TESTIMONY OF

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Professional background

I have been a registered pharmacist in the state of Illinois for seven years. I earned the equivalent of a Bachelor of Science degree with a major in biology at Northern Illinois University before transferring, in 1975, to the College of Pharmacy at the University of Illinois Medical Center in Chicago. After three years of additional intensive education with an emphasis on drugs and their effects, I earned a Bachelor of Pharmacy degree in 1978.

During my last year of pharmacy school I worked in a clinical setting at the University of Illinois Hospital in Chicago, where I accompanied physicians on patient rounds and counseled the physicians and their patients on drug therapies. This was the first of many professional experiences by which I gained a firsthand knowledge of "real-life" drug effects following several years of formal training. Later, I served as a drug consultant to family practice physicians for three years at MacNeal Memorial Hospital, a major metropolitan-area hospital in one of the Chicago suburbs (Berwyn, Illinois). I also provided drug counseling during this period to patients of the hospital, including many with additional problems. My official work station at MacNeal was the outpatient pharmacy. I subsequently worked for a year in the hospital pharmacy at the Foster G. McGaw

Memorial Hospital at Loyola Medical Center in Maywood, Illinois, a major teaching hospital near Chicago. I have also worked about two years in retail drugstores, including one in the heart of Chicago where contact with substance abusers occurred on a daily basis.

From the start of my career, I have always felt personally responsible for the proper use and ultimate effectiveness of drugs that I dispense. I therefore make sure that may patients know exactly what drugs they are taking, exactly how to take them and exactly what precautions to observe and what side effects to watch for. The goal--my professional purpose--is successful drug therapy.

MDMA's potential for abuse

Let's consider closely the DEA's analysis of MDMA for drug abuse potential: similarity of one drug (MDMA) with another having known abuse potential (MDA). The DEA seems to believe that because MDMA's molecular structure is similar to that of MDA, it is guilty by association. That would be a fair assumption if it weren't for the fact that MDMA and MDA show opposite isomer activity in affecting the central nervous system. The DEA acknowledges this difference (then ignores it) in its recommendation to put MDMA in Schedule I, where it cites the research findings of Nichols and other researchers. According to the DEA's report, prepared by its Drug Control Section (1982):

> It has been suggested that the active ("R") isomer of MDA might act by a direct receptor effect while the active ("S") isomer of MDMA might work by the

> release of an endogenous neurotransmitter (Nichols, et al., 1982). Nichols, et al., studies the isomers of MDA and MDMA for their effect on the release of (3H) serotonin from whole rat brain synaptosomes. No differences were noted in the potencies of the MDA isomers while the "S" isomer of MDMA was more effective in inducing the release of the neurotransmitter than the "R" isomer. Since it is the "S" isomer of MDMA which is the active enantiomer, the activity of MDMA may be due to the release of the serotonin neurotransmitter.

Conseqently, though MDMA and MDA have similar molecular structures, there is reason to believe that they have different physiological effects. An illustration is provided by two common drugs with an even closer structural relationship--quinine and quinidine. These drugs are enantiomers--they have the same molecular structure but with different stereoisomers. The result of this mirror-image isomerism is that quinidine performs as a cardiac suppressant--a specific effect-- while quinine, with more general effects, is prescribed to treat malaria and leg cramps and is used as a schlerosing agent.

Another criterion by which to judge if a drug has abuse potential is whether the drug is addictive, either physically or psychologically.

There is no evidence, at any rate, that MDMA is physically addictive. Nor does the DEA claim that it is. The drug's possible physical side effects--including blurred vision, muscle tightness of the jaw and/or sweating--are more likely to discourage frequent use or high-dosage abuse.

MDMA's therapeutic value

I can testify, based on my several years of experience in pharmacy, that no other drug is available which has the positive effects ascribed to MDMA. There are drugs that are used as a supplement to guided psychotherapy--the antidepressants and tranquilizers--but none that can be used, like MDMA, as an adjunct to such therapy in order to facilitate the process of communication. Most psychopharmaceuticals used for the treatment of mental dysfunction are prescribed by a doctor, dispensed by a pharmacist and taken by the patient in the form of daily dose between therapy sessions. With MDMA, the drug is provided directly to the patient by the therapist and used only during the therapy session. Thus, the therapist or possibly a trained assistant stays right there with the patient throughout the drug's duration of principal action, which normally lasts about two to three hours. Safety therefore is assured by the therapist's presence and guidance.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed this _____ day of April, 1985.

SIGNED: _____
June E. Riedlinger, R.Ph.

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