

# A Justice-Based Argument for the Uniform Regulation of Psychoactive Drugs

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In the author's view, modern drug control legislation is founded upon myth and prejudice rather than on principles of justice and scientific validity. Restricting his analysis to psychoactive or psychotropic drugs, he makes a justice-based reform argument to the effect that since such drugs share the same characteristics, they should, as a matter of fairness, be made subject to one regulatory system. Current regulation of psychoactives ranges from prohibition with criminal sanctions to widespread availability for drugs like caffeine, nicotine and alcohol. The author explores five possibilities for reform and ultimately proposes the adoption of a public law system of tax disincentives.

Les "psychotropes" sont sujets à des systèmes de réglementation différents tels la prohibition sous peine de sanctions criminelles pour certains, la prescription médicale pour d'autres ou la libre circulation comme c'est le cas pour la caféine, la nicotine et l'alcool. L'auteur considère cette pluralité de réglementations comme étant discriminatoire étant donné que tous les psychotropes partagent les mêmes caractéristiques de base. Après avoir démontré que les dommages imposés à la société par l'usage des drogues ne sont pas assez élevés pour justifier une sanction criminelle, et que, d'autre part, la médicalisation générale des psychotropes conférerait au corps médical un pouvoir qu'il n'est pas apte à assumer, l'auteur en vient à la conclusion que le contrôle des psychotropes doit être pris en charge par l'État en créant un système uniforme de taxation sur la vente des psychotropes.

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*Synopsis***Introduction****I. The Legal and Scientific Classification of Drugs***A. Divergent Legal Classifications**B. Convergent Scientific Classification*

1. Mechanism of Action
2. Multi-purpose Effects
3. Health Impairment
4. Habit Formation and Dependency

**II. Drug Control and Principles of Justice***A. Justification**B. Proportionality**C. Fairness***III. A Comparative Justice Analysis***A. Taking Human Rights Semi-Seriously**B. Utilitarianism and Liberal Pragmatism**C. Taking Justice Seriously**D. Justice and Regulatory Design***IV. Uniform Regulation***A. Criminal Prohibition**B. Prescription and Medical Supervision**C. Government Rationing**D. Tax-Licensing Controls**E. Free Market Controls***Conclusion**

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**Introduction**

Over a century ago, Anglo-American laws tolerated prostitution and regulated, for the most part, the nuisance aspects of commercial sex. Then, following various scandals concerning venereal disease, child prostitution

and "white slavery", legislators bowed to pressure exerted by the self-righteous and enacted increasingly draconian anti-prostitution measures throughout the nineteenth century.<sup>1</sup> Often these measures compelled the women involved to submit to medical controls, a strategy still supported by those who would medicalize prostitution.<sup>2</sup> A similar wave of intolerance and medical imperialism altered the legal status of drugs and drug users during the same period.<sup>3</sup> By 1847, drunkenness had been labelled a "disease of the mind", the American Society for the Promotion of Temperance had been established and the State of New York had for two years banned the public sale of liquor. American lawmakers then moved federally to prohibit non-medical alcohol use, heroin production and marijuana cultivation.<sup>4</sup> By 1921, cigarettes were illegal in 14 states and they remain illegal to those "under age" in 47 states.<sup>5</sup> While the prohibition of alcohol and tobacco was largely abandoned through the 1920s, the zealous criminalization of other drug use was continued. This crusade prospered because it served certain purposes, none of which related to justice or public protection. In general disregard for principles of both justice and scientific validity, modern drug control

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<sup>1</sup>See J. McLaren, "Chasing the Social Evil: Moral Fervour and the Evolution of Canada's Prostitution Laws" (Address to the Canadian Learned Societies Conference, Université de Montréal, 31 May 1985) [unpublished].

<sup>2</sup>See R. Hamowy, "Medicine and the Crimination of Sin: 'Self-Abuse' in 19th Century America" (1977) 1 J. Libertarian Stud. 229. See also M. Rumack, "Prostitution: A Penal or a Medical Problem" (1972) 20 Chitty's L.J. 49 at 52ff., who claims that prostitution is a socio-medical problem and who endorses the suggestion that it is amenable to treatment by psychotherapy, especially if caught when first manifested in the juvenile in the form of promiscuity.

<sup>3</sup>See J. Cloyd, *Drugs and Information Control* (Westport, Conn.: Greenwood Press, 1982) at 56-57: "The latter part of the nineteenth century reflected an attempt by the dominant social institutions [in the U.S.] to reestablish a system of racial isolation . . . . Antidrug legislation was just an aspect of this process." The work of Lucy Gaston, founder of the Anti-Cigarette League, provides a good example of the social climate of that period. See L. Wallack, "Mass Media and Drinking, Smoking, and Drug-taking" (1980) 9 Contemp. Drug Probs 49 at 57-58. The propaganda of that period has been successful and durable. J. Zentner, "Heroin: Devil Drug or Useful Medicine?" (1979) 9 J. Drug Issues 333 at 333, notes that over the past century heroin "has been slandered to such an extent that today for most persons it is synonymous with evil." See also P. Lauderdale & J. Inverarity, "Regulation of Opiates" (1984) 14 J. Drug Issues 567.

<sup>4</sup>See T. Szasz, *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (New York: Anchor Press/Doubleday, 1974) at 4-27 and 190ff.

<sup>5</sup>E.M. Brecher & the Editors of *Consumer Reports, Licit and Illicit Drugs* (Boston: Little, Brown, 1972) at 231. Massachusetts outlawed tobacco use in 1629. In this century, New Hampshire prohibited the sale of cigarettes in 1901, while in 1907 Illinois established a \$100 or 30 days in jail penalty for the same offence. R.C. Schroeder, *The Politics of Drugs*, 2d ed. (Washington: Congressional Quarterly Press, 1980) at 103. See also H. Diehl, *Tobacco and Your Health* (New York: McGraw-Hill, 1969).

legislation was founded on class prejudice, medical self-interest, cultural chauvinism, racist bigotry and political scapegoating.<sup>6</sup>

This paper is concerned with the regulation of psychoactive or psychotropic drugs. Familiar psychoactives include caffeine, cocaine, alcohol, nicotine, morphine, heroin, mescaline and diazepam (Valium). Psychoactive substances alter mood by affecting the user's central nervous system, and may act as sleep aids, tranquillizers or stimulants.<sup>7</sup> These drugs are presently segregated into a number of complex, overlapping legal categories. However, according to the scientific evidence detailed below, psychoactives belong to a single, cohesive class and, despite important points of diversity, share the same basic characteristics. That is to say, every psychoactive tends to be habit forming, health impairing and capable of being used recreationally or medicinally as a symptom reliever.<sup>8</sup>

Fairness requires that if all psychoactives are essentially equivalent, they should be assigned to a single regulatory system. There are five possible systems to choose from: criminal law prohibition, medical prescription, rationing, tax-licensing and the free market. In deciding which of these systems would be preferable as a universal plan, I will speculate on which restraints on their own drug use individuals would accept in order to protect themselves from either the drug use of others or the effects of their own drug consumption. Once the drug control question is framed so as to take fairness seriously, reliance on either criminal law or medical controls will be shown to be untenable.

Since selective prohibition and prescription policies now dominate drug regulation, a justice-based reform argument faces two major challenges: the

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<sup>6</sup>For a recent review of the literature, see N. Boyd, "The Origins of Canadian Narcotics Legislation: The Process of Criminalization in Historical Context" (1984) 8 Dalhousie L.J. 102; R.J. Bonnie & C.H. Whitebread, "The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition" (1970) 56 Va L. Rev. 971.

<sup>7</sup>E. Goode, *Drugs in American Society*, 2d ed. (New York: Alfred A. Knopf, 1984) at 17, defines psychoactive substances as those that "have a direct and significant impact on the processes of the mind, that influence emotion, thinking, perception, feeling . . . ."

<sup>8</sup>The evidentiary basis for this claim is set out, *infra*, notes 37-95 and accompanying text. Claiming that every psychoactive exhibits these same basic characteristics is not the same as claiming that every drug is identical or equal in effect. For example, after detailing the addictiveness of coffee and the health impairment it causes, J. Kaplan, "The Role of the Law in Drug Control" [1971] Duke L.J. 1065 at 1084, observes that "[d]ifferences of degree and kind are, however, important and a legal system which made no distinction between heroin and coffee would leave a great deal to be desired." Yet Kaplan then admits that if more were known, "it could be said that it is not that some drugs are more dangerous than others, but rather that certain drugs are more dangerous to specific types of people."

decriminalization of illicit psychoactives and the demedicalization of prescription psychoactives. Legal scholars have focused on the issue of decriminalization, but many decriminalizers only go so far as to advocate the conversion of illicit drugs into quasi-medical substances and the transformation of criminal users into "patients".<sup>9</sup> This compromise policy merely shifts drugs and drug users from the control of one inappropriate system to another. It is ill-conceived because drug use is not directly a medical concern. To pretend otherwise is to disguise a legal, ethical and political problem as a purely technical matter best left to the medical profession.<sup>10</sup> This does not imply that technical pharmacological data should be ignored, merely that interpretations of such data should not be accepted on faith alone. For example, it is often assumed uncritically that all new psychoactives should be marketed as "medicines" rather than as competitors to alcohol and tobacco.<sup>11</sup> It is also assumed that legal classifications reflect major and valid differences between the drugs classified.<sup>12</sup>

Richard Blum predicts that legal academics in the drug field will assign the fewest drugs to extreme controls and rely least on criminal law sanctions.<sup>13</sup> This article bears out Blum's forecast in so far as no drugs are assigned to criminal law or extremist controls. I recommend instead a public law system employing tax disincentives designed to duplicate many of the features of a collective tort action against those responsible for generating drug-related damages. Mild but universal sanctions applied to all drug use

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<sup>9</sup>See, e.g., R.J. Bonnie, "Decriminalizing the Marijuana User: A Drafter's Guide" (1977) 11 U. Mich. J.L. Ref. 3; M.G. Kurzman & H. Magell, "Decriminalizing Possession of All Controlled Substances: An Alternative Whose Time Has Come" (1977) 6 Contemp. Drug Probs 245; T.J. Stachnik, "The Case Against Criminal Penalties for Illicit Drug Use" (1972) 27 Am. Psychol. 637. For a criticism of the treatment of drug-dependent possessors of opiates as "patients", see the dissenting conclusions of Commission member M.-A. Bertrand in Canada, *Final Report of the Commission of Inquiry into the Non-Medical Use of Drugs* (Ottawa: Queen's Printer, 14 December 1973) at 245-46 (Chair: G. Le Dain).

<sup>10</sup>See T. Szasz, "The Ethics of Addiction" in C.C. Brown & C. Savage, eds, *The Drug Abuse Controversy* (Baltimore: National Educational Consultants, 1971) 39 at 47.

<sup>11</sup>See, e.g., D. Bovet, "Medical Science and Drug Classification" in R.H. Blum *et al.*, *Controlling Drugs* (San Francisco: Jossey-Bass, 1974) 85 at 110. Similarly D.A. Kay, *The International Regulation of Pharmaceutical Drugs* (St Paul, Minn.: West, 1976) at 6, announces without comment that regulatory authorities are concerned with ensuring, *inter alia*, that "[n]ew drugs are evaluated for safety and efficacy for their intended therapeutic use." Kay simply assumes that all new drugs must be "therapeutic" if they are to reach the market. H.F. Dowling, *Medicines for Man: The Development, Regulation, and Use of Prescription Drugs* (New York: Alfred A. Knopf, 1970) at 4, in the same vein, defines "prescription drugs" as "[n]ew drugs, those used for serious illnesses or those having considerable potency for harm if misused." [emphasis added]

<sup>12</sup>See, e.g., the material quoted in R.H. Blum, "Interest Groups" in Blum *et al.*, *ibid.*, 62 at 62ff.

<sup>13</sup>Blum, *ibid.* at 69.

will better protect society than extreme penalties applied rarely, haphazardly and unfairly against minority drug use.

## I. The Legal and Scientific Classification of Drugs

### A. Divergent Legal Classifications

The industrial nations classify drugs in similar ways, modelled primarily on the American example.<sup>14</sup> The central division is between medical and non-medical psychoactives. Non-medical or secular drugs are freely available, like caffeine, or are prohibited to minors and subject to a variety of tax-licensing measures, as is the case with alcohol and tobacco. Use of these three psychoactives constitutes most of the consumption of mood altering substances.<sup>15</sup> The less important drugs, in terms of *per capita* usage, are classified as medicines. The pertinent federal legislation in Canada is found in the *Food and Drugs Act*,<sup>16</sup> the *Narcotic Control Act*,<sup>17</sup> the *Tobacco Restraint Act*,<sup>18</sup> and the *Proprietary or Patent Medicine Act*,<sup>19</sup> and at the provincial level, in statutes like Ontario's *Liquor Control Act*.<sup>20</sup>

Medical drugs fall into a confusing array of legal cubbyholes. Some psychoactives are found among the over-the-counter (OTC) preparations

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<sup>14</sup>See W.M. Wardell, ed., *Controlling the Use of Therapeutic Drugs: An International Comparison* (Washington: American Enterprise Institute for Public Policy Research, 1978); J. Kaplan, "Classification for Legal Control" in Blum *et al.*, *supra*, note 11, 284 at 284-90. The U.S. fumbled into a leading role in the drug-abuse crusade partly as a result of its first colonial efforts in the Philippines in the early 1900s. Governor W.H. Taft commissioned a study on how to deal with the "opium problem" inherited from the Spanish. Unfortunately, American missionaries ignored the moderate recommendations made by Taft's Commission and demanded complete prohibition. The resulting black market led, in 1912, to the Hague Opium Convention which was forced into adoption solely by the U.S. See R. King, "The American System: Legal Sanctions to Repress Drug Abuse" in J.A. Inciardi & C.D. Chambers, eds, *Drugs and the Criminal Justice System* (Beverly Hills: Sage, 1974) 17 at 20.

<sup>15</sup>The proportions of young American adults regularly using the popular psychoactives are: caffeine (91 per cent), alcohol (75 per cent), marijuana (39 per cent), tobacco (21 per cent), analgesics (41 per cent), and prescribed (17 per cent). For tobacco and caffeine "regular use" is likely to mean daily maintenance dosage. See A.M. Vener, L.R. Krupka & J.J. Climo, "Drugs (Prescription, Over-the-Counter, Social) and the Young Adult: Use and Attitudes" (1982) 17 Int'l J. Addictions 399. In terms of negative impact, H. Teff, *Drugs, Society and the Law* (Westmead, Eng.: Saxon House, 1975) at 147, estimates that alcohol or barbiturates cause premature death at thirty times the rate of heroin, and tobacco at a thousand times the rate of heroin.

<sup>16</sup>R.S.C. 1970, c. F-27. For a general discussion of the relevant legislation see E.M. Sellers & S. Sellers, "Canada" in Wardell, *supra*, note 14, 71 at 78-84.

<sup>17</sup>R.S.C. 1970, c. N-1.

<sup>18</sup>R.S.C. 1970, c. T-9.

<sup>19</sup>R.S.C. 1970, c. P-25.

<sup>20</sup>R.S.O. 1980, c. 243.

and may be purchased without physician approval.<sup>21</sup> Many other psychoactives fall under the general medical heading as available by prescription only.<sup>22</sup> In addition, there exist special status substances. So-called "narcotics", including morphine and cannabis, and "controlled drugs" like methaqualone, may be prescribed but under onerous conditions.<sup>23</sup> Amphetamine and other "designated drugs" can be prescribed but only for certain conditions such as narcolepsy. Methadone, the sanctioned heroin substitute, is in a class by itself since its prescription requires approval from the Minister of Health and Welfare.<sup>24</sup> "Restricted drugs" such as psilocybin and LSD are available only to persons authorized by regulation.<sup>25</sup> Thalidomide and certain combination products cannot be prescribed under any conditions.<sup>26</sup> Possession and use of medical psychoactives outside approved channels normally carries the risk of minor-to-severe criminal law penalties and, in the case of physicians, the possible loss of their licences to practise.<sup>27</sup>

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<sup>21</sup>Since 1976, OTC drugs have been subject to certain general standards set out in the *Food and Drugs Act*, *supra*, note 16, ss 3 and 8-11, as am. S.C. 1976-77, c. 28, s. 16(1) and S.C. 1981, c. 47, s. 19. Such standards involve conditions of manufacture, labelling, advertising and sale. OTC drugs are also governed by the *Proprietary or Patent Medicine Act*, *supra*, note 19. For a discussion of the effectiveness of current standards see J. Hollobon & D. Lipovenko, "Many Drugs Haven't Passed Modern Tests" *The [Toronto] Globe and Mail* (18 October 1982) 5. OTC psychoactives, including analgesics, antihistamines, sedatives and "diet" pills, are widely used. See Vener, Krupka & Climo, *supra*, note 15 at 402. Aspirin, the most common OTC product, is used primarily as an analgesic or antipyretic but for some people "it even works as a mild sedative": *Consumer Reports*, eds, *The Medicine Show* (New York: Pantheon Books, 1974) at 13.

<sup>22</sup>Prescription-only psychoactives are listed in Schedule F of the *Food and Drug Regulations*, C.R.C. 1978, c. 870, C.01.041. Provincial pharmacy acts may also set out a schedule of prescription drugs, a list that can add to, but not subtract from, the federal list. Sellers & Sellers, *supra*, note 16 at 72. See, e.g., *Health Disciplines Act*, R.S.O. 1980, c. 196, s. 145ff. and the schedules appended to R.R.O. 1980, Reg. 451.

<sup>23</sup>"Narcotics" are listed in the Schedule to the *Narcotic Control Act*, *supra*, note 17. "Controlled drugs" such as barbiturates are listed in Schedule G to the *Food and Drugs Act*, *supra*, note 16. See also s. 33ff. of that *Act*. These drugs may be prescribed by a physician under the respective regulations. See *Narcotic Control Regulations*, C.R.C. 1978, c. 1041, s. 53 and *Food and Drug Regulations*, *ibid.*, G.04.001.

