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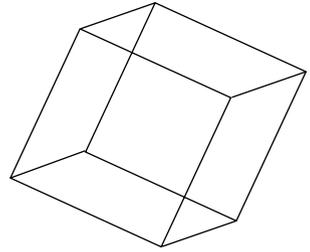
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The *Journal of Cognitive Liberties* is a scholarly forum for expressing thoughts on the importance of cognitive freedom, and for discussing the politics, policy, and prospects of integrating and protecting full-spectrum thinking in a modern society.

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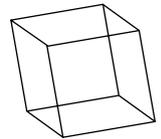
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Notes from the Director

Wrye Sententia

On June 16, 2003, the United States Supreme Court ruled in favor of a St. Louis dentist, Dr. Charles Thomas Sell, who was fighting to resist government attempts to force medicate him with powerful psychoactive drugs in order to make him competent to stand trial on fraud charges.

The Center for Cognitive Liberty & Ethics entered Dr. Sell's case because we maintain that freedom of thought depends upon an underlying right to autonomy over one's own neurochemistry. A lower federal court had found that Dr. Sell was not a danger to himself or others, and his competence to make his own medical decisions was not an issue in his case. Under such circumstances, the CCLE believes that the individual, as opposed to the government, has a Constitutional right to make his or her own decisions about what psychoactive drugs to take, or to refuse.

On behalf of Dr. Sell, the CCLE filed legal briefs in the Eighth Circuit Court of Appeal as well as in the United States Supreme Court. The CCLE's *amicus* briefs introduced the nine justices of the United States Supreme Court to the concept of cognitive liberty, arguing that the First Amendment right to Freedom of Thought is meaningless without an

Wrye Sententia is director and neuroethicist for the Center for Cognitive Liberty & Ethics.

inherent right to autonomy and self-determination over one's own functional neurochemistry.

The Supreme Court's ruling in this case carries future implications for cognitive liberty. Ruling in favor of Dr. Sell, the Court placed high hurdles to overcome, should future government efforts aim to forcibly drug a nondangerous person in instances where the government believes such a person incompetent to stand trial, though competent to make his or her own medical decisions. Unfortunately, the Court stopped short of considering whether forced medication violated the First Amendment, as the CCLE had urged them to do. While the Court ruled in favor of Dr. Sell, the justices missed a major opportunity to recognize that freedom of thought is, at least partly, rooted in brain chemistry and that giving the government broad powers to directly manipulate the brain chemistry of a non-violent citizen not only violates the First Amendment, it jeopardizes the very foundation of most of our freedoms.

In this issue of the *Journal of Cognitive Liberties*, we present the CCLE's brief filed in the United States Supreme Court on behalf of Dr. Sell. The CCLE will continue to develop the cognitive liberty argument contained in the brief and is working to extend its scope to draw upon an array of fundamental rights in addition to the First Amendment.

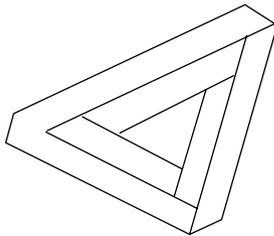
On June 26, ten days after the Supreme Court ruled in favor of Dr. Sell, the Court brought to a close decades of state laws criminalizing consensual homosexual sex. The Court's decision in *Lawrence v. Texas* was an astounding reversal of a 1986 decision in which the Court had held that people have no Constitutional right to engage in homosexual sex. As Richard Glen Boire and Julie Ruiz-Sierra discuss in their piece titled "The Transcendent Dimensions of Liberty," beyond vindicating certain freedoms traditionally associated with the body, the decision in *Lawrence* has

potentially far reaching implications for the developing legal understanding of cognitive liberty. Examining gay rights as a successful social movement, Julie Ruiz-Sierra queries whether cognitive liberty is a social movement ripe for current times.

We round out this issue with two articles by members of the CCLE's Advisory Board, and close the circle with Richard Glen Boire's thoughts on reading Jacob Sullum's new book *Saying Yes*.

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Sell v. United States ***Amicus Curiae* Brief of the CCLE**

Filed in the United States Supreme Court

Richard Glen Boire

The following brief was filed by the CCLE in support of Dr. Charles Thomas Sell, a St. Louis dentist whom the government was seeking to forcibly inject with mind-altering drugs in order to make him legally competent to stand trial. On June 16, 2003, the US Supreme Court ruled in favor of Dr. Sell, noting that the government's power to forcibly compel a nondangerous person to take psychoactive drugs is limited to "rare" circumstances.

*The full opinion in the case is available online at: <http://www.supremecourtus.gov/opinions/02pdf/02-5664.pdf>
For further information on the case, go to: http://www.cognitiveliberty.org/dll/sell_index.htm . —Ed.*

Richard Glen Boire is director and chief legal counsel of the Center for Cognitive Liberty & Ethics.

With the written consent of the parties reflected in letters lodged with the Clerk, undersigned counsel for the Center for Cognitive Liberty & Ethics (CCLE), submits this brief as *amicus curiae* in support of petitioner pursuant to Rule 37 of the Rules of Court.¹

The CCLE is a nonprofit education, law, and policy center working in the public interest to foster cognitive liberty—the right of each individual to think independently, to use the full spectrum of his or her mind, and to have autonomy over his or her own brain chemistry. The CCLE encourages social policies that respect and protect the full potential and dignity of the human intellect. The CCLE was an *amicus curiae* party to this case, in support of petitioner Dr. Sell at the petition stage, and before the Eighth Circuit when

Petition for Rehearing/ Rehearing *en banc* was filed in this case.

The CCLE encourages social policies that respect and protect the full potential and dignity of the human intellect.

As an organization charged with defending freedom of thought, the CCLE has a vital interest in this case because the forc-

ible injection of a citizen with a mind-altering drug directly infringes on cognitive liberty and mental autonomy.

The CCLE is deeply concerned that the decision below seriously compromises the core of the freedoms guaranteed by the First Amendment and, if permitted to stand, will undermine the fundamental right of all citizens to have autonomy over their own minds and mental processes.

In particular, the CCLE seeks to assist the Court by demonstrating that the right at stake in this case is a fundamental First Amendment right; the infringement of which must withstand strict scrutiny. The CCLE seeks to show that more is at issue in this case than what courts have commonly

termed "bodily integrity." At stake is a fundamental right: the right to freedom of thought.

SUMMARY OF ARGUMENT

The CCLE submits that the court of appeals mischaracterized the fundamental right at issue in this case, and as a result, erred by applying an inappropriately low standard of review.

The fundamental right to control one's own intellect and mental processes is protected by the First Amendment, and is eviscerated if courts permit the government to forcibly drug citizens. If government agents, with the concurrence of the courts, can constitutionally order the forcible manipulation of Dr. Sell's mind in order that he may stand trial, then any accused defendant, who poses no danger to self or others, is also at jeopardy of losing his or her First Amendment right to freedom of thought. This is particularly true in light of ongoing pharmacological and technological developments, which provide unprecedented tools for forcibly altering the inner workings of the mind.

To clarify, the CCLE does not propose that the state cannot regulate the *behavior* of individuals, including the acts of individuals who are incoherent or who spit on or otherwise assault judges. We maintain that the state cannot, consistent with the First Amendment of the Constitution, forcibly manipulate the *thought processes* of individuals who do not pose a clear and present danger to others. The government may, of course, use words and other expression to advocate and persuade with the intent to alter thoughts, but the First Amendment must be read to strictly forbid the government from directly and forcibly manipulating a person's brain with the intent of changing what, or how, the person thinks.

ARGUMENT

The First Amendment Guarantees Freedom of Thought

The First Amendment, which Professor Tribe terms “the Constitution’s most majestic guarantee,”² provides:

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances. *U.S. Const. Amend. I.*

While “[t]he First Amendment literally forbids the abridgment only of ‘speech,’” this Court has “long recognized that its protection does not end at the spoken or written word.” *Texas v. Johnson*, 491 U.S. 397, 404 (1989); *See also Globe Newspaper Co. v. Superior Court*, 457 U.S. 596, 604 (1982) (“[W]e have long eschewed any ‘narrow, literal conception’ of the [First] Amendment’s terms, ...for the Framers were concerned with broad principles...”).

This Court has repeatedly observed that there are derivative and corollary rights that are essential to effectuate the purposes of the First Amendment, or which are inherent in the rights expressly enumerated in the Amendment. For example, in *Lamont v. Postmaster Gen.*, 381 U.S. 301, 308 (1965), Justice Brennan, in his concurring opinion explained:

It is true that the First Amendment contains no specific guarantee of access to publications. However, the protection of the Bill of Rights goes beyond the specific guarantees to protect from congressional abridgement those equally fundamental personal rights necessary to make the express guarantees fully meaningful.

Likewise, in *Globe* this Court observed that “[t]he First Amendment is...broad enough to encompass those rights

that, while not unambiguously enumerated in the very terms of the Amendment, are nonetheless necessary to the enjoyment of other First Amendment rights." *Globe*, 457 U.S. at 604. Thus, in 1982, this Court recognized a "right to receive information and ideas," locating the right as "an inherent corollary of the right of free speech and press" guaranteed by the First Amendment. *Board of Educ. v. Pico*, 457 U.S. 853, 867 (1982) (plurality opinion).

Freedom of thought, while not expressly guaranteed by the First Amendment, is one of those fundamental rights necessary to make the express guarantees meaningful. As Justice Benjamin Cardozo extolled, "freedom of thought...is the matrix, the indispensable condition, of nearly every other form of freedom. With rare aberrations a pervasive recognition of that truth can be traced in our history, political and legal." *Palko v. Connecticut*, 302 U.S. 319, 326-27 (1937).

As this Court noted as recently as 2002, "[t]he right to think is the beginning of freedom, and speech must be protected from the government because speech is the beginning of thought." *Ashcroft v. Free Speech Coalition* 533 U.S. 234 (2002). "The guarantee of free expression," notes Professor Tribe, "is inextricably linked to the protection and preservation of open and unfettered mental activity..." L. Tribe, *supra*, § 15-7, at 1322 (2nd ed. 1988).³

Repeatedly, this Court has recognized that freedom of thought is one of the most elementary and important rights inherent in the First Amendment.

In *West Virginia State Board of Education v. Barnette*, 319 U.S. 624 (1943), this Court, in an 8-1 decision, invalidated a school requirement that compelled a flag salute on the ground that it was an unconstitutional invasion of "the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from official control." *Id.* at 642. The First Amendment, declared this Court, gives a constitutional preference for "individual freedom of

mind" over "officially disciplined uniformity for which history indicates a disappointing and disastrous end." *Id.* at 637. At the center of our American freedom, is the "freedom to be intellectually and spiritually diverse." *Id.* at 641. "We can have intellectual individualism and the rich cultural diversities that we owe to exceptional minds," this Court explained, "only at the price of occasional eccentricity and abnormal attitudes." *Id.* at 641-42.

This principle, that freedom of thought is central to the First Amendment and protected thereby, has guided other important decisions of this Court. In *Wooley v. Maynard*, 430 U.S. 705 (1977), the Court invalidated a New Hampshire

statute that required all noncommercial vehicle license plates to bear the state motto "Live Free or Die," finding the requirement inconsistent with "the right of freedom of thought protected by the First Amendment." *Id.* at 714.

"Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds. "

In *Stanley v. Georgia*, 394 U.S. 557 (1969), this Court struck down a Georgia law that banned the private possession of obscene material, finding the law

"wholly inconsistent with the philosophy of the First Amendment." *Id.* at 565-66. "Our whole constitutional heritage," explained this Court, "rebels at the thought of giving government the power to control men's minds." *Id.* at 565.

Justice Harlan, concurring in *United States v. Reidel*, 402 U.S. 351 (1971), characterized the Constitutional right protected in *Stanley* as "the First Amendment right of the individual to be free from governmental programs of thought control, however such programs might be justified in terms of permissible state objectives," and as the "freedom from governmental manipulation of the content of a man's mind..." *Id.* at 359 (Harlan J., concurring).

In *Aboud v. Detroit Board of Education*, 431 U.S. 209 (1977), this Court invalidated a statute forcing public school teachers to contribute money to a union that advanced partisan political views. This Court characterized the case as one concerning “freedom of belief” and emphasized “freedom of belief is no incidental or secondary aspect of the First Amendment’s protections... [A]t the heart of the First Amendment,” noted this Court, “is the notion that an individual should be free to believe as he will, and that in a free society one’s beliefs should be shaped by his mind and his conscience rather than coerced by the State.” *Id.* at 234-35.

The Government’s Forcible and Direct Manipulation of a Person’s Mental Processes Violates the First Amendment

The government is seeking to directly modify Dr. Sell’s thoughts and thought processes by forcibly administering antipsychotic drugs designed to manipulate the chemistry of his brain and thereby change the way he thinks. The forcible administration of antipsychotic medication is not an effort to control Dr. Sell’s behavior, with merely an incidental effect on his thinking. It is an effort aimed *directly* at changing his *mind* and *mental processes* by forcibly manipulating his brain chemistry. As such, this Court should recognize it as a serious affront to the First Amendment’s protection of freedom of thought.

This Court’s Rulings in *Harper and Riggins* Did Not Address A First Amendment Claim

In 1990, and again in 1992, this Court reviewed decisions in which defendants were medicated with psychiatric drugs against their will. However, in neither of those cases did the defendant raise a First Amendment freedom of thought claim.

In *Washington v. Harper* 494 U.S. 210 (1990), this Court (6-3) held that a state prisoner's "significant liberty interest" in refusing unwanted psychiatric drug treatment was constitutionally protected, but was outweighed by the state's interest in prison security. *Harper*, 494 U.S. at 221, 236.

Harper was a post-conviction prisoner forced to take antipsychotic drugs on order of the prison psychiatrist. *Id.* at 213-18. This Court acknowledged that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Id.* at 229. This Court held, however, that when an inmate is dangerous to others and the treatment is in his best interest, the Due Process Clause permits the state to treat the inmate with antipsychotic drugs against his will. *Id.* at 227.

Harper is distinct from the instant case in two important ways. First, Harper was a post-conviction prison inmate, whereas Dr. Sell is a pretrial detainee. Harper's status as a prisoner, led this Court to apply the deferential "standard of reasonableness," which this Court has traditionally employed to decide constitutional claims in prisons. *Id.* At 223-24.⁴ Second, unlike Dr. Sell, Harper was found to present "a danger to others," an important fact underscored by this Court:

[w]here an inmate's mental disability is the root cause of the threat he poses to the inmate population, the State's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness. *Id.* 494 U.S. at 225-26.

In *Harper*, this Court did not examine the possible First Amendment implications of forced psychiatric drug treatment. *Id.* at 258, n. 32 (Stevens J., concurring in part and dissenting in part). Additionally, because the case involved a dangerous post-conviction prisoner, rather than a nondangerous pretrial detainee deemed incompetent to stand trial,

Harper provides background, but little guidance, for evaluating the claim in the instant case.

In *Riggins v. Nevada*, 504 U.S. 127 (1992), this Court suggested that *Harper* was to be read narrowly, noting that *Harper* turned on “the unique circumstances of penal confinement.” *Id.* at 134-135. Riggins sought to raise an insanity defense to murder charges. During his trial he was medicated against his will with the antipsychotic drug Mellaril® (thioridazine HCl). His defense failed and he appealed his death sentence on the ground that the forced drugging violated his right to due process by manipulating his demeanor during trial and by hindering his ability to communicate with his attorney. In a 7-2 ruling, this Court reversed Riggins’ conviction, finding that the trial court erred by failing to acknowledge Riggins’ liberty interest in resisting the drugs, and by failing to examine whether any less intrusive alternatives to forced drugging existed. *Id.* at 133-37.

