While literally (and somewhat accidentally) on my way to attending the beginning of medical school, I experienced the effects of a potent plant-based medicine considered a psychedelic drug. I had an extremely positive, profound experience that was so outside the paradigm of language as to be impossible to describe. The next morning, in my naivety, I thought, “Oh my, this drug has tremendous therapeutic value as a medicine, and if everyone would take it, they would have the same experience I had, and the world would be in order.” It is now over 30 years later, and I have since learnt otherwise.

Many others who have their first plant medicine experience have the same reaction and want to work with these plant medicines. Yet if these medicines are to be given in a safe, therapeutic model to treat specific diseases in the United States, they will need to be handled by those with medical credentials and expertise to administer them safely and effectively for specific conditions seen in illnesses in the U.S. medical diagnosis code book. Whatever the plant medicine, credentialed therapists, specifically trained for treating patients with specific plant medicines, will be a critical component before, after, and sometimes during the ingestion of the medicine. With this preparation, we could achieve the goal of obtaining sustainable positive results that surpass today’s pharmacopeia, and bringing more joy into our patients’ lives.

Every decision, career path, and patient I have treated since has been greatly affected by what I learned from that initial psychedelic journey. From the beginning of medical school, it was my hope to someday incorporate plant medicines into psychiatry and medicine in general. I coined a term for this as a young medical student: “neuropsychiatric immunology,” the power a plant-based substance has to assist one’s brain in healing itself. After finishing medical school and completing my residencies and additional trainings, I worked in the field of Emergency Medicine for over a decade. My journey took me far away from my original optimism of using plant medicines in the United States.

The current U.S. healthcare system is not a model of “well-care” but one of “sick-care” based on profits and actuarial tables. We wait until patients get sick and then try to find drugs that alleviate and occasionally cure those conditions. Big Pharma and insurance companies in a capitalistic society exist to turn profits for their shareholders, as perhaps they should. However, in this model, no drug is a good drug unless patients must take it forever. Drugs that are taken infrequently or may actually be disease-modifying or curative can cost many thousands of dollars, making access for the majority of those people who need those drugs impossible.

Around 1997, a Ph.D. of renown from the University of Miami approached me of about a plant-based African medicine called ibogaine. Ibogaine is derived from the root part of the African plant Tabernanthe iboga. It has been used by indigenous tribes in Gabon for centuries in its natural form as a rite of passage. Ibogaine exists in many forms, from root bark to extract to others. For the purpose of this article, I am speaking of 98% pure ibogaine hydrochloride (ibogaine HCL), chemically extracted from the plant to produce an orally administered medication that can be given on a milligram per kilogram basis to treat specific substance use disorders (SUDs). That scientist
claimed to me that a single dose of Ibogaine HCL could greatly ameliorate opioid withdrawal symptoms in less than 24 hours, as well as being extremely beneficial for patients who suffered from other SUDs. Being a scientist, I was very skeptical.

As coincidence would have it, at the time I met this researcher, I had many years of opiate abstinence myself, freeing myself from opioid dependence the hard way, on my own and going through 90 days of abject hell. I became Board Certified in Addiction Medicine, detoxifying patients on a daily basis and always thought, “There has to be a better way.”

I possessed a unique skillset that this researcher needed to begin giving ibogaine to a large number of addicted patients in a highly monitored setting: I was an internist with additional training in cardiology who was Board Certified in Addiction Medicine, had treated a vast array of cardiovascular and respiratory emergencies during my years as an emergency room physician, and was a recovering addict myself. In addition, I had experienced the benefits of psychedelic introspection myself.

I remember the first few patients who received treatment on Saint Kitts, British West Indies. What I witnessed was nothing short of a miracle. I saw patients with massive opioid dependencies who had failed many cycles of the best treatments available in the U.S. feel well within 24 hours post-ibogaine flood dosing. They were in the same physical and mental state, 24 hours post ibogaine treatment, that would take a patient 90 days of suffering to achieve in the U.S. model of pharmaceutical substitution detoxification followed by aftercare treatment. Aside from rapid amelioration of withdrawal symptoms, cessation of cravings, and diminution of withdrawal severity, patients have relate gaining valuable insight into their behavior equivalent of years of perfect psychotherapy done in one day.

Here we are in 2020, on the verge of major breakthrough in psychedelic medicine. Psychedelics as medicine is a hot topic in the media, science, and business world. Esketamine has been FDA-approved as a treatment for refractory depression, and there are currently Phase 3 clinical trials in the U.S. using psilocybin for the treatment of major depressive disorder and treatment-resistant depression, and using MDMA to assist with psychotherapy for posttraumatic stress disorder (PTSD). This comes with a lot of optimism, but also many caveats.

I have served as a principal investigator in dozens of U.S. clinical trials for pharmaceutical companies to get new medications FDA-approved. The complexity and expense of bringing out a single new drug to the US market boggles the mind. Many ibogaine clinics have opened up all over the world in countries where use of the drug is not illegal. Aside from the professionals who possessed the skills and knowledge to treat the possible known adverse events that can occur during ibogaine flood dose treatment.

