surprising. Perhaps through the unconscious process of displacement it became particularly easy for people to believe that the drug of the Blacks and the Spanish-speaking must have something to do with crime, violence, sexual excess, addiction, personality deterioration, amotivation, etc. By the same token, to the extent that this kind of bigotry is still a vital force in the United States today we would expect that it would be difficult, despite the increasingly widespread dissemination of evidence to the contrary, for people to give up these false beliefs; this certainly appears to be the case. On the other hand, there are some facets of amphetamines and their history which may have made it more difficult for people to perceive them as more harmful than they are generally thought to be. They are, after all, products of modern technology and like many other such products this fact, at least until very recently among a growing number of consumer skeptics, lent them a certain degree of legitimacy. Furthermore, whenever one picks up a trade journal in a doctor's office he sees impressive, multicolor advertisements for the many amphetamine congeners. Perhaps most important, the crucial link in the selling of this drug (with respect to "legitimate" distribution) is the physician. The drug companies do not direct their enormous advertising campaigns to the consumer, but, because the various amphetamines are prescription drugs, the doctors are the recipients of countless pieces of promotional mail, medical journals are peppered with advertisements, and there are even outright gifts. When the doctor recommends a drug, he confers on it a great deal of legitimacy — so much so that the psychoactive agents that doctors recommend are medicines, not "drugs." What is more, beyond the fact that he is a physician and, therefore, an expert on drugs, the doctor is a figure in whom people have great trust. A recent public survey conducted by psychologists at the University of Connecticut listed 20 major occupations and asked participants to rate each from the standpoint of truthfulness, competence, and altruism; physicians came out on top with clergymen second.
Car salesmen were rated last, just one place behind politicians who were 19th.) To the extent that the doctor has been an unwitting pusher of this drug, he has also been a most trusted one.

Finally, cultural factors also appear to play an important role in the perpetuation of the mirror-image relationship that exists with regard to general views, attitudes, and beliefs about cannabis and amphetamine. Societies and cultures have certain norms for acceptable behavior and performance and tend to sanction, for social use, those drugs whose psychopharmacological properties are in accord with these norms. Cannabis has been accepted for centuries among the Brahmans in India whose cultural background and religious teaching support introspection, meditation, and bodily passivity while eschewing the life of action and individual achievement. Clearly this more introspective, meditative, nonaggressive stereotype associated with marihuana goes against the Western cultural mainstream, perhaps particularly in the United States. The West, with its emphasis on achievement, activity, efficiency, speed, and aggressiveness finds amphetamine much more culturally compatible than cannabis. Beyond this very general way in which the psychopharmacologic properties of amphetamines make it fit so neatly to the fast-moving American culture template, there are some specific societal values and goals whose achievement is commonly thought to be abetted through the use of this drug. Thus, the many Americans who have been propagandized into placing great value on being energetic, confident, vitally dynamic, and very thin are particularly susceptible to the lure of a drug with a grossly unappreciated potential for harm.

MR. ATKINS: Thank you, Dr. Grinspoon. We will now hear from Mr. John Finlator. Mr. Finlator is presently a private consultant on drug abuse problems and the author of a book, Nark, which will be published in the fall. That is an appropriate title. Mr. Finlator worked for a number of years with various federal law enforcement agencies, and most recently was the Deputy Director of the Federal Bureau of Narcotics and Dangerous Drugs. I think it would be most appropriate for him to comment on the changing attitude of the Federal Bureau of Narcotics, and possibly on his own changing attitude as an individual concerned with law enforcement.

MR. JOHN FINLATOR: Thank you very much. I was going to tell you about the evils of marihuana but I was preempted by the film. I was going to tell you a little about the Bureau, but I was preempted by Dr. Grinspoon on that. So, I think I will take about sex if it is all right with you.
Mr. Raymond Shafer, who was head of the Marihuana and Drug Abuse Commission, tells a story that he says is true. I do not know if it is, but I would like to pass it along to you. He tells about one nice spring morning at Camp LeJeune when this lady Marine got up—I guess I should now call her a Ms. Marine. It was a beautiful day. She walked out through the woods, through the trees and shrubbery, and saw a little lake. She decided that she would take a bath in the altogether, which she promptly decided to do. She took her clothes off, dropped them on the edge of the water and was playing around like a little mermaid when all of a sudden she heard a strong male voice give a command and all the trees and bushes walked away, leaving just one Marine standing there by her clothes. She started to stand up but quickly got back into the water. She said, “Sir.”

