

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

BOSTON MUNICIPAL COURT
CENTRAL DIVISION
DOCKET # 0701CR7229

COMMONWEALTH OF MASSACHUSETTS,)
)
v.)
)
RICHARD CUSICK,)
 Defendant)

and

DOCKET # 0701CR7230

COMMONWEALTH OF MASSACHUSETTS,)
)
v.)
)
RUSSELL K. STROUP,)
 Defendant)

**AFFIDAVIT OF LESTER GRINSPOON, M.D. IN SUPPORT OF
DEFENDANTS' MOTION FOR RECONSIDERATION OF THEIR
MOTION TO DISMISS, AND REQUEST FOR AN EVIDENTIARY
HEARING**

I, LESTER GRINSPOON, M.D., on oath depose and state:

1. I am an Associate Professor of Psychiatry (emeritus), at Harvard Medical School in Boston, Massachusetts, where I have taught for more than 42 years. I am also the Founding Editor of The Harvard Mental Health Letter. My area of research is psychoactive drugs. For the last two decades I have been particularly interested in the medicinal properties of cannabis. If called as a witness, I could and would testify competently to the facts set forth below. I have attached a copy of my *Curriculum Vitae*. For the Court's convenience, where appropriate I have provided footnotes referencing the sources upon

which I have relied.

2. I received a Bachelor's degree in 1951 from Tufts College and an M.D. in 1955 from Harvard Medical School. I subsequently completed an internship in Medicine at Beth Israel Hospital in Boston, Massachusetts (1955-1956), and a residency in psychiatry at Massachusetts Mental Health Center (1958-1961). I received further training as a field instructor for the National Cancer Institute in Los Angeles, California (1956-1958).

3. Since joining the Harvard Medical School faculty in 1958, I have held numerous positions, including Assistant Clinical Professor, Associate Clinical Professor and associate professor at the Harvard Medical School. My other research and teaching appointments include: Assistant in Medicine at the University Of Southern California School of Medicine (1956-1958), Director of the Clinical Research Center at the Massachusetts Mental Health Center (1961-1968), Consultant in Psychiatry and Research for Boston State Hospital (1963-1970) and an Examiner for the American Board of Psychiatry and Neurology (1969-1980). I have also held several positions for the American Psychiatric Association such as Vice-Chairperson (1975-1977) and Chairperson for the Council on Research (1977-1979), Vice-Chairperson (1979-1980) and Chairperson of the Scientific Program Committee (1980-1984).

4. I have served on several professional and community boards. These include many years as a member of the Beneficial Plant Research Association (1980-1984), the

Drug Policy Foundation (1987-1995), Physicians for Human Rights (1986-1995), the Drug Research Group (1995-2000), and Scientific and Policy Advisor of the American Council on Science and Health (1997 - present). I served as Chairperson for the Board of Directors for the National Organization for the Reform of Marihuana Laws (1993-1995). I was also a faculty member for the Zinberg Center for Addiction Studies on Cambridge, Massachusetts (1993-1996). I have served several editorial boards, including the Harvard Health Letter(1990-2007), the Journal of Social Pharmacology (1985-2000), and Addiction Research (1991- present). I founded and the Harvard Mental Health Letter in 1985 and served as its Editor until 2000.

5. I have testified before the National Marijuana Commission and the Subcommittee of the Senate Small Business Committee in 1972, the House Select Committee on Narcotics in 1977, 1979 and 1989, the Controlled Substances Advisory Committee, the Drug Abuse Research Advisory Committee in 1978, the Senate Judiciary Committee in 1980, and the House Judiciary Committee, Sub-Committee on Crime in 1997. I am also a frequent presenter at national and international conferences.

6. I have authored and co-authored over 170 articles in scholarly and professional journals, most of which deal with clinical comparisons of drug therapies. I have contributed chapters of medical textbooks, research publications, clinical protocols and conference reports. My work has been published in the *Journal of Clinical Endocrinology and Metabolism*, *New*

England Journal of Medicine, Journal of the National Cancer Institute, Mental Patients in Transition, Science Digest, Archives of General Psychiatry, Comprehensive Psychiatry, Clinical Medicine, Journal of Psychiatric Research, Psychosomatic Medicine, Diseases of the Nervous System, American Journal of Psychiatry, Scientific American, Psychopharmacologia, International Journal of Psychiatry, Encyclopedia of Science and Technology, International Narcotic Report, New York Law Journal, Journal of Consulting and Clinical Psychology, Drug Therapy, World Journal of Psychosynthesis, Medical Tribune, Contemporary Drug Problems, Social Science and Medicine, Villanova Law Review, Congressional Digest, Biological Psychiatry, The Sciences, Journal of Ethnopharmacology, Handbook on Drug Abuse, The Hastings Center Report, Harvard Mental Health Letter, Harper's, Nova Law Review, New Harvard Guide to Psychiatry, Journal of State Government, Cancer Treatment & Marijuana Therapy, Journal of Drug Issues, North Carolina Journal of International Law & Commercial Regulation, Encyclopedia of Human Biology, Drugs, Society and Behavior, Journal of American Medical Association, University of West Los Angeles Law Review, and Journal of Psychoactive Drugs.