<sup>24</sup>*Food and Drug Regulations*, *ibid.*, G.04.001(4)(a)(i). "Designated drugs" are a subset of the "controlled drugs". The conditions governing the prescription of methadone may be found in the *Narcotic Control Regulations*, *ibid.*, ss 53(3) and 68(1).

<sup>25</sup>See *Food and Drugs Act*, *supra*, note 16, ss 41, 45 and Schedule H and *Food and Drug Regulations*, *ibid.*, J.01.002.

<sup>26</sup>*Food and Drugs Act*, *ibid.*, s. 15 and Schedule F. See Sellers & Sellers, *supra*, note 16 at 82.

<sup>27</sup>See *Food and Drugs Act*, *ibid.*, s. 26; *Narcotic Control Act*, *supra*, note 17, ss 3-6. For a discussion of the effects of these penalties on marijuana users, see P.G. Erickson, *Cannabis Criminals: The Social Effects of Punishment on Drug Users* (Toronto: Addiction Research Foundation, 1980) at 2. In the U.S., similar distinctions among drugs are established under the *Comprehensive Drug Abuse Prevention and Control Act of 1970*, 21 U.S.C. § 801. Schedule I drugs like heroin cannot be prescribed but Schedule II drugs like morphine and methadone

Critics charge that drug classification laws were not well reasoned, well founded or widely discussed before their enactment.<sup>28</sup> The central inconsistency in every legal classification scheme is the cross-category appearance of different members of the same drug group. Sedative-hypnotics like alcohol, diazepam and the barbiturates occupy three quite distinct legal categories. The same is true for stimulants such as caffeine, theobromine, amphetamine and cocaine.<sup>29</sup> On the proper legal classification of cannabis in particular, the Le Dain Commission reported that:

Cannabis has ... characteristics in common with a wide variety of drugs including alcohol, LSD and mescaline, nitrous oxide, amphetamines, atropine, opiate narcotics, barbiturates and the minor and major tranquilizers... [C]annabis has been shown to have stimulant, sedative, analgesic and psychedelic effects.<sup>30</sup>

Since cannabis resembles drugs which belong to different legal categories, there is no compelling rational reason to classify it one way or another. Given this open-ended discretion, lawmakers have always been free to classify cannabis as they please.<sup>31</sup>

Pharmaceutical categorizations do not solve the inconsistency in legal classifications. Most pharmaceutical research is commercial, specific and

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can be prescribed under restrictive conditions. Harsh penalties are also the norm in the U.S. Four states provide death sentences for selling "narcotics" to minors. Penalties for illicit drug possession vary widely between states from fines and conditional discharges to life imprisonment. See H.R. Levine, *Legal Dimensions of Drug Abuse in the United States* (Springfield, Ill.: Charles C. Thomas, 1974) at 7-8. As for the impact on physicians, Szasz, *supra*, note 4 at 150, reports that following passage of the *Harrison Act* in 1914, 25,000 physicians were charged with selling narcotics, 3,000 served prison terms and thousands had their licences revoked.

<sup>28</sup>See, e.g., H.R. Levine, unpublished paper (1971) quoted in Blum, *supra*, note 12 at 64-65; H. Kalant & O. Kalant, *Drugs, Society and Personal Choice* (Toronto: University of Toronto Press, 1971) at 116. Brecher & the Editors of *Consumer Reports*, *supra*, note 5 at 522-25, also criticize the "unscientific" basis of legal drug classifications built upon "political compromise". They recommend, *supra* at 266, a more unified classification scheme for all potentially abusive or abusable drugs, and conclude that "a sound policy for any of these drugs . . . will almost certainly be a consistent policy for all of them."

<sup>29</sup>C.B. Schultz, "Statutory Classification of Cocaine as a Narcotic: An Illogical Anachronism" (1983) 9 Am. J.L. & Med. 225.

<sup>30</sup>Canada, *Report of the Commission of Inquiry into the Non-Medical Use of Drugs: Marijuana* (Ottawa: Information Canada, 1972) at 16 (Chair: G. Le Dain).

<sup>31</sup>In thirteen states marijuana is a narcotic but in thirty-seven it is a hallucinogen. In three states LSD is also a narcotic. The legal penalties for unauthorized use of these two drug categories often varies drastically. Numerous countries inflict the death penalty or long prison terms for "narcotic offences". See R. Smart, *Forbidden Highs* (Toronto: Addiction Research Foundation, 1983) at 224. But as Levine, *supra*, note 27 at 5-6 and 11, correctly argues, the "purpose of classifying drugs should be to impose penalties proportionate to the inherent dangers of the controlled substances."



designed to meet regulatory requirements. Firms test new chemicals in narrow circumstances with a view toward particular uses.<sup>32</sup> Specificity of drug action is desired in medical practice and specificity is promoted even when the drug in question has numerous other uses and effects.<sup>33</sup> As a new chemical, THC, the active ingredient in *cannabis sativa*, would probably be tested, approved and marketed strictly for treatment of glaucoma or as an anti-nausea agent for cancer chemotherapy cases.<sup>34</sup> A cannabis based drug, marketed under a brand name such as "Cervil" or "Canab", could be prescribed and ingested with neither physician nor patient suspecting that the medicine was connected with an illicit substance of ill-repute.<sup>35</sup>

The dozens of apparently precise pharmaceutical categories falsely imply that psychoactives have *only* specific effects and constitute specialized weapons in the arsenal of the well-equipped physician.<sup>36</sup> Specificity is of value in medicine and medical classification schemes are narrow, exclusionary and misleading for legal purposes. A legal classification scheme requires instead the broadest coverage possible. Laws must take account not only of what a drug now happens to be used for but also of what it could be used for. It would be foolish to approve cannabis for glaucoma treatment or alcohol as a sedative while ignoring the euphoriant and recreational potential of these drugs.

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<sup>32</sup>William N. Hubbard Jr, Executive Vice-President of the Upjohn Company, explains that pharmaceutical producers want "to market only major breakthroughs that represent unique contributions to therapy." Specific use is also a factor in gaining patent protection for new substances. See W.N. Hubbard Jr, "Preclinical Problems of New Drug Development" in R.L. Landau, ed., *Regulating New Drugs* (Chicago: University of Chicago Center for Policy Study, 1973) 36 at 50. See also E.W. Kitch, "The Patent System and the New Drug Application: An Evaluation of the Incentives for Private Investment in New Drug Research and Marketing" in Landau, *supra*, 82 at 85.

<sup>33</sup>Chlorpromazine, for example, was first hailed as an antihistamine and then subsequently used in the symptomatic treatment of schizophrenia. G. Claridge, *Drugs and Human Behavior* (New York: Praeger, 1970) at 19, admits that "hayfever remedies" often produce drowsiness and lethargy, typical signs of sedation, but then claims that these antihistamines "would not be considered psychotropic in the accepted sense". By "accepted sense" Claridge means the accepted use in psychiatry. Thus, in his view, alcohol would also fall in a different category from the "standard sedatives", merely because psychiatrists do not prescribe alcohol.

<sup>34</sup>One psychiatrist claims that modern drugs are "better tailored" and specifically produced to "make sick people well and not to push normal people toward chemical pathology." The same author promotes THC for glaucoma and other therapeutic uses. S. Rosenblatt & R. Dodson, *Beyond Valium: The Brave New World of Psychochemistry* (New York: Putnam, 1981) at 234.

<sup>35</sup>See *ibid.* at 235 where it is recommended that THC be administered in pill or capsule form to distance the drug from marijuana and to avoid the more pronounced euphoric effect of smoking cannabis.

<sup>36</sup>See, e.g., Claridge, *supra*, note 33 at 19-21.

## B. Convergent Scientific Classification

Researchers employing a classification scheme based on drug effects commonly identify five classes of psychoactives: sedative-hypnotic-depressants, stimulant-convulsants, narcotic-analgesics, antipsychotics and hallucinogens.<sup>37</sup> These categories are not strict. A given drug, depending on dosage and the user's experience and expectations, may trigger effects in a number of categories.<sup>38</sup> Psychoactives apparently share certain fundamental characteristics with regard to their mechanisms of action, multi-purpose use, health impairment and habit formation.

### 1. Mechanisms of Action

Psychoactive drugs do not provide nutrients or necessary trace elements; nor do they heal, repair or permanently improve the functioning of human tissue. (Alcohol is unique in that it is caloric; by one estimate alcohol provides 8 per cent of the average American adult's caloric intake.<sup>39</sup>) Psychoactives trigger effects by directly disrupting human biochemistry so that various systems, particularly those of the brain, are dampened, repressed or "short-circuited".<sup>40</sup> Drugs work, according to Julius Rice, "by interfering with the fundamental functioning of the brain cells [which] may irreparably damage brain-system operations."<sup>41</sup>

Despite extensive investigation and sophisticated knowledge and techniques, the precise and complete mechanisms involved in any psychoactive's action are not known or understood.<sup>42</sup> Pharmacology is almost entirely

<sup>37</sup>R.M. Julien, *A Primer of Drug Action*, 3d ed. (San Francisco: Freeman, 1981) c. 2.

<sup>38</sup>J. Fort, "The Marijuana Abuser and the Abuser of Psychedelic-Hallucinogens" in J.G. Cull & R.E. Hardy, eds, *Types of Drug Abusers and Their Abuses* (Springfield, Ill.: Charles C. Thomas, 1974) 134 at 134-35, advises that the "common pharmacological categories which are widely used in talking about these drugs are only of limited benefit . . .". He concludes that the best way of referring to a given drug is by its name rather than by its designated category. See also the discussion on drug classification in R.S. De Ropp, *Drugs and the Mind* (New York: Delacourte Press, 1976) at 6-7.

<sup>39</sup>R.L. DuPont Jr, *Getting Tough on Gateway Drugs: A Guide for the Family* (Washington: American Psychiatric Press, 1985) at 45.

<sup>40</sup>"Stimulation, or tranquilization, by drugs, electricity or hormones, can be so effective, initially, because organic *restrictive mechanisms can be easily interrupted*." Caffeine, for example, stimulates brain action by blocking the effect of adenosine, an organic depressant. D.G. Garan, *Against Ourselves: Disorders from Improvements under the Organic Limitedness of Man* (New York: Philosophical Library, 1979) at 58.

<sup>41</sup>J. Rice, *Ups and Downs: Drugging and Doping* (New York: Macmillan, 1972) at 6.

<sup>42</sup>*Ibid.* at 7. Others agree that despite continual investigation "it is still not clear exactly what [psychoactive drugs] do to behavior nor how they do it." See E.R. Gritz & M.E. Jarvick, "Psychoactive Drugs and Social Behavior" in K.R. Hammond & C.R.B. Joyce, eds, *Psychoactive Drugs and Social Judgment: Theory and Research* (New York: Wiley, 1975) 7 at 8. The Le Dain Commission also understood that "[t]he details of cellular physiology are largely

descriptive and applied; there is little theoretical content.<sup>43</sup> Active substances are discovered by trial and error, by accident or by close extrapolation from known chemical structures.<sup>44</sup>

## 2. Multi-purpose Effects

Any psychoactive drug can be used, with varying degrees of success, as a symptom reliever, a social facilitator, an intoxicant or a substance with ceremonial significance.<sup>45</sup> Most drug classifications contradict the flexible nature of psychoactives because the drugs are labelled according to their current pattern of usage.<sup>46</sup> Drug "abuse" is generally subjectively defined as excessive use unrelated to acceptable medical practice or simply as any non-medical use.<sup>47</sup> Medical or orthodox use is not an acceptable legal standard because medical orthodoxy is affected by professional self-interest and by prevailing attitudes. The difference between medical and non-medical psychoactives is, in the words of Thomas Szasz, the difference between holy water and water.<sup>48</sup> John Marks, Jock Young and a number of others now

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unknown and with rare exceptions there is little information as to the mechanism by which any particular drug changes the activity of the nervous system." Canada, *Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs* (Ottawa: Queen's Printer, 6 April 1970) at 20 (Chair: G. Le Dain).

<sup>43</sup>Pharmacologists do theorize about drug action mechanisms, neurotransmitters and the like, but fundamental theoretical work is conspicuous in its absence. Compare the generality of Garan's psychological hypothesis, *supra*, note 40, with the standard and more trivial work by Claridge, *supra*, note 33.

<sup>44</sup>B. Barber, *Drugs and Society* (New York: Russell Sage Foundation, 1967) at 9-10.

<sup>45</sup>A. Weil, *The Natural Mind* (Boston: Houghton Mifflin, 1972) c. 2.

<sup>46</sup>Goode, *supra*, note 7 at 5, notes that "[t]he social context of [drug] use influences or determines at least four central aspects of the drug reality, aspects that traditionally have been presumed to grow directly out of the chemical and pharmacological properties of the drugs themselves. These four aspects are *drug definitions*, *drug effects*, *drug-related behavior*, and the *drug experience*." As Teff, *supra*, note 15 at 6, argues, "the law tends to reflect prevailing social attitudes [thus] it is hardly surprising that it has endorsed some of the commonplace fallacies."

<sup>47</sup>Biased definitions of "drug abuse" are self-serving rationales in defence of the status quo. Non-biased definitions are available but they entail radical implications. Julien, *supra*, note 37 at 209, defines drug abuse as "use of any drug for a medical or recreational purpose when other alternatives are . . . warranted or where drug use endangers either the users or those around them." By this measure, almost all drug use is "abuse". R.E. Carney, "The Abuser of Tobacco" in Cull & Hardy, *supra*, note 38, 160 at 162, defines drug abuse to mean "using drugs solely to modify feeling states or in such a manner so as to endanger health." Carney admits that by this standard all tobacco use is abuse. Similarly, Fort, *supra*, note 38 at 136, defines abuse as "excessive" use of a drug that "impairs health or social or job functioning". Like other "radicals", Fort deplors the focus on illicit drugs and the denial of the far greater problem posed by the abuse of licit drugs. Finally, J. Rublowsky, *The Stoned Age — A History of Drugs in America* (New York: Putnam, 1974) at 21, notes that "alcohol abuse is hardly deviant behaviour — it is practically the norm!"

<sup>48</sup>Szasz, *supra*, note 4 at 17.

admit that no basic differences exist between prescription drugs, socially accepted drugs and illicit drugs.<sup>49</sup>

Psychoactives are medical or recreational depending on the motives, attitudes and biases of users, sellers and controllers. The variable employment of sedative-hypnotics illustrates the point. Robert Julien explains that these drugs are "all virtually identical pharmacologically", that meprobamate induces the same basic effects as the barbiturates and that alcohol differs from the rest only in that it is used primarily in a social and recreational, rather than a medical, context.<sup>50</sup> Alcohol is as medical as its prescribed cousins and has been lauded throughout history as good treatment for practically all diseases and discomforts.<sup>51</sup> Alcohol is also used in certain cultures, including our own, as a source of mystical inspiration.<sup>52</sup> During Prohibition, alcohol was permitted in Christian rituals just as the otherwise forbidden peyote or mescaline is now permitted to the Native American Church.<sup>53</sup> Alcohol is no longer avidly promoted as a medicine despite continued reports of therapeutic value partly because medical interests no longer enjoy an exclusive franchise to sell the drug.

The primary differences in the effects of the sedative-hypnotics result from the doses. With increasing dosage, effects range from anxiety relief

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<sup>49</sup>J. Marks, *The Benzodiazepines: Use, Overuse, Misuse, Abuse* (Baltimore: University Park Press, 1978) at 69 and 73. See also J. Young, *The Drugtakers* (London: MacGibbon & Kee, 1971) at 9-10; S.M. Greenberg, "Compounding a Felony: Drug Abuse and the American Legal System" in Inciardi & Chambers, *supra*, note 14, 183; Kurzman & Magell, *supra*, note 9; R. Whitaker, *Drugs and the Law: The Canadian Scene* (Toronto: Methuen, 1969) at 3-5.

<sup>50</sup>Julien, *supra*, note 37 at 214. In addition, Julien, *supra* at 217, describes tranquilizers as "a martini in a pill". Nitrous oxide was isolated in 1772 and recommended for surgery but instead it and ether were used recreationally for amusement until 1846 when surgeons claimed them as anaesthetics. M. Crichton, *Five Patients: The Hospital Explained* (New York: Alfred A. Knopf, 1970) at 87-88.

<sup>51</sup>Alcohol was the most prescribed drug in nineteenth-century psychiatric institutes. See S. Williams, "The Use of Beverage Alcohol as Medicine, 1790-1860" (1980) 41 J. Stud. Alcohol 543. See also S. Lucia, *A History of Wine as Therapy* (Philadelphia: J.B. Lippincott, 1963); C.D. Leake & M. Silverman, *Alcoholic Beverages in Clinical Medicine* (Chicago: Year Book Medical, 1966). Alcohol's continued therapeutic value is praised by J. Kaplan, "Classification for Legal Control" in Blum *et al.*, *supra*, note 11, 284 at 293, who observes that "it is likely that many people cope successfully with serious mental problems by relaxing and reducing anxiety with one or other of these drugs [alcohol and marijuana]."

<sup>52</sup>Dr William Sharpe wrote in 1882 that the "stimulus of alcohol when judiciously controlled, always leads to higher mental efforts . . . in which the mind . . . sweeps intuitively into the veiled and distant regions of universal truth." See N. Longmate, *The Water Drinkers: A History of Temperance* (London, Ont.: Hamish, Hamilton, 1968) at 178. Rublowsky, *supra*, note 47 at 58, reports that historically the "euphoria that accompanied the drinking of spirits was associated, at first, with the divine and was looked on as a blessing from God Himself . . ."