“Yes, ma’am.”

“Will you get the hell out of here?”

He said, “No, ma’am.”

By this time, she knew she was in trouble and so she fished around in the water and finally found a dishpan. She pulled it up, stood up with it in front of her and said, “I’m so mad. Do you know what I am thinking?”

He said, “Yes, ma’am, you think there is a bottom in that dishpan, don’t you?”

Seriously, I recommend Dr. Grinspoon’s book, *Marihuana Reconsidered* to you. For those of you who have not looked at it, it is the most scholarly work I have read which discusses the medical side of marihuana, and my reading in the area has been considerable. There is a “companion piece” by John Kaplan, Professor of Law at Stanford University, called *Marihuana, the New Prohibition*. From both the legal and the medical points of view, these are two of the most outstanding works I have seen.

Professor Kaplan studied the members of the football team at Stanford University and their drug use. He found that 73 per cent of the football team that beat Ohio State in the Rose Bowl 3 or 4 years ago had used marihuana at one time or another. As a matter of fact, he found there was more marihuana use by members of the first team than by those who sat on the bench, but he did not know what the correlation was between the two.

I talked to Professor Kaplan about that one day and asked, “How in hell did that team ever beat Ohio State University?” He replied, “I do not know, but I suspect that somebody ought to study the drug usage of that particular football team.”
Most of you know the problems that the Bureau I at one time represented has had, and the stance that it took. I am not going to discuss that except to say that most of it was born in ignorance. The Bureau did what it did because you let it happen; because the medical profession and the scientific community let it happen. It was a wide open field — they grabbed the ball and ran with it.

We all know the story and history of marihuana, so I will not go into that, but even at the hearings on the Marihuana Tax Act,\textsuperscript{32} Congressman Snell asked what the bill was about and Sam Rayburn said that it had something to do with something called marihuana, which he believed was a narcotic of some kind.

At that time, Harry Anslinger had become Commissioner of Narcotics and had already made his stamp on the world. He bullied through the stories about marihuana. You have heard some of them today and I could quote them by the millions. They were not all his fault. As Dr. Musto tells you in his book, the administration itself actually pushed the horrors of marihuana. Harry Anslinger was the man with the charisma, the personality, the ringmaster, the clown. He was the one who could speak, and speak he did; he just overwhelmed the House and the Senate on every bill that considered marihuana and in nice, sweet, docile compliance they did what he said. The scientific world never spoke up, nor did the medical or legal professions with the exception of that poor little guy, Dr. Woodward, of whom Dr. Grinspoon reminded us, who went to Washington and was berated because Harry Anslinger passed the word, “Kill him.” That was the kind of man we had running the Bureau at that time.

Marihuana, however, is not really our worst problem. Our worst problem is something that the President’s Commission has just told us about — alcohol. Dr. Joel Fort, who is on the program, has a new book called \textit{Alcohol, America’s Biggest Drug Problem}. But alcohol does not bother us anymore, although it should. We have settled that one. We have gone through alcohol prohibition and no one really gives a damn about that problem anymore.

The first national legislation to regulate narcotic distribution was the Act of 1909,\textsuperscript{33} which was an act that prohibited the importation and use of opium. It was very ineffective. There was no way to enforce it. It just floundered around and nothing happened.

In 1914, we became even more concerned about the narcotic problem and passed the Harrison Act.\textsuperscript{34} It provided for fines up to

\textsuperscript{33} Act of Feb. 9, 1909, ch. 100, 35 Stat. 614.
\textsuperscript{34} Act of Dec. 17, 1914, ch. 1, 38 Stat. 785.
$2,000 and 5 years in jail, but was unenforceable, although they tried to enforce it with the Narcotic Division, which was in the Prohibition Unit of what was then the IRS.