7. I have authored, co-authored and edited some 10 books, several of which deal with the history and medical use of cannabis. These books include *Marihuana Reconsidered* (Harvard University Press, 2d ed. 1977), *Psychedelic Drugs Reconsidered* (Basic Books, 2d ed. 1981), *Psychedelic Reflections* (Human Sciences Press,

1982), *The Long Darkness: Psychological and Moral Perspectives on Nuclear Winter* (Yale University Press, 1986), and *Marihuana, The Forbidden Medicine* (Yale University Press, Revised Edition 1997).

8. Based on my research, I have found that cannabis is remarkably safe. Although not harmless, it is surely less toxic than most of the conventional medicines it would replace if it were legally available. Despite its use by millions of people over thousands of years, cannabis has never caused an overdose death. The most serious concern is respiratory system damage from smoking, but that can easily be addressed by increasing the potency of cannabis and by making use of the technology to separate the particulate matter in marijuana smoke from its active ingredients, the cannabinoids (through devices known as vaporizers). Once cannabis regains the place in the U.S. Pharmacopoeia that it lost in 1941 after the passage of the Marihuana Tax Act (1937), it will be among the least toxic substances in that compendium. Right now the greatest danger in using cannabis medically is the illegality that imposes a great deal of anxiety and expense on people who are already suffering.

9. I have done extensive research on the history of the use of cannabis for medical purposes, as well as its legal regulation in the United States. The marijuana, cannabis, or hemp plant is one of the oldest psychoactive plants known to humanity. A native plant of central Asia, cannabis may have been cultivated as much as ten thousand years ago. It was certainly cultivated in China by 4000 B.C and in

Turkestan by 3000 B.C. It has long been used as a medicine in India, China, the Middle East, Southeast Asia, South Africa, and South America. The first evidence of the medicinal use of cannabis was published during the reign of the Chinese Emperor Chen Nun five thousand years ago. Cannabis was recommended for, among other things, malaria and rheumatic pains. Another Chinese herbalist recommended a mixture of hemp, resin, and wine as an analgesic during surgery. Hemp was also noted as a remedy by Galen and other physicians of the classical and Hellenistic eras, and it was highly valued in medieval Europe.

10. Between 1840 and 1900, more than one hundred papers on the therapeutic uses of cannabis were published in American and European medical journals. It was recommended as an appetite stimulant, muscle relaxant, analgesic, sedative, anticonvulsant, and as a treatment for opium addiction. A professor at the Medical College of Calcutta, W.B. O'Shaughnessy, was the first Western physician to observe the use of cannabis as a medicine. He gave cannabis to animals, satisfied himself that it was safe, and began to use it with patients suffering from rabies, rheumatism, epilepsy, and tetanus. In a report published in 1839, he wrote that he had found tincture of hemp (a solution of cannabis in alcohol, taken orally; later to be referred to as *Cannabis indica*) to be an effective analgesic. He was also impressed with its muscle relaxant properties and called it "an anticonvulsive remedy of the greatest value." In 1890, J.R. Reynolds, a British physician, summarized thirty

years of experience with *Cannabis indica*, finding it valuable in the treatment of various forms of neuralgia, including tic douloureux (a painful facial neurological disorder), and added that it was useful in preventing migraine attacks. He also found it useful for certain kinds of epilepsy, for depression, and sometimes for asthma and dysmenorrhea. *Cannabis indica* was most commonly used as an analgesic and hypnotic (sleep medication).

11. By 1890 the medical use of cannabis was in decline. Because at that time the potency of cannabis preparations could not be accurately determined, individual clinical responses to orally ingested cannabis seemed erratic and unpredictable. Another reason for the neglect of research on the analgesic properties of cannabis was that the greatly increased use of opiates after the invention of the hypodermic syringe in the 1850s allowed soluble drugs to be injected for faster pain relief; hemp products are insoluble in water and so cannot easily be administered by injection. Toward the end of the nineteenth century, the development of such synthetic drugs as aspirin, chloral hydrate, and barbiturates, also contributed to the decline of cannabis as a medicine. But these new drugs had, and still have today, striking disadvantages. More than a thousand people die from aspirin induced bleeding each year in the United States, and barbiturates are, of course, far more dangerous.