While both *Harper* and *Riggins* declared that a person has a “significant liberty interest” in resisting unwanted administration of antipsychotic drugs, neither case discussed: 1) the nature of that liberty interest; 2) whether it is a “fundamental” interest deserving of strict scrutiny; or 3) whether it could be overcome

A government that is permitted to manipulate a citizen's consciousness at its very roots does not need to censor speech, because it can prevent the ideas from ever occurring in the mind of the speaker.

simply on a finding that the defendant was incompetent to stand trial. Most specifically, in neither case was a First Amendment freedom of thought claim presented or evaluated. As discussed in the following section, First Amendment principles are at the nexus of this case, and are clearly implicated when the state forcibly administers drugs intended and designed to alter the way a person thinks.

The First Amendment Right to Freedom of Thought Is Violated when the Government Forcibly Subjects a Person to Drugs or Other Technology for the Purpose of Directly Altering the Person's Thought Processes

Antipsychotic Drugs Manipulate the Brain With the Intent and Effect of Manipulating Thought

In the instant case, the Eighth Circuit has held that the state may forcibly inject a nondangerous citizen with mind-altering antipsychotic drugs for the sole purpose of making him competent to stand trial on fraud charges. *United States v. Sell*, 282 F.3d 560 (2002). The Eighth Circuit's decision goes far beyond *Harper* or *Riggins*, or any other holding of this Court, concerning the power of the state to directly intrude into the innermost workings of a person's mind. The sweeping breadth of the Eighth Circuit's decision places freedom of thought in jeopardy, threatening the very foundation of the First Amendment as well as basic notions of individual freedom upon which this country was founded.

Sixty years ago this Court opined "[f]reedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind." *Jones v. Opelika*, 316 U.S. 584, 618 (1942). Since the advent of powerful antipsychotic drugs in the 1950s (as well as other technologies discussed in Section C2, *infra*), the government now *does have* the capability to "control the inward workings of the mind." The critical question, which the instant case frames for this Court, is whether or not the Constitution grants the government the power to alter a person's thinking processes against his or her will solely in an effort to render that person competent to stand trial. Here, the state seeks to forcibly change the way Dr. Sell *thinks*, by directly manipulating his brain chemistry.⁵ Antipsychotic

drugs, this Court has noted, are “mind altering,” and “[t]heir effectiveness resides in their capacity to achieve such effects.” *Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982). These drugs “alter the chemical balance in a patient’s brain, leading to changes...in his or her cognitive processes.” *Harper*, 494 U.S. at 229.⁶

Given that alteration of thinking is both the design and effect of antipsychotic drugs, permitting the government to *force* a citizen to take such drugs outside of the narrow context of *Harper*, cannot be squared with the supremely fundamental nature of the right to freedom of thought.

By forcing a person to take a mind-altering drug against his or her will, the government is commandeering that person’s mind, and forcibly changing his or her very ability to formulate particular thoughts. *In re guardianship of Roe*, 421 N.E.2d 40, 52-3 (1981), (“the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality.”) By directly manipulating the manner in which a person’s brain processes information and formulates ideas, the government *ipso facto* manipulates and alters both the form and content of that person’s subsequent expression and thereby completely undermines the First Amendment’s free speech guarantee.

Thus, a government action that directly and intentionally alters the way a person thinks by forcibly modifying that person’s brain, directly violates the First Amendment right to freedom of thought. By manipulating the way that Dr. Sell thinks, through the forcible act of administering mind-altering drugs to him, the state commits a type of *cognitive* censorship—suppressing Dr. Sell’s own thoughts in favor of state-approved, drug-induced, “normal,” “acceptable,” or “competent” thoughts.⁷ Such state action is surely no less disfavored under the First Amendment than the censorship of speech.⁸ A government that is permitted to manipulate a citizen’s consciousness at its very roots does not need to

ensor speech, because it can prevent the ideas from ever occurring in the mind of the speaker.⁹ Chemical or technological manipulation of the brain, therefore, has the potential to become the ultimate prior restraint on speech.¹⁰

If "at the heart of the First Amendment is the notion that...in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State" (*Abood*, 431 U.S. at 234-235), then there can be no doubt that the government infringes on the First Amendment when outside the narrow context of *Harper* it acts to alter what, or how, a person thinks by forcibly and directly manipulating a person's brain.

Federal Courts Have Recognized a First Amendment Violation When the Government Forces a Person to Take Mind-Altering Drugs

Federal courts have recognized the First Amendment freedom of thought implications of government-ordered forced drugging with psychiatric drugs.

In *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) a prisoner complained that he was being forced to take the drug succinylcholine, which he characterized as a "breath-stopping and paralyzing 'fright drug,'" (*id.* at 877) used at the time in aversive therapy. The Ninth Circuit reversed and remanded the case for a hearing on the prisoner's allegations, noting that "[p]roof of such matters could, in our judgment, raise serious constitutional questions respecting...impermissible tinkering with the mental processes." *Id.* at 878.

In *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), the Tenth Circuit found that the First Amendment is implicated when the government forcibly administers antipsychotic drugs to pretrial detainees. In *Bee*, a pretrial detainee brought suit after employees of the Salt Lake City Jail forcibly injected him with the antipsychotic drug thiorazine.

Quoting this Court, the Tenth Circuit in *Bee* recognized that “liberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action,”¹¹ and reasoned that “[i]f incarcerated individuals retain a liberty interest in freedom from *bodily* restraints...then *a fortiori* they have a liberty interest in freedom from physical and mental restraint of the kind potentially imposed by antipsychotic drugs.” *Bee*, 744 F.2d at 1393 (emph. in orig). Most specifically, the Tenth Circuit found that the First Amendment is implicated when the government forcibly administers antipsychotic drugs to a person, explaining:

The First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas. [Citations omitted] Antipsychotic drugs have the capacity to severely and even permanently affect an individual’s ability to think and communicate. *Id.* at 1393-94.

Continuing, the Tenth Circuit in *Bee* observed:

“In a society whose ‘whole constitutional heritage rebels at the thought of giving government the power to control men’s minds,’ the governing institutions, and especially the courts, must not only reject direct attempts to exercise forbidden domination over mental processes; they must strictly examine as well oblique intrusions likely to produce, or designed to produce, the same result.” L. Tribe, [*supra*] at 899 (1978) (quoting *Stanley*, [*supra*] 394 U.S. 557, 565...). *Bee*, 744 F.2d at 1394.

The Tenth Circuit’s reasoning in *Bee* was followed by the Sixth Circuit in a case involving a pretrial detainee whom the government sought to forcibly drug in an effort to make him competent to stand trial. In *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998) the Sixth Circuit agreed with

the *Bee* court that a pretrial detainee has, among other interests, "a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas." *Brandon*, 158 F.3d at 953.

The Fundamental Right to Freedom of Thought Must Be Jealously Guarded By A Clear Bright-Line Rule

In light of the importance that this Court and federal courts have placed upon the constitutional right of an individual to freedom of thought and integrity over his or her thought processes, it is imperative that this Court strictly circumscribe, and make unequivocally clear, the limits on the government's power to forcibly and directly alter the thoughts of citizens. The absence of such an unambiguous bright-line rule at the jurisprudential crossroads of psychiatry and technology, exposes the very foundation of the First Amendment to erosion, and grants "government the power to control men's minds." *Stanley*, 394 U.S. at 565.

Abuse and Misapplication of Mental Diagnosis Threatens to Undermine Freedom of Thought In the Absence of an Unequivocal and Narrow Rule

The former Soviet Union had a First Amendment equivalent, but it was merely an unenforced "paper" right. It was not uncommon for Soviet psychiatrists to forcibly drug political dissidents after labeling them "mentally ill." See Sidney Bloch & Peter Reddaway, *Psychiatric Terror: How Soviet Psychiatry Is Used to Suppress Dissent* (1977); See also James F. Clarity, A Freed Dissident Says Soviet Doctors Sought to Break His Political Beliefs; *N. Y. Times*, Feb. 4, 1976, at A1, 8. Similar political misuse of psychiatry reportedly continues today in the People's Republic of China. See Robin Munro, "Judicial Psychiatry in China and its Political Abus-

es," Vol. 14, no.1 *Columbia Jnl. Asian Law* 1-128 (2000); Munro, "Political Psychiatry in Post Mao China and its Origins in the Cultural Revolution," Vol. 30, n. 1 *Jnl. Amer. Acad. Psychiatry & Law* 97-106 (2002).

Even in the absence of overt political abuse, this Court has acknowledged that distinguishing "normal" thoughts from "abnormal" or "disordered" thoughts is fraught with peril: "the inquiry itself is elusive, for it presupposes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all." *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring).¹² Indeed, this Court has previously recognized that "[t]he subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations," because "[p]sychiatric diagnosis . . . is to a large extent based on medical impressions drawn from subjective analysis and filtered through the experience of the diagnostician." *Medina v. California*, 504 U.S. 437, 451 (1992), quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979). "Psychiatry," this Court has observed, "is not...an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment..." *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985); See also Ennis & Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," 62 *Calif. Law Review* 693, 697-708, 729-32 (1974).

In light of the difficulties inherent in categorizing and diagnosing "disordered" thought, the government's power to "correct a person's thinking by manipulating the person's brain against his or her will, must be strictly and unambiguously limited.

Technological Developments Threaten to Undermine Freedom of Thought in the Absence of an Unequivocal and Narrow Rule

Vigorous protection of freedom of thought is particularly important today, given major advances in technology and pharmacology.

Pharmaceutical companies are increasingly interested in the development and marketing of new drugs aimed at modulating consciousness by modifying brain chemistry. The sale of Prozac® and similar antidepressant drugs is currently one of the most profitable segments of the pharmaceutical drug industry.¹³ Sales of "antipsychotic" drugs are currently the eighth largest therapy class of drugs with worldwide sales of \$6 billion in the year 2000, a 22 percent increase in sales over the previous year.¹⁴

Machines such as brain imagers, brain monitors, and new biological interventions are rapidly increasing our knowledge of how the brain works, while simultaneously increasing the ability to monitor and/or alter its workings in both gross and subtle ways.¹⁵ The development of such drugs and technologies is to be applauded for their potential to aid millions of suffering Americans who *voluntarily* use them. But the instant case raises the dark prospect of the government *forcibly* employing existing and new technologies to overtly or covertly alter the way that the populace, or individual citizens, think.¹⁶

As cautioned by Professor Winnick, "...a vast array of treatment technologies now exist that enable government for the first time to intrude directly and powerfully into an individual's mental processes and therefore pose a potential for abuse that cannot be ignored." *Winnick, supra*, at 8. "Advances in the psychic and related sciences," conjectured Justice Brandies 75 years ago, "may bring means of exploring unexpressed beliefs, thoughts and emotions." *Olmstead*

v. *United States*, 277 U. S. 438, 474 (1928) (Brandeis, J., dissenting opinion). Technological progress is indeed turning “mind control” fiction into fact, with the possibility that neurochemical drugs or other technology could be deployed as tools of individual and social control.¹⁷ Already in use, and undergoing further development, is a “brain fingerprinting” machine, a brainwave-measuring device intended for law enforcement use. See United States General Accounting Office, Investigative Techniques: Federal Agency Views on the Potential Application of “Brain Fingerprinting.” *Report GAO-02-22*, (Oct. 2001).

Dr. John D. Norseen, systems scientist for Lockheed Martin, has been quoted as saying “[w]e are at the point where... we can use a single electrode or something like an airport security system where there is a dome above your head to get enough information that we can know the number you’re thinking.” Sharon Berry, “Decoding Minds, Foiling Adversaries,” *Signal Mag.*, (Oct. 2001).¹⁸

The Department of Defense’s Joint Non-Lethal Weapons Directorate (JNLWD) is exploring the use of various pharmaceutical psychoactive “calmative” agents in a number of contexts, including civilian crowd control by blanket sedation.¹⁹ An October 2000 JNLWD report, notes that potential “use environments” for calmative drugs include “a group of hungry refugees that are excited over the distribution of food and unwilling to wait patiently,” an “agitated population” and “riot and/or hostage situations.” *Id.* at 3, 10. Examples of more tailored means of calmative drug distribution described in the report include “application to drinking water, topical administration to the skin, an aerosol spray inhalation route, or a drug-filled rubber bullet.” *Id.* at 10.

As this Court noted in 1985, the U.S. government has, in the past, crossed ethical and legal lines by administering psychoactive drugs on unwitting civilians. See *CIA v. Sims*, 471 U.S. 159 (1985) (“Several MKULTRA subprojects

involved experiments where researchers surreptitiously administered dangerous drugs, such as LSD, to unwitting human subjects. At least two persons died as a result of MKULTRA experiments, and others may have suffered impaired health because of the testing.”)²⁰

Recently, this Court observed with respect to the Fourth Amendment, that “[i]t would be foolish to contend that the degree of privacy secured to citizens by the Fourth Amendment has been entirely unaffected by the advance of technology.... The question...is what limits there are upon this power of technology to shrink the realm of guaranteed privacy.” *Kyllo v. United States* 533 U.S. 27, 34 (2001). When that same question is asked about technological developments like those discussed in this section, the First Amendment guarantee of freedom of thought demands an answer by this Court that establishes unequivocal limits on the government’s power to invade the inner workings of a person’s mind.

Violating a Person’s Fundamental Right to Freedom of Thought Solely to Advance the Government’s Interest in Adjudicating Crimes Does Not Withstand Strict Scrutiny

To infringe on a fundamental right such as the First Amendment right to freedom of thought, the government must justify its action by no less a standard than strict scrutiny. See *N.A.A.C.P. v. Button*, 371 U.S. 415, 438 (1963) (“The decisions of this Court have consistently held that only a compelling state interest...can justify limiting First Amendment freedoms.”); *Brandon*, 158 F.3d at 957 (“[T]o forcibly medicate [a non-dangerous pretrial detainee] the government must satisfy strict scrutiny review and demonstrate that its proposed approach is narrowly tailored to a compelling interest.”).

The Government's Interest in Adjudicating Crimes Is, Standing Alone, Insufficiently Compelling to Justify Forcible Alteration of a Defendant's Thought Processes

To survive strict scrutiny, the governmental interest advanced "must be paramount, one of vital importance, and the burden is on the government to show the existence of such an interest." *Elrod v. Burns*, 427 U.S. 347, 362 (1976). Here, the sole interest asserted by the state is its "interest in bringing a defendant to trial." *Sell*, 283 F.3d at 568. While this is undeniably a *legitimate* governmental interest, the CCLE submits that it is insufficiently *compelling, by itself*, to override a person's First Amendment right to freedom of thought.

This Court should reject the Eighth Circuit's assertion that some charges are sufficiently "serious" to justify forced drugging with antipsychotics. *Sell*, 282 F.3d at 568. The CCLE submits that a bare determination of a defendant's incompetence to stand trial, regardless of the "seriousness" of the offense, may not, standing alone, serve as the overriding justification for the state directly intruding into a person's brain and manipulating how he or she thinks. To permit such an important First Amendment right to turn on how various courts characterize the "seriousness" of offenses would invite confusion and inconsistent application of the law. One need only look at the Eighth Circuit's perfunctory conclusion that fraud and money laundering (nonviolent economic crimes), are "serious" enough to justify drugging Dr. Sell, to clearly glimpse how important it is for this Court to unequivocally state that a finding of incompetence to stand trial is, alone, insufficient to justify the government in forcibly administering mind-altering drugs to a defendant.