By 1930, though, we had severed that little unit and created something called the Federal Bureau of Narcotics. That was when the hard push against marihuana began. Actually, the effort was not all at the federal level. At one time 31 states had laws against marihuana before there was any federal law concerning it. Some of the reasons for the drive against marihuana have been explained by Dr. Grinspoon — racial prejudice and the fear that it was addictive. The stories that came out of the Geneva Convention of 1925 had their effects on the states, but it was the Bureau that took up the cudgel and really made marihuana the killer weed. When those words were coming from our federal government they became important; it was out of the mouth of the Great White Father — when he said something, people believed it.

As a matter of fact, close to 80 per cent of the people believe that crap right now. Mr. Nixon knows that and that is why he acts as he does.

The Narcotics Control Act of 1956 imposed stronger penalty structures on narcotics and included marihuana within its coverage. Again, there was no opposition from the medical profession, the scientific world, nor the legal profession. It just rolled through.

Then in the 1960's, marihuana became the thing. The Bureau still fought hard against it, but something else happened — the law enforcement bureau of the Food and Drug Administration, HEW, called the Bureau of Drug Abuse Control (BDAC), of which I was named director was established. We took a rather soft line on marihuana. We did not think that it was that bad, and we realized that there were many other things that were much worse. That position got me into a lot of trouble. However, in 1968, we amalgamated the old FBN and BDAC and put them into the President’s Bureau of Narcotics and Dangerous Drugs. The “merger” resulted in a change of attitude. In one of the bureaus we had a chief medical officer, we had a staff of pharmacologists and scientists. They had an effect upon the new Bureau, so by the time we got past the Controlled Substances Act of 1970, the Bureau itself had proposed lessening the penalties on first-time marihuana offenses. That was not enough for many people but the proposal did come from a law enforcement bureau — something they would have considered strange had they considered it.

So, today we see that the Bureau has changed to the extent that it spends very little time or manpower on the marihuana problem. The Bureau is still officially against it and the laws are still against it, but a real metamorphosis has taken place. That is where we are today, sir.

MR. ATKINS: Thank you. Since we are running behind in time, I will quickly introduce our next speaker, Mr. Keith Stroup, an attorney. Some of you may have read a feature article on him several weeks ago in *The New York Times Magazine*. He is the founder and now the Executive Director of the National Organization for the Reform of Marihuana Laws (NORML). Keith will give us a few comments on some of the legal changes in, and some of the political influence on, the marihuana laws.

MR. R. KEITH STROUP: Thank you.

It is important to understand that the marihuana issue is not, in fact, a smoker’s issue. At NORML we spend a lot of time trying to impress that on people. The fact is that people in this country now smoke marihuana in great numbers as a matter of personal choice. We, in the panel today, have pretty well established that the laws are wrong. They originated in prejudice and ignorance, but we still have them, and they exist on the federal level. There are 26 million Americans who have smoked marihuana at least once and there are 13 million who consider themselves regular smokers. That means that 16 per cent of the adult population in this country break the law. Sixty-seven per cent of all college students have smoked marihuana — that is two out of three. There are 280,000 retail “dealers” in this country, all of whom are outlaws. They import approximately 4 tons of marihuana everyday. An estimated 13 per cent of it is confiscated and 87 per cent gets through to the consumer.

It is estimated that there were 226,000 marihuana-related arrests in this country last year, over a quarter of a million, and yet, we hear the police tell us confidently (and as was just indicated, at least, at the federal level) that the emphasis is no longer on marihuana. The police often tell us that they are only after the pusher, not the user, yet the statistics do not back that up. Of those 226,000 arrests, most of which were on a state level, 93 per cent were for possession and use, while only 7 per cent were for sale. Of those arrests that were for possession and use, two thirds were for possession of less than 1 ounce — hardly what I would consider a big dealer.

The State of Texas still has a law that permits from 2 years to life in prison for simple possession of even the smallest amount of
marihuana. In Texas right now there are over 700 people locked up for possession and use of marihuana with the average length of sentence 9½ years. If you will think about that, you will agree that it is incredibly shocking. Those people have done nothing that most of you have not done, that I have not done, and that 15 per cent of our adult population does not do now; but they were caught and, more than that, they were caught in the wrong place.

We are trying to get the government to understand that once there is a significant, although minority, portion of your population that is determined to use a drug like marihuana as a recreational drug, and once it has been established that marihuana does not present any significant threat to the society as a whole, or to the individual user, the government's role should be the same as it is with other "legal" drugs — to minimize the potential for abuse. That is really what we should be talking about. The government's role is not to lock up people who differ in their choice of drugs, whether they choose alcohol or marihuana.

