UTAH LAW REVIEW

Volume 2009 Number 1

SYMPOSIUM: DRUGS, ADDICTION, THERAPY, AND CRIME

STUDENT NOTES

UTAH LAW REVIEW

VOLUME 2009 NUMBER 1

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ACKNOWLEDGEMENTS: The editors of the *Utah Law Review* wish to express their gratitude to the following: The University of Utah S.J. Quinney College of Law, the Journal Alumni Association, the University of Utah Publications Council for their support and to the Associated Students of the University of Utah for their generous donations; Professor Amy J. Wildermuth, faculty advisor; Angela Turnbow, editorial assistant; and the S.J. Quinney College of Law faculty and staff.

Printed in the United States of America by Joe Christensen, Inc.
ISSN 0042-1448

UTAH LAW REVIEW

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INTRODUCTION
DRUGS, ADDICTION, THERAPY, AND CRIME SYMPOSIUM

Margaret P. Battin* and Arthur G. Lipman**

"Drug"—the very term conjures up a range of different associations for different people, from the prescription medications that a physician might mean when speaking of drugs, to the illicit substances an attorney or a judge might think of, to illicit recreational drugs that a teenager may associate with "rave" parties, to the performance enhancing substances an athlete might have in mind. In fact, though perhaps used with varying inflections, the full range of drugs includes at least seven basic categories:

- prescription pharmaceuticals
- over-the-counter medicines
- complementary and alternative medications (largely dietary supplements or herbal drugs)
- common socially used drugs, especially alcohol, tobacco, and caffeine
- religious-use drugs, including peyote, ayahuasca, and others
- sports-enhancement drugs
- illegal recreational drugs, such as street, club, and party drugs[1]

These various categories of drugs have different histories of development, regulation, use, and criminalization. Some are handed down through the centuries as ancient practices—the use of intoxicants, stimulants, narcotics, and hallucinogens, for example, in medical settings, social settings, and religious practices. Throughout history, various attempts have been made to control, regulate, or suppress the use of some drugs in most developed societies.[2] But the United States differs from most other countries in the way our drug law has evolved.

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[1] *See* MARGARET P. BATTIN, ERIK LUNA, ARTHUR G. LIPMAN, PAUL M. GAHLINGER, DOUGLAS E. ROLLINS, JEANETTE C. ROBERTS, AND TROY L. BOOHER, DRUGS AND JUSTICE: SEEKING A CONSISTENT, COHERENT, COMPREHENSIVE VIEW 8–9 (2008).

[2] *See id.* 29–30 (identifying historical attempts to regulate drug use).

In most other developed countries, health care is a public matter and drug law is written in the context of a government-run health care system. In the United States, health care is traditionally a private matter based on contracts, written or implied, between individual providers and consumers of care. While the federal government oversees interstate commerce and most drug manufacturing, distribution and consumption involves interstate commerce, licensure of health professionals (including drug prescribers) falls into the constitutional category of police powers, making licensure the purview of the states (and other jurisdictions), not the federal government.

Another aspect of drug law that is unique to the United States is that much regulation of drugs was relegated by Congress to an agency comprised entirely of volunteers, the United States Pharmacopeial Convention (USPC), that today publishes the major drug compendia—the United States Pharmacopeia (USP) and the National Formulary (NF), and sets most drug standards.[3] USP membership consists of representatives of each state medical and pharmacy association, each American medical and pharmacy school, and several fraternal organizations, including the American Medical and American Pharmaceutical Associations plus representatives of the Surgeons General of the United States Public Health Service, Army, Navy and Air Force.[4]

USP also approved the legal definition for both a "Drug" and a "New Drug." Those definitions, as incorporated into the United States Code, are as follows:

Drug:

> (A) articles recognized in the official United States Pharmacopeia, official Homeopathic Pharmacopeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any substances specified in clause (A), (B) or (C) [with exclusions for certain dietary supplements].[5]

New Drug:

> (1) Any drug . . . the composition of which is such that such drug is not generally recognized, among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, as safe and effective for use under the conditions prescribed, recommended, or

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[3] *See* 21 U.S.C. § 321(g)(1)(A) (2006) (defining the term "drug" for purposes of the Food, Drug and Cosmetic Act, by reference to determinations made by United States Pharmacopeia).

[4] *See* United States Pharmacopeia, Organizations Eligible to Appoint Delegates to the USP Convention (Apr. 2009), http://www.usp.org/pdf/EN/members/organizations EligibleToAppoint.pdf.

[5] 21 U.S.C. § 321(g)(1).

> suggested in the labeling thereof [excluding certain drugs subject to the Food and Drug Act of 1906]; or
>
> (2) Any drug . . . the composition of which is such that such drug, as a result of investigations to determine its safety and effectiveness for use under such conditions, has become so recognized, but which has not, otherwise than in such investigations, been used to a material extent or for a material time under such conditions.[6]

Clearly, many substances that are commonly termed "drugs" in society do not meet either of these definitions.

In the United States, drugs in all categories were essentially unregulated until about a century ago, and widespread use of opium derivatives was common.[7] But "snake-oil" salesmen and other unscrupulous purveyors of ineffective or dangerous nostrums came to be viewed as a public hazard, and the need to regulate quality (as distinct from efficacy) was increasingly recognized. The year 1906 saw the passage of the first federal drug law, the Federal Food and Drugs (F&D) Act, which simply prohibited adulterated or misbranded drugs from interstate commerce.[8] That law did not address either safety or efficacy.[9]

In 1914, the Harrison Narcotics Act was passed to begin regulation of opium derivatives.[10] But that law was written primarily to address treaty obligations that the United States had with trading partners, not to protect the public health, per se.[11]

In 1937, more than 100 people died after ingesting a commercial preparation of the then-new anti-infective drug sulfanilamide, which was marketed to treat sore throats in children.[12] Wanting to make a good-tasting liquid formulation, a manufacturer dissolved the bitter chemical in the sweet, pink solvent diethylene glycol.[13] Diethylene glycol is a highly toxic chemical commonly found in automotive antifreeze, but no law at that time prohibited or even discouraged sale of such formulations.[14] The ensuing public uproar led to passage of the Food Drug and Cosmetic (FDC) Act of 1938, which remains the cornerstone federal drug law

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[6] *Id.* § 321(p).

[7] *See* BATTIN ET AL., *supra* note 1, at 31, 41 (discussing use of opium derivatives and the shift in regulation that occurred at the turn of the century).

[8] *See* Pub. L. No. 59-384, 34 Stat 768 (1906) *repealed by* Federal Food, Drug, and Cosmetic Act, ch. 675, § 902(a), 52 Stat. 1040, 1059 (1938).

[9] *See id.*

[10] Pub. L. No. 63-223, 38 Stat. 785 (1914), *superseded by* Controlled Substances Act of 1970, Pub. L. No 91-513, 84 Stat. 1236, 1242 (codified as amended at 21 U.S.C. §§ 801-971); *see also* BATTIN ET AL., *supra* note 1, at 33–34.

[11] *See id.* at 33–34.

[12] Carol Ballentine, *Taste of Raspberries, Taste of Death: The 1937 Elixir Sulfanilimide Incident*, FDA CONSUMER, June 1981, at 18, *available at* http://www.fda.gov/oc/history/elixir.html.

[13] *Id.*

[14] *Id.* at 18–21.

in the United States today.[15] However, the original FDC Act only required testing of drugs for safety with no requirement for efficacy.[16] It was not until passage of the 1951 Durham-Humphrey amendment to the FDC Act,[17] coauthored by then Senator Hubert H. Humphrey, Jr.—a pharmacist and later Vice President of the United States—that efficacy was first required for drugs approved for human and veterinary use in the United States.[18] That same amendment introduced a new legal concept: that some medications required prescription by a licensed prescriber.[19] Prior to 1951, nonnarcotic drugs were available to anyone without a prescription in this country. Thus, differentiation of medications considered safe for use without supervision of a licensed prescriber, known as nonprescription or over-the-counter (OTC) drugs were then regulated differently from those requiring a prescription. That differentiation has only been in effect in the United States for a little over half a century. Numerous other amendments have broadened and strengthened the FDC Act since its inception.

In 1970, the Federal Controlled Substances Act (CSA)[20] created a third legal category of medications: those that could only be prescribed by a practitioner licensed to do so by one of the jurisdictions and who also registered with the then-new Federal Drug Enforcement Administration (DEA) to prescribe controlled substances.[21] The five schedules of controlled substances range from those with the highest abuse potential, which are not recognized as having legitimate medical use and which are illegal to use without a special investigational exemption, to those that can be purchased from a pharmacy without a prescription in most jurisdictions.[22]

In 1994, Congress passed the Dietary Supplement Health and Education Act (DSHEA), which essentially deregulated "dietary supplements."[23] The DSHEA established a formal definition of "dietary supplement" using several criteria. A dietary supplement is defined in that act as a product:

- (other than tobacco) that is intended to supplement the diet that bears or contains one or more of the following dietary ingredients: a

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[15] *Id.* at 21; Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (current version at 21 U.S.C. §§ 301–399 (2006)).

[16] *See* BATTIN ET AL., *supra* note 1, at 41–42 (explaining that efficacy requirements were introduced by 1962 amendments to the Food, Drug, and Cosmetic Act).

[17] *See* Pub. L. No. 82-215, 65 Stat. 648 (1951) (current version at 21 U.S.C. §§ 301–399 (2006)).

[18] *See* BATTIN ET AL., *supra* note 1, at 42.

[19] *Id.*

[20] Pub. L. No. 91-513, 84 Stat. 1242 (1970) (codified as amended at 21 U.S.C. §§ 801–971 (2006)).

[21] *See* BATTIN ET AL., *supra* note 1, at 62–63.

[22] *Id.* at 64 tbl.3.1; *see also id.* at 57–58 (explaining the rationale for the five schedules of regulated drugs).

[23] Pub. L. No. 103-417, 108 Stat. 4325 (1994) (codified in scattered sections of 21 U.S.C.).

vitamin, a mineral, an herb or other botanical, an amino acid, a dietary substance for use by man to supplement the diet by increasing the total daily intake, or a concentrate, metabolite, constituent, extract, or combinations of these ingredients.
- that is intended for ingestion in pill, capsule, tablet, or liquid form.
- that is not represented for use as a conventional food or as the sole item of a meal or diet.
- that is labeled as a "dietary supplement.
- that includes products such as an approved new drug, certified antibiotic, or licensed biologic that was marketed as a dietary supplement or food before approval, certification, or license (unless the Secretary of Health and Human Services waives this provision).[24]

The then-small U.S. dietary-supplement industry burgeoned, and many substances—some of which were impure and adulterated—were marketed with vague, new health claims.[25] Dietary supplement manufacturers did not need to demonstrate either safety or efficacy as do drug manufacturers.[26] Only when serious public harm is proven can the Food and Drug Administration act to withdraw a supplement from the market.[27] Thus the burdon of proof for product safety was removed from the seller and the burden to prove a product unsafe was placed on the FDA for dietary supplements. Tragically, deaths have resulted.

Criminalization of specific drugs—that is, classification of specific drugs within the federal schedule that prohibits their use except in extremely limited research circumstances—occurred in response to specific public prejudices and fears: for example, opium was made illegal based on fears associated with Chinese railroad workers; heroin because it was believed to be used primarily by black men in the South making them sexual threats to white women; and marijuana because of its association with Mexican immigrants.[28] These episodes of criminalization were typically made without careful analysis of the drug in question, its chemical or physical properties, or its actual patterns of use or the pathology or social

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[24] *See* 21 U.S.C. § 321(ff) (2006).

[25] *See* Jennifer Arke Hill, *Creating Balance: Problems Within DSHEA and Suggestions for Reform*, 2 J. Food L. & Pol'y 361, 363, 381–82 (2006) (discussing the role of DSHEA in allowing "the dietary supplement industry to develop," and examining the FDA's determination that "supplements containing ephedra were adulterated").

[26] BATTIN ET AL., *supra* note 1, at 44.

[27] *Id.*; *see* 21 U.S.C. § 342(f)(1).

[28] *See* BATTIN ET AL., *supra* note 1, at 32–33; *see also Importation and Use of Opium: Hearings on H.R. 25240, H.R. 25241, H.R. 25242, and H.R. 28971 Before the H. Comm. on Ways and Means*, 61st Cong. 82–83 (1911) (additional statement of Mr. Hamilton Wright, American Delegate to the International Opium Commission) ("I have most reliable evidence that the crime of rape has largely been caused by the use of cocaine among the Negroes in the South in the last 10 or 15 years.").

deviance said to be associated with it.[29] As efforts to regulate, protect, or prohibit various sorts of drugs progressed during the twentieth century—the century, it might be said, of near-total drug control in policy, though certainly not in practice—five principal federal agencies emerged to regulate drugs in various areas:[30]

The Food and Drug Administration (FDA)

The FDA is the Operating Division of the U.S. Public Health Service, which resides within the U.S. Department of Health and Human Services. The FDA regulates studies of investigational new drugs and approves them for clinical use. This includes both prescription and OTC drugs. The FDA also approves controlled substance drugs and shares regulatory authority over those with the Drug Enforcement Administration.

The Drug Enforcement Administration (DEA)

This is an agency of the U.S. Department of Justice. The mission of the DEA is to enforce the controlled-substances laws and regulations of the United States and to bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States. The DEA also recommends and supports nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. The DEA is prohibited by law from interfering with medical practrice. However, DEA efforts at limitng drug availability have been alleged on numerous occasions to do just that.

The (New) Alcohol, Tobacco, Firearms and Explosives Agency (ATF) and The Alcohol and Tobacco Trade and Tax Agency (TTB)

The Bureau of Alcohol Tobacco Firearms and Explosives (ATF), an agency of the Department of Homeland Security, was created in 2003 to conduct criminal investigations into illegal trafficking of those four categories of substances. Those responsibilities were previously the purview of Bureau of Alcohol, Tobacco and Firearms (also termed the ATF) which was in the Department of the Treasury because regulation was largely through taxation. When the (new) ATF was

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[29] *See* BATTIN ET AL., *supra* note 1, at 33 ("[H]armful potentials were rarely the sole or even primary impetus behind the movement to criminalize drugs . . . .").

[30] For a more detailed discussion of each of these agencies, see *id.* at 60–67.

created, the Alcohol Tobacco Tax and Trade Bureau (TTB) was established within the Department of the Treasury to continue to regulate trade through taxation.

The Office of National Drug Control Policy (ONDCP)

This agency within the Office of the President of the United States was created to coordinate drug control policy. It is directed by the individual commonly known as the federal "Drug Czar." The efforts of the ONDCP are directed almost exclusively to policies on illicit drugs.

The rationales for these agencies have varied widely, from paternalistic concern for the vulnerability of patients and the importance of safety and efficacy of medical drugs, to quite punitive attitudes aimed at stopping drug "abuse" in recreational settings.[31] Furthermore, while the five listed above are the major agencies involved in drug-policy development, many others play a substantial role—for example, the U.S. Border Patrol and the U.S. Customs Service, both now part of the Department of Homeland Security.[32] State agencies in general mirror federal agencies with one noteworthy exception: numerous state laws decriminalizing medical marijuana despite the federal listing of the drug as a Schedule I controlled substance.

In addition to federal and state agencies regulating drug use in multiple categories, there are also nongovernmental agencies intended specifically to regulate sports-drugs use. These include:

- The World Anti-Doping Agency (WADA), established to regulate drug use by Olympic and now also other elite-class athletes
- The U. S. Anti-Doping Agency (USADA)
- Individual amateur sport regulatory bodies, e.g., Track and Field, rowing, cycling
- The collegiate sports regulatory body (National Collegiate Athletic Association (NCAA)
- Professional sports regulatory bodies (National Football League (NFL), Major League Baseball (MLB), etc.)[33]

Despite this elaborate set of regulatory agencies, some drugs remain essentially unregulated—those herbals classed as "dietary supplements"[34]—as well as any not listed in the federal schedules, nutmeg and datura stramonium, for example.[35]

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[31] *See id.* at 68–69 (examining the "Conflicting Rationales for Regulation").

[32] *See id.* at 67.

[33] *See id.* at 47–48, 67–68 (discussing the "patchwork of regulations" that have been employed to control doping in various ways).

[34] *See supra* notes 23–27 and accompanying text.

[35] *See* BATTIN ET AL., *supra* note 1, at 63 (suggesting that the side effects of using nutmeg and datura stramonium are so painful that formal regulation is unnecessary).

In exploring this patchwork of regulation, it also becomes apparent that some of the most basic notions used in the discussion of what to do about drugs—*addiction* and *harm*—are used in less than fully consistent ways in various areas of concern with drugs. What "addiction" means to the pain-management clinician treating cancer patients, for example, differs from what the psychologist working with adolescent behavioral problems and criminal activity has in mind; these differences are subtle and difficult to articulate, but they play a major role in our thinking about drugs.[36]

What "harm" means also varies from one area of drug discussion to another. Does it include reference to criminal penalties—in which case, for example, the harm of using a drug like marijuana can be quite large? Or does it refer only to physiologic function—in which case it is quite small? For some areas of drugs, benefits are foregrounded—this is common in the discussion and advertising of prescription, over-the-counter, herbal, and some common-use drugs, while attention to harms is modest, usually taking the form of mention of "side effects," while for other areas of drugs—sports-enhancement and illegal drugs, for instance, discussion typically foregrounds the harms and ignores whatever benefits these drugs may also offer. Vastly different assessments of risk also characterize the different areas within which drugs are discussed.[37]

More specific critiques of drug management and regulation can also be launched: for example, that some drugs are clearly miscategorized within the federal framework:

- Aspirin as Over The Counter (would be a prescription drug if introduced today)
- Ibogaine as a Schedule I Controlled Substance (it does have medical uses; antiaddictive properties)
- Tobacco and alcohol regulated only by age of access and circumstances of consumption (addictive and potentially lethal)
- Bufotenine as a Schedule I Controlled Substance (not psychoactive and not abusable)
- Hydrocodine in combination dosage forms as a Schedule III controlled substance while it is clearly comparable to other Schedule II opioids and should be scheduled as such

In short, the landscape of drug theory, policy, and practice is highly "siloed"—divided into differing spheres of discussion that appeal to differing underlying assumptions, that are regulated by different federal and other entities operating under quite different rationales, and that have quite different consequences for

[36] For a more detailed discussion of the potentially varied meanings of 'addiction,' see *id.* at 90–130.

[37] For a more detailed discussion of the potentially varied meanings of 'harm,' see *id.* at 131–174.

people who use drugs, from prescription medications to a social drink in the evening to illegal street drugs.

This is the circumstance we find inconsistent, incoherent and disturbing—and to which this collection is addressed.

THE HARMFUL SIDE EFFECTS OF DRUG PROHIBITION

Randy E. Barnett*

I. INTRODUCTION: CURING THE DRUG LAW ADDICTION

Some drugs make people feel good. That is why some people use them. Some of these drugs are alleged to have side effects so destructive that many advise against their use. The same may be said about statutes that attempt to prohibit the manufacture, sale, and use of drugs. Advocating drug prohibition makes some people feel good because they think they are "doing something" about what they believe to be a serious social problem. Others who support these laws are not so altruistically motivated. Employees of law enforcement bureaus and academics who receive government grants to study drug use, for example, may gain financially from drug prohibition. But as with using drugs, using drug laws can have moral and practical side effects so destructive that they argue against ever using legal institutions in this manner.

One might even say—and not altogether metaphorically—that some people become psychologically or economically *addicted* to drug laws.[1] That is, some people continue to support these statutes despite the massive and unavoidable ill

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 This article revises and updates Randy E. Barnett, *Curing the Drug Law Addiction: The Harmful Side-Effects of Legal Prohibition, in* DEALING WITH DRUGS (Ronald Hamowy ed., 1987). My thanks to Professor Erik Luna for his interest in seeing that this article receive a wider audience and to the editors of the Utah Law Review for helping to update it.

[1] For those who would object to my use of the word *addiction* here because drug laws cause no physiological dependence, it should be pointed out that, for example, the Illinois statute specifying the criteria to be used to pass upon the legality of a drug nowhere requires that a drug be physiologically addictive. The tendency to induce physiological dependence is just one factor to be used to assess the legality of a drug. Drugs with an accepted medical use may be controlled if they have a potential for abuse, and abuse will lead to "psychological *or* physiological dependence." 720 ILL. COMP. STAT. 570/205 (2006) (emphasis added); *see also id.* §§ 570/207, 570/209, 570/211. Thus, applying the same standard to drug-law users as they apply to drug users permits us to characterize them as addicts if they are psychologically "dependent" on such laws. Personally, I would favor limiting the use of the term addiction to physiological dependence. As John Kaplan put the matter, "while the concept of addiction is relatively specific and subject to careful definition, the concept of psychological dependence, or habituation, often merely reflects the common sense observation that people who like a drug will continue to use it if they can—so long as they continue to like it: effects." JOHN KAPLAN, MARIJUANA: THE NEW PROHIBITION 160 (1970). The same might be said about those who like drug laws.

effects that result.[2] The psychologically addicted ignore these harms so that they can attain the "good"—their "high"—they perceive that drug laws produce. Other drug-law users ignore the costs of prohibition because of their "economic" dependence on drug laws; these people profit financially from drug laws and are unwilling to undergo the economic "withdrawal" that would be caused by their repeal.[3]

Both kinds of drug-law addicts may deny their addiction by asserting that the side effects are not really so terrible or that they can be kept "under control." The economically dependent drug-law users may also deny their addiction by asserting that (1) noble motivations, rather than economic gain, lead them to support these statutes; (2) they are not unwilling to withstand the painful financial readjustment that ending prohibition would force them to undergo; and (3) they can "quit" their support any time they want to—provided, of course, that they are rationally convinced of its wrongness.

Their denials notwithstanding, both kinds of addicts are detectable by their adamant resistance to rational persuasion. While they eagerly await and devour any new evidence of the destructiveness of drug use, they are almost completely uninterested in any practical or theoretical knowledge of the ill effects of illegalizing such conduct.[4] Yet in a free society governed by democratic principles, these addicts cannot be compelled to give up their desire to control the consumption patterns of others. Nor can they be forced to support legalization in spite of their desires. In a democratic system, they may voice and vote their opinions about such matters no matter how destructive the consequences of their desires are to themselves or, more importantly, to others. Only rational persuasion may be employed to wean them from this habit. As part of this process of persuasion, drug-law addicts must be exposed to the destruction their addiction wreaks on drug users, law enforcement, and on the general public. They must be made to understand the inherent limits of using law to accomplish social objectives.

This Article will not attempt to identify and "weigh" the costs of drug use against the costs of drug laws. Instead, it will focus exclusively on identifying the harmful side effects of drug law enforcement and showing why these effects are unavoidable. So one-sided a treatment is justified for two reasons. First, a cost-

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[2] *See* David C. Leven, *Our Drug Laws Have Failed–So Where Is the Desperately Needed Meaningful Reform?*, 28 FORDHAM URB. L.J. 293, 305–06 (2000) (stating that many people still support the current drug laws).

[3] *See* David R. Henderson, *A Humane Economist's Case For Drug Legalization*, 24 U.C. DAVIS L. REV. 655, 662 (1991) (noting that some scholars argue that illegality is more profitable).

[4] *See* James Ostrowski, *The Moral & Practical Case for Drug Legalization*, 18 HOFSTRA L.REV. 607, 647–50 (1990) (many proponents of drug laws mischaracterize their effects to gain support).

benefit or cost-cost analysis may simply be impossible.[5] Second, discussions by persons who support illegalizing drugs usually emphasize only the harmful effects of drug use while largely ignoring the serious costs of such policies. By exclusively relating the other side of the story, this Article is intended to inject some balance into the normal debate.

The harmful side-effects of drug laws have long been noted by a number of commentators, although among the general public the facts are not as well known as they should be.[6] More importantly, even people who agree about the facts fail to grasp that it is the nature of the means—coercion—chosen to pursue the suppression of voluntary consumptive activity that makes these effects unavoidable. This vital and overlooked connection is the main subject of this Article.

II. CLARIFYING OUR TERMS

The inherently destructive effects of drug laws, results from the combination of two aspects of drug prohibition that need to be distinguished. The first is the coercive nature of the means being used. The second is the type of conduct being coerced. Only by understanding the kind of conduct that is the subject of drug laws and how it differs from other kinds of conduct regulated by law can we begin to see why legal coercion is an inappropriate means in which to pursue our objectives.

Drug laws reflect the decision of some persons that other persons who wish to consume certain substances should not be permitted to act on their preferences. Nor should anyone be permitted to satisfy the desires of drug consumers by making and selling the prohibited drug. For the purposes of this discussion, the most important characteristic of the legal approach to drug use is that these consumptive and commercial activities are being regulated by *force*.[7] Drug-*law*

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[5] *See* Randy E. Barnett, *Pursuing Justice in a Free Society: Part One–Power vs. Liberty*, 4 CRIM.L JUST. ETHICS 50, 63–65 (1985) (discussing some of the problems with efforts at cost benefit calculation).

[6] While there certainly is no consensus on the conclusions that ought to be drawn from the facts of this tragic story, the facts themselves are not unknown in law enforcement or in academia. *See, e.g.*, ARTHUR D. HELLMAN, LAWS AGAINST MARIJUANA: THE PRICE WE PAY 16 (1975) (describing the costs and benefits of drug laws); JOHN KAPLAN, THE HARDEST DRUG: HEROIN AND PUBLIC POLICY 94–100 (1983) (noting the problems that would be remedied by free availability); Glenn Garvin et al., *Heroin: Should it be Legal—Advocates are few but Persuasive*, WASH. TIMES, Sept. 28, 1984, at A1; Alan L. Otten, *Dealing With Drugs–The Drug Trade: Experts in the Field of Narcotics Debate Ways to Curb Abuse–One Side Touts Legalization, Other Wants Crackdown; Probably Neither Is Right–Corporate Attitudes Change*, WALL ST. J., Nov. 29, 1984, at 1; Megan Cox, *Dealing With Drugs–The Drug Trade: Abuse of Narcotics in US is by No Means A Recent Phenomenon—In the 1800s Doctors' Praise of Opium and Morphine Caused Much Addiction–Cocaine for the Common Cold*, WALL ST. J., Dec. 3, 1984, at 1.

[7] While force is a neglected element of a proper moral evaluation of law, it may not be a *necessary* characteristic of law. Some institutions that may be characterized as

users wish to decide what substances others may consume and sell, and they want their decision to be imposed on others by force. The forcible aspect of the legal approach to drug use is one of two factors that combine to create the serious side effects of drug-law use. The other contributing factor is the nature of the conduct that drug laws attempt to prohibit.

No one claims that the conduct sought to be prohibited is of a sort that, if properly conducted, inevitably causes death or even great bodily harm.[8] Smoking tobacco is bad for your health. It may shorten your life considerably. But it does not immediately or invariably kill you. The same is true of smoking marijuana.[9] Of course, prohibited drugs can be improperly administered and cause great harm indeed, but even aspirin can be harmful in certain cases. Further, the conduct that drug laws prohibit is not inevitably addicting.[10] Some users become psychologically or physically dependent on prohibited substances. Others do not.[11]

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genuinely legal in nature may do their work without using force. *See, e.g.*, LON L. FULLER, THE MORALITY OF LAW 108–10 (1965). What is important here is that the particular kind of law advocated by drug control enthusiasts is that kind that *does* involve the use of force. Therefore, in this chapter I will be using the term "law" in this limited sense, and although I will not repeatedly qualify this use in the manner suggested by Fuller's analysis, such a limited use is intended and should be implied. *See* Dale A. Nance, *Legal Theory and the Pivotal Role of the Concept of Coercion*, 57 U. COLO. L. REV. 1, 2–3 (1985) (discussing the role of coercion in legal theory).

[8] Like the federal government, the State of Illinois classifies or "schedules" controlled substances according to their varying characteristics from most serious (Schedule I) to least serious (Schedule V). That drugs can cause death or great bodily harm is not a requirement for prohibition. For drugs under schedules 11-V, potential for causing death or great bodily harm is not even a factor to be considered in determining the classification of a controlled substance. *See* 720 ILL. COMP. STAT. ANN. 570/201–212 (West 2003 & Supp. 2008). Schedule I drugs are those drugs that have a "high potential for abuse" and have "no currently accepted medical use in treatment in the United States *or* lack[] accepted safety for use in treatment under medical supervision." 720 ILL. COMP. STAT. ANN. 570/203 (emphasis added). In other words, if a drug has no accepted medical use in treatment in the United States, all that is required for it to be scheduled is that it have a "high potential for abuse." *Id.*

[9] In discussing the effects of marijuana, the legislative declaration of the Cannabis Control Act of the State of Illinois states only that "the current state of scientific and medical knowledge concerning the effects of cannabis makes it necessary to acknowledge the physical, psychological and sociological damage which is incumbent upon its use." 720 ILL. COMP. STAT. ANN. 550/1. *But see, e.g.*, Munir A. Khan, Assad Abbas, and Knud Jensen, *Cannabis Usage in Pakistan: A Pilot Study of Long Term Effects on Social Status and Physical Health*, *in* CANNABIS AND CULTURE 349–50 (Vera Rubin, ed., 1975) ("The most significant point which emerged was that in a society such as Pakistan where cannabis consumption is socially accepted, habituation does not lead to any undesirable results. . . . Our study appears to show that cannabis does not produce any serious long-term effects.").

[10] "[C]ultural and social factors . . . in combination with the individual's somatic and psychic characteristics, determine the pattern of his drug behavior once he has chosen to experiment with it. The majority of individuals who reach this point progress no further and often discontinue marihuana use." NATIONAL COMMISSION ON MARIJUANA AND DRUG

What then characterizes the conduct being prohibited by statutes illegalizing drugs? It is conduct where persons either introduce certain intoxicating substances into their own bodies, or manufacture or sell these substances to those who wish to use them.[12] The prime motivation for the drug user's behavior is to alter his state of mind to get "high."[13] The harmful effects of the substances are not normally the effects being sought by the user; thus they are usually termed "*side* effects." People could introduce all sorts of harmful substances into their bodies, but do not generally do so unless they think that it will have a mind-altering effect. Anyone who wishes to ingest substances to cause death or great bodily harm will always have a vast array of choices available to him at the corner hardware store. A widespread black market in poisons has not developed to meet any such demand.

One can speculate about the underlying psyche of those who would engage in such risky behavior. One can argue that such persons must be "self-destructive"—that is, out to harm themselves in some way. It is doubtful, however, that such generalizations are any truer for drug users than they are for alcohol users or cigarette smokers, for whom the adverse health effects may be both more likely and more severe than those of many prohibited substances,[14] or for skydivers,

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ABUSE, MARIHUANA: A SIGNAL OF MISUNDERSTANDING 44 (1972); *see also* PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND THE ADMINISTRATION OF JUSTICE, THE CHALLENGE OF CRIME IN A FREE SOCIETY 13 (1967) ("Physical dependence does not develop"); Khan, Abbas, and Jensen, *supra* note 9, at 349 ("We have deliberately used the word habituation rather than addiction because we did not find either increased tolerance or withdrawal symptomatology, which are the essential prerequisites for addiction"); Kaplan, *supra* note 1, at 157–69 (arguing that there is little evidence to prove marijuana causes a physical dependence).

The Illinois statute prohibiting certain substances exemplifies the fact that drug laws are not aimed exclusively at addictive drugs. The criteria of Schedule I drugs, quoted *supra* note 8, requires only that the substance have a high potential for abuse. The other schedules make it clear that "abuse" is not the same as potential for "psychological or physiological dependence," by consistently listing them as separate factors that must be found before a drug that does have a legitimate medical usage in the United States may be legally controlled. *See* 720 ILL. COMP. STAT. ANN. 570/201–212 (West 2003 & Supp. 2008).

[11] For a summary of research on the pharmacology of opiates and their effects on the street user, see KAPLAN, *supra* note 6, 5–22.

[12] *See supra* note 8.

[13] One objection to the definition offered in the text for the subject of drug laws is that it would apply to alcohol and caffeine consumption and for this reason must miss some special purpose of drug laws. On the contrary, the manufacture and sale of alcohol were once made illegal for similar reasons. Only the disastrous consequences that resulted from alcohol prohibition and the social acceptability of both alcohol and coffee have kept both substances legal to date. Moreover, at least with alcohol, regulation and even prohibition is constantly being advocated by some and implemented in certain locales.

[14] *See* John C. Ball & John Chapman Urbaitis, *Absence of Major Medical Complications Among Chronic Opiate Addicts*, *in* THE EPIDEMIOLOGY OF OPIATE ADDICTION IN THE UNITED STATES 301, 304–06 (1970); World Health Org. Special Comm., *Problems Related to Alcohol Consumption: The Changing Situation*, 9 CONTEMP. DRUG PROBS. 185, 194–98 (1980). Since the much heralded appearance of the U.S. DEP'T

skiers, or bicyclers on city streets—not to mention the millions of people who refuse to wear their seat belts.

We can conclude then that the *end* or purpose of drug laws is to discourage people from engaging in risky activity in which they wish to engage either because they desire the intoxicating effects they associate with the consumption of a drug or because they desire the profit that can be realized by supplying intoxicating drugs to others.[15] The *means* that drug laws employ to accomplish this end is using force against those who would engage in such activities, either to prevent them from doing so or to punish those who nonetheless succeed in doing so.

With this understanding of means and ends, I now explain why using force against people who wish to use intoxicants *inevitably* harms them, harms the general public, and harms the legal system.

III. THE HARMFUL EFFECTS OF DRUG LAWS ON DRUG USERS

At least part[16] of the motivation for drug prohibition is that drug use is thought to harm those who engage in it.[17] A perceived benefit of drug prohibition is that fewer people will engage in self-harming conduct than would in the absence of prohibition.[18] While the contention that drug use can be harmful will not be

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OF HEALTH, EDUC., AND WELFARE, REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE, SMOKING AND HEALTH, PUBLIC HEALTH SERVICE PUB. NO. 1103 (Jan. 11, 1964), the adverse health effects of tobacco smoking have been much studied and are quite well known.

[15] *See infra* notes 19–21 and accompanying text (discussing the typical policy rationales used to justify drug laws that prohibited perceived self-harming conduct).

[16] The other important motivation for drug prohibition is the perceived effects of drug use on the rest of society. *See infra* note 18 (Illinois legislature declaring its belief that drug consumption creates "consequences upon every element of society"). For a discussion on the countervailing costs imposed on society by drug laws will also be discussed, *see infra* Section IV.

[17] In its legislative declaration, the legislature of the State of Illinois expressed this typical sentiment:

> The abuse and misuse of alcohol and other drugs constitutes a serious public health problem the effects of which on public safety and the criminal justice system cause serious social and economic losses, as well as great human suffering. It is imperative that a comprehensive and coordinated strategy be developed . . . to empower individuals and communities through local prevention efforts and to provide intervention, treatment, rehabilitation and other services to those who misuse alcohol or other drugs (and, when appropriate, the families of those persons) to lead healthy and drug-free lives and become productive citizens in the community.

20 ILL. COMP. STAT. 301/1-5 (2009).

[18] *See* 720 ILL. COMP. STAT. 570/100 (1998) ("It is the intent of the General Assembly, recognizing the rising incidence in the abuse of drugs and other dangerous

disputed here, there is another dimension of the issue of harm to drug users that may seem obvious to most when pointed out, but nonetheless is generally ignored in policy discussions of drug prohibition. Much of the harms associated with drug use is caused not by intoxicating drugs, but by the fact that such drugs are illegal.

A. Drug Laws Punish Users

The most obvious harm to drug users caused by drug laws is the legal and physical jeopardy in which they are placed. Imprisonment must generally be considered a harm to the person imprisoned or it would hardly be an effective deterrent.[19] To deter certain conduct it is advocated that we punish—in the sense of forcibly inflict unpleasantness upon—those who engage in this conduct.[20] In so doing it is hoped that people will be discouraged from engaging in the prohibited conduct.

But what about those who are not discouraged and who engage in such conduct anyway? Does the practice of punishing these persons make life better or worse for them? The answer is clear. As harmful as using drugs may be to someone, being imprisoned often makes matters much worse.

Normally when considering matters of legality, we are not concerned about whether a law punishes a lawbreaker and makes him worse off. Indeed, normally such punishment is deliberately imposed on the lawbreaker to protect *someone else* who we consider to be completely innocent—like the victim, or potential victim, of a rape, robbery, or murder.[21] We are therefore quite willing to harm the lawbreaker to protect the innocent. In other words, the objects of these laws are the victims; the subjects of these laws are the criminal.

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substances and its resultant damage to the peace, health, and welfare of the citizens of Illinois, to provide a system of control over the distribution and use of controlled substances which will more effectively: . . . (2) deter the unlawful and destructive abuse of controlled substances; (3) penalize most heavily the illicit traffickers and profiteers of controlled substances, who propagate and perpetuate the abuse of such substances with reckless disregard for its consumptive consequences upon every element of society.").

[19] Imagine if we told people that if we caught them using drugs, we would send them to the Riviera for a few years, all expenses paid.

[20] *See* Stanley I. Benn, *Punishment*, *in* 7 THE ENCYCLOPEDIA OF PHILOSOPHY 29, 29 (Paul Edwards ed., Reprint ed. 1972) ("Characteristically, punishment is unpleasant. It is inflicted on an offender because of an offense he has committed; it is deliberately imposed, not just the natural consequence of a person's action (like a hang-over), and the unpleasantness is essential to it, not an accidental accompaniment to some other treatment (like the pain of a dentist's drill).").

[21] Punishment is also favored on the grounds that the lawbreaker deserves to be punished. *See, e.g.*, John Hospers, *Retribution: The Ethics of Punishment*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION, AND THE LEGAL PROCESS 181, 181–209 (Randy E. Barnett & John Hagel III eds., 1977) (discussing criminal punishment under the retributive theory). *But see* Walter Kaufmann, *Retribution and the Ethics of Punishment*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION, AND THE LEGAL PROCESS 211, 211–30 (Randy E. Barnett & John Hagel III eds., 1977).

Drug laws are different in this respect from many other criminal laws. With drug prohibition we are supposed to be concerned with the well-being of prospective drug users. So the object of drug laws—the persons whom drug laws are supposed to "protect"—are often the same persons who are the subject of drug laws. Whenever the object of a law is also its subject, however, a problem arises. The means chosen for benefiting prospective drug users seriously harms those who still use drugs and does so in ways that drugs alone cannot: by punishing drug users over and above the harmful effects of drug use. But the harm done by drug prohibition to drug users goes beyond the direct effects of punishment.

B. Drug Laws Raise the Price of Drugs to Users

Illegalization makes the prices of drugs rise.[22] By increasing scarcity, all else being equal, the confiscation and destruction of drugs causes the price of the prohibited good to rise. And by increasing the risk to those who manufacture and sell, drug laws raise the cost of production and distribution, necessitating higher prices that reflect a "risk premium."[23] Like the threat of punishment, higher prices may very well discourage some from using drugs who would otherwise do so. This is, in fact, a principal rationale for interdiction policies.[24] But higher prices take their toll on those who are not deterred, and these adverse effects are rarely emphasized in discussions of drug laws.