In the instant case, the Eighth Circuit affirmed that Dr. Sell is not a danger to himself or others. *Sell*, 283 F.3d at 565. ("Upon review, we agree that the evidence does not

support a finding that Sell posed a danger to himself or others at the Medical Center"). Dr. Sell has merely been found incompetent to stand trial. The test for determining competence to stand trial is whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." *Dusky v. United States*, 362 U.S. 402, 402 (1960). Professor Winnick has suggested that the test for competency to stand trial should not be conflated with the

The right of a person to liberty, autonomy and privacy over his or her own thought processes is situated at the core of what it means to be a free person.

test of competency to make medical treatment decisions, explaining: "at least some and perhaps many defendants found incompetent to stand trial are competent to make medical treatment decisions, it would [therefore] seem unconstitution-

al conclusively to presume that all defendants found incompetent to stand trial are also incompetent [to make their own medical decisions]." *Winnick, supra*, at 294, n.165.

Indeed this Court has recognized, "commitment and competency proceedings address entirely different substantive issues." *Cooper v. Oklahoma*, 517 U.S. 348, 368 (1996). Dr. Sell has *not* been found to be incompetent to make his own *medical decisions*. In order to civilly commit a person, and thereby substitute the state's authority in treatment decisions for the person's own authority, this Court previously emphasized:

...due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of "surviving safely in freedom," *id.*, at 573-576. The test for competence to stand trial, by contrast, is whether the defendant has the present ability to under-

stand the charges against him and communicate effectively with defense counsel. *Cooper*, 517 U.S. at 368.

Accordingly, simply because Dr. Sell has been declared incompetent to stand trial, the state must not, *ipso facto*, be handed the enormous power of reworking his brain and “correcting” his thoughts. A clear rule that the First Amendment prohibits the government from altering the way a person thinks merely because that person has been declared incompetent to stand trial, also comports with principles of fundamental fairness and other constitutional guarantees. As Justice Kennedy noted in his concurring opinion in *Riggins*:

[c]ompetence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross examine witnesses, and the right to testify on one’s own behalf or to remain silent without penalty for doing so. *Riggins* 504 U.S. at 139-140.

Justice Kennedy’s comments underscore that the government’s interest is not merely to bring defendants to trial, but to conduct a fair and just trial. See *Brecht v. Abrahamson*, 507 U.S. 619, 652 (1993) (O’Connor, J., dissenting) (“[T]he central goal of the criminal justice system...[is the] accurate determination of guilt and innocence”); *Estes v. Texas*, 381 U.S. 532, 542-43 (1965) (“The criminal trial under our Constitution has a clearly defined purpose, to provide a fair and reliable determination of guilt, and no procedure or occurrence which seriously threatens to divert it from that purpose can be tolerated.”) “The Constitution,” this Court has explained, “recognizes an adversary system as the proper method of determining guilt, and the Government, as a litigant, has a legitimate interest in seeing that cases in

which it believes a conviction is warranted are tried before the tribunal which the Constitution regards as most likely to produce a fair result." *Singer v. United States*, 380 U.S. 24, 36 (1965).

It is precisely because our criminal justice system is *adversarial*, and because the Constitution demands a *fair trial*, that the government's "legitimate interest in seeing that cases...are tried," must not be found to encompass the power to forcibly drug its adversaries into "competence." Indeed, the Eighth Circuit's ruling turns "competence to stand trial" into a weapon against the defendant, by transforming it into a gruesome test that the defendant must pass in order to escape having his mental processes forcibly manipulated by the state. This turns the principles underlying the rule on their head. What pretrial detainee will feel safe raising the issue of trial competence when the result could well be a forced injection of mind-altering drugs?

Further, drugging a defendant with antipsychotics or other psychoactive drugs will likely affect the person's demeanor at trial and/or his or her testimony. As Justice Kennedy noted in his concurring opinion in *Riggins*:

The avowed purpose of [antipsychotic] medication is not functional competence, but competence to stand trial. In my view, elementary protections against state intrusion require the State, in every case, to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel. Based on my understanding of the medical literature, I have substantial reservations that the State can make that showing. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring).

This position was earlier expressed by the Tenth Circuit in *Bee*. There, the Tenth Circuit applied strict scrutiny after finding that a pretrial detainee has a constitutionally protected liberty interest in avoiding antipsychotic drugs. *Bee*, 744 Fd.3. at 1394. While remanding the case for further proceedings because the trial court granted the government's motion for summary judgment without a sufficient hearing, the Tenth Circuit expressed extreme skepticism that the government's interest in bringing a defendant to trial could *ever* be a sufficiently compelling reason to drug a detainee against his will:

...although the state undoubtedly has an interest in bringing to trial those accused of a crime, we question whether this interest could *ever* be deemed sufficiently compelling to outweigh a criminal defendant's interest in not being forcibly medicated with antipsychotic drugs. With their potentially dangerous side effects, such drugs may not be administered lightly. Generally speaking, a decision to administer antipsychotics should be based on the legitimate treatment needs of the individual, in accordance with accepted medical practice. A state interest unrelated to the well-being of the individual or those around him simply has no relevance to such a determination. The needs of the individual, not the requirements of the prosecutor, must be paramount where the use of antipsychotic drugs is concerned. *Id.* at 1395 (emph. added).

There Are Less Intrusive Means To Advance the Government's Interest

Under strict scrutiny analysis, the government's infringement on a fundamental right must be "narrowly tailored"²¹ or "no

greater than necessary or essential"²² to protect the governmental interest at stake.

[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental liberties when the end can be more narrowly achieved. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

As the CCLE reads the record, far less intrusive therapies, such as psychotherapy, psychoanalysis, counseling, group therapy, and a panoply of behavior therapies have yet to be tried in the instant case. *Sell*, 282 F.3d at 563-64. Psychoanalytical treatments are non-invasive, and do not directly alter the electro-chemical status of the brain. They have virtually no side effects, nor do they run the risk of chemically altering Dr. Sell's demeanor at trial or of hindering his ability to communicate with counsel or the jury. Thus, they present a far less intrusive means of advancing the state's interest than does the forcible administration of mind-altering drugs.

Finally, if this Court upholds Dr. Sell's fundamental right to freedom of thought against government efforts to forcibly drug him into competence, the result will not be to grant him his freedom. Rather, both federal and state laws provide long-standing and comprehensive procedures for dealing with defendants who are found incompetent to stand trial. See R. Roesch & S. Golding, *Competency To Stand Trial* (1980) 48-49; 18 U.S.C. §§ 4241-4248; *Greenwood v. United States*, 350 U.S. 366, 373 (1956) ("[T]he bill [enacting 18 U.S.C. 4241 *et seq.*] was proposed by the Judicial Conference of the United States after long study by a conspicuously able committee, followed by consultation with federal district and circuit judges...[and] deals comprehensively with those persons charged with federal crime who are insane or mentally incompetent to stand trial"); *Riggins*, 504 U.S. at 145 (Kennedy, J., concurring) ("If the State cannot render

the defendant competent without involuntary medicine, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means"); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (noting that if a detainee is not competent to stand trial, the government may "institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen"). These existing systems protect society while also protecting the best medical interest of the individual. Following these established procedures protects the right to freedom of thought as well as the state's interest in adjudicating crimes.

As this Court observed nearly 100 years ago:

There is... a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will. *Jacobson v. Massachusetts*, 197 U.S. 11, 29 (1905).

A person's intellect is surely within that protected sphere. The right of a person to liberty, autonomy and privacy over his or her own thought processes is situated at the core of what it means to be a free person. It is essential to the most elementary concepts of human freedom, dignity, and self-expression, and demands this Court's steadfast protection. The right to sovereignty over one's own thought processes is the quintessence of freedom, and is protected by the First Amendment.

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges the Court to reverse the decision of the Eighth Circuit. Respectfully submitted,

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Notes

1. No counsel for a party authored this brief in whole or part, and no person or entity other than the *amicus curiae*, its members or its counsel, made a monetary contribution to the preparation and submission of this brief.

2. Laurence Tribe, *American Constitutional Law*, § 12-1, 785 (2nd ed. 1988).

3. Professor Emerson makes the same point. Situating freedom of thought as the foundation of the First Amendment, he explains:

Forming or holding a belief occurs prior to expression. But it is the first stage in the processes of expression, and it tends to progress into expression. Hence safeguarding the right to form and hold beliefs is essential in maintaining a system of freedom of expression. Freedom of belief, therefore, must be held included within the protection of the First Amendment. (Thomas Emerson, *The System of Freedom of Expression*, 21-22 (1970)).

4. "[P]rison regulations...are judged under a 'reasonableness' test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights." *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987).

5. The order granting the petition in this case limited the issue to whether petitioner's rights under the First, Fifth, and Sixth Amendments are violated by allowing the government to administer antipsychotic drugs to him against his will in order to make him competent to stand trial for nonviolent offenses. While the CCLE's brief is limited to articulating the First Amendment right to freedom of thought, the CCLE observes that government authorized forced drugging of a person with mind-altering drugs implicates other constitutional guarantees (federal and state) including the right to privacy, the rights guaranteed by the Fourth, Fifth, Sixth, Ninth, Tenth and Fourteenth Amendments, as well as International resolutions, laws, and treaties such as the Universal Declaration of Human Rights, adopted by the United Nations General Assembly. See,

e.g., William J. Brennan, "State Constitutions and the Protection of Individual Rights," 90 *Harv. L. Rev.* 389 (1977); Michael Perlin, "State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?," 20 *Loy. L.A. L. Rev.* 1249, 1250-51 (1987); Bruce Winnick, "The Right to Refuse Mental Health Treatment," Am. Psychol. Ass'n, Wash., D.C. (1997); G.A. Res. 217, U.N. GAOR, 3rd Sess., at 71, U.N. Doc. A/810 (1948); *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, G.A. Res. 119, U.N. GAOR, 46th Sess., Supp. No. 49, Annex, at 188-92, U.N.Doc. A/46/49 (1991).

It is obligatory that Helsinki signatory states not manipulate the minds of their citizens; that they not step between a man and his conscience or his God; and that they not prevent his thoughts from finding expression through peaceful action. *Hearings on Abuse of Psychiatry in the Soviet Union before the Subcomm. on Human Rights and Int'l Orgs. of the House Comm. on Foreign Affairs*, 98th Cong., 106 (1983) (remarks by Max Kampelman, Chair of the U.S. Delegation, to the Plenary Session of the Comm. on Security and Cooperation in Europe), quoted in *Harper*, 494 U.S. at 238, n3 (Stevens, J., dissenting).

6. For many people, antipsychotic drugs may provide life-enhancing benefits. For others, the physical and mental side effects of the drugs may be unacceptable, even dangerous. See, e.g., *Harper*, 494 U.S. at 229 ("While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects"). The medical efficacy of antipsychotic drugs, however, is not the issue in this case. Even in the absence of physical and mental "side effects," the fact remains that antipsychotic drugs strongly affect thought processes. The First Amendment should be read to allocate to the individual, as opposed to the government, the final say about whether to manipulate his or her own brain for the purpose of occasioning or suppressing thoughts.

7. It should be noted that antipsychotic drugs do not cure mental illness; rather they suppress the symptoms of the illness. See Gerald Davison & John Neale, *Abnormal Psychology* 305 (8th ed. 2001).

8. Professor Shapiro has outlined the core logic of this proposition as follows:

(1) The First Amendment protects communication of virtually all kinds, whether in written, verbal, pictorial, or any symbolic form, and whether cognitive or emotive in nature.

(2) Communication entails the transmission and reception of whatever is communicated.

(3) Transmission and reception necessarily involves mentation on the part of both the person transmitting and the person receiving.

(4) It is in fact impossible to distinguish in advance mentation that will be involved in or necessary to transmission and reception from mentation that will not.

(5) If communication is to be protected, all mentation (regardless of its potential involvement in transmission or reception) must therefore be protected. Michael Shapiro, "Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies," 47 *S. Cal. L. Rev.* 237, 256 (1974).

9. "If they can get you asking the wrong questions, they don't have to worry about the answers." Thomas Pynchon, *Gravity's Rainbow* 293 (Bantam Books 1974).

10. "Any prior restraint on expression comes to...[the] Court with a 'heavy presumption' against its constitutional validity." *Organization for a Better Austin v. Keefe*, 402 U.S. 415, 419 (1971) (quoting *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58, 70 (1963)).

11. *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982), (quoting *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18, (1979) (Powell, J., concurring in part and dissenting in part)).

12. Dr. Robert Spitzer, chair of the American Psychiatric Association committees that developed two earlier versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (DSM-III and DSM-III-R) and special advisor to the committee that developed the latest DSM (DSM-IV, 1994), has acknowledged that "[t]he concept of 'disorder' always involves a value judgment." Spitzer, "The Diagnostic Status of Homosexuality in DSM-III: A Reformula-

tion of the Issues," 138 *Am. J. Psychiatry* 210, 214 (1981). For example, until 1972 the DSM defined homosexuality as a mental disorder. "Treatment," in addition to counseling, included penile plethysmograph shocks (electronic shock triggered by penile erection), drugging, and hypnosis. See N. McConaghy, "Subjective and Penile Plethysmograph Responses Following Aversion-Relief and Apomorphine Aversion Therapy for Homosexual Impulses," 115 *Brit. J. Psychiatry* 723-730 (1969); B. James & D. Early, "Aversion Therapy for Homosexuality," 1 *Brit. Med. J.* 538 (1963); M. Feldman & M. MacCulloch, "A Systematic Approach to the Treatment of Homosexuality by Conditioned Aversion: Preliminary Report," 121 *Am. J. Psychiatry* 167-171 (1964); E. Callahan & H. Leitenberg, "Aversion Therapy for Sexual Deviation: Contingent Shock and Covert Sensitization," 81 *J. Abnormal Psychol.* 60-73 (1973). In 1973, following intense debate within the American Psychiatric Association, the diagnostic disorder category of "homosexual" was removed from the DSM. *Spitzer*, *supra*, at 214.

13. According to IMS Health, a fifty-year-old company specializing in pharmaceutical market intelligence and analyses, "antidepressants, the #3-ranked therapy class worldwide, experienced 18 percent sales growth in 2000, to \$13.4 billion or 4.2 percent of all audited global pharmaceutical sales." IMS Health, *Antidepressants* (summary online <<http://www.imshealth.com/public/structure/navcontent/1,3272,1034-1034-0,00.html>>).

14. See IMS Health, *Antipsychotics* (summary online <<http://www.imshealth.com/public/structure/navcontent/1,3272,1035-1035-0,00.html>>). A report published by the Lewin Group in January 2000, found that within the Medicaid program alone, "Antidepressant prescriptions totaled 19 million in 1998...[and] [a]ntipsychotic prescriptions totaled 11 million in 1998." Lewin Group, "Access and Utilization of New Antidepressant and Antipsychotic Medications" (Jan. 2000).