As I said, the government's role should be to minimize the potential for abuse and I think that there are two areas in which it can contribute to that. One is the age area. There is no doubt that a lot of people 13, 14, 15 years old, get marihuana and smoke it. Even Dr. Grinspoon and others who have come out strongly in favor of legalizing marihuana agree that that is a potential for hazard that we should not permit. The Canadian Commission, which was the equivalent of our National Commission on Marihuana and Drug Abuse recommended, in its report, the decriminalization of marihuana in Canada and indicated that the only area of concern they had was adolescent use and abuse. It is not that marihuana is particularly harmful to the adolescent who occasionally gets it; it is rather that the adolescent does not necessarily have the maturity to know when or to what extent to use it, and may end up basing his life on marihuana or other drugs and may not develop, as I have heard Dr. Grinspoon say, his coping mechanisms. The only way you can control that sort of problem is through a regulatory system, some form of governmental regulation over the distribution which would require that a person be a certain age, probably 18, before he could get it.

We know the "alcohol age" doesn't work perfectly — most of us managed to get alcohol before we were 18 or 21. However, such regulation does have the effect of creating a policy of social discouragement. Most older Americans do not understand that it is more difficult today for adolescents to get alcohol than it is for them to get marihuana.
The second area in which the government can validly act to curb the potential for abuse is with adulteration. While it may not yet be a major problem — and I hope it does not develop into one — there are indications that some marihuana grown, say in Kansas, may not be very strong and sometimes is adulterated with much more potentially harmful drugs such as the hallucinogens, acid NBA, and strychnine. The person who has decided to smoke marihuana should not have to take the added risk of not knowing what has been added to it. Clearly, the government should realize that it is not in its interest to have a marihuana consumer playing a grabbag game. When you buy marihuana, testing it before you buy by smoking a joint, your decision to buy is, assumedly, based on whether or not you think it is good, whether or not you get high from smoking the joint. The consumer has no way of knowing whether he is getting high from good marihuana, or whether it is weak marihuana that has had LSD added to it. The government must understand that we are only going to be able to control adulteration and will only have any impact on adolescent drug use by having some system of distribution other than the black market.

However, that would mean some form of legalization, and legalization, in the public mind, has numerous bad connotations. It means no control and often means commercialization, although it does not necessarily have to result in either. Legalization does not mean that the cigarette companies will automatically enter the market and make millions of dollars.

The point is that, at this time, we need to minimize the areas in which the potential for abuse is greatest.

I would like, now, to read the end of a statement that I had prepared because I think that it is appropriate.

It would be impossible to read the proposals which President Nixon recently made concerning drugs, including mandatory life sentences, selective use of the death penalty, and a general overall reliance on the deterrent effect of criminal penalties to combat all unwanted drug use without thinking back to the drug legislation passed in the 1930's. In particular, the President's willingness to ignore the many excellent studies which have been made available to him, including the results of the National Commission on Marihuana and Drug Abuse, and to cling to his long-standing reliance on the criminal approach for use and even possession of marihuana, is reminiscent of the 1930's.

If the Congress and the state legislatures were to consider marihuana prohibition today, with no prior history of emotionalism and prejudice, I believe that not a single one would prohibit its use with
The criminal sanctions. Most would probably discourage its use, regulate its distribution and sale, control purity to avoid problems of adulteration, and add a tax as a means of raising needed revenues. Those were precisely the recommendations of the new comprehensive report by the Consumers Union in *Licit and Illicit Drugs*.

Today, we seem to be at a social impasse. Everyone is willing to say we were wrong in the 1930's, that we overestimated marihuana's potential for harm, and that we probably legislated out of ignorance. Yet, marihuana prohibition continues out of a general fear that public misinformation and morality are rooted so deeply as to spell political defeat for anyone who would challenge it.

At NORML we perceive our job as principally twofold. On one hand, we spend as much time as possible with legislators and their staffs in an attempt to be sure that they are well informed about marihuana and its potential effects on the user. We want to be sure that whatever stand they take, albeit shaped by the politics of reality, is an informed stand.