Ibogaine can cause cardiovascular issues such as hypotension, bradycardia, QTc prolongation, HeRG blockade, and complex cardiac arrhythmias. The reports of these deaths, some by well-intentioned lay providers, have fueled an anti-ibogaine sentiment being perpetuated by those who continue to make billions of dollars from selling pain medications and other medications for SUDs such as methadone, buprenorphine. These medications can be prescribed legally in the U.S. but leave patients dependent upon them, yielding significant profit for the pharmaceutical industry.

Is this the best we can do? I think not. I, along with a select few other physicians, have overseen thousands of successful ibogaine flood dose treatments with zero mortality, due to the specific strict medical protocols we have followed and the medical skills we possessed.

Proper ibogaine treatment includes not only diligent...
pretreatment consisting of medical/psychosocial history and examination but also comprehensive labs, cardiovascular assessment, and pre-ibogaine therapy. The importance of having a firm aftercare plan with trained therapists to achieve sustainable recovery is of critical importance. In addition, ibogaine as a drug must be standardized as a product to ensure that all providers are giving exactly the same drug orally based on bodyweight. Constant IV access and cardiac monitoring, and the presence of a medical physician who is not only Advanced Cardiac Life Support certified but also experienced treating complex cardiac arrhythmias and other possible flood-dose complications must be bedside at all times. All providers must be intimately familiar with what the patient will experience while under the effects of a flood dose of ibogaine.

Let’s parallel the Iboiganed flood procedure to another standard accepted medical procedure in the U.S.: a screening colonoscopy. When you need a colonoscopy, you don’t go to someone who thinks they can do a colonoscopy because they had one; instead you see a gastroenterologist who has many years of training in that specialty and that procedure. Prescreening labs, medical history, and cardiovascular status are reviewed prior to the procedure to ensure the colonoscopy can be done safely. The day of your colonoscopy, you arrive, an IV is placed, and you are given anesthesia by an anesthesiologist, who is present throughout the procedure which is done under constant cardiac monitoring. This anesthesiologist is well qualified to handle any adverse effects that may occur, including hypotension, bradycardia, arrhythmias, and other abnormalities. This procedure is considered so safe that it is the standard of care in the U.S. for anyone over the age of 55 and is suggested to be repeated every five years.

I assert that if such diligence is followed for ibogaine flood dosing in the US, hundreds of thousands of lives would be saved per year, and the morbidity and mortality would match that of a simple procedure like a colonoscopy. In the face of an opioid epidemic, there is a massive amount of anecdotal and scientific evidence that ibogaine flood dosing, administered in a very specific medical model which would be considered the “standard of care” for this treatment, can be given safely and effectively in the U.S., resulting in significantly improved outcomes when compared to any model of SUD treatment that exists in the United States to date.

Under a patient’s inalienable “right to try,” should an addict who has failed multiple cycles of standard U.S. treatment not be allowed to try ibogaine flood dosing with full informed consent? Many barriers exist to this happening, including:

- Big Pharma’s model that no drug is a good drug unless you must keep taking it (ibogaine flood dosing is a single dose treatment for detoxification for opioid dependence)
- The lengthy, exorbitantly costly FDA model of obtaining approval for the use of a new drug for specific disorders in the U.S.
- The fact that ibogaine’s efficacy would greatly cut into the profits already being made by pharmaceutical stakeholders and those currently vested in the for-profit system of addiction treatments that exists in the U.S. today.

Aside from those barriers, many of the world’s leading ibogaine experts who possess advanced credentials as scientists, researchers, and clinicians are seeking ways to own the rights to use ibogaine and other psychedelic drugs to treat a myriad of conditions in a profit-based model of finding a drug that Big Pharma would like. As a clinical trial principal investigator, scientist, and a physician, I have no financial interest in this medicine.

For over two decades, I have advocated for a science-based, ethical, and affordable model of ibogaine flood-dose administration in the United States. I have asked myself: How many lives could have been saved—how much pain and suffering alleviated—had this drug been approved after the initial off-shore trials were completed?

It is clear through the hard-fought diligent efforts of organizations like MAPS that we are at the dawning of a new era in which psychedelics are accepted medical treatments for specific psychiatric maladies, including SUDs. In the face of a global opiate epidemic which is exponentially growing without any relief in sight, it is my hope that ibogaine may gain emergency drug status approval in the near future.

Ibogaine, in my opinion, is far superior to any treatments we have today in the United States not only for opiates, but also for alcoholism, cocaine dependency, methamphetamine dependency; and perhaps psychiatric disorders such as depression, obsessive compulsive disorder, and PTSD. With the help of organizations such as MAPS and Ibogaine Research Institute (IRI)—a not for-profit company trying to get clinical trials expedited in the U.S.—the future remains optimistic. As I often say: “Be realistic: expect a miracle.”

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