<sup>53</sup>See Kaplan, *supra*, note 51 at 289; Goode, *supra*, note 7 at 3.

through disinhibition, sedation, sleep, general anaesthesia, coma and death.<sup>54</sup> At low dosage levels circumstantial factors, including the placebo effect,<sup>55</sup> may be more important variables than the specific drug ingested. In spite of this generality of effect, new sedatives are not marketed as alcohol substitutes but as "medicines". Alcohol producers enjoy a legally created monopoly in the licit recreational sedative market. Potential competitors must characterize their work as "medical" because if a new drug were advertised as a recreational intoxicating substance of no more therapeutic worth than alcohol, its use would be prohibited. To win sales, every new sedative must be touted as a medicine. For example, barbiturates and benzodiazepines, the most popular and alcohol-like of the new drugs, were first marketed as "medical" notwithstanding that these drugs were sometimes known on the street as "solid booze". All eight benzodiazepines now available have similar impact, though flurazepam is sold as a sleeping pill whereas Valium and Librium are prescribed as daytime tranquilizers.<sup>56</sup>

Tranquilizers are also found among the other drug groups. P. Rosenberg predicts that if heroin, usually classified as a narcotic, were legal it might be "the tranquilizing drug of choice".<sup>57</sup> The opiates, before Valium and the *Harrison Act* or the *Narcotic Control Act*, were indeed the tranquilizer of choice for the same largely female, middle to upper class group that now takes the benzodiazepines.<sup>58</sup> Opiates boast a long history of medical use as sedatives and pain killers as well as for the relief of diarrhea and coughs.<sup>59</sup>

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<sup>54</sup>The potency of drugs also varies so that very small quantities of some drugs, like nicotine or LSD, have considerable impact. In practice, however, drugs are processed and packaged and used in ways that tend to nullify variations in potency. Packaging strong drugs in weak form, for example, beer as compared to pure distilled alcohol, does not prevent excessive use; it merely prevents inadvertent excessive use by adults. Since people take sedative-hypnotics purposefully to achieve certain effects it is largely irrelevant whether 50 milligrams of drug X are required to match the effect of 10 milligrams of drug Y.

<sup>55</sup>The placebo effect is common and, although psychological, the effect is based on self-induced bio-chemical responses. Such responses are perfectly drug-like in effect and after-effect. As Claridge, *supra*, note 36 at 26, explains, the placebo aftermath "can be as frequent and as unpleasant as in the case of pharmacologically active drugs." See also S. Bok, "The Ethics of Giving Placebos" *Scientific American* (November 1974) 17 at 17 and 22.

<sup>56</sup>E. Bargmann *et al.*, *Stopping Valium, Ativan, Centrax, Dalmane, Librium, Paxipam, Restoril, Serax, Tranxene and Xanax* (Washington: Public Citizen, 1982). Flurazepam is marketed by Roche Laboratories as Dalmane.

<sup>57</sup>P. Rosenberg, "The Abusers of Stimulants and Depressants" in Cull & Hardy, *supra*, note 38, 123 at 129.

<sup>58</sup>"During the nineteenth century the dominant [opiate] addict type was a middle-aged, middle-class or upper-class female and the majority of cases were medical in origin." D.T. Courtwright, *Dark Paradise: Opiate Addiction in America Before 1940* (Cambridge, Mass.: Harvard University Press, 1982) at 113.

<sup>59</sup>Rublowsky, *supra*, note 47 at 118-21.

The opiates, which should be included as a sub-branch of the sedative-hypnotics, also produce euphoric effects.<sup>60</sup> Thus, like every other psychoactive, opiates may attract widespread use.

Equivalence is also found among the stimulants. Nicotine effects are quite similar to those triggered by amphetamine, cocaine, pemoline, phenmetazine and methylphenidate.<sup>61</sup> All the stimulants trigger euphoric and symptom relieving effects though the euphoric potential of some, like tobacco, appears to be quite low.<sup>62</sup> At similar dosage levels the stimulants are fairly interchangeable. Cocaine use, for example, diminished in the 1930s simply because the new amphetamines cost much less and provided a longer lasting stimulus.<sup>63</sup> New stimulants are promoted as medicines though there is scant evidence that they are safer or more medicinal than cocaine.<sup>64</sup>

The hallucinogens present a similarly broad picture. Contrary to popular opinion, hallucinogens such as LSD or mescaline are not unique. According to some experts, hallucinogens can be characterized as a sub-branch of the stimulants.<sup>65</sup> Indeed, given proper dosage and circumstances any psychoactive "can sometimes produce hallucinations or delusions".<sup>66</sup>

### 3. Health Impairment

All psychoactives induce some range of symptomatic relief. Such relief is readily obtained; one merely requires a chemical capable of disrupting organic systems so that the biochemical processes producing anxiety, for instance, no longer function properly. Symptomatic relief is useful, especially in short run, emergency situations. However, drug benefits are gained at a certain price, part of which is damage to health, long term functional impairment and genetic interference.<sup>67</sup>

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<sup>60</sup>See Julien, *supra*, note 37 at 100.

<sup>61</sup>Carney, *supra*, note 47 at 166.

<sup>62</sup>Rosenberg, *supra*, note 57 at 125, reports that many patients "overlook the basic euphoria and sense of powerfulness that goes along with amphetamine use, believing instead that they are taking the amphetamines for weight reduction, or because the doctor prescribed it."

<sup>63</sup>Julien, *supra*, note 37 at 87.

<sup>64</sup>In "therapeutic" contexts, it is difficult to know when one is taking amphetamines or other stimulants because they are variously labelled as anorexics, analeptics (invigorants), local anaesthetics, antidepressants and so on. See Rice, *supra*, note 41 at 3.

<sup>65</sup>*Ibid.* at 3.

<sup>66</sup>Fort, *supra*, note 38 at 135.

<sup>67</sup>See, e.g., R. Hughes & R. Brewin, *The Tranquilizing of America* (New York: Harcourt Brace Jovanovich, 1979) c. 2 and c. 4. It is interesting to note that the majority of people brought to hospital for detoxification are using "medical", rather than illicit, drugs. See M. Silverman & P.R. Lee, *Pills, Profits and Politics* (Berkeley: University of California Press, 1974) at 273.

Every psychoactive, including caffeine, nicotine and alcohol, is a "teratogen", *i.e.* a substance that is capable of producing birth defects. Thalidomide, a sedative once advertised as being "completely safe" for pregnant women, is a severe example of a general characteristic of the class.<sup>68</sup> In Rice's opinion, if thalidomide had merely caused a common birth defect, like harelip, instead of the uncommon, specific defects it did cause, it would probably still be on the market.<sup>69</sup> Fortunately, prospective parents are increasingly aware of the potential for drug-related birth defects.<sup>70</sup>

The extent of drug-related damage to users' health depends upon many factors including dosage, duration of use, condition of the user and so forth. Heavy daily intake of caffeine may be more damaging than moderate periodic use of alcohol.<sup>71</sup> Intravenous use under unsanitary conditions of an adulterated substance can turn even morphine or aspirin into serious perils. Similarly, nicotine pills do less damage than nicotine derived from tobacco smoke.<sup>72</sup> Not surprisingly, most drug-related health impairment is attributable to popular, widely-used drugs.<sup>73</sup> Ill effects owing to use of illicit and medical psychoactives are relatively minor when one looks at the drug-consuming public as a whole because use of these drugs is minor. For every cocaine user in the United States there are 100 alcohol users. In Britain, about 75 per cent of adults use alcohol, 50 per cent use nicotine and only 15 to 20 per cent receive psychoactives medically.<sup>74</sup>

Appreciating the health impact of psychoactives is impeded by biases which distort the nature of drugs according to their legal and social status.<sup>75</sup>

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<sup>68</sup>See H. Teff & C. Munro, *Thalidomide: The Legal Aftermath* (Westmead, Eng.: Saxon House, 1976) at 2; M. Mintz, *The Therapeutic Nightmare* (Boston: Houghton Mifflin, 1965) at 261.

<sup>69</sup>Rice, *supra*, note 41 at 36.

<sup>70</sup>Many popular works now warn parents, especially pregnant women, to refrain from drug use. See, *e.g.*, R.S. Mendelsohn, *Confessions of a Medical Heretic* (Chicago: Contemporary Books, 1979).

<sup>71</sup>See Kaplan, *supra*, note 8 at 1083.

<sup>72</sup>This does not suggest that smokeless tobacco products are harmless, just that they are less damaging than smoked products. On the issue of snuff and chewing tobacco hazards see C. Wallis, "Mouths of Babies" *Time* (15 July 1975) 54.

<sup>73</sup>Some researchers have constructed comparative risk profiles for psychoactives. Green, for example, ranks cannabis after both alcohol and nicotine in terms of impairment potential: cited in C.N. Mitchell, "A Comparative Analysis of Cannabis Regulation" (1983) 9 *Queen's L.J.* 110 at 115 [footnote omitted].

<sup>74</sup>Marks, *supra*, note 49 at 52. In the U.S. in 1974, 94 million persons used alcohol, 67 million used tobacco, 13 million used cannabis and one million each used cocaine and the psychedelics. In the U.K. during the same period there were 61 deaths connected with heroin, 1,829 with alcohol and 1,930 with barbiturates. Teff, *supra*, note 15 at 146-48, concludes from these and other findings that alcohol is the most dangerous drug.

<sup>75</sup>See, *e.g.*, J. Helmer, *Drugs and Minority Oppression* (New York: Seabury Press, 1975) at 4-6, who claims that labour conflict and repression of popular unrest led to the creation of the heroin mythology whereby "the most effective analgesic . . . and the best cough mixture . . . became the number one outlaw in the land." See also notes 4, 6, 11, 28, 37, 46, 47 and 84.

As popular recreational and industrial mainstays, the risks of tobacco and alcohol have been downplayed.<sup>76</sup> On the other hand, the dangerousness of illicit drugs has been systematically and grossly exaggerated in order to rationalize the unwarranted criminalization of these substances. Most people now harbour the illusion that heroin is an incredibly attractive and harmful drug, yet authorities claim that heroin use is less damaging than amphetamine or barbiturate use.<sup>77</sup> Similarly, cannabis is apparently less socially disruptive than alcohol.<sup>78</sup>

An equal but opposite distortion occurs with medical psychoactives. The health impairing capacity of OTC and prescription drugs is seriously underestimated in order to promote and rationalize their status as approved medicines.<sup>79</sup> Illicit drugs are harmful and evil until proven benign whereas

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<sup>76</sup>During World War II, tobacco was classified as an "essential crop" in the U.S., and the draft board gave deferments to farmers of tobacco, wheat and corn. R. Sobel, *They Satisfy: The Cigarette in American Life* (New York: Anchor Books/Doubleday, 1978) at 131. See also Fort, *supra*, note 38 at 135. Carney, *supra*, note 47 at 160, marvels that tobacco use is "rarely considered to be one of our greatest drug problems", an oversight he considers "amazing" when compared to the hysteria surrounding marijuana.

<sup>77</sup>L. Grinspoon & P. Hedblom, in their excellent survey of the amphetamine literature, *The Speed Culture: Amphetamine Use and Abuse in America* (Cambridge, Mass.: Harvard University Press, 1975) at 67, discuss the "traditional lore about heroin, passed along by ill-informed rumor, exaggerated literary descriptions, and even medical and pharmacological texts . . .". They argue that heroin withdrawal pains and health impairment have been "vastly overestimated". In contrast, amphetamines are more dangerous, more violence related, and more naturally attractive than opiates to people in blind tests. Amphetamines are euphoric, hallucinogenic, teratogenic and associated with "insightfulness and religiosity". Medically, the early papers on amphetamines were promotional, not scientific. When critical work became available, physicians ignored it. Prescribed for decades as the overwhelming drug of choice for weight loss, it now appears that users often gain back more weight than they initially lose. Grinspoon & Hedblom, *supra* at 51, 67, 108, 146, 159 and 179. Rosenberg, *supra*, note 57 at 128, states that "[h]eroin is not a harmful drug. It can be taken for years with almost no physically deleterious effects." Barbiturate use also causes greater physical harm and personality deterioration than opiate use. A. Malleson, *Need Your Doctor Be So Useless?* (London: George Allen & Unwin, 1973) at 60.

<sup>78</sup>See, e.g., M. Schofield, *The Strange Case of Pot* (Harmondsworth, Eng.: Penguin Books, 1971).

<sup>79</sup>Most new psychoactives are launched upon "waves of enthusiasm" from drug companies, detailmen, research papers and anecdotal medical reports but, as the cynics explain, the rush is necessary because new drugs must be used quickly "before they stop working". S. Fredman & R.E. Burger, *Forbidden Cures: How the FDA Suppresses Drugs That Could Save Your Life* (New York: Stein & Sage, 1976) at 174. New drugs are normally marketed with the claim that they "retain potent hypnotic qualities without acute toxicity and potential for dependence; then with unhappy experience the latter qualities become apparent." W.B. Mendelson, *The Use and Misuse of Sleeping Pills: A Clinical Guide* (New York: Plenum, 1980) at 39. See also E. Hartmann, *The Sleeping Pill* (New Haven: Yale University Press, 1978). Mintz, *supra*, note 68 at 57-62 and 185, notes the "grotesque exaggerations" of therapeutic potency and the "sensationally favorable" press new drugs received in the 1950s. Nonetheless, some physicians continue to tout psychoactives as the solution to almost every problem. See Rosenblatt & Dodson, *supra*, note 34 at 19.



medical psychoactives are helpful and benign until proven harmful.<sup>80</sup> Since illicit drugs are in fact harmful the first onus can never be satisfied. However, the second onus can be and is repeatedly met as previous "wonder drugs" like heroin, amphetamine and barbiturate are discredited.<sup>81</sup> The difficulty is that these discredited drugs have been readily replaced by new medical psychoactives.

#### 4. Habit Formation and Dependency

Every drug capable of "favorably altering mood ... or of creating a pleasurable state of consciousness is capable of inducing psychological dependence."<sup>82</sup> Every psychoactive can be habit forming, some, like LSD, to a slight degree and some, like nicotine, to a pronounced degree.<sup>83</sup> Social

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<sup>80</sup>Malleon, *supra*, note 77 at 39. By 1954, Japan had already implemented controls on amphetamines whereas a noted professor of pharmacology described these drugs as safe and useful "in a wide variety of clinical conditions". See C.D. Leake, *The Amphetamines: Their Actions and Uses* (Springfield, Ill.: Charles C. Thomas, 1958) cited in Grinspoon & Hedblom, *supra*, note 77 at 221. See also Rice, *supra*, note 41 at 67. O.J. Kalant, *The Amphetamines: Toxicity and Addiction*, 2d ed. (Toronto: University of Toronto Press, 1973) at vii, politely refers to Leake's book as "outdated". Experts now state that amphetamines have "an insignificantly small part to play in the legitimate practice of medicine." Rice, *supra* at 68.

<sup>81</sup>Valium (diazepam), the most famous new psychoactive, is probably safer than the barbiturates it largely replaced; however, Bargmann *et al.*, *supra*, note 56 at 27-39, report that Valium causes birth defects, loss of coordination, serious depression, and a worrisome lack of a desire to breathe. They conclude that the short term and temporary benefits are not worth the harm. In addition, all psychoactives may be socially disruptive in subtle ways. One experiment of note found that students taking the tranquillizer chlorpromazine cheated more than a control group. See D. Glaser, "A Review of Crime-Causation Theory and Its Application" in N. Morris & M. Tonry, eds, *An Annual Review of Research - Crime and Justice*, vol. 1 (Chicago: University of Chicago Press, 1980) 203 at 215.

<sup>82</sup>Julien, *supra*, note 37 at 34. According to Rice, *supra*, note 41 at 3, hormones, antibiotics and the like are not "drugs of abuse" because they are "not excitant or calmativ, not psychoactive that is". Not surprisingly, psychoactives which are pain causing are not habit forming. For example, phenothiazine and chlorpromazine are said not to produce "euphoria"; this, however, is doubtful. A clearer case is lithium, which Julien, *supra* at 131-35, says is "not a euphoriant" and has "almost no discernible psychotropic effect in normal persons". The case of iproniazid shows how difficult it is to classify a drug as non-euphoriant. Iproniazid was used to treat tuberculosis until its "euphoric effect" was noticed, whereupon it was prescribed to depressed persons as a symptom reliever. Barber, *supra*, note 47 at 14-15.

<sup>83</sup>Tobacco produces classic tolerance and physical addiction, a fact largely ignored before the 1960s because most smokers continued their habit until their deaths — few attempted to quit so there was little evidence about the strength of the addiction. Gritz & Jarvik, *supra*, note 42 at 11. Where tobacco supplies are cut off, as happened recently during strikes in Israel, smokers riot, are described as "crazed" and comb through ashtrays looking for butts. "Smokers in Israel Left Fuming" *The [Toronto] Globe and Mail* (5 July 1985) 9. Dupont, *supra*, note 39 at 32-33, states his belief that all psychoactives including social psychoactives like gambling and TV viewing, create "biologically reinforced, pleasure-producing behaviour disorders", and that nicotine use creates "the most common and deadly of all addictions". He also argues that

biases again operate here to exaggerate the addictiveness of illicit drugs and to ignore, deny or downplay the addictiveness of medical and licit drugs.<sup>84</sup> Enforcement agents have often portrayed illicit drug users as stupid or unwitting slaves sold into a life of bondage by dastardly "pushers",<sup>85</sup> but these assertions have proven baseless.<sup>86</sup> On the medical side, new psychoactives are introduced as being safe, effective and non-habit-forming.<sup>87</sup> This illusion can be maintained so long as clients take small doses for brief periods.<sup>88</sup> However, enough people use medical psychoactives over extended periods to demonstrate that their habituation potential is as great as that of illicit and recreational drugs.<sup>89</sup>

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tobacco is not intoxicating, but alcohol-like intoxication is not a prerequisite of dependency. Drug-induced satisfactions come in many forms including appetite suppression and relief from pain, anxiety or fatigue.

<sup>84</sup>Hughes & Brewin, *supra*, note 67 at 32-36, charge that physicians and drug companies are blind to the available evidence of tranquillizer addiction. Grinspoon & Hedblom, *supra*, note 77 at 156, cite related examples of a "peculiar blindness" in medical researchers to the addictiveness of amphetamines. See also Courtwright, *supra*, note 58 at 144-47; Goode, *supra*, note 7 at 228-31. Conversely, the addictive potential of cannabis is slight. Fredman and Burger, *supra*, note 79 at 152. Yet the drug control literature repeatedly asserts a weak correlation between cannabis and heroin while ignoring the almost universal connection between initial use of tobacco and use of other drugs. See Carney, *supra*, note 47 at 164-67.

<sup>85</sup>See, e.g., E.F. Murphy, *The Black Candle* (Toronto: T. Allen, 1922); H.J. Anslinger & W.F. Tompkins, *The Traffic in Narcotics* (New York: Funk & Wagnalls, 1953) at 20-25; H.W. Morgan, *Drugs in America — A Social History, 1800-1980* (Syracuse, N.Y.: Syracuse University Press, 1981).