15. Aside from growing applications of available brain scan devices including: functional magnetic resonance imaging f(MRI), positron emission tomography (PET), electroencephalographic monitoring (EEG); developments in fields related to nanotechnology point to possibilities for minute-scaled (physical, chemical, ther-

modynamic, mechanical, and biological) devices deployed in the body that would be capable of closer monitoring, intervention and manipulation. See Robert Freitas. *Nanomedicine Volume 1: Basic Capabilities* (1999), which methodically describes the capabilities of molecular machine systems that may be required by many, if not most, medical nanorobotic devices. These include: the abilities to recognize, sort, and transport important molecules; sense the environment; alter shape or surface texture; generate onboard energy to power effective robotic functions; communicate with doctors, patients, and other nanorobots; navigate throughout the human body; manipulate microscopic objects and move about inside a human body; timekeep, perform computations, and disable living cells and viruses. In Chapter One, Freitas writes "... most of us suppose that we are endowed with free will. But if choices by free will are simply the resolution of conflicts of neurological subsystems, and we become consciously aware of those subsystems and are able to intervene in their processes, do we run the risk of runaway instabilities at the deepest levels of what we presently call our 'minds'? Will we find that these instabilities are profound counterparts to the maladies we currently designate as epilepsy, or psychosomatic illnesses? In any redesigns of our brains which would involve opening doors to, quite literally, the ultrastructure of our thoughts, we could become 'naked to ourselves' in ways that we can only vaguely speculate about at present. Along with any other dangers we might encounter, this will raise entirely new issues of the proper role of psychotherapy and the sanctity of personal privacy" *Nanomedicine*, supra, Volume 1: Chapter 1.2 Current Medical Practice, § 1.2.5 "Changing View of the Human Body"

16. Already, for example, at least one public school has reportedly mandated drugging a student with Dextrostat, (a version of Ritalin®) and Paxil®, in order to attend school. See Douglas Montero, "I Was Told To Dope My Kid," *N. Y. Post*, Aug. 7, 2002; Karen Thomas, "Parents pressured to put kids on Ritalin: N.Y. court orders use of medicine," *USA Today*, Aug. 8, 2000 ("An Albany, N.Y. couple put their 7-year-old son back on Ritalin after a family court ruled that they must continue medicating him for ADD."). See also Lehtinen, "Technological Incapacitation: A Neglected Alternative," *2 Q. J. Corrections* 31, 35-36 (1978) (Suggesting sub-dermal im-

planting of long-acting tranquilizers as an alternative to incarceration).

17. The 20th century imagination is peppered with ruminations on the coercive potential of electronic and chemical technologies. Variations on theme form the basis for countless dystopian novels, most notably *Nineteen Eighty-Four*. (“Don’t you see that the whole aim of Newspeak is to narrow the range of thought?... Every year fewer and fewer words, and the range of consciousness always a little smaller”). George Orwell, *Nineteen Eighty-Four* 46 (Harcourt, Brace 1949); see also, *id.*, Appendix “The Principles of Newspeak;” A psychoactive drug named “Soma” controls citizens’ behavior in the novel *Brave New World*. Aldous Huxley, *Brave New World*, (Doubleday 1932); In *A Clockwork Orange*, the protagonist, Alex, is conditioned into a docile model citizen through aversion therapy. Anthony Burgess, *A Clockwork Orange*, (W. W. Norton 1963); In *The Terminal Man*, a man’s violent tendencies are controlled by implanting electrodes into his brain. Michael Crichton, *The Terminal Man*, (Knopf 1972); In *This Perfect Day*, inhabitants are genetically engineered and drugged daily into a calm state of mind. Ira Levin, *This Perfect Day*, (Random House 1970); In *Woman on the Edge of Time*, the heroine is incarcerated in a mental hospital and subjected to a panoply of forced drugs and is subjected to electrode implantation in the brain. Marge Piercy, (Knopf 1976); In *Synners*, socket nanotechnology allows imperceptibly small brain implants to directly interface with a readily available cybernetic information network. Pat Cadigan, *Synners*, (Bantam Spectra 1991); In *Mindplayers*, mind-to-mind technology works by infusing a chemical bath of sedatives to the brain, then engaging skull caps connected directly to neurons. For the central character, this experience has the effect of “producing a change in brain chemistry that felt as natural as changing your mind” Pat Cadigan, *Mindplayers* 4, (Bantam Books 1987); See generally Kenneth Melvin, Stanley Brodsky and Raymond Fowler, Jr., eds. *Psy-fi One: An Anthology of Psychology in Science Fiction* (1st ed.: Random House, 1977).

18. *Signal Magazine* is the Armed Forces Communications and Electronics Association’s “Journal for Communications, Electronics, Intelligence, and Information Systems Professionals.”

19. See Joan Lakoski, W. Murray, John Kenny, "The Advantages and Limitations of Calmatives for Use as a Non-Lethal Technique," U. Pa, (Oct. 3, 2000) (report obtained by the Sunshine Project <<http://www.sunshine-project.org>> under a FOIA Request.)

There are numerous pharmaceutical agents with a profile of producing a calm-like behavioral state currently available in clinical practice. Moreover, wide arrays of new compounds with unique cellular and molecular mechanisms are under development by the pharmaceutical industry for their ability to produce calm and tranquil-like states of behavior. Therefore, this report serves as an essential first step in identification of calmative pharmaceutical agents with potential utility as non-lethal techniques. *Id.* at 6.

20. See also *Final Report of the Select Comm. to Study Gov't Operations with Respect to Intelligence Activities*, S. Rep. No. 94-755, Book I, (1976); Report to the President by the Comm'n on CIA Activities Within the United States 226-228 (June 1975); Project MKULTRA, the CIA's Program of Research in Behavioral Modification: Joint Hearings before the Select Comm. on Intelligence and the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong., 1st Sess. (1977); *Human Drug Testing by the CIA, 1977: Hearings on S. 1893 before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong., 1st Sess. (1977).*

21. *Florida Star v. B.J.F.*, 491 U.S. 524, 541 (1989); *Miller v. Johnson*, 515 U.S. 900, 920 (1995) ("To satisfy strict scrutiny, the State must demonstrate that its...legislation is narrowly tailored to serving a compelling governmental interest").

22. *Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 32 (1984) (quoting *Procurier v. Martinez*, 416 U.S. 396, 413 (1974)).

The Transcendent Dimensions of Liberty

Notes Concerning the Cognitive Liberty
Implications of *Lawrence v. Texas*

Julie Ruiz-Sierra & Richard Glen Boire

Heralded as a landmark victory for gay rights, last term's Supreme Court decision in *Lawrence v. Texas* struck down Texas' "Homosexual Conduct" law, which criminalized consensual sex between homosexual adults. Invalidating anti-sodomy laws in 13 states, the Court's decision also overturned *Bowers v. Hardwick*, 478 U.S.186, a controversial 1986 decision holding that homosexuals have no Constitutional right to engage in gay sex.

The *Lawrence* opinion focused on legal concepts of liberty and privacy in a way that will also have lasting impact outside the struggle for gay rights. Writing for the majority, Justice Kennedy explained:

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Liberty protects the person from unwarranted government intrusions into a dwelling or other private places. In our tradition the State is not omnipresent in the home. And there are other spheres of our lives and existence, outside the home, where the State should not be a dominant presence. Freedom extends beyond spatial bounds. Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct. The instant case involves liberty of the person in both its spatial and more transcendent dimensions.

The Supreme Court's express recognition of a fundamental "liberty of the person in both its spatial and more transcendent dimensions," that among other things protects consensual, private sexual conduct between adults, leaves room for a future recognition of cognitive liberty. "At the heart of liberty," wrote Justice Kennedy, "is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." (*Quoting, Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992).)

Combining the right to privacy with the liberty interest, the Court noted:

The petitioners are entitled to respect for their private lives. The State cannot demean their existence or control their destiny by making their private sexual conduct a crime. Their right to liberty under the Due Process Clause gives them the full right to engage in their conduct without intervention of the government. It is a promise of the Con-

stitution that there is a realm of personal liberty which the government may not enter.

Elsewhere in the *Lawrence* opinion, the Supreme Court commented that individual liberty was not to be trumped by government desires to use criminal law to enforce a moral code, noting, "the issue is whether the majority may use the power of the State to enforce these views on the whole society through operation of the criminal law. Our obligation is to define the liberty of all, not to mandate our own moral code."

In time, many of the arguments advanced by the *Lawrence* court may be recognized as equally true about private consensual drug use by adults. Like the liberty of the person, cognitive liberty also has multiple dimensions. In a physical (or "spatial") sense

cognitive liberty can be seen as autonomous control over one's own neurochemistry; in an abstract (or "transcendent") sense it is about the freedom to experience and assign personal value to the full spectrum of consciousness. As with intimate sexual expression, the experience of cognition is one of the private realms of personhood where the state should have no presence. And blanket criminal drug prohibition may yet come to be understood as the enforcement of a moral code through criminal law.

The Court also noted that time can change how we view liberty, and that new dimensions of the right (e.g., 'cognitive liberty') may well bloom as time unfolds. Explaining how

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liberty is not static, but is instead constantly evolving, Justice Kennedy wrote:

Had those who drew and ratified the Due Process Clauses of the Fifth Amendment or the Fourteenth Amendment known the components of liberty in its manifold possibilities, they might have been more specific. They did not presume to have this insight. They knew times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.

Note

The full opinion in *Lawrence* can be read online at: <http://laws.findlaw.com/us/000/02-102.html>

Is it Time for a Cognitive Liberty Social Movement?

Julie Ruiz-Sierra

The explicit invocation of the right to cognitive liberty,¹ and particularly the growing support it has enjoyed among the public, in academia and in the mainstream media, point to the recognition of a concept whose time has come. Broadly defined as the fundamental right to “freedom of thought” and, more narrowly, as the legal right of individuals to autonomous self-determination over their own brain chemistry, “cognitive liberty” was, in part, a phrase coined to describe the rights of conscience sweepingly infringed by criminal drug prohibition in the United States. But while the last two decades have seen the strong emergence of a committed grass roots social movement to reform American drug policy, it is perhaps time to ask whether the drug policy reform movement is sufficient to secure policies that protect freedom of thought, or whether the defense of cognitive liberty requires a movement of its own.

Social movements are collective actions in which the populace is mobilized to redress social problems or grievances and restore critical social values.² They are arguably as vital to the health of a participatory democracy as constitutionally established checks and balances because they are a means for the citizenry to bring about change despite the resistance of entrenched private and public power.³ As

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such they ensure that necessary social evolution takes place when the system becomes deadlocked.

Theorists who study modern social movements identify three or more different stages that describe a common developmental trajectory. Movements tend to begin in a condition of latency, where people have begun to recognize a

Cognitive liberty as a concept exposes the argument that the drug policy reform movement has conspicuously shied away from making: namely that drug prohibition is untenable because it infringes freedom of thought, the fundamental principle that underlies so many other constitutional guarantees.

problem but have not yet organized to address it.⁴ A social movement will not gather momentum until a series of enabling historical forces accrue. For example, the Supreme Court's decision in *Brown vs. Board of Education*,⁵ provided a legal basis for dismantling segregation in 1954.⁶ And although the push for civil rights in America began far earlier, conditions for a civil rights movement did not become

ripe until the sixties, when the government publicly promoted an ideology of freedom and democracy as part of its global effort to oppose the spread of communism. By then, northward migration of black populations and integration of blacks into the US military had made segregation increasingly difficult to perpetuate.

When conditions for social change are ripe, a highly publicized crisis, or series of crises, often described as a 'trigger event', brings the problem and its victims into public awareness and typically galvanizes people involved in one or more pre-existing, sympathetic communications networks into action. There are numerous trigger events in any movement, but one example for the civil rights movement might be Rosa Parks' eventful refusal to cede her seat to a white patron on

a public bus in Montgomery, Alabama. Immediately afterwards, African Americans in Montgomery organized through their churches and community institutions—communications networks that were sympathetic to the cause—to mount a crippling boycott against the city bus system. Finally, after activism on an issue takes off, subsequent organization serves to weld independent activist groups into a cohesive movement and the movement puts the issue on the social agenda.⁷

Social movements are actively engaged in the production of meaning for their participants and the public alike, debunking long-held social myths and exposing new social truths. It is the way that a movement conceptualizes its issues that largely determines its success. Most theorists agree that it is crucial that the aims of the movement fit within pre-established social norms for change to happen easily. To ultimately succeed, a movement must convince the majority that movement, and not the elite power holders, truly represent society's widely held values and sensibilities.⁸ The social movement for drug policy reform, which is arguably the open communications network through which the call for cognitive liberty emerged and developed, has framed the social problem of criminal drug prohibition in terms of a harm reduction analysis. A sensible drug policy should strive to minimize the harms associated with drug use, the argument goes, but our current drug policies do more harm than good. Harm reduction has now dominated the public debate about drug policy for several years, and may continue to do so indefinitely since harm is notoriously difficult to quantify. While harm reduction draws on public health principles and core ideals of privacy and compassion, it fails to frame the drug policy debate in terms of widely held fundamental values.

It is precisely by reframing what drug prohibition *means* that cognitive liberty makes its greatest contribution to the

drug policy reform movement. Cognitive liberty as a concept exposes the argument that the drug policy reform movement has conspicuously shied away from making: namely that drug prohibition is untenable because it infringes freedom of thought, the fundamental principle that underlies so many other constitutional guarantees. The movement's reluctance is understandable. Arguing that, as a matter of conscience, a fundamental right to freedom of thought protects the autonomous modulation of consciousness through chemical means, doesn't fit neatly into a consequentialist scheme of harm evaluation. On balance one could conclude that people do not have the right to "harm" themselves, or that those who freely elect to "harm" themselves thereby forfeit any claim to social resources directed at ameliorating harm.

But cognitive liberty is not just the proposition that we all have a fundamental right to get high. In simplest terms, it is about the inviolability of our brain chemistry, and the way that brain chemistry is central to how we think. In a free democracy the government has no authority to dictate the content or form of our brain functions. To the extent that criminal drug prohibition limits the responsible private use of drugs to modulate consciousness, it infringes the most basic of our guaranteed freedoms. Such a level of government intervention into the most intimate sphere of personhood cannot be justified even by the most extreme circumstances, let alone by the poorly quantified public health risks associated with private drug use by adults.

The distinction between a right to get high and the right to unrestricted thinking may seem subtle but it is vitally important to vindicating private choices about responsible drug use. Consider this analogy from another modern social movement. In the early 1950s, when the first organized opposition to anti-gay discrimination emerged, homosexuality was a condition listed in the American Psychiatric Association's

Diagnostic and Statistical Manual of Mental Disorders. At that time, it would have been completely unheard of to regard autonomous determination of sexual orientation as a fundamental right of personhood. Yet today that notion is largely accepted because of decades of activism wherein the gay rights movement refused to engage power holders, including the medical and psychiatric establishment, in a debate about whether homosexuality is a disorder or an illness. Instead the gay rights movement exposed a different meaning about the social justice it sought. The movement rephrased the issue at stake in terms of deeper values and did so in a way that American society could no longer acknowledge its self-professed ideal of "liberty, equality, and the pursuit of happiness" for all and not extend that ideal to homosexuals.

Can criminal drug prohibition be abolished without a rights and principles-based argument? Maybe. But would that be the same victory? Not likely. Suppose institutionalized discrimination on the basis of sexual orientation had been dismantled because homosexuality had come to be understood as an incurable psychological disorder and the movement had convinced the greater public that society ought not discriminate against the disabled? Would gay rights be the same today? I submit that they would not. By the same analysis, ending prohibition because it causes more harm than it prevents, without a deeper understanding of the inviolable right of free cognition, only invites the development of better, more efficient forms of prohibition. This simply provides an opportunity for prohibition to resurface as soon as the scales of harm tip the other way.

The drug war, however, is but one issue on the cognitive liberty agenda. Abolishing criminal drug prohibition alone, even with recognition of how it infringes freedom of thought, will not necessarily guarantee social policies that respect and protect autonomous thought and the right to experience

the full range of human cognition. Ending the drug war will not ensure that consideration for civil liberties guides the development of norms for human testing of new psychopharmaceuticals. Nor will it necessarily assure privacy over the content of our own thoughts when that privacy is threatened.