Higher prices require higher income by users. If users cannot earn enough by legal means to pay higher prices, then they may be induced to engage in illegal conduct—theft, burglary, robbery—in which they would not otherwise engage.[25] The increased harm caused to the victims of these crimes will be discussed below as a cost inflicted by drug laws on the general public. Relevant here is the adverse effect drug laws have on the life of drug users. By raising the costs of drugs, drug laws breed criminality.[26] They induce some drug users who would not otherwise

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[22] Morgan Cloud, *Cocaine, Demand, and Addiction; A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 757 (1989).

[23] *Id.* Price increases will not incur indefinitely, however, because at some level higher prices will induce more production.

[24] Ian D. Midgley, *Just One Question Before We Get to Ohio v. Robinette: "Are You Carrying any Contraband . . . Weapons, Drugs, Constitutional Protections . . . Anything Like That?"*, 48 CASE W. RES. L. REV. 173, 212 (1997).

[25] The traditional linkage between drug use and crime can be accounted for in three ways. First, as suggested in the text, the higher prices caused by illegality induce many drug users to commit profitable crimes to pay for the drugs. Second, criminalization of drug users can force them out of legitimate employment and into criminal employment. *See infra* notes 33-34 and accompanying text. Third, not mentioned in the text, some persons who, for whatever reason, are criminally inclined may be just the sort of persons who are also inclined to use drugs. However, even if the third account is true for some (which it undoubtedly is), the first and second will be true for others; meaning drug laws are causing a comparative increase in the number of persons who are criminally inclined—an effect of drug laws that hardly benefits those drug users so affected.

[26] *See supra* note 25.

have contemplated criminal conduct to develop into the kind of people who are willing to commit crimes against others.

Higher prices can also make drug use more hazardous for users.[27] Intravenous injection, for example, is more popular in countries where high drug prices caused by prohibition drive users to the most "efficient" means of ingesting the drug. In countries where opiates are legal, the principal methods of consumption are inhaling the fumes of heated drugs or snorting. [28] Before the Harrison Act of 1914, "when opiates were cheap and plentiful, they were very rarely injected. Moreover, injection is rare in those Asian countries where opiates are inexpensive and easily available."[29] While physical dependence may result from either inhalation or snorting, neither is as likely as intravenous injections to result in an overdose.[30] And consumption by injection can cause other health problems as well. For example: "Heroin use causes hepatitis only if injected, and causes collapsed veins and embolisms only if injected intravenously."[31] Finally, the scourge of HIV-AIDS has been caused, in part, by the sharing of unsterilized needles by drug users. [32]

C. Drug Laws Make Drug Users Buy from Criminals

Drug laws attempt to prohibit the use of substances that some people wish to consume. Thus because the legal sale of drugs is prohibited, people who still wish to use drugs are forced to do business with the kind of people who are willing to make and sell drugs in spite of the risk of punishment. Such transactions must deliberately be conducted away from the police. This puts drug users in great danger of physical harm in two ways.

First, users are forced to rely upon criminals to regulate the quality and strength of the drugs they buy. No matter how carefully they measure their dosages, an unexpectedly potent supply may result in an overdose. And if the drug

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[27] *See* KAPLAN, *supra* note 6, at 128.

[28] *See id.* ("For instance, in Hong Kong until recently, heroin, though illegal, was cheap and relatively available, and the drug was inhaled in smoke rather than injected. In the last few years, however, law enforcement has been able to exert pressure on the supply of the drug, raising its price considerably and resulting in a significant increase in the use of injection.")(footnote omitted).

[29] *Id.*

[30] Shane Darke & Wayne Hall, *Heroin Overdose: Research and Evidence-Based Intervention*, 80 J. URBAN HEALTH, 189, 195 (2003).

[31] JOHN KAPLAN, *supra* note 6, at 9 (citing Jerome H. Jaffe, *Drug Addiction and Drug Abuse*, *in* GOODMAN AND GILMAN'S: THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 535, 546 (Alfred Goodman Gilman et al., eds., 6th ed. 1980)). Kaplan argues that intravenous injection can also increase dependence by producing strong conditioning effects. *See id.* at 44 (citing Travis Thompson & Roy Pickens, *Drug Self-Administration and Conditioning*, *in* SCIENTIFIC BASIS OF DRUG DEPENDENCE 177, 177–98 (Hannah Steinberg, ed., 1969)).

[32] Robert W. Stewart, *Increase Urged in Government AIDS Effort*, L.A. TIMES, Feb. 17, 1987, at 3.

user is suspected to be a police informant, the dosage may deliberately be made potent by the supplier.

Second, users are likely to be the victims of crime. I would estimate that approximately half the murder cases I prosecuted as an Assistant States Attorney in Cook County, Illinois were "drug related" in the sense that the victim was killed because it was thought he had either drugs or money from the sale of drugs. Crimes are also committed against persons who seek out criminals from whom to purchase prohibited drugs. Because drug users and dealers want to avoid the police, crimes against these groups are unlikely to be reported.[33] As a result, these crimes are likely brought to the attention of the authorities only when a victim's body is found.

In 1979, I obtained the confessions that were ultimately used in a prosecution involving the savage murder of three young men. [34] One of the three had approached four members of the Latin Kings to purchase marijuana. When his initial attempt to do business with the gang members was rebuffed, he mistakenly believed that this was due to a lack of trust—rather than a lack of marijuana, which was the case. To ingratiate himself with the gang members, he boasted (falsely) about his gang-affiliated friends and his gang membership. Unfortunately the persons he named were members of a rival street gang, the Latin Eagles. The gang members then told him that they could supply marijuana after all and asked the three to accompany them to an alley. There they were held at gun point and eventually stabbed to death. These young men were not members of any street gang. These are drug-*law*-related deaths. Three young men are dead because drug laws prevented them from buying marijuana cigarettes as safely as they could buy tobacco cigarettes. While smoking either kind of cigarette may have been hazardous to their health, that issue is now moot. Where and how are their deaths registered in the cost-benefit calculation of drug-law advocates?

D. Drug Laws Induce the Invention of New Intoxicating Drugs

Drug laws make some comparatively benign intoxicating drugs—like opiates—artificially scarce and thereby create a powerful black market incentive for clandestine chemists to develop alternative "synthetic" drugs that can be made more cheaply and with less risk of detection by law enforcement.[35] The hallucinogen, phencyclidine hydrochloride—or "PCP"—is one drug that went from industrial to recreational usage in by this route.[36] Some of these substitute

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[33] *See* Margaret P. Spencer, *Sentencing Drug Offenders: The Incarceration Addiction*, 40 VILL. L. REV. 335, 342 (1995).

[34] *See* People v. Caballero, 464 N.E.2d 223, 225 (Ill. 1984) (relating the factual details of the case).

[35] *See* Marissa A. Miller, *History and Epidemiology of Amphetamine Abuse in the United States*, *in* AMPHETAMINE MISUSE: INTERNATIONAL PERSPECTIVES ON CURRENT TRENDS 113–117 (Hilary Klee ed., 1997).

[36] Although originally developed by Parke-Davis, "[t]he PCP that is now on the streets is illegally manufactured. Unfortunately, it is very easy and very inexpensive to

drugs may turn out to be far more dangerous than the substances they replace, both to the user and to others.[37]

E. Drug Laws Criminalize Users

Prohibition automatically makes drug users into "criminals." While this point would seem too obvious to merit discussion, the effects of criminalization can be subtle and hidden. Criminalized drug users may not be able to obtain legitimate employment. This increases still further the likelihood that the artificially high prices of illicit drugs will lead drug users to engage in criminal conduct to obtain income. It is difficult to overestimate the harm caused by forcing drug users into a life of crime. Once this threshold is crossed, there is often no return. Such a choice would not be nearly so compelling, nor as necessary, if prohibited substances were legally available and reasonably priced.

Further, criminalization increases the hold that law enforcement agents have on drug users. This hold permits law enforcement agents to extort illegal payments from users or to coerce them into serving as informants who must necessarily engage in risky activity against others.[38] Thus, prohibition both motivates and enables the police to inflict harm on drug users in ways that would be impossible in the absence of the legal leverage provided by drug laws.

In all these ways, drug laws harm users of drugs well beyond any harm caused by drug use itself, and this extra harm is an inescapable consequence of using legal coercion as means to prevent people from engaging in activity they deem desirable. While law enforcement efforts typically cause harm to criminals who victimize others, such effects are far more problematic with laws that seriously harm the very people for whom these laws are enacted to help. Support for drug laws in the face of these harms is akin to saying that we have to punish, criminalize, poison, rob, and murder drug users to save them from the harmful consequences of using intoxicating drugs.

To avoid these consequences, some have proposed abolishing laws against personal use of certain drugs, while continuing to ban the manufacture and sale of these substances.[39] However, only the first and last of the five adverse consequences just discussed result directly from punishing and criminalizing users. The other three harms to the user result indirectly from punishing those who

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make, and you don't even need a chemistry background." OAKLEY RAY, DRUGS, SOCIETY, & HUMAN BEHAVIOR 414 (3d ed. 1983).

[37] Because of the "reefer madness" phenomenon that surrounds early reports of the ill-effects of drug use, such reports should be heavily discounted until time permits more objective researchers to do more extensive studies.

[38] *See, e.g.*, DOUGLAS HUSAK, LEGALIZE THIS! THE CASE FOR DECRIMINALIZING DRUGS 149 (2002) (discussing the causal link between drug activity and corruption); ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES 120 (2001) (describing police behavior toward informants).

[39] *See, e.g.*, KAPLAN, *supra* note 6, at 189–235 (1983), for such a proposal concerning heroin.

manufacture and sell drugs. Decriminalizing the use of drugs would undoubtedly be an improvement over the status quo, but the remaining restrictions on manufacturing and sale would continue to cause serious problems for drug users beyond the problems caused by drug use itself.

As long as coercion is used to reduce drug use, these harms are unavoidable. They are caused by (1) the use of force to inflict pain on users, thereby directly harming them; and (2) the dangerous and criminalizing black market in drugs that results from efforts to stop some from making and selling a product others genuinely wish to consume. There is nothing that more enlightened law enforcement personnel or a more efficient administrative apparatus can do to prevent these effects from occurring. But, as the next section reveals, enlightened law enforcement personnel or an efficient administrative apparatus are not what results from employing legal force to prevent adults from engaging in consensual activity.

IV. THE HARMFUL EFFECTS OF DRUG LAWS ON THE GENERAL PUBLIC

The harmful side effects of drug laws are not limited to drug users. This section highlights the various harms that drug laws inflict on the general public. There is an old saying in the criminal courts that is particularly apt here: "What goes around, comes around." In an effort to inflict pain on drug users, drug laws inflict considerable costs on nonusers as well.

A. Resources Spent on Drug Law Enforcement

The most obvious cost of drug prohibition is the expenditure of scarce resources to enforce drug laws—resources that can thus not be used to enforce other laws or be allocated to other productive activities outside of law enforcement. Every dollar spent to punish a drug user or seller is a dollar that cannot be spent collecting restitution from a robber. Every hour spent investigating a drug user or seller is an hour that could have been used to find a missing child. Every trial held to prosecute a drug user or seller is court time that could be used to prosecute a rapist in a case that might otherwise have been plea bargained. These and countless other expenditures are the "opportunity costs" of drug prohibition.

B. Increased Crime

By artificially raising the price of illicit drugs and thereby forcing drug users to obtain large sums of money, drug laws create powerful incentives to commit property and other profitable crimes. And the interaction between drug users and criminally-inclined drug sellers presents users with many opportunities to become involved in all types of illegal conduct apart from the drug trade.

Finally, usually neglected in discussions of drugs and crime are the numerous "drug-related" robberies and murders (sometimes of innocent parties wrongly thought to have drugs) created by the constant interaction between users and

criminal sellers.[40] Drug dealers and buyers are known to carry significant quantities of either cash or valuable substances.[41] They must deliberately operate outside the vision of the police. They can rely only on self-help for personal protection.

Many drug-law users speculate quite freely about the intangible "adverse effects of drug use on a society."[42] They are strangely silent, however, about how the fabric of society is affected by the increase in both property crimes and crimes of violence caused by drug laws.[43]

C. Harms Resulting from the "Victimless" Character of Drug Use

The most overlooked and well-hidden harms to the general public caused by drug prohibition may also be the most serious. These are harms that result from efforts to legally prohibit activity that is "victimless." It was once commonplace to call drug consumption victimless, but not anymore. Therefore, before proceeding, it is very important to explain carefully the very limited concept of "victimless" crime that will be employed in this section.

To appreciate the hidden costs of drug law enforcement, it is not necessary to claim that the sale and use of drugs are "victimless" in the *moral* sense—that is, to claim that such activity harms only consenting parties and therefore that it violates no one's rights and may not justly be prohibited.[44] For this limited purpose it is not necessary to question the contentions that drug users and sellers "harm society" or that drug use violates "the rights of society."[45]

Nevertheless, to understand the hidden costs of drug laws, it is vitally important to note that drug laws attempt to prohibit conduct that is "victimless" in a strictly nonmoral or *descriptive* sense: there is no victim to complain to the police and to testify at trial.

1. The Incentives Created by Crimes without Victims

When a person is robbed, the crime is usually reported to the police by the victim. When the robber is caught, the victim is the principal witness in any trial that might be held. As a practical matter, if the crime is never reported, there will normally not be a prosecution because the police will never pursue and catch the

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[40] *See* THE ROYAL COLLEGE OF PHYSICIANS, DRUGS: DILEMMAS AND CHOICES 93–95 (2000).

[41] *See* Chris Wilkins, *Cannabis Transactions and Law Reform*, 8 AGENDA 321, 328 (2001).

[42] *See* THE ROYAL COLLEGE OF PHYSICIANS, *supra* note 40, at 83–94.

[43] *See id.* at 88–89.

[44] I will discuss later the issue of whether drug laws are just. *See infra* Part V.

[45] *See, e.g.*, William F. McDonald, *The Role of the Victim in America*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION AND THE LEGAL PROCESS 295 (Randy E. Barnett & John Hagel III eds., 1977) (discussing the history of social attitudes toward crime and asserting that today "[c]rime is regarded as an offense against the state").

robber. From the perspective of the legal system, it will be as though the robbery never took place. So too, if the victim refuses to cooperate with the prosecution after a suspect has been charged, the prosecution of the robber will usually not go forward.[46] What special law enforcement problems result from an attempt to prosecute crimes in the absence of a "complaining witness" who will assist law enforcement officials?

To answer this question, let us imagine that robbery—a crime that undoubtedly has a victim[47]—was instead a "victimless" crime in this very limited sense, and that the police set out to catch, and prosecutors to prosecute, all robbers whose victims refused to report the crime to the police and cooperate with the prosecution. How would the police detect the fact that a crime had occurred? How would they go about identifying and proving who did it? How would the case be prosecuted?

To detect unreported crimes, the police would have to embark on a program of systematic surveillance. Because they could not simply respond to a robbery victim's complaint as they do at present, the police would have to be watching everywhere and always. Robberies perpetrated in public places—on public streets or transportation, in public alleys or public parks—might be detected with the aid of sophisticated surveillance equipment located in these spaces. Those robberies committed in private places—homes and stores would require even more intrusive practices.

If the police did detect a robbery, they would be the principal witnesses against the defendant at trial. It would be their word against that of the alleged robber. As a practical matter, it would be within their discretion to go forward with the prosecution or not. There would be no victim pressing them to pursue prosecution and potentially questioning any decision they might make to drop the charges or withhold a criminal complaint.

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[46] *See* Maria T. Lopez & Carol M. Bast, *The Difficulties in Prosecuting Stalking Cases*, 41 NO. 1 CRIM. L. BULLETIN 2 (2009) (discussing a prosecutor's option "to either drop the case or continue the case even with a low probability of success" when an uncooperative victim's testimony is the only evidence); Marc C. Miller & Ronald F. Wright, *The Black Box*, 94 IOWA L. REV. 125, 146 (2008) (discussing the "proof problem" presented to prosecutors when victims of alleged crimes refuse to cooperate). To enforce his decision of noncooperation, the victim always has available the threat of unhelpful testimony at trial. "I don't remember if that is the man who robbed me" is all the victim need say to end the case—and (notwithstanding the theoretical availability of perjury charges) prosecutors know this.

[47] *See* Guyora Binder, *The Culpability of Felony Murder*, 83 NOTRE DAME L. REV. 965, 1038 (2008) (discussing robbery victims). I have chosen robbery as my example because I wish in this section to separate the issue of who is affected by a crime (who is and who is not a "victim" in this sense) from the issue of how certain crimes must be enforced in the absence of a cognizable victim-witness complainant. Robberies undoubtedly "affect" the persons who are robbed, and other persons as well. But notwithstanding these effects, if robberies were "victimless" in the sense used in the text—that is, if there was no victim complaining to the police and testifying at trial—certain unavoidable enforcement problems would develop.

We can easily imagine the probable results of such a policy of victimless robbery enforcement. To the extent that they were doing their job and that money permitted, the police would be omnipresent. One could not do or say anything in public without the chance that police agencies would be watching and recording. The enormous interference with individual liberty that such surveillance would cause is quite obvious. And putting robbery prosecutions entirely in the hands of the police would create lucrative new opportunities for corruption in at least two ways, depending on whether a crime had or had not in fact occurred.

When a crime had occurred, if the effective decision of whether or not to prosecute is solely in the hands of the police, police officers would be far more able to overlook a criminal act than they are when a cognizable victim exists. As a result, the opportunities for extortion of bribes and the incentives for robbery suspects to offer bribes are both tremendously increased.[48] When a crime had not occurred, the fact that the courts would be accustomed to relying solely on police testimony in such cases would give the police a greater opportunity to fabricate, or threaten to fabricate, cases to punish individuals they do not like, to coerce someone into becoming an informant, or to extort money from those they think will pay it.

All of the increased opportunity for corruption would result directly from an attempt to prosecute robberies when robbery victims do not come forward to report and prosecute the crime themselves. If robbery were victimless in this descriptive sense, the natural counterweight to these corrupt practices—the potential outrage of the victim of the robbery and the normal reliance by courts on victim testimony—would be absent.

Of course we know that this is not how robbery victims normally behave. Victims do routinely report instances of robbery, creating a case that the police department must "clear" in some way. And they are usually willing to cooperate with the prosecution, giving the police far less ability to influence the success of a given prosecution. Where a victim exists, the problem of corruption is enormously reduced; this is true even for the crime of murder where, in the absence of the victim can be a witness, a coroner's office exists to establish causes of death.

Now suppose that, in addition to not reporting the crime and not testifying at trial, robbery victims were willing to pay to be robbed; that they actively but secretly sought out robbers, deliberately meeting them in private places so that the crime would be perpetrated without attracting the attention of the police; that billions of dollars in cash were received by robbers in this way.

Such a change in the behavior of robbery victims would dramatically affect law enforcement efforts. First, as will be discussed in the next section, the secrecy

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[48] *See* Randy E. Barnett, *Bad Trip: Drug Prohibition and the Weakness of Public Policy*, 103 Yale L.J. 2593, 2597 (1994) (reviewing STEVEN B. DUKE & ALBERT C. GROSS, AMERICA'S LONGEST WAR: RETHINKING OUR TRAGIC CRUSADE AGAINST DRUGS (1990)); Stephanie A. Martz, Note, *Legalized Gambling and Public Corruption: Removing the Incentive to Act Corruptly, or, Teaching an Old Dog New Tricks*, 13 J. L. & Pol. 453, 463 (1997) (noting police propensity for corruption in victimless crimes).

engendered by the consensual nature of this transaction would make necessary far more intrusive kinds of investigative techniques than we at first supposed. Second, the victims' willingness to pay robbers to be robbed would make robbery more lucrative than it would otherwise be and would thus increase the ability of robbers to bribe the police when they are caught.

Police who are willing to fabricate evidence against someone they knew to be a robber would expect that such a person would probably be able to afford a substantial payoff. Of course, corrupt police officers would be risking detection by honest officers and prosecutors. So we can expect that corrupt officers will attempt to minimize their risk by entering into a regular prepayment arrangement with professional robbers to ensure that they would not be arrested when they commit a robbery. Such an illicit arrangement could be enforced by the corrupt officer's credible threat to prosecute a legitimate case or, if necessary, to fabricate a case.

The sale and use of illicit drugs are like victimless robberies, including this final twist. Drug users not only fail to report violations of the drug laws, they actively seek out sellers in ways that are designed to avoid police scrutiny. Drug use is an act deliberately conducted in private. And, because drugs users desire to consume drugs, they are quite willing to pay for the product.

Because drug use and sale are "victimless" in the purely descriptive sense employed here, the hypothetical consequences of policing victimless robberies are the very real results of drug law enforcement. The next three sections will discuss some of the more serious of these consequences.

2. Drug Laws and Invasion of Privacy.

Because drug use takes place in private and drug users and sellers conspire to keep their activities away from the prying eyes of the police, law enforcement surveillance must be extremely intrusive to be effective. The police must somehow gain access to private areas to watch for this activity.

One way to accomplish this is for a police officer, or more likely an informant, to pose as a buyer or seller. This means that the police must initiate the illegal transaction and run the risk that the crime being prosecuted was one that would not have occurred but for the police instigation.[49] And, since possession alone is also illegal, searches of persons without probable cause might also be necessary to find contraband.[50]

Such illegal conduct by police is to be expected when one seeks to prohibit activity that is deliberately kept away from normal police scrutiny by the efforts of both parties to the transaction, thereby requiring police intrusion into private areas if they are to detect these acts.[51] It is impossible for police to establish probable

[49] *See, e.g.*, HELLMAN, *supra* note 6, at 60–88; EDWIN M. SCHUR, CRIMES WITHOUT VICTIMS 136 (1965).

[50] *See* HELLMAN, *supra* note 6, at 66–70.

[51] *Id.* at 103 ("[A] large proportion of . . . .[marijuana] arrests result from police conduct that violates the spirit if not the letter of the Fourth Amendment's prohibition

cause for every search for illicit drugs, no matter how small the quantity. Where no constitutional grounds exist for such an intrusion, a police department and its officers are forced to decide which is more important: the protection of constitutional rights or the political consequences of failing to get results.

3. The Weakening of Constitutional Rights

The fact that such privacy-invading conduct by police may be unconstitutional and therefore illegal does not prevent it from occurring.[52] Some of those who are most concerned about the harm caused by drug laws are lawyers who have confronted the massive violations of constitutional rights that drug laws have engendered.[53] Such unconstitutional behavior is particularly likely, given our bizarre approach to policing the police.[54]

At present we attempt to rectify police misconduct mainly by preventing the prosecution from using any illegally seized evidence at trial.[55] While this would generally be enough to scuttle a drug law prosecution, it will not prevent the police from achieving at least some of their objectives. They may be more concerned with successfully making an arrest and confiscating contraband than they are with obtaining a conviction.[56] This is especially true when they would have neither confiscation nor conviction without an unconstitutional search.

> A policeman who is unwilling to lie about probable cause or to conceal a prior illegal search may still be inclined to make an arrest for possession of marijuana, even if he is aware that it will not stand up under judicial scrutiny. At a minimum he will have confiscated a supply of an illegal drug. The defendant will be jailed and have to post bail, and in many cases will have to hire a lawyer; these alone serve as forms of punishment. Finally, there is always the possibility that the defendant will plead guilty to a lesser offense rather than risk a felony conviction.[57]

In most instances, the success of a suppression motion depends on whether the police tell the truth about their constitutional mistake in their report and at

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against unreasonable searches and seizures"); *see* KAPLAN, *supra* note 6, at 96 ("Many of the techniques used to enforce heroin laws do end up violating the constitutional rights of individuals").

[52] *See* Randy E. Barnett, *Resolving the Dilemma of the Exclusionary Rule: An Application of Restitutive Principles of Justice*, 32 EMORY L.J. 941–42 (1983).

[53] *See id.* at 975–77.

[54] The discussion that immediately follows in the text is only suggestive of a detailed analysis of this problem and a possible solution I have presented elsewhere. *See id.* at 937–85 (noting especially the discussion on victimless crimes spanning pages 980–85).

[55] *See id.* at 941.

[56] Comment, *Possession of Marijuana in San Mateo County: Some Social Costs of Criminalization*, 22 STAN. L. REV. 101, 114–15 (1969).

[57] *Id.* at 115.

trial.[58] They may not do so if they think that their conduct is illegal.[59] "There is substantial evidence to suggest that police often lie in order to bring their conduct within the limits of the practices sanctioned by judicial decisions."[60] The only person who can usually contradict the police version of the incident is the defendant, and a defendant's credibility does not generally compare favorably with that of police officers.[61]

Those who have committed no crime—who possess no contraband—will have no effective recourse at all. Because no evidence was seized, there is no evidence to exclude from a trial.[62] As a practical matter, then, the police only have to worry about unconstitutional searches if something illicit turns up; but if they can confiscate whatever turns up and make an arrest, they may be better off than if they respect constitutional rights and do nothing at all.[63] Moreover, by encouraging such frequent constitutional violations, the enforcement of drug laws desensitizes the police to constitutional safeguards in other areas as well.

The constitutional rights of the general public are therefore threatened in at least two ways. First, the burden placed on law enforcement officials to enforce possessory laws without complaining witnesses virtually compels them to engage in wholesale violations of constitutional prohibitions against unreasonable searches and seizures. For every search that produces contraband there are untold scores of searches that do not. Given our present method of deterring police misconduct by excluding evidence of guilt, there is little effective recourse against the police available to those who are innocent of any crime.[64]

Second, the widespread efforts of police and prosecutors to stretch the outer boundaries of legal searches can be expected, over time, to contribute to the eventual loosening up of the rules by the courts. In drug prosecutions, the evidence being suppressed strongly supports the conclusion that the defendants are guilty. The more cases that police bring against obviously guilty defendants, the more opportunities and incentives appellate courts will have to find a small exception here or there.[65] And instead of prosecuting the police for illegal conduct, the prosecutor's office becomes an insidious and publicly financed source of political and legal agitation in the defense of such illegal conduct. As I have said elsewhere, "the arm of the government whose function is to prosecute illegal conduct is called upon, in the name of law enforcement, systematically to justify police irregularities. If these arguments are successful, the definition of illegal conduct

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[58] *See* Barnett, *supra* note 52, at 953.

[59] HELLMAN, *supra* note 6, at 105.

[60] *Id.*

[61] *See* Barnett, *supra* note 52, at 960–61.

[62] *Id.*

[63] *See id.*

[64] *See* Barnett, *supra* note 52, at 962.

[65] *See id.* at 959–66 (discussing the costs imposed on courts that decide to suppress evidence).

will be altered." [66] Refusing to consider these long run effects on the stability of constitutional protections is both dangerous and unrealistic.

One point should be made clear. The police are not the heavies in this tale. They are only doing what drug-law advocates have asked them to do by the only means such a task can be done effectively. It is the drug-law advocates who must bear the responsibility for the grave social problems caused by their favored policies. By demanding that the police do a job that cannot be done effectively without violating constitutional rights, drug-law proponents ensure that constitutional rights will be violated and that the respect of law enforcement personnel for these rights will be weakened.

4. The Effect of Drug Laws on Corruption

While most people have read about corrupt law enforcement officials who are supposed to be enforcing drug laws, few people are fully aware how this corruption is caused by the type of laws being enforced.[67] Drug laws allow the police to use force to prevent voluntary activities.[68] Unavoidably, the power to prohibit also gives the police a de facto power to franchise the manufacture and sale of drugs, in return for a franchise fee.[69]

The corruption caused by prohibiting consensual activity is increased still further by the ease with which law enforcement officers can assist criminals when there is no complaining witness. As was seen in the discussion of "victimless robberies," without a victim to file an official complaint, it is easier for police to overlook a crime that they might see being committed. When there is no victim to contradict the police version of events, it is much easier for police to tailor their testimony to achieve the outcome they desire, for example by describing circumstances of a bad search that would lead to the evidence beings suppressed and the charges dropped. When it is the word of the police against the defendant's, the defendant usually loses. With no victim pressing for a successful prosecution, the police, prosecutor, or judge may scuttle a prosecution with little fear of public exposure.

When compared to a victim crime like robbery, the victimless character of drug offenses (in the descriptive sense discussed above), and the fact that drug users are willing to pay for drugs, creates perverse incentives. When robbery is made illegal, robbers who take anything but cash must sell their booty at a tremendous discount. In other words, laws against robbery reduce the profit that sellers of illegally obtained goods receive and thereby discourage both robbery and the potential for corruption.[70]

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[66] *Id.* at 976.

[67] HELLMAN, *supra* note 6, at 150.

[68] *Id.* at 6–8.

[69] *See* KAPLAN, *supra* note 6, at 97–98.

[70] Organized burglary and auto theft remain profitable victim crimes, in spite of the fact that they are legally prohibited, and the profits earned from these crimes are used in part to pay for the services of corrupt law enforcement officials. Note however that—as

Drug laws have the opposite effect. Drug law enforcement creates an artificial scarcity of a desired product resulting in sellers receiving a *higher* price than they would without such laws. While it is true that drug prohibition makes it more costly to engage in the activity, this cost is partially or wholly offset by an increased return in the form of higher prices and by attracting criminal types who are less risk-averse—that is, individuals who are less likely to discount their realized cash receipts by their risk of being caught.[71] For such persons, the subjective costs of providing illicit drugs are actually less than they are for more honest persons.

The extremely lucrative nature of the illicit drug trade makes the increased corruption of police, prosecutors, and judges all but inevitable. And this corruption extends far beyond the enforcement of drug laws. Beginning with the prohibition of alcohol, we have witnessed the creation of a multibillion dollar world-wide industry to supply various prohibited goods and services.[72] The members of this industry are ruthless profit maximizers whose comparative market advantage is their ability and willingness to rely on violence and corruption to maintain their market share and to enforce their agreements.

The prohibition of alcohol and other drugs has created a criminal subculture that cares little about the distinction between crimes with victims and those without. To make matters worse, hiding the source of their income from tax and other authorities encourages these criminals to become heavily involved in legal businesses so that they may launder their illegally obtained income. They then can bring to these "legitimate" businesses their brutal tactics, which they use to drive out honest competitors.

The fact that law enforcement personnel are corrupted by drug laws should be no more surprising than the fact that many people decide to get high by ingesting certain chemicals. Among the many tragic ironies of drug prohibition is that by attempting to prevent the latter, they make the former far more prevalent. Yet drug-law advocates typically avoid the question of whether the increased systemic

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compared with robbery—these crimes typically occur when the victim is not around, making them effectively "victimless" with respect to having occurrence witnesses available. And property insurance policies greatly reduce the victim's enthusiasm to cooperate in the prosecution, which is another feature of a truly victimless crime.

[71] For a discussion of the "time horizons" of criminals that may affect their internal rate of discount, see Edward C. Banfield, *Present-Orientedness and Crime*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION, AND THE LEGAL PROCESS 133, 133–42 (1977); *see also* Gerold P. O'Driscoll, Jr., *Professor Banfield on Time Horizon: What Has He Taught Us About Crime*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION, AND THE LEGAL PROCESS 143, 143–62 (1977); Mario J. Rizzo, *Time Preference, Situational Determinism, and Crime*, *in* ASSESSING THE CRIMINAL: RESTITUTION, RETRIBUTION, AND THE LEGAL PROCESS 163, 163–77 (1977).

[72] *See* Morgan Cloud, III, *Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 727–28 (1989) (stating that the illegal drug industry collects annual revenues of 100 billion dollars or more).

corruption that their favored policies unavoidably cause is simply too high a price to pay for whatever reduction in the numbers of drug users is achieved.

V. THE INJUSTICE OF DRUG LAWS

To this point, my argument has dwelled exclusively on exposing the hidden costs of drug prohibition—costs that unavoidably result from the fact that drug use is consensual and victimless. There is, however, a more principled lesson to be drawn from this discussion of harmful consequences of today's drug policy: Policy makers, are inherently much more limited in their ability to construct good policy than is normally acknowledged. First, policy makers suffer from a pervasive ignorance of consequences.[73] In advance of implementing certain kinds of social programs, it is difficult, if not impossible, to predict the precise effects they will have. The foregoing discussion of the hidden costs of drug laws illustrates that it is often very difficult even to detect and demonstrate the adverse effects of policies that have already occurred.

Second, the judgment of policy makers and other "experts" is often influenced by self-interest (as all judgment can be). After staking one's career on a commitment to certain kinds of programs, rejecting them becomes difficult when their consequences are not as expected. Jobs will be lost if programs are seen as counterproductive or harmful. In rendering opinions, such influences can be hard to resist.

To minimize decisions made in ignorance or out of self-interest, legal policy makers must somehow be constrained. And one historically important way to constrain them is by crafting general principles and rules that are based on a conception of individual rights that rests on fundamental principles of justice.[74]

A sound legal system requires a firmer foundation for analyzing questions of legality than ad hoc arguments about the exigencies of particular policies. It requires the identification of general principles that reduce the hidden costs of the sort we have seen results from drug laws without resorting to an endless series of explicit cost-benefit analyses. It requires principles of general application that can be defended as basically just and right, despite the fact that circumstances will arise when adherence to such principles appears to be causing harm, which a deviation from principle would seem to be able to rectify.

A legal system based on such principles—if such principles can actually be identified—would not be as vulnerable to the shifting winds of opinion and prejudice as are particularistic public-policy discussions. I have discussed the vital social role and the appropriate substance of individual rights at greater length

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[73] For an excellent summary of the literature that discusses the "knowledge problem" facing public policy analysts, see DON LAVOIE, NATIONAL ECONOMIC PLANNING: WHAT IS LEFT? 51–92 (1985).

[74] This section is based on the analysis of the pervasive social problems of knowledge, interest, and power in RANDY E. BARNETT, THE STRUCTURE OF LIBERTY: JUSTICE AND THE RULE OF LAW (1998).

elsewhere and shall not repeat the analysis here.[75] The conclusion of such an analysis when applied to drug laws is that such laws are not only harmful, they are unjust.

The only practical way of facilitating the pursuit of happiness for each individual who chooses to live in a social setting is to recognize the rights of individuals to control their external possessions and their bodies—traditionally known as property rights—free from the forcible interference of any other person. If the pursuit of happiness is the Good for each person, then property rights are the prerequisites for pursuing that Good while living in close proximity to others. And the social prerequisites of the Good are the tenets of justice that all must live by. To deny these rights is to act unjustly.

The inalienable rights of individuals to live their own lives and to control their own bodies are, according to this analysis, essential to human survival and fulfillment in a social setting. Drug laws undermine this control by seeking to subject the bodies of some persons to the forcible control of other persons. Such laws seek forcibly to prevent persons from using their bodies in ways that they desire and that do not interfere with the equal liberty of others.

A proper rights analysis would avoid wasteful, and often irreversible, social experimentation. Two factors were seen above to generate the hidden costs of drug laws: the use of forcible *means* to achieve the *end* of controlling consensual conduct. These are the very factors that together identify drug laws as violations of individual rights and unjust interferences with individual liberty.

Just as you do not need to try PCP to know it is, on balance, bad for you, a proper rights analysis can reveal that we do not have to try drug laws to know they are socially harmful. This illustrates why a system of rights is ultimately preferable to a system of ad hoc public policy determinations. Had we adhered to a system of properly crafted individual rights, we would have avoided these serious harms in the first place.

John Stuart Mill once provided a defense of the distinction between matters of justice or rights that are properly subject to legal enforcement and matters of morality or vice that are not: "Justice is a name for certain classes of moral rules, which concern the essentials of human well-being more nearly, and are therefore of more absolute obligation, than any other rules for the guidance of life. . . ." [76] And "the essence of the idea of justice," is "that of a right residing in the individual. . . ." [77] As Mill then concluded, "[t]he moral rules which forbid mankind to hurt one another (in which we must never forget to include wrongful interference with each other's freedom), are more vital to human well-being than any maxims, however important, that only point out the best mode of managing

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[75] *See id.*

[76] JOHN STUART MILL, UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT 55 (Ernest Rhys ed., E.P. Dutton & Co 1920) (1910).

[77] *Id.*

some department of human affairs."[78] The proposition that the law should not attempt to regulate all vices is, of course, much older than Mill.[79]

A rights analysis does it deny that drug use can adversely "affect" the lives of others. Many kinds of conduct from quitting school to having sex with strangers—can adversely affect the lives of those close to the persons who engage in such activity. But this does not justify collapsing the distinction between acts that adversely affect another and acts that violate another's rights.

Herbert Spencer considered the objection that there is no "essential difference between right conduct toward others and right conduct toward self, [because] . . . what are generally considered purely private actions, do eventually affect others to such a degree, as to render them public actions; as witness the collateral effects of *drunkenness* or suicide."[80] In this allegation, he conceded "there is much truth; and it is not to be denied that under a final analysis, all such distinctions as those above made must disappear."[81] Nevertheless, the difficulty of drawing such a line is characteristic of all classifications. "The same finite power of comprehension which compels us to deal with natural phenomena by separating them into groups and studying each group by itself," he replied, "may also compel us to separate those actions which place a man in direct relationship with his fellows, from others which do not so place him; although it may be true that such a separation cannot be strictly maintained."[82]

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[78] *See id.* at 73.

[79] *See, e.g.*, Thomas Aquinas, *The Summa Theologica II*, *in* 20 GREAT BOOKS OF THE WESTERN WORLD 205 (Robert Maynard Hutchins & Mortimer J. Adler eds., Fathers of the English Dominican Province trans., 1952). There he poses the question, "Whether It Belongs to Human Law to Repress All Vices?" and answers in part:

> Thus the same is not possible to a child as to a full-grown man, for which reason the law for children is not the same as for adults, since many things are permitted to children which in an adult are punished by law or at any rate are open to blame. In like manner many things are permissible to men not perfect in virtue which would be intolerable in a virtuous man. Now human law is framed for a number of human beings, the majority of whom are not perfect in virtue. Therefore human laws do not forbid all vices, from which the virtuous abstain, but only the more grievous vices, from which it is possible for the majority to abstain, and chiefly those that are *to the hurt of others, without the prohibition* of *which human society could not be maintained;* thus human law prohibits murder, theft and the like.

Id. at 231–32 (emphasis added). The absence of tangible "injuries to others" led some modern writers to characterize laws regulating matters of vice as "victimless crimes." *See, e.g.*, EDWIN M. SCHUR, CRIMES WITHOUT VICTIMS 163 (1965).

[80] HERBERT SPENCER, SOCIAL STATICS; OR THE CONDITIONS ESSENTIAL TO HUMAN HAPPINESS SPECIFIED, AND THE FIRST OF THEM DEVELOPED 85–87 (D. Appleton and Co., 1888) (1865) (emphasis added).

[81] *Id.*

[82] *Id.*

Legal institutions are not capable of correcting every ill in the world. On this point most would agree. Serious harm results when legal means are employed to correct harms that are not amenable to legal regulation. The harmful side-effects of drug laws represent a case in point. A properly formulated analysis of individual rights provides a way of distinguishing harms that are properly subject to legal prohibition from those that are not.

VI. CONCLUSION

An addiction to drug *laws* is caused by an inadequate understanding of individual rights and the vital role such rights play in deciding matters of legality. As a result, policies are implemented that cause serious harm to the very individuals whom these policies were devised to help and to the general public.

If the rights of individuals to choose how to use their person and possessions are fully respected, there is no guaranty that people will exercise their rights wisely. Some may mistakenly choose the path of finding happiness in a bottle or in a vial. Others may wish to help these people by persuading them of their folly and supporting them when they seek to wean themselves from their dependency.