<sup>86</sup>See J. Kaplan, *The Hardest Drug: Heroin and Public Policy* (Chicago: University of Chicago Press, 1983) at 25ff.; Schroeder, *supra*, note 5 at 72-73; Grinspoon & Hedblom, *supra*, note 77 at 153; Helmer, *supra*, note 75, c. 1. Compare Rosenberg, *supra*, note 57 at 128-29.

<sup>87</sup>In defining a "medical" drug, Kaplan, *supra*, note 51 at 287-88, cites as one characteristic that it should not be especially sought by illegal users. He then argues that amphetamines and barbiturates are unique because they are in substantial demand for "recreational purposes". Actually, Kaplan's two exceptions have just been available longer than other new "medical" psychoactives. F.M. Berger, "Introduction" in W.G. Clark & J. del Giudice, eds, *Principles of Psychopharmacology* (New York: Academic Press, 1970) 1 at 4, also falsely claims that, unlike alcohol and opium, "psychotherapeutic agents do not make healthy people feel 'happy', nor improve their disposition . . .". In contrast, Mendelson, *supra*, note 79 at 128-36, notes that the introduction of every new hypnotic "has been followed within a few years by reports of abuse." Hypnotic use induces psychic dependency, leads to morphine-like withdrawal, higher mortality rates and impaired driving. Most chronic users started on prescription or in hospital although hypnotic use has little scientific support. See Mendelson, *supra* at 178-81 where he provides a review of the inconclusive findings.

<sup>88</sup>Psychoactives are often tested medically at such low dosages that in blind tests, placebos prove more powerful than the actual drug. Such tests are unlikely to uncover the drug's recreational or abusive potential.

<sup>89</sup>When benzodiazepines are taken in large enough doses for long enough, then "(like most if not all psychotropic drugs) . . . physical dependence can result." Marks, *supra*, note 49 at 41. See also H. Petursson & M.H. Lader, "Benzodiazepine Dependence" (1981) 76 Brit. J. Addiction 133.

Drug habituation following use is neither inevitable nor irreversible. Alcohol dependency may take years to acquire. Untutored, first-time users of opiates often find the experience unpleasant.<sup>90</sup> Most users of heroin, cannabis, alcohol and cocaine are not addicted; the perpetual heroin addict is a myth.<sup>91</sup> Nicotine may be the most difficult drug to quit.<sup>92</sup> However, in addition to the addicting potential of various drugs, the social context of use and the nature of the user must also be considered. Some people are more addiction prone than are others and will become more strongly tied to any psychoactive they regularly use.<sup>93</sup> Those most attached to tobacco, for example, are those who smoke to relieve anxiety.<sup>94</sup>

The question of drug dependency is actually one of derivative importance. There are other self-impairing behaviours that are not of major concern because they are not fun, pleasant or popular. There are also many unpleasant but productive activities like working and learning to which we strive diligently to addict or habituate our children. Habit formation is thus in and of itself a neutral concept. If drug use were benign it would scarcely matter if drugs were addictive but for the problem of economic exploitation. If all drugs were equally harmful then, of course, the most addicting would be the worst. However, in reality, harmfulness and addictiveness are not necessarily directly connected and the second is only relevant if the first is present.

To conclude, the varied but socially constrained use of psychoactive drugs is nearly universal.<sup>95</sup> Considering the weight of evidence available, it is possible to conclude that psychoactives are best regarded as a single class of substances. As a class, psychoactives can be distinguished from substances such as food and water or drugs like antibiotics which are not mood elevating, health impairing and addicting.

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<sup>90</sup>DuPont, *supra*, note 39 at 33-40.

<sup>91</sup>Most analyses of heroin addiction treat a temporary, short-run situation as if it were permanent. See G. Bernard, "An Economic Analysis of the Illicit Drug Market" (1983) 18 Int'l J. Addictions 681 at 693ff. See also M. Rosenthal, "Partial Prohibition of Non-Medical Drug Use: A Proposal" (1979) J. Drug Issues 437 at 447 and 451.

<sup>92</sup>M.A.H. Russel, "Tobacco Smoking and Nicotine Dependence" in Addiction Research Foundation, *Research Advances in Alcohol and Drug Problems*, vol. 3 (New York: Wiley, 1976) 1 at 1.

<sup>93</sup>After reviewing the dependency literature, Marks, *supra*, note 49 at 41, concludes that it is better to speak of "dependence-prone individuals . . . [who] can develop dependence upon any or all of [these substances]." See also Kaplan, *supra*, note 8 at 1084; Goode, *supra*, note 7 at 5.

<sup>94</sup>Carney, *supra*, note 47 at 173.

<sup>95</sup>Weil, *supra*, note 45.

## II. Drug Control and Principles of Justice

### A. Justification

Justifiable coercive state measures against drug use depend upon two prerequisites: first, that the use of drugs generates real defensive needs and second, that self-help measures and private law remedies provide insufficient self-defence thus forcing recourse to public law solutions.<sup>96</sup>

Drug use evidently does create significant defensive needs. In economic terms, drug users impose costs on third parties. Examples of direct drug-related externalities include litter, smoke damage, fires and a general increase in accidents, errors and overall social risk.<sup>97</sup> The bulk of drug-related costs are borne by users themselves in the form of ill health, incapacity, and shorter life.<sup>98</sup> This self-harm element is not a direct component of harm to others. Suicide is not even broadly comparable to murder. Nonetheless, self-harm is rarely pure or isolated. Self-harm does hurt others; the degree and range of harm depends on cost-spreading techniques and social inter-dependence. In a welfare-medicare state, the individual's health is a public issue, as citizens come to realize that their neighbour's drug use, ill health, absenteeism and lower productivity increase their taxes, costs and insurance premiums.<sup>99</sup>

Even if drug-related harms do merit a self-defence response, one must still determine whether public law measures are called for. Informal social restraints are all that primitive societies require in the way of drug controls.<sup>100</sup> Similarly, an important anti-smoking mechanism in Western culture is the perception that smoking is no longer intelligent, attractive or stylish.<sup>101</sup>

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<sup>96</sup>This follows the argument of R. Nozick, *Anarchy, State and Utopia* (New York: Basic Books, 1974) at 23-26, that an ethically justified "minimal state" monopolizes the use of legitimate coercion solely to provide a collective system of protection.

<sup>97</sup>See, e.g., Mitchell, *supra*, note 73 at 114-15.

<sup>98</sup>DuPont, *supra*, note 39 at 5, ascribes 30 per cent of all premature fatalities in the U.S. to the use of alcohol and tobacco. He also suggests that the eight-year life expectancy advantage enjoyed by women is due almost entirely to the higher rate of drug consumption by men.

<sup>99</sup>J.H. Knowles, "The Responsibility of the Individual" in J.H. Knowles, ed., *Doing Better and Feeling Worse: Health in the United States* (New York: Norton, 1977) 57 at 59, observes that "one man's freedom in health is another man's shackle in taxes and insurance premiums . . . [T]he idea of a right to health should be replaced by the idea of an individual moral obligation to preserve one's health . . . ."

<sup>100</sup>See D. Maloff *et al.*, "Informal Social Controls and Their Influence on Substance Use" (1979) 9 J. Drug Issues 161.

<sup>101</sup>See J. Brody, "The Growing Militancy of the Nation's Nonsmokers" *The New York Times* (15 January 1984) 6E; M. Livingston, "Restricting Smoking in the Workplace" *The Financial Post Magazine* (1 June 1983) 7.

However, while smoking is going out of style, since 1945, alcohol has regained some of its former popularity.<sup>102</sup> Informal controls have also failed to cope well with the rapid growth in availability of new and exotic psychoactives. Alcohol's introduction devastated many cultures unprepared for its attractions. Likewise, Western culture was unprepared for the hundreds of new psychoactives introduced in recent decades. The social practices and attitudes limiting use of alcohol, tobacco, coffee and symptom relievers like opium could not adapt rapidly enough to deal with the new substances.<sup>103</sup>

A social control failure does not in itself justify a public law response. An intermediate position based on private law also exists. Drug users commit torts, or civil wrongs, in imposing harm on others. The injured persons could thus initiate private actions against the drug-using defendants. For example, children might sue their drug-using parents for negligence in causing their birth-defects. Other drug-related harms might be legally categorized as battery or nuisance.<sup>104</sup>

Tort law, however, is ill-suited in practice to counteract most types of drug-related harm. Most drug-related harm to others is minor, causally uncertain, and spread over a large, indeterminate plaintiff class.<sup>105</sup> Transaction costs severely hamper the effective collectivization of small, broad-based interests. Civil procedure is often hostile to collective actions.<sup>106</sup> Rules in some jurisdictions forbidding contingency fees also inhibit class actions.<sup>107</sup> And even when a class action is launched and a favourable judgment won, a major portion of the award of damages will go toward legal costs.<sup>108</sup> The more massive the action, the less the plaintiffs' and attorneys' interests

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<sup>102</sup>K. Mäkelä *et al.*, *Alcohol, Society and State*, vol. 1 (Toronto: Addiction Research Foundation, 1981) c. 2.

<sup>103</sup>In the words of I. Illich, *Limits to Medicine* (London: Marion Boyars, 1976) at 63, "[p]owerful medical drugs easily destroy the historically rooted pattern that fits each culture to its poisons . . . ."

<sup>104</sup>"Smoking tobacco allows you to cause smoke damage to the persons and properties of others the extent of which must be enormous, but has never been calculated." Carney, *supra*, note 47 at 170, thus suggests that smoking not only creates a nuisance, it provides an outlet for aggressive acts against other people.

<sup>105</sup>See D. Rosenberg, "The Causal Connection in Mass Exposure Cases: A 'Public Law' Vision of the Tort System" (1984) 97 Harv. L. Rev. 849 at 900-5. See also J. Trauberman, "Statutory Reform of 'Toxic Torts': Relieving Legal, Scientific and Economic Burdens on the Chemical Victim" (1983) 7 Harv. Env. L. Rev. 177; W. Freedman, *Products Liability for Corporate Counsels, Controllers and Product Safety Executives* (New York: Van Nostrand Reinhold, 1984).

<sup>106</sup>Note, "Class Actions" (1976) 89 Harv. L. Rev. 1318.

<sup>107</sup>Contingency fees are prohibited or severely limited in Canada and England.

<sup>108</sup>The Rand Corporation study estimates that legal expenses took 75 cents of every dollar paid out to plaintiffs in asbestos damage lawsuits. Letter from G.W. Bailey to the Editor (23 February 1982), reprinted as "Asbestos: The Argument for a Fund..." in *The New York Times* (7 March 1982) F16.

correspond. Collective actions become a hybrid substitute for purely public law.<sup>109</sup>

Other problems with a private law response should be noted.<sup>110</sup> Prevention of harm is a superior goal to after-injury compensation but tort law is designed to compensate. Civil courts are not inclined or equipped to enforce complicated injunctive remedies. Tort law enforcement necessarily depends on the vagaries of private initiative and is thus unreliable. Even when a single wrong is suffered by an identifiable plaintiff, public ignorance, costs and attitudes seriously limit recourse to tort law solutions.<sup>111</sup> Expanding public law has been a justifiable response to tort law's failure to provide adequate deterrence. The incentive that propels tort actions is compensation; deterrence is an optional side-effect. The opposite is true of public law. Deterrence is the primary goal of criminal law while compensation to the victim is optional.

Since private law fails to deter drug harms adequately, a public law response is justified. However, such a response need not necessarily be modelled on the criminal law.

### **B. Proportionality**

State coercion is justified solely on the basis of an unmet, *bona fide* need for collective defense; therefore, the degree of coercion employed must be proportional to the harm defended against.<sup>112</sup> Extreme harms, like homicide, call for severe responses whereas minute dangers, like illegal parking, merely justify the mildest legal restraints. The ethical demand for proportional punishment is quite obvious, yet the rule is flaunted by modern drug control legislation.

Three basic methods exist for determining the relative degree of punishment a given wrongdoing deserves. The standard method is to measure the amount of harm caused. Most drug-related harm is minor and comparable to general, chronic nuisances like littering and pollution. Such harms are on a different scale from the severe, acute losses caused by sexual assault,

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<sup>109</sup>K. Scott, "Two Models of the Civil Process" (1975) 27 Stan. L. Rev. 937.

<sup>110</sup>See, e.g., R.J. Pierce Jr, "Encouraging Safety: The Limits of Tort Law and Government Regulation" (1980) 33 Vand. L. Rev. 1281.

<sup>111</sup>See M. Kinsley, "Fate and Lawsuits: Litigation Doesn't Work — How About Socialism?" *The New Republic* (14 June 1980) 20; W.J. Blum & H. Kalven Jr, "Public Law Perspectives on a Private Law Problem — Auto Compensation Plans" (1964) 31 U. Chi. L. Rev. 641.

<sup>112</sup>See A. Brudner, "Retributivism and the Death Penalty" (1980) 30 U.T.L.J. 337 at 341.

murder or robbery.<sup>113</sup> Drug use does not fit the traditional criminal law model. Drug users do not consume drugs to harm others. The harm to others is usually minor and results indirectly from self-harm. Sedative-hypnotic use, especially alcohol use, increases the probability that the drug user will engage in anti-social acts. We are justified in punishing this wilful creation of risk but this process must be separated from the serious harms that some inebriates commit. Violent crimes are often perpetrated by alcohol-impaired offenders, but the vast majority of alcohol users do not commit violent crimes.<sup>114</sup> The law should punish only the harm that necessarily flows from acts or attempted acts. What necessarily flows from mass drug use are higher third party costs, public nuisances and increased social risk.

When drug consumers under the influence cause serious harm the criminal law should punish that harm alone, not the drug use. Alcohol does not cause murder. Alcohol use, even excessive use, is common. Murder is rare. The criminal law treatment of murder should not be contingent on the presence or absence of drug use. Self-induced drug impairment should rarely serve as a partial excuse.<sup>115</sup> Conversely, drug use should not amplify criminal penalties. By this analysis, statutes that criminalize impaired driving are unethical. An inebriated tavern patron may stagger home in a belligerent mood and kill her spouse but this outcome is such a remote possibility that we do not charge her preventively with being "drunk and dangerous". Yet this is what the law does if the inebriate assumes control of a motor vehicle. Millions of people drive after consuming drugs. The likelihood of any one of those drivers causing serious damage is low although the risk is higher than for non-drugged drivers.<sup>116</sup> All drug-using drivers act in a mildly antisocial manner, some actually drive dangerously and cause severe harm.

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<sup>113</sup>N. Morris & G. Hawkins, *The Honest Politician's Guide to Crime Control* (Chicago: University of Chicago Press, 1969) at 2, feel that the criminal law threshold is not crossed provided a person "does not directly injure the person or property of another." This test is acceptable only when indirect harm also happens to be minor harm. Treason may only result in indirect injury; nonetheless, that injury may be major.

<sup>114</sup>C. Bartol, *Criminal Behaviour - A Psychosocial Approach* (Englewood Cliffs, N.J.: Prentice-Hall, 1980) at 345-47. See also H. Fingarette & A. Hasse, *Mental Disabilities and Criminal Responsibility* (Berkeley: University of California Press, 1979) at 101.

<sup>115</sup>See C.N. Mitchell, "Culpable Mental Disorders and Criminal Liability" (1985) 8 Int'l J.L. & Psych. [forthcoming].

<sup>116</sup>The Department of Health and Human Services estimates that 35-65 per cent of drivers in fatal traffic accidents had been using alcohol. But what portion of drivers not involved in accidents had also been drinking? DuPont, *supra*, note 39 at 101-2, reports that 60 per cent of American adults use alcohol regularly with the average drinker taking three doses a day. Since young men both drink and drive more than do other groups, the average driver may be consuming from 2 to 5 drinks a day. Millions of drivers probably mix driving and alcohol frequently. Furthermore, tobacco and other psychoactives also impair driving skills, for example, by limiting peripheral vision. He argues that to drive after even one drink is risky and antisocial. By that standard a large portion of drivers are drug abusers.

In many cases where impaired driving charges are laid the driver will in fact have been engaged in dangerous driving but the two offences are different. Dangerous driving is not predictive, nor is it related to the driver's condition. It focuses properly on actual driving behaviour.

Moving to proportionate penalties against drug use will disturb those whose drug use is encouraged or subsidized by the present system. Supporters of criminalization will be displeased as well since their program is premised on the assumption that use of illicit drugs causes tremendous harm comparable to the consequences of war or plague. Here the test for proportionality is the degree of fear engendered rather than the actual harm caused. Such a test is likely to be unethical since a subjective fear of drugs need not be realistic or fair. Those who fear illicit drug use err in three major respects. First, they attribute severe harm, like murder or robbery, to the drug rather than to the drug-using criminal. Second, they observe the extensive harms caused by criminal prohibitions of drug use and mistakenly blame those harms on the drugs.<sup>117</sup> Third, they ignore evidence indicating that illicit drugs are no more harmful than licit or medical psychoactives. The much vilified opiates, for example, are less inherently criminogenic than is alcohol.<sup>118</sup>

A third method of determining the deserved punishment is the forced-choice analysis.<sup>119</sup> Here respondents are directed to choose the lesser of two harms. People would be asked, as an example, whether they would prefer either being offered a chance to buy heroin or being compelled at gunpoint to permit their leg to be crushed. If most people prefer the first choice we may safely conclude that it should be punished less severely than the second. Contrast this method with the usual survey questionnaire designed to elicit the public's punitive attitudes toward drug use. These surveys normally employ a costless, noncomparative approach by asking, for example: "Do you favour longer prison terms for heroin traffickers?" A "yes" answer to such a question costs the respondent nothing. In contrast, the forced-choice process imposes a type of pricing mechanism. In the example above, a vote for severe penalties against heroin sellers would hypothetically cost a crushed leg. Given such a choice, legislators would immediately retract current laws subjecting heroin traders to life imprisonment.

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<sup>117</sup>See D.A.J. Richards, "Drug Use and the Rights of the Person: A Moral Argument for Decriminalization of Certain Forms of Drug Use" (1981) 33 Rutgers L. Rev. 607 at 643-46.