12. Cannabis use in the United States was not particularly a matter of state or federal regulation

until 1911, when Massachusetts prohibited marijuana possession without a prescription.¹ In 1930, the year in which the Federal Bureau of Narcotics was founded, only sixteen states had laws prohibiting the use of cannabis. In contrast, by 1937, nearly every state had adopted legislation outlawing cannabis. Sociologists have speculated that pressure from the liquor lobby figured among the more subtle factors in this sudden legal onslaught. More important, lack of scientific understanding concerning the effects of cannabis enabled the unsubstantiated statements of the Federal Bureau of Narcotics to go substantially unchallenged. The Marihuana Tax Act of 1937 was the culmination of a series of efforts on the part of the Federal Bureau of Narcotics to generate anti-marijuana legislation.

13. One might have expected that Western physicians, as they became increasingly aware of the side (toxic)-effects of the synthetic analgesics and hypnotics, to reconsider marijuana as a medicine, but the Act undermined any such possibility. It imposed a transfer tax upon certain dealings with marijuana, and it provided that anyone who imports, manufactures, produces, compounds, sells, deals in, dispenses, prescribes, administers, or gives away marijuana was required to register, record transactions and pay special taxes depending on the defined purposes. Those who failed to comply were subject to large fines or prison for tax evasion. Although it was ostensibly designed to prevent non-medical use of cannabis, the Marihuana Tax Act of 1937 made cannabis so difficult

¹ Chapter 372 of the Acts of 1911.

to obtain that cannabis was removed from the United States Pharmacopoeia and National Formulary in 1941. The Boggs Act of 1951 established mandatory prison terms and large fines for violation of any federal drug law, and the Narcotic Control Act of 1956 strengthened those penalties.

14. In the 1960s, however, the public began to rediscover the medical value of cannabis, as letters appeared in lay publications from people who had learned that it could relieve their asthma, nausea, muscle spasms, or pain and wanted to share that knowledge with readers who were familiar with the drug. Meanwhile, legislative concern about recreational use of cannabis increased, and in 1970 Congress passed the Comprehensive Drug Abuse Prevention and Control Act (also called the Controlled Substances Act), which assigned psychoactive drugs to five schedules and placed cannabis in Schedule I, the most restrictive.

15. A few patients have been able to obtain medical cannabis legally in the last thirty years. Beginning in the 1970s, thirty-five states passed legislation that would have permitted medical use of cannabis but for the federal law. Several of those states actually established special research programs, with the permission of the federal government, under which patients who were receiving cancer chemotherapy would be allowed to use cannabis. These projects demonstrated the value of both smoked marijuana and oral THC (tetrahydrocannabinol). The FDA approved oral (synthetic) THC (Marinol) as a prescription medicine

in 1986. In 1976, the federal government introduced the Individual Treatment Investigational New Drug program (commonly referred to as the Compassionate IND), which provided cannabis to a few patients whose doctors were willing to undergo the paperwork-burdened and time-consuming application process. About three dozen patients eventually received cannabis before the program was discontinued in 1992, and five survivors are still receiving it - the only persons in the country for whom it is not a forbidden medicine.

16. The most effective spur to the movement for medical marijuana came from the discovery that it could prevent the AIDS wasting syndrome. It is not surprising that the Physicians Association for AIDS Care was one of the medical organizations that endorsed the California initiative prohibiting criminal prosecution of medical marijuana users.

17. I have conducted an extensive review of the literature concerning medical uses of cannabis and I am familiar with studies on the topic. Review of medical literature is a commonly used research tool. I have also studied clinically many patients who have used cannabis for the relief of a variety of symptoms; this clinical experience forms the basis of my book, *Marihuana, The Forbidden Medicine*. In my book I provide first-person accounts of the ways that cannabis alleviates symptoms of cancer chemotherapy, multiple sclerosis, osteoarthritis, glaucoma, AIDS and depressions, as well as symptoms of such less common disorders as Crohn's disease, diabetic gastroparesis, and post-traumatic stress disorder. The patient

narratives illustrate not only cannabis's therapeutic properties but also the unnecessary further pain and anxiety imposed on sick people who must obtain cannabis illegally.