We must not, however, give in to the powerful temptation to grant some the power to impose their consumptive preferences on others by force. This power—the essence of drug laws—is not only addictive once tasted, it also carries with it one of the few guaranties in life: the guaranty of untold corruption and human misery.

MEDICAL MARIJUANA: THE CONFLICT BETWEEN SCIENTIFIC EVIDENCE AND POLITICAL IDEOLOGY

Peter J. Cohen*

Cannabis, more commonly referred to as marijuana, has a long history of medical use in this country and worldwide. Accounts dating back as far as 2700 B.C. describe the Chinese using marijuana for maladies ranging from rheumatism to constipation. There are similar reports of Indians, Africans, ancient Greeks and medieval Europeans using the substance to treat fevers, dysentery and malaria. In the United States, physicians documented the therapeutic properties of the drug as early as 1840, and the drug was included in the United States Pharmacopoeia, the official list of recognized medical drugs, from 1850 through 1942. During this period, lack of appetite was one of the indications for marijuana prescription.[1]

The earliest available references to the cultivation of poppies and preparation of opium date back to about 5000 BC as seen in clay tablets left by the Sumerians . . . [and was] used in Egypt as far back as 2000 BC as a children's sedative and teething remedy. . . . Galen [who] was the leading most physician in Rome from about AD 169–192 . . . so enthusiastically lauded the virtues of opium that its popularity grew to new heights by the end of the second century. . . . Opium was also used extensively by Arab physicians, the most celebrated of whom was Avicenna (AD 980–1037). Avicenna recommended opium especially for diarrhoea and eye problems . . . . A form of opium known as "laudanum" (from the Latin word Laudare, meaning "to praise") became very popular in the seventeenth century for treating dysentery. The British physician, Thomas Sydenham (1624–89), sometimes known as "the English Hippocrates," virtually put an official stamp of approval by advocating its use in dysentery and other such conditions.[2]

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[1] Mathew W. Grey, Comment, *Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship*, 30 U. RICH. L. REV. 249, 251–52 (1996) (footnotes omitted).

[2] ANIL AGGRAWAL, NARCOTIC DRUGS 17–22 (1995).

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I. INTRODUCTION—MEDICAL MARIJUANA: FORBIDDEN FRUIT OR BOON FOR HUMANITY?

Two plants—*Cannabis sativa* (marijuana) and *Papaver somniferum* (the opium poppy[3])—which have been cultivated for millennia, have a remarkable ability to alleviate physical and mental pain. Yet both may also cause harm. Opioids have significant addiction liability, and even a small dose causes measurable respiratory depression while larger doses are capable of producing respiratory arrest and death.[4] Even so, their undisputed capability to relieve pain[5] is thought to far outweigh these risks. Consequently, opium and its derivatives are a legal mainstay in today's medical practice. In contrast, although marijuana[6] is far less addictive than the opioids[7] and there is no documented evidence of death

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[3] Morphine and some other opioids may be extracted from the opium poppy. *See* Jerome H. Jaffe & William R. Martin, *Opioid Analgesics and Antagonists*, *in* GOODMAN & GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, 494, 502 (Alfred Goodman Gilman et al., eds., 6th ed. 1980) Additional opioids possessing similar pharmacologic effects, but not found in the opium poppy, are the products of synthesis. *See id.*

[4] *Id.* at 502 ("Morphine is a primary and continuous depressant of respiration . . . . The respiratory depression is discernible even with doses too small to disturb consciousness, and increases progressively as the dose is increased. In man, death from morphine poisoning is nearly always due to respiratory arrest.").

[5] *See, e.g.*, *id.* at 499 ("In man, morphine [derived from opium] produces *analgesia*, *drowsiness*, *changes in mood*, and *mental clouding*. . . . When therapeutic doses of morphine are given to patients with pain, they report that the pain is less intense, less discomforting, or entirely gone. . . . In addition to relief of distress, some patients experience euphoria.").

[6] Although "marijuana" and "cannabis" refer to the same compound, I will refer to "marijuana" rather than "cannabis" unless "cannabis" was used in a quotation.

[7] For example, one researcher compares the dependency rates of marijuana to those of alcohol and other drugs, including heroin, an opioid:

> A new study by researchers at Johns Hopkins University (FA Wagner and JC Anthony, *From the First Drug Use to Drug Dependence: Developmental Periods of Risk for Dependence upon Marijuana, Cocaine, and Alcoho*l, 26 NEUROPHARMACOLOGY 479 (2002)) gives us some [useful] numbers. Based upon data from the National Comorbidity Survey with 8,100 people (men and women ages 15 to 54) who were interviewed for when they first used drugs and for when they became dependent, it was found that 12 to 13 percent became dependent on alcohol in a 10-year period. About 15 to 16 percent of people who used cocaine became dependent in the 10-year period [5-6% during their first year of use], and about 8 percent of marijuana users became dependent during the same period. . . .
>
> [These data] are very close to previously published incidence numbers for dependence: alcohol (10 percent of users); cocaine (17 to 18 percent of users); marijuana (4 percent of users) . . . nicotine (40 percent); heroin (40 percent).

resulting from its use, even in large doses,[8] it is illegal under federal law to cultivate or distribute marijuana in order to treat patients or for a sick individual to use it on the advice of a physician.[9] Indeed, in some jurisdictions, even a physician's recommendation[10] to patients that marijuana might alleviate their symptoms is unlawful.[11] Nonetheless, medical marijuana has now been legalized by thirteen states either by legislation or direct statewide popular vote in referenda

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Carlton K. Erickson, *Epidemiology of Dependence: Understanding the Population*, 1 ADDICTION PROFESSIONAL 6, 6–7 (2003); *see also* Sandra P. Welch & Billy R. Martin, *The Pharmacology of Marijuana*, *in* PRINCIPLES OF ADDICTION MEDICINE 249, 260 (Allan W. Graham et al., eds., 3d. ed. 2003) ("Clinical and epidemiologic evidence indicates that a cannabis dependence syndrome occurs in heavy chronic users, as exhibited by a lack of control over use and continued use of the drug despite adverse personal consequences. . . . The risk of becoming dependent on cannabis probably is more like the risk for alcohol than for nicotine or the opioids, with around 10% of those who ever use cannabis eventually meeting the criteria for dependence."(citations omitted)).

[8] STEVEN B. DUKE & ALBERT C. GROSS, AMERICA'S LONGEST WAR: RETHINKING OUR TRAGIC CRUSADE AGAINST DRUGS 51 (1993); *see also* J. Michael Walker & Susan M. Huang, *Cannabinoid Analgesia*, 95 PHARMACOLOGY & THERAPEUTICS 127, 133 (2002) (stating that "an overdose of [Δ^9-THC] would almost certainly not be lethal"). Findings are similar for long–term use:

> Millions . . . have used marijuana on a regular, almost daily basis for decades. Despite these massive numbers of long-term users, no reliable evidence has appeared that such use has *any* adverse effects on their physical health. . . . [I]n no less than nine official investigations of the problem, in both the United States and elsewhere, none have found any significant adverse effects on human health, even mental health.

DUKE & GROSS, *supra* at 8.

Other literature implies that marijuana's effects on circulation and respiration are not lethal in nature:

> The most consistent effects on the cardiovascular system are an increase in heart rate [and] an increase in systolic blood pressure . . . . The increase in heart rate is dose related, and its onset and duration correlate well with the concentration of Δ^9-THC in blood. . . . There are no consistent changes in respiratory rate . . . .

Jaffe & Martin, *supra* note 3, at 561.

[9] *See* Controlled Substances Act, 21 U.S.C. § 812 (2006) (classifying marijuana as a controlled substance with a high potential for abuse, no currently accepted medical value in the United States, and a lack of accepted safety for use under medical supervision); Dominica Minore Bassett, *Legislative Review Medical Use and Prescription of Schedule I Drugs in Arizona: Is the Battle Moot?*, 30 ARIZ. ST. L.J. 441, 453 (1998).

[10] Physicians may *prescribe* only those drugs which have been approved by the Food and Drug Administration.

[11] *See Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 120–21 (D.D.C. 2001).

or ballot initiative.[12] The federal government, however, has asserted that the Controlled Substances Act (CSA)[13] preempts such actions by the individual states, a claim that has been upheld by the Supreme Court.[14]

This article examines the legal, political, policy, and ethical problems raised by the recognition of medical marijuana by almost one-quarter of our states in the face of federal opposition. It uses the term "medical marijuana" to refer to any form of *cannabis sativa* used (usually by smoking[15]) to treat a wide variety of pathologic states and diseases. Although draconian punishment can be imposed for

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[12] *See* CONG. RESEARCH SERV., 109TH CONG.: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES 17–18 & n.59 (2005) ("Twelve states, [Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington] covering about 22% of the U.S. population, have enacted laws to allow the use of cannabis for medical purposes."), *available at* http://digital.library .unt.edu/govdocs/crs/permalink/meta-crs-8244:1. *See also* Dawson Bell, Proposal 1: Voters Support Letting Severely Ill Grow Own Pot, *Detroit Free Press*, November 5, 2008 at News 1. ("Michigan voters favored sanctioning the use of medical marijuana to treat debilitating illness . . . apparently rejecting arguments that doing so would increase crime and juvenile drug use. The marijuana measure, Proposal 1, led 63% to 37%, with half of all precincts tallied . . . When it goes into effect—10 days after the vote is certified later this month—patients suffering from cancer, glaucoma, HIV/AIDS and other conditions can be authorized to cultivate, possess and use marijuana without fear of prosecution under state law. Michigan becomes the 13th state to approve medical marijuana, meaning that one in four Americans will live in a place where the use of the herb for medical purposes will be legal, according to advocates for legalization.").

[13] 21 U.S.C. §§ 801–971.

[14] *See* Gonzales v. Raich, 545 U.S. 1, 17 (2005). In *Gonzles*, the Court stated that

> Our case law firmly establishes Congress' power to regulate purely local activities that are part of an economic "class of activities" that have a substantial effect on interstate commerce. As we stated in *Wickard* [*v. Filburn*, 317 U.S. 111, 125 (1942)], "even if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce." We have never required Congress to legislate with scientific exactitude. When Congress decides that the "total incidence" of a practice poses a threat to a national market, it may regulate the entire class.

Id. (citations omitted).

[15] Advocates of medical marijuana claim (with some pharmacologic justification) that smoking allows easy titration and rapid onset of its therapeutic effects, thereby allowing its users to inhale the minimal dose necessary to achieve the desired medical effects while avoiding the frequently undesired psychological attributes of marijuana. *See* J. Ryan Conboy, 55 FOOD & DRUG L.J. 601, 614 (2000) (discussing researcher's acknowledgement of the benefits of inhaling marijuana compared to oral consumption due to the rapid onset and more consistent results achieved).

the "recreational" use of marijuana,[16] this article will not address the contentious question of whether to legalize or decriminalize the use of marijuana solely for its psychotropic effects, a fascinating and important area of law and policy that is outside the scope of this paper.[17] Instead, the specific focus of this article will be on

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[16] Weldon Angelos, a first-time offender, was convicted in federal court of selling marijuana in 2004 and received a mandatory minimum sentence of 55 years in prison. United States v. Angelos, 433 F.3d 738, 743 (10th Cir. 2006). While this harsh sentence was based on Weldon's possession of a gun during the drug deals (although the weapon was never used), a sentence of six to eight years would have been required *even in the absence of a gun*. United States v. Angelos, 345 F. Supp. 2d 1227, 1232 (D. Utah 2004). On December 4, 2005, the Supreme Court refused to hear Angelos' appeal. Angelos v. United States, 549 U.S. 1077 (2006). While this may be an extreme example, the imposition of significant incarceration is by no means an isolated phenomenon. Conviction of possession of more than one kilogram of marijuana in Rhode Island carries a mandatory minimum sentence of 10 years. *See* Elizabeth Gudrais, *State May Revise Guidelines for Drug Sentences*, PROVIDENCE J. June 14, 2007, at A1. Possession of larger amounts may result in a maximum sentence of life in prison while the highest mandatory minimum sentences imposed by Connecticut and Massachusetts are five years. *Id.* However, even a *short* period of incarceration can have an extraordinary impact. Jonathan Magbie received a sentence of 10 days in prison for marijuana possession despite being a quadriplegic and first-time offender. Henri E. Cauvin, *D.C. Jail Stay Ends in Death For Quadriplegic Md. Man; Care Provided by Hospital, Corrections Dept. in Question*, WASH. POST, Oct. 1, 2004, at B1. Unfortunately, failure of the prison to provide essential medical care resulted in his death during his incarceration. *Id.*

[17] Recreational marijuana has not always been a drug subject to opprobrium.

> Unlike opiates and cocaine, marijuana was introduced during a period of drug intolerance. Consequently, it was not until the 1960s, 40 years after marijuana cigarettes had arrived in America, that it was widely used. The practice of smoking cannabis leaves came to the U.S. with Mexican immigrants, who had come North during the 1920s to work in agriculture, and it soon extended to white and black musicians.
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> As the Great Depression of the 1930s settled over America, the immigrants became an unwelcome minority linked with violence and with growing and smoking marijuana. Western states pressured the federal government to control marijuana use. The first official response was to urge adoption of a uniform state Narcotics law. Then a new approach became feasible in 1937, when the Supreme Court upheld the National Firearms Act. This act prohibited the transfer of machine guns between private citizens without purchase of a transfer tax stamp—and the government would not issue the necessary stamp. Prohibition was implemented through the taxing power of the federal government.
>
> Within a month of the Supreme Court's decision, the Treasury Department testified before Congress for a bill to establish a marijuana transfer tax. The bill became law, and until the Comprehensive Drug Abuse Act of 1970, marijuana was legally controlled through a transfer tax for which no stamps or licenses were available to private citizens.

the conflict between the development of policies based on evidence obtained through the use of scientific methods[18] and those grounded on ideological and political considerations that have repeatedly entered the longstanding debate regarding the legal status of medical marijuana.[19] The article addresses a basic question: should the approval of medical marijuana be governed by the same statute that applies to all other drugs or pharmaceutical agents, the Food, Drug, and Cosmetic Act (FD&C Act),[20] after the appropriate regulatory agency, the Food and Drug Administration (FDA), has evaluated its safety and efficacy?[21] If not, should medical marijuana be exempted from scientific review and, instead, be evaluated by the Congress, state legislatures, or popular vote? This article argues that advocacy is a poor substitute for dispassionate analysis, and that popular votes should not be allowed to trump scientific evidence in deciding whether or not marijuana is an appropriate pharmaceutical agent to use in modern medical practice.

Part II will examine the authority of the Food, Drug, and Cosmetic Act and the Controlled Substances Act, focusing on their application to the approval of medical marijuana. The article proposes that since those advocating for medical marijuana are proposing its use as a drug, it should be evaluated as a drug according to the statutory requirements of the Food, Drug, and Cosmetic Act.

Part III will address the known risks of medical marijuana as documented in the peer-reviewed scientific literature. When possible, I will distinguish between

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David F. Musto, *Opium, Cocaine and Marijuana in American History*, 265 SCIENTIFIC AMERICAN 40, 45–46 (1991).

[18] Ismail Serageldin, *Science in Muslim Countries*, 321 SCIENCE 745, 745 (2008) ("[T]he scientific method should operate through observation, measurement, experiment, and conclusion, the purpose being to 'search for truth, not support of opinions'" (quoting *Ibn Al-Haytham,* (965–c.1040))).

[19] Note, however, that the "recreational" use of marijuana far exceeds its legal (under state law) incorporation into the practice of medicine, the focus of the remainder of this article. For example, while 11.1 million individuals (80% of those reporting any illicit drug use) used marijuana within one month prior to the survey, in 1997, OFFICE OF NAT'L DRUG CONTROL POLICY, THE NATIONAL DRUG CONTROL STRATEGY: 1999 at 13 (1999), a 2005 report estimated that only 115,000 people had made use of medical marijuana in the ten states in which the cultivation, possession, and use of marijuana for medical purposes was legal at the time. Susan Okie, *Medical Marijuana and the Supreme Court*, 353 NEW ENGL. J. MED. 648, 649 (2005). Although this number probably increased as legalization was extended to a total of thirteen states by 2007, see *supra* note 12, it is clear that the number of people using marijuana for therapeutic purposes will continue to be miniscule in comparison to its recreational use.

[20] 21 U.S.C. §§ 301–399 (2006).

[21] Safety and efficacy must be demonstrated by "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience." 21 U.S.C. § 355(d)(7).

the adverse effects of recreational and medical use of marijuana since its pathology may not be identical in both settings.

Part IV will summarize the known benefits of medical marijuana as demonstrated in the peer-reviewed scientific literature.

Part V will examine the battle between investigators who have attempted to obtain scientifically valid data to use as a basis for formulating public policy and those who, apparently for ideological and political reasons, have erected barriers to such studies. I will propose that both disapproval by the Congress and approval by state referenda are equally inappropriate since each bypasses the normal FDA regulatory and evaluation procedure.

Part VI will examine the potential impact of two approved medications that contain at least one active ingredient of marijuana and analyze why their legitimate use does not moot the question of whether medical marijuana should also be accepted.

Part VII will conclude that activists on both sides are responsible for the current state of affairs and that scientific evidence devoid of political considerations should be allowed to guide future decisions regarding the status of *Cannabis sativa* when used for medical purposes.

II. THE AUTHORITY OF THE FOOD, DRUG, AND COSMETIC ACT AND THE CONTROLLED SUBSTANCES ACT

A. The FDA: New Drug Evaluation and Medical Marijuana

Marijuana is not just a natural remedy, an "herbal cure," or a "holy and gracious" herb.[22] Marijuana, whether smoked or taken orally as a therapeutic—not recreational—agent, is a *drug* as defined by the FD&C Act.[23] "The term 'drug' means . . . articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and . . . articles (other than food) intended to affect the structure or any function of the body of man or any other animals."[24] New drugs (pharmaceuticals) are subject to stringent premarket approval. The FD&C Act requires that all new drugs be scientifically evaluated before they may be allowed to enter the stream of

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[22] Famous Quotes about Cannabis, Apr. 19, 2007, http://www.woyano.com/view/2073/Famous-Quotes-About-Cannabis ("To forbid or even seriously restrict the use of so holy and gracious a herb would cause widespread suffering and annoyance, and to large bands of worshipped ascetics, deep-seated anger. It would rob the people of a solace in discomfort, of a cure in sickness, of a guardian whose precious protection saves them from the attacks of evil influences" (quoting J. M. Campbell, NOTE ON THE RELIGION OF HEMP BRITISH INDIAN DRUGS COMMISSION REPORT 1839–1894)).

[23] 21 U.S.C. § 321(g)(1).

[24] *Id.*

interstate commerce.[25] As a result, drugs may not be advertised and sold in the absence of "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved."[26]

The Food and Drug Administration is charged with ensuring the safety and efficacy of drugs marketed within the United States.[27] Its authority is based on the government's responsibility to provide for public safety, a power that may at times be used in ways that abrogate individual rights.[28] The tension between the state's police power and personal autonomy was set forth exquisitely by the Supreme Court over a century ago in a case pitting an individual's assertion of the right to refuse vaccination during a smallpox epidemic in Boston against the Commonwealth of Massachusetts which invoked its police power to enforce this necessary public health measure:

> The liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. . . . Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will . . . . [but is] liberty regulated by law.[29]

The authority and justification for governmental regulation of pharmaceutical agents in order to ensure public safety was reiterated in 1979.[30] In a case involving patients who claimed that an unapproved drug, Laetrile, represented their last hope for survival, the Supreme Court held that public safety must prevail over the rights of both terminally ill patients seeking a cure and "inventive minds" who manufacture and sell unproven panaceas:

> To accept the proposition that the safety and efficacy standards of the Act have no relevance for terminal patients is to deny the Commissioner's authority over all drugs, however toxic or ineffectual, for such individuals. If history is to be any guide, this new market would not be long overlooked. Since the turn of the century, resourceful

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[25] 21 U.S.C. § 355(a) ("No person shall introduce or deliver for introduction into interstate commerce any new drug, unless an approval of an application . . . is effective with respect to such drug.").

[26] 21 U.S.C. § 355(d).

[27] *See* 21 U.S.C. § 393 (b).

[28] *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 26 (1905) (holding vaccination law is an allowable restraint on each person for the "common good" of society).

[29] *Id.*

[30] *See* United States v. Rutherford, 442 U.S. 544, 558–559 (1979).

> entrepreneurs have advertised a wide variety of purportedly simple and painless cures for cancer, including liniments of turpentine, mustard, oil, eggs, and ammonia; peat moss; arrangements of colored floodlamps; pastes made from glycerine and limburger cheese. . . . In citing these examples, we do not, of course, intend to deprecate the sincerity of Laetrile's current proponents, or to imply any opinion on whether that drug may ultimately prove safe and effective for cancer treatment. But this historical experience does suggest why Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise.[31]

1. A Brief History of the FDA

Today's FDA was born in response to investigative journalism and developed out of disasters rather than foresight.[32] Much of the impetus behind its origin in 1906 came from the public's reaction to the revelation of abuses within the food industry.[33] The need for government regulation became grossly apparent through shocking disclosures of unsanitary conditions in food processing plants, none more significant than those revealed in Upton Sinclair's chilling novel *The Jungle*, which vividly described the fraud and abuse occurring in the meat packing industry in the early 1900s.[34] The novel's powerful role in precipitating the passage of the first Food and Drug Act is displayed in the following excerpt:

> There would be meat that had tumbled out on the floor, in the dirt and saw-dust, where the workers had tramped and spit uncounted billions of consumption germs. There would be meat stored in great piles in rooms; and the water from leaky roofs would drip over it, and thousands of rats would race about on it. It was too dark in these storage places to see well, but a man could run his hand over these piles of meat and sweep off handfuls of the dried dung of rats. These rats were nuisances, and the packers would put poisoned bread out for them; they would die, and then rats, bread, and meat would go into the hoppers together. This is no fairy-story, and no joke; the meat would be shoveled into carts, and the man who did the shoveling would not trouble to lift out a rat even when he saw one . . . .[35]

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[31] *Id.* at 557–58.

[32] *See, e.g.*, Peter J. Cohen, *Science, Politics, and the Regulation of Dietary Supplements: It's Time to Repeal DSHEA*, 31 AM. J.L. & MED. 175, 178 (2005).

[33] *See id.*

[34] UPTON SINCLAIR, THE LOST FIRST EDITION OF UPTON SINCLAIR'S THE JUNGLE (Gene DeGruson ed., Peachtree Publishers 1988) (1906).

[35] *Id.* at 121–22.

Congress reacted to these disclosures by passing the original Federal Foods and Drug Act in 1906.[36] This Act, the progenitor of today's FD&C Act, prohibited interstate commerce of misbranded and adulterated food, drinks, and drugs and required accurate listing of contents (including narcotics and marijuana) on labels of patent medicines shipped in interstate commerce.[37] The subsequent evolution of food and drug legislation clearly illustrates what I term "government by crisis." It took the elixir of sulfanilamide tragedy,[38] in which a mislabeled and adulterated medication killed over one hundred people in fifteen states, as far east as Virginia and as far west as California, to bring about passage of the Food, Drug, and Cosmetic Act of 1938.[39] This act required not only that drugs be correctly labeled but that they meet safety standards prior to marketing.[40] It was not until 1962, after the use of thalidomide by pregnant women had resulted in the birth of thousands of newborns with major physical disabilities, that the Kefauver-Harris Amendment mandated that drugs be demonstrated *effective* as well as safe before they could enter interstate commerce.[41] These and other changes in the scope of the FD&C Act were made out of the conviction that only strong governmental action could protect individuals from harm that they had no way of combating on their own.[42]

2. How the FDA Evaluates New Drugs

Before a drug is permitted to enter the stream of interstate commerce,[43] the FD&C Act[44] requires that the FDA evaluate its safety and efficacy as demonstrated

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[36] *See* PETER BARTON HUTT & RICHARD A. MERRILL, FOOD AND DRUG LAW: CASES AND MATERIALS 8 (2d. ed. 1991) (1980).

[37] James Harvey Young, *The Long Struggle for the 1906 Law*, FDA CONSUMER, June 1981, at 16, *available at* http://www.foodsafety.gov/~lrd/ history2.html.

[38] Carol Ballentine, *Taste of Raspberries, Taste of Death: The 1937 Elixir Sulfanilamide Incident*, FDA CONSUMER, June 1981, at 18, *available at* http://www.fda.gov/oc/history/elixir.html.

[39] Arthur H. Hayes, Jr., *Food and Drug Regulations After 75 Years*, 246 J. AM. MED. ASS'N, 1223, 1224 (1981).

[40] 21 U.S.C. § 355(b)(1) (2006).

[41] Kefauver-Harris Amendment of 1962, Pub. L. No. 87-781, 76 Stat. 780 (codified in scattered sections of 21 U.S.C. §§ 301–399); *see also* C. Frederick Beckner III, *The FDA's War on Drugs*, 82 GEO. L.J. 529, 529–30 (1993) (explaining the effect of the Kefauver-Harris Amendment).

[42] Beckner, *supra* note 41, at 530 (describing how information asymmetries in the pharmaceutical industry create market failures that demonstrate the need for consumer protection).

[43] The *Commerce Clause* encompasses virtually all aspects of drug marketing and advertising, as they are "part of an economic 'class of activities' that have a substantial effect on interstate commerce." Gonzales v. Raich, 545 U.S.1, 2, 17 (2005).

[44] Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321 et. seq.

by "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience."[45] The Act does not require that the new drug be proven superior to already approved drugs,[46] only that the sponsor of the drug provide "substantial evidence that the drug will have the effect it purports . . . ."[47]

That marijuana is a botanical should not, in itself, preclude scientific investigation of the drug and, if warranted, its approval as a legitimate therapeutic agent. Botanicals are the source of the active ingredients in many drugs commonly used in today's medical practice. Digitalis leaf, derived from *Digitalis purpurea* (the foxglove plant), is the source of drugs commonly used to treat congestive heart failure.[48] *Papaver somniferum* (the opium poppy) provides opium[49] from which morphine used to treat pain is derived.[50] Donnatal™, a medication used to treat irritable bowel syndrome, contains belladonna alkaloids—originally found in *Atropa belladonna*, the deadly nightshade plant—as one of its active ingredients.[51] Ephedrine (derived from the plant *Ephedra sinica*) is used to treat hypotension[52] and aspirin (found in the bark of *Salix alba,* the White Willow tree,[53] is a

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[45] 21 U.S.C. § 321.

[46] *See, e.g.*, Robert Temple, Susan S. Ellenberg, Placebo-Controlled Trials and Active-Control Trials in the Evaluation of New Treatments, 133 ANN INTERN MED 455, 460 (2000) ("[U]nder law, a drug need not be superior to or even as good as [another drug] to be approved."); *see also* HUTT & MERRILL, *supra* note 36, at 527 ("The history of the 1962 Amendments clearly reveals Congress' intention that FDA not refuse to approve a drug on the ground of 'relative efficacy,' *i.e.*, that a more effective drug is available.").

[47] 21 U.S.C.A. § 355(d).

[48] *See* Paul J. Hauptman & Ralph A. Kelley, *Digitalis*, 1999 CIRCULATION 1265, 1265 (explaining the use of *digitalis purpurea* to treat congestive heart failure), *available at* http://circ.ahajournals.org/cgi/content/full/99/9/1265.

[49] *See* Jaffe & Martin, *supra* note 3, at 494, 509 ("Powdered opium . . . is a light brown powder. The official morphine content of opium is 10.0 to 10.5% by weight. . . . Paregoric, U.S.P. (*camphorated opium tincture*) is a hydroalcoholic preparation in which there is also benzoic acid, camphor, and anise oil. The usual adult dose is 5 to 10 ml, which corresponds to 2 to 4 mg of morphine.").

[50] *See* Paul L. Schiff, Jr., *Opium and Its Alkaolids*, 66 AM. J. OF PHARMACEUTICAL EDUC, 186, 189 (2002), *available at* http://www.ajpe.org/legacy/pdfs/aj660217.pdf; William H. Wehmacher, *Digitalis Treatment Decreases Mortality and Morbidity in Heart Failure Patients*, 108 CARDIOLOGY, 157, 157–58 (2007).

[51] *See* E.A. Mayer, K. Tillisch & S. Bradesi, *Review Article: Modulation of the Brain-gut Axis As a Therapeutic Approach in Gastrointestinal Disease*, 24 ALIMENTARY PHARMACOLOGY & THERAPEUTICS 919, 921 (2006); Donnatal Facts and Comparisons at Drugs.com, http://www.drugs.com/cdi/donnatal.html (last visited Mar. 28, 2009).

[52] *See* Marcel P. Vercauteren et al., *Prevention of Hypotension by a Single 5-mg Dose of Ephedrine During Small-Dose Spinal Anesthesia in Prehydrated Cesarean Delivery Patients*, 90 ANESTHESIA & ANALGESIA 324, 327 (2000).

[53] S. Chrubasik et al., *Treatment of Low Back Pain Exacerbations with Willow Bark Extract: A Randomized Double-Blind Study*, 109 AM. J. MED. 9, 9 (2000).

ubiquitous over-the-counter remedy.[54] Taxol™, a potent therapy for breast cancer,[55] is derived from *Taxus brevifolia* (Pacific Yew Tree).[56] All of these agents are legal and FDA-approved when employed for legitimate therapeutic use.[57]

With this background, this article now briefly outlines the statutory procedure for conducting adequate testing for safety and efficacy in appropriate animals and then humans.[58] After the initial studies of the pharmacological and physiological effects have been completed in animals, the manufacturer must apply to the FDA for an investigational new drug (IND) exemption which, if approved, allows the drug to be transported across state lines for extensive testing of safety and efficacy in humans.[59] The IND application must provide the FDA with information

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[54] *Id.*

[55] *See* M. Hezari et al., *Purification and Characterization of Taxa-4(5),11(12)-diene Synthase from Pacific Yew (Taxus Brevifolia) that Catalyzes the First Committed Step of Taxol Biosynthesis*, 322 ARCHIVES OF BIOCHEMISTRY AND BIOPHYSICS 437, 437 (1995).

[56] *See* Frankie Ann Holmes et al., *Phase II Trial of Taxol, an Active Drug in the Treatment of Metastatic Breast Cancer*, Abstract 83 J. NAT'L CANCER INST. 1797, 1797 (1991), *available at* http://inci.oxfordjournals.org/cgi/content/abstract/abstract/83/24/1797-a.

[57] *See* Tyler M. Simpson, *Balking at Responsibility: Baseball's Performance-Enhancing Drug Problem in Latin America*, 14 L. & BUS. REV. AM. 369, 376 (2008); U.S. Food & Drug Administration, "Taxol" http://www.accessdata.fda.gov/Scripts /cder/Drugsat FDA/; *see also* Taxol Information from Drugs.com, http://www.drugs. com/taxol.html (last visited Mar. 11, 2009) (noting common therapeutic uses of Taxol); Access Medicine—Hyoscyamine, Atropine, Scopolamine & Phenobarbital (Donnatal, others), http://www.accessmedicine.com/content.aspx?aID=2697089 (last visited Mar. 11, 2009) (noting common therapeutic uses of Donnatal). The multi-billion dollar "dietary supplement" industry depends on the use of a wide variety of botanical agents that are exempt from the strict FDA pre-market review demanded for pharmaceutical agents. Dietary Supplement Health and Education Act of 1994, Pub. L. No. 103-417, 108 Stat. 4325 (codified as amended in scattered sections of 21 U.S.C. §§ 301–399 (2000)); *see, e.g.*, David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States, 1990–1997: Results of a Follow-up National Study*, 280 J. AM. MED. ASS'N 1569, 1569 (1998) ("Use of at least 1 of 16 alternative therapies during the previous year increased from 33.8% [of those surveyed] in 1990 to 42.1% in 1997 ($P \leq .001$). The therapies increasing the most included herbal medicines . . . [and] megavitamins . . . . [A]lternative therapies were used most frequently for chronic conditions, including back problems, anxiety, depression, and headaches.").

I have previously proposed that the majority of these dietary supplements should be subject to premarket review identical to that required for new pharmaceutical agents. *See supra* Cohen, note 32. In this article, I suggest that a similar approach to the evaluation of medical marijuana would be both good science and rational policy.

[58] In setting forth the FDA's review process, I have made use of an excellent discussion of the review process: see James L. Zelenay, Jr., *The Prescription Drug User Fee Act: Is a Faster Food and Drug Administration Always a Better Food and Drug Administration?*, 60 FOOD & DRUG L.J. 261, 266–88 (2005).

[59] Investigational New Drug Application, 21 C.F.R. § 321.1(a) (2008).

regarding proposed clinical investigations; the chemistry, formula, and manufacturing details of the investigational drug; and any pharmacological or physiological data from prior studies.[60] The FDA has thirty days to respond to the IND application, after which the manufacturer may begin clinical testing if it has not heard from the FDA.[61] Of course, the FDA can halt clinical testing at any time if the agency feels that new information indicates the investigational new drug no longer meets safety and efficacy standards.[62]

Clinical testing is not carried out by the FDA itself but is the responsibility of the drug's manufacturer (sponsor). The necessary investigations, conducted by academic institutions or by private contractors, involve three discrete phases designed to document safety and efficacy through "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience."[63] In Phase I, the drug's toxicity and human tolerance to it are examined usually in fewer than one hundred subjects with the primary purpose of evaluating potential toxicity rather than efficacy (although gaining knowledge of effectiveness is not precluded).[64] In Phase II, which begins after dose-response and toxicity data are deemed sufficient to continue the process of clinical investigation, detailed studies are carried out in several hundred humans.[65] This phase, involving "controlled clinical studies conducted to evaluate the effectiveness of the drug for a particular indication . . . in patients with the disease or condition under study,"[66] is designed to verify the drug's effectiveness, major side effects, and appropriate dose.[67] In Phase III, which is commenced once the drug under consideration has been deemed sufficiently safe and effective for further testing and evaluation, large-scale studies—involving as many as several thousand patient volunteers—are conducted to determine complications of low incidence as well as efficacy in a large cohort of the general population with the disease.[68]

Once these three phases of drug evaluation have been completed, the manufacturer of the drug files a New Drug Application (NDA) with the FDA.[69] This document must provide the results of all preclinical and clinical investigations and include the names of all of the clinical investigators; describe all components of the drug; document manufacturing, processing, and packaging methods; and

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[60] Zelaney, *supra* note 58, at 267 n.48.
[61] *Id.* at 267 n.49.
[62] *Id.*
[63] *See* 21 U.S.C. § 355(d) (2006) (defining "substantial evidence").
[64] *See* 21 C.F.R. § 312.21(a) (2008) (describing Phase I of the investigation process).
[65] *See id.* § 312.21(b) (describing Phase II of the investigation process).
[66] *Id.*
[67] *Id.*
[68] *See id.* § 312.21(c) (describing Phase III of the investigation process).
[69] Zelaney, *supra* note 58, at 268.

furnish samples of the proposed labeling.[70] If the FDA deems the benefits of using the drug for the purposes proposed in the NDA outweigh its risks, it will grant approval and the drug may then enter the stream of interstate commerce.[71]

The FDA's approval of an NDA does not require that the investigational new drug be superior to, or even as effective as, an already approved medication.[72] The data need only demonstrate that it is safe and effective.[73] Therefore, for medical marijuana, as with any other investigational new drug, only its safety and efficacy need be demonstrated—*not its superiority*.

An important part of regulatory oversight involves the labeling and advertising of approved drugs. A manufacturer can explicitly advertise or otherwise promote medications *only* for indications approved by the FDA.[74] Furthermore, all advertising must be based on data that were approved by the FDA for inclusion in the labeling of the drug.[75] A drug may be deemed to be misbranded "because the labeling or advertising is misleading."[76] Thus, the Act requires both proven safety and efficacy *and* accurate labeling and advertising of a drug.[77] As a condition of approval, the FDA may require postmarket surveillance studies ("Phase IV studies") to gain the additional knowledge that is possible only with observation of even larger numbers of patients.[78] Even after the FDA's final approval has been gained, the FDA can suspend or revoke the manufacturer's

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[70] *See* 21 U.S.C. § 355(b)(1) (2006) (listing the required content of the NDA application).

[71] *See* Zelaney, *supra* note 58, at 268–69 (describing the FDA's review process).

[72] *See* 21 U.S.C. § 355(d) (listing the possible grounds for denying the NDA application).

[73] *See id.*

[74] *See* 21 U.S.C. § 352 (describing drug advertising and labeling requirements).

[75] *See id.* § 352(n) (listing advertising requirements); 21 C.F.R. § 202.1 (listing advertising requirements).

[76] 21 U.S.C. § 321(n).

[77] *See supra* notes 72–73, 76 and accompanying text.

[78] *See, e.g.*, Peter J. Cohen, *'Off-Label' Use of Prescription Drugs: Legal, Clinical and Policy Considerations*, 14 EUR. J. ANAESTHESIOLOGY 231, 233 (1997).

> [A]cquisition of information concerning drug action does not stop at the time of FDA approval. Invaluable information, not available during the limited phase of clinical investigation, is gleaned only through post-market surveillance. Newly approved drugs are administered to patients with a variety of diseases, and who may be taking a panoply of other medications. Adverse effects occurring with extremely low frequency, unlikely to have been noted during the phase of clinical investigation, may only become manifest after approval. Often, clinical studies designed to gather data to support the NDA do not include members of every group who will eventually receive the medication.

Id.

license based on new evidence that calls into question the drug's safety or efficacy.[79]

Recent events have illuminated major deficiencies in the FDA's ability to protect the public, including overly hasty and, in the views of some, far too permissive drug approval; real and perceived conflicts of interest; and lack of appropriate postmarketing surveillance.[80] In addition, what some consider to be an intrusion by politics into the FDA's decision-making procedures has severely damaged the agency's reputation.[81] Finally, the Administration and some members of the Congress have proposed changes that some believe will undermine the FDA's authority to regulate the advertising of off-label use[82] and thereby threaten the agency's ability to protect the public.[83] Even so, these deficiencies in the FDA's regulation of pharmaceuticals do not provide a rationale for disregarding its major role in protecting the public. Indeed, the FDA, in its "watchdog" function, has successfully served the public far more often than not.[84] Therefore, this analysis considers the FDA in light of its successes and promises rather than these deficiencies.

B. The Controlled Substances Act: Scheduling and Medical Marijuana

If the FDA finds that a drug's addiction liability requires additional regulation under authority granted by the Controlled Substances Act (CSA),[85] it petitions the Drug Enforcement Agency (DEA) to place the drug on the list of controlled substances.[86] The scheduling process[87] begins with a scientific review performed by two divisions of the Department of Health and Human Services (DHHS)—the FDA and the National Institute on Drug Abuse (NIDA), the latter of which is an institute of the National Institutes of Health (NIH).[88] Once their analysis is

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[79] *See* 21 U.S.C. § 355(e) (listing the grounds for withdrawal of approval of an application).

[80] *See Cohen*, *supra* note 32, at 211–13 (discussing the major deficiencies in the FDA's ability to protect the public).

[81] *Id.* at 212.

[82] Off-label use, the prescription of drugs for purposes that were not part of the approved NDA, is further discussed in Part VI.

[83] *See infra* notes 311–313 and accompanying text.