<sup>118</sup>A recent survey of heroin-using criminals revealed that the criminals were more likely to be under the influence of alcohol during the commission of an offence, that alcohol was taken to aid in committing the crime and that their criminal income was used to purchase alcohol before other drugs. See D. Strug *et al.*, "The Role of Alcohol in the Crimes of Active Heroin Users" (1984) 30 Crime & Delinq. 551.

<sup>119</sup>For an application of this type of analysis, see M. Davis, "Setting Penalties: What Does Rape Deserve?" (1984) 3 L. & Phil. 61 at 83.



I suspect that very few people would prefer any physical harm to the opportunity to participate in any of the "victimless crimes". Even lesser harms, like being robbed of ten dollars, would not be chosen, in preference to being offered heroin. That choice is reasonable since in itself selling heroin causes no harm. Consider then the choice between having a friend, colleague, relative or neighbour use psychoactive X or being robbed of ten dollars. Most people would likely prefer the first source of harm except where the consumer of the alcohol, antihistamine or cannabis is their own child. Since in many situations people are indifferent to their neighbour's drug use, I would predict that there are non-criminal harms that would be ranked as more disturbing than drug use. Examples of the nuisances that neighbours inflict on others that might be so ranked include burning garbage outside, keeping barking dogs, leaving grounds unattended, racing motor vehicles or being rude. The results of a forced-choice analysis should demonstrate that the drug use of others is on a par with nuisances that impose a level of harm far below the threshold needed to justify criminal law penalties.

### C. Fairness

Justified and proportional legal restrictions against drug use must also be fair. Apologists for selective enforcement argue that if we choose to punish A but not B for the same offence, that is not an injustice to A since A deserves punishment independently of what befalls B. K.C. Davis correctly responds that "if equality of treatment is one ingredient of justice, one cannot know whether penalizing A is just without looking at B's case — and C's and D's."<sup>120</sup> Therefore, individuals should have constitutional recourse to defend against criminal charges and penalties on grounds of systematic or selective non-enforcement. Similarly, it is unjust to assign alcohol to a given regulatory scheme if nicotine, caffeine, cannabis and other psychoactives are not also included. This does not imply that every psychoactive would be treated identically any more than every offence in the criminal law system is punished identically. A thorough fairness argument would expand to include non-drug equivalents as well — what Marks calls the "social psychoactives".<sup>121</sup>

Fairness plays a central role in contract theories of justice. Since experience shows that the fairest contracts are those negotiated by equally resourceful parties, it is arguable that the best recipe for deriving fair laws is to put legal contractors into the same position. John Rawls achieves equality theoretically by placing his "original contractors" behind a "veil

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<sup>120</sup>K.C. Davis, *Discretionary Justice: A Preliminary Inquiry* (Baton Rouge: Louisiana State University Press, 1969) at 170.

<sup>121</sup>Marks, *supra*, note 49 at 9-10.

of ignorance".<sup>122</sup> Legislators devising drug laws from the original position would not know whether in reality they were cocaine importers, tobacco addicts, brewers, college students, marijuana plantation owners, physicians or law enforcers. They would be appraised of all the historical and scientific information about psychoactive drugs but they would be ignorant of their own preferences and social position. Under such constraints, these legislators would not reinvent current drug laws because those laws reflect the unjust exploitation of social power and majoritarian interests.

In the Rawlsian ideal, a legal system should duplicate the results of a voluntary agreement between unbiased and equal contractors. Legal equality and fairness apply to drug users in two respects: equivalent treatment for users of similar substances and equivalence between drug users and persons engaged in equally harmful but non-drug-using behaviours. Systematic equality for drug users means that all psychoactives should be subject to the same uniform control system. Before considering which of the five possible control models is most suitable, the paper will first examine the justice-based arguments of certain other drug control reformers.

### III. A Comparative Justice Analysis

#### A. *Taking Human Rights Semi-Seriously*

David Richards rests his case for drug law reform on the rights-based approaches of Kant, Rawls and Gewirth.<sup>123</sup> He dismisses the utilitarian framework and criticizes other reformers for relying strictly on a cost-benefit analysis. Richards admits that current drug laws are wasteful and ineffective but he asserts that it is more important to argue that criminalizing drug use violates human rights.<sup>124</sup>

Richards rejects prohibition because it fails the test for proportionality. He demonstrates that the reputed criminality of illicit drug users is ridiculously exaggerated, that habituation is miscast as enslavement and that any degree of illicit use is falsely portrayed as serious abuse. In short, the harm caused by illegal drugs is magnified to match the level of harm that

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<sup>122</sup>J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Belknap Press, 1971). Likewise, J. Skolnick, "Coercion to Virtue: The Enforcement of Morals" (1968) 41 S. Cal. L. Rev. 588 at 624, instructs his hypothetical legislator to "ask himself how he would respond to penal sanctions forbidding the smoking of cigarettes, the drinking of coffee, . . . or any other commonly practiced activity which, if 'excessively' indulged in, might lead to social and personal harm."

<sup>123</sup>Richards, *supra*, note 117 at 619.

<sup>124</sup>The central legal argument Richards makes is that decriminalizing vice offences such as drug use would uphold and reaffirm constitutional rights, especially the right to privacy. D.A.J. Richards, *Sex, Drugs, Death, and the Law: An Essay on Human Rights and Overcriminalization* (Totawa, N.J.: Rowman & Littlefield, 1982) at 30-34.

would justify current legal penalties. Law enforcers foster this deception to maintain their self-respect. For Richards, the obvious solution is to lower penalties so that they match the actual harm caused. Richards then dismisses a free market control system because he judges it to be insufficiently restrictive.<sup>125</sup>

The problem with Richards' analysis concerns the fairness requirement. Fairness is considered but not in a consistent manner.<sup>126</sup> A rationing system for marijuana is rejected on universalist grounds. Richards argues that if rationing would be "inappropriate in the cases of such drugs as alcohol or nicotine, it would seem, *a fortiori*, that it should be rejected in the case of marijuana."<sup>127</sup> He labels marijuana rationing "hypocritical" since it ignores the greater harm caused by alcohol and because it does not sufficiently honour personal choice. Richards then tentatively suggests that people "may have a right to take potentially harmful drugs". Yet following this, Richards decides that heroin, mescaline, LSD and certain other drugs should be available, solely on prescription, from state authorized medical authorities. Prescription is described as a "kind of license" the state gives physicians so that they can exercise "proven medical competence" to minimize drug-related damage.<sup>128</sup>

Richards presents no evidence to prove that either heroin or mescaline is more damaging than alcohol. Nevertheless, he assigns them to a separate control system, a discriminatory policy he condemned when applied to cannabis. Secondly, prescription is ethically equivalent to the compulsory committal Richards earlier rejected as an unwarranted measure.<sup>129</sup> A prescription system forces drug users to accept medical supervision. Such coercion is much less onerous than forced confinement in a "detoxication" centre but the ethical difference is merely one of degree. Both surrender individual autonomy to medical authority in a state-run system where physicians serve a police, rather than a medical, role.

Richards understands that psychoactives are used for creative, ceremonial, recreational and symptomatic relief purposes. This understanding

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<sup>125</sup>*Supra*, note 117 at 681.

<sup>126</sup>*Ibid.* at 682. For another discussion of Richards' inconsistencies, see D. Galloway, Book Review (1984) 34 U.T.L.J. 100 (Review of Richards, *supra*, note 124).

<sup>127</sup>Richards, *ibid.* at 681.

<sup>128</sup>*Ibid.* at 673ff. and 680.

<sup>129</sup>*Ibid.* at 679. DuPont, *supra*, note 39 at 63, 116 and 317, evidences the same curious bias and lack of integrity. On one hand, he urges us to ignore the different legal status and historical usage of the various psychoactives. He understands that alcohol and tobacco are the major drug problems. Nevertheless, he regrets having once promoted the decriminalization of cannabis; he recommends criminal law controls without the slightest consideration of their justice or cost; and he casts physicians in a leading police role as monitors of illicit drug use among their own patients.

puts into sharper relief his failure to explain why physicians rather than lawyers, bartenders, coaches, teachers or clerics should have supervisory control over drug use. Richards' claim that physicians exercise proven competence in controlling drug use is unsupported by evidence. On the contrary, the evidence suggests that MDs often prescribe drugs carelessly, even negligently, and that their rehabilitative efforts are consistently marked by failure.<sup>130</sup> Many critics identify physicians as part of the drug-abuse problem because of their personal example and their overpromotion of deceptive chemical "solutions".<sup>131</sup>

Richards is also wrong in comparing prescription to a licensing system. Under a licensing scheme, individuals have a right to use drugs, a right subject to certain legal restraints. Under a prescription system, the individual has no right to use the controlled drugs. He may have a right to treatment but this right is limited by the power of medical interests to determine what constitutes "treatment". Almost every drug now classed as illicit or non-medical was once a medical treatment.<sup>132</sup> Prescription is much closer to prohibition than licensing.

In the *The Heroin Solution*, Arnold Trebach, like Richards, condemns American policy makers because they "criminalized heroin, converted addicts into criminals, and proselytized this repressive policy to the world".<sup>133</sup> Trebach realizes that people use drugs like heroin for fun and that 90 per cent of heroin users are not "addicts". He also calls for drug control solutions that are "democratic", a term implying a willingness to promote fairness. However, Trebach decriminalizes heroin only to medicalize it. Heroin use is called a disease; he speaks of a global "epidemic" for which there is no "complete cure". Nevertheless, we are urged to "bring addicts into a varied system of medical, caring treatment".<sup>134</sup>

Under Trebach's proposal, physicians could prescribe heroin to the "organically ill and the addicted".<sup>135</sup> Since he knows most heroin users are

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<sup>130</sup>See Mintz, *supra*, note 68 at 39 and 185. See also Illich, *supra*, note 103; Malleon, *supra*, note 77.

<sup>131</sup>See E.C. Lambert, *Modern Medical Mistakes* (Bloomington: Indiana University Press, 1978); Mendelsohn, *supra*, note 70; Garan, *supra*, note 40.

<sup>132</sup>See, e.g., Rublowsky, *supra*, note 47 at 166; J.B. Bakalar & L. Grinspoon, *Drug Control in a Free Society* (Cambridge: Cambridge University Press, 1984) at 74-75; and see, generally, notes 31-33.

<sup>133</sup>A. Trebach, *The Heroin Solution* (New Haven: Yale University Press, 1982) at 289. See also M.H. Moore, "Regulating Heroin: Kaplan and Trebach on the Dilemmas of Public Policy" [1984] *Am. Bar Found. Res. J.* 723 at 724 and 728. Moore supports coerced treatment for heroin users; thus, he describes both Kaplan and Trebach, with whom he agrees, as "realistic" and "careful scholars".

<sup>134</sup>Trebach, *ibid.*

<sup>135</sup>*Ibid.* at 290.

not addicts, Trebach must intend to prohibit their access to the drug. They are not sick. Physicians will be free to experiment with every "rational approach" to drug user rehabilitation, including methadone maintenance and Zen Buddhism. In other words, physicians as state agents will be permitted to operate scientifically discredited programs and to co-opt any religious rituals. Clerics will, of course, not acquire countervailing medical privileges. Trebach's unstated objective is actually the bolstering of a therapeutic state at the expense of a once powerful theocracy. Since heroin is merely a battlefield on which political gains can be amassed, the scientific evidence is immaterial to Trebach.<sup>136</sup> Unfortunately, elitist therapeutic controls, like their theocratic predecessors, are potentially much more dangerous than are state criminal controls because they are administered without regard for due process or rule of law.

### ***B. Utilitarianism and Liberal Pragmatism***

John Kaplan, a pioneer cannabis decriminalizer and medicalizer, believes public law restrictions on drug use are justified in terms of both public harm and self-harm.<sup>137</sup> Justifying state action on the basis of self-harm leads Kaplan into a confrontation with J.S. Mill. Mill's familiar argument is that government is generally not justified in compelling people to act or to forbear from acting merely for their own good or, in other words, that prohibiting the use of alcohol or other drugs is not warranted on self-harm grounds. Mill allowed for two exceptions, however, either of which, Kaplan claims, suffices to defeat a policy of permitting drug use as a matter of right.

Mill's first exception concerned children. He felt that children "must be protected against their own actions". While true, this rule does not justify state action. Mill mistakenly believed that society has "absolute power over [children] during all the early portion of their existence".<sup>138</sup> But in the main it is parents who control children not "society". Since real paternalism is far more powerful and important than state controls, the state traditionally has been a minor factor in children's lives.<sup>139</sup> Parents hold nearly absolute power over their children's religious, political, ethical, cultural and dietary

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<sup>136</sup>*Ibid.* at 293.

<sup>137</sup>See Kaplan, *supra*, notes 8, 51 and 86. See also J. Kaplan, *Marijuana: The New Prohibition* (New York: World, 1970).

<sup>138</sup>J.S. Mill, "On Liberty" in R. Wollheim, ed., *Three Essays* (London: Oxford University Press, 1975) 5 at 15 and 101.

<sup>139</sup>The doctrine of *patria potestas*, dominant until the fourteenth century, did not allow for any state intervention with respect to children. Thereafter, the *parens patriae* doctrine emerged, whereby in limited circumstances the state would assume the obligations of the natural parents. In recent centuries, many statutory limits concerning child labour, compulsory schooling, child welfare, delinquency and treatment for infectious diseases have limited the control of parents. See L.C. Wilson, *Juvenile Courts in Canada* (Toronto: Carswell, 1982) at 1-3.

frameworks. State prohibitions applying to children alone compete directly with parental control and are usually perceived as violations of parental prerogatives. Mill's rule justifies parental, not state, regulation of children. Parents should limit their child's access to drugs, just as they should prohibit bad posture, poor study habits, rudeness, fighting and excessive television viewing. The state is not justified in enacting similar prohibitions. Where such attempts are made — for example, Canada and most American states prohibit children's use of tobacco — they are unenforced and irrelevant.<sup>140</sup>

According to Mill's second exception, the state should prohibit voluntary slavery because it is "not freedom to be allowed to alienate [one's] freedom".<sup>141</sup> Mill's case against absolute freedom of contract in the personal service field, even if accepted, need not be applied because heroin use is not slavery. Kaplan suggests that for "some" heroin users "the metaphor of slavery ... is not so farfetched."<sup>142</sup> But drug addiction does not seriously restrict choice as evidenced by the millions of alcohol, nicotine and caffeine addicts who can adequately cope as long as they are permitted to secure a supply legally.

In the end, Kaplan rejects Mill's entire proposition, noting that "no modern state ... has ever followed Mill's principle with respect to all activities."<sup>143</sup> The legislative record of modern states in the drug control field seems to be a shaky basis for an ethical argument. In any event, Mill's rule only applied to self-harming behaviour that did not also harm others. Drug use tends to impose costs on others.

Kaplan then turns to Rawls for support on the self-harm issue. A Rawlsian contractor, Kaplan argues, might consent to laws that made "reasonable efforts to prevent his weakness from causing him *great* damage."<sup>144</sup> This is a valid moral justification for intervention in a case of pure self-harm. The contentious matters are the nature of reasonable limits and the meaning of "great" harm. Kaplan implies that full prohibition could seem reasonable to a risk averse contractor but that is unlikely in drug regulation since criminal law penalties are usually more detrimental than the self-harm caused

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<sup>140</sup>Mitchell, *supra*, note 73 at 127-29.

<sup>141</sup>Mill, *supra*, note 138 at 126.

<sup>142</sup>Kaplan, *supra*, note 86 at 105. The slavery metaphor of foreclosing future liberty raises two issues: the permanence or severity of foreclosure and the effects of foreclosure. Kaplan, *supra* at 34-38, realizes that most heroin users are not permanent users and he may even grant that under controlled circumstances all heroin consumers could abstain. In contrast, contractual arrangements such as marriage can be made both permanent and severely restricting. Marriage, although in some respects a mutual voluntary slavery, is condoned because its effects are largely positive. Conversely, heroin addiction is wrong even if only slightly compelling, because its effects are negative.

<sup>143</sup>*Ibid.* at 106.

<sup>144</sup>*Ibid.* at 108 [emphasis added].

by drug use. Some level of legal restraint might be voluntarily accepted but it would not be the criminal law. Kaplan answers critics who charge that present heroin laws grossly exceed traditional levels of paternalism in Western law by identifying an "endless" list of other paternalistic measures from building codes to minimum wage laws.<sup>145</sup> Kaplan makes two mistakes here. First, if his other examples are themselves unjust and counterproductive, their alleged consistency with heroin prohibition provides no ethical support.<sup>146</sup> Second, Kaplan fails to cite criteria determining the acceptability of paternalism. In many cases high decision-making costs force individuals to transfer some decision-making authority to the government.<sup>147</sup> Kaplan avoids such social contract explanations because he wants to equate drug prohibition with consumer protection laws. But the difference in scope and impact of these two types of state intervention is monumental. Heroin prohibition involves criminal penalties and state coercion of the highest order. Pure food laws involve standard setting and minor, non-criminal disincentives usually assessed against businesses.

Kaplan fails to consider seriously the non-prohibitionist tradition in American jurisprudence. The American Constitution does not explicitly guarantee the right to use drugs but the framers probably did not think it necessary to spell out such an obvious personal prerogative. For the same reason they did not guarantee the right to wear the clothes, eat the food or sing the songs of one's choice.<sup>148</sup> A right to self-medication may be implicitly granted by explicit protections given to the pursuit of happiness.<sup>149</sup> It is noteworthy that an Amendment to the Constitution was required to permit the prohibition of alcohol.

Erich Goode adopts the same pragmatic approach as Kaplan but with less recourse to philosophic considerations. Perhaps as a result, Goode's recommendations are more realistic. Goode assumes that "[d]rug use is here to stay, and the only way to eliminate *illegal* drug use is to eliminate the

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<sup>145</sup>*Ibid.* at 102-3.

<sup>146</sup>With respect to minimum wage laws M. Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962) at 180, makes the familiar argument that "insofar as [they] have any effect at all, their effect is clearly to increase poverty."