Should we be concerned, then, with establishing a more comprehensive movement to secure the benefits of cognitive liberty? On the one hand, the theory of social movements, based as it is on historical hindsight, suggests that a cognitive liberty social movement should spontaneously emerge when conditions are ripe. And there is no doubt that they are *ripening*. As developments in psychopharmacology and brain surveillance technologies augment the precision with which human behavior can be controlled, their implementation increasingly generates conflicts and prospective trigger events. Parents are beginning to question the wisdom of school boards that condition their children's right to public education on medicating them with drugs like Ritalin®.⁹ The CCLE, along with several other civil rights organizations recently contested, all the way to the Supreme Court, the government's claim of authority to force medicate a non-violent pre-trial detainee with anti-psychotic drugs for the sole purpose of attempting to render him competent to stand trial.¹⁰ New technologies, too, have raised concerns about the future of mental privacy: these include possible security screening and commercial marketing uses of magnetic resonance imagery techniques for detecting neural activity. Some claim that these "brain scanning" technologies can reveal even thoughts people are unaware of thinking.¹¹ All of these concerns could easily be united under the banner of a common cognitive liberty movement.

Freedom of thought is already a universally recognized human right.¹² It is the widespread appeal of freedom of thought as a fundamental value that would assure the

success of the movement's message. By focusing on the universality of human cognition rather than the thoughts that its constituents may or may not share in common, such a movement would ultimately see its support base grow. If, as I believe, a nascent cognitive liberty movement is emerging in an era of ripening social conditions, there is much we can do to precipitate it.

On a personal level, we can begin by reclaiming our right to cognitive liberty. We can use this term when we educate our friends, family, and peers about their right to freedom of thought. We can discuss cognitive liberty in public every chance we get. Bring it up at work, in class, or on the bus. We can write letters to the editor voicing a cognitive liberty approach to debates about drugs, new technologies, or freedom of thought. And we can certainly write to our elected officials to let them know we count on them to uphold constitutional protections for cognitive liberty when they consider new legislation or discharge the duties of their office. Perhaps the biggest contribution anyone can make is getting involved. Support organizations that defend cognitive liberty. And while financial support is very helpful, giving money is only one of many ways to get involved. As social theorist Jo Freeman points out, "it is a mistake to judge the affluence of [a] movement by its monetary contributions."¹³ People are the indispensable resource of any social movement and cognitive liberty is relying on you now more than ever.

Notes

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2. Moyer, Bill et. al., *Doing Democracy: The MAP Model for Organizing Social Movements*, (New Society Publishers, 2001).
3. Ibid.
4. Social Movements from www.marxists.org/glossary, MIA Encyclopedia of Marxism (online at <http://www.marxists.org/glossary/terms/s/o.htm>; last accessed on May 6, 2003).
5. 347 U.S. 483 (1954).
6. Moyer et. al., *supra* at note 1.
7. Freeman, Jo, "On the Origins of Social Movements," published in *Waves of Protest: Social Movements Since the Sixties*, (Rowman and Littlefield, 1999, pp. 7-24. Based on a paper written in 1971 and first published in *Social Movements of the Sixties and Seventies*, (Longman 1983). (Available online at <http://www.jofreeman.com/socialmovements/origins.htm> last accessed 5/7/03).
8. Moyer et. al., *supra* at note 2.
9. Associated Press, "Mom says school made her give Ritalin to son", 8/9/2002; Schmalzer, Tracy, "Vermont Ritalin use provokes bill", *Rutland Herald*, 1/31/2002.
10. CCLE, "US Supreme Court Hears Oral Argument in Forced-Drugging Case," http://www.cognitiveliberty.org/news/Sell_Oral_Arguments.html, 3/1/2003.
11. Goldberg, Carey, "Some fear loss of privacy as science pries into brain," *Boston Globe*, 5/1/2003.
12. Article 18 of the *Universal Declaration of Human Rights* provides, "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance."
13. *A Model for Analyzing the Strategic Options of Social Movement Organizations*, available online at <http://www.jofreeman.com/socialmovements/analyzesoc.htm>, last accessed on 5/7/2003.

The Medical Marijuana Problem

Lester Grinspoon, M.D.

Unless we put medical freedoms into the Constitution, the time will come when medicine will organize into a...dictatorship. To restrict the art of healing to one class of men and deny equal privileges to others will constitute the Bastille of medical science. All such laws are un-American and despotic and have no place in a republic. The Constitution of this republic should make special privilege for medical freedom as well as religious freedom.

—Benjamin Rush, physician and signer of the Declaration of Independence

The medical marijuana problem is a Janus-like conundrum; one view of the problem is seen through the eyes of patients and another through those of their government. One face regards with dismay the problem of denying marijuana to the growing number of pained, impatient patients who find it useful, often more useful, less toxic and cheaper than the legally available medications. Through the patients' eyes the problem is, of course, how to acquire and use this medicine without swelling the ranks (already more than 700,000 annually) of those who are arrested for using this illegal substance and how to avoid jeopardizing job security through random urine testing. The other face, the backward looking one, is that of an obdurate government as it defensively and inconsistently insists that "marijuana is not a medicine," and backs up this ill-informed,

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arrogant position with the full force of its vast legal power as it is presently doing in the state of California.

There are many thousands of patients who currently use cannabis as a medicine. Only seven are legally authorized by the US Government. They are the only survivors among the several dozen patients who were awarded Compassionate Use INDs during a period of time from 1976 until 1991 when the government halfheartedly acknowledged that marijuana has medicinal properties. This program was actually discontinued because of the exponentially growing number of Compassionate IND applications; the official reason was provided by James O. Mason, then chief of the Public Health Service: "It gives a bad signal. I don't mind doing that if there is no other way of helping these people... But there is not a shred of evidence that smoking marijuana assists a person with AIDS." Each of the surviving IND recipients receives monthly a tin containing enough rolled marijuana joints to treat his or her symptoms for that month. Because the quality of the cannabis is poor, it requires more inhalation than a superior quality medicinal cannabis would. In fact, some of the recipients have been known to supplement this "Government Issue" with better quality street marijuana.

In 1985 the Food and Drug Administration (FDA) approved dronabinol (Marinol) for the treatment of the nausea and vomiting of cancer chemotherapy. Dronabinol is a solution of synthetic tetrahydrocannabinol in sesame oil (to prevent its being smoked). Dronabinol was developed by Unimed Pharmaceuticals Inc. with financial support from the United States government. This was the first hint that the "pharmaceuticalization" of cannabis would provide the government with a solution to the medical marijuana problem; the problem of how to make the medicinal properties of cannabis available while prohibiting its use for any other purpose. But Marinol did not displace marijuana as "the treatment of choice;" most patients found the herb itself much

more useful than dronabinol in the treatment of the nausea and vomiting of cancer chemotherapy. In 1992, the treatment of the AIDS wasting syndrome was added to dronabinol's labeled uses; again, patients reported that it was inferior to smoked marijuana. Because it was thought that it would sell better if it were placed in a less restrictive Drug Control Schedule, it was moved from Schedule II to Schedule III in the year 2000. But Marinol has not solved the marijuana-as-a-medicine problem because so few of the patients who have discovered the therapeutic usefulness of marijuana use dronabinol. In general, they find it less effective than smoked marijuana, it cannot be titrated because it has to be taken orally, it takes at least an hour for the therapeutic effect to manifest itself, and even with the prohibition tariff on street marijuana, Marinol is more expensive. Thus, the first attempt at pharmaceuticalization proved not to be the answer. In practice, for many patients who use marijuana as a medicine the doctor-prescribed Marinol serves primarily as a cover from the threat of the growing ubiquity of urine tests.

Most of the patients who use cannabis as a medicine smoke or ingest it in some form. In so doing they are in violation of federal law throughout the country and of state laws in all but nine states. In those states, notably California, which allow for doctor-recommended use of cannabis, buyers' clubs or compassion clubs have evolved as cannabis pharmacies for patients with appropriate physician documentation. Two distribution models have evolved. One is based on the conventional delivery system for medicine: a patient visits a buyers' club (read: pharmacy), where he or she presents a note from a physician, certifying that the patient has a condition for which the physician recommends cannabis (read: prescription). The proprietor of the club (read: pharmacist) fills the prescription and the patient leaves to use the medicine, presumably at home. This model preserves the medical profession's authority to decide who shall use a med-

icine and for how long. The pharmacy provides a source—in this case a nonprofit one—for the medicine. If the doctor and the pharmacist behave ethically, only those who have a medical need for marijuana can receive it. In turn, patients have a reliable source for the drug, relieving them of the stress of buying it on the street or secretly growing their own. The staid set-up of the club and the attitudes of the proprietors make it clear that the patient is no more expected to use his medicine there than he would be in a conventional pharmacy.

The second distribution model resembles a social club more than it does a pharmacy. The dispensing area is plastered with menus offering types, grades and prices. Large rooms are filled with brightly colored posters, lounge chairs and sofas, tables, magazines and newspapers. While some patients remain only long enough to buy their medicine, most stay to smoke and talk. There are animated conversations, laughter, music and the pervasive, pungent odor of cannabis. The atmosphere is informal, welcoming and warm, providing support for patients who may be socially isolated and have little opportunity to share concerns and feelings about their illnesses. This type of club is a blend of Amsterdam-style coffeehouse, American bar and medical support group. The model was epitomized by the San Francisco Cannabis Cultivators' Club.

Until some kind of legal accommodation makes it possible for patients to obtain marijuana without violating the law, buyers' clubs are the best approach to the problem. Yet the federal government, including the White House, the Drug Enforcement Administration and federal law enforcement at all levels, remains opposed to the idea. While for a short period of time after the publication of the Institute of Medicine report, "Marijuana and Medicine: Assessing the Science Base," the Feds retreated somewhat from their posi-

tion that marijuana has no therapeutic value, they are now working diligently to close the cannabis clubs.

Many if not most advocates who recognize the importance of buyers' clubs believe that the first model is preferable to that represented by the San Francisco club. The former is more businesslike, conforms more closely to the pharmacy model and at least appears to be more vigilant about checking the documentation of people who present themselves as patients. The San Francisco model club, largely because of the on-site marijuana smoking and its relaxed atmosphere, appeared to be more casual in its commitment to confirming medical need, which made even the supporters of buyers' clubs a little nervous.

Yet the importance of the social aspect of buyers' clubs cannot be underestimated and, in my view, offers a medically significant new model for future conventional use of cannabis as a medicine. It is becoming increasingly clear that emotional support—contacts with and help from fellow-patients, friends, family, co-workers and others—plays a salutary role in battling many illnesses. This kind of support improves the quality of life, and there is growing evidence that it may even prolong life. In one study, socially isolated women were found to be five times more likely to die from ovarian and related cancers than women with networks of friends and families. In another study, women with breast cancer were found to be 50 percent less likely to die in the first few months after surgery if they had confidants. In a four-year study of 133 breast cancer patients, married women had a longer average survival time. Researchers have consistently found that support groups are effective for patients with a variety of cancers. Participants become less anxious and depressed, make better use of their time and are more likely to return to work than patients who are given only standard care, regardless of whether they have serious psychiatric

symptoms. There is evidence that even brief supportive therapy can have benefits that last for months. Some researchers have made the controversial claim that mere participation in support groups can prolong cancer patients' lives. The San Francisco buyers' club functioned very much as an informal support group. It was not designed by psychiatrists and social scientists to provide supportive group therapy, but there is reason to believe it did. One of the properties of marijuana may have contributed to its effectiveness: when people use cannabis, they tend to be more sociable and find it easier to share difficult thoughts and feelings. If there is even one kernel of truth to the idea that talking about the stress, setbacks and triumphs in the battle against an illness can help a patient cope and recover, it is clear that the San Francisco model provides the best environment for the dispensing of medicinal marijuana. Furthermore, the existence of this kind of medical service would solve a difficult problem for the physician who recommends marijuana to a patient, particularly an older one who lacks experience. Unlike most prescriptions which require little more preparation than providing the patient with an understanding of the possible toxic ("side-") effects, many marijuana-naïve patients will require someone to teach them how to use it comfortably. Such instruction is readily available at a San Francisco-type facility. Unfortunately, we live in a culture that considers such a facility a public nuisance and criminalizes a compassionate form of caring out of loyalty to a symbolic war on drugs. In any event, the present federal government is not going to allow the development of a separate distribution system, and certainly not on the San Francisco model, for this one medicine.

Now that the federal government has embarked on a cruel and so far successful campaign to close down buyers' clubs, what options are available to the many thousands of patients who find cannabis of great importance, even es-

sential, to the maintenance of their health? They can either use Marinol, which most find unsatisfactory, or they can break the law and use marijuana. Why is a government that considers itself compassionate (“compassionate conservatism”) criminalizing these patients? What is the government’s problem with medical marijuana? The problem as seen through the eyes of the government is the belief that as growing numbers of people observe relatives and friends using marijuana as a medicine, they will come to understand that this is a drug which does not conform to the description the government has been pushing for years. They will first come to appreciate what a remarkable medicine it really is; it is less toxic than almost any other medicine in the pharmacopoeia; it is, like aspirin, remarkably versatile; and it is less expensive than the conventional medicines it displaces. They will then begin to wonder if there are any properties of this drug which justify denying it to people who wish to use it for *any* reason, let alone arresting more than 700,000 citizens annually. The federal government sees the acceptance of marijuana as a medicine as the gateway to catastrophe, the repeal of its prohibition. In so far as the government views as anathema any use of plant marijuana, it is difficult to imagine it accepting a legal arrangement that would allow for its use as a medicine, while at the same time vigorously pursuing a policy of prohibition of any other use. Yet, there are many who believe this type of arrangement is possible and workable. In fact, this is the option that the Canadian and Dutch governments are presently pursuing as are various states in the United States. Let us consider what might be involved in establishing and maintaining such a legal arrangement in this country.

The first requirement at this time is that the FDA approve marijuana as a medicine. One can argue, however, that FDA approval is superfluous where cannabis as a medicine is concerned. Drugs must undergo rigorous, expensive, and

time-consuming tests before they are approved by the Food and Drug Administration for marketing as medicines. The purpose is to protect the consumer by establishing safety and efficacy. Because no drug is completely safe or always efficacious, an approved drug has presumably satisfied a risk-benefit analysis. When physicians prescribe for individual patients they conduct an informal analysis of a similar kind, taking into account not just the drug's overall safety and efficacy, but its risks and benefits for a given patient with a given condition. The formal drug approval procedures help to provide physicians with the information they need to make this analysis. This system is designed to regulate the commercial distribution of drug company products and protect the public against false or misleading claims about the efficacy and safety. The drug is generally a single synthetic chemical that a pharmaceutical company has acquired or developed and patented. It submits an application to the FDA and tests it first for safety in animals and then for clinical efficacy and safety. The company must present evidence from double-blind controlled studies showing that the drug is more effective than a placebo. Case reports, expert opinion, and clinical experience are not considered sufficient.

The standards have been tightened since the present system was established in 1962, and few applications that were approved in the early 1960s would be approved today on the basis of the same evidence. Certainly we need more laboratory and clinical research to improve our understanding of medicinal cannabis. We need to know how many patients and which patients with each symptom or syndrome are likely to find cannabis more effective than existing drugs. We also need to know more about its effects on the immune system in immunologically impaired patients, its interactions with other medicines, and its possible uses for children.

But I have come to doubt whether the FDA rules should apply to cannabis. There is no question about its safety. It is

one of humanity's oldest medicines, used for thousands of years by millions of people with very little evidence of significant toxic effects. More is known about its adverse effects than about those of most prescription drugs. The government of the United States has conducted through its National Institute of Drug Abuse (NIDA) a decades-long multi-million-dollar research program in a futile attempt to demonstrate significant toxic effects that would justify the prohibition of cannabis as a non-medical drug. Should time and resources be wasted to demonstrate for the FDA what is already so obvious?