[84] *See, e.g.*, Cohen, *supra* note 32, at 179. The FDA's oversight was responsible for averting a major disaster by prohibiting the use of thalidomide in the United States after its widespread distribution in Europe had led to the catastrophe of malformed infants born after maternal use of the compound. *See id.*

[85] 21 U.S.C. §§ 801–971.

[86] John H. King, *Federal Regulations for the Prescription of Controlled Substances*, *in* MARIHUANA AND MEDICINE 745, 747 (Gabriel G. Nahas et al., eds., 1999) Petitions may also be filed by any other interested parties such as the pharmaceutical sponsor, public interest group, or concerned physicians. *Id.*

[87] *See id.* at 745–50 (describing the scheduling process).

[88] *Id.* at 747.

complete, DHHS makes a preliminary binding[89] recommendation that is printed in the Federal Register for public comment.[90] Thereafter, if the scientific experts of the FDA recommend that scientific evidence supports placing the drug on the list of scheduled controlled substances, the actual level of scheduling—as determined by specific factors detailed in the CSA[91]—is assigned by the DEA.[92] In assigning

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[89] Once the FDA recommends that the drug be scheduled, the DEA is responsible for assigning the level of scheduling. *Id.* at 748. In doing so, however, the scientific findings presented by the FDA and NIDA are *binding* on the DEA. *Id.*

[90] *Id.*

[91] Controlled Substances Act 21 U.S.C. §§ 801–904 (2006). The specific factors for scheduling are set forth in the CSA as follows:

> **Title 21, § 812. Schedules of controlled substances**
>
> **(a) Establishment**
>
> There are established five schedules of controlled substances, to be known as schedules I, II, III, IV, and V. Such schedules shall initially consist of the substances listed in this section. The schedules established by this section shall be updated and republished on a semiannual basis during the two-year period beginning one year after October 27, 1970, and shall be updated and republished on an annual basis thereafter.
>
> **(b) Placement on schedules; findings required**
>
> Except where control is required by United States obligations under an international treaty, convention, or protocol, in effect on October 27, 1970, and except in the case of an immediate precursor, a drug or other substance may not be placed in any schedule unless the findings required for such schedule are made with respect to such drug or other substance. The findings required for each of the schedules are as follows:
>
> **(1) Schedule I.—**
>
> (A) The drug or other substance has a high potential for abuse.
>
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
>
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.
>
> **(2) Schedule II.—**
>
> (A) The drug or other substance has a high potential for abuse.
>
> (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
>
> (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.
>
> **(3) Schedule III.—**
>
> (A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
>
> (B) The drug or other substance has a currently accepted medical use in treatment in the United States.

the appropriate schedule, the DEA must ensure that the determination is based on objective and verifiable scientific findings.[93] The level of scheduling is based on the following questions: (1) Does the drug have a "currently accepted medical use" in the United States?[94] (2) What is the drug's safety under medical supervision? Will it be a hazard to those using it or to others? (3) What is its addiction liability? (4) Is there a potential for (or history of) significant diversion for illegal use? (5) Are individuals using it on their own initiative or only on physician's prescription? (6) Is the drug similar in its pharmacology to other controlled drugs?[95]

The Controlled Substances Act also provides that the Congress may take any action it wishes regarding scheduling on its own *without regard to available scientific evidence.*[96] The significance of this authority will be discussed further in Part V.

III. POTENTIAL RISKS OF USING MEDICAL MARIJUANA

The decision of whether or not to grant approval of any new drug requires a careful balancing of its potential risks and benefits. All approved medications used in the legitimate practice of medicine are associated with adverse effects; there is

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(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) Schedule IV.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) Schedule V.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

21 U.S.C. § 812.

[92] *See* KING, *supra* note 86, at 745 ("The DEA must determine whether a substance meets the criteria for any of the schedules.").

[93] *Id.* at 746.

[94] *Id.* (citing 21 U.S.C. § 812(b)(1)(B)).

[95] *Id.*

[96] *See, e.g.*, Gonzales v. Raich, 545 U.S. 1, 14 (2005) ("In enacting the CSA, *Congress classified marijuana as a Schedule I drug.*") (*emphasis added*).

no *a priori* reason why marijuana should be different. Before assessing the potential pathology of marijuana, it is necessary to distinguish between its recreational and medical use.

When used recreationally, marijuana might be taken in large doses over long periods of time for its psychotropic effects. In contrast, when used as medical therapy, marijuana is administered only in doses sufficient to produce the desired clinical effect and only for as long as is medically necessary. The effects of any pharmaceutical agent, whether beneficial or pathologic, depend on the route of administration (e.g., oral, intravenous, intramuscular, or smoked), the dose administered, the pharmacologically active fraction of the administered dose that reaches the desired site of action, the rate at which the drug is metabolically inactivated, and the frequency and duration of use. Thus, it may be misleading to assume that marijuana's properties as manifested in individuals who have used it frequently, often in large quantities, and over a long period of time, can predict the effects of marijuana in patients who use it only as often as necessary under the advice of a medical professional and who carefully titrate the drug to achieve a desired clinical effect.

Another factor to consider is the significant biologic differences between the developing brains of children and adolescents[97] and the more mature brains of

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[97] *See* JUVENILE JUSTICE CENTER, AMERICAN BAR ASSOCIATION, CRUEL AND UNUSUAL PUNISHMENT: THE JUVENILE DEATH PENALTY, ADOLESCENCE, BRAIN DEVELOPMENT AND LEGAL CULPABILITY 1 (2004), *available at* http://www.abanet.org/crimjust/juvjus/Adolescence.pdf.

> Scientists are now utilizing advances in magnetic resonance imaging (MRI) to create and study three-dimensional images of the brain without the use of radiation (as in an x-ray). This breakthrough allows scientists to safely scan children over many years, tracking the development of their brains.
>
> Researchers at Harvard Medical School, the National Institute of Mental Health, UCLA, and others, are collaborating to "map" the development of the brain from childhood to adulthood and examine its implications.
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> . . . .
>
> This discovery gives us a new understanding into juvenile delinquency. The frontal lobe is "involved in behavioral facets germane to many aspects of criminal culpability," explains Dr. Ruben C. Gur, neuropsychologist and Director of the Brain Behavior Laboratory at the University of Pennsylvania. "Perhaps most relevant is the involvement of these brain regions in the control of aggression and other impulses. . . . If the neural substrates of these behaviors have not reached maturity before adulthood, it is unreasonable to expect the behaviors themselves to reflect mature thought processes.
>
> The evidence now is strong that the brain does not cease to mature until the early 20s in those relevant parts that govern impulsivity, judgment, planning for the future, foresight of consequences, and other characteristics that make people morally culpable. . . . Indeed, age 21 or 22 would be closer to the 'biological' age of maturity.

adults.[98] These differences in brain structure and function suggest that marijuana's long-term pathology may be age dependent and that a "universal" policy applying to all age groups is therefore probably unwarranted.

At the present time, only limited data regarding adverse effects of medical marijuana are available. This contrasts sharply with our extensive knowledge of the pathology of both recreational marijuana and cocaine, morphine, and other "hard" drugs.

A. Marijuana and Death

Many legal drugs subject to the CSA are both indispensable to modern medical practice and potentially lethal (e.g., morphine, Fentanyl™, Demerol™, and Phenobarbital,). Indeed, an appreciation of the possibility that such medications can cause death when used inappropriately is essential to medical training. For instance, the mechanism by which drugs such as morphine can cause death is set forth in a major textbook of pharmacology: "Morphine is a primary and continuous depressant of respiration . . . The respiratory depression is discernible even with

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Id. at 1–2 (footnotes omitted). One court cited the significant biological differences between the developing brains of children and adolescents as follows:

> Three general differences between juveniles under 18 and adults [are recognized under our laws]. First, as any parent knows and as the scientific and sociological studies respondent and his *amici* cite tend to confirm, "[a] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and are more understandable among the young. These qualities often result in impetuous and ill-considered actions and decisions." It has been noted that "adolescents are overrepresented statistically in virtually every category of reckless behavior." In recognition of the comparative immaturity and irresponsibility of juveniles, almost every State prohibits those under 18 years of age from voting, serving on juries, or marrying without parental consent.
>
> The second area of difference is that juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure. This is explained in part by the prevailing circumstance that juveniles have less control, or less experience with control, over their own environment. ("[A]s legal minors, [juveniles] lack the freedom that adults have to extricate themselves from a criminogenic setting").
>
> The third broad difference is that the character of a juvenile is not as well formed as that of an adult. The personality traits of juveniles are more transitory, less fixed.

Roper v. Simmons, 543 U.S. 551, 569–70 (2005) (citations omitted).

[98] Adults are more likely candidates for medical marijuana than patients in the pediatric age group.

doses too small to disturb consciousness, and increases progressively as the dose is increased. In humans, death from morphine poisoning is nearly always due to respiratory arrest."[99] In contrast, there is no evidence that the recreational use of marijuana is associated with death. The absence of lethal action (whether marijuana is used recreationally or medically) is documented in the American Society of Addiction Medicine's *Principles of Addiction Medicine*: "In healthy young users, [marijuana's] cardiovascular effects are unlikely to be of clinical significance. Documented evidence of death resulting from recreational use, even in large doses, is lacking."[100]

The possibility that marijuana might cause death is not mentioned in a discussion of its pathology in a standard textbook of pharmacology.[101] The author only calls attention to a reversible effect of marijuana on heart rate and blood pressure suggesting an absence of a relationship between use of marijuana and death:

> The most consistent effects on the cardiovascular system are an increase in heart rate [and], an increase in systolic blood pressure . . . . The increase in heart rate is dose related, and its onset and duration correlate well with concentrations of Δ9- THC in blood . . . . There are no consistent changes in respiratory rate. . . .[102]

Obviously, marijuana can be a factor in causing death when it accompanies the use of other potent drugs such as alcohol or heroin, or is smoked during potentially hazardous activities such as driving.

B. Harmful Properties of Marijuana

It is not an exaggeration to state that all approved pharmaceuticals are associated with some degree of pathology; although these effects are not necessarily life threatening. Marijuana is not an exception. However, risk alone is a poor determinant of whether marijuana should be approved as a legitimate therapeutic agent. Far more important to the analysis of marijuana and, indeed, all investigational new drugs, is the relationship of their inherent risks to their proposed benefits.[103] In this section, I will analyze the available evidence concerning the addiction liability of marijuana, its possible association with

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[99] Jaffe & Martin, *supra* note 3, at 494, 502.

[100] Welch & Martin, *supra* note 7, at 261–63.

[101] *See, e.g.*, Jerome H. Jaffe, *Drug Addiction and Drug Abuse*, *in* GOODMAN AND GILMAN'S: THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 535, 561–62 (Alfred Goodman Gilman et al., eds., 6th ed. 1980).

[102] *Id.* at 561.

[103] THOMAS M. GARRETT, HAROLD W. BAILLIE & ROSELEEN M. GARRETT, HEALTH CARE ETHICS 54–55 (2d ed. 1993) ("Unless there is a sufficient reason not to, one has an obligation do those acts that are likely to do more good than harm.").

cognitive impairment, whether its use is either associated with or causes mental illness, the question of marijuana smoking and pulmonary carcinoma (lung cancer), and marijuana's role as a "gateway drug."

1. Marijuana and Addiction Liability

Although there is little doubt that recreational marijuana is associated with addiction liability, its ability to produce dependence is less significant than that associated with either alcohol or pharmaceutical agents such as morphine, Phenobarbital, and Valium™, which are all used in the legitimate practice of medicine.[104]

> Clinical and epidemiologic evidence indicates that a cannabis dependence syndrome occurs in heavy chronic users, as exhibited by a lack of control over use and continued use of the drug despite adverse personal consequences . . . . [However, t]he risk of becoming dependent on cannabis probably is more like the risk for alcohol than for . . . the opioids, with around 10% of those who ever use cannabis eventually meeting the criteria for dependence.[105]

Epidemiological data from a national study indicate that about 10 percent of regular marijuana users become addicted to it.[106] This incidence is more like that of alcohol use (15 percent becoming addicted) than either nicotine (32 percent) or the opioids (23 percent).[107] These data did not escape public attention. An Op-Ed piece published in the Washington Post emphasized that marijuana's addiction liability was less than that of either alcohol or nicotine, both of which are legal drugs: "Fewer than one in 10 marijuana smokers become regular users of the drug, and most voluntarily cease their use after 34 years of age. By comparison, 15 percent of alcohol consumers and 32 percent of tobacco smokers exhibit symptoms of drug dependence."[108]

Although the use of recreational marijuana may result in addiction, the relevant question to consider is the possibility of becoming addicted when marijuana is used for medical purposes as directed by a licensed health care professional. However, marijuana has not been used in a medical context for a sufficiently long period to allow the collection of scientific observations and data

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[104] *See* J.C. Anthony, L.A. Warner & R.C. Kessler, *Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances and Inhalants: Basic Findings from the National Comorbidity Survey*, 2 EXPERIMENTAL AND CLINICAL PSYCHOPHARMACOLOGY 244, 251 (1994).

[105] Welch & Martin, *supra* note 7, at 260 (citations omitted).

[106] *Id.*

[107] Anthony et al., *supra* note 104, at 254–55.

[108] Keith Stroup & Paul Armentano, *The Problem is Pot Prohibition*, WASH. POST, May 4, 2002, at A19.

analysis necessary for a definite answer. Nonetheless, valid information concerning the likelihood that patients will become addicted to marijuana when using it medically may be extrapolated from the medical use of other controlled substances whose ability to produce addiction has been well documented. As Denise Kandel has observed:

> There are, unfortunately, no empirical data to guide policy. However, inferences can be made from appropriate medical use of morphine, which does not lead to addiction. This is a curious phenomenon that points out the complexity of drug behavior and the role of psychological and social conditions in shaping its development.[109]

The use of opioids is a significant component of pain therapy; when using these drugs, treating physicians must be aware of the possibility of addiction.[110] Nonetheless, when the benefits and risks of opioid therapy are balanced, these drugs are generally considered to be a legitimate component of treatment.[111] A discussion of pain management by Barry Stimmel, a specialist in pain management, typifies this view:

> Existing evidence suggests that iatrogenic [physician-induced] drug dependence is a real phenomenon but one that occurs infrequently when dependence-producing drugs are prescribed in an appropriate manner. Consistent narcotic use in chronic pain of known etiology that is unable to be relieved by other means, while associated with physical dependence [in contrast to true *addition*[112]], may nonetheless allow an individual to function in a productive manner.[113]

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[109] Denise B. Kandel, *Does Marijuana Use Cause the Use of Other Drugs?* 289 J. AM. MED. ASS'N 482, 483 (2003).

[110] *See* Barry Stimmel, *Constraints on Prescribing and the Relief of Pain*, *in* PRINCIPLES OF ADDICTION MEDICINE 1479, 1479–80 (Allan W. Graham et al., eds., 3rd ed. 2003) ("Fear of producing addiction to narcotics is foremost in the minds of most physicians when asked to provide medication for pain relief. This fear often interferes with their ability to provide adequate analgesia.").

[111] *See id.*

[112] Physical dependence and tolerance, a normal consequence of opioid administration, differs significantly from addiction. *See, e.g.*, Charles P. O'Brien, *A 50-Year-Old Woman Addicted to Heroin: Review of Treatment for Heroin Addiction*, 300 J. AM. MED. ASS'N 314, 315 (2008) ("[I]t is essential to distinguish between addiction, which involves a [pathologic] compulsion to take drugs, and simple tolerance with physical dependence, which is a normal phenomenon seen in everyone treated with opiates over the long term. In fact, tolerance begins with the first dose of opiates . . .").

[113] Stimmel, *supra* note 110, at 1480.

Experience with other approved controlled substances used appropriately in the practice of medicine suggests that while the possibility of addiction (in contrast to physical dependence or tolerance) cannot be ruled out, it should be balanced with the potential benefits of the drug.[114] The basic principle of balancing risk and benefit when deciding whether to approve a drug for medical treatment is equally applicable when evaluating the acceptability of marijuana as a safe and effective medication.

2. Marijuana and Cognitive Impairment

(a) Recreational Marijuana Use and Cognitive Impairment

Can the recreational use of marijuana cause cognitive impairment? The most obvious answer is "yes"—after all, this is the basic reason for its recreational use. The consensus of workers in the field is that chronic recreational use of marijuana may be associated with cognitive dysfunction and, indeed, that this significant pathology is related to structural changes in the brain.[115] "Marijuana has an adverse effect on cognitive functions and tests, but the *sine qua non* of use appears to be impairment of the ability to learn. . . . Marijuana intoxication interferes with the formation of new memories. . . . Depersonalization and other behavioral effects also have been associated with marijuana use."[116]

A recent study demonstrated that smoking four joints or more per week resulted in a decrement in mental test performance; subjects who had smoked regularly for a decade or more did the worst.[117] The investigators found that long-term marijuana users were impaired 70 percent of the time on a decision-making test, compared to 55 percent for short-term users and 8 percent for nonusers.[118]

More significant than the acute effects of marijuana is that cognitive dysfunction may persist after its use has ceased. This phenomenon was described by Pope and Yurgelon-Todd who measured cognitive function after sufficient abstinence to ensure that the subjects were not acutely intoxicated by the drug:

> Heavy marijuana use [daily for at least one month,][119] is associated with residual neuropsychological effects even after a day of supervised

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[114] *See infra* Part IV.

[115] *See, e.g.*, Mark S. Gold, *The Pharmacology of Marijuana*, *in* PRINCIPLES OF ADDICTION MEDICINE 163, 164–66 (Allan W. Graham & Terry K. Schultz, eds., 2nd ed. 1998).

[116] *Id.* at 165.

[117] Lambros Messinis, Anthoula Kyprianidou, Sonia Malefaki & Panagiotis Papathanasopoulos, *Neuropsychological Deficits in Long-term Frequent Cannabis Users*, 66 NEUROLOGY 737, 737–39 (2006).

[118] *Id.*

[119] Harrison G. Pope, Jr. & Deborah Yurgelon-Todd, *The Residual Cognitive Effects of Heavy Marijuana Use in College Students*, 275 J. AM. MED. ASS'N 521, 521 (1996).

> abstinence from the drug. However, the question remains open as to whether this impairment is due to a residue of drug in the brain, a withdrawal effect from the drug, or a frank neurotoxic effect of the drug.[120]

Block and coworkers tested subjects' memory as demonstrated by memorizing words. Although marijuana users refrained for at least twenty-six hours prior to testing (in order to obviate any residual acute cognitive effects of marijuana), they required approximately three times the number of word presentations to demonstrate the same degree of recall evidenced by nonusing controls.[121] The authors therefore suggested that marijuana use altered memory-related brain function, an effect that persisted beyond the expected period of acute marijuana-induced pathology.[122] These changes in brain function appeared to be related to or associated with anatomic and metabolic alterations in the brain (it is also possible that a longer period of abstinence might have resulted in different findings):

> Using positron emission tomography (PET), memory-related regional cerebral blood flow was compared in frequent marijuana users and nonusing control subjects after 26+ h[ours] of monitored abstention. Memory-related blood flow in marijuana users, relative to control subjects, showed decreases in prefrontal cortex, increases in memory-relevant regions of cerebellum, and altered lateralization in hippocampus. Marijuana users differed most in brain activity related to episodic memory encoding.[123]

However, other investigators have been unable to demonstrate that the hippocampus, an area of the brain that plays a significant role in memory, is involved in marijuana's possible effects on memory.[124] For example, Tzilos and colleagues state:

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[120] *Id.*

[121] *See* Robert I. Block et al., *Effects of Frequent Marijuana Use on Memory-Related Regional Cerebral Blood Flow*, 72 PHARMACOLOGY BIOCHEMICAL BEHAVIOR, 237, 241, 246 (2002). *See also* Nadia Solowij, Robert S. Stephens, Roger A. Roffman, Thomas Babor, Ronald Kadden, Michael Miller, Kenneth Christiansen, Bonnie McRee, Janice Vendetti, *Cognitive Functioning of Long-term Heavy Cannabis Users Seeking Treatment* 287 J. Amer. Med. Ass. 1123 (2002) (Long-term heavy cannabis users showed impairments in memory and attention that endured beyond the period of intoxication).

[122] *See* Block, *supra* note 121, at 245–49.

[123] *Id.* at 237.

[124] *See* Golfo K. Tzilos et al., *Lack of Hippocampal Volume Change in Long-Term Heavy Cannabis Users*, 14 AM. J. ADDICTION. 64, 64–65 (2005).

> We used magnetic resonance imaging to investigate these effects in a group of 22 older, long-term cannabis users (reporting a mean [SD] of 20,100 [13,900] lifetime episodes of smoking) and 26 comparison subjects with no history of cannabis abuse or dependence. When compared to control subjects, smokers displayed no significant adjusted differences in volumes of gray matter, white matter, cerebrospinal fluid, or left and right hippocampus. Moreover, hippocampal volume in cannabis users was not associated with age of onset of use nor total lifetime episodes of use. These findings are consistent with recent literature suggesting that cannabis use is not associated with structural changes within the brain as a whole or the hippocampus in particular.[125]

This study did not dispute that marijuana could produce long-term cognitive effects. Rather, it suggested that marijuana's action on brain sites other than the hippocampus might be responsible for these mental changes.[126]

In view of these studies indicating that the use of recreational marijuana impairs mental ability, it should not be surprising that its use may also be associated with a significant decrement in driving ability. A recent study of fatal automobile accidents conducted in France demonstrated the presence of marijuana in 8.8 percent of drivers found to be at fault compared with only 2.8 percent of those involved in fatal accidents but deemed to be without fault.[127] Parenthetically, alcohol was associated with a far greater number of such accidents.[128]

The pathological effects of chronic recreational marijuana use by a judge (Superior Court Judge Philip Marquardt) who was presiding at a capital murder case have been substantiated in case law.[129] In what may be one of the most dramatic illustrations of marijuana's effect on mental function documented in the legal (as opposed to medical) literature, the Court of Appeals for the Ninth Circuit stated: It is the raw material from which legal fiction is forged:

> A vicious murder, an anonymous psychic tip, a romantic encounter that jeopardized a plea agreement, an allegedly incompetent defense, and a death sentence imposed by a purportedly drug-addled judge. But, as Mark Twain observed, "truth is often stranger than fiction because fiction has to make sense."
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> . . . .
>
> Judge Marquardt advised the parties that he would deliberate over the weekend and announce his decision on Monday. Unbeknownst to

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[125] *Id.* at 64 (emphasis omitted).

[126] *See id.* at 64–65, 69–70.

[127] Bernard Laumon et al., *Cannabis Intoxication and Fatal Road Crashes in France: Population Based Case-Control Study*, 331 BRIT. MED. J. 1371, 1374 (2005).

[128] *Id.* (While 2.5% of fatal crashes were attributed to the use of marijuana, at least 28.6% were caused by the use of alcohol.).

> Summerlin [the defendant], Judge Marquardt was a heavy user of marijuana at the time, a fact that the State conceded in the federal habeas proceedings before the district court in this case.
>
> The amount of marijuana that Judge Marquardt may have used during the trial or deliberations is unknown because the district court did not allow discovery on this issue, although there is record support for Summerlin's claim that Judge Marquardt was either having difficulty concentrating or experiencing short-term memory loss.[130]
>
> There are instances during pretrial hearings and at trial when Judge Marquardt exhibited confusion over facts that had just been presented to him. He also made some quite perplexing, if not unintelligible, statements at various times during the trial.[131]

It is important to note that while marijuana's acute detrimental effects on cognition have been well-documented by some investigators, there is no consensus regarding the long-term sequelae of its chronic use. In a study of 1,318 subjects during a twelve-year period, Lyketsos and coworkers demonstrated that although the "Mini-Mental State Examination" had demonstrated a decline in cognitive function of marijuana users during this period, the changes were similar in heavy users, light users, and nonusers of marijuana.[132] The authors, therefore, concluded that "over long time periods, in persons under age 65 years, . . . [cognitive decline] is closely associated with aging and educational level but does not appear to be associated with cannabis use."[133]

Other data support the hypothesis that chronic marijuana use does not produce changes in cognitive function that are irreversible:

> U.S. government-sponsored population studies conducted in Jamaica, Greece and Costa Rica found no significant cognitive differences between long-term marijuana smokers and nonsmokers. Similarly, a 1999 study of 1,300 volunteers published in the American Journal of Epidemiology reported "no significant differences in cognitive decline between heavy users, light users, and nonusers of cannabis" over a 15-year period. Most recently, a meta-analysis of neuropsychological studies of long-term marijuana smokers by the U.S. National Institute on Drug Abuse reaffirmed this conclusion.[134]

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[129] Summerlin v. Stewart, 341 F.3d 1082, 1084 (9th Cir. 2003).

[130] *Id.* at 1084, 1089–90.

[131] *Id.* at 1090 n.2.

[132] Constantine G. Lyketsos et al., *Cannabis Use and Cognitive Decline in Persons Under 65 Years of Age*, 149 AMER. J. EPIDEMIOL. 794, 794 (1999).

[133] *Id.*

[134] Stroup & Armentano, *supra* note 108, at A19.

(b) Medical Marijuana and Long-Term Cognitive Impairment

In contrast to the effects of its recreational use, what are the cognitive effects of controlled exposure to marijuana administered to treat symptomatic pathology as recommended by a physician? The basic answer is that at this point in time there is no definite answer. Nonetheless, there are a few relevant considerations to keep in mind.

Most important is that medical marijuana is recommended to patients as a *bona fide* medical treatment to relieve the pathologic symptoms of their disease, not to enable patients to get "high."[135] This is analogous to the prescription of opioids, e.g., morphine, for legitimate medical treatment of both acute and chronic pain, not for their psychotropic effects. Morphine, like marijuana, even when used under a physician's direction, can cause cognitive changes; indeed, this is a reason why some patients reject its use for long-term therapy and seek other modes of alleviating their distress.[136] In most cases, however, this adverse effect is dose-related and therefore can often be controlled by decreasing the dose of either drug.[137]

Finally, physicians are often confronted with the problem of making not the *best* choice but the *least worst* choice. In balancing the burdens and potential benefits of marijuana,[138] it is a truism for the practicing physician that many of the conditions for which marijuana has been recommended—pain, spasticity, nausea, lack of appetite, weight loss, and depression—can also produce cognitive impairment.

3. Marijuana and Mental Illness

Perhaps of even greater concern than the effects of marijuana on cognition is its possible association with manifestations of serious psychiatric illness. Available scientific data suggest that there may be a strong association between some forms of psychiatric abnormalities and the recreational use of marijuana.[139] Jaffe has documented the effect of recreational marijuana:

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[135] *See, e.g.*, Mark Wallace et al., *Dose-dependent Effects of Smoked Cannabis on Capsaicin-Induced Pain and Hyperalgesia in Healthy Volunteers*, 107 ANESTHESIOLOGY 785, 795 (2007). Smoked marijuana in appropriate doses relieved pain in healthy volunteers but did not appear to produce significant decrements in mental performance. *See* discussion *infra* Part IV.

[136] *See* Jaffe & Martin, *supra* note 3, at 508.

[137] *Id.* at 509–09.

[138] *See infra* Part IV.

[139] *See* Cécile Henquet et al., *Prospective Cohort Study of Cannabis Use, Predisposition for Psychosis, and Psychotic Symptoms in Young People*, 330 BRIT. MED. J. 11, 11 (2005).

> Higher doses of Δ^9-THC can induce frank hallucinations, delusions, and paranoid feelings. Thinking becomes confused and disorganized; depersonalization and altered time sense are accentuated. Anxiety reaching panic proportions may replace euphoria, often as a result of the feeling that the drug-induced state will never end. With high enough doses, the clinical picture is that of a toxic psychosis with hallucinations, depersonalization, and loss of insight; this can occur acutely or only after months of use.[140]

A confounding factor is that preexisting psychiatric illness may play a significant role in the development of mental illness in individuals using marijuana.[141] For example, Henquet and colleagues evaluated and compared 2,437 individuals fourteen to twenty-four years of age with and without a history of preexisting psychosis; psychiatric symptoms were evaluated at the initial interview and during a follow up four years later.[142]

> After adjustment for age, sex, socioeconomic status, urbanicity, childhood trauma, predisposition for psychosis at baseline, and use of other drugs, tobacco, and alcohol, cannabis use at baseline increased the cumulative incidence of psychotic symptoms at follow up . . . . The effect of cannabis use was much stronger in those with any predisposition for psychosis at baseline . . . . There was a dose-response relation with increasing frequency of cannabis use.[143]

The authors concluded that cannabis use moderately increases the risk of psychotic symptoms in young people but has a much stronger effect in those with evidence of predisposition for psychosis.[144]

Three additional studies have suggested that frequent use of marijuana may lead to (or be associated with) depression and other mental illness.[145] The first study, by doctors in Australia, tracked 1,600 teenage students for seven years.[146] The research showed that young women who used marijuana every day were five times more likely to suffer from depression and anxiety than nonusers.[147] Teenage girls who used the drug at least once every week were twice as likely to develop

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[140] Jaffe, *supra* note 101, at 561 (citation omitted).

[141] *See id.*

[142] Henquet, *supra* note 139, at 11.

[143] *Id.*

[144] *Id.*

[145] *See generally* BBC News, Cannabis Link to Depression, Friday, 22 November, 2002, 00:00 GMT, *available at* http://news.bbc.co.uk/2/hi/health/2498493.stm.

[146] George C. Patton et al., *Cannabis Use and Mental Health in Young People: Cohort Study*, 325 BRIT. MED. J. 1195, 1195 (2002).

[147] *Id.* at 1197.

depression compared to those who did not use the drug.[148] A study by Swedish researchers provided evidence that marijuana use can significantly increase the risk of schizophrenia.[149] The study found that 0.71 percent of roughly 50,000 Swedish military conscripts who smoked marijuana in the late 1960s developed schizophrenia.[150] A third investigation by British researchers found that schizophrenia is more likely in people who start using the drug as teenagers.[151] In a study of a thousand people in their early twenties, one in ten who used marijuana as a teenager had since been diagnosed with schizophrenia.[152]

Whether marijuana *caused* these phenomena directly or whether it was only *associated* with them is a significant question that likely could be completely answered only by subjecting randomly selected subjects (without a preexisting history of psychiatric illness) to long-term exposure to the drug and comparing them with a similar and also randomly selected nonexposed cohort. Although such a study might provide a definitive answer to the question, it would clearly be unethical. Moreover, whether controlled medical use will lead to psychiatric illness is another important question to which we do not yet have the answer. Therefore, future studies of medical marijuana should include evaluating possible long-term effects on mental health.

4. Marijuana Smoking and the Development of Pulmonary Cancer

Can smoking marijuana cause lung cancer as does the smoking of tobacco? This is an area of considerable controversy. Several respected researchers have supported the hypothesis that smoking marijuana and lung cancer are causally related.[153] Gold has called attention to the ability of some ingredients found both in marijuana and tobacco smoke to cause pulmonary symptoms:

> Marijuana and tobacco smoke are very similar, and the effects of marijuana smoking are similar to the effects of tobacco smoking. Marijuana smoke contains many of the same carcinogenic components identified in tobacco smoke . . . . Chronic marijuana smoking (at least four days a week for six to eight weeks) results in mild airway obstruction, which may not be readily reversible with abstinence. Marijuana smoking

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[148] *Id.*

[149] Stanley Zammit et al., *Self Reported Cannabis Use as a Risk Factor for Schizophrenia in Swedish Conscripts of 1969: Historical Cohort Study*, 325 BRIT. MED. J. 1199, 1202 (2002).

[150] *Id.* at 1200.

[151] Louise Arseneault et al., *Cannabis Use in Adolescence and Risk for Adult Psychosis: Longitudinal Prospective Study*, 325 BRIT. MED. J. 1212, 1212–13 (2002).

[152] *Id.*

[153] *See* Mark S. Gold, *The Pharmacology of Marijuana*, *in* PRINCIPLES OF ADDICTION MEDICINE 163, 164 (Allan W. Graham & Terry K. Schultz eds., 2d ed. 1998).

> also causes decreased exercise tolerance, chronic cough, bronchitis and decreased pulmonary function.[154]

Similarly, Mehra and colleagues advise caution without presenting specific epidemiologic data. "Given the prevalence of marijuana smoking and studies predominantly supporting biological plausibility of an association of marijuana smoking with lung cancer on the basis of molecular, cellular, and histopathologic findings, physicians should advise patients regarding potential adverse health outcomes until further rigorous studies are performed that permit definitive conclusions."[155]

Moir and coworkers measured the concentrations of known carcinogens in tobacco and marijuana smoke and found them to be similar thereby suggesting that marijuana and tobacco had the same potential to cause lung cancer.[156] However, their data did not examine the actual incidence of lung cancer in marijuana smokers:

> The chemical composition of tobacco smoke has been extensively examined, and the presence of known and suspected carcinogens in such smoke has contributed to the link between tobacco smoking and adverse health effects. . . . [Although] there have been only limited examinations of marijuana smoke . . . [a]mmonia was found in mainstream marijuana smoke at levels up to 20-fold greater than that found in tobacco. Hydrogen cyanide, NO, NOx [toxic oxides of nitrogen], and some aromatic amines were found in marijuana smoke at concentrations 3–5 times those found in tobacco smoke.[157]

The authors concluded that the presence "of known carcinogens and other chemicals implicated in respiratory diseases is important information for public health and communication of the risk related to exposure to such materials."[158]

On the basis of such data, Aldington and coworkers declared that "smoking a single marijuana joint is equivalent to smoking 2.5 to 5 cigarettes in terms of damage to the lungs."[159] However, they also stressed the importance of the mode of using the particular cigarette: "The deep drags taken by marijuana users, along with their penchant for holding smoke in before exhaling, can cause problems like

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[154] *Id.* (citations omitted).

[155] Reena Mehra et al., *The Association Between Marijuana Smoking and Lung Cancer: A Systematic Review*, 166 ARCHIVES INTERNAL MED. 1359, 1359 (2006).

[156] David Moir et al., *A Comparison of Mainstream and Sidestream Marijuana and Tobacco Cigarette Smoke Produced Under Two Machine Smoking Conditions*, 21 CHEMICAL RES. TOXICOLOGY 494, 496–500 (2007).

[157] *Id.*

[158] *Id.*

[159] Sarah Aldington et al., *The Effects of Cannabis on Pulmonary Structure, Function and Symptoms*, 62 THORAX 1058, 1062 (2007).

obstructed airways and hyperinflation of the lungs. The lack of filters on marijuana joints also contributes to lung problems. All of the smokers reported coughing and wheezing as acute manifestations of marijuana smoking."[160]

Although only tobacco smokers demonstrated signs of emphysema, a chronic pulmonary disease, the authors concluded that the equivalence "between cannabis joints and tobacco cigarettes in causing airflow obstruction is of major public health significance."[161]

Nevertheless, strong epidemiological data argue against the hypothesis that cigarette and marijuana smoke are similar in their ability to cause lung cancer. For example, Hashibe and coworkers studied 2,252 volunteers including 1,212 with signs of cancer, of whom 39 percent had evidence of pulmonary cancer, to determine whether or not there was an association between marijuana use and the risk of developing lung and upper digestive tract cancer.[162] Those with cancer and an approximately equal number of cancer-free controls were matched with respect to age, gender, and the neighborhoods in which they lived.[163] The subjects were interviewed with a standardized questionnaire.[164] On the basis of their data, the authors concluded that "the association of these cancers with marijuana, even long-term or heavy use, is not strong and may be below practically detectable limits,"[165] and thereby argued that smoking marijuana (in contrast to tobacco) is not positively associated with lung cancer.[166] It is noteworthy that the considerable media publicity[167] that this study received after its publication typified the often bitter conflict between scientific evidence and ideological advocacy that continues to pervade the discussion of medical marijuana. Finally, a recent study provided further evidence that the pathology of smoked tobacco and smoked marijuana are

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[160] *See id.* at 1060–61.

[161] *Id.* at 1063.

[162] *See* Mia Hashibe et al., *Marijuana Use and the Risk of Lung and Upper Aerodigestive Tract Cancers: Results of a Population-Based Case-Control Study*, 15 CANCER EPIDEMIOLOGY BIOMARKERS PREVENTION 1829, 1829–30 (2006).

[163] *Id.*

[164] *Id.* at 1830.

[165] *Id.* at 1829.

[166] *See id.* at 1831–33.

[167] *See, e.g.*, Marc Kaufman, *Study Finds no Cancer-Marijuana Connection*, WASH. POST, May 26, 2006, at A3 ("The largest study of its kind has unexpectedly concluded that smoking marijuana, even regularly and heavily, does not lead to lung cancer. The new findings 'were against our expectations,' said Donald Tashkin [the senior author] of the University of California at Los Angeles, a pulmonologist who has studied marijuana for 30 years. 'We hypothesized that there would be a positive association between marijuana use and lung cancer, and that the association would be more positive with heavier use,' he said. 'What we found instead was no association at all, and even a suggestion of some protective effect.' . . . While no association between marijuana smoking and cancer was found, the study findings, presented to the American Thoracic Society International Conference this week, did find a 20-fold increase in lung cancer among people who smoked two or more packs of cigarettes a day.").

not necessarily identical. The investigators demonstrated that while smoking both tobacco and marijuana "synergistically increased the risk of respiratory symptoms and COPD [chronic obstructive pulmonary disease]," this pulmonary abnormality did *not* develop when only marijuana was smoked.[168]

In summary, the question of whether medically recommended smoked marijuana can cause pulmonary carcinoma is currently unanswered and awaits further epidemiologic studies.

5. Marijuana and the "Gateway" Hypothesis

One of the most controversial claims about the effects of marijuana use is that while marijuana itself may not cause significant harm, it can serve as a "gateway" or "trigger" that predisposes the user to experiment with and become dependent on more harmful drugs. Supporters of the gateway hypothesis acknowledge that many possible mechanisms might contribute to this phenomenon. It is theorized that marijuana may "'trigger' a biochemical craving for other psychoactive substances."[169] It is also proposed that the "permissive atmosphere associated with its use" is an equally plausible explanation of why marijuana users escalate their use to other drugs.[170] That one's peers are also using marijuana is yet another possible explanation of marijuana's capacity to function as a gateway to other drugs.[171]

Well-founded arguments have been raised against the gateway hypothesis. For example, although a large proportion of our population has used marijuana at some point in time, the majority has eventually stopped, or markedly diminished its use, and has not progressed to using other illegal substances.[172] In addition, and relevant to the thrust of this article, data presented in a recent report provide strong support for the view that medical use of a controlled substance will not inevitably progress to dependence on either the same drug or on other drugs with addiction liability.[173] Mannuzza and coworkers concluded that initiation of methylphenidate (Ritalin) treatment in children with attention deficit hyperactivity disorder (ADHD)

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[168] Wan C. Tan, Christine Lo, Aimee Jong, Li Xing, Mark J. FitzGerald, William M. Vollmer, Sonia A. Buist, Don D. Sin, *Marijuana and Chronic Obstructive Lung Disease: A Population-Based Study*, 180 CAN. MED. ASS. J. 814 (2009).

[169] PETER J. COHEN, DRUGS, ADDICTION, AND THE LAW: POLICY, POLITICS, AND PUBLIC HEALTH 30 (2004).

[170] *Id.*

[171] *Id.* at 30–32.

[172] *See, e.g.*, OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL STRATEGY 26–28 (1999) (reporting that in a one month period during 1997, approximately 11.1 million individuals self-reported having used marijuana; however, during the same period of time, only 1.5 million (13.5%) reported using either powdered or crack cocaine).