On the other hand, a major portion of our work has to do with public re-education. We must demonstrate to the elected officials that significant segments of the population have changed their mind about marihuana prohibition and are now willing to experiment with a non-criminal approach. In a country as big as this, that necessarily requires the involvement of opinion-makers, both individually and institutionally. It is obviously impossible to personally discuss the issues with over 200 million people. We are all busy and all have a myriad of issues fighting for our attention.

For most people, the marihuana laws simply do not merit high enough priority to permit firsthand investigation, so they look for signposts, for indications that they can use to form their personal position. That is where you can be of great help.

As Dr. Grinspoon has excellently documented in his paper and his book, *Marihuana Reconsidered*, the American Medical Association has been particularly at fault in the continuation of an ill-advised drug policy in this country. After its lonely opposition to the earlier legislative efforts, the AMA quickly fell in line, and up to the present time has supported the status quo. It would appear that their interest in the marihuana issue has been limited to the periodic publication of articles purporting to show the harmful effects of its use. Last year, after the governing board of the AMA recommended a policy which would have endorsed the Marihuana Commission's recommendations, the AMA House of Delegates refused to adopt it. They backed off,
A misdemeanor in this country permits one year in jail and/or a $1,000 fine. If you have any idea of the conditions of our jails and of the natural consequences of spending a year locked up, you will understand that that is no light penalty. Certainly, it is progress, better than life imprisonment, which is still the maximum permissible sentence for possession of marihuana in Texas, but the person who goes to jail in this country, even for a year, may find the truly dangerous drugs more available there than on the street. He will likely be subjected to homosexual attack, and will surely leave his prison experience with considerable alienation and bitterness for the system which unfairly defined him as a criminal. For what reason? What has he done that is so harmful that we cage him like an animal? Who are we helping by making him a criminal? Obviously, we are only exacerbating the situation. So this year at the AMA convention, let us support a resolution endorsing decriminalization. It can be done if you want to make it a big enough issue. The medical evidence is so conclusive and the evils of unnecessarily criminalizing people so obvious that the AMA can no longer refuse to act.

The same applies to the ABA. It appears that 1972 was the first year that the ABA has ever taken a stand of any kind concerning marihuana prohibition. Since most legislators are lawyers, it is incredible that the bar association has chosen to ignore the issue so long. Despite the recommendations of two separate committees that the ABA endorse decriminalization, the House of Delegates like the AMA, backed off at their convention. Apparently not wanting to appear to be acting in haste, they offered a resolution that condemned excessive penalties but clearly left open the possibility of misdemeanor sanctions. I challenge the law students here to make sure that that does not happen this summer at the next annual ABA meeting.

Let us get decriminalization endorsements this year from both groups. We at NORML are available to work with you, we can help you, we can equip you with the facts to make a convincing argument for the need to decriminalize the personal use of marihuana.

Our government has a policy of discouraging all recreational drug use. That includes alcohol, tobacco, and marihuana. We concur in this policy and we are willing to work hand in hand with the government toward that goal. But the campaign should be honest, it should be factual, and it should avoid the mythology of the 1930's. Most importantly, it should altogether avoid the use of criminal pen-
alties for those who, despite our advice to the contrary, continue to smoke marijuana.

We must continue research into the potential ill effects of long-term marijuana use. If there is anything harmful about marijuana, certainly we smokers want to know. We should warn the consumer of the potential harm, as we now do with cigarettes, but, while we are warning we should stop making criminals out of those who simply ignore our advice.

There is still much debate about how we should handle legal marijuana, whether it should be available through liquor stores, whether private companies should be allowed to sell it, what type of government controls should be imposed, etc. Of course, there is a need for more study in many of these areas, but, in the meantime, let us stop focusing our law enforcement efforts on the users. Twenty-six million Americans have now tried marijuana, including two-thirds of the nation's college students; 13 million use it regularly — it is time we changed the laws.

MR. ATKINS: During the past year or so, I had the opportunity to work with the Pennsylvania Legislature. At first, I was involved with testimony taken before the House committees. The committees started working towards a full revision of the laws about three and a half years ago. I remember some people who, at that time, recommended that marijuana should be legalized, but I also remember getting telephone calls from people, such as one particular woman, who called me and then called the attorney general and said that she thought that the death penalty should be imposed on people who were arrested on marijuana charges. What was most remarkable and frightening was that the woman did not even care if the person had a trial, mere arrest was enough.