<sup>147</sup>S. Kelman, "Regulation and Paternalism" (1981) 29 *Pub. Pol'y* 219.

<sup>148</sup>This reasoning follows the discussion in T. Szasz, *The Therapeutic State* (Buffalo: Prometheus Books, 1984) at 264.

<sup>149</sup>For an extended analysis of this issue see J.S. Oteri & H.A. Silverglate, "The Pursuit of Pleasure: Constitutional Dimensions of the Marihuana Problem" (1968) 3 *Suffolk U.L. Rev.* 55 reprinted in (1971) 1 *Drug Abuse L. Rev.* 502 [hereinafter cited to *Drug Abuse L. Rev.*]. The vitality of the constitutional arguments possible in the U.S. contrasts strikingly with the narrow, legalistic and uncritical pre-Charter inquiry in Canada. See J.B. Laskin, "Constitutional Authority in Relation to Drugs and Drug Use" (1980) 18 *Osgoode Hall L.J.* 554.

laws outlawing the use of certain drugs.”<sup>150</sup> For Goode, the central policy issue can be briefly stated: “[g]iven a population of heavy drug users ... how can we minimize harm to everyone involved?”<sup>151</sup> He argues that the hysteria over a relatively minor group of heroin users is “misplaced” and that drug laws are prejudiced against young, non-white, working class and non-medical users.<sup>152</sup> Goode concludes that “drastic measures” to control drug use are not feasible, and that instead measures to regulate the use and sale of all psychoactives should be considered. Goode does not propose a control program himself but he is clearly more willing than Kaplan to apply drug controls broadly.

### C. *Taking Justice Seriously*

Thomas Szasz is perhaps the leading advocate of freeing drug users from both police and medical supervision.<sup>153</sup> Szasz realizes that drug use is self-harming, sometimes severely so. Nonetheless, he believes citizens should have the right to ingest any drug just as they have right to freedom of speech and religious observance.<sup>154</sup> Since this position piggybacks on existing constitutional protections, it implicitly imports legal restraints judged reasonable in other contexts. Self-expression can harm others, hence the state imposes restrictions with respect to libel and slander, sedition, false advertising, copyright infringement, obscenity, hate literature and so on. The freedom of speech does not excuse a public nuisance created by amplified broadcasts, nor does religious freedom excuses what would otherwise be a serious crime. Neither artistic expression nor divine inspiration excuses murder or assault. Szasz recommends the same legal result for voluntary drug use: a basic right constrained by reasonable laws promoting public defence.<sup>155</sup>

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<sup>150</sup>Goode, *supra*, note 7 at 254. The Shafer and Le Dain Commissions rejected cannabis regulation because they feared it would institutionalize a transient phenomenon. Goode's uniform approach precludes such a consideration because while use of one drug might decline and end, use of all psychoactives must be regarded as long term. See F. Logan, ed., *Cannabis — Options for Control* (Sunbury, Eng.: Quartermaine House, 1979) at 39.

<sup>151</sup>Goode, *ibid.* at 254-55.

<sup>152</sup>*Ibid.* at 268-69.

<sup>153</sup>Szasz, *supra*, note 148 at 263. A. Hellman, *Laws Against Marijuana* (Chicago: University of Illinois Press, 1975) at 6-15, in his discussion of Szasz's position, makes the usual error of assuming that proof of marijuana's harmfulness suffices to defeat the decriminalizer's argument. For his part, Hellman rules out criminal law controls for cannabis by relying on Kaplan's cost-benefit approach.

<sup>154</sup>Szasz, *ibid.* at 263-66.

<sup>155</sup>“Like most rights, the right of self-medication should apply only to adults, and it should not be an unqualified right. . . . [T]he limiting condition . . . should be the inflicting of actual (as against symbolic) harm on others.” Szasz, *supra*, note 10 at 42-43.



This position assumes that protection of autonomy does not depend upon proof of harmlessness. Voting rights and church independence are protected despite the possibility of voters making harmful choices or church members entertaining fantastic delusions. Szasz may agree with Karl Marx that religion is an intoxicating and harmful "opiate of the masses" but Szasz would not on that account prohibit or repress church membership.<sup>156</sup>

Since no scientific tests can distinguish licit from illicit drugs, Szasz concludes that the drug question is ethical, not medical. From this perspective the medicalization of drug users raises a parallel between a theocratic and a therapeutic dictatorship. The centuries-long struggle to separate church and state is compared by Szasz to the current legal battles against joint medical-state enterprises such as forced treatment, protected medical monopolies, involuntary committal and drug prohibitions.<sup>157</sup> Richards agrees that criminal laws have been abused by "majoritarian legislators" to enforce a specific theocratic ideology, yet he appears to favour the enforcement of a particular medical ideology.<sup>158</sup> Szasz does not make that mistake.

Szasz's argument is also more legalistic than Richards' case for human rights because Szasz stresses the need for legal equality. He criticizes drug criminalizers for failing to see that licit drugs as well as "countless other objects in the environment" are as dangerous as the substances we prohibit.<sup>159</sup> Criminalizers may respond that although the existing restrictions are not fair they at least limit some drug-related harm. But this rationalization does not adequately account for the fact that illicit drugs cause such a small fraction of total drug harm that any non-biased planner would concentrate on major problems like alcohol and tobacco use. Furthermore, concern for the health of illicit drug users cannot be the real reason for prohibition since these users would be healthier under some less extremist scheme. What then is the purpose of prohibition? Szasz suggests that certain drugs are outlawed as symbols of sin and wickedness. As symbols, these drugs are forced into roles and burdened with fictional characteristics by groups who simultaneously create and purport to solve the "drug problem".<sup>160</sup>

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<sup>156</sup>Szasz, *supra*, note 148 at 265.

<sup>157</sup>*Ibid.*

<sup>158</sup>See Richards, *supra*, note 117 at 680, where he states that if decriminalized "some form of the medical license would, most plausibly, be required for heroin use."

<sup>159</sup>Szasz, *supra*, note 148 at 267.

<sup>160</sup>The drug persecution complex can also be instructively compared with the persecution of masturbators in the nineteenth century. It appears fantastic in retrospect but masturbation was widely accredited by experts and the public alike to be a terrible, pathogenic vice. See Szasz, *supra*, note 3 at 116-17. Such views are now ridiculed with many experts even reversing course to claim that "self-abuse" is therapeutic. See B. Zilbergeld, *The Shrinking of America: Myths of Psychological Change* (Boston: Little, Brown, 1983) at 201-2. That theory probably lacks scientific merit as well but at least it proves less abusive of human rights.

Since Szasz understands that drug use is not significantly more or less dangerous than harmful pastimes we do not prohibit or assign to medical control, he argues that justice precludes dissimilar treatment before the law for drug users.<sup>161</sup> Szasz also rejects current control systems since they apply only to certain drugs and are thus unfairly discriminatory.<sup>162</sup> Drug laws are unethical then because they are not uniform and because they do not deal with equivalent behaviours or wrongdoings consistently. The remaining issue, which is one Szasz does not address, is what level and type of legal restraint on the right to use drugs would be reasonable.

#### *D. Justice and Regulatory Design*

The conclusions drawn from a justice-based analysis depend less on the technique chosen than on the thoroughness, consistency and empirical accuracy with which that technique is employed. Any of the techniques so far surveyed are capable of producing the same general answers about the design of an optimum drug control system. Consider briefly, in turn, a cost-benefit analysis and a rights-based analysis of drug regulation. According to the cost-benefit technique, regulation aims to achieve the greatest benefits at the lowest costs. Benefits include the amount of harm avoided. This will depend upon the harm caused by the regulated behaviour and the degree to which that behaviour is deterred or positively modified by the regulatory program. For example, completely deterring behaviour that causes little harm will not achieve significant benefit. Benefits also include compensation paid by wrongdoers to those they injure. Preventing injury is preferable to compensating injury but where injury has occurred, compensation is the best solution. Against such benefits are counterbalanced the costs of regulation. Such costs include enforcement expenses, legal "side-effects" and the impact of regulation on wrongdoers.

Of the five possible regulatory models, both criminal law controls and medical prescription are low benefit-high cost systems. As will be explained below in greater detail, they are low benefit programs because they fail to deter much drug use. Indeed, both systems may encourage drug use. For example, criminal law prohibitions and attendant media sensationalism serve

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<sup>161</sup>See also H.M. Greenstein & P.E. DiBianco, "Marijuana Laws — A Crime Against Humanity" (1972) 48 Notre Dame Law. 314.

<sup>162</sup>Szasz, *supra*, note 148 at 262-67.

to advertise the existence and euphoriant properties of illicit drugs. Similarly, medical psychoactives are promoted by their designation as "medicines" and are portrayed as acceptable drug solutions.<sup>163</sup> Prohibition and prescription are high cost programs, first, because they are individualized. That is, they process or treat single individuals one at a time. Moreover, the two systems employ expensive, professional personnel such as lawyers, police, judges and physicians. The second reason for high costs is that both systems trigger expensive "side-effects". As Kaplan demonstrates, prohibition gives rise to black markets, organized crime, quality control problems, police corruption and disrespect for the law.<sup>164</sup> Prescription control compels physicians to play a police role and thus compromises the ethical and professional duties they owe to their patients.

One of the five regulatory possibilities is a medium benefit-low cost system. This is the free market-private law control program. It is a medium benefit system because social sanctions<sup>165</sup> and private actions can significantly deter drug-related harms and because damage awards serve to compensate injured parties. It is not a high benefit system because of imperfections in and inherent limits to the available sanctions.<sup>166</sup> The regulatory costs are

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<sup>163</sup>Pharmaceutical manufacturers are often blamed for the promotion of drug use but, according to Illich, *supra*, note 103 at 72, "the per capita use of medically prescribed drugs around the world seems to have little to do with commercial promotion; it correlates mostly with the number of doctors, even in socialist countries where the education of physicians is not influenced by drug industry publicity and where corporate drug-pushing is limited."

<sup>164</sup>Kaplan, *supra*, note 86 at 95ff. For an account of drug-related police corruption in Britain, see B. Cox, J. Shirley & M. Short, *The Fall of Scotland Yard* (London: Penguin Books, 1977). Recently in Australia the Premier of New South Wales was convicted of a drug-related offence, the Prime Minister's daughter confessed to being a "heroin addict" and commentators report that the New South Wales police force has been "almost completely discredited" due to drug-related corruption. See R. Phinney, "Scandal on High Down Under" *The [Toronto] Globe and Mail* (15 June 1985) 9. Perhaps the best and most thorough overview of the present drug law is found in S. Wisotsky, "Exposing the War on Cocaine: The Futility and Destructiveness of Prohibition" [1983] *Wis. L. Rev.* 1305. Wisotsky, *supra* at 1421, states as his main concern that the futility of prohibition leads to a "built-in tendency of the law enforcement apparatus to grow inexorably . . . in an authoritarian direction." S.D. Cashman, *Prohibition: The Lie of the Land* (New York: Free Press, 1981) at 210-19, recounts how, under the *Volstead Act* during the 1920s, the frustrated goal of alcohol prohibition led repeatedly to logical extension of the law, a process that continued until shortly before the Roosevelt administration spearheaded repeal of the Eighteenth Amendment.

<sup>165</sup>R.C. Ellickson, "The Inadquacies of Law-and-Economics and Other Theories of Social Control" in Faculty of Law, University of Toronto, *Law and Economics Workshop Series* (30 October 1985) at 17-20 [unpublished], offers an interesting response to the belief of "legal centralists" that governments are always the chief source of rule (or law) enforcement. According to Ellickson, norms and rules are largely enforced through "self-help measures, not legal processes". Inducements are also used increasingly by businesses seeking to reduce employee drug use. See A. Toufexis, "Goodies to the Good" *Time* (18 November 1985) 126.

<sup>166</sup>See *infra*, note 207ff. and accompanying text.

low because the government's role is small or irrelevant and because social and private law sanctions tend to have minor impact on wrongdoers.

The last two regulatory models considered are rationing and tax-licensing. These tend to be high benefit-low cost programs for the following reasons. First, both systems offer attractive deterrent potential through either direct limits on drug supplies or price control. Deterrence depends not just on the scale of the penalty or disincentive but on the certainty, frequency and swiftness of its application. The impact of a mild sanction universally imposed can exceed that of a severe punishment rarely inflicted. Second, tax controls, but not rationing controls, make possible the related payment of compensation to injured persons. With respect to costs, both systems are depersonalized, mass control programs capable of reducing administrative expenses to pennies per transaction, and of being operated by non-professional personnel. Since neither system imposes major sanctions, affected parties are not unduly burdened, significant black market activity is not sparked and the inducements for police corruption and abuse are limited. A thorough cost-benefit analysis should, therefore, conclude that an optimum drug control scheme will closely resemble the present tax-licensing regulation of alcohol and tobacco. Not surprisingly, these two drugs are not only the major psychoactives consumed, they are the drugs Western culture has had the most time to learn, through trial and error, how to regulate.

Though a rights-based analysis employs different techniques and concepts, similar conclusions about which drug control system is superior can be reached. The concepts that will now be considered may be summarized under the headings of proportionality, equality and natural rights.

Proportionality in tort law essentially limits a plaintiff's damages to the actual amount of injury suffered. In criminal law, proportionality limits the extent to which the state is justified in imposing penalties; the basic ethical limit established is that punishment should be fitting given the nature of the offence.<sup>167</sup> Criminal assault and tort battery that involve the merest touching, little apprehension and minimal harm should be met with a small award of damages and a minor criminal law sentence. Conversely, an assault and battery resulting in severe pain and suffering should be counteracted by a large damage award and a harsh criminal sentence. When the proportionality limit is applied to the minute harm to others caused by an individual act of drug taking, an objective observer must conclude that there

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<sup>167</sup>See, e.g., the comparative discussion of the justice of criminal penalties and tort damages in G. Williams, "The Aims of the Law of Tort" (1951) 4 *Curr. Legal Probs* 137. Williams, *supra* at 147, claims that tort law "still seeks 'the object all sublime — to make the punishment fit the crime' . . . when the criminal law is giving up the effort to do so." For an alternate and more recent appraisal of criminal law retribution see G. Newman, *Just and Painful Punishment: The Case for Corporal Punishment in Criminal Justice* (New York: Macmillan, 1983).

is no criminal law penalty small enough to match that level of harm. Likewise, the level of compensation justified will almost always be far below that which a practical tort system can provide.<sup>168</sup> Certainly, a court can award damages of 10 dollars or even 10 cents but very few parties will seek compensation worth far less than the effort expended to gain it.

In most cases, a proportional response to drug use will not include criminal or medical controls because they are "over-repressive". Conversely, proportional responses could include social sanctions, tort damages or injunctions, rationing, taxation and standards governing time and place for drug use. The scale and nature of such disincentives are in keeping with the scale and nature of drug-related harms.

The second traditional rights-based ethical requirement is equality or fairness — the enjoinder that like cases should be treated alike. As discussed above, the question of whether taking different psychoactive drugs is "like behaviour" may be answered culturally or scientifically. At present, Western culture embodies certain strong biases about drugs so that the subjective-cultural answer is that drug taking in general does not constitute "like behaviour". Scientifically and objectively the opposite conclusion may be reached. Therefore, what is at stake is not the applicability of the equality requirement but rather the equivalence or non-equivalence of psychoactive drug consumption.

If the empirical evidence presented above and the conclusions drawn from it are accepted, then fairness demands that all psychoactives be treated legally as equivalent substances. This does not mean that all drug users would be treated identically; rather they would all be subject to the same general control program. Equality itself does not determine which control program should be universally applied. For example, it would be fair as between drug users if the criminal law prohibited all such drug use on pain of death. Similarly, it would be fair if no drugs were prohibited.

Without relying on cost-benefit calculations, the choice of which regulatory program to universally apply can be arrived at through consensus or public election. It is argued in Part IV that if people are forced to make a fair choice and to regulate their own drug use exactly as they regulate the drug use of others, they will reject criminal or medical controls in favour of one of the less intrusive control programs. Certainly, individuals may employ their own cost-benefit analysis to determine which control system

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<sup>168</sup>J. Stapleton, "Compensating Victims of Diseases" (1985) 5 Oxford J. Legal Stud. 248 at 248, argues that because the "conceptual machinery [of tort law] dramatically favours" accident victims, "effective tort liability is principally confined to cases of traumatic injury." Specifically, she claims, *supra* at 250, that "the most important barrier to the success of tort claims for man-made disease is medical causation."

they prefer to inflict on themselves. However, that process of calculation differs substantially from the formalist process adopted by Kaplan whereby the theorist attempts to produce a general cost-benefit conclusion. In the rights-based framework described above, the conclusion depends on individual choice and preference, leading to consensus.

The third and final rights-based analysis begins by proclaiming the existence of certain basic, natural or inalienable rights. For instance, the new *Canadian Charter of Rights and Freedoms* states that everyone has such "fundamental freedoms" as "freedom of conscience and religion" and "freedom of thought, belief, opinion and expression ...".<sup>169</sup> The establishment of such rights is conclusory. No formula is provided by which the selection of certain rights and the exclusion of others can be explained. In this context, a right to use the drugs of one's choice can be promoted in two ways. First, such a right or freedom can simply be proclaimed as part of the basic rights protection package. If such a proclamation is lacking, the second possibility is to argue that a specified right, such as "the right to liberty" guaranteed in section 7 of the *Charter*, extends far enough to cover the disputed action.<sup>170</sup> Attempts to rule out drug prohibitions in the United States on constitutional grounds have so far failed. The constitutional positions put forward have been logical, attractive and empirically accurate. They have failed, nonetheless, because of the courts' strong biases in drug matters and because of the courts' reluctance to overrule duly elected legislators.<sup>171</sup>

Should either method succeed in establishing a basic right to use the drug of choice, that right will be legally circumscribed in certain ways. The *Charter*, for example, subjects the guaranteed rights "only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."<sup>172</sup> In other words, a basic right to use drugs would be subject to legal limits traditionally employed to restrict other basic rights.

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<sup>169</sup>Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11, s. 2 [hereinafter the *Charter*].