[173] Salvatore Mannuzza et al., *Age of Methylphenidate Treatment Initiation in Children With ADHD and Later Substance Abuse: Prospective Follow-Up Into Adulthood*, 165 AM. J. PSYCHIATRY, 604, 608 (2008).

at an early age (six to twelve years) did not increase the risk of later substance abuse disorders and, indeed, had beneficial long-term effects on ameliorating the symptoms of their ADHD.[174]

Moreover, the observations and data supporting the gateway hypothesis do not permit a distinction between marijuana as a *direct cause* of later drug use and a simple *association* of marijuana's use with later behavior. For example, Lynskey and colleagues sought to determine whether there was an association between early marijuana use and subsequent progression to use of and addiction to other drugs by examining genetic and shared environmental influences.[175] They surveyed an Australian national volunteer sample of 311 young adult identical and dizygotic (nonidentical) same-sex twin pairs who varied in their early (prior to age seventeen) marijuana use.[176] Those who had used marijuana by age seventeen had a 2.1 to 5.2 times greater incidence of other drug and alcohol abuse or dependence than did their co-twin who had not used marijuana before age seventeen.[177] However, while early marijuana use and later addiction to other drugs appeared to be related, the association did not differ significantly between identical and fraternal (nonidentical) twins.[178] The authors therefore concluded that while genetic factors were unlikely to be a significant factor in marijuana's acting as a "gateway" to later drug use, the available data did not allow them to distinguish between *cause* and *association*:

> The association [between early marijuana use and later drug use and abuse or dependence] may arise from the effects of the peer and social context within which cannabis is used and obtained. In particular, early access to and use of cannabis may reduce perceived barriers against the use of other illegal drugs and provide access to these drugs.[179]

Kandel's perceptive editorial accompanying Lynskey's article reiterated the problem of differentiating between cause and association in humans:

> Whether or not a true *causal link* exists between the use of marijuana and other drugs, the association between the 2 has been well established.
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> . . . .

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[174] *Id.* at 605, 608.

[175] Michael T. Lynskey et al., *Escalation of Drug Use in Early-Onset Cannabis Users vs. Co-twin Controls*, 289 J. AM. MED. ASS'N 427, 427–28 (2003).

[176] *Id.*

[177] *Id.* at 430.

[178] *Id.* at 427, 431. If both identical and fraternal twins have the same environmental background and identical twins share the same genetic makeup why did only *one* of the twins voluntarily begin to use marijuana? Does this suggest that an individual's behavior does not depend solely upon genetic and environmental influences?

[179] *Id.* at 427.

> [T]he central question remains: does marijuana use cause the use of other illicit drugs? The search for causes in the absence of direct experimental manipulation may be elusive. Nonetheless, the search for mechanisms is necessary if only to explain the association between the use of different drug classes. . . . [Only in human beings] can one explore the many other social, psychological, and contextual factors that are also important in drug use behavior.[180]

In summary, while the gateway drug hypothesis may be attractive to some, it has not been scientifically validated. Moreover, even if this hypothesis were substantiated, marijuana would not be a unique "gateway" to other drugs. For example, although there is an association between tobacco smoking and alcohol use,[181] both remain legal activities unconstrained by the possibility that each might function as a "gateway" to the other. Finally, as with alcohol and tobacco, even if recreational marijuana were a gateway drug, this would not necessarily provide a rationale for public policy barring the use of marijuana for medical therapy.[182]

While the debate regarding marijuana as a gateway drug has focused mainly on its recreational use, its medical use may have a significantly different spectrum of effects. While the medical use of other controlled drugs does not lead to experimentation with other drugs, we simply do not know whether the use of marijuana for medical purposes will have this undesired effect. As Kandel concluded: "There are, unfortunately, no empirical data to guide policy. However, inferences can be made from appropriate medical use of morphine, which does not lead to addiction."[183]

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[180] Kandel, *supra* note 109, at 483 (2003) (emphasis added).

[181] *See, e.g.*, Christi A. Patten et al., *Can Psychiatric and Chemical Dependency Treatment Units be Smoke Free?*, 13 J. SUBSTANCE ABUSE TREATMENT 107, 107–08 (1996) (describing the potential difficulties of prohibiting smoking in alcohol dependency programs); Allan C. Collins & Michael J. Marks, *Animal Models of Alcohol-Nicotine Interactions*, *in* ALCOHOL AND TOBACCO: FROM BASIC SCIENCE TO CLINICAL PRACTICE 129, 129 (Joanne Fertig & John P. Allen eds., 1995) ("[Approximately] 70 percent of alcoholics are heavy smokers (i.e., smoke more than [one pack of] cigarettes per day), compared with 10 percent of the general population.").

I should also note that my work with drug-dependent physicians suggests that alcohol use often precedes the abuse of, and addiction to, illegal drugs.

[182] *See* Keith Stroup & Paul Armentano, Editorial, *The Problem is Pot Prohibition*, WASH. POST, May 4, 2002, at A19 ("[It is reasonable to suggest] that marijuana, like other drugs, is not for kids. We permit adults to do many activities that we forbid children to do, such as motorcycle riding, skydiving, signing contracts, getting married, drinking alcohol and smoking tobacco. But we do not condone arresting adults who responsibly engage in these activities in order to dissuade our children from doing so. Nor can we justify arresting adult marijuana smokers at the pace of some 734,000 per year on the grounds of sending a message to children.").

[183] Kandel, *supra* note 109, at 483.

Finally, the risks and benefits of the medical use of marijuana cannot be considered as though they are unique to this drug. Rather, they must be evaluated in light of the knowledge of the risks of all approved, legal, and potentially addicting controlled prescription drugs. Morphine, meperidine, Fentanyl™, barbiturates, and tranquilizers such as diazepam (Valium™) are among the many FDA-approved and DEA-scheduled controlled substances that play a significant role in legitimate medical practice. Their addicting liability alone has not automatically been allowed to contraindicate their use. It would be contrary to the basic principles of medical ethics to forgo the use of these medications to treat the physical and emotional effects of chronic pain due to metastatic cancer because of fear that they might cause addiction or function as gateway drugs. It would be unfortunate, indeed, if opioid-induced pain relief were denied during or after surgery because of concern about its possible risks, while ignoring its known benefits.[184] The linchpin for medical decision making is not *risk*—for no treatment is without risk—but the *balancing of risks and benefits*. Both must be carefully and scientifically evaluated; available scientific evidence should be dispositive.

IV. POTENTIAL BENEFITS OF MEDICAL MARIJUANA

The medical use of marijuana, once officially recognized by the United States Pharmacopoeia[185] (based on anecdotal rather than scientific evidence), was eventually made illegal by Congressional legislation.[186] This section will provide a

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[184] *See, e.g.*, Peter J. Cohen, *Medical Marijuana, Compassionate Use, and Public Policy: Expert Opinion or* Vox Populi*?*, 36 HASTINGS CENTER REP. 19, 20 (2006) ("As an anesthesiologist, I have legally administered more narcotics (in the course of providing medical care) than many low-level illegal drug dealers.").

[185] The United States Pharmacopeia (USP) is an official public standards-setting authority for all prescription and over-the-counter medicines and other health care products manufactured or sold in the United States. USP also sets widely recognized standards for food ingredients and dietary supplements. USP sets standards for the quality, purity, strength, and consistency of these products critical to the public health. USP's standards are recognized and used in more than 130 countries around the globe. These standards have helped to ensure public health throughout the world for close to 200 years.

> USP is a non-governmental, not-for-profit public health organization whose independent, volunteer experts work under strict conflict–of–interest rules to set its scientific standards. USP's contributions to public health are enriched by the participation and oversight of volunteers representing pharmacy, medicine, and other health care professions as well as academia, government, the pharmaceutical and food industries, health plans, and consumer organizations.

About USP-An Overview, http://www.usp.org/aboutUSP/ (last visited Mar. 11, 2009).

[186] 21 U.S.C. § 801 (2006).

brief historical background to the medical use of marijuana and will then address the current state of knowledge of its medical benefits based on scientific evidence.

A. Early History of Medical Marijuana

Marijuana has not always been a pariah drug within the community of healers. In 1851, the United States Pharmacopoeia granted marijuana the status of a legitimate medical compound.[187] In the same year, another government-recognized publication declared (supported more by anecdotal input than scientific data): "The complaints in which it [cannabis] has been specially recommended are neuralgia, gout, rheumatism, tetanus, hydrophobia, epidemic cholera, convulsions, chorea, hysteria, mental depression, insanity, and uterine hemorrhage."[188] The Fourth Edition of the United States Pharmacopoeia (1864) described the preparation of *Extractum Cannabis Purificatum*:

> Take of extract of hemp two troy ounces; alcohol a sufficient quantity. Rub the Extract with two fluidounces of Alcohol until they are thoroughly mixed; and, having added twelve fluidounces of Alcohol, allow the mixture to macerate for twenty-four hours. Then filter the tincture through paper, passing sufficient Alcohol through the filter to exhaust the dregs completely. Lastly, by means of a water-bath, at a temperature not exceeding 160°, evaporate to dryness.[189]

More recently, in 1974, an herbal medical text proposed (again apparently without supporting scientific evidence):

> The principal use of Hemp in medicine is for easing pain and inducing sleep, and for a soothing influence in nervous disorders. It does not cause constipation nor affect the appetite like opium. It is useful in neuralgia, gout, rheumatism, delirium tremens, insanity, infantile convulsions, insomnia, etc.
>
> The tincture helps parturition, and is used in senile catarrh, gonorrhea, menorrhagia, chronic cystitis and all painful urinary affections. An infusion of the seed is useful in after pains and prolapsus

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[187] THE PHARMACOPOEIA OF THE U.S., EXTRACTUM CANNABIS (3d ed. 1851) ("*Extract of hemp.* An alcoholic extract of the dried tops of Cannabis sativa . . . variety *Indica*.").

[188] GEORGE B. WOOD & FRANKLIN BACHE, THE DISPENSATORY OF THE UNITED STATES OF AMERICA 354 (9th ed. 1851); Ian William Goddard *Cannabis: Medical Reality versus Authoritarian Brutality*, *available at* http://www.ukcia.org/research/MedicalRealityVsAuthoritarianBrutality.html (quoting GEORGE B. WOOD & FRANKLIN BACHE, THE DISPENSATORY OF THE UNITED STATES OF AMERICA 354 (9th ed.1851)).

[189] THE PHARMACOPOEIA OF THE U.S., EXTRACTUM CANNABIS PURIFICATUM (4th ed. 1864).

> uteri. The resin may be combined with ointments [to remedy] . . . inflammatory and neuralgic complaints.[190]

Anecdotal reports[191] of marijuana's safety and efficacy are not confined to the past. George Annas provides an especially telling description of its use by Stephen Jay Gould, a respected scientist, who had smoked marijuana to alleviate the nausea and discomfort he experienced during chemotherapy for abdominal mesothelioma:

> Absolutely nothing in the available arsenal of anti-emetics worked at all. I was miserable and came to dread the frequent treatments with an almost perverse intensity. . . . Marijuana worked like a charm. The sheer bliss of not experiencing nausea—and not having to fear it for all the days intervening between treatments—was the greatest boost I received in all my year of treatment, and surely the most important effect upon my eventual cure.[192]

B. Scientific Evidence of the Benefits of Medical Marijuana

It is not unreasonable to believe that a botanical remedy whose successful use has been part of numerous cultures for thousands of years might have some healing properties. Nonetheless, while history and anecdotal reports are suggestive, they do not constitute the firm scientific proof that is essential to justify the approval of medical marijuana as a legitimate pharmaceutical agent. The standard of review, as set forth by the FD&C Act, demands "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved."[193] Therefore, it is appropriate to detail some of the scientifically validated and peer-reviewed published evidence regarding the safety and efficacy of medical marijuana.

Severe and unremitting pain is a major cause of morbidity in those suffering from HIV-AIDS. While anecdotal reports from the AIDS community have proclaimed the efficacy of smoked marijuana, it was not until 2007[194] that these claims were clearly verified when the efficacy of smoked marijuana in treating

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[190] M. GRIEVE, A MODERN HERBAL 397 (C. F. Leyel ed., Hafner Press 1974) (1931).

[191] Such anecdotal reports are not confined to marijuana, but have anteceded scientific documentation of the efficacy of many of today's commonly used therapeutic agents. Thomas Sydenham (1624–1689) said, "Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium." Thomas Sydenham—The Hippocrates of English Medicine, http://opioids.com/opium/thomas-sydenham.html (last visited Mar. 11, 2009).

[192] George J. Annas, *Reefer Madness—the Federal Response to California's Medical-Marijuana Law*, 337 NEW ENG. J. MED. 435, 436 (1997) (citation omitted).

[193] Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321 (2006).

[194] *See* discussion *infra* Part V.

such pain was reported in a scientific, peer-reviewed publication by Donald Abrams and coworkers.[195] In this investigation, a prospective randomized placebo-controlled trial involving adults with painful HIV-associated sensory neuropathy, volunteers were randomly assigned to smoke either marijuana (3.56% Δ9-tetrahydrocannabinol) or identical placebo cigarettes[196] three times daily for five days.[197] The investigators evaluated both the individual subjects' quantitative description of chronic pain intensity and the percentage of subjects who reported more than a 30 percent reduction in pain intensity.[198] They found that smoked marijuana reduced daily pain by an average of 34 percent.[199] Over twice as many of the subjects who smoked marijuana reported a significant reduction in pain compared with the placebo group.[200] Pain relief was rapid; the first marijuana cigarette reduced chronic pain by 72 percent while only 15 percent of the placebo group reported immediate relief.[201] No serious adverse events occurred during the study.[202] The authors concluded that "smoked cannabis was well tolerated and effectively relieved chronic neuropathic pain from HIV-associated sensory neuropathy."[203]

Abrams's study involved volunteers with symptoms of pathological (disease-related) pain. Another approach to measuring the analgesic potency of a drug is to evaluate its ability to mitigate artificially induced pain. In 2007, Wallace and colleagues reported the effect of smoked marijuana on pain that had been produced by the injection of capsaicin (similar to injecting an extract of jalapeno peppers) under the skin in a randomized, double-blind, placebo trial involving fifteen healthy volunteers.[204] Three doses of marijuana were administered: low (2 percent), medium (4 percent), and high (8 percent Δ9-tetrahydrocannabinol by weight). While the low dose had no analgesic effect, there was a significant decrease in capsaicin-induced pain within forty-five minutes after the medium dose was smoked.[205] However, as with some other analgesic agents, the highest dose actually produced an increase in subjective pain perception.[206] An important observation was that there was no significant impairment of performance among volunteers in the study as evaluated by neuropsychological testing.[207]

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[195] D. I. Abrams et al., *Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial*, 68 NEUROLOGY 515 (2007).

[196] From which the cannabinoids had been extracted.

[197] *See* Abrams et al., *supra* note 195, at 516.

[198] *Id.* at 517.

[199] *Id.*

[200] *Id.*

[201] *Id.* at 518.

[202] *Id.*

[203] *Id.* at 515.

[204] Wallace et al., *supra* note 135, at 785.

[205] *Id.*

[206] *Id.* at 791.

[207] *Id.* at 790–91.

Marijuana's analgesic potency may not be universally acceptable to all patients; this is a phenomenon similar to that observed with other approved medications. In 2008, Wilsey and colleagues[208] reported the results of a double-blinded, placebo-controlled, crossover (one group received active and the other group placebo in the first phase; this was then reversed in the second phase of the investigation) study evaluating the analgesic efficacy of smoking marijuana for neuropathic pain.[209] Thirty-eight patients with central and peripheral neuropathic pain smoked a high dose (7 percent), low-dose (3.5 percent), or placebo marijuana.[210] Smoked marijuana produced a dose-related analgesic response.[211] Minimal and well-tolerated psychoactive effects were observed with the lower dose.[212] However, higher doses were associated with some acute cognitive effects, particularly with regard to memory.[213] The authors concluded that while marijuana may be useful in mitigating severe pain, cognitive dysfunction may prove a drawback in some patients:

> This study adds to a growing body of evidence that cannabis may be effective at ameliorating neuropathic pain, and may be an alternative for patients who do not respond to, or cannot tolerate, other drugs. However, the use of marijuana as medicine may be limited by its method of administration (smoking) and modest acute cognitive effects, particularly at higher doses.[214]

These findings were recently corroborated by investigators working in the Department of Neurosciences of the University of California San Diego who compared the ability of smoked marijuana (1–8 percent THC) to alleviate HIV-

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[208] Barth Wilsey et al., *A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain*, 9 J. PAIN 506 (2008).

[209] *Id.* at 507–08.

[210] *Id.* at 508–09.

[211] *Id.* at 511–12.

[212] *Id.* at 513–14.

[213] *Id.* at 515–16. The ability of some drugs to affect memory is certainly not confined to marijuana. Dealing with undesirable mental effects of approved medications is an essential component of pain management. Moreover, memory loss is not always an undesirable pharmacologic effect; legal anti-anxiety and amnesia-inducing drugs (falling within the ambit of the CSA) may be prescribed specifically for their ability to modify memory. *See, e.g.*, David V. Heisterkamp & Peter J. Cohen, *The Effect of Intravenous Premedication with Lorazepam (Ativan), Pentobarbitone or Diazepam on Recall*, 47 BRIT. J. ANAESTHESIA 79, 81 (1975) ("Lorazepam 3 and 5 mg was found to affect anterograde recall significantly . . . . Patient acceptance of lorazepam was very good [and two patients] requested the drug for a second operation.").

[214] Wilsey et al., *supra* note 208, at 506.

associated neuropathic pain with that of a placebo.[215] Active and placebo cigarettes were administered four times daily for five consecutive days followed by a two week "washout" period.[216] Another five-day period was then reinstituted with the control and active group reversed.[217] Subjects and investigators were blinded regarding whether they had received the placebo or active drug.[218] Active marijuana produced a statistically significant decrement in the subjects' pain score while their mood and daily functioning improved.[219] Side effects were mild and self-limited; however, two of the thirty-four subjects dropped out of the investigation because of unpleasant symptoms.[220] The authors concluded that "smoked cannabis was generally well tolerated and effective [in treating] patients with medically refractory pain due to HIV."[221]

A recent study suggests that marijuana may be a useful addition to the often debilitating chemotherapy for hepatitis C (HCV), a potentially deadly viral infection.[222] While drugs used to treat HCV are effective, their severe side effects—extreme fatigue, nausea, muscle aches, loss of appetite and depression—often lead patients to stop treatment.[223] Sylvestre and colleagues found that smoked marijuana significantly ameliorated these symptoms, thereby enabling significantly more patients to complete therapy than those who did not use marijuana.[224] The investigators concluded that marijuana use "may offer symptomatic and virological benefit [a diminished number of disease-producing viruses in the blood] to some patients undergoing HCV treatment by helping them maintain adherence to the challenging medication regimen."[225] An accompanying editorial provided strong support for the necessity of dispassionate scientific evaluation in analyzing the potential efficacy of medical marijuana's effects:

> While further research is required on the biological and clinical aspects of the benefits of cannabis use for HCV treatment, and the effectiveness of

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[215] *See* Ronald J. Ellis et al., *Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial*, NEUROPSYCHOPARHMACOLOGY 2009:34:672.

[216] *Id.* at 1–2.

[217] *Id.* at 2.

[218] *Id.* at 6–7.

[219] *Id.*

[220] *Id.* at 1, 5.

[221] *Id.* at 1.

[222] *See* Diana L. Sylvestre et al., *Cannabis Use Improves Retention and Virological Outcomes in Patients Treated for Hepatitis C*, 18 EUR. J. GASTROENTEROLGY & HEPATOLOGY 1057, 1057 (2006) (citing that cannabis use relieves "side-effects associated with HCV treatment, including nausea, anorexia, weight loss, musculoskeletal pain, insomnia, anxiety, and mood instability").

[223] *Id.*

[224] *Id.* at 1060.

[225] *Id.* at 1057, 1062.

> cannabis use for HCV treatment needs to be explored in larger study populations, we advocate that in the interim existing barriers to cannabis use are removed for drug users undergoing HCV treatment until the conclusive empirical basis for evidence-based guidance is available.[226]

These scientific data strongly suggest that marijuana has medical utility. Therefore, its designation as a Schedule I controlled substance[227] should be reevaluated to determine whether the evidence supports the concept that marijuana now "has a currently accepted medical use in treatment in the United States" under the CSA. However, despite such studies, medical marijuana remains illegal under federal law. The next section will address this disconnect between scientific data and federal policy.

V. THE BATTLE BETWEEN SCIENCE AND POLITICS

This section will discuss the pervasive intrusion of politics into what should have been a scientifically based determination of marijuana's status as a safe and efficacious drug for the treatment of certain medical conditions. It considers why it took so long for peer-reviewed studies evaluating the medical use of marijuana to appear in the scientific literature. The article will then ask why, in face of the documented safety and efficacy of medical marijuana, Congress continues to designate it as a Schedule I controlled substance and therefore illegal for medical use. It continues by exploring the question of why the medical use of marijuana was legitimatized by popular vote in California and twelve other states[228] rather than by "experts qualified by scientific training and experience."[229] Finally, this article queries whether the legalization of the use of marijuana for medical purposes will inevitably result in its inappropriate use, i.e., will it result in "gaming the system"?

A. Peer-Reviewed Scientific Studies of Medical Marijuana Have Been Published Only Recently

As discussed in Part IV, the first objective study of the safety and efficacy of smoked marijuana was published less than two years ago. Why did it take so long for this study to appear in the peer-reviewed scientific literature? Why did the pharmaceutical industry fail to show any interest in this promising compound?

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[226] Benedikt Fischer et al., *Treatment for Hepatitis C Virus and Cannabis Use in Illicit Drug User Patients: Implications and Questions*, 18 EUR. J. GASTROENTEROLOGY & HEPATOLOGY 1039, 1039 (2006).

[227] *See* 21 U.S.C. § 812(c)(10) (2006).

[228] CRS Report for Congress, *supra* note 12, at 12–16.

[229] *See* 21 U.S.C. § 321(p)(1) (defining the term "new drug" as used in the Federal Food, Drug, and Cosmetic Act).

Some might prefer a simple answer: since marijuana is a naturally occurring botanical, it cannot be patented,[230] thus removing any incentive for investing the considerable amount of corporate funds required when seeking FDA approval. This consideration does not apply to the purified derivatives or extracts of marijuana[231] which have either been approved or are currently undergoing clinical evaluation.[232]

This article argues that this is far too facile an explanation for the inordinate delay in bringing information of the medical efficacy of marijuana into the scientific literature. This article will demonstrate how one scientist, attempting to conduct "science, not ideology,"[233] was stymied by overwhelming political considerations. The history of his numerous attempts to engage in a well-designed scientific study of the efficacy (or its lack) of smoked marijuana in alleviating serious pain secondary to HIV-AIDS exemplifies the dominant role of politics in this issue.[234]

In 1992, Dr. Donald Abrams, a clinical pharmacologist, Professor of Medicine at the University of California San Francisco, and Chair of the Bay Area's Community Consortium on HIV research, proposed a study "designed to provide objective data about whether or not smoked marijuana could ease subjective symptoms of AIDS wasting and produce objective gains in body weight."[235] The University of California planned to fund the study, the FDA approved the IND, and the ethics of the study protocol were approved by the University Hospital's Institutional Review Board.[236] However, Dr. Abrams was

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[230] *See, e.g.*, Diamond v. Chakrabarty, 447 U.S. 303, 309 (1980) (stating "[t]he laws of nature, physical phenomena, and abstract ideas have been held not patentable"); *see also* Jessie A. Leak, *Herbal Medicines: What Do We Need to Know*, ASA NEWSLETTER, Feb. 2000, at 6, *available at* http://www.asahq.org/Newsletters/2000/02_00/herbal0200.html (recognizing "[p]lants and parts of plants are not patent-eligible"); Christopher Mitchell & Mehdi Ganjeizadeh, *Claiming Pitfalls in Bioinformatics Patent Applications*, 4 THE SCITECH LAW 5 (2008) (noting that for a patent claim to contain eligible subject matter, it must recite a "new and useful process, machine, manufacture, or composition of matter, or any new and useful improvement thereof" (quoting 35 U.S.C. § 101)).

[231] Dronabinol (synthetic THC, Marinol™) is an FDA-approved schedule III medication. *See* 21 C.F.R. § 1208.13(g) (2008). Sativex™ (an oromucosal spray containing equal amounts of Δ9-tetrahydrocannabinol and cannabidiol) is under investigation in the United States and Europe and has been approved in Canada. *See* Ethan B. Russo, *Cannabinoids in the Management of Difficult to Treat Pain*, 4 THERAPEUTICS & CLINICAL RISK MGMT. 245, 251 (2008).

[232] *See infra* Part VI.

[233] THE NATIONAL INSTITUTES OF HEALTH, NATIONAL INSTITUTE ON DRUG ABUSE: A RESOURCE GUIDE 38 (2005), http://www.aamc.org/research/adhocgp/pdfs/nida.pdf.

[234] *See* COHEN, *supra* note 169, at 292.

[235] *Id.*

[236] *Id.*

denied permission to import marijuana from the Netherlands as he had originally planned or to use illegal marijuana that had been seized by the DEA.[237]

Since the National Institute on Drug Abuse (NIDA) grows marijuana and is the only domestic source for scientific investigators,[238] Dr. Abrams requested their assistance, a request that would have involved only a minimal expense to NIDA.[239] However, it was then the policy of the NIH to restrict its provision of marijuana only to investigators who had received a peer-reviewed NIH grant to conduct a study.[240] Because Abrams's funding had originated at his university, and not the National Institutes of Health (NIH) of which NIDA is a part, he was refused access to NIH's marijuana.[241]

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[237] Lisa M. Krieger, *Study Targets Stalemate Over Medicinal Use of Marijuana*, SAN JOSE MERCURY NEWS, July 19, 1998, at 1A (explaining that "[f]ive years ago, Abrams first tried to win permission to scientifically study the drug. He found a supplier of pot in the Netherlands, but the Drug Enforcement Administration (DEA) refused to let it be imported. Nor would the DEA donate pot confiscated in arrests").

[238] NATIONAL ADVISORY COUNCIL ON DRUG ABUSE, PROVISION OF MARIJUANA AND OTHER COMPOUNDS FOR SCIENTIFIC RESEARCH: RECOMMENDATIONS OF THE NATIONAL INSTITUTE ON DRUG ABUSE NATIONAL ADVISORY COUNCIL (1998), http://www.nida.nih.gov/about/organization/nacda/marijuanastatement.html ("According to international treaties, only an agency of the Federal government can produce and supply cannabis. Although NIDA has been the responsible Federal agency since 1974, any other Federal agency could assume both the costs and responsibilities of maintaining the farm and supplying cannabis. NIDA's legal authority allows for the provision of cannabis only for drug abuse research purposes. . . . [i]n addition to providing cannabis for research activities, NIDA also provides cannabis to the seven patients still covered by the single patient INDs.").

[239] *See* MULTIDISCIPLINARY ASSN. FOR PSYCHEDELIC STUDIES, REPORT TO NIDA'S EXPERT PANEL ON MEDICAL MARIJUANA RESEARCH, (1997), *available at* http://www.maps.org/mmj/022597mmj.shtml ("NIDA currently has a monopoly on the supply of marijuana available to researchers who have obtained FDA approval for their proposed protocols. The cost to NIDA of its marijuana has been cited as a main justification for the need for extensive NIH peer-review of all new medical marijuana protocols. Just how expensive is NIDA marijuana? Dr. ElSohly, director of NIDA's marijuana farm at the University of Mississippi, estimates that the production cost is $1,120 per kilogram. This is a relatively minor cost compared to NIDA's estimated $487 million budget.").

[240] *See* COHEN, *supra* note 169, at 292.

[241] Krieger, *supra* note 237 ("The National Institutes of Drug Abuse would give him government-grown pot only if the National Institutes of Health approved the study. But his proposal was turned down by NIH, which . . . expressed concerns about the risks of smoking."); *see also Waiting to Inhale: Hemp for Health?*, MSNBC, Nov. 1997, http://www.erowid.org/plants/cannabis/cannabis_medical_media6.shtml ("San Francisco AIDS specialist Dr. Donald Abrams has been trying to unravel marijuana's mysteries since 1992, when he proposed a pilot trial to determine if marijuana helps to increase appetite in HIV-positive patients—give them the 'munchies,' as it were—thereby warding off the debilitating weight loss associated with the AIDS wasting syndrome. 'But our proposal was

In May of 1996, hoping that the NIH had changed its policies, Dr. Abrams resubmitted his study proposal to the NIH.[242] At that time, the study had again been approved and funded at the university level; thus, NIH approval was required not for funding, but to allow him to obtain federally grown marijuana.[243] In October 1996, four years after he had first initiated requests to obtain marijuana legally, he was again informed that the NIH would not supply it.[244]

In 1998, after six years of frustrating attempts to obtain marijuana[245] either in the United States or abroad, the NIH finally approved Dr. Abrams's request and he

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turned down time and again,' he says."); *see also* COHEN, *supra* note 169, at 292 (describing Dr. Abrams' struggles to get research materials).

[242] COHEN, *supra* note 169, at 292.

[243] *Id.*

[244] Whether these events were actually *a direct cause of* or were simply *associated in time with* California's action:

> On November 5, 1996, California voters passed the Compassionate Use Act (Proposition 215) by a wide margin (56% to 44%). This law permitted "seriously ill" patients and their primary caregivers to cultivate and possess marijuana for the patients' personal medical use if they had the "written or oral recommendation or approval of a physician." Several diagnoses for which marijuana may have palliative benefit were listed in Proposition 215, but its use was not limited to these diagnoses, and there was no age limitation on those who used it.

COHEN, *supra* note 169, at 293.

[245] For Abrams' personal response to NIDA's intransigence, see Donald I. Abrams et al., 333 NEW ENGL. J. MED. 670, 671 (1995), in which he states:

> Inhaled marijuana is being used increasingly by people with HIV infection, especially for its purported benefit as an anti-emetic agent and an appetite stimulant in those with the AIDS wasting syndrome. Up to 2000 people infected with HIV are reported to be obtaining marijuana at a cannabis buyer's club in our area. . . .
>
> In an effort to determine whether inhaled marijuana is truly of any potential benefit and, more important, to evaluate its safety in people with AIDS, [we] designed a pilot study . . . of the overall feasibility of investigating inhaled marijuana use by such patients, before embarking on a full-scale trial of its efficacy. The pilot-drug-evaluation staff at the FDA provided valuable comments on the design of the protocol. . . .
>
> The FDA and the institutional review board supported the study. Unfortunately, the DEA and the NIDA opposed it. Most disturbing was the absence of a response from either agency for an unacceptably long period, followed by the NIDA's outright rejection of the proposal without any opportunity for dialogue or compromise. Such behavior is offensive not only to the investigators but to the patients for whom we seek to find safe and effective treatments.

was able to obtain marijuana legally. Abrams then initiated the first federally funded effort to study the effects of marijuana on patients with AIDS, an investigation that was eventually published in the peer-reviewed scientific literature.[246]

This was not the only instance in which the federal government appeared to place significant roadblocks in the way of university-sponsored research directed toward obtaining information about the possible medical uses of marijuana. Because of difficulties in obtaining marijuana from NIDA's "marijuana farm," Lyle E. Craker, PhD, a professor in the Department of Plant and Soil Sciences at the University of Massachusetts Amherst, petitioned the Drug Enforcement Agency (DEA) in 2003[247] for permission to cultivate marijuana to use in university-approved clinical studies that would evaluate marijuana's ability to provide pain relief and control nausea in patients with cancer, as well as to alleviate some of the symptoms of multiple sclerosis in other patients.[248] His petition was denied by the DEA in spite of DEA Administrative Law Judge Mary Ellen Bittner's nonbinding opinion that it would be in the public interest to grant

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[246] *See* Abrams et al., *supra* note 195, at 515. The availability of marijuana for scientific investigations also removed barriers to the studies that were detailed in Part IV. *See supra* Part IV.

[247] *See* Manufacturer of Controlled Substance, 68 Fed. Reg. 43,755 (Drug Enforcement Admin. July 24, 2003) (notice of application). The notice states that:

> Pursuant to Section 1301.33(a) of Title 21 of the Code of Federal Regulations (CFR), this is notice that on June 25, 2001, the University of Massachusetts, Lyle E. Craker, Professor, Department of Plant and Soil Science, Stockbridge Hall, Box 37245, Amherst, Massachusetts 01003, made application to the Drug Enforcement Administration (DEA) for registration as a bulk manufacturer of Marijuana (7360) and Tetrahydrocannabinols (7370), basic classes of Schedule I controlled substances.
>
> The University of Massachusetts-Amherst plans to bulk manufacture (cultivate) Marijuana and Tetrahydrocannabinols for distribution to approved researchers.

Id.

[248] *See id.* ("Pursuant to Section 1301.33(a) of Title 21 of the Code of Federal Regulations (CFR), this is notice that on June 25, 2001, the University of Massachusetts, Lyle E. Craker, Professor, Department of Plant and Soil Science, Stockbridge Hall, Box 37245, Amherst, Massachusetts 01003, made application to the Drug Enforcement Administration (DEA) for registration as a bulk manufacturer of Marijuana (7360) and Tetrahydrocannabinols (7370), basic classes of Schedule I controlled substances. The University of Massachusetts-Amherst plans to bulk manufacture (cultivate) Marijuana and Tetrahydrocannabinols for distribution to approved researchers.").

it.[249] She stated in that opinion that the federal government's system for evaluating requests for marijuana for clinical study had hindered investigation of the drug's safety and effectiveness.[250] As of mid-2008, the case is still pending.[251] Four years after the petition was filed, DEA spokesman Steve Robertson told the *American Medical News* that the agency was reviewing the decision but he declined to comment other than to declare that "[t]he government maintains that no sound scientific studies exist to support marijuana's medical value."[252]

The federal government's stance regarding scientific investigation of medical marijuana has, however, been far from monolithic. While those individuals within the NIH who acted on Dr. Abrams's request appeared to reject even minimal support of scientific study of the medical use of marijuana, other NIH personnel appeared to take an opposite stance. After considerable "wide-ranging public discussion on the potential medical use of marijuana, particularly smoked marijuana,"[253] the National Institutes of Health convened a conference "to review the scientific data concerning the potential therapeutic uses for marijuana and the need for and feasibility of additional research" in February 1997.[254]

At this forum,[255] a group of experts in anesthesiology, internal medicine, neurology, oncology, ophthalmology, pharmacology and psychiatry maintained that there was a need for accurate and nonbiased scientific investigation of medical marijuana.[256] The participants suggested that although Δ9-tetrahydrocannabinol, the major psychoactive component of marijuana, is currently available as a separate and approved medication, this should not obviate the need to study the efficacy of smoked marijuana itself.[257] They noted the plant may also contain other compounds with important therapeutic properties.[258] Moreover, "the bioavailability

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[249] Amy Lynn Sorrel, *DEA Judge's Ruling Could Help Medical Marijuana Research*, AMER. MED. NEWS, Mar. 19, 2007, http://www.ama-assn.org/amednews/2007/03/19/gvsb0319.htm.

[250] *See id.* This is not the first time that an Administrative Law Judge's ruling was overturned by the DEA. In 1998, "Administrative Law Judge Francis L. Young granted a petition by the National Organization for the Reform of Marijuana Laws to have the DEA downgrade marijuana from a schedule I to a schedule II controlled substance. The administration rejected the decision." *Id.*

[251] Mark Kaufman, *Researchers Press DEA to Let Them Grow Marijuana*, WASH. POST, May 24, 2007, at A03.

[252] Sorrel, *supra* note 250.

[253] NATIONAL INSTITUTES OF HEALTH, WORKSHOP ON THE MEDICAL USE OF MARIJUANA (1997) [hereinafter NATIONAL INSTITUTES OF HEALTH], http://www.nih.gov/news/medmarijuana/MedicalMarijuana.htm. I did not participate in this workshop.

[254] *Id.*

[255] This conference took place only a few months after California voters had passed Proposition 215. *Id.*

[256] *Id.*

[257] *See id.* ("The availability of THC in capsule form does not fully satisfy the need to evaluate the potential medical utility of marijuana.").

[258] *Id.*

and pharmacokinetics of THC from smoked marijuana are substantially different than those of the oral dosage form."[259]

The expert group proposed that the possibly beneficial (or even superior[260]) role of smoked marijuana cannot be delineated without proper investigation.[261] They maintained that studies of marijuana should not be precluded because effective approved therapy was currently available for the diseases in which it might also be efficacious.[262] The members proposed that:

> For at least some potential indications, marijuana looks promising enough to recommend that there be new controlled studies done. The indications in which varying levels of interest were expressed are the following:
>
> - Appetite stimulation and cachexia
> - Nausea and vomiting following anticancer therapy
> - Neurological and movement disorders
> - Analgesia
> - Glaucoma[263]

The expert group's recommendations presented a statement of the overarching goals and principles of scientific investigation in general and the scientific rationale of studying smoked marijuana in particular:

> In summary, the testing of smoked marijuana to evaluate its therapeutic effects is a difficult, but not impossible, task. Until studies are done using scientifically acceptable clinical trial design and subjected to appropriate statistical analysis, the questions concerning the therapeutic utility of marijuana will likely remain much as they have to date—largely unanswered. *To the extent that the NIH can facilitate the development of a scientifically rigorous and relevant database, the NIH should do so.*[264]

This was not the only expert discussion suggesting that the use of medical marijuana should not be dismissed out of hand. A meeting sponsored by the National Academies of Sciences–Institute of Medicine to discuss the medical use of marijuana (*Workshop on Prospects for Cannabinoid Drug Development,*

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[259] *Id.*

[260] *See supra* note 15 (explaining that smoking marijuana allows greater drug effectiveness and thus requires a lower dosage).

[261] *See* NATIONAL INSTITUTES OF HEALTH, *supra* note 253.

[262] *Id.*

[263] *Id.*

[264] *Id.* (emphasis added).

National Academies of Sciences–Institute of Medicine) was held in February 1998; the proceedings were published in 1999.[265] Discussion at this meeting centered on both the adverse effects and potential benefits of smoked marijuana.[266] Participants indicated that smoked marijuana could be a valuable agent in the treatment of chemotherapy-induced nausea and vomiting, HIV-related gastrointestinal disorders, AIDS wasting, severe pain, and some forms of spasticity.[267] Some participants stressed—as had those at the NIH conference held the preceding year—that since the whole marijuana plant contains many possibly active cannabinoids besides THC, its possible efficacy may not be replicated by medications containing only THC.[268]

Nonetheless, the suggestion by an impartial conference of experts that marijuana might have some medical utility that should be discussed and that its properties should be subjected to scientific investigation evoked a forceful but inaccurate response from the federal government:

> A past evaluation by several Department of Health and Human Services (HHS) agencies, including the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Drug Abuse (NIDA), concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use.[269]

This "authoritative" statement did not go unnoticed by the media. A reporter for the New York Times observed that:

> The Food and Drug Administration said Thursday that "no sound scientific studies" supported the medical use of marijuana, contradicting a 1999 review by a panel of highly regarded scientists.
>
> The announcement inserts the health agency into yet another fierce political fight . . . .
>
> . . . .
>
> . . . [It] directly contradicts a 1999 review by the Institute of Medicine [IOM], a part of the National Academy of Sciences, the

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[265] *See generally* INSTITUTE OF MEDICINE, MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE, (Janet E. Joy et al., eds., 1999).