Faced with such pressures from all sides, the House first came up with one bill, then the Senate, and then the Conference Committee. There were many proposals that were considered, with the final result that the possession of a "small" amount of marijuana was unanimously declared a misdemeanor with a maximum of 30 days' imprisonment, whether it involved first or second or multiple arrests. That was a significant change from the prior 5 year maximum. The legislators realized that in college and high school settings, most users of marijuana occasionally distribute it to friends or that one person may purchase it one time and another the next. Since that casual delivery, without remuneration, was the equivalent of possession, the 30 day penalty was also applied to possession with intent to deliver a small
amount, and for delivery of a small amount without remuneration. That contrasts with the previous penalty which was 20 years for the first offense and mandatory life for a third offense.

The legislature then considered the quantity that should be considered a "small" amount. It had to be an amount which would be appropriate for the entire state, and while it was felt that in Philadelphia 3 to 6 ounces, or even half a pound might be considered "small," some of the representatives felt that, in other areas of the state, one or two joints would be a small amount. It was finally determined that approximately an ounce would be a proper amount to consider "small" throughout the Commonwealth. Some questioned what would happen if someone unwillingly purchased an ounce and got a gram or so more. The legislature, therefore, declared that instead of 28.375 grams as the limit of a "small" amount, the limit should be set at 30 grams to protect the purchaser. Similarly, when it was determined, after listening to all the evidence, that hashish was approximately three to five times as potent and approximately four times as expensive, a quarter of an ounce was set as the "small" amount limit for it. Instead of setting that limit at 7.205 grams, it was set at 8 grams — again to protect someone who might purchase slightly more than the true "small" amount.

Another area of concern was the position marihuana should occupy on the schedule of controlled drugs. The original bills gave the Drug, Device and Cosmetics Board and the Secretary of Health the power, once a drug was scheduled, to reschedule it from the higher, more tightly controlled schedules or to remove the penalties entirely — remove it from control, based on the scientific and other evidence. The members of the House decided that was inappropriate and the power of removal from complete control was retained by the legislature. The compromise finally reached on all substances was that they can be changed from schedule to schedule by the Secretary and the Board, but that all penalties and all control can be removed only by the Legislature.

Finally, I want to say that if I am asked whether marihuana will ever be legalized in this state or elsewhere, I would say that it will not depend, that much, on chemical and scientific studies as to its harmfulness. It was clear to me that, in 1972, in Pennsylvania, it was public opinion that demanded that marihuana possession be reduced to a misdemeanor. The legislators received a great deal of pressure from their constituents because sons, daughters, and friends were getting involved.
A few years from now, if the Legislature reconsiders, I believe that, even if all the tests show that marihuana is relatively benign and very safe, even in its long-term effect, if the majority of the people, at that time, think that it should not be legalized, it will not be legalized. If, in a few years, there are studies which show that marihuana is very dangerous, but the majority of people are smoking it or are sympathetic to its use, then it will become legal. The legislative process is partly political, partly social, and certainly not all scientific.

B. General Discussion

MR. ATKINS: We now have time for a few questions.

PARTICIPANT: I would like to ask Mr. Stroup what NORML is doing in terms of influencing public opinion, especially with regard to the media.

MR. STROUP: There is a prejudice in the media against legalization because of the control of older people who went through thirty-five years of indoctrination and who are frightened by it. We find that numerous times people are afraid to allow us to present our views because they assume that we are screaming radicals who will wreak havoc on their program. What we try to do to offset that impression is to explain that the issue has very little, if anything, to do with smoking marihuana; it has to do with people's freedom. We are generally finding that there is a second reaction. The media is fascinated by the subject of marihuana and there are times when we have been allowed to explain the process in which we are involved. I think that there are times that the issue may be given more media play than it deserves because of that fascination.

I know it may surprise you, but the truth is that state legislators are not generally ignorant about marihuana. They have staffs, they read books, and they know now that marihuana does not present a significant threat. But is it not an issue like Vietnam and they are not going to make or break their careers over the marihuana law. So, while privately, both in Washington and on the state level, they will assure you that they understand and would be delighted if they could remove criminal penalties altogether, the fact is that until we can demonstrate to them that such a stand will not throw them out of office, most will not have the courage to act. Javits and Hughes, on the federal level, are obvious exceptions.