<sup>170</sup>American courts have considered whether drug use is a "fundamental right". A 1968 decision of the Massachusetts Superior Court affirmed that there is no all inclusive list of fundamental rights; such rights as have thus far been recognized tend to be related "to some commonly acknowledged moral or legal duty and not merely to a hedonistic seeking after pleasure." Oteri & Silvergate, *supra*, note 149 at 506 [footnote omitted]. See also *supra* at 517, where they conclude that courts should abandon the "fundamental right" concept and instead begin to consider "the least restrictive alternative", a concept based explicitly on cost-benefit determinations.

<sup>171</sup>*Ibid.* at 507. The authors question, *supra* at 530, whether the laws, "by treating substantial equals (alcohol and marihuana, although alcohol is generally acknowledged to be the more harmful) as unequals, thereby run afoul of the requirements of equal protection."

<sup>172</sup>*Charter, supra*, note 169, s. 1.

This would rule out prohibition and prescription since books, churches and political rallies are not subject to stringent criminal law or medical controls. It would not rule out social sanctions or private law actions since a right to free expression does not excuse libel or other civil obligations. A right to use drugs would also not rule out a tax on drug sales, no-smoking rules for public places, anti-littering ordinances or even rationing. All of these regulations could be "demonstrably justified" as "reasonable" limits within Western legal traditions.

#### IV. Uniform Regulation

##### A. *Criminal Prohibition*

In submitting each regulatory scheme to a public-choice test wherein the program selected must be applied to all psychoactives, it is clear to begin with that uniform prohibition of all drugs is readily ruled out. Other people's drug use imposes minor costs on those injured so individuals would be unwilling to avoid such costs by subjecting their own drug use to the possibility of penalties. With murder, the calculus is quite different. Individuals willingly bear the small risk of being punished for murder in order to defend themselves against the severe harm of someone murdering them. The Rawlsian contractor's answer to self-harm through drug use would also reject criminal law sanctions because a tobacco habit is less harmful than prison and a criminal record. In practice, the users of tobacco, coffee, alcohol and diazepam would not criminalize their own behaviour merely to defend themselves against the very minor threat posed by cannabis or cocaine users.

Other obstacles to a universal prohibition are readily noted. Indeed, the costs, disruptions and social expense of a total drug prohibition are so large that they cannot be seriously contemplated. Since almost everyone would be a drug criminal, there would be a drastic shortage of non-compromised administrators. Furthermore, the millions of people now dependent for their income on the production and sale of drugs would suffer severe financial loss. Alcohol sales alone netted \$66.4 billion in the United States in 1984.<sup>173</sup> Since full enforcement would be impossible, universal prohibition would probably extend and amplify the side effects of current prohibitions namely police corruption, selective enforcement, black markets, organized crime, dubious legal judgments and international conflict with countries not sharing the same policies.<sup>174</sup>

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<sup>173</sup>J.D. Reed, "Water, Water Everywhere" *Time* (20 May 1985) 68 at 70.

<sup>174</sup>On these and other costs of prohibition see Kaplan, *supra*, note 51. See also N.M. Regush, *The Drug Addiction Business* (New York: Dial Press, 1971); P. Rock, ed., *Drugs and Politics* (New Brunswick, N.J.: Transaction Books, 1977).

### **B. Prescription and Medical Supervision**

The probable lack of public support for total mandatory prescription is suggested by the fact that only two categories of psychoactives are usually assigned to medical controls. These are new drugs that have no existing body of users to antagonize, and illicit drugs, like heroin, whose users are so heavily punished already that a shift to medical control may represent a relative lessening of restrictions. In contrast, coffee, alcohol and tobacco users would feel intolerably imposed upon if their drugs were reclassified as "controlled substances". The majority of licit drug users, who are also the majority of voters,<sup>175</sup> would likely reject prescription-only access as too expensive, inconvenient and demeaning.

Universal prescription is also objectionable because it would provide insufficient social protection against drug harms. The duties, training and incentives of physicians render them ill-suited to perform the role of social protectors. If physicians were the sole legitimate source not only of Valium but of all alcohol products, they would reap enormous, monopolistic profits from the rapid scripting of alcohol prescriptions and they would buy into distilleries and breweries as they have bought into pharmacies and drug manufacturers.<sup>176</sup> Alcohol producers would presumably bribe physicians with gifts, sponsored symposia, free samples and private "research grants" just as pharmaceutical firms do now.<sup>177</sup> Physicians wanting to act on behalf of social protection would face a major dilemma. If they refused to prescribe alcohol many of their customers would turn to other, "less ethical" physicians. Or, if a group of prescribers organized a joint anti-social campaign, their customers would frequently turn to adulterated and possibly unsafe black market products. Even physicians convinced of alcohol's overall negative impact could still properly calculate that prescribing alcohol was in the best interests of their client.

As a rule, permissive prescribing would be needed to forestall criminal elements from dominating the trade. This strategy would be forced upon any private group or profession awarded a drug distribution monopoly — either distribute moderately if not generously, or be eclipsed by illicit traders. Within this constraint some incentives variations would occur. The standard, fee-for-service physician would most likely practise assembly-line prescription whereas salaried medics would be more restrictive, either under

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<sup>175</sup>See *supra*, notes 7, 15, 74 and 116.

<sup>176</sup>See Mintz, *supra*, note 68 at 306 and 313; S.M. Wohl, *The Medical Industrial Complex* (New York: Crown, 1984) at 89 and 92; M. Silverman, P.R. Lee & M. Lydecker, *Prescriptions for Death* (Berkeley: University of California Press, 1982) at 120 and 127-28.

<sup>177</sup>During Prohibition, American physicians did become assembly line script writers for alcohol prescriptions. See Szasz, *supra*, note 4 at 127. On the present relationship between physicians and drug producers see Silverman & Lee, *supra*, note 67 at 54-75.



public plans like the British National Health Service, or private plans like the Kaiser system in California.<sup>178</sup>

Physicians as controllers are hindered by their duty to their clients. The role of protector, confidante and fiduciary forces the physician to put individual needs before collective interests. It is redundant and foolish to compromise physicians with police tasks since we can easily empower non-fiduciaries to serve as enforcement agents. As it stands, the law usually gives physicians public police powers without imposing countervailing responsibilities. Physicians are not made liable for the drug-related costs inflicted on other people by their clients. Since physicians do not internalize third-party costs, they are not motivated to curtail drug consumption rates to the extent possible. Physicians could be compelled to bear all the costs of their prescribing choices if the government set annual license-to-prescribe fees at the requisite level. Faced with such fees, physicians would be forced to abandon their drug monopoly because, unlike government, the medical profession lacks the police resources to enforce drug sales at a cost-internalizing price in light of competition from illegal sources. Physicians can therefore only succeed as social protectors if they operate as government agents. Such a partnership is unstable because government can operate effective controls on drug use without any assistance from physicians. Moreover, government is, to some degree, representative of, and responsible to, the public, whereas a private profession is usually elitist and undemocratic.

If universal prescription is unattractive as a social defence measure, might it still be acceptable as a shield against self-harm? Clients seek professional expertise when they lack special knowledge or skill, and where errors would be costly. To reduce risks, clients in many situations delegate authority to physicians.<sup>179</sup> However, delegating prescriptive authority is not warranted by this analysis since drug use does not require much technical expertise, because physicians are not the most reliable or cost-effective source

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<sup>178</sup>Grinspoon & Hedblom, *supra*, note 77 at 9, give anecdotal evidence of permissive prescribing, describing the case of one amphetamine user who approached over 50 MDs during a six-year period and was only once denied free samples or a liberal prescription. On the issue of salary versus fee-for-service structures see J. Allsop, *Health Policy and the National Health Service* (New York: Longman, 1983).

<sup>179</sup>See S. Peltzman, "The Health Effects of Mandatory Prescriptions" (Consumer and Corporate Affairs Seminar Series, Carleton University, 22 November 1985) [unpublished] at 1, who states that prior to the 1938 *Food, Drug and Cosmetic Act*, Americans could purchase any "non-narcotic" drug without prescription. Nevertheless, from 25-35 per cent of all drug purchases involved prescription prior to 1939. *Supra* at 4 and 7. Peltzman, *supra* at 41, concludes from his recent investigation that "enforcement of prescription-only regulation does not significantly improve the health of drug consumers." (Note that this study included both psychoactives and medicines such as antibiotics.)

of expertise or information about drugs and because there are important conflicts between the interests of physicians and their patients.<sup>180</sup>

Physicians systematically fail to act in the best interests of their patients. The literature provides many instances of widespread abusive practices where physicians overpromote drugs, surgeries and psychotherapies which are unnecessary and counterproductive.<sup>181</sup> Practising physicians are not disinterested scientists; they are members of a powerful guild organization.<sup>182</sup> Loyalty to the guild and fraternity often supercedes loyalty to patients or to the public. Medical priorities are evidenced in a variety of circumstances: by collusion among physicians not to testify in malpractice suits,<sup>183</sup> by the failure of medical associations to remove or restrain unfit members,<sup>184</sup> by

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<sup>180</sup>Hughes & Brewin, *supra*, note 67 at 193-95 and 194, claim that physicians are very susceptible to drug-firm influence and that their reliance on pharmaceutical companies for education "is a blatant case of conflict of interest that would not be tolerated in any other profession." See also K. Koumjian, "The Use of Valium as a Form of Social Control" (1982) 15 Soc. Sci. & Med. 245 at 248; N. Layne Jr, "Restricting Access to Non-Psychoactive Medications: Public Health Necessity or Disabling Professional Prerogative?" (1984) 14 J. Drug Issues 595. On the adequacy of ethical and legal guidance available to physicians with respect to the confidentiality of patient records see R.M. Gellman, "Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy" (1982-83) 62 N.C. L. Rev. 255.

<sup>181</sup>The average physician treats 75 per cent of her patients by drug prescription, the most prescribed drugs being tranquilizers, analgesics and sedatives. J. Graedon, *The People's Pharmacy* (New York: St Martin's Press, 1976) at 3-4. Wohil, *supra*, note 176 at 182, estimates that 80 per cent of emergency room visits are unnecessary, 40 per cent of all hospital stays are not medically indicated and, *supra* at 92, that about \$21 billion is lost each year to "unnecessary drug-related hospitalizations". See also Malleson, *supra*, note 77 at 20-21, 37 and 61. See also A.L. Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services* (London: Nuffield Provincial Hospital Trust, 1972); A. Allentuck, *Who Speaks for the Patient?: The Crisis in Canadian Health Care* (Don Mills, Ont.: Burns & MacEachen, 1978); L. Tushnet, *The Medicine Men: The Myth of Quality Medical Care in America Today* (New York: St Martin's Press, 1971); D. Wolcott, F. Fawzy & R. Coombs, "Reinforcing Networks: The Medical, Pharmaceutical, Mass Media and Paraphernalia Establishments" (1984) 14 J. Drug Issues 223. For a critical analysis of medical psychiatry in particular see M.L. Gross, *The Psychological Society* (New York: Random House, 1978); Zilbergeld, *supra*, note 160.

<sup>182</sup>See E. Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Atherton Press, 1970); I. Kennedy, *The Unmasking of Medicine* (London: Allen & Unwin, 1981).

<sup>183</sup>H.R. Lewis & M.E. Lewis, *The Medical Offenders* (New York: Simon & Schuster, 1970) at 302. In general, physicians tend to be uninterested in disciplinary activity. State medical practice acts do not help as they usually "uphold the malpractitioner and victimize the patient". Lewis & Lewis, *supra* at 63 and 29. See also A.K. Dolan, "Antitrust Law and Physician Dominance of Other Health Practitioners" (1980) 5 J. Health Pol., Pol'y & L. 675.

<sup>184</sup>See, e.g., R.S. McCleery et al., *One Life-One Physician: An Inquiry into the Medical Profession's Performance in Self-Regulation* (Washington: Public Affairs Press, 1971); W.J. Goode, "The Protection of the Inept" (1967) 32 Am. Sociological Rev. 5.

lobbying efforts against patient protection laws<sup>185</sup> and by chauvinistic aggression against female patients.<sup>186</sup>

Physician-client conflicts can be reduced in the drug therapy field if prescribers are in practice made liable for drug-related harm suffered by the drug taker. Physicians are liable in law for drug harms intentionally or negligently inflicted<sup>187</sup> but liability is easily avoided for a number of reasons.<sup>188</sup> Drug harms are often subtle, long term and causally uncertain.<sup>189</sup> Patients change physicians, take other drugs and physicians move, retire or die. In many cases, neither party will link final results with a particular course of drug use. These problems are minimized when the harm is acute or when the prescribed drug is taken for a short, well-defined period. But given the euphoriant potential and popular appeal of psychoactive drugs, such substances attract repeated, chronic and even lifelong use. This would be true for prescribed alcohol and it has become the case for new sedatives like barbiturates and diazepam. Such developments tend to be ignored or blamed on human perversity since physicians do not intend long-term use to occur.<sup>190</sup> Thus new drugs are marketed before the results of chronic consumption are known. If alcohol were invented in the 1950s instead of diazepam, alcohol would now be prescribed as a safe, effective, non-habit forming sedative or tranquillizer. But as patients began to take alcohol for months and years rather than weeks, its medical gloss would fade and a

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<sup>185</sup>"For the past forty years, the American Medical Association has worked to the detriment of the patient in nearly every way imaginable." Crichton, *supra*, note 50 at 62. "Despite the strong opposition of the AMA, a federal law passed in 1963 now requires that all contraindications of drug use . . . be published in every advertisement . . ." Note also the AMA's uncritical support of the Federal Bureau of Narcotics. Grinspoon & Hedblom, *supra*, note 77 at 264 and 287. See also E. Cray, *In Failing Health* (Indianapolis: Bobbs-Merrill, 1970); M.L. Gross, *The Doctors* (New York: Random House, 1966).

<sup>186</sup>See, e.g., C. Dreifus, ed., *Seizing our Bodies: The Politics of Women's Health* (New York: Vintage Books, 1977); G. Corea, *The Hidden Malpractice — How American Medicine Treats Women as Patients and Professionals* (New York: William Morrow, 1977); R.S. Mendelsohn, *Male Practice: How Doctors Manipulate Women* (Chicago: Contemporary Books, 1981).

<sup>187</sup>See, e.g., J.E. Britain, "Product Honesty is the Best Policy: A Comparison of Doctors' and Manufacturers' Duty to Disclose Drug Risks and the Importance of Consumer Expectations in Determining Product Defect" (1984) 79 Nw. U.L. Rev. 342 at 370-74.

<sup>188</sup>See Stapleton, *supra*, note 168.

<sup>189</sup>Iatrogenic drug-related harm is underestimated according to Mintz, *supra*, note 68 at 2-9, because many drug mishaps are not recognized (autopsy is still rare), some mishaps are not connected to their drug-related cause (e.g., impotence due to tranquillizer use), physician reporting systems are "unreliable or nonexistent", and both physicians and drug producers are loathe to indict themselves by volunteering evidence.

<sup>190</sup>Prescription analyses reveal that for most recipients medication is not repeated after one month, although 15 per cent in one study continued to receive prescriptions continuously for at least a year. See J. Murray, T. Williams & A. Clare, "Health and Social Characteristics of Long-Term Psychotropic Drug Takers" (1982) 16 Soc. Sci. & Med. 1595 at 1595.

growing critical literature would warn the public to avoid alcohol just as they are now counselled to avoid the use of benzodiazepines.<sup>191</sup>

Since chronic use of psychoactives apparently brings net disvalue to users, physicians would refuse to prescribe except on an emergency basis if they were *de facto* liable for the damage. Emergency-only prescribing would protect people from self-harm. But such extreme medical restraint would fuel a pervasive black market. To curtail the black market, physicians would have to prescribe generously but they could not do that and at the same time accept liability for self-harm to patients. Prescription would then be feasible only on condition that the drug taker assume full responsibility but such a condition would contradict the rationale of compulsory prescription. No private supplier could afford to sell psychoactives to a mass market and be held liable for the resulting damages.

As for technical expertise, much drug use involves social influences, rituals, cultural imperatives, styles and other matters in which physicians are not expert. Even when technical skill and knowledge are relevant, physicians are questionable sources of expertise. For example, physicians rely heavily on pharmaceutical firms for drug information.<sup>192</sup> Both producers and prescribers have some interest in looking for benefits and in not looking for long-term consequences. In many reported cases, physicians continue to prescribe a drug despite plain warnings from both producers and government agencies.<sup>193</sup> Physicians often resist informing their patients about the drug prescribed; package inserts are not included and contraindications are not mentioned.<sup>194</sup> In some countries, physicians protest if pharmacists put the drug's trade name on the container.<sup>195</sup> Pharmacists are legally prevented from advising customers directly although they are often more knowledgeable about drugs than are physicians.<sup>196</sup> Trade secrets masquerade as expertise as physicians restrict client access to drug information to amplify client dependency and to elevate their own status and income. According to a number of reports, physicians tend to be poorly trained in pharmacological areas.<sup>197</sup> The focus of medical training is crisis intervention — the

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<sup>191</sup>See Marks, *supra*, note 49; Bargmann *et al.*, *supra*, note 56.

<sup>192</sup>Grinspoon & Hedblom, *supra*, note 77 at 258-65. See also *supra*, note 177.

<sup>193</sup>Mintz, *supra*, note 68 at 12-14, 39 and 76; Graedon, *supra*, note 181 at 37ff.

<sup>194</sup>See, e.g., A. Spake, "The Pushers" in Dreifus, *supra*, note 186, 177.

<sup>195</sup>M. Muller, *The Health of Nations: A North-South Investigation* (London: Faber & Faber, 1982) at 211. See also M. Tonkin, *South Africa — A Nation of Pill Swallowers* (Johannesburg: Institute for the Study of Man in Africa, 1977).

<sup>196</sup>Silverman & Lee, *supra*, note 67 at 310-12.

<sup>197</sup>*Ibid.* at 301 and 307. H. Bloch, "Toward Better Systems of Drug Regulation" in Landau, *supra*, note 32, 243 at 247, argues that most physicians are scientifically "naive" and incapable of properly evaluating all drug information; he therefore recommends a special prescribers licence.

technical solution of immediate, often life-threatening conditions. Non-crisis fields such as nutrition, neurosis and drug habituation are clearly not marked by medical successes.<sup>198</sup>

Individuals sometimes require detailed, accurate information about drugs and drug interactions but that need does not justify a system that also compels them to acquire medical permission to take the psychoactive.<sup>199</sup> Nor does it justify a monopoly allowing only physicians, and not nurses, paramedics, pharmacists or psychologists, to sell such information. It is likely that more informed choices about the use of psychoactive drugs would be made if it were not for forced reliance upon physicians as the sole information source.