But even if it were legally and practically possible to do the various phased studies to win FDA approval, where would the money to finance these studies come from? New medicines are almost invariably introduced by drug companies that spend many millions of dollars on the development of each product. They are willing to undertake these costs only because of the anticipated large profits during the 20 years they own the patent. Obviously pharmaceutical companies cannot patent marijuana. In fact they are very much opposed to its acceptance as a medicine because it will compete with their own products.

It is unlikely that whole smoked marijuana should or will ever be developed as an officially recognized medicine via this route. Thousands of years of use have demonstrated its medical value; the extensive government-supported effort of the last three decades to establish a sufficient level of toxicity to support the harsh prohibition has instead provided a record of safety that is more compelling than that of most approved medicines. The modern FDA protocol is not necessary to establish a risk-benefit estimate for a drug with such a history. To impose this protocol on cannabis would be like making the same demand of aspirin, which was accepted as a medicine more than 60 years before the advent of the double-blind controlled study. Many years of ex-

perience have shown us that aspirin has many uses and limited toxicity, yet today it could not be marshaled through the FDA approval process. The patent has long since expired, and with it the incentive to underwrite the substantial cost of this modern seal of approval. Cannabis, too, is unpatentable, so the only sources of funding for a “start-from-scratch” approval would be non-profit organizations or the government, which is, to put it mildly, unlikely to be helpful. Other reasons for doubting that marijuana would ever be officially approved are today’s anti-smoking climate and, most important, the widespread use of cannabis for purposes disapproved by the government.

To see some of the obstacles to this approach to the problem, consider the effects of granting marijuana legitimacy as a medicine while prohibiting it for any other use. How would the appropriate “labeled” uses be determined and how would “off-label” uses be monitored? Let us suppose that studies satisfactory to the FDA are somehow completed affirming that marijuana is safe and effective as a treatment for the AIDS wasting syndrome and/or AIDS-related neuropathy, and physicians are able to prescribe it for those conditions. This will present unique problems. When a drug is approved for one medical purpose, physicians are generally free to write off-label prescriptions—that is, prescribe it for other conditions as well. If marijuana is approved as a medicine, how will off-label prescribing play out? Surely, knowledgeable physicians will want to prescribe it for some patients with multiple sclerosis, Crohn’s disease, migraine, convulsive disorders, spastic symptoms, and other conditions for which the use of cannabis is well established by a mountain of anecdotal evidence. But what about premenstrual syndrome? Surely women who suffer from this disorder consider it a serious problem, and many of them find cannabis the most useful and least toxic treatment. What about the loss of erectile capacity in paraplegics? What about

intractable hiccups? And then there is depression, not the DSM-IV defined major affective disorder, but the common low-level dysphoric condition for which general practitioners frequently prescribe SSRIs such as Prozac®? What about bipolar disorder?

Generally speaking, the more dangerous a drug is, the more serious or debilitating must be a symptom or illness for which it is approved. Conversely, the more serious the health problem, the more risk is tolerated. If the benefit is very large and the risk very small, the medicine is distributed over the counter (OTC). OTC drugs are considered so useful and safe that patients are allowed to use their own judgment without a doctor's permission or advice. Thus, today anyone can buy and use aspirin for any purpose at all. This is permissible because aspirin is considered to be so safe; it takes "only" one to two thousand lives a year in the United States. The remarkably versatile ibuprofen (Advil) and other non-steroidal anti-inflammatory drugs (NSAIDs) can also be purchased OTC because they, too, are considered very safe; "only" 10,000 Americans lose their lives to these drugs annually. Acetaminophen (Tylenol®), another useful OTC drug, is responsible for about 10 percent of cases of end-stage renal disease. The public is also allowed to purchase many herbal remedies whose dangers and efficacies have not been well determined. Compare these drugs with marijuana. Today, no one can doubt that it is, as DEA Administrative Judge Francis L. Young put it, "...among the safest therapeutic substances known to man." If it were now in the official pharmacopoeia, it would be a serious contender for the title of least toxic substance in that compendium. In its long history, cannabis has never caused a single overdose death.

Then there is the question of who will provide the cannabis. The federal government now provides marijuana from its farm in Mississippi to the seven surviving patients covered by the now-discontinued Compassionate IND program.

But surely the government could not or would not produce marijuana for many thousands of patients receiving prescriptions, any more than it does for other prescription drugs. If production is contracted out, will the farmers have to enclose their fields with security fences and protect them with security guards? How would the marijuana be distributed? If through pharmacies, how would they provide secure facilities capable of keeping fresh supplies? Would the price of pharmaceutical marijuana have to be controlled: not too high, lest patients be tempted to buy it on the street or grow their own; not too low, lest people with marginal or fictitious "medical" conditions besiege their doctors for prescriptions? What about the parallel problems with potency? When urine tests are demanded of workers, what would be the bureaucratic and other costs of identifying those who use marijuana legally as a medicine as distinguished from those who use it for other purposes?

To realize the full potential of cannabis as a medicine in the setting of the present prohibition system, we would have to address all these problems and more. A delivery system that successfully navigated this minefield would be cumbersome, inefficient, and bureaucratically top-heavy. Government and medical licensing boards would insist on tight restrictions, challenging physicians as though cannabis were a dangerous drug every time it was used for any new patient or purpose. There would be constant conflict with one of two outcomes: patients would not get all the benefits they should, or they would get the benefits by abandoning the legal system for the black market or their own gardens and closets.

A solution now being proposed, notably in the Institute of Medicine (IOM) Report, is what might be called the "pharmaceuticalization" of cannabis: prescription of isolated individual cannabinoids, synthetic cannabinoids, and cannabinoid analogs. The IOM Report states that "...if there is any

future for marijuana as a medicine, it lies in its isolated components, the cannabinoids, and their synthetic derivatives." It goes on: "Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, non-smoked cannabinoid delivery systems." This position was recently echoed by Antonio Maria Costa, Executive Director, Office on Drugs and Crime, the United Nations at the International Symposium on Cannabis in Stockholm on March 7, 2003:

I am not sure I understand the controversy about the medical virtues of cannabis: First, if and when they are ascertained, society should definitely make use of them. Who would oppose the advances of medicine? Who would stand in the way of reducing suffering? My concern is to prevent that, by proclaiming the (medical) virtues of cannabis, we open a back door to its wider (recreational) consumption. Society would end up regretting such abuse, just as we now regret tobacco addiction. If proven to be medically useful—and this is my second point—cannabis should be treated like any other medicine, namely as a pharmaceutical preparation to be prescribed for specific symptoms in accordance with properly determined dosages and standards. In other words, either we are serious about the medical properties of cannabis (and we, in this hall, take the question very seriously) or it is just a matter of using such properties as a Trojan horse to reach other goals—namely, the de facto decriminalization of its production and trafficking. In this case I would be strongly negative.

Some cannabinoid analogs may indeed have advantages over whole smoked or ingested marijuana in limited circumstances. For example, cannabidiol may be more effective as an anti-anxiety medicine and an anticonvulsant when it is not taken along with THC, which sometimes generates anxiety. Other cannabinoids and analogs may prove more useful than marijuana in some circumstances because they can be administered intravenously. For example, 15 to 20 percent of patients lose consciousness after suffering a thrombotic or embolic stroke, and some people who suffer brain syndrome after a severe blow to the head become unconscious. The new analog dexanabinol (HU-211) has been shown to protect brain cells from damage when given immediately after the stroke or trauma; in these circumstances, it will be possible to give it intravenously to an unconscious person. Presumably other analogs may offer related advantages. Some of these commercial products may also lack the psychoactive effects which make marijuana useful to some for non-medical purposes. Therefore, they will not be defined as "abusable" drugs subject to the constraints of the Comprehensive Drug Abuse and Control Act. Nasal sprays, vaporizers, nebulizers, skin patches, pills, and suppositories can be used to avoid exposure of the lungs to the particulate matter in marijuana smoke.

The question is whether these developments will make marijuana itself medically obsolete. Surely many of these new products would be useful and safe enough for commercial development. It is uncertain, however, whether pharmaceutical companies will find them worth the enormous development costs. Some may be (for example, a cannabinoid inverse agonist that reduces appetite might be highly lucrative), but for most specific symptoms, analogs or combinations of analogs are unlikely to be more useful than natural cannabis. Nor are they likely to have a significantly wider spectrum of therapeutic uses, since the natural prod-

uct contains the compounds (and synergistic combinations of compounds) from which they are derived. For example, the naturally occurring THC and cannabidiol of marijuana, as well as dexamabinol, protect brain cells after a stroke or traumatic injury.

The cannabinoids in whole marijuana can be separated from the burnt plant products (which comprise the smoke) by vaporization devices that will be inexpensive when manufactured in large numbers. These devices take advantage of the fact that finely chopped marijuana releases the cannabinoids by vaporization when air flowing through the marijuana is held within a fairly large temperature window below the ignition temperature of the plant material. Inhalation is a highly effective means of delivery, and faster means will not be available for analogs (except in a few situations such as parenteral injection in a patient who is unconscious or suffering from pulmonary impairment). It is the rapidity of the response to inhaled marijuana which makes it possible for patients to titrate the dose so precisely. Furthermore, any new analog will have to have an acceptable therapeutic ratio. The therapeutic ratio (an index of the drug's safety) of marijuana is not known because it has never caused an overdose death, but it is estimated, on the basis of extrapolation from animal data, to be an almost unheard of 20,000 to 40,000. The therapeutic ratio of a new analog is unlikely to be higher than that; in fact, new analogs may be much less safe than smoked marijuana because it will be physically possible to ingest more of them. And there is the problem of classification under the Comprehensive Drug Abuse and Control Act for analogs with psychoactive effects. The more restrictive the classification of a drug, the less likely drug companies are to develop it and physicians to prescribe it. Recognizing this economic fact of life, Unimed Pharmaceuticals Inc. has fairly recently succeeded in getting Marinol (dronabinol) reclassified from Schedule II to Schedule III.

Nevertheless, many physicians will continue to avoid prescribing it for fear of the drug enforcement authorities.

A somewhat different approach to the pharmaceuticalization of cannabis is being taken by a British company, G. W. Pharmaceuticals. It is attempting to develop products and delivery systems that will skirt the two primary popular concerns about the use of marijuana as a medicine: the smoke and the psychoactive effects (the "high"). To avoid the need for smoking, G. W. Pharmaceuticals has developed an electronically controlled dispenser to deliver cannabis extracts sublingually in carefully controlled doses. The company expects its products (extracts of marijuana) to be effective therapeutically at doses too low to produce the psychoactive effects sought by recreational and other users. My clinical experience leads me to question whether this is possible in many or even most cases. The issue is complicated by tolerance to the psychoactive effects. Recreational users soon discover that the more often they use marijuana, the less "high" they experience. A patient who smokes cannabis frequently for the relief of, say, chronic pain or elevated intraocular pressure will experience little or no "high." Furthermore, as a clinician who has considerable experience with medical cannabis use, I have to question whether the psychoactive effect is always separable from the therapeutic. And I strongly question whether the psychoactive effects are necessarily undesirable. Many patients suffering from serious chronic illnesses report that cannabis generally improves their spirits. If they note psychoactive effects at all, they speak of a slight mood elevation—certainly nothing unwanted or incapacitating.

The great advantage of the administration of cannabis through the pulmonary system is the rapidity with which its effects are experienced. This in turn allows for the self-titration of dosage, the best way of adjusting individual dosage. With other routes of delivery the response time is longer

and self-titration becomes more difficult. Thus, self-titration is not possible with oral ingestion of cannabis. While the response time for sublingual or oral mucosal administration of cannabis is shorter than it is with oral ingestion, it is significantly longer than that from absorption through the lungs and therefore a considerably less useful route of administration for self-titration. Furthermore, the design of the G. W. Pharmaceuticals dispenser negates whatever self-titration capacity sublingual administration may have. The device has electronic controls that monitor the dose and prevent delivery if the patient tries to take more than the physician or pharmacist has set it to deliver during predetermined time windows. The proposal to use this cumbersome and expensive device apparently reflects a concern that patients cannot accurately titrate the therapeutic amount or a fear that they might take more than they need and experience some degree of "high" (always assuming, doubtfully, that the two can easily be separated, especially when cannabis is used infrequently). Because these products will be considerably more expensive than natural marijuana, they will succeed only if patients are intimidated by the legal risks, and patients and physicians consider the health risks of smoking marijuana (with and without a vaporizer) much more compelling than is justified by either the medical or epidemiological literature and they believe that it is essential to avoid any hint of a psychoactive effect.

In the end, the commercial success of any psychoactive cannabinoid product will depend on how vigorously the prohibition against marijuana is enforced.

It is safe to predict that new analogs and extracts will cost much more than whole smoked or ingested marijuana even at the inflated prices imposed by the prohibition tariff. I doubt that pharmaceutical companies would be interested in developing cannabinoid products if they had to compete with natural marijuana on a level playing field. The most com-

mon reason for using Marinol is the illegality of marijuana, and many patients choose to ignore the law for reasons of efficacy and cost. The number of arrests on marijuana charges has been steadily increasing and has now reached more than 700,000 annually, yet patients continue to use smoked cannabis as a medicine. I wonder whether any level of enforcement would compel enough compliance with the law to embolden drug companies to commit the many millions of dollars it would take to develop new cannabinoid products. Unimed is able to profit from the exorbitantly priced dronabinol only because the United States government underwrote much of the cost of development. Pharmaceutical companies will undoubtedly develop useful cannabinoid products, some of which may not be subject to the constraints of the Comprehensive Drug Abuse and Control Act. But, it is unlikely that this pharmaceuticalization will displace natural marijuana for most medical purposes.

It is also clear that the realities of human need are incompatible with the demand for a legally enforceable distinction between medicine and all other uses of cannabis. Marijuana use simply does not conform to the conceptual boundaries established by twentieth century institutions. It enhances many pleasures and it has many potential medical uses, but even these two categories are not the only relevant ones. The kind of therapy often used to ease everyday discomforts does not fit any such scheme. In many cases what lay people do in prescribing marijuana for themselves is not very different from what physicians do when they provide prescriptions for psychoactive or other drugs. The only workable way of realizing the full potential of this remarkable substance, including its full medical potential, is to free it from the present dual set of regulations—those that control prescription drugs in general and the special criminal laws that control psychoactive substances. These mutually reinforcing laws established a set of social categories that strangle

its uniquely multifaceted potential. The only way out is to cut the knot by giving marijuana the same status as alcohol—legalizing it for adults for all uses and removing it entirely from the medical and criminal control systems.

Two powerful forces are now colliding: the growing acceptance of medical cannabis and the proscription against any use of the plant marijuana, medical or non-medical. There are no signs that we are moving away from absolute prohibition to a regulatory system that would allow responsible use of marijuana. As a result, we are going to have two distribution systems for medical cannabis: the conventional model of pharmacy-filled prescriptions for FDA-approved cannabinoid medicines, and a model closer to the distribution of alternative and herbal medicines. The only difference, an enormous one, will be the continued illegality of whole smoked or ingested cannabis. In any case, increasing medical use by either distribution pathway will inevitably make growing numbers of people familiar with cannabis and its derivatives. As they learn that its harmfulness has been greatly exaggerated and its usefulness underestimated, the pressure will increase for drastic change in the way we as a society deal with this drug.