I suspect that the manner in which public opinion will be best affected is by working through groups like the Jaycees. We have a
group in Dallas, Texas, called Concerned Parents for Marihuana Reform. They represent parents of kids who have been arrested and some still have kids in jail. These are people who are not generally involved in the political system. But, when the suburban housewife goes down and talks to the Governor of Texas about her son who is locked up for 23 years in a Dallas jail, he listens, and much more so than he does to us.

Specifically, the answer to your media question is that we have not been able to bring suit against the FCC because we honestly do not feel that we have a case to make at this point. We did file a protest with the FCC when they covered something Nixon said about marihuana and we wanted equal time. They documented, convincingly to me, that marihuana had been given quite a bit of time on the evening news.

PARTICIPANT: I have a question for Mr. Finlator. Yesterday you spoke to Mr. Sonnenreich about methaqualone, which is becoming the new marihuana in terms of abuse. He said that last Thursday a recommendation to control that substance was submitted to the BNDD. I asked how long he thought that process would take and when the drug would be controlled. He replied that it would take 3 to 6 months. It seems clear that the bureaucracy in Washington is extremely prone to pressures from the pharmaceutical industry. I wonder what the procedure of study is and why it is that when the dangers have been known for at least a year, there is still no pressure being applied to control the use, etc., of the drug.

MR. FINLATOR: The reasons are many. First, the government has to determine that the drug is abused. One cannot say so just because that is read in the news. The point must be proved. Once that is done, then a hearing must be held. The manufacturers can come in and object to any proposal. If they do, then the BNDD has to get the permission or advice of the Secretary of Health, Education and Welfare (HEW), and sometimes it takes time for those two organizations to come to an agreement. When they do, the drug is placed on the schedule. Sometimes they can move pretty fast, and I think that they are going to move pretty fast on this one.

I hate to give you an evasive answer like that but it is a long process. Each step has to be taken before the next one, and very often there are arguments between the scientific side of the government, HEW, and the enforcement side — the Justice Department.
MR. ATKINS: I think there is full agreement on the federal level on methaqualone. The BNDD has just recommended, very strongly, that it be scheduled as a controlled substance.

In Pennsylvania, in January the Drug, Device and Cosmetic Board met and recommended that methaqualone be scheduled as a controlled substance and it looks as though, in Pennsylvania, it may, and probably will be, controlled in the next few weeks. There has been an all-out effort to have the serious potential for abuse of methaqualone recognized.

PARTICIPANT: I have a question for Dr. Grinspoon and Mr. Finlator. In view of what Dr. Grinspoon said about the wisdom of the AMA and what Mr. Finlator said about the rate of motion of most of the federal government, I would like to know what steps they would recommend for the regulation of drugs — how they would evaluate and regulate drugs in a wiser way.

DR. GRINSPOON: That is an enormous question and one, of course, with which we are all struggling. As far as the AMA part of the problem is concerned, I tried to point out how the AMA has been remiss in its approach. It strikes me that the AMA has allowed itself to be used as an instrument to provide a kind of quasi-scientific rationale for various attempts at moral hegemony. The literature on masturbation at the turn of this century, when there was a great moral concern about that "evil" practice, indicated that a person who masturbated would shrink his brain, would become demotivated, and would have sexual difficulties. Clearly physicians allowed themselves to be used in a moral issue. Similarly, I think that has happened with regard to marihuana. As I say, there are other motivations for the AMA's approach to such other drugs as amphetamines.

Generally, I would recommend a total ban on the advertising of all drugs as one step towards a more rational approach to the use of drugs. I am concerned that we are providing a kind of drug "education" to everybody in this country which, unfortunately, is a kind of education in which we tell youngsters who watch the television (some surveys indicate that children watch television more hours than they go to school) and see pills go into a little plastic man, that their problems, whatever they may be, get solved through drugs.

I am interested in control and decriminalization of marihuana, legal availability with control, but I would certainly not allow the tobacco or alcohol industries to become involved. I would rather marihuana simply be not advertised and not promoted.