18. Cannabis has several uses in the treatment of cancer. As an appetite stimulant, it can help to slow weight loss in cancer patients. It may also act as a mood elevator. But the most common use is the prevention of nausea and vomiting associated with cancer chemotherapy. About half of patients treated with anticancer drugs suffer from severe nausea and vomiting, which are not only unpleasant and painful but a threat to the effectiveness of the therapy. Retching can cause tears of the esophagus and rib fractures, prevent adequate nutrition, and lead to fluid loss. Some patients find the nausea so intolerable they say they would rather die than go on. The antiemetics most commonly used in chemotherapy are metoclopramide (Reglan), the relatively new ondansetron (Zofran), and the newer granisetron (Kytril). Unfortunately, for many cancer patients these conventional antiemetics do not work at all or provide little relief.

19. The suggestion that cannabis might be used in the treatment of cancer arose in the early 1970s when some young patients receiving cancer chemotherapy found that marijuana smoking reduced their nausea and vomiting. In one study of 56 patients who got no relief from standard antiemetic agents, 78% became

symptom-free when they smoked marijuana.² Oral tetrahydrocannabinol (THC) has proved effective where the standard drugs were not³, but smoking generates faster and more predictable results because it raises THC concentration in the blood more easily to the needed level. Also, it may be hard for a nauseated patient to take oral medicine. In fact, there is strong evidence that most patients suffering from nausea and vomiting prefer smoked marijuana to oral THC.

20. Oncologists may have been ahead of other physicians in recognizing the therapeutic potential of cannabis. In the spring of 1990, two investigators randomly selected more than 2,000 members of the American Society of Clinical Oncology and mailed them an anonymous questionnaire to learn their views on the use of cannabis in cancer chemotherapy. Almost half of the recipients responded. Although the investigators acknowledged that this group was self-selected and that there might be a response bias, their results provide a rough estimate of the views of specialists on the use of Marinol (dronabinol, oral synthetic THC) and smoked marijuana. Only 43% said the available legal antiemetic drugs (including Marinol) provided adequate relief to all or most of their patients, and only 46% said the side effects of these drugs were

² Vinciguerra, V., et al. Inhalation Marijuana as an antiemetic for cancer chemotherapy. *New York State Journal of Medicine* 1988; 88:525-527.

³ Sallan, S.E., et al. Antiemetic effect of delta-9-tetrahydrocannabinol in patients receiving cancer chemotherapy. *New England Journal of Medicine* 1975; 293:795-797.

rarely a serious problem. Forty-four percent had recommended the illegal use of cannabis to at least one patient, and half would prescribe it to some patients if it were legal. On average, they considered smoked marijuana more effective than Marinol and roughly as safe.⁴

21. Cannabis is also useful in the treatment of glaucoma, the second leading cause of blindness in the United States. In this disease, fluid pressure within the eyeball increases until it damages the optic nerve. About a million Americans suffer from the form of glaucoma (open angle) treatable with cannabis. Glaucoma is treated chiefly with eyedrops containing betablockers such as timolol (Timoptic), which inhibit the activity of epinephrine (adrenaline). They are effective but may have serious side effects such as inducing depression, aggravating asthma, slowing the heart rate, and increasing the risk of heart failure. Cannabis causes a dose-related, clinically significant drop in intraocular pressure that lasts several hours in both normal subjects and those with the abnormally high ocular tension produced by glaucoma. Oral or intravenous THC has the same effect, which seems to be specific to cannabis derivatives rather than simply a result of sedation. Cannabis does not cure the disease, but it can retard the progressive loss of sight when conventional medication fails and surgery is too dangerous.⁵

⁴ Doblin R. Kleiman M. Marijuana as anti-emetic medicine: a survey of oncologists' attitudes and experiences. *Journal of Clinical Oncology* 1991; 9:1275-80.

⁵ Hepler, R.S., et al. Ocular Effects of Marijuana

22. About 15-20% of epileptic patients do not get much relief from conventional anticonvulsant medications. Cannabis has been explored as an alternative at least since 1975 when a case was reported in which marijuana smoking, together with the standard anticonvulsants Phenobarbital and diphenylhydantoin, was apparently necessary to control seizures in a young epileptic man.⁶ The cannabis derivative that is most promising as an anticonvulsant is cannabidiol. In one controlled study, cannabidiol in addition to prescribed anticonvulsants produced improvement in seven patients with grand mal convulsions; three showed great improvement. Of eight patients who received a placebo instead, only one improved.⁷ There are patients suffering from both grand mal and partial seizure disorders who find that smoked marijuana allows them to lower the doses of conventional anticonvulsant medications or to dispense with them altogether. Furthermore, anticonvulsants have many potentially serious side effects, including bone softening, anemia, swelling of the gums, double vision, hair loss, headaches, nausea, decreased libido, impotence, depression, and psychosis. Overdoses or idiosyncratic reactions may lead to loss of motor coordination, coma or even death.