[266] *See id.* at 15–16 (describing the discussions that took place at the National Academy of Sciences-Institution of Medicine workshops).

[267] *See id.* at 20–24 (discussing the range of participants and their utilization of medical marijuana).

[268] *Id.* at 3, 150. *See infra* Part VI (discussing dronabinol, a cannabinoid).

[269] Press Release, U.S. Food and Drug Administration, Inter-Agency Advisory Regarding Claims that Smoked Marijuana Is a Medicine (Apr. 20, 2006), www.fda.gov/bbs/topics/NEWS/2006/NEW01362.html.

> nation's most prestigious scientific advisory agency. That review found marijuana to be "moderately well suited for particular conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting."[270]

Dr. John Benson, cochairman of the IOM committee and professor of internal medicine at the University of Nebraska Medical Center, whose report had suggested that smoked marijuana could have therapeutic value, strongly disputed the FDA's stance. "The federal government loves to ignore our report," said Dr. Benson, "They would rather it never happened."[271] Dr. Jerry Avorn, a medical professor at Harvard Medical School, declared, "Unfortunately, this is yet another example of the F.D.A. making pronouncements that seem to be driven more by ideology than by science."[272]

More recently, the American College of Physicians (ACP) issued a position paper emphasizing the importance of sound scientific study to evaluate the role of marijuana in modern medical therapy.[273] The ACP paper stressed that this agent was neither devoid of potentially harmful effects nor universally effective.[274]

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[270] Gardiner Harris, *F.D.A. Dismisses Medical Benefit from Marijuana*, N.Y. TIMES, Apr. 21, 2006, at A1.

[271] *Id.*

[272] *Id.*

[273] TIA TAYLOR, AM. COLL. OF PHYSICIANS, SUPPORTING RESEARCH INTO THE THERAPEUTIC ROLE OF MARIJUANA 1 (2008), *available at* http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf.

[274] *See, e.g.*, *id.* at 3. The ACP recommends that cannabis not be used to treat glaucoma, stating that:

> High intraocular pressure (IOP) is a known risk factor for glaucoma. Cannabinoids have been shown to have neuroprotective properties and to reduce IOP, pupil restriction, and conjunctival hyperemia. Smoked or eaten marijuana and oral THC can reduce IOP by approximately 25% in people with normal IOP who have visual field changes, with similar results exhibited in healthy adults and glaucoma patients. However, the effects of cannabinoids on IOP are short-lived, and high doses are required to produce any effects at all. There is concern that long-term use of marijuana could reduce blood flow to the optic nerve because of its systemic hypotensive effects and its potential for interaction with other antiglaucoma drugs. In addition, the cardiovascular and psychoactive effects of smoked marijuana contraindicate its use in glaucoma patients, many of whom are elderly and have comorbidities. This led to the development and testing of a topical THC, but its effect on IOP was insignificant. As a result, the IOM and American Academy of Ophthalmology concluded that no scientific evidence has demonstrated increased benefits or diminished risks of marijuana use to treat glaucoma compared with the wide variety of pharmaceutical agents currently available.

Id. (citations omitted).

Nonetheless, it strongly recommended that marijuana should not be summarily rejected as a bona fide therapeutic agent and urged "an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule."[275] The ACP paper stated that the review "should consider the scientific findings regarding marijuana's safety and efficacy in some clinical conditions as well as evidence on the health risks associated with marijuana consumption, particularly in its crude smoked form." [276]

The ACP took note of the historical fact that marijuana has been smoked for its medicinal properties for centuries.[277] It cited extant scientific data and stated that "[p]reclinical, clinical, and anecdotal reports suggest numerous potential medical uses for marijuana."[278] The ACP's position paper recognized that while the indications for using marijuana to treat "some conditions (e.g., HIV wasting and chemotherapy-induced nausea and vomiting) have been well documented, less information is available about other potential medical uses."[279] The report reached several important conclusions. It stated that:

> Additional research is needed to clarify marijuana's therapeutic properties and determine standard and optimal doses and routes of delivery. Unfortunately, research expansion has been hindered by a complicated federal approval process, limited availability of research-grade marijuana, and the debate over legalization.
>
> Marijuana's categorization as a Schedule I controlled substance raises significant concerns for researchers, physicians, and patients. As such, the College's policy positions on marijuana as medicine are as follows:
>
> - ACP supports programs and funding for rigorous scientific evaluation of the potential therapeutic benefits of medical marijuana and the publication of such findings.
> - ACP supports increased research for conditions where the efficacy of marijuana has been established to determine optimal dosage and route of delivery.
> - Medical marijuana research should not only focus on determining drug efficacy and safety but also on determining efficacy in comparison with other available treatments.
> - ACP encourages the use of nonsmoked forms of THC that have proven therapeutic value.

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[275] *Id.* at 8.
[276] *Id.* at 8.
[277] *Id.* at 1.
[278] *Id.*
[279] *Id.* at 1.

- ACP urges review of marijuana's status as a schedule I controlled substance and its reclassification into a more appropriate schedule, given the scientific evidence regarding marijuana's safety and efficacy in some clinical conditions.
- ACP strongly supports exemption from federal criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for physicians who prescribe or dispense medical marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.[280]

C. Marijuana, Scheduling, and Politics

The FD&C Act requires that a new drug be proven safe and effective for the specific condition for whose treatment approval is sought, not that it be proven superior to already approved medications. As discussed above, marijuana has documented beneficial properties for the treatment of a number of diseases and has minimal risks when used under a physician's supervision. Yet, it remains a Schedule I controlled substance "without currently accepted medical use in treatment in the United States."[281] This decision was not made by scientific experts but by Congressional legislative fiat. What was the role of politics in Congress's decision to circumvent, albeit legally, the review process that has governed approval decisions for almost all medications?[282]

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[280] *Id.*

[281] 21 U.S.C. § 812(b)(1) (2006) ("The drug . . . has a high potential for abuse . . . [and] has no currently accepted medical use in treatment in the United States.").

[282] The marijuana-related conflict between political ideology and scientific evidence is not a recent phenomenon, but was seen over 70 years ago during Congressional hearings to discuss the Marijuana Tax Act. *See, e.g.*, DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 225, 228 (Oxford University Press Expanded ed. 1999) (1973).

> The Treasury Department collected and considered scientific and medical opinion prior to the Tax Act hearings, but the desire to present a solid front when the department appeared before the committees of Congress caused the officials to ignore anything that qualified or minimized the evils of marijuana. The political pressure to put "something on the books" . . . [made] the marijuana hearings a classic example of bureaucratic overkill. . . .
>
> Everyone from the Treasury Department who appeared for the Tax Act gave it full support while those who might have had more moderate views remained in the background. . . .
>
> [Even] the most "liberal" spokesmen were among the most eager to protect the public by prohibiting cannabis.

In passing the CSA, Congress specifically designated marijuana as a Schedule I Controlled Substance, thereby pronouncing that it has no currently accepted medical use in treatment in the United States. The statute[283] designates the following compounds as Schedule I controlled substances:

- Marihuana
- Tetrahydrocannabinols
- Peyote
- Lysergic acid diethylamide
- Heroin[284]

Id.

Congressional action based on politics rather than scientific evidence has not been confined to marijuana. A far more recent example is the fate of an effective public health measure based on an inaccurate, but politically expedient belief, that needle exchange (supplying clean needles to drug users) would increase illegal drug use. *See. e.g.*, Prevention Works!—Harm Reduction in the Nation's Capital, http://www.preventionworks dc.org/about.html (last visited Mar. 27, 2008). Until 2008, Congress had repeatedly legislated against this proven means of preventing transmission of HIV and hepatitis. As a result, "The District of Columbia [was] the only city in the nation barred by federal law from investing its own locally raised tax dollars to support needle exchange programs." *Id.*

[283] 21 U.S.C. § 812(c).

[284] Heroin, designated as a schedule I controlled substance under 21 U.S.C. § 812(b)(10), is an accepted and legal therapeutic agent in many countries therefore there is no scientific justification for designating it as schedule I. *See, e.g.*, M. Giovannelli, N. Bedforth, A. Aitkenhead, *Survey of Intrathecal Opioid Usage in the UK*, 25 EUR. J. ANAESTHESIOL 118, 118 (2008) (finding that opioids such as diamorphine were used in 136 (78.2%) of departments); *see also* A Hallett et al., *Patient-Controlled Intranasal Diamorphine for Postoperative Pain: An Acceptability Study*, 55 ANAESTHESIA 532, 538 (2000) ("We conclude that patient–controlled intranasal [heroin] is an effective form of postoperative pain relief which was well tolerated by patients and nurses with acceptably few side-effects."); M. Hewitt et Al., *Opioid Use in Palliative Care of Children and Young People with Cancer*, 152 J. PEDIATRICS 39, 39 (2008) (stating that the use of heroin was documented in 58% of pediatric patients undergoing palliative care for terminal cancer); Jason M. Kendall et al., *Multicentre Randomised Controlled Trial of Nasal Diamorphine for Analgesia in Children and Teenagers with Clinical Fractures*, 322 BRIT. MED. J. 261, 261 (2001) ("Nasal diamorphine [heroin] spray should be the preferred method of pain relief in children and teenagers presenting to emergency departments in acute pain with clinical fractures. The diamorphine spray should be used in place of intramuscular morphine."); J. Sawynok, *The Therapeutic Use of Heroin: a Review of the Pharmacological Literature*, 64 CAN. J. PHYSIOL. PHARMACOL. 1, (1986) ("Administered orally, heroin is approximately 1.5 times more potent than morphine in controlling chronic pain in terminal cancer patients . . . . Given parenterally for acute pain, heroin is 2–4 times more potent than morphine and faster in onset of action. When the potency difference is accounted for, the pharmacological effects of heroin do not differ appreciably from those of morphine."). Indeed, once heroin is administered to humans, it is converted to morphine

This congressional action was brought to the attention of the Supreme Court when the Oakland Cannabis Club challenged the federal government's authority to enjoin its distribution of medical marijuana on the grounds that *congressional* designation as a Schedule I controlled substance was invalid.[285] The Court declared that congressional scheduling was binding, and that it was of no legal consequence that the Schedule I designation had been based on congressional action rather than scientific evidence.[286] The Court stated:

> The Cooperative points out, however, that the Attorney General [who would have acted on the scientific findings made by the FDA] did not place marijuana into schedule I. *Congress put it there, and Congress was not required to find that a drug lacks an accepted medical use before including the drug in schedule I.* We are not persuaded that this distinction has any significance to our inquiry. . . . Nothing in the statute . . . suggests that there are two tiers of schedule I narcotics, with drugs in one tier more readily available than drugs in the other. On the contrary, the statute consistently treats all schedule I drugs alike.[287]

Four years later, the high Court again emphasized the significance of congressional authority to issue a schedule I classification for marijuana:

> In enacting the CSA, *Congress classified marijuana as a Schedule I drug.* . . . Schedule I drugs are categorized as such because of their high potential for abuse, lack of any accepted medical use, and absence of any accepted safety for use in medically supervised treatment. . . . By classifying marijuana as a Schedule I drug, as opposed to listing it on a lesser schedule, the manufacture, distribution, or possession of marijuana became a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration pre-approved research study.
>
> The CSA provides for the periodic updating of schedules . . . . Despite considerable efforts to reschedule marijuana, it remains a Schedule I drug.[288]

(schedule II) by the liver and, therefore, has properties not dissimilar to those of morphine. Rania Habal, *Toxicity: Heroin*, EMEDICINE, Aug. 12, 2008, http://www.emedicine.com/med/TOPIC1003.HTM ("Heroin is rapidly converted to 6-monoacetylmorphine (6-MAM) by the liver, brain, heart, and kidney and may not be detected in the blood at the time of blood draw. 6-MAM is then converted to morphine."). Its designation as schedule I exemplifies that the interaction of politics and science is not confined to medical marijuana.

[285] *See* United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 491 (2001).

[286] *Id.* at 492–93.

[287] *Id.* (emphasis added) (citations omitted).

[288] Gonzales v. Raich, 545 U.S. 1, 13 (2005) (emphasis added) (citations omitted).

Thus, in the face of several well-controlled studies demonstrating marijuana's safety and efficacy in relieving both pathologic and experimentally induced pain as well as the often-incapacitating symptoms of nausea, vomiting, loss of appetite, and depression,[289] the recommendations of several scientific groups (some with the support of the federal government) that research should be unrestrained by political considerations, and the finding by an administrative law judge as well as well-regarded scientific committees that its designation as a Schedule I controlled substance was unjustified,[290] marijuana remains a Schedule I medication and there have been no realistic attempts to bring about a change in this situation. Legislators rather than "experts qualified by scientific training and experience"[291] have acted to deny marijuana admission to legitimate medical practice.

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[289] Note, however, that if medical marijuana were removed from schedule I and approved for relief of these conditions, it probably could then be used "off-label" for any purpose a physician deemed reasonable. *See* United States v. Evers, 643 F.2d 1043, 1048 (5th Cir. 1981) (discussing "off-labeling" of prescription drugs and holding that "[o]nce (an approved) new drug is in a local pharmacy after interstate shipment, the physician may, as part of the practice of medicine, lawfully prescribe a different dosage for his patient, or may otherwise vary the conditions of use from those approved in the package insert, without informing or obtaining the approval of the Food and Drug Administration"). For further discussion, see infra Part VI.

[290] *See, e.g.*, *Gonzales*, 545 U.S. at 15 n.23 ("After some fleeting success in 1988 when an Administrative Law Judge (ALJ) declared that the DEA would be acting in an 'unreasonable, arbitrary, and capricious' manner if it continued to deny marijuana access to seriously ill patients, and concluded that it should be reclassified as a Schedule III substance, *Grinspoon v. DEA*, 828 F. 2d 881, 883–884 (CA1 1987), the campaign has proved unsuccessful. The DEA Administrator did not endorse the ALJ's findings, 54 Fed. Reg. 53767 (1989), and since that time has routinely denied petitions to reschedule the drug, most recently in 2001. 66 Fed. Reg. 20038 (2001)."); *see also* George J. Annas, *Reefer Madness—the Federal Response to California's Medical-Marijuana Law*, 337 NEW ENGL. J. MED. 435, 438 (1997) ("In 1988, after two years of hearings, DEA administrative-law judge Francis Young recommended shifting marijuana to Schedule II on the grounds that it was safe and had a 'currently accepted medical use in treatment.' Specifically, Judge Young found that 'marijuana, in its natural form, is one of the safest therapeutically active substances known to man. . . . At present, it is estimated that marijuana's LD-50 (median lethal dose) is around 1:20,000 or 1:40,000. In layman's terms . . . a smoker would theoretically have to consume 20,000 to 40,000 times as much marijuana as is contained in one marijuana cigarette . . . nearly 1500 pounds of marijuana within about fifteen minutes to induce a lethal response.' As for medical use, the judge concluded, among other things, that marijuana 'has a currently accepted medical use in treatment in the United States for nausea and vomiting resulting from chemotherapy treatment.' The administrator of the DEA rejected Young's recommendation, on the basis that there was no scientific evidence showing that marijuana was better than other approved drugs [this is *not* required by the FDA statute—all that must be demonstrated is safety and efficacy]. Further attempts to get the courts to reclassify marijuana have been unsuccessful.").

[291] *See* 21 U.S.C. § 321(p)(1) (2006).

The citizens of California disagreed with Congress and maintained that marijuana had medical value. Why was the use of medical marijuana legitimatized through legislation, ballot initiatives, and referenda in thirteen states rather than by "experts qualified by scientific training and experience?" While this article's response to this question will focus on California, it is likely that many of the factors that led to the adoption of California's Proposition 215 also impelled the citizens of the other twelve states to take similar action. The promulgation of Proposition 215[292] and its overwhelming acceptance by the people of California

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[292] Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West 2001). The Act states:

> SECTION 1. Section 11362.5 is added to the Health and Safety Code, to read:
>
> 11362.5. (a) This section shall be known and may be cited as the Compassionate Use Act of 1996.
>
> (b)(1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:
>
> (A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.
>
> (B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.
>
> (C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.
>
> (2) Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.
>
> (c) Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.
>
> (d) Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.
>
> (e) For the purposes of this section, "primary caregiver" means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person.
>
> SECTION 2. If any provision of this measure or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other

represented a popular sense that patients were being denied a medication that could alleviate suffering. It expressed a reaction to perceived federal intransigence and even arrogance, and the lack of interest in sponsoring research on this compound on the part of the pharmaceutical industry. The voters' decision was, in effect, a repudiation of the proposition that scientific data should be dispositive in drug approval that was akin to the stance taken by Congress. The voters' view that powerful forces were preventing access to novel therapies manifested a recurring conflict between the desire for personal autonomy and what they perceived as paternalistic interference by the government.

This conflict is exemplified by the significant case brought by Angel Raich.[293] Ms. Raich claimed that she had a fundamental right to use medical marijuana, an agent that she believed necessary to preserve her life.[294] Although her use of medical marijuana was legal under California's Proposition 215, it was illegal under federal law.[295] Raich challenged the constitutionality of the CSA, asserting that her right to use marijuana was "deeply rooted in this nation's history and traditions and implicit in the concept of ordered liberty."[296] The Court of Appeals for the Ninth Circuit denied her appeal.[297] Her statements after this decision—"It's not every day in this country that someone's right to life is taken from them"[298] and "[t]oday you are looking at someone who really is walking dead"[299]—exemplified

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provisions or applications of the measure that can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

[293] Raich v. Gonzales, 500 F.3d 850, 855 (9th Cir. 2007).

[294] *Id.* ("Appellant Angel McClary Raich is a Californian who uses marijuana for medical treatment. Raich has been diagnosed with more than ten serious medical conditions, including an inoperable brain tumor, a seizure disorder, life-threatening weight loss, nausea, and several chronic pain disorders. Raich's doctor . . . testified that he had explored virtually every legal treatment alternative, and that all were either ineffective or resulted in intolerable side effects. [Additionally, he] provided a list of thirty-five medications that were unworkable because of their side effects.").

[295] *Id.* at 854–55.

[296] *Id.* at 863.

[297] *Id.* at 869.

[298] *See, e.g.*, Jesse McKinley, *Dying Woman Loses Appeal On Marijuana As Medication*, N.Y. TIMES, Mar. 15, 2007, at A18 ("Angel McClary Raich says she uses marijuana [eating or smoking it every couple of hours] on doctors' recommendation to treat an inoperable brain tumor and a battery of other serious ailments [including scoliosis and chronic nausea]. Ms. Raich, 41, asserts that the drug effectively keeps her alive, by stimulating appetite and relieving pain, in a way that prescription drugs do not.").

[299] *Id.*; *see also* Bob Egelko & Jim Herron Zamora, *Medical Pot User Loses Again in Federal Court*, S.F. CHRON., Mar. 15, 2007, at A11 (quoting Angel Raich as saying, "I don't want that coffin, but from this point on I am walking dead. . . . I will continue to use cannabis. I will continue to smoke cannabis. . . . This is real medicine and the federal government cannot tell us any differently").

the thoughts and feelings of many advocates for medical marijuana. These individuals sincerely believed that they did not need outside scientific experts to approve what they were doing. Indeed, even the Ninth Circuit's holding implied that if medical marijuana were to be eventually accepted and legalized, it would not necessarily require scientific evidence obtained through investigation but could be accomplished simply by judicial fiat or the will of the people.[300]

D. "Gaming the System"

Will approval and legitimization of the cultivation, prescription, and dispensing of medical marijuana have unintended consequences? Recent events in California, one of thirteen states that has approved the use of marijuana for medical purposes, suggest to some that legalization might increase the cultivation of and traffic in marijuana for purposes other than bona fide medical therapy.[301] In the

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[300] *Raich*, 500 F.3d at 866 ("We agree with Raich that medical and conventional wisdom that recognizes the use of marijuana for medical purposes is gaining traction in the law as well. But that legal recognition has not yet reached the point where a conclusion can be drawn that the right to use medical marijuana is 'fundamental' and 'implicit in the concept of ordered liberty.' *For the time being, this issue remains in the arena of public debate and legislative action.* (emphasis added) (citation omitted)).

[301] This problem has not escaped the notice of California's Attorney General. *See, e.g.*, *California Issues New Medical-Marijuana Guidelines*, JOIN TOGETHER, Sep. 2, 2008, http://www.jointogether.org/news/headlines/inthenews/2008/california-issues-new.html. Indeed, the following article notes the following:

> New guidelines from the California Attorney General's office aim to clear up some of the confusion that has long plagued the state's 1996 medical-marijuana law.
>
> . . .
>
> The guidelines, issued by AG Jerry Brown this week, give legal sanction under state law to storefront medical-marijuana collectives, but also clarify the circumstances under which law enforcement can go after drug dealers using the law as a front for illicit marijuana sales. "It clarifies the rules and makes it easier for law enforcement to do their jobs . . . and the users and advocates are happy because it restated what is permitted by the initiative and the statute," Brown said. "It did what law is supposed to do—it set the ground rules for action both by individuals and by the government."
>
> Dispensaries cannot be operated for profit, the guidelines say, and must maintain detailed records, including documents proving that customers are legitimate medical users.
>
> "The collective should not purchase marijuana from, or sell to, nonmembers; instead, it should only provide a means for facilitating or coordinating transactions between members," the new guidelines state." The cycle should be a closed circuit of marijuana cultivation and consumption with no purchases or sales to or from nonmembers. To help prevent diversion of medical marijuana to nonmedical markets, collectives and cooperatives should

past year, the *New York Times* reported that marijuana farming is on the rise in California:

> There is probably no marijuana-friendlier place in the country than here in Mendocino County, where plants can grow more than 15 feet high, medical marijuana clubs adopt stretches of highway, and the sticky, sweet aroma of cannabis fills this city's streets during the autumn harvest.
>
> Lately, however, residents of Mendocino County, like those in other parts of California, are wondering if the state's embrace of marijuana for medicinal purposes has gone too far. . . .
>
> [I]n Arcata, home of Humboldt State University, [] town elders say roughly one in five homes are "indoor grows," with rooms or even entire structures converted into marijuana greenhouses. . . .
>
> In May, Arcata declared a moratorium on clubs to allow the city council time to address the problem. Los Angeles, which has more than 180 registered marijuana clubs, the most of any city, also declared a moratorium last year.
>
> "There were a handful initially and then all the sudden, they started to sprout up all over," said Dennis Zine, a member of the Los Angeles City Council. "We had marijuana facilities next to high schools and there were high school kids going over there and there was a lot of abuse taking place."[302]

Legalization of marijuana for medical use, however, was not the cause of this problem. Rather, the ubiquitous Internet has ensured that the cultivation, distribution, and use of marijuana for nonmedical purposes will not be confined to jurisdictions that have legalized its use. A recent "Google search" for "buy medical marijuana" resulted in 1,210,000 "hits" originating from throughout the world.[303]

> document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana."
>
> . . .
>
> Brown's office and federal law enforcement continue to conduct raids on medical-marijuana dispensaries thought to be violating state and/or federal laws.

Id.

[302] Jesse McKinley, *Marijuana Hotbed Retreats on Medicinal Use*, N.Y. TIMES, June 9, 2008, at A1.

[303] *See, e.g.*, Head Shop Supply: Medical, Medicinal Marijuana Seeds, http://www.headshopsupply.com/medical.php (last visited Mar. 16, 2008) ("[G]rowing medical marijuana is now legal in many states in the United States such as California, Nevada, Alaska and Oregon . . . . If you are wondering how to become licensed for medical marijuana as a grower or a user you can seek out and ask questions at your local compassion club. If you are licensed to grow a certain number of plants for personal

Moreover, the phenomenon of permissive and illegal online purchasing is not confined to marijuana alone. Diversion and illegal use of FDA-approved controlled substances is a contemporary phenomenon, as evidenced by a telling report that the vast majority of "online pharmacies" do not require that customers provide a physician's prescription in order to obtain controlled drugs.[304] The National Center on Addiction and Substance Abuse (CASA) stated that only two out of 365 websites that sold prescription drugs online had been certified by the National Association of Boards of Pharmacy.[305] Although only 42 percent of the websites surveyed explicitly stated that no prescription was required to obtain drugs, 85 percent actually sold their drugs without a prescription.[306] CASA's report stated that, "even among the sites that require a prescription, half allow customers to fax their scrip in, which is an invitation to fraud."[307]

It was, perhaps, inevitable that similar abuses of marijuana would occur whether or not it was made legal for medical use. However, the illegal dispensing of approved controlled substances such as morphine and Valium™ has not resulted in banning the use of these medications when required for legitimate medical treatment. Similarly, blatantly inappropriate sales of marijuana masquerading as medical therapy would not justify the federal government's refusal to remove the current Schedule I classification for medical marijuana if scientific data suggested rescheduling were warranted.

Such illegal access to controlled substances (including marijuana were it to be approved) is not totally without remedy. While Internet crime may be extraordinarily difficult to combat, there is no reason to believe that either the civil[308] or the criminal justice systems[309] are incapable of dealing effectively with illegal activities conducted outside the web.

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medical marijuana use and you need medical marijuana seeds we have many available at a discount price for medical marijuana growing."); Mary Jane's Garden: Marijuana Seeds & Supplies, http://www.maryjanesgarden.com (last visited Mar. 16, 2008) ("Amsterdam Marijuana Seeds now has on [*sic*] for sale where you can get 10 free when you buy indoor or outdoor pot seeds for a limited time only."); Medical Marijuana Provider Form, http://www.mainevocals.net/printablemedform.htm (last visited Mar. 16, 2008); *see also* Welcome to SIMM, http://www.medicalmarijuana.org (last visited Mar.16, 2008) ("Our purpose—to produce and supply patients with high quality medical cannabis, at the lowest possible price.").

[304] *85 Percent of Online Pharmacies Don't Require Prescription, CASA Study Finds*, July 10, 2008, http://www.jointogether.org/news/research/summaries/2008/85-percent-of-online.html.

[305] *Id.*

[306] *Id.*

[307] *Id.*

[308] *See* Hurwitz v. Bd. of Medicine, No. 96-676, 1998 WL 972259, at *2 (Va. Cir. Ct. June 30, 1998) (holding that "the board of medicine exercised its summary suspension power, concluding that the doctor's unprofessional conduct, coupled with an apparent unquestioning compliance with patients' requests for prescriptions and refills, all justified board intervention to prevent danger to his patients. 'It [was] not just a "clerical error" [for

VI. WILL THE FUTURE USE OF EXTRACTS OF MARIJUANA MOOT THE QUESTION OF MEDICAL MARIJUANA?

As observed earlier, many of today's useful medications are derived from plants. It should, therefore, not be surprising that pharmaceuticals derived from the plant *Cannabis sativa* are now, or soon will be, available. This section will examine two such compounds, Dronabinol and Sativex™, briefly discuss their pharmacologic properties, and address the question of whether their use as legal and approved agents in medical practice will render further consideration of smoked (or otherwise used) cannabis unnecessary.

A. Dronabinol

Dronabinol (also known as "synthetic THC" or "Marinol") is a Schedule III oral medication approved by the FDA for the treatment of AIDS-related wasting and chemotherapy-induced nausea and vomiting.[310] Although this approval for only two indications may appear restrictive, once a drug has been approved by the FDA to treat a specific pathologic condition, it can usually be prescribed legally for any disease for which a physician deems such therapy appropriate ("off-label" prescription).[311] While physicians may prescribe the medication for uses not approved by the FDA, the manufacturer's advertising and promotion for off-label

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the doctor] to fail to record the justification for refilling prescriptions, but it [was] an absence of certifying the medical necessity for the excess dosage in the patient's medical records as required by Va. Code Ann. § 54.1–2971.01'").

[309] *See* Jerry Markon, *Va. Pain Doctor's Prison Term Is Cut to 57 Months; Originally Sentenced to 25 Years, Specialist Did More Good than Harm, Judge Says*, WASH. POST, July 14, 2007, at B1. (noting that after Dr. William Hurwitz was convicted of illegal drug trafficking his 25-year prison term was voided. *See* United States v. Hurwitz, 459 F.3d 463 (4th Cir. 2006). However, a second trial again convicted him of 16 counts of drug trafficking and he was sentenced to 57 months in jail).

[310] *See, e.g.*, Marinol—the Legal Medical Use for the Marijuana Plant, http://www.justice.gov/dea/ongoing/marinol.html (last visited Mar. 16, 2009); Marinol Product Information, http://www.solvaypharmaceuticalsus.com/products/marinolproduct information/0,998,12413-2-0,00.htm (Last visited Mar. 28, 2009).

[311] *See, e.g.*, United States v. Evers, 643 F.2d 1043, 1048 (5th Cir. 1981) (holding that "a physician has a right to prescribe any lawful drug for any purpose . . . . Congress did not intend the Food and Drug Administration to interfere with medical practice . . . [or] regulate the practice of medicine as between the physician and the patient. Congress recognized a patient's right to seek civil damages in the courts if there should be evidence of malpractice, and declined to provide any legislative restrictions upon the medical profession"). On this basis, physicians can legally prescribe Dronabinol for treating multiple sclerosis, spasticity, or depression.

therapy is regulated.[312] Pharmaceutical companies may not directly advertise their approved medications for off-label use, but they may distribute scientific literature that supports such use.[313] Some authorities, however, maintain that these proposed changes in federal oversight may not protect the public.[314]

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[312] *See* Press Release, U.S. Food and Drug Administration, FDA Proposes Guidance for Dissemination of Information on Unapproved Uses of Medical Products (February 15, 2008), *available at* http://www.fda.gov/bbs/topics/NEWS/2008/NEW01798.html.

[313] *Id.*

> The U.S. Food and Drug Administration (FDA) today issued draft guidance on "Good Reprint Practices" for industry use in the distribution of medical or scientific journal articles and reference publications that involve unapproved uses of FDA-approved drugs and medical devices.
>
> . . .
>
> . . . Section 401 of the Food and Drug Administration Modernization Act set out guidelines that allowed the dissemination of information on unapproved uses of FDA-approved products. As long as the guidelines were met by the manufacturers, the dissemination of such materials was not viewed by the FDA as evidence of an intent to promote the product for an "off-label" use. However, Section 401 expired on Sept. 30, 2006.
>
> The FDA's "Good Reprint Practices" draft guidance recommends principles manufacturers should follow when they distribute scientific or medical journal reprints, articles, or reference publications.
>
> Some of the principles include ensuring that the article or reference be published by an organization that has an editorial board. The organization also should fully disclose any conflicts of interest or biases for all authors, contributors or editors associated with the journal article. Articles should be peer-reviewed and published in accordance with specific procedures.
>
> In addition, the draft guidance recommends against distribution of special supplements or publications that have been funded by one or more of the manufacturers of the product in the article, and articles that are not supported by credible medical evidence are considered false and misleading and should not be distributed.
>
> *The FDA retains legal authority to determine whether distribution of an article or publication constitutes promotion of an unapproved "new use," or whether such activities cause a product to be considered misbranded or adulterated under The Federal Food, Drug and Cosmetic Act.*

Id. (emphasis added).

[314] *See, e.g.*, Mike Mitka, *Critics Say FDA's Off-Label Guidance Allows Marketing Disguised as Science*, 299 J. AM. MED. ASS'N 1759, 1759 (2008) ("Critics say the proposed guidance, as currently written, will allow companies to selectively use as a marketing tool peer-reviewed journal articles that support off-label use of their product. They also argue the guidelines could possibly harm public health by allowing manufacturers a back door for putting products into health care setting for unapproved uses without having to conduct rigorous clinical studies to gain FDA approval."); Aaron S. Kesselheim & Jerry Avorn, *Pharmaceutical Promotion to Physicians and First Amendment Rights*, 358 NEW ENGL. J.

Could Dronabinol be substituted for marijuana itself for either an approved or an off-label use? The answer is not clear at this time. Dronabinol's route of administration poses a significant problem, as the entire capsule must be taken orally and may neither be crushed nor chewed.[315] This requirement may prove problematic in the face of nausea or vomiting. Moreover, while the delay in onset of action and the time to peak effect of Dronabinol may pose no difficulties in the treatment of chronic conditions such as AIDS wasting, it may represent a significant problem in treating acute nausea and vomiting. In contrast, smoked marijuana's rapid onset and easy titration to the desired effect—antiemesis without unwanted psychogenic symptoms—suggest an advantage over Dronabinol.[316] Finally, the cost of Dronabinol is greater than that of marijuana. For such reasons, many who advocate the medical use of marijuana maintain that Dronabinol is not an entirely satisfactory substitute. It would therefore be both appropriate and essential in the future to undertake a scientific comparison of Dronabinol's utility and efficacy to that of smoked marijuana in order to assess whether, or under what conditions, Dronabinol could replace marijuana as effective medical therapy.

B. Sativex™

Sativex™ (produced by GW Pharma), a cannabinoid-based oral-mucosal spray, was developed in response to the inherent problems posed by the oral medication Dronabinol.[317] Sativex™ contains equal amounts of Δ9-tetrahydrocannabinol (THC) and cannabidiol (CBD) which are found in *Cannabis sativa*, but is devoid of the other compounds found in the whole plant.[318] The rapid absorption of Sativex™ allows easy titration, a property that may provide a major advantage over Dronabinol.[319]

MED. 1727, 1731 (2008) ("Courts should consider the complex nature of the evaluation of medications when applying the *Central Hudson* test in the pharmaceutical context and should permit appropriate and necessary constraints on commercial speech in the pharmaceutical industry."); Bruce M. Psaty & Wayne Ray, *FDA Guidelines on Off-Label Promotion and the State of the Literature from Sponsors*, 299 J. AM. MED. ASS'N 1949, 1951 (2008) ("Attempting to use peer-reviewed literature for a purpose [i.e., as a substitute for studies mandated and analyzed by the FDA] for which it is so ill suited is likely not only to fail to adequately regulate off-label use but also to degrade the quality of peer-reviewed literature.").

[315] *See*, Marinol Prescribing and Safety Information, http://www.solvaypharmaceuticals-us.com/static/wma/pdf/1/3/2/5/0/004InsertText500012 RevMar2008.pdf (Last visited Mar. 16, 2009).

[316] Note also that THC is not the only active and useful compound found in *Cannabis sativa*. For example, cannabidiol is another active constituent of the whole plant. *See* GW Pharmaceutical: FAQs, http://www.gwpharm.com/faqs.asp (last visited Mar. 16, 2009) (addressing frequently asked questions about Savitex).

[317] *Id.*

[318] *See id.*

[319] *See id.*

In April 2005, GW Pharma received regulatory approval for Sativex™ in Canada for symptomatic relief of neuropathic pain in multiple sclerosis.[320] In August 2007, Health Canada approved Sativex™ as an adjunctive analgesic treatment in patients with advanced cancer who experience moderate to severe pain during the highest tolerated dose of strong opioid therapy for persistent pain.[321] The use of Sativex™ in treating multiple sclerosis is now allowed in the United Kingdom[322] and the drug is currently undergoing late-stage clinical testing in Europe and the United States.[323] It is therefore likely that Sativex™ will eventually be approved by the FDA as a scientifically based therapeutic agent.

Several published studies support the efficacy of Sativex™ in ameliorating the symptoms of neuropathic pain and spasticity. In a five-week, randomized, double-blind, placebo-controlled study, the intensity of neuropathic pain of peripheral origin was significantly ameliorated by Sativex™, as compared with placebo.[324]

In another investigation, Iskedjian and coworkers summarized the safety and efficacy data derived from four studies evaluating the ability of Sativex™ to assuage the debilitating pain associated with multiple sclerosis.[325] These randomized, double-blinded studies compared Sativex™ and placebo and found Sativex™ to be superior to placebo.[326] Multiple sclerosis–associated spasticity was significantly reduced by Sativex™ in another randomized, placebo-controlled study performed in three medical centers.[327]

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[320] *Multiple Sclerosis—Canada Approves Cannabis Derived Pharmaceutical Treatment, Sativex™(reg)*, MEDICAL NEWS TODAY, Apr. 22, 2005, http://www.medical newstoday.com/articles/23299.php.

[321] Press Release, GW Pharmaceuticals, Innovative Treatment Option for Cancer Pain Now Available in Canada (Jul. 8, 2007), *available at* http://production.investis.com /gwp/pressreleases/currentpress/2007-08-07.

[322] *See, e.g.*, *MS Society Welcomes Information on Sativex™, UK*, MEDICAL NEWS TODAY, Dec. 14, 2007, http://www.medicalnewstoday.com/articles/91814.php (stating that although currently unlicensed in the United Kingdom, it is legally available to people with multiple sclerosis and around 1,200 people have so far received the drug).

[323] *See* GW Pharmaceutical: Research & Development / Product Pipeline, http://www.gwpharm.com/research_pipeline.asp (last visited Mar. 16, 2009).

[324] Turo J. Nurmikko et al., *Sativex™ Successfully Treats Neuropathic Pain Characterised by Allodynia: A Randomised, Double-blind, Placebo-controlled Clinical Trial*, 133 PAIN 210, 217–19 (2007).

[325] Michael Iskedjia et al., *Meta-analysis of Cannabis Based Treatments for Neuropathic and Multiple Sclerosis-related Pain*, 23 CURR. MED RES. & OPIN. 17, 17 (2007).

[326] *Id.* ("[T]he cannabidiol/THC buccal spray [was] effective in treating neuropathic pain in MS.").

[327] Derick T. Wade et al., *Do Cannabis-Based Medicinal Extracts Have General or Specific Effects on Symptoms in Multiple Sclerosis? A Double-Blind, Randomized, Placebo-Controlled Study on 160 Patients*, 10 MULTIPLE SCLEROSIS 434, 434 (2004)

In view of the scientific data presented above, it is quite possible that Sativex™ will be approved by the FDA in the next few years. Since its rate of absorption is similar to that of smoked marijuana, it is reasonable to ask whether the FDA's approval of Sativex™ will overcome any scientifically based arguments favoring approval of medical marijuana as another *Cannabis*-derived medication.[328] Since many might believe that the approval of Sativex™ will end the long debate over medical marijuana, it is scientifically appropriate (although not legally required) to determine whether Sativex™ is truly the equivalent of smoked marijuana in order to respond to this question. Since the *Cannabis sativa* plant contains many bioactive compounds besides THC and cannabidiol,[329] it cannot be stated a priori that Sativex™ will be an ideal replacement for marijuana in every medical situation.

C. Comparing the Safety and Efficacy of Dronabinol, Sativex™, and Smoked Marijuana

While it might appear counterintuitive that either Sativex™ or Dronabinol could undergo a "blind" comparison with smoked marijuana, such an evaluation is not impossible. A frequently used approach is the "double-blind double-dummy" technique in which the blinded subjects randomly receive either: (1) active drug #1 (e.g., active Sativex™ spray) + placebo drug #2 (smoked inactive marijuana); or (2) placebo drug #1 (inactive Sativex™ spray) + active drug #2 (e.g., smoked active marijuana).[330] While complete blinding may be difficult when Dronabinol is being evaluated (because of its longer time to onset of action and peak effect), the double dummy technique is appropriate and valuable when two rapidly-effective compounds (smoked marijuana and Sativex™) are being compared. Such testing is not only feasible but essential in order to demarcate the indications and contraindications of Dronabinol, Sativex™, and marijuana in the rational practice of medicine.