If the cynical attitude of the federal government toward patients who use medical marijuana, its attempt to intimidate physicians who recommend it, its arrest of people who, with permission of the local authorities, grow marijuana for medical patients, and its recent despotic actions against buyers' clubs in California lend credence to Benjamin Rush's concern about medical fascism, then the patients and the people who help them in a variety of ways constitute a resistance movement against medical dictatorship. It is my belief that this resistance will continue until freedom to responsibly use this plant as we choose is secured.

Marijuana Medicalization: Bad Cause, Bad Faith

Thomas Szasz, M.D.

On January 31, 2003, marijuana grower Ed Rosenthal—“deputized” by the City of Oakland, California, to grow “medical marijuana”—was convicted on marijuana cultivation and conspiracy charges in San Francisco. The conviction provoked a chorus of indignation. An editorial in the *San Francisco Chronicle* (February 7, 2003) declared: “The state must take the lead in how to implement Proposition 215, the medical marijuana law.” Indeed. However, there is no evidence that the “state” means business. If the State of California really wanted to provide marijuana for selected patients, it would not have delegated the job to famed “ganja guru” Ed Rosenthal.

In 1996, soon after Californians approved Proposition 215, the federal government announced that it would prosecute doctors who recommended marijuana for patients. In 2001, the Supreme Court, in an 8-0 ruling, rebuffed the Ninth Federal District Court’s pussyfooting with the “medical necessity” rhetoric (used also by advocates of physician-assisted suicide). Marijuana medicalizers act as if they were not aware that medical rhetoric is the federal government’s game: drug prohibition is justified on the ground that it “protects” 280 million Americans from the dread disease of “drug abuse.”

Thomas Szasz, M.D. is a member of the CCLE Board of Advisors and professor emeritus of psychiatry at the State Univ. of New York Health Science Center. He is the author of over 30 books, including *The Myth of Mental Illness* and *Our Right to Drugs*.

Most people who support medical marijuana consider themselves liberals. Liberals have consistently opposed “states’ rights,” a slogan that has become synonymous with racism. Liberals continue to be the core constituents of the

struggle to transform the United States from the Founder’s creation of a Republic, a confederacy (that dreaded word) of states, into a monolithic national state, with a single central government regulating all but the most trivial affairs of its citizens.

Either we have the right to poison and kill ourselves with food, alcohol, and drugs, or we don’t... I am not arguing for marijuana prohibition. I am arguing for individual liberty, personal responsibility, and the rule of law.

This struggle began with

the Civil War and the abolition of states’ rights permitting the ownership of slaves, and continued up until the civil rights legislations of the 1960s. This is the legacy to which the liberal medical marijuana advocates now appeal. They are fighting a bad cause in bad faith.

Rosenthal claimed that, having been “deputized” by Oakland authorities, he was entrapped: “I was following 215 in good faith. I had been made an officer of the city and been immunized.”

Good faith is the last thing anyone with a conscience can claim in this affair. If the California State authorities had wanted to implement Proposition 215, they ought to have assumed the task of growing and distributing marijuana under the direction of the State’s health department, by State health department personnel, on State premises. The fact that they didn’t—and have not announced any plans to do so now—speaks for itself.

Prohibition, let us recall, was also a federal law. Anti-Prohibitionists did not try to circumvent it with phony claims

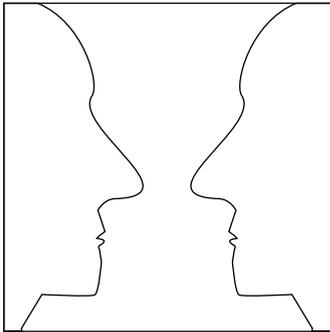
about states' rights and vacuous arguments about "medical necessity." (Countless cancer patients who "need" opiates are denied the drug.) Prohibition was repealed because, in the end, Americans were ready to reclaim their fundamental right to drink liquor, a right that, in principle, does not differ from the right to drink milk (which may be more harmful for adults than alcohol).

Either we have the right to poison and kill ourselves with food, alcohol, and drugs, or we don't. For nearly half a century I have opposed drug prohibition and the increasing power of the therapeutic state. I am not arguing for marijuana prohibition. I am arguing for individual liberty, personal responsibility, and the rule of law. The way to deal with bad laws is by repealing them, not by multiplying them.

Note

On June 4, 2003, US District Court Judge Charles Breyer sentenced Ed Rosenthal to one day in federal prison, with credit for time served—basically setting him free. He had been convicted on three counts of marijuana cultivation in January 2003. For more details, see the CONTEXT section.

88 Cognitive Liberty News



CONTEXT

A bricolage of news related to cognitive liberty

More Human Than Human: New Brain Chip

BBC News,
March 12, 2003,
<http://news.bbc.co.uk>

A new silicon chip designed by USC scientists is designed could help Alzheimer's patients, epileptics, and stroke victims. The device is intended to replace the hippocampus, a portion of the brain that enables memory storage.

The research, however, may provoke controversy—the hippocampus affects consciousness, mood and memory—key players in human identity.

The USC research team has spent 10 years developing the chip, and will soon begin testing on whole rat brains.

Scientists developed a mathematical model of the brain using electrical stimulation and slices of rat hippocampus. They then programmed the model onto a chip.

Pop a Pill to Remember: Cogniceutical Future?

Brain Waves,
March 17, 2003
www.corante.com

A new class of drugs has the potential to help solve a number of memory related problems—or create pharmaceutically-enhanced minds. „Cogniceuticals,” as these drugs are called, affect thinking, decision-making, learning, attention, and memory.

Experts say that the development of true cogniceuticals will require much more research. Nonetheless, drug discovery companies such as Memory Pharmaceuticals (www.memorypharma.com) are working to develop cogniceuticals as a treatment for Alzheimer's and other memory-affecting disorders.

Backers of cogniceutical research say that the development of cogniceuticals may provide businesses, government and individuals a new way to achieve a competitive cognitive advantage.

ACLU Blasts NJ Anti-Terror Chief's Plan for Martial Law

Politech,

March 21, 2003

www.politechbot.com

New Jersey residents may be confined to their homes in the event of a „Red Alert“ issued by the Homeland Security Department, according to one official. Sid Caspersen, Director of the New Jersey Office of Counter-Terrorism, said, „You literally are staying at home...What we're saying is, Everybody sit down! If you are left standing, you are probably a terrorist.“

Civil liberties groups and concerned citizens immediately opposed the threatened lockdown, which provoked widespread outrage. „What that statement describes is essentially martial law,“ said Deborah Jacobs, Executive Director of the ACLU of New Jersey, „...comments like Caspersen's seem only to exacerbate things.“

Caspersen's comments further concern the ACLU since New Jersey conducted secret arrests of suspected terrorists this spring.

Company Aims to Create Cell Phone Implants

Business Weekly,

April 28, 2003

www.businessweekly.co.uk

British company BTextact is developing a method for implanting electronic devices into human skin, predicting that the technology will be viable by 2010. Ian Pearson, BTextact's futurologist, describes the technology as a set of incredibly small electronic circuits inkjet printed onto the surface of the skin to create „active skin.“

The circuits, each smaller than a human skin cell, would be built in layers within different levels of the skin.

Pearson says that medical technology could be improved by active skin technology. He suggests that active skin could be used to monitor blood chemistry remotely and enable hospitals to check up on, and perhaps even dispense drugs to, patients. A wide range of consumer electronics: cell phones, MP3 players, keyboards and TVs could be printed onto body parts.

Loose Lips Build Databases: FBI Can Now Use Rumors

Washington Post,
March 25, 2003
www.washingtonpost.com

The Justice Dept. recently loosened requirements for timeliness and accuracy of information on criminals and victims in FBI databases.

The system, run by the FBI's National Crime Information Center, includes data about terrorists, fugitives, missing persons, gang members, warrants, and stolen property. The nation's most comprehensive law enforcement database, it is used to monitor information and decide whether to monitor or arrest suspects. The records are closed to the public, and police have faced prosecution for abusing the database to find personal information such as the names of girlfriends and former spouses.

Civil liberties advocates decried the lifting of accuracy requirements, while FBI officials insist that investigators need access to unconfirmable information that may be useful in future investigations.

Do Not Flip Off Big Brother

Canadian Press,
April 29, 2003
www.cp.org

A Canadian man who flipped off a photo radar system was arrested in an apparent case of surveillance rage this April. Edmonton police arrested the man after he used his car to block a photo radar camera van in protest over a speeding ticket he had received a week earlier in the same spot. After parking and blocking the radar van, the van driver asked the disgruntled man to leave. Instead, he refused to move, replying with the familiar rude gesture, and police were summoned to arrest him.

The driver now faces a charge of obstructing a police officer and a parking ticket as well as the photo radar ticket. „It was a fairly expensive protest,” said a police spokesman.

He is not alone: seven recent reports of vandalism on local photo radar vans including slashed tires, rock damage, a smashed window and damage to camera equipment.

Guantanamo Bay To Be Death Camp?

Utne Reader,
May 2003,
www.utne.com

The US camp for suspected terrorists in Guantanamo Bay, Cuba, may soon contain a death row and an execution chamber. According to one report, prisoners would be tried without jury or appeal and executed at the camp. Major-General Geoffrey Miller revealed these plans in a May 24 interview with a reporter with Britain's *Daily Telegraph*.

Human rights activists have condemned the plans, saying that they show a disregard for international law and prove that the US planned to execute the prisoners from the start. „This camp was created to execute people,“ said Jonathan Turley, an American law professor and activist.

The Guantanamo prison, created in 2001 to hold accused terrorists captured in Afghanistan, currently holds 680 prisoners from 43 countries.

US Prisoners Now a Quarter of World's Total

Sojourners Magazine,
May/June 2003
www.sojo.net

The United States, with one twenty-second of the world's population, now houses one fourth of the world's population of prisoners. One quarter of these prisoners are charged with drug offenses, (many of them nonviolent) making US drug offenders one eighth of the world's prisoners.

The US now has more nonviolent drug prisoners than the entire prison population in 1980, and is now operates the world's largest penal system.

The cost of carrying out the drug war has increased as well. In 1972, the US drug war budget was approximately \$100 million; it now approaches \$20 billion yearly.

Pentagon Unleashes Meta-Surveillance

Associated Press,
June 2, 2003,
www.ap.org

A new research initiative funded by the Pentagon will create a complete digital „diary“ of a subject’s life. The „LifeLog“ project would create a record of everything the user experienced. A camera, sensors, a Global Position System unit, and microphone would record everything a subject felt, read, wrote, saw or heard, then analyze the information for patterns, relationships and routines.

LifeLog critics, however, maintain that such technology is simply a new, unprecedentedly powerful surveillance technology. They are also concerned that the technology would be available both to the government and to the private sector.

Pentagon officials say they do not consider LifeLog to be an anti-terrorist technology, and deny allegations that LifeLog will be used to invade citizens’ privacy.

No Forcible Drugging for Canadian Astrophysicist

Toronto Globe and Mail,
June 6, 2003
www.globeandmail.com

Scott Starson, noted Canadian physicist, won the right to refuse forcible drugging in the psychiatric institution where he has been held for the past four years. Starson, who has spent years in and out of psychiatric hospitals, says that the drugs prescribed for him in the past interfere with his thinking and render him unable to write and work.

The Ontario Supreme Court ruled that the Ontario Consent and Capacity Board, which ruled against Starson, cannot interpret Starson’s best interests against his will and forcibly medicate him.

Anna Szigeti, a lawyer who wrote an *amicus curiae* brief in Starson’s defense, called the ruling „a victory for all patients, past and future, who may want to retain control over their bodies.“ Though he cannot be forcibly medicated, Starson can be held indefinitely in psychiatric hospitals.

Librarians Use Shredder to Resist Patriot Act

Associated Press,
May 28, 2003
www.ap.org

Palo Alto librarians say they'll delete computer records and shred files as an act of resistance to the USA Patriot Act, the federal anti-terrorism law that allowed the FBI easy access to library records. Librarians say they're committed to fighting for readers' privacy. „We've had a longstanding policy of confidentiality of library records, and in light of the passage of the Patriot Act, we're reviewing and tightening our business practices,” said Diane Jennings, the acting city librarian.

To that end, they will delete all computer records within six days of the transaction. All written records, such as including inter-library loan requests, book reserve lists and sign-up lists for the library's public computers, will be shredded immediately.

A report released by the Justice Department showed that FBI agents have obtained records from 50 libraries throughout the country. More than 100 communities nationwide, including the city of Palo Alto, CA and the CCLE's town of Davis, CA have passed resolutions protesting the Patriot Act.

Ed Rosenthal Gets One-Day Sentence

Bay City News,
June 4, 2003
www.kron.com

In a move that delighted medical marijuana supporters and enraged the DEA, US District Judge Charles Breyer sentenced medical marijuana activist and author Ed Rosenthal to one day in jail, with credit for time served.

The 58-year-old Rosenthal said he believed he was acting in accordance with California's 1996 Proposition 215, a law that sanctioned medical marijuana. He had been deputized by City of Oakland officials to grow *cannabis* for medical marijuana clubs.

Placebo Beats Prozac

Washington Post,
May 7, 2002,
www.washingtonpost.com

Sugar pills work as well or better than many traditional antidepressants, new research shows.

An analysis of past research conducted by drug companies shows that placebos have repeatedly performed comparably to or better than SSRIs such as Prozac in clinical trials of depressed patients. One study showed that placebos had effects superior to both St. John's wort and Zoloft. Furthermore, research suggests that patients on placebos undergo similar brain modifications to patients on SSRIs, throwing their mechanism of operation into doubt.

In Jan. 2002, a study in the *American Journal of Psychiatry* reported that many placebo-taking patients showed changes in mood-regulating parts of the brain identical to those patients taking SSRIs.

Researchers suggest that the antidepressants may work most effectively in concert with the professional care and attention that is part of most clinical trials—but not part of the treatment of most patients prescribed antidepressants.

US Officials Push Truth Serum for Interrogations

CBS News,
April 7, 2003
www.cbsnews.com

Several US officials are eager to use drugs known as „truth serums“ to help interrogate prisoners from Iraq, suspected al-Qaeda members, and others.

Since Fall 2001, intelligence agencies have upped the severity of their techniques to gain information from suspects. Cofer Black, former director of the CIA's Counterterrorist Center, said, „After 9/11, the gloves came off.“ Among the methods considered are the use of truth serums, barbiturates like sodium amytal, pentothal and brevil, which act as depressants and may lower the subject's inhibitions.

Jed Babbin, a deputy undersecretary of defense in the first Bush administration, thinks interrogators should be able to use truth serum to extract information from terrorists.

„If we find one of these clowns—Ifm talking about the terrorists now—and we have any reason to believe that he has current operational information, we should be shooting him so full of sodium amytal that he thinks he's talking to Allah.“

A Close Call for *Salvia*

Submitted by Rasmus Folehave Hansen,
May 26, 2003

In February 2003, Danish national television aired a feature on *Salvia divinorum* which included footage of two men smoking the plant, followed by a member of Parliament and the Health Minister's comments in favor of a ban on the plant. Consequently, the Health Administration conducted an investigation of *Salvia divinorum* to assess the need for a ban.

Surprisingly, *Salvia* steered clear; in its recommendation to the minister, the Health Administration stated that due to the limited use and appeal of the drug, combined with the absence of reports on serious health problems, a ban was not warranted at the moment. The recommendation included a surprising note; that a ban would not stop the small group of psychedelically inclined people from experimenting, with *Salvia* and a variety of other plants, exotic and local. This statement seems to contradict the administration's previous approach to entheogens; in 2001, psilocybin mushrooms and 2-CB were added to Denmark's list of banned substances.