23. There are many case reports of cannabis smokers

Smoking. M.C. Braude, S. Szara (eds.).
The Pharmacology of Marijuana. New York: Raven Press, 1976.

⁶ Consroe, Paul F., et al. Anticonvulsant nature of Marijuana smoking. *Journal of the American Medical Association* 1975; 234-306-307.

⁷ Cunha, J.M., et al. Chronic administration of cannabidiol to healthy volunteers and epileptic

using the drug to reduce pain: post-surgery pain, headache, migraine, menstrual cramps, and so on. Ironically, the best alternative analgesics are the potentially addictive and lethal opioids. In particular, cannabis is becoming increasingly recognized as the most effective treatment for the pain that accompanies muscle spasm, which is often chronic and debilitating, especially in paraplegics, quadriplegics, other victims of traumatic nerve injury, and people suffering from multiple sclerosis or cerebral palsy. Many of them have discovered that cannabis not only allows them to avoid the risks of other drugs, but also reduces muscle spasms and tremors; some are even able to leave their wheelchairs.⁸

24. One of the most common causes of chronic pain is osteoarthritis, which is usually treated with synthetic analgesics. The most widely used of these drugs - aspirin, acetaminophen (Tylenol), and nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen and naproxen - are not addictive, but they are often insufficiently powerful. Furthermore, they have serious side effects. Stomach bleeding and ulcer induced by aspirin and NSAIDs are the most common serious adverse drug reactions reported in the United States, causing an estimated 7,000 deaths each year. Acetaminophen can cause liver damage or kidney failure when used regularly for long periods of time; a recent study suggests its chronic use may account for 10% of

patients. *Pharmacology* 1980; 21:175-185.

⁸ Petro, D.J. Ellenberger, C., Treatment of human spasticity with delta-9-tetrahydrocannabinol. *Journal of Clinical Pharmacology* 1981; 21:413-416.

all cases of end-stage renal disease, a condition that requires dialysis or a kidney transplant.⁹ Cannabis, as I pointed out earlier, has never been shown to cause death or serious illness. The University of Iowa conducted a study of cannabis for the relief of pain. Researchers gave oral THC or placebo at random to hospitalized cancer patients who were in severe pain. The THC relieved pain for several hours in doses as low as 5-10 mg, and for even longer at 20 mg. At this dose and in this setting, THC proved to be a sedative as well. It had fewer physical side effects than other commonly used analgesics.¹⁰

25. Oncologists are legally permitted to administer the synthetic THC (Marinol) orally in capsule form. But inhaled cannabis may be necessary for several reasons. For one thing, oral THC is subject to the variability of bioavailability. This means that two patients who take the same amount may absorb different proportions of the dose, and a given patient may respond differently on different days, depending on the condition of the intestinal tract and other factors. Furthermore, the effects of smoked cannabis are perceived almost immediately, so patients can smoke slowly and take only what they need for a therapeutic effect. Patients who swallow Marinol may discover after an hour or so that they have taken too

⁹ Perneger, T.V., Whelton, P., Klag, M.J. Risk of kidney failure associated with the use of acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs. *New England Journal of Medicine* 1994; 331:25:1675-1679.

¹⁰ R. Noyes, S.F. Brunk, D.A. Baram, and A. canter, "Analgesic Effects of Delta-9-tetrahydrocannabinol,

much for comfort or not enough to relieve their symptoms. In any case, a patient who is severely nauseated and constantly vomiting may find it almost impossible to keep the capsule down. Furthermore, Marinol makes some patients anxious and uncomfortable.

26. In theory, all the therapeutic properties of cannabis could be used if individual cannabinoids in addition to THC were isolated and made available separately as medicines. But this would be an enormously complicated procedure. Research sponsors would have to determine the therapeutic potential and evaluate the safety of sixty or more substances, synthesize each one found to be useful, and package it as a pill or aerosol. As some of these substances probably act synergistically, it would also be necessary to look at various combinations of them. However, no drug company would provide the resources needed for such a project because cannabis can not be patented; it is a plant material containing many chemicals rather than a single one and no drug in the present pharmacopoeia is delivered by smoking.

27. Although the spread of AIDS has slowed among homosexual men, the reservoir is so huge that the number of cases is sure to grow. Women and children as well as both heterosexual and homosexual men are now being affected; the disease is spreading most rapidly among intravenous drug abusers and their sexual partners. The disease can be attacked with anti-viral drugs, of which the best known are zidovudine (AZT)

Journal of Clinical Pharmacology 15 (February-March 1975): 139-143.

and protease inhibitors. Unfortunately, these drugs sometimes cause severe nausea that heightens the danger of semi-starvation for patients who are already suffering from nausea and losing weight because of the illness - a condition sometimes called the AIDS wasting syndrome.