(noting that spasticity was significantly reduced by Sativex™ in comparison with placebo and that "[t]here were no significant adverse effects on cognition or mood").

[328] Although the FD&C Act does not require that a new drug be shown to be superior—or even equivalent—to already approved medications, the FDA's approval of Sativex™ would very likely be used as a potent political argument in favor of denying approval to medical marijuana even if it were shown to be safe and effective. *See* 21 U.S.C. § 355(b)(1) (2006).

[329] *See supra* Part V (discussing recommendations of the NIH Workshop).

[330] *See* Steven R. Salbu, *Regulation of Drug Treatments for HIV and AIDS: A Contractarian Model of Access*, 11 YALE J. ON REG. 401, 435–36 (1994) (explaining how double-blind experiments are particularly useful in testing effects of medication).

VII. CONCLUSION

At the beginning of this article, a basic question was posited: Should the approval or disapproval of medical marijuana as a legitimate therapeutic agent be governed by the same statute (and philosophy) that applies to all other new drugs or pharmaceutical agents, the Food, Drug, and Cosmetic Act, and should the drug be evaluated by the appropriate regulatory agency, the Food and Drug Administration, for its safety and efficacy as demonstrated by "evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience"?[331] If not, should medical marijuana be exempt from scientific review and either be forbidden by the Congress or legitimatized by a vote of the people?

What should have been a straightforward question has been complicated by politics, ideology, prejudice,[332] and unwarranted fear.[333] These have led to the

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[331] Federal Food, Drug, and Cosmetic Act 21 U.S.C. 355(e) (2006).

[332] A justice with impeccable liberal credentials called attention to the phenomenon of overreaction, prejudice, and stigmatization. *See, e.g.*, Robinson v. California, 370 U.S. 660, 672 (1962) (Douglas, J., concurring).

> To be a confirmed drug addict is to be one of the walking dead. . . . The teeth have rotted out; the appetite is lost and the stomach and intestines don't function properly. The gall bladder becomes inflamed; eyes and skin turn a bilious yellow. In some cases membranes of the nose turn a flaming red; the partition separating the nostrils is eaten away — breathing is difficult. Oxygen in the blood decreases; bronchitis and tuberculosis develop. Good traits of character disappear and bad ones emerge. Sex organs become affected. Veins collapse and livid purplish scars remain. Boils and abscesses plague the skin; gnawing pain racks the body. Nerves snap; vicious twitching develops. Imaginary and fantastic fears blight the mind and sometimes complete insanity results. Often times, too, death comes — much too early in life. . . Such is the torment of being a drug addict; such is the plague of being one of the walking dead.

Id.

[333] *See, e.g.*, David F. Musto, *Opium, Cocaine and Marijuana in American History*, 265 SCI. AM. 40, 45–46 (1991). Musto explains that

> The practice of smoking cannabis leaves came to the U.S. with Mexican immigrants, who had come North during the 1920s to work in agriculture, and it soon extended to white and black jazz musicians.
>
> As the Great Depression of the 1930s settled over America, the immigrants became an unwelcome minority linked with violence and with growing and smoking marijuana. Western states pressured the federal government to control marijuana use. The first official response was to urge adoption of a uniform state antinarcotics law. Then a new approach became feasible in 1937, when the Supreme Court upheld the National Firearms Act. This act prohibited the

repudiation of the concept that a new drug's approval should be based on scientific evidence, rather than political and ideological considerations. Both Congress, through unsubstantiated and inappropriate scheduling, and a majority of voters within thirteen states, through approval by referenda or ballot initiatives, have cast aside the concept that a drug's safety and efficacy should be assessed scientifically on the basis of its risks and benefits. Congress and the federal government have succumbed to a "reefer madness"[334] philosophy and closed their eyes to the possibility that marijuana might be, on balance, an extremely beneficial addition to our medical armamentarium. At the same time—in part due to perceived governmental obstinacy—advocates of marijuana have rejected the role of scientific evidence and replaced it with political action. This has resulted in adoption of permissive medical marijuana statutes by thirteen states. Both regimens are flawed. Scientific evidence should be dispositive in deciding whether the risk-benefit profile of marijuana justifies its approval by the FDA.[335]

> transfer of machine guns between private citizens without purchase of a transfer tax stamp—and the government would not issue the necessary stamp. Prohibition was implemented through the taxing power of the federal government.
>
> Within a month of the Supreme Court's decision, the Treasury Department testified before Congress for a bill to establish a marijuana transfer tax. The bill became law, and until the Comprehensive Drug Abuse Act of 1970, marijuana was legally controlled through a transfer tax for which no stamps or licenses were available to private citizens.

Id.

[334] *See, e.g.*, Reefer Madness (aka Tell Your Children) (George A. Hirliman Productions 1936) (a 1936 film that was originally produced as a morality tale designed to convince parents of the dire events, including manslaughter, suicide, rape and automobile accidents, that would befall their children if they used marijuana. Since its original production, it took on new life as an "unintentional comedy among cannabis smokers," inspired an off-Broadway musical satire in 2001, and has achieved the status of a "cult film").

[335] Although a "favorable" risk-benefit ratio is an ideal concept, the threshold required for "favorable" cannot be expressed with mathematical precision. Instead, some may consider that the approach taken by regulatory bodies is akin to the standard for evaluating the presence or absence of "hard core pornography" proposed by Justice Stewart in *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964): "I know it when I see it . . . ." There are several reasons for what I believe to be this inherent lack of precision. First of all, every individual determines his or her own standard for evaluating the balance of risks and benefits for any action, including approval of a new medication. Therefore, it would be difficult, indeed, for society to formulate a universally acceptable approach. Moreover, there are significant philosophical differences between basing the "proper" balance on the concept that *nobody* should be harmed, as opposed to the utilitarian approach that seeks to maximize the good while conceding that some may be adversely affected.

Public discourse leading to legislative action would be appropriate if the debate dealt with the legalization of recreational marijuana. However, this mode of decision making is flawed when applied to the question of whether marijuana should be grown, sold, given away, or prescribed/recommended *as a drug by licensed health care professionals*. The decision whether to legalize the medical use of marijuana should be based on a dispassionate scientific analysis; neither disapproval by the legislature nor approval by popular vote should be dispositive.

Medical marijuana is being advocated and recommended for use as a *drug* as defined by the FD&C Act. While political considerations have made it difficult to pursue appropriate scientific studies, a number of such investigations have recently been published in the peer reviewed literature. Data from these studies suggest that medical marijuana has demonstrated safety and efficacy in treating several devastating human pathologies. Some individuals may believe that this documentation now warrants marijuana's approval for use as a legitimate therapeutic agent and that a Schedule I designation is no longer justified. Others may think that additional scientific scrutiny is necessary. In either case, it is no more appropriate for Congress to legislate that marijuana has

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Baruch Fischhoff, Professor of Social and Decision Sciences and of Engineering and Public Policy at Carnegie Mellon University, discussed the risk-benefit equation in terms of technological innovations:

> A technology has a societally acceptable level of risk if its *benefits outweigh its risks for every member of society.*
>
> . . . .
>
> There is no reason why these "benefits" should be restricted to economic consequences or even noneconomic ones for which putative economic equivalents exist. People could in principle, be compensated by peace of mind, feelings of satisfaction, or reduction of other risks.
>
> . . . .
>
> . . . [In contrast,] one should look at the *overall balance of consequences for society, while ignoring the balance actually experienced by individuals.* Under this assumption, one would not care if a technology made society as a whole better off, at the price of making some of its members miserable. Nor would one care if a few people received very large net benefits, while many others had small net losses; or, if many people had small net benefits, while imposing large net losses on a few (e.g., those living near a landfill that accepts hazardous wastes from a large area).

Baruch Fischhoff, *Acceptable Risk: A Conceptual Proposal*, http://www.fplc.edu/risk/vol5/winter/fischhof.htm (last visited Mar. 16, 2008) (emphasis added).

Nonetheless, the drug approval process requires that decisionmakers within the FDA evaluate the risks and benefits of a proposed medication and determine whether the drug meets societally reasonable criteria for approval. While mathematical precision might be desirable as a basis for this decision, its absence should not be an insurmountable obstacle to the FDA's legal mandate to make an appropriate decision.

no "currently accepted medical use in treatment in the United States" than for a popular vote to reach the opposite conclusion and declare by referendum or ballot initiative that it is a legitimate pharmaceutical agent.

Instead, the FDA should be allowed to evaluate medical marijuana with the same methodology, standards, and diligence that the agency would apply to any other investigational drug. While the FDA's role in drug evaluation is not perfect,[336] deficiencies in its regulation and evaluation of pharmaceuticals should not be taken as an excuse to disregard the fundamental utility of the agency and to abandon the philosophy that science rather than politics should be dispositive with regard to acceptance or rejection of medications. If standards of safety and efficacy are met, the drug should be approved and then appropriately scheduled. Conversely, if medical marijuana's analysis as an investigational new drug fails to satisfy these criteria, approval should be denied.[337]

Should marijuana be approved as a bona fide medication? This article was not intended to provide an answer. Instead, it has strongly argued in favor of the concept that scientific data and methodology, rather than political and ideological considerations, can and should lead to a rational decision. Whether the data derived from current and future scientific investigations will justify the approval or disapproval of medical marijuana, or whether other purified *Cannabis*-derived medications will prove superior to the totality of ingredients found only in the whole plant—thereby mooting many of the questions this article has addressed—remains a challenging issue for the future.

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[336] *See, e.g.*, Cohen, *supra* note 32, at 211–13 ("Recent events have illuminated major deficiencies in the FDA's ability to protect the public. Overly hasty and, in the views of some, far too permissive drug approval, real and perceived conflicts of interest and poor morale, lack of post-marketing surveillance, and the intrusive role of politics in the FDA's decision-making procedures have severely damaged the agency's reputation. . . . The public's response to at least some of these problems has resulted in significant changes in the way manufacturers report data and journals publish them." (citations omitted)).

[337] Restoring Scientific Integrity in Policy Making: Scientists Sign-on Statement, http://www.ucsusa.org/scientific_integrity/abuses_of_science/scientists-sign-on-statement.html (last visited Mar. 16, 2009) (quoting statement made by President George H.W. Bush in an address to the National Academy of Science made on April 23, 1990: "Science, like any field of endeavor, relies on freedom of inquiry; and one of the hallmarks of that freedom is objectivity. Now, more than ever, on issues ranging from climate change to AIDS research to genetic engineering to food additives, government relies on the impartial perspective of science for guidance").

Addendum: Since the paper was submitted, the United States Attorney General has adopted a new policy: there will be no federal prosecutions of the use of marijuana for medical purposes provided that it is done in compliance with state law.[338]

[338] Solomon Moore, Dispensers of Marijuana Find Relief in Policy Shift, *The New York Times*, March 20, 2009 at A15:

> Attorney General Eric H. Holder Jr. [has stated] that the federal authorities would no longer take action against medical marijuana dispensaries if they were in compliance with state and local laws.
>
> While 13 states, including California, have laws allowing medical use of marijuana, they had not been recognized by the federal government. . . .
>
> Mr. Holder's statement that he would not authorize raids on medical marijuana dispensaries appeared to shift Justice Department policy, at least rhetorically, away from the Bush administration's stated policy of zero tolerance for marijuana, regardless of state laws. Advocates of medical marijuana welcomed the change. . . .
>
> A spokesman for the drug enforcement agency, Garrison Courtney, pointed out that the attorney general's statement indicated that the federal authorities would continue to go after marijuana dispensaries that broke state and federal laws by selling to minors, selling excessive amounts or selling marijuana from unsanctioned growers.

PREDICTING THE FUTURE: A BAD REASON TO CRIMINALIZE DRUG USE

Douglas Husak*

In a series of books and articles, I have proposed that drugs should be *decriminalized.*[1] Because commentators disagree about the meaning of this proposal, I have sought to clarify it. If a given drug were decriminalized, its use and possession for use would not be a criminal offense. To say that x would not be a criminal offense is to say that persons would not be subject to punishment for engaging in x. Admittedly, exactly what constitutes punishment is unclear and controversial. Does coerced treatment count as punishment? What about a small monetary fine? These questions are important, but should not be allowed to distract us from the core of the proposal I defend. *Whatever* punishment is, *that* is what those who favor decriminalization insist should not be done to drug users. It is crucial to notice that decriminalization as I have defined it *has* no implications for whether drug manufacture and sale should continue to be a criminal offense. Proposals to decriminalize drugs are neutral on such important matters. Perhaps the decriminalization of manufacture and sale are good ideas, but they are not entailed by drug decriminalization itself. In my judgment, theorists should begin by deciding how the criminal justice system should respond to drug users before moving to the more difficult question of how the state should respond to manufacturers and sellers. If I am correct, proposals to decriminalize drugs do not describe a comprehensive drug policy to rival the status quo. The position is wholly negative: Whatever else the government or the private sector should inflict upon drug users, those users should not be subjected to state punishment.

I have also adopted a strategy to defend decriminalization. I began by reframing the fundamental question that needs to be addressed in the debate. The basic issue is whether the use (and possession for use) of a given drug should be punished. Thus the fundamental question is not whether drug use should be *decriminalized,* as so often is asked. Instead, the fundamental question is whether drug use should be *criminalized.* If I have correctly identified the most important issue to be addressed, I now will suggest what I take to be the best response to it. In my judgment, the best reason *not* to criminalize drug use is that no argument *in favor* of criminalizing drug use is any good—not nearly good enough to justify criminalization. I believe that *no* drugs should be criminalized—although it is

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[1] Significant portions of this article have been previously published. *See* DOUGLAS HUSAK, DRUGS AND RIGHTS (1995); DOUGLAS HUSAK, LEGALIZE THIS! THE CASE FOR DECRIMINALIZING DRUGS (2002) [hereinafter HUSAK, LEGALIZE THIS!]; DOUGLAS HUSAK & PETER DE MARNEFFE, THE LEGALIZATION OF DRUGS 3–105 (2005); Douglas Husak, *Four Points About Drug Decriminalization*, 22 CRIM. JUST. ETHICS 21 (2003) [hereinafter Husak, *Four Points*].

apparent that reasons to punish users may be stronger for some substances than for others. In what follows, however, I will not differentiate one drug from another.

Clearly, this strategy is inconclusive. It depends on many controversial matters. First, it depends on a rough agreement about principles of criminalization. We cannot decide whether we have a good reason to punish persons who use drugs in particular unless we understand what constitutes a good reason to punish anyone for anything. Legal philosophers do not really *have* a theory of criminalization to apply in the real world,[2] unless "more is always better" qualifies as such a theory.[3] Moreover, this strategy depends on my ability to "prove a negative"—that is, to show that no argument in favor of drug criminalization is persuasive. All I can hope to do is to respond to the most prominent arguments that prohibitionists have advanced in favor of our present punitive policy. Until a rationale has been put on the table, there is nothing to which I can respond. Without an argument in favor of criminalization, it is hard to know how to proceed. I am reminded of a remark made by Hume: "'Tis impossible to refute a system, which has never yet been explain'd. In such a manner of fighting in the dark, a man loses his blows in the air, and often places them where the enemy is not present."[4] This is the predicament I face in trying to defend drug decriminalization.

In what follows, I will respond critically to just one of many possible arguments that might be given in favor of drug criminalization. I will not comment on drugs and adolescents, drugs and health, drugs and crime, or drugs and morality. Each of these complex topics deserves careful scrutiny. Despite its popularity, however, the particular argument on which I will focus should *not* be taken very seriously. This argument predicts that the use of certain drugs would soar if we stopped punishing persons who use them. I will contend that this claim is deficient both for empirical as well as for normative reasons. I will briefly discuss both of these grounds. Although I will devote far more attention to a discussion of the empirical difficulties with this argument, I believe its normative problems are equally good or better in discrediting it. My empirical conclusion is that we simply have no reliable method to predict how the number of drug users—or the amount of harm they will cause—would be changed if we stopped punishing those who use drugs. My normative conclusion is that we would lack a good reason to criminalize drug use even if we could be confident in our projections about how the incidence of drug use would increase if decriminalization were implemented.

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[2] *But see* DOUGLAS HUSAK, OVERCRIMINALIZATION 178–206 (2008) (describing and criticizing three theories of criminalization that legal philosophers have constructed, namely: economic analysis, utilitarianism, and legal moralism; but doubting whether these theories stand up to scrutiny).

[3] *C.f.* William Stuntz, *The Pathological Politics of Criminal Law*, 100 MICH. L. REV. 505, 508 n.5 (2001) (criticizing legislators for ignoring normative theories of criminalization and instead almost exclusively favoring policies that increase the scope of criminal law).

[4] DAVID HUME, A TREATISE OF HUMAN NATURE 464 (Prometheus Books 1992) (1739).

Many persons find my empirical uncertainty to be unwarranted. Economic models indicate that the frequency of use is a function of its costs. Decriminalize, and the monetary and nonmonetary costs of drugs will go down. The trouble is that all existing predictions about how rates of consumption will rise after use is decriminalized assume that nothing *else* will change. One thing we *can* predict is that many other things *will* change if drug use is decriminalized. I will mention several variables that almost certainly would change and make all such predictions perilous.

I begin by challenging the claim that decriminalization will cause the monetary price of drugs to plummet. Why assume that decriminalization will make illicit drugs significantly more affordable? Decriminalization itself, as I have emphasized, need not allow illicit drugs to be sold with impunity. Opponents probably imagine that decriminalized drugs will become as freely available as alcohol, sold by reputable businesses at every street corner. But we need not suppose that newly decriminalized drugs would be distributed according to an alcohol model. If decriminalization does not extend to manufacture and sale, it need not have much effect on the monetary cost of drugs. But even if manufacture and sale *were* decriminalized, the monetary price of illicit drugs would be very hard to estimate. At least three factors contribute to this uncertainty.

First, illicit drugs would suddenly become subject to taxation. I will not try to estimate the optimal rate of taxation.[5] Clearly, negative consequences would ensue if taxes were either too low or too high. If taxes were too low, levels of use might become unacceptable; if taxes were too high, the black market might reappear. Experimentation would be required to determine an ideal rate. Whatever the exact amount, we can be sure that taxes would add enormously to the price of newly decriminalized drugs, and thus would have the potential to curb demand dramatically.

Moreover, we need to inquire how and where illicit drugs will be produced if manufacture and sale were decriminalized. Although no one is sure, roughly one-fourth of all marijuana now consumed in the United States is probably grown domestically.[6] How would this ratio be altered by decriminalization? Would production be outsourced, or would the ease of bringing local goods to market further the trend toward producing drugs in the United States? How would economies of scale affect the costs of production? Would production be concentrated among a few companies, or would it remain decentralized? And how would the answers to these questions differ from one drug to another? Opiates, for example, could be grown quite easily within our borders, whereas coca has proved resistant (so far) to domestic cultivation. These variables might affect price enormously, and any claim purporting to make precise estimates about them should be taken with a large grain of salt.

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[5] For a discussion of the complexities of taxing vices, or "sin tax," see JIM LEITZEL, REGULATING VICE: MISGUIDED PROHIBITIONS AND REALISTIC CONTROLS 140–77 (2008).

[6] RAYMOND GOLDBERG, DRUGS ACROSS THE SPECTRUM 243 (2005).

A final factor influencing the monetary price of drugs is very hard to estimate if the manufacture and sale as well as the use of drugs were decriminalized. If illicit drugs are anywhere near as harmful as many people believe, some mechanism must be created to compensate victims for the harms they suffer when drugs are consumed. These harms might befall users themselves, or be suffered by others. One way to compensate victims for each of these kinds of harms is by allowing lawsuits against sellers or producers of illicit drugs. Our legal system has been reluctant to allow such lawsuits in the cases of tobacco, alcohol, or firearms; powerful lobbies have fought against them for years.[7] But we need not be so reticent if we establish a new system of manufacture and sale for illicit drugs. Producers or sellers could be made to pay for the costs of the various harms that their customers cause to themselves or to others. Manufacturers or distributors would be able to pay these costs, and remain in business, only if they could pass them along to buyers by raising their prices. How much of an increase in price would be needed to compensate all of the victims for the harms they suffer when illicit drugs are consumed? No one can be sure. We cannot begin to answer this question unless we know how dangerous illicit drugs really are. I believe that the dangers of illicit drugs tend to be grossly exaggerated. Even if I am mistaken about the dangers of illicit drugs today, we can be confident that illicit drugs would become far less dangerous in a world in which production and sale had been decriminalized. In such a world, suppliers would have huge incentives to make their drugs as safe as possible in order to limit the amount of money they would be required to pay for the various harms that are caused by the use of their products. If a given drug is very dangerous, we might even find that no company could hope to make a profit by selling it, causing it to disappear from the lawful market. We simply do not know how dangerous illicit drugs will turn out to be after decriminalization, but financial incentives are bound to make them less harmful.

As a result of the complex interplay between these three factors, we have almost no method for estimating how the monetary price of decriminalized drugs would differ from their price in today's black market—if decriminalization were extended to production and sale. We do not know how much states will decide to tax the sale of drugs. We have no method for estimating the costs of producing drugs. Finally, we do not know how much defendants will have to charge in order to survive when tort liability is imposed on them. If this latter figure is high, drugs will be expensive, and fears about cheap drugs will be put to rest. If this figure is low, the price of drugs will decrease. But if the amount sellers must charge as a result of these lawsuits is low, it probably means that drugs turned out to be less dangerous than we thought. If this is the case, we will come to wonder why we were so worried about making them more affordable in the first place.

However uncertain we may be about how decriminalization will affect the *monetary* price of drugs, it will clearly eliminate their *nonmonetary* cost—the fear

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[7] *See, e.g.*, Jeffrey H. Birnbaum, *The Influence Merchants*, FORTUNE, Dec. 7, 1998, at 137, 142 (listing lobbies of the National Rifle Association of America, National Beer Wholesalers Association, and Tobacco Institute as among most powerful).

of arrest, prosecution and conviction. To the extent that this fear has helped to keep illicit drug use in check, we can anticipate that decriminalization would cause the incidence of drug use to rise. But to what extent? How will consumption be affected if drug users need not worry about punishment? No single piece of evidence on this point is decisive, but several reasons conspire to suggest that the threat of punishment is not especially effective in deterring drug use. In what follows, I will propose a number of reasons to doubt that the removal of criminal penalties would necessarily cause a significant increase in the consumption of illicit drugs.

One source of evidence is obtained through surveys. People who have never used drugs may be asked to explain their reasons for abstaining, and to speculate how their willingness to experiment would be affected by a change in the law. Very few respondents cite their fear of punishment as a substantial factor in their decision not to try drugs.[8] The more dangerous the drug is perceived to be, the smaller the number of respondents who mention the law when asked to explain their reluctance to consume it.[9] Other surveys could try to ascertain why former users decided to quit. In at least one study, those who were former drug users were asked why they do not continue to use drugs today, and to explain why their behavior has changed. Very few respondents report that fear of arrest and prosecution led them to stop using drugs.[10] Rather, most cite a bad experience with a drug, or some new responsibility like a job or a newborn—but not the risk of punishment.[11] Of course, the value of such surveys is questionable. We may doubt that people have accurate insights into why they behave as they do, what caused them to alter their conduct in the past, or what might lead them to behave differently in the future. Surely, however, data provide better evidence than mere conjecture. These surveys suggest that the fear of punishment is not a major factor in explaining why drug use is not more pervasive than it is.

What other evidence is relevant in deciding how the fear of punishment affects the incidence of drug use? We might examine how trends in illicit drug use over the past thirty years are correlated with changes in law enforcement. If the

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[8] *See, e.g.*, LLOYD D. JOHNSON ET AL, U.S. DEP'T HEALTH AND HUMAN SERVS., DRUG USE, DRINKING, AND SMOKING: NATIONAL SURVEY RESULTS FROM HIGH SCHOOL, COLLEGE, AND YOUNG ADULTS POPULATIONS 1975–1988, at 144 (1989) (reporting majority of high school seniors indicated they would not use marijuana "even if it were legal and available," while less than ten percent would try marijuana for the first time if it were legal and available); ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES 85 (2001) ("In public opinion surveys, nonusers are much more likely to mention 'not interested' than 'fear of legal reprisals' as the primary reason why they don't use marijuana.").

[9] LLOYD D. JOHNSON ET AL, U.S. DEP'T HEALTH AND HUMAN SERVS., DRUG USE, DRINKING, AND SMOKING: NATIONAL SURVEY RESULTS FROM HIGH SCHOOL, COLLEGE, AND YOUNG ADULTS POPULATIONS 1975–1988, at 132-133.

[10] *See* MITCHELL EARLEYWINE, UNDERSTANDING MARIJUANA: A NEW LOOK AT THE SCIENTIFIC EVIDENCE 247–48 (2002).

[11] *See* HUSAK, LEGALIZE THIS!, *supra* note 1, at 158.

fear of punishment were a significant factor in deterring illicit drug use, one would expect that rates of consumption would decline as punishments increased in frequency and severity. There appears to be no correlation, however, between the frequency and severity of punishment and trends in drug use.[12] If we look at the decade from 1980 to 1990, a case could be made that punishments were effective in deterring consumption. The incidence of illicit drug use—which generally peaked in 1979—steadily decreased throughout the 1980s.[13] However, frequent and severe punishments have not caused further declines after the 1990s—drug use has for the most part increased slightly or remained relatively flat in the past fifteen or twenty years.[14] We reach the same conclusion when we examine the data on a state-by-state basis. States with greater rates of incarceration for drug offenders tend to experience higher rates of drug use.[15] Prohibitionists who predict a massive increase in drug use after decriminalization must struggle to explain these data. If punitive drug policies help to keep drug use in check, why do actual trends in consumption appear to prove so resistant to the massive efforts we have made to punish drug users?

Additional evidence can be gleaned from the experience of other countries, where the fear of arrest and prosecution for the use of given drugs is practically nonexistent. Most countries have lower rates of illicit drug use, even though given drugs are higher in quality, lower in price, and less likely to result in punishments.[16] American teenagers consume more marijuana and more of most other illicit drugs than their counterparts on the European continent, although European youth are more likely to smoke cigarettes and drink alcohol.[17] Consider the Netherlands, known for its relatively permissive drug laws: "Although marijuana prevalence rates are roughly comparable in the two countries, about twice as many residents of the United States have experimented with other kinds of illicit drugs."[18] In general, data from other parts of the world provide better evidence for an inverse than for a positive correlation between severities of punishment and rates of illicit drug use. Admittedly, this evidence is inconclusive. After all, no country in the world has implemented de jure decriminalization as I have defined it here. Still, I repeat that such data are better than an unsubstantiated guess.

The history of the United States provides further reason to doubt that fear of punishment plays a major role in reducing the use of illicit drugs. For all practical purposes, drug prohibition did not begin until the early part of the twentieth century. In the nineteenth century, purchases of opium, morphine, cocaine and

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[12] *Id.*

[13] *Id.*; *see also* ROBERT J. MACOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES & PLACES 15–16 (2001) (showing a decrease in the percentage of illicit drug use since 1979).

[14] *See* HUSAK, LEGALIZE THIS! *supra* note 1, at 158.

[15] *Id.*

[16] *Id.*

[17] HUSAK, LEGALIZE THIS!, *supra* note 1, at 159.

[18] *Id.*

marijuana were subject to almost no restrictions. Americans could buy these drugs in many different varieties from several distinct sources—including by mail order. But even though criminal penalties were not imposed for the use of opiates and cocaine, these drugs were no more popular—and probably less popular—than today.[19] Admittedly, however, history's verdict is mixed. Most Americans agree that our era of alcohol prohibition was a dismal failure. By most accounts, however, per capita consumption of alcohol decreased throughout prohibition, and did not return to preprohibition levels for many years.[20] This finding has led some social scientists to conclude that prohibition "worked" after all—if a reduction in use is the most important criterion of success.[21] Others scoff. They point out that the decrease in alcohol consumption at the onset of prohibition merely continued to follow a downward trajectory that began well before prohibition was implemented.[22] In any event, however, even those social scientists who insist that alcohol prohibition was effective almost never recommend that our country should reinstate that policy. We all recognize moral limits to the lengths our society should go to deter the use of even the most dangerous drugs.

Recent trends in the use of *licit* drugs provide yet another source of evidence about the relation between threats of punishment and rates of consumption. Prohibitionists tend to point to a reduction in illicit drug use over the last thirty years as evidence that severe punishments have been effective in curbing consumption. Comparable or more substantial declines in the use of alcohol and tobacco, however, have taken place over this same period of time—even *without* the threat of penal liability for mere consumption. Rates of monthly illicit drug use in the United States peaked at about 14 percent in 1979, steadily fell to a low of just above 5 percent in 1992, and slowly increased thereafter to about 6 percent since 2001.[23] Trends in alcohol and tobacco use exhibit more similarities than dissimilarities with these patterns.[24] The overall use of alcohol and binge drinking declined throughout the 1980s, and rebounded somewhat during the 1990s.[25] We have ample reason to believe that the use of licit drugs can be decreased without the need to resort to penal sanctions. We probably should assume that the same is true of illicit drugs.

If changes in the certainty and severity of punishment are not major factors in explaining trends in illicit drug use, what *does* account for these patterns? This is

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[19] *Id.* (noting that despite the historical lack of criminal penalties for the use of opiates and cocaine, "these drugs were far less popular than alcohol and tobacco today").

[20] Husak, *Four Points*, *supra* note 1, at 27.

[21] *See, e.g.*, Mark Moore, *Actually, Prohibition Was a Success*, N.Y. TIMES, Oct. 16, 1989.

[22] Angela K. Dills, Mireille Jacobson, and Jeffrey A. Miron, *The Effect of Alcohol Prohibition on Alcohol Consumption: Evidence from Drunkenness Arrests*, 86 ECON. LETTERS 279 (2005).

[23] Husak, *Four Points, supra* note 1, at 27.

[24] *Id.*

[25] Mary K. Serdula et al., *Trends in Alcohol Use and Binge Drinking, 1985–1999: Results of a Multi-State Survey*, 26 AM. J. PREV. MED. 294 (2004).

one of the most fascinating and difficult questions about drug policy, and I confess to having no good answer to it. Trends in the use of both licit and illicit drugs are as baffling and mysterious as trends in fashion. Our forecasts are bound to be simplistic unless we have better theories to explain why some people use drugs and others do not. When experimentation takes place, three results (roughly) might follow. First, the user may dislike his experience and never repeat it. Or the user may enjoy his experience and become a regular consumer. Finally, the user may enjoy his experience but decide that further consumption is too risky. No one has a convincing explanation of why the ratio of persons who experiment with a given drug changes between these three scenarios. No one has a deep understanding of why the use of a particular substance increases or decreases within a given population in a given place at a given time. By 2001, the popularity of crack in inner cities had waned enormously.[26] Crack is less likely to be regarded as "cool" or "hip." Why? No simple answer can be given. Most experts believe that a heightened consciousness about health contributed to the reduction in the use of licit drugs during the 1980s. But what caused this growing concern about health—and why did it not lead rates of drug use to fall still further throughout the 1990s? Again, no answer is clearly correct. However, we strain credibility if we suppose that a factor is important in accounting for decreases in the consumption of alcohol and tobacco, but is unimportant in accounting for decreases in the consumption of illicit drugs—especially when the patterns of these decreases are roughly comparable. In any event, we have little reason to believe that punishments play a central role in explaining trends in drug use.

I have provided several reasons to doubt that punishment is needed to keep rates of illicit drug use within reasonable bounds. But skepticism about the efficacy of punishment as a deterrent to drug use is only a small part of the reason why forecasts about the incidence of consumption after decriminalization are so tenuous. Recall the meaning of decriminalization. The only change that this policy requires is that the state would not *punish* persons simply for using a drug. Even if manufacture and sale were decriminalized as well, the state may adopt any number of devices to discourage drug use—as long as these devices are not punitive. Even more importantly, institutions other than the state can and do play a significant role in reducing consumption. After decriminalization, some of these institutions might exert even more influence. Private businesses, schools, insurance companies and universities, to cite just a few examples, might adopt policies that discriminate against drug users. Suppose that employers fired or denied promotions to workers who use cocaine. Suppose that schools barred students who drink alcohol from participating in extracurricular activities. Suppose that insurance companies charged higher premiums to policy holders who smoke tobacco. Suppose that colleges denied loans and grants to undergraduates who consume marijuana. I do not endorse any of the foregoing ideas; many seem unwise and destined to

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[26] *See* Husak, *Four Points*, *supra* note 1, at 28. *See also, e.g.*, National Institute on Drug Abuse, *Research Report Series - Cocaine Abuse and Addiction*, http://www.drugabuse.gov/ResearchReports/Cocaine/cocaine2.html (July 22, 2008).

backfire. Removing drug-using kids from schools, for example, is bound to *increase* their consumption. I simply point out that these institutions could have a far greater impact than our criminal justice system on decisions to use drugs. Their influence is likely to become even greater after the implementation of decriminalization.

Substitution effects create additional doubts about how a change in legal policy would affect rates of drug use. Suppose that the state proscribes drug A, and threats of punishment succeed in reducing its use. No one would declare a regimen of prohibition to be effective if many users simply switched to a more harmful drug B. The substitution effects of drug prohibitions are largely unknown. But some commentators have argued that the development and popularity of hazardous substances like PCP and crack would not have occurred but for the criminalization of less dangerous drugs.[27] In short, one must always examine substitution effects before prohibition is proclaimed to be successful. The failure to take these effects into account in making predictions about behavior is just as pernicious as the failure to take opportunity costs into account in applying a theory of economics.

Forecasts about the incidence of drug use after decriminalization are confounded by yet another phenomenon—the *forbidden fruit effect*. Many individuals—most notably adolescents—are known to be attracted to a type of conduct precisely *because* it is banned. These individuals are more likely to engage in given behaviors that have been proscribed. Although all drug-policy experts acknowledge the importance of the forbidden fruit phenomenon in explaining the prevalence of drug use, its true extent is unknown.[28] Still, its role is probably significant. Social scientists have vividly described how social norms motivate people to engage in risky conduct. The decision to smoke a cigarette or not to buckle a seatbelt is less a function of the utility of these behaviors than of their impact on reputations. Since reputations are especially important to adolescents, and are altered by the legal status of the conduct in question, it follows that drug use almost certainly is subject to a substantial forbidden fruit effect. For all we know, the forbidden fruit phenomenon is sufficiently extensive to increase the incidence of drug use as much or more than threats of punishment reduce it.

An additional mechanism explains how the prevalence of drug use might decrease even though punishments no longer are imposed. The majority of drug users quit voluntarily after a relatively brief period of experimentation—typically, within about five years of initial use.[29] But millions of citizens have been arrested and convicted, and punishment itself can raise the probability of subsequent deviance by exacerbating criminogenic tendencies in the long run. Although sentences for drug offenses are severe, no one seriously proposes to keep users

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[27] *See, e.g.*, Kurt L. Schmoke, *An Argument in Favor of Decriminalization*, 18 HOFSTRA L. REV. 501, 505 (1990) (noting that by eliminating legitimate sources, prohibition has ensured the profitability of the illegal drug trade).

[28] *See* ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, & PLACES 89–90 (2001) (noting that "[t]he drug research literature has no systematic research on the forbidden fruit hypothesis.").

[29] *See id.* at 16.

behind bars indefinitely.[30] Because of their criminal records, drug offenders who have been incarcerated are less likely to find housing or employment, to reestablish ties with families, or to regain their self-esteem.[31] As a result, they are at greater risk to resume their use of drugs. If the increase due to punishment were equal to or greater than the decrease due to deterrence, criminal sanctions would actually bring about more rather than less drug use. In combination, the foregoing factors may show drug proscriptions to be ineffective and perhaps even counterproductive in curbing use. This conclusion is plausible, since threats of punishment are not especially effective in deterring drug consumption. Only an honest empirical assessment can help to establish whether this conclusion is correct. Needless to say, the hysteria and hyperbole of the drug war has not facilitated a good faith evaluation of existing policy.[32]

Alarming predictions about future use also assume that the drugs of tomorrow will resemble the drugs of today. This assumption seems extraordinarily naïve. The development of new and different substances makes estimates about consumption enormously speculative. Even though many illicit drugs—heroin and ecstasy, for example—were originally created by pharmaceutical companies,[33] reputable corporations have tried hard to disassociate their substances from illicit drugs. Decriminalization may lead pharmaceutical companies to expend their talent and ingenuity to create better and safer recreational drugs. One can only wonder about the products that might be developed if the best minds are put to the task. If more enjoyable and less dangerous drugs could be perfected, consumption might boom. But the development of better and safer drugs would make the increase in consumption less of a problem, partly by driving existing drugs from the market.

For all of these reasons, we should avoid predictions about how the decriminalization of given drugs will affect rates of consumption. But an even more important point is that these empirical conjectures are not especially relevant to the topic at hand. Legal philosophers should look for a respectable reason to criminalize drug use. Predictions about how decriminalization will cause an increase in drug use simply do not provide such a reason. Indeed, this reason could be given to retain virtually *any* law, however unjustified and silly it may be. Let me illustrate this point by providing an example of an imaginary crime that I assume everyone would agree to be unjustified. Obesity is a major health problem in the United States today. Suppose that the state sought to curb obesity by

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[30] The Constitution, however, creates no barriers to life imprisonment for drug possession. *See* Harmelin v. Michigan, 501 U.S. 957, 996 (1991) (affirming a sentence of life imprisonment for cocaine possession).

[31] The probability of many of these results is increased by the collateral consequences of drug convictions. *See* Nora V. Demleitner, *"Collateral Damage": No Re-Entry For Drug Offenders*, 47 VILL. L. REV. 1027, 1027 (2002).

[32] Some progress has been made. *See* TODD R. CLEAR, IMPRISONING COMMUNITIES: HOW MASS INCARCERATION MAKES DISADVANTAGED NEIGHBORHOODS WORSE 12 (2007) (noting that "[t]here are signs that the seemingly overwhelming political obstacles to reform are becoming less daunting.").

[33] *See* MACCOUN & REUTER, *supra* note 28, at 197.

prohibiting people from eating ice cream. Imagine that the editors of the *Utah Law Review* convened a conference and solicited contributions from scholars to debate whether we should *change* this law and *de*criminalize ice cream. Some scholar would be bound to protest that repealing this offense would cause the consumption of ice cream to increase. Subject to the uncertainties I have recounted, I suppose he would be correct. But surely this prediction would not serve to *justify* retaining this imaginary crime. If we lacked a good reason to attack the problem of obesity by punishing consumers of ice cream in the first place, the effects of prohibition of ice cream consumption would hardly provide such a reason. And so it is with drugs. This prediction does not provide a good reason to *continue* to impose punishments unless we already *have* such a reason. Of course, this is precisely the point at issue.

If there is a good reason to criminalize illicit drug use, we have yet to find it. We need a better reason to criminalize something than conjectures about how its frequency would increase if punishments were not imposed. These predictions are dubious both normatively and (in this case) empirically. Despite my uncertainty about the future, there is *one* prediction about which we can be absolutely confident: After decriminalization, persons who use illicit drugs will not face arrest and prosecution. The lives of drug users would not be devastated by a state that is committed to waging a war against them. Punishment, we must always be reminded, is the worst thing a state can do to us. The single prediction we can safely make about decriminalization is that it will not undermine the quality of life of the hundreds of thousands of people who otherwise would be punished for the crime of drug use.