ACLU: Pull Plug on Total Information Awareness

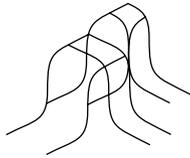
Politech,
June 19, 2003
www.politechbot.org

The ACLU recommended a complete shutdown of the Pentagon's Total Information Awareness surveillance system to a Pentagon advisory board charged with responding to public concern about the program.

The name change to „Terrorism Information Awareness,% and other alterations are merely cosmetic changes, the ACLU claims: „The Pentagon's recent push to tone down the Orwellian overtones of this highly troubling program is nothing but spin,% said Jay Stanley, Communications Director for the ACLU Technology and Liberty Project, who testified today. „Don't be fooled—this program would dramatically undercut our privacy and civil liberties%”

In June, in order to comply with oversight legislation, the Pentagon released a report detailing the privacy and civil liberties threats posed by the controversial TIA.

99 *Saying Yes: Book Review*
Richard Glen Boire



Book Review

It's rare that I read books about drug policy. After just a little exposure to the genre, one finds, over and over again, the same dates, the same key people, the same arguments from the government and the same arguments from the policy reform camp. There is the grand narrative told by the government ("drugs are bad"), and there is the counter-narrative told by the reformers ("drug prohibition is worse"). It sometimes reminds me of how in the late 1970s I'd sometimes adjust our family's Pong game so that the paddles would continually reflect the pong ball back and forth, leave for school and return to find the ball had remained in motional equipoise.

Yet when I heard that Jacob Sullum was working on a book about drugs and drug policy, my expectations for something new were lifted. As a senior editor for *Reason Magazine*, a publication devoted to intelligent discussions over how to best allocate power between the government and the individual, Sullum had penned a number of fairly unorthodox essays about drugs. I was looking forward to getting more of his thoughts on a topic that while always in motion, rarely seems to advance.

Saying Yes: In Defense of Drug Use is the fruit of Sullum's thinking about drugs and drug policy. Compared to most books in this genre, *Saying Yes* is refreshing and insightful, and could well produce some of the traction needed to advance beyond the policy of Just Say No—an infantile policy equivalent to "Don't Put that in Your Mouth."

SAYING YES:

In Defense of Drug Use Jacob Sullum

Jeremy P. Tarcher, 2003.

\$25.95, 340 pp.

Saying Yes dismantles much of the exaggeration concerning illegal drugs, leading the reader to conclude that this or that illegal drug isn't nearly as harmful as the government has led us to believe.

Sullum's book is anchored in a particular level of discourse about drugs—the fact-based, medical, scientific, analytical, reporter level. Sullum's arguments tend to conclude at the point where he has taken the government's thumb off the harm scale. While he sometimes takes the government to task for trying to rig the scale, he seldom explores the government's fundamental motivations for playing unfairly in the first place.

Rarely does Sullum address drugs or drug policy from a deeper philosophical or principled perspective. This is a book about drugs that is grounded in rationality. While this is the book's strength, it is also its weakness. Empiricism will only get you so far when the landscape has been constructed by the irrational forces, deep-seated fears, religion, power, and money.

An ever-present theme in Sullum's book is what he calls "voodoo pharmacology" the idea, largely promoted by the government, that certain drugs have the power to hijack a person and enslave him or her in an inescapable prison of craving and compulsion. Sullum's aim is to show that this is a myth, that only a very small percentage of illegal drug users become addicts, while the vast majority of people who use illegal drugs live normal, productive, loving lives.

Sullum's book is filled with valuable insights derived from deconstructing government statistics about drugs and drug use. He shows how even the most vilified drugs such as heroin and crack cocaine are not nearly as addicting as the government would have us believe.

He adds a new gloss to these statistics by suggesting that one reason why marijuana is widely perceived as a "soft" drug, deserving of less stringent controls than say crack or

heroin is, at least in part, because over 30 percent of the US population has tried marijuana and that makes it very hard for the government to sustain a false stereotype of marijuana users. In contrast, it is much easier for the government to maintain a disparaging stereotype about crack and heroin users, because those drugs are used by a relatively small percentage of Americans. A drug like LSD, which has been used by roughly nine percent of the US population at least once, falls somewhere in the middle; more vilified than marijuana, but less than crack or heroin.

The bulk of Sullum's book is devoted to logically demonstrating that most drugs aren't as bad as most people believe. Sullum never denies that some people do indeed get into problems with illegal drugs, but he marshals plenty of evidence to prove that even with the "hard drugs" like crack and heroin problem users are a small minority of users; the exception rather than the rule.

Saying Yes is best, however, when Sullum goes beyond the empirical and begins to explore *why* even intelligent, responsible, drug users have such a difficult time getting outside the established frames that define drug use.

Sullum suggests (but only quickly) that because there is so much political, legal, and social pressure to abstain from using illegal drugs, that many people who do use them are quite anxious about doing so and as a result, commonly feel driven to justify their drug use. For some, this manifests as a need to frame their drug use as "medical" or "religious"—two categories that abstainers of illegal drugs might appear more willing to accept. Sullum writes:

The search for excuses reflects the lingering suspicion that drug use is sinful without a special justification. Yet the desire to alter one's consciousness appears to be a fundamental aspect of human nature. Like sex, it is nothing to be ashamed

of, but it needs to be constrained by moral principles, which means getting beyond the unthinking blanket rejection of drugs.

At another point Sullum also expresses frustration (but again without much elaboration) with drug policy reformers who rely almost exclusively on harm-reduction arguments (e.g., the war on drugs does more harm than good), calling attention to the fact that such reformers have an almost universal tendency to stress that they are opposed to drug

use. The bumper sticker statement "Drug use is bad, but the drug war is worse," epitomizes this position.

Why can't we recognize that there are perfectly good nonmedical reasons for why a person might want to use a drug?

Gary Johnson, former governor of New Mexico,

and a darling of the drug reform movement was a poster-child for this position, calling drugs a "handicap" and a "bad choice," and telling a group of college students, "I hate to say it, but the majority of people who use drugs use them responsibly." Sullum rightly wants to know why, since most people do in fact use drugs responsibly, Gary Johnson "hates to say it."

Echoing the point made by Thomas Szasz (most recently in his book *Pharmacracy*), Sullum identifies the evolution of modern medicine as largely responsible for the current bifurcation that divides "good drugs" from "bad drugs." If a drug changes the way a person thinks or elevates a person's mood, it is taboo unless it is being used to improve a medical deficit. Nonmedical use of drugs, including nonmedical use of prescription drugs, is viewed as "abuse" by the government and by most of the medical establishment.

This is the uneasy tension that exists with respect to marijuana. More and more Americans seem willing to accept

marijuana's use within a medical framework, but they remain deeply concerned that some people will make bogus medical claims in order to simply get high. Indeed, as Sullum points out, the medical model for drug use is now so overgrown that it has prompted some school districts to coerce parents to place their children on Ritalin in order to attend school. In other words not only does a medical imprimatur make drug use acceptable, a medical purpose can be enough to *force* a person to take a drug.

Sullum rightly asks why it is that "legitimate" drug use must satisfy a medical model. Why can't we recognize that there are perfectly good nonmedical reasons for why a person might want to use a drug? Why is it so hard for most people to accept that drugs can be used responsibly for the express purpose of enhancing the senses, boosting mood, occasioning a pleasant evening, or eliciting a spiritual experience? As Sullum notes, all of these uses of drugs are legitimate. Indeed Sullum is weary of creating hierarchies that characterize some reasons for using drugs as acceptable, but others as unacceptable. Sullum writes:

Seeking a medical or religious exemption from drug prohibition amounts to asserting that *my* use of this substance is important, that it deserves respect in a way that more frivolous uses do not....The urge to offer such excuses is based on the sense that drug use is morally suspect without an elaborate and serious sounding defense....Wine drinkers generally do not feel compelled to proclaim that their beverage was endorsed by God, that it relieves anxiety or reduces their risk of heart disease. They simply say, "I like a nice glass of wine."

It is in these portions of *Saying Yes*, where Sullum moves into a more principled examination of drug use, that he is at

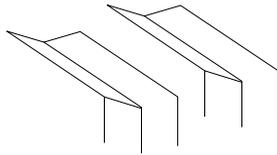
his best. Yet, just as Sullum begins to travel off the beaten path, the book concludes, leaving one feeling the textual equivalent of a dreaded drug under-dose.

Nevertheless, for dissipating much of the hype surrounding the dangers commonly associated with illegal drugs, *Saying Yes* is the best book of this type since Andrew Weil's *The Natural Mind*. It is hard to imagine an open-minded person reading Sullum's book and coming away from it without a much more informed understanding of why so many intelligent people choose to use illegal drugs.

—Review by Richard Glen Boire

Boire is director and chief legal counsel of the Center for Cognitive Liberty & Ethics.

109 Conference Calendar



Conferences & Events

2003 AUGUST 27-31

THE ITALIAN SOCIETY FOR THE STUDY OF THE STATES OF CONSCIOUSNESS: Plants, Dreams & Visions

Perinaldo, Italy

info: <http://www.ecn.org/sissc/>, e-mail sissc@ecn.org

The publishers of *Eleusis*, the journal of psychedelic plants and compounds, present their 2003 conference, „Plants, Dreams, & Visions%. Presentations will be held in both Italian and English. Presentations include those by:

- Marco Margnelli, Neurophysiologist, „Dream as State of Consciousness%
- Gilberto Camilla, Psychoanalist: Mushrooms and Man: Entheogenic Taboo or Sexual Taboo?
- Fulvio Gosso, Psychologist: The Dream on the Rock. Prehistorical Visionary Art
- Carl Ruck: Heretical Visionary Sacraments among the Ecclesiastical Elite: Titian's Bacchanal of the Andrians
- Holotropic Workshop led by Piero Coppo and Fulvio Gosso, Certified Holotropic Breathwork Facilitors.

2003 SEPTEMBER 12-14

ACCELERATING CHANGE CONFERENCE (ACC2003)

Stanford, California

Info: www.accelerating.org

This September 12 to 14, the Institute for Accelerating Change will host its first Accelerating Change Conference (ACC2003). The only gathering of its type in the world, ACC2003 offers a unique opportunity to become familiar with leading thinkers in the science, technology, business, and humanism of accelerating change.

ACC2003 will network top change-aware, future-oriented individuals with diverse backgrounds, who seek increasingly balanced, global, and inclusive ways of understanding the changes that affect their lives. Presentations include those by:

- Ray Kurzweil, CEO, Kurzweil Technologies, Winner of the National Medal of Technology and the MIT-Lemelson Prize
- Tim O'Reilly, President, O'Reilly & Associates, leading open source activist, creator of The Emerging Technology Conference

2003 SEPTEMBER 19-20

THE FACE OF THE FUTURE: TECHNOSAPIENS?

Oakland, California

Info: <http://www.thecbc.org/>, e-mail Jennifer.Lahl@thecbc.org

This unique event brings together key players in the next great debate—how we confront the technologies of the day after tomorrow—technologies being developed today.

As the federal government massively increases its funding of nanotechnology, and movies like *AI* and *Bicentennial Man* focus public attention on the fusion of „mecha% and „orga%, the Center for Bioethics and Culture and the Council for Biotechnology Policy have joined forces to open a dialogue. Presentations include those by:

- Wrye Sententia—Co-Director, Center for Cognitive Liberty and Ethics
- Christine Peterson, President, Foresight Institute
- Nigel M. de S. Cameron Ph.D.—Executive Chairman of The CBC and Director of the Council for Biotechnology Policy (www.biotechpolicy.org)
- William Hurlbut M.D.—Stanford University, member of President's Council on Bioethics (www.bioethics.gov)

2003 SEPTEMBER 19-23

STRATEGIES FOR LIFE EXTENSION:

Reasons Why Genuine Control of Aging May be Forseeable
Sponsored by the International Association of
Biomedical Gerontology

Queen's College, Cambridge, United Kingdom

Info: <http://www.gen.cam.ac.uk/iabg10/>

e-mail: ag24@gen.cam.ac.uk

The purpose of the IABG is (1) to make the general public more aware of the potential of biomedical aging research to increase the span of

healthy productive life and to decrease the social and economic problems of age; and (2) to promote greater communication among the worldwide community of individuals engaged in biomedical aging research. Presentations include those by:

- Arthur Caplan, President, American Association of Bioethics, „Is Death Overrated? The Moral Case for a War on Aging%”
- Aubrey de Grey, et al., „Preparing Society for Control of Aging%”
- Streven Austad, „Social, Political & Ethical Obstacles to Human Life Extension%”
- Gregory Stock, „The Promises and Pitfalls of Planning for Demographic Change%”

2003 OCTOBER 16-19

POP!TECH 2003: Sea/Change

Camden, Maine

info: www.poptech.org, e-mail info@poptech.org

Pop!Tech 2003 will explore the notion of Sea-Change—the dramatic transformative changes that are being (or are about to be) wrought in our lives, our societies, our planet, and our understanding of the universe. Consider the many areas of our lives which are undergoing such profound alteration:

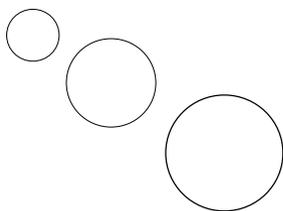
- the transformation in the global social order brought about by new communications technologies;
- the rapid globalization of the economy;
- the redefinition of the nature and terms of terrorism and warfare;
- the unlocking of the genome and the beginning of the biologic century;

Presentations include those by:

- Lawrence Lessig, cyberlaw pioneer director, Stanford Center for Internet & Society
- Constance Adams, NASA spacecraft architect & designer, Founder, Synthesis International

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THE CENTER FOR COGNITIVE LIBERTY & ETHICS is a nonprofit 501 (c)(3) public education, law & policy center working in the public interest to protect fundamental civil liberties. We seek to establish, promote, and protect cognitive liberty—a basic human right to multiple modes of thought, alternative states of consciousness, and the right to control one's own cognitive processes.

We maintain that the principles embodied in the US Constitution, the Bill of Rights, and the UN Universal Declaration of Human Rights, all support cognitive liberty.

Membership dues (which begin at \$US 40 per year) allow the Center for Cognitive Liberty & Ethics to introduce and elucidate the concept of cognitive liberty, in an effort to redefine and revitalize the public debate over human autonomy and freedom. See our Web site (www.cognitiveliberty.org) for a comprehensive statement of our mission and goals.

All members of the CCLE receive a one-year subscription to the *Journal of Cognitive Liberties*.

If you believe that the world needs an organization giving voice to the critical importance of cognitive liberty, please join us.

See membership form on next page.

If you believe in cognitive liberty. . . please join us!

Members of the Center for Cognitive Liberty & Ethics are among the world's most informed and conscientious advocates for cognitive liberty—the fundamental right to multiple modes of thought, alternative states of consciousness, and individual mental autonomy.

Membership dues allow the Center for Cognitive Liberty & Ethics to advance our goal of fostering the fundamental right to cognitive liberty. All members receive a three issue subscription to the *Journal of Cognitive Liberties*.

The Journal briefs members on the latest threats to cognitive liberty, and provides a scholarly forum for examining the politics, policy, and prospects of reintegrating full-spectrum thinking into a modern society.

Membership dues and donations are tax-deductible.

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| <input type="checkbox"/> \$ 75.00 Supporter | <input type="checkbox"/> \$ 2,000.00 Visionary |
| <input type="checkbox"/> \$ 200.00 Advocate | <input type="checkbox"/> \$ _____ Other |

MEMBERSHIP PREMIUMS

• *Journal of Cognitive Liberties* (our gift to all members)

In addition: **\$75 level**– Supporter: choose 1 book.

\$200 level– Advocate (or above): choose 2 books.

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