28. Cannabis is particularly useful for patients who suffer from AIDS because it not only relieves the nausea but also retards weight loss by enhancing appetite. In one study the body weight and caloric intake of twenty-seven marijuana users and ten control subjects were compared for twenty-one days on a hospital research ward. The marijuana smokers ate more than the controls and gained weight; the controls did not. When they stopped smoking marijuana, they immediately started to eat less.¹¹ When it helps patients regain lost weight, it can prolong life. Although Marinol has been shown to relieve nausea and retard or reverse weight loss in patients with HIV infection, most patients prefer smoked cannabis for the same reasons that cancer chemotherapy patients prefer smoked cannabis. Cannabis is more effective and has fewer unpleasant side effects, and the dosage is easier to adjust. Many patients report that cannabis provides an appetite and pain relief without the semi-comatose effect of narcotics.

29. Opponents of medical cannabis often object that the evidence of its usefulness, although strong, comes

¹¹ I. Greenberg, J. Kuelmle, J.H. Mendelson, and J.G. Bernstein, "Effects of Marijuana Use of Body Weight and Caloric Intake in Humans," *Journal of Psychopharmacology* (Berlin) 49 (1976): 79-84.

only from case reports and clinical experience. It is true that there are, as yet, few doubleblind controlled studies meeting the standards of the Food and Drug Administration, chiefly because legal, bureaucratic, and financial obstacles have been constantly put in the way.

However, we know more about cannabis than about most prescription drugs. Furthermore, individual therapeutic responses are often obscured in group experiments, and case reports and clinical experience are the source of much of our knowledge of drugs. As Dr. Louis Lasagna has pointed out, controlled experiments were not needed to recognize the therapeutic potential of chloral hydrate, barbiturates, aspirin, insulin, or penicillin.¹² Nor was that the way we learned about the use of propranolol for hypertension, diazepam for status epilepticus, and imipramine for enuresis; these drugs had originally been approved for other purposes.

30. In the experimental method known as the single patient randomized trial, active and placebo treatments are administered randomly in alternation or succession. The method is often used when large-scale controlled studies are inappropriate because the disorder is rare, the patient is atypical, or the response to treatment is idiosyncratic.¹³ Several

¹² Lasagna, L. Clinical trials in the natural environment. C. Stiechele, W. Abshagan, J. KichWeser (eds). *In Drugs Between Research and Regulations*. New York: Springer-Verlag, 1985:45-49.

¹³ Larson, E.B. N-og-1 clinical trials: A technique for improving medical therapeutics. *Western Journal of Medicine* 1990; 152:52-56; Guyatt, G.H. Keller, J.L., Jaschke, R., et

patients have told me that they assured themselves of cannabis's effectiveness by carrying out such experiments on themselves, alternating periods of cannabis use with periods of abstention. I am convinced that the medical reputation of cannabis is derived partly from similar "experiments" conducted by many other patients.

31. Some physicians may regard it as irresponsible to advocate use of a medicine on the basis of case reports, which are sometimes disparaged as merely "anecdotal" evidence which counts apparent successes and ignores apparent failures. That would be a serious problem only if cannabis were a dangerous drug. The years of effort devoted to showing that cannabis is exceedingly dangerous have proved the opposite. It is safer, with fewer and less serious side effects, than most prescription medicines, and far less addictive or subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics.

32. Based on the best available medical information, it is evident that cannabis should be made available even if only a few patients could get relief from it, because the risks are so small. For example, as I mentioned, many patients with multiple sclerosis find that cannabis reduces their muscle spasms and pain. A physician may not be sure that such a patient will get more relief from cannabis than from the standard drugs baclofen, dantrolene, and diazepam - all of which are potentially dangerous or addictive - but it is almost

al. The N-of-1 randomized controlled trial: Clinical usefulness. *Annals of Internal Medicine* 1990; 112:293-299.

certain that a serious toxic reaction to cannabis will not occur. Therefore the potential benefit is much greater than any potential risk.

33. During the past few years, the medical uses of cannabis have become increasingly clear to many physicians and patients, and the number of people with direct experience of these uses has been growing. Therefore, the discussion is now turning from whether cannabis is an effective medicine to how it should be made available.

34. The government's position that cannabis has no accepted medical use is not rational, given the wealth of information confirming that cannabis is an effective medicine. Moreover, in my view, the government has long obstructed efforts to conduct research concerning cannabis. Had the United States government not stood in the way of such research, I believe that we would be at least 50 years ahead of where we are today in making cannabis available to persons who need it for medical reasons.

Signed under the pains and penalties of perjury this

___ day of March, 2008


Lester Grinspoon M.D.