### C. Government Rationing

Under rationing controls, drug users would neither be criminalized nor subject to compulsory medical supervision. Individuals would have the right to use drugs in the form and the amounts made available. The only prohibition would be against non-authorized sales.

Rationing by a public body avoids the conflicts inherent in medical controls. Unlike physicians, government exists to promote collective self-defence and is liable for defensive failures. Government health, welfare and other agencies bear a significant portion of drug-related costs. Government also possesses enforcement resources and the monopoly on police action needed to maintain a restricted supply of drugs.

Rationing would be less intrusive and less expensive than either criminal law or medical controls. Clerks rather than physicians would operate the system and few police resources would be required. Rationing could serve social defence needs by setting ceilings on national drug consumption rates as the Soviet government is presently doing with alcohol. Such ceilings could be restrictive without being prohibitive. For example, a government might decide to cut alcohol consumption by half. Rationing could also

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<sup>198</sup>According to J.J. Fried, *The Vitamin Conspiracy* (New York: Saturday Review Press, 1975) at 200, physicians are "particularly ignorant about nutrition". There is new evidence that increasing access to health care (long the sole measure of medical program success) does not in fact improve health. See also P.K. Diehr *et al.*, "Increased Access to Medical Care — The Impact on Health" (1979) 17 *Med. Care* 989; Knowles, *supra*, note 99; Illich, *supra*, note 103.

<sup>199</sup>Peltzman, *supra*, note 179 at 42, claims that individuals are not less likely to seek a physician's advice regarding antibiotics, even if such drugs can be obtained without prescription. In other words, people know enough to seek expert medical assistance when they need it. This implicitly suggests that mandatory prescription exists primarily to force individuals who do not want or require medical services to purchase them anyway.

prevent self-harm more effectively than would prescription because government has stronger incentives to pursue disease-preventing policies. Reducing overall drug use is the major preventive measure in this field but, in addition, government could selectively ration the more damaging forms of the various drugs. The public could also be provided with comprehensive information about adverse drug effects. Such information could be provided inexpensively through package inserts, warning labels, school instruction and public service advertising. Drug information is more efficiently conveyed by public agencies and word-of-mouth than by expensive private interviews in a physician's office. Under a rationing scheme, people could still seek professional advice about drugs but they would not be forced to do so.<sup>200</sup>

Rationing systems are not without their faults, as experience with war time rationing, rent controls, minimum wage laws and the Soviet "command economy" rationing of many personal goods and services illustrate.<sup>201</sup> Rationing coupons are counterfeited. Ceilings are arbitrarily set. The signalling role of market prices is subverted or destroyed. Distribution is often inefficient and competition is reduced. Unproductive disincentives such as waiting in line replace price disincentives. Product quality declines. Bureaucratic systems are vulnerable to political abuse. Multi-tier arrangements evolve, with low rations for the masses and special supplies for foreigners and political elites. Rationing also tends to be cumbersome as it ignores variations in individual preferences.

Despite these drawbacks, Rawlsian contractors would prefer universal drug rationing to either universal prohibition or prescription because rationing would limit externalities and mitigate self-harm more effectively and at a lower cost. An estimation of actual public support should come to the same conclusion. During wartime, voters accept rationing and, as noted above, much of the Soviet economy embodies rationing mechanisms. In addition, many people in the Western world actively call for increased rationing in such areas as rental housing, energy, income, education and employment opportunities. These demands are understandably met with vigorous

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<sup>200</sup>In Yugoslavia, for example, the government pays for drugs on prescription while the same drugs are available without prescription: *ibid.* at 5 n. 1.

<sup>201</sup>See, e.g., A.P. Lerner, *The Economics of Control* (New York: Macmillan, 1944) at 50-52, who suggests that despite its faults, war rationing is justified as "a form of state guardianship to prevent foolish spending". Lerner does not explain what constitutes foolish spending but would probably include the purchase of addicting, health impairing psychoactive drugs. See M.I. Goldman, *Soviet Marketing — Distribution in a Controlled Economy* (New York: Free Press of Glencoe, 1963). See also "Socialism: Trials and Errors" *Time* (13 March 1978) 24 at 35 where it is reported that "[c]orruption, black marketeering, bribery and theft are endemic in Communist states". See also a report on the massive trafficking in food stamps in the U.S.: "Definitely Not USDA Approved" *Time* (23 August 1982) 10.

opposition and in the case of drugs such opposition would come mainly from users of current recreational drugs since their drugs are the most freely available.

#### *D. Tax-Licensing Controls*

The differences between tax controls and rationing reflect the differences between market allocation and a centrally ordered economy. The rationale for tax controls is to counteract market imperfections, such as pollution and drug-related costs, by forcing prices to account for the full social costs involved. The tax-inflated price signals some degree of official disapproval and manipulates buyers through general economic disincentives. Unlike rationing, tax controls retain the flexibility of market allocations with their allowances for personal preferences. No arbitrary ceilings need be set. Taxes also raise revenue and thus provide incentives for government to enforce the controls. Like rationing, tax controls would not criminalize or medicalize drug use. Law enforcement resources would focus on the prevention of untaxed sales, not on the harassment of drug users.<sup>202</sup>

The conceptual objective of tax and licensing controls for distributors, retailers and on-premise sellers would be to duplicate the results of a class action against drug users. Since government already exists as a collective agency, a public law program against drug "defendants" is the lowest cost alternative to an actual tort action. Public law controls also avoid certain drawbacks inherent in private law initiatives against chronic, repeated wrongdoing. Courts lack the apparatus to assess and collect small compensatory sums for the duration of the continual tortious acts. Tax controls solve this problem. Taxes are also superior to fines or judgments because these must be extracted directly from the tortfeasor. In contrast, taxes can be collected impersonally at the wholesale or retail level before the tort is committed. Taxes thus pre-emptively limit drug-related harm by reducing drug consumption whereas fines compensate or punish harm already caused. On the other hand, the tax is predictive in that it anticipates harm and it is generalizing since it does not distinguish between two persons buying the same amount of drug although in fact they will impose different costs on third parties. Still, the burden can vary according to the type and amount of drugs used so that in general those generating the highest externalities will pay the most tax. Such approximations and other deviations from the pure individuality of tort law are necessary if liability is to be borne by the millions of drug users.

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<sup>202</sup>On the acceptability of excise taxes in general and sumptuary taxes in particular see C.N. Mitchell, "Willingness-to-Pay: Taxation and Tax Evasion" (1985) 21 Mem. St. U.L. Rev. 127 at 156-75.

A regulatory tax based on the tort model must be a fault-based tax. That is, tax level should be proportional to the level of harm caused by the drug use. If alcohol per standard dosage is more harmful than caffeine or cannabis then the tax on alcohol should be higher. Similarly, tax rates for smokeless tobacco products should be lower than those for cigarettes because of the absence of smoke damage to other persons.

Criminal, medical and rationing controls attempt to deter drug-related costs but they ignore compensation needs. In contrast, tax controls raise revenue which can be used to finance remedial efforts or to reduce other tax burdens. In either case, an approximation of the plaintiff class would receive some compensatory benefit paid by a general defendant class. Having drug users pay tax compensation directly to government also avoids the legal costs and deadweight losses of a real class action. However, for this system to work, the setting and collecting of tax should probably not be left to revenue departments. The United States Treasury's role in fomenting the present extremist controls is well known.<sup>203</sup> Control responsibility should instead be assigned to health, education or welfare departments.

In addition to tax disincentives, a range of injunctive measures are required to regulate no-smoking zones, product quality, returnable bottle systems, advertising standards, warning labels, and so forth.<sup>204</sup> Again, courts are not well suited to administer such long term, continual and complex regulatory measures.

Tax-licensing controls are also plausible restrictions in terms of self-harm. Price disincentives can be designed to discourage the more damaging modes of drug intake and to encourage less damaging modes. Sniffing, smoking or injecting drug X is more damaging than eating or drinking the same substance. Tax rates could reflect this difference. Price differentials can similarly dampen demand for the more harmful drugs in a given drug family. Since barbiturates are evidently more damaging than benzodiazepines, they should be more heavily taxed regardless of whether the two drug types are associated with different levels of harm to others. Since tax penalties are quite minor relative to the possibilities for self-harm, drug users are likely to accept such restraints more readily than they would accept the previous models.

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<sup>203</sup>B. Freemantle, *The Fix: The Inside Story of the World Drugs Trade* (London: Michael Joseph, 1985) at 69.

<sup>204</sup>Advertising controls and health warnings appear to play a minor role in reducing tobacco consumption. In contrast, taxes are an effective restriction. See J. Bishop & Jang H. Yoo, "'Health Scare', Excise Taxes and Advertising Ban in the Cigarette Demand and Supply" (1985) 52 South. Econ. J. 402 at 410.



Government efforts to limit and prevent self-harm do not mean that government should be liable for self-harm. A major failing of the prescription system is that it holds out the false promise of physician liability. The belief that physicians are liable for self-harm leads patients to assume that physicians would not prescribe any harmful, addicting drug. This presumption would be true if physicians were, in fact as well as in law, responsible for compensating all drug-related damage. But since liability is easily avoided, individuals are inappropriately encouraged to be less defensive, less critical and less self-reliant than they should be.<sup>205</sup> No such confusion or empty assurances will occur in connection with either tax controls or rationing. People will be forewarned that all psychoactives are harmful and habit forming. They will then bear the cost of that portion of self-harm that is not automatically covered by welfare-medical programs.

Would Rawlsian contractors accept tax disincentives as a self-protection measure? The answer is not certain. Even with ample warnings about drug effects, some people optimistically assume that they will not become dependent on the drug or that use will not cause them serious damage. If humans naturally discount future risks to some degree then Rawlsian contractors will do likewise. Thus contractors who overestimate their self-control and discount drug risks might be reluctant to bear "needless" tax penalties. However, the contractors would delegate authority to some public body to enforce drug quality and safety standards.

Practical acceptance of tax controls will depend primarily on the trade off between personal restraint and the avoidance of costs imposed by others. The strongest supporters will be abstainers or light users who suffer more harm from others than they inflict in return. Since these people will pay less in tax than they receive in compensation they will generally welcome tax controls. Opposition will come from those in the higher drug tax brackets who will pay out in compensation more than they receive. Hardest hit will be the heavy, polydrug users, appropriately enough, since they cause the most damage. Current criminalizers will also oppose tax controls because an objective fault-based system necessarily rejects the implicit and subjective indices of fault contained in statutory penalties for drug use offences, which ignore alcohol and nicotine users and punish cannabis and cocaine consumers. (For convenience, reference is made to people as users of a single

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<sup>205</sup>According to Graedon, *supra*, note 181 at 4, most patients are "utter fools" because they consider their prescribed drugs to be "completely safe". Grinspoon & Hedblom, *supra*, note 77 at 271, write that most physicians "have discovered that the American public has been trained to expect only good from drugs, especially new drugs, and many doctors either capitalize on this situation or fail to meet its pressures. They are particularly apt to prescribe psychoactive drugs even when no definite indications for *any* drug treatment exist . . . ."

drug, but most people use a variety of drugs. For example, most serious abusers of any drug are also nicotine addicts.)<sup>206</sup>

### *E. Free Market Controls*

Under this least restrictive alternative, drugs would be dealt with like other commodities. Certain general regulations and laws would therefore apply. New drugs would be tested and quality standards set. False and misleading advertisement would be curtailed.<sup>207</sup> Physicians would be liable for harm caused by reasonable reliance on their advice. Producers would be liable for damage resulting from defective products or from failure to warn. The right to use drugs would be subject to the same limitations affecting other rights.

Much of the restrictive potential of free market controls depends upon private law developments and expanding theories of liability.<sup>208</sup> Drug use would be inhibited if employees could sue employers for failing to provide a smoke-free environment or if employers could sharply discriminate against drug users in hiring and firing employees. Considerable restraint would also be achieved if drug users, like tobacco smokers, were successful in negligence suits against tobacco companies. A finding of negligence could conceivably be based on the manufacturer's failure to warn customers that tobacco was both damaging and addictive.<sup>209</sup> A rash of such actions would force producers to raise prices, thereby deterring some consumption. Drug producers in that tort climate would probably find it less expensive to practise full disclosure. By issuing full and comprehensive warnings they could eventually avoid blame for their customers' self-harm. Drug advertising might

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<sup>206</sup>Carney, *supra*, note 47 at 160-65.

<sup>207</sup>See, e.g., Note "Restraints on Alcoholic Beverage Advertising: A Constitutional Analysis" (1985) 60 Notre Dame L. Rev. 779.

<sup>208</sup>See, e.g., Note "The Liability of Providers of Alcohol: Dram Shop Acts?" (1984) 12 Pepperdine L. Rev. 177; F.H. Fern & W. Sichel, "Evolving Tort Liability Theories: Are They Taking the Pharmaceutical Industry into an Era of Absolute Liability?" (1985) 29 St Louis U. L.J. 763; L.W. Brackins, "The Liability of Physicians, Pharmacists, and Hospitals for Adverse Drug Reactions" (1985) 34 Def. L.J. 273.

<sup>209</sup>Paul Monzione, a lawyer working with Marvin Belli in San Francisco, is employing this argument on behalf of his now-deceased client, John Galbraith, a long time nicotine addict. Addiction allows Monzione to argue that, although the plaintiff knew about the health risks of smoking, his addiction rendered him incapable of acting wisely or responsibly. The interesting development here is to see whether the "thin skull" principle will be extended to include the addiction or habituation prone personality. G.F. Will, "Tobacco vs. 'Thin Skull Doctrine'" *The [Ottawa] Citizen* (11 February 1985) A8. See also B. Rudolph, "Tobacco Takes a New Road" *Time* (18 November 1985) 98 at 98-99; H.M. Sapolsky, "The Political Obstacles to the Control of Cigarette Smoking in the United States" (1980) 5 J. Health Pol., Pol'y & L. 277 at 288.

be voluntarily eliminated under these conditions. Promotional advertisement would also be abandoned if the courts were to determine that any measure intended to encourage drug use was itself negligent. Under such a doctrine, newspapers, magazines and other advertising media could be held liable independently.

Since the courts are unlikely to promote revolutionary changes in tort liability for drug-related externalities, a free market system would be less restrictive than either rationing or tax controls. This failure to provide sufficient protection or deterrence could lead Rawlsian contractors to reject free market controls. On the other hand, many business interests would support a free market because of the impetus it would provide to drug sales. Without current excise taxes on alcohol products, alcohol prices would plunge and sales would increase. Alcohol consumption in the United States is below European levels and is, per capita, only about half of what it was in 1850.<sup>210</sup> Potential for major sales increases also exists for tobacco, if not taxed, and for cocaine, cannabis and opium, if not prohibited. The change would benefit farmers of corn, tobacco and marijuana, brewers, vintners and distillers, chemical producers, packagers, shippers and drug retailers. For non-commercial reasons many people would support a free market (or tax controls) because it would eliminate police power over drug use, drug crusades, corruption in the drug control agencies,<sup>211</sup> the scapegoating of drug users by politicians and much of the life-support system for organized crime. Firmly against free market controls would be the temperance interests, police, organized crime, medical associations and those agencies burdened by drug-related damages.

## Conclusion

Assume that the electorate is faced with a binding referendum in which one of the five control systems described above must be selected as the single mode for control of all psychoactive substances. Assume also that the vote would take place after two years of debate, lobbying and education. Having eliminated in advance most people's first choice, namely the status

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<sup>210</sup>Mäkelä *et al.*, *supra*, note 102.

<sup>211</sup>As one example of bureaucratic corruption in high places, Freemantle, *supra*, note 203 at 73, claims that Senator Joe McCarthy, an alcohol and morphine addict, was supplied opiates by Harry Anslinger, head of the Narcotics Bureau.

quo, what would be the results of this hypothetical vote?<sup>212</sup> Universal prohibition and prescription would likely stand as the least preferred alternatives. Among the three plausible contenders, a tax-licensing system would probably be judged the best compromise. Tax controls are familiar from their role in the control of tobacco and alcohol and they are superior to rationing on a number of grounds including greater sensitivity to personal preferences, less need for bureaucratic apparatus and a capacity to serve a compensatory function. Furthermore, unlike free market controls, tax controls do not leave social protection needs to the uncertain premises and vagaries of private law initiatives.

Whatever the exact outcome of such a public choice operation might be, the salient feature of the exercise is that it would force individuals to include their own drug use and drug abuse in their political calculations.<sup>213</sup>

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<sup>212</sup>Schofield, *supra*, note 78 at 186, whose research shows most of the British electorate opposed to any change in the law, identifies the same basic drug control models as discussed herein. Schofield, however, does not explore these alternatives in depth but merely suggests some minor changes concerning lesser penalties for marijuana offences. If cultural inertia actually constitutes a major obstacle to any legal reform, why go to the bother of besting that high threshold merely for the sake of gaining a minor advantage? In other words, major, comprehensive reforms may not incite much more opposition than minor, piecemeal legal changes.

<sup>213</sup>Schroeder, *supra*, note 5 at 10-11, writes of the drug problem "dilemma" wherein any drug can "be portrayed as 'good' or 'bad', or . . . as 'hard' or 'soft', depending on which of its properties are emphasized by authorities", yet the public "has arbitrarily declared some drugs as acceptable and others as unacceptable, without reference to their effects on mental and physical health." This unwarranted and unjust discrimination is the major problem faced in the "drug problem" field. Wisotsky, *supra*, note 164 at 1422-23, does not blame the public but rather governments which have successfully avoided any serious popular criticism of drug policy: "[s]even decades of government propaganda about the evils of drugs have deprived the public of the power of critical thought respecting drugs, or cowed it into silence . . . . As a result, criticism of drug prohibition is confined almost entirely to academicians, a group notably lacking the political clout necessary to precipitate a public rethinking of the issue."