LESTER GRINSPOON, M.D.

Date of birth: June 24, 1928, Newton, Massachusetts

Marital status: married, three children

EDUCATION:

- 1951 B.S., Tufts College, Medford, Massachusetts, magna cum laude.
- 1955 M.D., Harvard Medical School, Boston, cum laude.

POSTGRADUATE TRAINING AND EXPERIENCE:

- 1955-1956 Intern in Medicine, Beth Israel Hospital, Boston, Massachusetts.
- 1956-1958 Field Investigator for the National Cancer Institute, Los Angeles, California.
- 1958-1961 Resident in Psychiatry, Massachusetts Mental Health Center, (Chief of Drug Unit 1959-1960; Chief of Service 1960-1961).

RESEARCH AND TEACHING APPOINTMENTS:

- 1950-1951 Olmstead Fellow in Biology, Tufts College, Medford, Massachusetts
- 1956-1958 Assistant in Medicine, University of Southern California School of Medicine, Los Angeles, California
- 1958-1959 Teaching Fellow in Psychiatry, Harvard Medical School, Boston, Massachusetts
- 1961-1962 Assistant in Psychiatry, Harvard Medical School, Boston, Massachusetts
- 1961-1963 Lecturer on Social Relations, Harvard University, Cambridge, Massachusetts
- 1962-1964 Instructor in Psychiatry, Harvard Medical School,
1962-1965 Boston, Massachusetts
- 1961-1991 Senior Psychiatrist, Massachusetts Mental Health Center, Boston, Massachusetts
- 1964-1965 Clinical Associate in Psychiatry, Harvard Medical School, Boston, Massachusetts

1965-1968 Assistant Clinical Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

1968-1973 Associate Clinical Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

1973-1998 Associate Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

1998-2000 Associate Clinical Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

2000- Associate Professor of Psychiatry Emeritus, Harvard Medical School, Boston, Massachusetts

OTHER APPOINTMENTS:

1961-1968 Director, Clinical Research Center, Massachusetts Mental Health Center

1962 Director, Summer Institute on Alternative Ways of Handling Conflict: Behavioral Science Research Toward Peace, Sponsored by the American Academy of Arts and Sciences

1963-1970 Consultant in Psychiatry and Research, Boston State Hospital

1969- Examiner, American Board of Psychiatry and Neurology

1972-1988 Advisory Board, National Organization for the Reform of Marijuana Laws

1973-1974 Budget Committee, American Psychiatric Association

1973- Executive Director, Massachusetts Mental Health Research Corporation

1974-1979 Consultant, Task Force on Interface between Psychiatry and Industry, American Psychiatric Association

1974-1979 Council on Research, American Psychiatric Association

1975-1977 Vice-Chairperson, Council on Research, American Psychiatric Association

1976-1981 Advisory Board, The Center for the Study of Non-Medical Drug Use

- 1977-1979 American Psychiatric Association Representative to the American Association for the Advancement of Science
- 1977-1979 Chairperson, Council on Research, American Psychiatric Association
- 1979-1980 Vice-Chairperson, Scientific Program Committee, American Psychiatric Association
- 1979-1980 Chairperson, Subcommittee on Awards for Scientific Exhibits, American Psychiatric Association
- 1979- Council on Marihuana and Health, National Organization for the Reform of Marijuana Laws
- 1980-1984 Chairperson, Scientific Program Committee, American Psychiatric Association
- 1980-1984 Scientific Advisory Board, Beneficial Plant Research Association
- 1984-1985 Chairperson, Task Force on Soviet/American Relations, American Psychiatric Association
- 1986-1990 Founding Board of Directors, Physicians for Human Rights
- 1987- Advisory Board, The Drug Policy Foundation
- 1987- Board of Advisors, The Albert Hofmann Foundation
- 1989- Vice President, International Antiprohibitionist League
- 1989-1991 Advisory Board, Civil Liberties Union of Massachusetts/ACLU
- 1989-1991 Board of Directors, Center for Psychological Studies in the Nuclear Age
- 1990- Advisory Board, Physicians for Human Rights
- 1990-1992 Board of Directors, Drug Policy Foundation
- 1991-1993 Board of Directors, Civil Liberties Union of Massachusetts
- 1993-1996 Faculty Member, Zinberg Center for Addiction Studies, Cambridge, Massachusetts
- 1994-1995 Chairperson, Board of Directors, National Organization for the Reform of Marihuana Laws

- 1995- Advisory Board, The Drug Research Group
- 1997- Board of Scientific and Policy Advisors of the American Council on Science and Health
- 1997- Honorary Member, Arbeitsgemeinschaft Cannabis als Medizin (Alliance for Cannabis as Medicine), Germany
- 1997- International Advisory Committee, Physicians for Human Rights
- 1999 Reviewer of the draft report on the usefulness of marijuana as a medicine by the Institute of Medicine, subsequently published (Marijuana and Medicine: Assessing the Science Base) by National Academy Press, Washington, D.C., 1999
- 2000- National Advisory Council, Center for Cannabis Research, University of California

EDITORIAL BOARDS:

- 1982-1984 Editor, Psychiatry Update: The American Psychiatric Association Annual Review; Volumes I-III
- 1982-1993 Journal of Psychiatric Research
- 1984-2000 Editor, The Harvard Mental Health Letter
- 1985- Journal of Social Pharmacology
- 1985- The Harvard Health Letter
- 1991- Addiction Research
- 1998- Journal of Cognitive Liberty and Ethics
- 2001 Journal of Cannabis Therapeutics

OTHER PROFESSIONAL ACTIVITIES:

Testified before legislative committees in the states of Massachusetts, Colorado, New Jersey, Washington, Vermont, and New York. Also testified before the National Marijuana Commission (1972), the House Armed Services Committee (1962), the Monopoly Subcommittee of the Senate Small Business Committee (1976), the House Select Committee on Narcotics (1977, 1979, 1989), the Controlled Substances Advisory Committee, the Drug Abuse Research Advisory Committee (1978), and the Senate Judiciary Committee (1980), etc.

HONORARY SOCIETIES:

Phi Beta Kappa
Alpha Omega Alpha
Boylston Society, Harvard Medical School
Columbia University Seminar Associate

PROFESSIONAL ORGANIZATIONS:

Massachusetts Medical Society
American Psychiatric Association (Fellow)
American Association for the Advancement of Science (Fellow)
Group for the Advancement of Psychiatry
Society of Biological Psychiatry
World Federation of Mental Health

MEDICAL LICENSING AND CERTIFICATION:

Diplomate, National Board of Medical Examiners
Licensed, State of Massachusetts
Diplomate, American Board of Psychiatry

PSYCHOANALYTIC TRAINING:

Graduate, Boston Psychoanalytic Institute, Boston,
Massachusetts, April 1967

Member, Boston Psychoanalytic Society, Boston, Massachusetts,
1967-1985

AWARDS:

Mencken Award: Honorable Mention Winner for contribution to
Dealing with Drugs, 1988

Alfred R. Lindesmith Award for Achievement in the Field of
Scholarship, a \$10,000 award of the Drug Policy Foundation,
Washington, D.C., 1990*

Norman E. Zinberg Award for Marijuana Research, an award of The
National Organization for the Reform of Marijuana Laws,
Washington, D.C., 1990

National Organization for the Reform of Marijuana Laws, First
Annual Lester Grinspoon Award For Outstanding Achievement in
Marijuana Law Reform: In grateful recognition of a lifetime
dedicated to reforming unjust marijuana laws, selfless devotion
to healing the sick with medical marijuana, and willingness to
champion an unpopular cause, regardless of professional
consequences, November 14, 1998

Alliance of Reform Organizations, The ARO Lifetime Achievement Award for Distinguished Service in Drug Policy Reform, 1998

*see citation, page 25

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2. Alexander, B., Meyers, L., Kenny, J., Goldstein, R., Gurewich, V., and Grinspoon, L.: Blood coagulation in pregnancy: Proconvertin and prothrombin, and the hypercoagulable state. New England Journal of Medicine, 254:358-363, 1956.
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Citation for
The Alfred R. Lindesmith Award for Achievement
in the Field of Scholarship

Presented to Dr. Lester Grinspoon
1990

Dr. Lester Grinspoon of Harvard Medical School is the complete medical scholar. His research and writing have covered a broad spectrum but perhaps his most important work has been his pursuit of truth about the nature of certain illegal drugs. In the course of that work, like Alfred R. Lindesmith, he upset many powerful people, including some in the medical establishment, who viewed impartial research on feared drugs as tantamount to heresy. Yet, in the face of that criticism, Dr. Grinspoon has persisted in his heretical pursuit of truth.

Although his earlier medical education had convinced him that the drug was dangerous, upon reviewing all of the available scientific and clinical evidence, he found marijuana to be relatively benign and to have several helpful applications for human beings.

Dr. Grinspoon was one of the most important witnesses in the suit which won a ruling from the chief administrative law judge of the DEA that marijuana was one of the safest therapeutically active drugs known to the human race.

Lester Grinspoon represents all those scholars who report the results of their research truthfully, despite the political consequences of this unwelcomed honesty.