RECREATIONAL DRUG REGULATION: A PLEA FOR RESPONSIBILITY

Donald A. Dripps*

TABLE OF CONTENTS

I. INTRODUCTION

That tedious yet terrible phrase, "the war on drugs," perfectly captures at least one truth. U.S. public policy has characterized substances, rather than persons, as the problem. This Article explains the implicit conflict between the premises of prohibition and the criminal law's presumption of responsibility. The Article then explores how indifference to responsibility has distorted the debate about prohibition. Leaving people out of the equation has led to miscounting the costs and benefits of drug use as well as the costs and benefits of prohibition.

The focus on substances that are said to cause harm has managed to exclude consumer welfare from calculations of costs and benefits. The United States manages to count as harms breaches of duty and even failures of potential that by

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themselves would never be thought by anyone to justify criminal prosecution. The focus on drugs, finally, misleads society into measuring the success of current policy by the size of marginal changes in consumption. Marginal users, however, inflict only a small fraction of the harms inflicted by users.

This argument is methodological rather than programmatic. It works quite explicitly within the pragmatic tradition of American legislation. Although indebted to those who have pointed out the tension between drug prohibition based on soft paternalism and the denial of any drug-based criminal-law excuse,[1] this argument goes much further. The claim is not that certain defenses of prohibition cannot peacefully coexist with certain reasons for rejecting an addiction defense. Rather, this Article asserts that prevailing cost-benefit calculations unduly focus on accounting rather than economics, thereby distorting assessments of costs and benefits.

This methodological focus does not imply any endorsement of consequentialism on first principles. A neglected feature of arguments about criminal justice is the degree to which any given writer's idealized system is subject to the constraints of democratic pluralism. Rough-and-ready utilitarianism, hedged by prevailing conceptions of fairness, is the lingua franca of a diverse society. Rejecting the assessments that thinking yields in favor of the coherence that only a single person's conception of justice, theorized all the way down, can yield puts the respective individual theories of penal justice ahead of theories of political legitimacy.

Suppose you are asked to accept a dictator, who makes you only one promise: I will faithfully implement your vision of criminal justice. You know the dictator always keeps her promises. You also know the dictator knows the meaning of "only one promise." If you decline the offer, you are stuck with what remains: reaching under-theorized, and therefore partially incoherent, agreements through some pluralistic political process. Everyone cares about consequences, but no one agrees about rights. This Article concentrates on consequences and how to evaluate them.

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[1] In 1999, Michael Corrado organized an excellent symposium in *Law and Philosophy* around the tension between the concepts of addiction and responsibility. Michael L. Corrado, *Addiction and Responsibility: An Introduction*, 18 LAW & PHIL. 579 (1999). His introduction frames the issue well:

> One who has lost the "power" of self-control is surely not responsible for what he does in the absence of that power, and protecting people from such a state would certainly seem desirable. Hence the restrictions on certain drugs.
>
> On the other hand, when addicts are charged with possession of prohibited substances to which they are addicted, the courts have generally refused to excuse their behavior as nonresponsible.

Id. at 579 (citation omitted).

This Article's methodological claim does not necessarily point in one direction or another on the legalization issue, although it does cast grave doubt on the present policy of de jure prohibition selectively enforced. If dragooned into the programmatic debate, the author would argue for experience with different approaches before society discounts the risk that modifying the current drug prohibition effort could result in a catastrophic epidemic. This risk is unlikely but not preposterous. Reform should start with baby steps, like decriminalizing marijuana grown and consumed in the privacy of the home by consenting adults in a couple of states with large urban populations. At the same time, the United States should experiment with expansions of coercive social intervention, such as linking drivers' licenses for teenagers to drug testing or a government undertaking to administer drug tests at no charge upon parental request. If experience shows that a discriminating focus on users can limit social harm at less cost than prohibition, a warrant would exist for undertaking similar experiments with heroin, cocaine, and methamphetamine.

Above all, this argument suggests extremely limited expectations for public policy. No policy can guarantee long and happy lives to citizens who make self-destructive choices. No policy can avoid some degree of coercive social control over choices about drug use. At present, the United States uses an extreme measure of coercion to achieve distinctly little in the way of public health and safety. If society views its challenge as improving on that, there are realistic grounds for optimism.

II. PROHIBITION AND RESPONSIBILITY

A. The Premise of Prohibition: The Problem Is Drugs

Society is told repeatedly that it is fighting a war on drugs. This war is said to be justified because drugs cause harm. For example, the DEA's white paper opposing drug legalization states: "Illegal drugs are illegal because they are harmful."[2] The leading defenders of prohibition in the policy debate echo this characterization: "Drug use is the core drug problem."[3] Furthermore, legalization's "consequences involve the intrinsically destructive nature of drugs and the toll they exact from our society in hundreds of thousands of lost and broken lives . . . ."[4]

The relentless focus on the drugs themselves is one way to cope with the sheer number of people who are breaking the criminal law. If society seriously

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[2] DRUG ENFORCEMENT ADMIN., U.S. DEP'T OF JUSTICE, SPEAKING OUT AGAINST DRUG LEGALIZATION 2, 8–9 (2003), *available at* http://www.usdoj.gov/dea/demand/speakout/speaking_out-may03.pdf [hereinafter SPEAKING OUT].

[3] Robert L. DuPont & Ronald L. Goldfarb, *Drug Legalization: Asking for Trouble*, *in* DRUGS: SHOULD WE LEGALIZE, DECRIMINALIZE OR DEREGULATE? 68, 68 (Jeffrey A. Schaler ed., 1998) [hereinafter DRUGS].

[4] William Bennett, *Should Drugs Be Legalized?*, *in* DRUGS, *supra* note 3, at 63, 63–64.

viewed drug use as blameworthy and harmful, it would hold individuals responsible for use, just as it holds individuals responsible for other harmful and blameworthy acts like theft. Enforcement agencies would conduct sell-and-bust operations aimed at first-time purchasers. Congress would make the failure to take and pass a drug test on a regular basis a criminal omission. The volume of violations makes such a strategy politically unacceptable and economically unthinkable.

Instead, the Federal Government aims criminal sanction at suppliers, characterizing users as victims, either of their suppliers or of a disease.[5] Society takes a different approach to some other contraband offenses. For instance, the producer of a felon's firearm or a burglar's housebreaking tools is not punished.[6] Even with murder-for-hire, the consumer is punished at least as harshly as the supplier.[7]

Drugs are treated the same way as prostitution, and for many of the same reasons. Consumer demand is so extensive that prosecution would be expensive and provoke political opposition.[8] There are fewer suppliers relative to consumers. Other suppliers will enter the market if enforcement triggers a large enough increase in price.[9] In both cases, lingering doubts remain about just how much harm is being done by the business.[10] These considerations reinforce each other. If millions of citizens demand an illegal product, there is some reason to reconsider the judgment that the product is harmful.

The focus on the product rather than the consumer is unusual but not unique. That focus, however, comes at a high intellectual price. Assessing that price requires comparing the product-centered thinking behind prohibition with the axiomatic focus on individual responsibility in the criminal law at large.

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[5] United States v. Moore, 486 F.2d 1139, 1210 (Wright, J., dissenting) (arguing that the court should adopt the principle that "a drug addict who, by reason of his use of drugs, lacks substantial capacity to conform his conduct to the requirements of the law may not be held criminally responsible for mere possession"); *see* GARY L. FISHER, RETHINKING OUR WAR ON DRUGS: CANDID TALK ABOUT CONTROVERSIAL ISSUES 7 (2006) (noting that 62 percent of drug treatment and prevention budget is allocated to supply reduction).

[6] *See* Protection of Lawful Commerce in Arms Act, 15 U.S.C. §§ 7901–7903 (2006).

[7] *See* 18 U.S.C. § 373 (2006).

[8] *See, e.g.*, James C. Backstrom, *Reflections of a Career Prosecutor on Effectively Addressing the Illegal Drug Problem in America*, 40 APR PROSECUTOR 26, *27 (2006) ("I have been criticized by a few policymakers, public defenders and judges for needlessly filling up the beds in our county jail, which are in short supply, with low-level drug offenders.").

[9] *See* JAMES P. GRAY, WHY OUR DRUG LAWS HAVE FAILED AND WHAT WE CAN DO ABOUT IT: A JUDICIAL INDICTMENT OF THE WAR ON DRUGS 50–54 (2001).

[10] *See* GLEN R. HANSON ET AL., DRUGS AND SOCIETY 19–32 (9th ed. 2006).

B. The Premise of the Criminal Law: People Are Responsible for Their Voluntary Acts

We have it on high authority that "universal and persistent in mature systems of law . . . [is the] belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil."[11] Utilitarians as well as retributivists have endorsed this principle of responsibility.[12] Criminal law theorists continue to debate the relationship between the philosophical problem of free will and the criminal law's doctrine of responsibility. This Article takes no position here on those debates; however they are resolved, voluntary use of recreational drugs will not be recognized as a legal excuse.

Let us begin with the positive law. U.S. criminal law characterizes any willed bodily movement as a voluntary act.[13] Even with respect to the individual who is clinically insane, many American jurisdictions hold the individual responsible absent a cognitive failure to perceive the nature and consequences of his acts or to distinguish right from wrong.[14] Typically, absent neurological abnormalities that produce convulsions or mental illness that induces exculpatory delusions or impairs moral cognition, the law presumes that people are responsible for their voluntary acts.[15]

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[11] Morissette v. United States, 342 U.S. 246, 250 (1952) (citation omitted).

[12] The principle is built into retributive accounts. H.L.A. HART, PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 180–81 (1968). There is also a utilitarian defense of responsibility. *See id.* at 181–82 (arguing that the principle of responsibility guarantees security against criminal liability for accidents and thereby increases social welfare).

[13] *See, e.g.*, 1 WAYNE R. LAFAVE, SUBSTANTIVE CRIMINAL LAW § 6.1(c) (2d ed. 2003).

[14] *See* Clark v. Arizona, 548 U.S. 735, 750–51 (2006).

> Seventeen States and the Federal Government have adopted a recognizable version of the *M'Naghten* test with both its cognitive incapacity and moral incapacity components. One State has adopted only *M'Naghten's* cognitive incapacity test, and 10 (including Arizona) have adopted the moral incapacity test alone. Fourteen jurisdictions, inspired by the Model Penal Code, have in place an amalgam of the volitional incapacity test and some variant of the moral incapacity test, satisfaction of either (generally by showing a defendant's substantial lack of capacity) being enough to excuse. Three States combine a full *M'Naghten* test with a volitional incapacity formula. And New Hampshire alone stands by the product-of-mental-illness test.

Id. (citations omitted).

[15] *See* LAFAVE, *supra* note 13, at §§ 6.1(c), 7.2(b)(1). Despite impeccable common law pedigree, a mandatory presumption to this effect may not be given to the jury. Sandstrom v. Montana, 442 U.S. 510, 521–24 (1979). This same presumption, however, is

U.S. positive law recognizes a few limited defenses based on behavioral pressure. The American Law Institute test for insanity (now a minority position) provides a complete defense, qualified by automatic mental-health commitment, when mental disease substantially impairs behavioral control.[16] The common law recognized a partial excuse for killing in hot blood and for intoxication that negated the specific intent required for most capital felonies.[17] The Model Penal Code test for manslaughter is now the majority U.S. view, but the current trend appears to be away from even the common law's partial excuse for voluntary intoxication.[18] The major behavioral-control defense recognized by U.S. positive law is duress.[19]

The duress defense, however, is narrowly drawn. There must be evidence of an imminent illegal threat of death or serious bodily injury, no reasonable opportunity to escape, and no fault in becoming vulnerable to the threat.[20] Given the gravity of the threat and the common rule that duress is no defense to murder, it is debatable whether the defense available under prevailing law really excuses any conduct that would not be justified by necessity.[21] The doctrinal line between intentional threats and natural emergencies is, from a moral point of view, arbitrary.

When drug users asked the courts to recognize a legal excuse based on volitional impairment caused by illegal drug use, the courts refused. The leading case is *United States v. Moore*.[22] Moore was convicted of two counts of heroin possession and asserted an addiction defense.[23] Four judges joined Judge Wright's dissenting opinion, which argued that the jury should have been instructed to acquit on possession charges if it found that by reason of addiction Moore lacked substantial capacity to control his behavior.[24] One of the judges joining Wright's

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permissible in permissive form: the basic idea is woven into the warp and woof of the criminal law. *Id.* at 519 & n.9.

[16] *See* MODEL PENAL CODE § 4.01(1) (1985) ("A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.").

[17] *See* Meghan Paulk Ingle, Note, *Law on the Rocks: The Intoxication Defenses Are Being Eighty-Sixed*, 55 VAND. L. REV. 607, 617–19 (2002).

[18] *See id.* at 631.

[19] *See* Peter Westen & James Mangiafico, *The Criminal Defense of Defense: A Justification, Not an Excuse–And Why It Matters*, 6 BUFF. CRIM. L. REV. 833, 836–37 (2003).

[20] *See, e.g.*, Claire O. Finkelstein, *Duress: A Philosophical Account of the Defense in Law*, 37 ARIZ. L. REV. 251, 254 (1995) (summarizing the elements of the duress defense).

[21] *See* Westen & Mangiafico, *supra* note 19, at 835–36 (arguing that duress is a justification defense, although this characterization requires a "moralized" or "contextualized" weighing of prospective harms).

[22] 486 F.2d 1139 (D.C. Cir. 1973) (en banc) (per curiam).

[23] *Id.* at 1142.

[24] *See id.* at 1209–10 (Wright, J., dissenting).

opinion, Judge Bazelon, would have gone further and extended this defense to all charges, including forcible felonies.[25] A majority of the court, however, rejected the claimed defense in all its forms—common law, statutory, and constitutional.[26]

Judge Wilkey's opinion, which Judge MacKinnon and Judge Robb joined, pointed out that even addicts have some degree of behavioral control: "Drug addiction of varying degrees may or may not result in loss of self-control, depending on the strength of character opposed to the drug craving."[27] It also emphasized that the claimed excuse logically extended to crimes of violence because the more dangerous and serious the offense the less control the actor is likely to have.[28] Judge Wilkey also pointed out that addiction, unlike insanity, is the result of the defendant's voluntary acts.[29] Judge Leventhal, joined by Judge McGowan, had some sympathy for both the Wilkey and Wright opinions, but concluded that the issue was best left to Congress.[30] Congress, of course, has not adopted an addiction defense.[31] Neither have state legislatures or state courts.[32]

The popular criminal law theories—utilitarianism and retributivism, in all their variations—support *Moore*'s holding. Just as with other situations that make compliance difficult but not impossible, drug addiction—even to heroin,[33] what John Kaplan has referred to as "the hardest drug"[34]—does not deprive the user of self-control or moral agency. Users typically do not suffer cognitive impairments that negate an understanding of the nature and consequences of their actions or that impair their understanding of society's legal and moral standards.[35] They engage in practical reasoning about alternative courses of conduct.[36] The voluntary choice to use addictive drugs is arguably a much more dramatic act of culpable character construction than the subtler self-construction of, say, a violent temperament.

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[25] *See id.* at 1260 (Bazelon, J., concurring in part and dissenting in part).

[26] *Id.* at 1156–59 (majority opinion).

[27] *Id.* at 1145, 1206–09.

[28] *Id.* at 1146 ("[T]he addict who restrains himself from committing any other crimes except acquisition and possession, assuming he obtains his funds by lawful means, has demonstrated a greater degree of self-control than the addict who in desperation robs a bank to buy at retail.").

[29] *Id.* at 1151 ("Moore could never put the needle in his arm the first and many succeeding times without an exercise of will. His *illegal acquisition and possession* are thus the direct product of a *freely willed illegal act.*") (citation omitted).

[30] *Id.* at 1160 ("[W]e think the ultimate problems of law and policy should be addressed by the Congress without judicial intrusion at this time.").

[31] *See* 2 WAYNE R. LAFAVE, SUBSTANTIVE CRIMINAL LAW §§ 9.5(i)–(j) (2d ed. 2003).

[32] *See id.*

[33] John Kaplan, *Taking Drugs Seriously*, *in* DRUGS, *supra* note 3, at 92, 94, 104.

[34] JOHN KAPLAN, THE HARDEST DRUG: HEROIN AND PUBLIC POLICY (1983).

[35] *See* Corrado, *supra* note 1, at 589 (describing approaches claiming "that the addict might know perfectly well what he is doing, and might know perfectly well what he ought to do, so that no defect of reason is involved").

[36] *Id.*

Even among addicts, as Judge Wilkey pointed out, character still varies.[37] All drug users refrain from crime some of the time, and most of them refrain from crimes extrinsic to their drug use all of the time.[38] So on choice as well as character accounts of retribution, the addiction excuse seems implausible. For utilitarians, the retention of a substantial degree of self-control means that the responsibility principle, understood as a side constraint, permits punishing drug users for their crimes and that exemplary punishment can reduce offending by other users.[39]

These considerations have led thoughtful commentators, as well as judges and legislators, to reject Judge Wright's plea for an addiction defense. In an excellent article, Professor Boldt notes that, given the empirical evidence about drugs and behavioral control, the free-will assumption built into the criminal law makes an excuse for addiction acceptable only at the risk of unhinging the theoretical basis of criminal law generally.[40] His proposed turn to a medical paradigm would not free the criminal justice system from the problem of handling those users who commit extrinsic crimes. So the dilemma would remain; but he rightly identifies the nub of the weakness in arguments for the addiction excuse: the criminal law deploys both public indignation and public force to compel hard choices, not easy ones.[41]

As Douglas Husak points out, rejection of the addiction defense turns largely on facts about the actual effects of intoxication and addiction.[42] Husak gives the hypothetical example of a villain who injects the defendant with an addictive drug.[43] The pain of withdrawal is comparable to the pain of great bodily injury of

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[37] United States v. Moore, 486 F.2d 1139, 1145 (1973).

[38] *Id.*

[39] *Id.* at 1145–46.

[40] Richard Boldt, *The Construction of Responsibility in the Criminal Law*, 140 U. PA. L. REV. 2245, 2249–50 (1992).

> At one level, it is probably accurate to say that chemically-dependent offenders regularly have been held criminally responsible for conduct such as possession of narcotics, despite their claims that such conduct is the result of a compulsion beyond their control, because they have failed to convince courts that they are disabled from engaging in a process of practical reasoning. At a deeper level, the failure of these exculpatory claims represents a recognition that acceptance of a loss-of-control defense for addicts and alcoholics could fundamentally undermine the system's capacity to articulate an ideology of individual responsibility.

Id.

[41] *See* Dwight B. Heath, *The War on Drugs as a Metaphor in American Culture*, *in* DRUGS, *supra* note 3, at 135, 139 (noting the "social rules" in the context of the "War on Drugs").

[42] *See* Douglas N. Husak, *Addiction and Criminal Liability*, 18 LAW & PHIL. 655, 658–59 (1999).

[43] *See id.* at 659.

the sort that would support a duress defense.[44] The villain withholds additional doses unless the defendant commits an offense.[45] Husak says, rightly, that on these facts the defendant has a defense of duress.[46]

Indeed, it is possible to imagine a drug with overwhelming power over human behavior. If science aimed at producing such a drug, its power might exceed the influence of schizophrenia, which supports a traditional insanity claim.[47] It might even have power enough to cause consumers to volunteer for certain death, proving its power greater than that of the gangster's threat in the traditional duress case.

The important recreational drugs—marijuana, methamphetamine, cocaine, and heroin—do not have effects of this magnitude. Relatively few users of cocaine or even heroin become addicted.[48] Withdrawal is unpleasant but does not in fact resemble the pressures that can support a duress defense.[49] The motivating effect of

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> Imagine that our villain does not threaten to break the defendant's leg, but continually injects him with an addictive substance for whatever period of time is required to give rise to withdrawal symptoms if the injections were discontinued. The villain then threatens to discontinue the injections—unless, of course, our unfortunate defendant agrees to drive the getaway car. If these symptoms were sufficiently severe, I have little difficulty accepting that such a threat—like the threat of a broken leg—could give rise to a defense of duress.

Id. (citation omitted).

[44] United States v. Walker, 272 F.3d 407, 412 (7th Cir. 2001); *see* Husak, *supra* note 42, at 658–59 (stating that severe withdrawal symptoms would be sufficient to support a duress defense).

[45] Husak, *supra* note 42, at 656–59.

[46] *Id.* at 659.

[47] Jones v. State, 648 P.2d 1251, 1256 (Okla. Crim. App. 1982) (allowing evidence that showed the interrelationship between schizophrenia medication and alcohol "could have produced a psychosis causing Jones not to understand the wrongfulness of his conduct").

[48] *See* Herbert Fingarette, *Addiction and Criminal Responsibility*, *in* DRUGS, *supra* note 3, at 306, 313–15 (noting that millions of patients receive morphine in hospitals but almost none try to take it again and that in a large sample of U.S. military personnel returning from Vietnam, 50 percent had tried heroin or opium, but only 20 percent developed physical or psychological dependence); Jeffrey A. Schaler, *Drugs and Free Will*, *in* DRUGS, *supra* note 3, at 235, 235–41 ("[M]ost social-recreational [cocaine] users are able to maintain a low-to-moderate use pattern without escalating to dependency.").

[49] *See* Husak, *supra* note 42, at 682 ("The severity of heroin withdrawal is frequently described as roughly comparable to the symptoms of a one-week flu or even a bad cold." (citation omitted)); Schaler, *supra* note 48, at 242–43 (noting that methamphetamine users experience withdrawal symptoms that include anxiety, depression, and a compulsive focus on repetitive tasks, whereas withdrawal from marijuana does not have significant side effects).

these drugs takes the form of craving, a pressure undoubtedly powerful but no more powerful than, say, the sexual drive of a pedophile.[50]

It is notable that the claimed addiction defense *to crimes intrinsic to the continued use of the addicting agent* is, although ultimately unpersuasive, at least a near miss. Any claim to a drug-based excuse for extrinsic crimes, such as theft, that are *motivated* by the need for drugs is much weaker. There are two familiar, accessible tests of behavioral control: the behavior of the defendant at other times, and the behavior of other people facing similar pressures. Even hard-core addicts do not spend all of their time stealing, and most drug users, even most addicts, do not commit extrinsic crimes.[51] Heroin addicts do indeed commit a great deal of property crime, but some do not. Those who do engage in criminal activity combine crime sprees with periods of relative honesty.[52] And hard-core addicts have, at least in theory, one last choice: to admit a loss of control and seek treatment, and, if necessary, undergo coercive treatment.

C. The Implicit Tension

The foundation of prohibition policy is the focus on drugs rather than users. The foundation of the criminal law at large is the principle of personal responsibility for voluntary acts. A serious tension exists between the respective premises of drug prohibition and the general criminal law. If *drugs* cause harm, why blame *users*? Conversely, if individual users are responsible for their conduct, why blame the drugs?

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[50] *See, e.g.*, Stephen J. Morse, *Addiction and Responsibility*, 19 LAW & PHIL. 3, 37 (1999) ("Assuming that the feared dysphoria of unconsummated cravings can be substantial, I suspect that it will seldom be as severe as the fear of death or grievous bodily harm.").

[51] *See, e.g.*, Patrick G. Erickson & Timothy R. Weber, *Cocaine Careers, Control and Consequences: Results from a Canadian Study*, *in* DRUGS, *supra* note 3, at 291, 291–92 (stating that an implication of research overall is that "[m]ost users are law-abiding, apart from their drug-related behavior"); *id.* at 303 (noting that in a study of Canadian cocaine users' self-reports, "[f]ewer than 10% of respondents had ever shoplifted, broken into a building or car, or engaged in prostitution in order to obtain money to buy cocaine. These results belie the popular notion that cocaine fuels various forms of predatory crime"); Boldt, *supra* note 40, at 2311 ("Despite the enormous volume of drug prosecutions, those arrested represent less than 3% of the nearly 40 million estimated users of illegal substances in the United States in a given year." (citation omitted)).

[52] *See, e.g.*, STEPHEN B. DUKE & ALBERT C. GROSS, AMERICA'S LONGEST WAR 57, 64 (e-reads 1999) (1982) (finding that heroin addicts increase criminality during periods of daily use and decrease criminality during abstinence or occasional use and that the degree of crime varies with the price of heroin).

The general rule in criminal law is that one who supplies instrumentalities of crime is not complicit absent a stake in the venture.[53] Hart and Honore make the point more generally:

> A deliberate human act is therefore most often a barrier and a goal in tracking back causes in such inquiries; it is often something *through* which we do not trace the cause of a later event and something *to* which we do trace the cause through intervening causes of other kinds.[54]

The seller of gasoline is not held liable for fires set by an arsonist, and the seller of pry bars escapes liability for armed burglaries committed by a purchaser. It would be strange indeed if society took arson as a warrant for a "war on gasoline" or burglary as a warrant for a "war on pry bars."

Consider the case of *Scott v. Greenville Pharmacy*.[55] The survivor of a suicide sued a pharmacist in tort, alleging that the defendant had sold the decedent barbiturates in violation of statutory requirements.[56] The decedent became addicted, and this, the plaintiff argued, was attributable to the misconduct of the pharmacist.[57] The court rejected the suit, finding suicide outside the realm of foreseeable consequences.[58] The consumer's voluntary acts relieved the supplier of liability.[59]

With a product like nerve gas or counterfeiting equipment that has no lawful use, a possessory offense is theoretically justified because possession always runs an unjustified risk of harm. Arguably, drugs should be classed with nerve gas, rather than with gasoline, prybars, and firearms. Most drugs users, however, do not commit crimes beyond those that are intrinsic to consumption, such as purchase or possession.[60] Indeed, most not only avoid extrinsic crimes; they inflict no significant harm on anyone.[61] Those who do are responsible for the harms they cause, as the positive law's rejection of the addiction defense attests.[62]

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[53] *See* G. Robert Blakey & Kevin P. Roddy, *Reflections on* Reves v. Ernst & Young*: Its Meaning and Impact on Substantive, Accessory, Aiding Abetting and Conspiracy Liability Under RICO*, 33 AM. CRIM. L. REV. 1345, 1389–90 (1996) ("The federal courts of appeals now uniformly use 'intent' as the necessary state of mind for accomplice liability.").

[54] H.L.A. HART & TONY HONORE, CAUSATION IN THE LAW 44 (2d ed. 1985).

[55] 48 S.E.2d 324 (S.C. 1948). This case was discussed in HART & HONORE, *supra* note 54, at 155.

[56] *Scott*, 48 S.E.2d at 325.

[57] *Id.*

[58] *Id.* at 328.

[59] *Id.*

[60] DOUGLAS N. HUSAK, LEGALIZE THIS! THE CASE FOR DECRIMINALIZING DRUGS 88–89 (2002).

[61] Mary M. Cleveland, *Economics of Illegal Drug Markets: What Happens if We Downsize the Drug War*, *in* DRUGS AND SOCIETY: U.S. PUBLIC POLICY 173, 174, (Jefferson

Ignoring personal responsibility has distorted the drug-policy debate in a variety of ways. By defining the problem as the chemical, rather than how users of the chemical behave, interests are implicated that are entirely inapposite to the criminal law, skewing the calculations.[63] The same focus has enabled the complete neglect of consumer welfare, the pole star of the law-and-economics movement, in the context of artificial restrictions on supply of disfavored products.[64]

The focus on substances has also distorted society's thinking about the costs and benefits of public policy. Defining the problem in terms of *use*, rather than *harm,* serves as a justification of extraordinary commitments of scarce resources and institutional violence, measuring "success" by the rate of usage rather than by the rate of harm.[65]

Personal responsibility turns out to be a fact as well as a principle (and the fact may very well be *a product of the principle*). A minority of users cause most of the harms attributed to drugs.[66] Focus on use rather than harm thus miscounts costs and benefits: large changes in marginal consumption produce much smaller

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M. Fish ed., 2006) (noting that one of the assumptions underlying alternative strategies to drug prohibition is that "most illicit drug users do not commit any non-drug related crimes").

[62] *See, e.g.*, United States v. Nunez, 146 F.3d 36, 38 (1st Cir. 1998) ("[T]he appellant cannot strip himself of all moral agency by virtue of his drug addiction."); *see also* United States v. Moore, 486 F.2d 1139, 1160 (D.C. Cir. 1973) ("Our conclusion that the addiction defense should not be recognized, even for drug possession offenses, at the present juncture, does not mean that we think this defense, is contrary to sound policy, but rather that the issues are such that the ultimate consideration of the problems of law and policy require the attention of the legislature."); Phillip E. Hassman, Annotation, *Drug Addiction or Related Mental State as Defense to Criminal Charge*, 73 A.L.R. 3D 16 (1976) ("[T]he defense of drug addiction has rarely served to completely exonerate a defendant.").

[63] HERBERT MORRIS, FREEDOM AND RESPONSIBILITY: READINGS IN PHILOSOPHY AND LAW 218 (1961) (discussing the requirement of mens rea and intention in criminal law).

[64] HUSAK, supra note 60, at 170 ("When prohibitionists prepare their list of costs and benefits, the central benefit of recreational drug use is conspicuous by its absence."); DOUGLAS N. HUSAK & PETER DE MARNEFFE, THE LEGALIZATION OF DRUGS 84–91 (2005); *see also* THOMAS H. MURRAY ET AL., FEELING GOOD AND DOING BETTER 16 (1984) (suggesting a cost-benefit comparison akin to pollution control: "[i]f we followed the same policy in regulating drugs, we would try to estimate how much loss in the benefits of recreational drug use we should tolerate for the sake of a reduction in their ill effects").

[65] *See* David F. Duncan et al., *Harm Reduction: An Emerging New Paradigm for Drug Education*, 24 J. DRUG EDUC. 281, 282–86 (1994) (discussing how harm-reduction strategies lead to better use of resources).

[66] *See, e.g.*, RAYMOND GOLDBERG, DRUGS ACROSS THE SPECTRUM 24–25 (5th ed. 2006) ("There are 750,000 to 1,000,000 hardcore heroin addicts in the United States and about 2.7 million chronic users of cocaine. These hardcore users also are responsible for most of the crime, child abuse, and fatal overdoses in the United States. . . . Most people who use drugs, however, do not become compulsive users." (citations omitted)).

yields in harm reduction.[67] This in turn is at least partly due to the problematic life prospects of those who become hard-core users. Denied their drug of choice, they do not straighten up and fly right.[68] They instead drift into other self-destructive or antisocial behavior patterns, of which heavy drinking is a common example.[69]

A reduction in marginal consumption is thus typically a *loss* for social welfare. The marginal users lose their consumer surplus, while the hard-core users either resort to increasingly desperate tactics to satisfy their needs or turn to substitute satisfactions that may be counterproductive from the standpoints of the actor and society.

III. DISTORTING THE PROHIBITION DEBATE, PART I: COSTS AND BENEFITS OF DRUG USE

A. Miscounting the Costs

Those who characterize use, rather than users, as the problem, typically count any bad behavior by users as social harm. Those who insist on personal responsibility might take a more discriminating approach. One might, for example, discriminate between the following types of antisocial consequences:

(1) criminal violence the user would not have committed but for intoxication at the time of the offense;

(2) criminal violence motivated by the craving for the drug, as with property offenses committed to collect the funds for purchasing the drug;

(3) breaches of duty threatening the health or safety of others, as with parents neglecting their children or workers operating dangerous machinery as a result of drug use, whether the actor is intoxicated or suffering the effects of prior use;

(4) adverse health consequences to the user, including society's share of the expense of treatment;

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[67] ROBERT J. MACCOUN, DRUG WAR HERESIES: AN AGNOSTIC LOOK AT THE LEGALIZATION DEBATE 386 (2001) ("The harm reduction critique of the enforcement-oriented U.S. drug strategy is twofold. First, it argues that prevalence reduction policies have failed to eliminate drug dependence, have at best only moderately reduced drug use, and have left its harms largely intact. Second . . . these harsh enforcement policies are themselves a source of many drug-related harms, either directly or by exacerbating the harmful consequences of drug use." (citation omitted)).

[68] DUKE & GROSS, *supra* note 52, at 245–46 ("Many heroin addicts report that when imprisoned, they lost all apparent desire for heroin, but as soon as they were released, they felt a powerful craving for it. . . . When people are accustomed to seeking euphoria through chemicals, that conditioning cannot be eradicated merely by denying them access to their drug of choice.").

[69] KENNETH BLUM & JAMES E. PAYNE, ALCOHOL AND THE ADDICTIVE BRAIN: NEW HOPE FOR ALCOHOLICS FROM BIOGENIC RESEARCH 104 (1991) ("Many opiate addicts, during a period of abstinence, will substitute alcohol for their drug of choice.").

(5) breaches of duty that do *not* involve threats to the health and safety of others, as in workplace absenteeism; and

(6) failures to achieve apparent potential, even absent breach of duty, as with promising students who drop out of school because of use.

Numbers (5) and (6) are predictable costs of any activity that humans find pleasurable. In Chicago, a day game at Wrigley Field causes absences from work and school.[70] In Minnesota, it is the opening of the walleye season.[71] In San Diego, the quality of the surf has an effect on class attendance.[72] Lawyers with long experience in the field of wills and trusts will tell you that inherited wealth can degrade human potential.

When rational individuals choose to miss work, this is, prima facie, a gain for economic welfare. The worker values the day more than the employer is willing to pay for it. Only by anthropomorphizing drugs—by pretending that bags of marijuana handcuffed the delinquent worker to his bed—can the worker's preference for leisure over the rewards offered by the employer count as a cost.

Employers know about absenteeism, and they can bargain for hourly pay rather than salaries, for penalties (including termination) for absenteeism, or, indeed, for mandatory drug testing. Employers who do not bargain for testing calculate that the marginal cost of insisting on the condition exceeds the marginal benefit. They may make this calculation because of the costs of testing, the value of some other agenda item in the negotiation, or doubts about whether drug use is any worse for productivity than such hobbies as baseball or fishing.

Employers retain the best workforce they can afford. Theoretically, they tolerate lost hours from drug users because drug users are, all things considered, the best workers they can afford. The government has no business herding people into the office, whether they are playing hooky because they are drug users, drunks, baseball fans, anglers, or playboys. Similarly, there are no more debtors' prisons. A breach of contract is just another civil matter, and society expects the parties to bargain about things like absenteeism and productivity.

Numbers (1), (2), and (3) are wrongs properly cognizable by the criminal law, on all theories, independent of their causal antecedents. There may be a degree of mitigation for intoxication where the common law's specific/general intent

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[70] *See* FERRIS BUELLER'S DAY OFF (Paramount Pictures 1986) (following a high school truant's hijinks that included a Cub's game at Wrigley Field); *cf.* ROBERT G. MCINTOSH, BOYS IN THE PITS 141 (2000) ("The lure of a circus or a game of baseball also periodically drew enough boys away from smaller mines to force a temporary closure.").

[71] *See* Sportsman's Blog, http://www.sportsmansblog.com/ (May 7, 2008, 03:38 PM), *available at* http://www.sportsmansblog.com/2008/05/playing-hooky-t.html (stating that "[s]till, I'm not allowing [my child] to go to school on Friday. I am such a terrible stepfather. What am I doing with him instead, you might ask? Hell, we're going fishing.").

[72] *See* Sherry Parmet, *Senior Ditch Day Proves Costly to School Districts*, SAN DIEGO UNION-TRIB., Nov. 26, 2004, at B3 (stating that "for the past seven years schools have lost money [because of] students with . . . unexcused [absences], such as [students] ditching school to surf.").

distinction is retained, but forcible felonies and deadly criminal negligence are regarded as criminal in every U.S. jurisdiction.[73] If the reason for the crime is drug use, then there is good reason to factor that into sentencing, in whatever direction that cuts in a particular case. Drug-testing techniques give society the option of suspending penalties conditioned on the convict's passing frequent, surprise tests.

If users are seen as moral agents, as they are in the addiction-excuse cases, prohibition is the reverse image of practical policy. With almost every other predictor of non-imminent criminality, such as youth, unemployment, male gender, and so on, the predictor is not addressed before a crime has been committed.[74] This is both cheap to society and fair to individuals. Drug exceptionalism in this context is greatly facilitated, if not enabled, by the focus on use rather than users.

That leaves harm to self with a share of the cost borne by others, given modern insurance arrangements. This cost is real, but the focus on use rather than users displays its significance in a false light. Bad habits tending to the ill health of the individual, with concomitant social costs, are ubiquitous. Sedentary lifestyles and bad diet are leading examples.[75] Unsafe sex, cigarette smoking, and workplace stress are others.[76] In each of these cases, society is apparently willing both to count consumer welfare as a counterweight to social cost, and to discount, if not completely disregard, harm to self because of the doctrine of *volenti non fit injuria*. The Article turns now to exploring society's curious reluctance to count consumer welfare when the product consumed is a disfavored drug.

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[73] *See, e.g.*, IOWA CODE ANN. § 702.11(1) (West Supp. 2008) (defining a forcible felony as "any felonious child endangerment, assault, murder, sexual abuse, kidnapping, robbery, arson in the first degree, or burglary in the first degree"); UTAH CODE ANN. § 76-2-306 (2003) ("[I]f . . . criminal negligence establishes an element of an offense and the actor is unaware of the risk because of voluntary intoxication, his unawareness is immaterial in a prosecution for that offense.").

[74] *See* Paul H. Robinson, Commentary, *Punishing Dangerousness: Cloaking Preventive Detention as Criminal Justice*, 114 HARV. L. REV. 1429, 1339 (2001) (stating that unemployment and age are "good predictors of future criminality, and thus could . . . determine the offender's liability and sentence. . . . Indeed, if incapacitation of the dangerous were the only distributive principle, there would be little reason to wait until an offense were committed to impose criminal liability and sanctions").

[75] *See* Press Release, World Health Organization, WHO/FAO Release Independent Expert Report on Diet and Chronic Disease (Mar. 3, 2003), *available at* http://www.who.int/mediacentre/news/releases/2003/pr20/en/ (discussing the effects of a sedentary lifestyle and poor diet on chronic disease).

[76] *See* Joe R. Feagin et al., *The Many Costs of Discrimination: The Case of Middle-Class African Americans*, 34 IND. L. REV. 1313, 1334 (2001) (stating that "[n]umerous studies have documented the harmful effects of workplace stress on the health of employees of any racial or ethnic group"); Cass R. Sunstein, *What's Available? Social Influences and Behavioral Economics*, 97 NW. U. L. REV. 1295, 1298 (2003) (noting that unsafe sex "kill[s] tens of thousands of Americans each year" while smoking "kill[s] hundreds of thousands of Americans annually").

B. Miscounting the Benefits

Defining the product rather than the consumer as the problem distorts prevailing assessments of costs and benefits by excluding consumer welfare from the benefits side of the calculation.[77] By sheer—really quite brazen—stipulation, a multibillion dollar market is treated as if nothing of value has changed hands.[78] Suppose, for a moment, we put on our economist's hat and assess the market for drugs as though marijuana, cocaine, heroin, and so on were those neutral, imaginary products known as widgets.

Suppose that the market for widgets consists of 100 consumers each paying $100 dollars per widget to suppliers in a competitive market (from the suppliers' standpoint, $100 is the price at which marginal cost and marginal revenue equilibrate). Suppose further that the average consumer buys ten widgets per year. What is the value of the widget market?

If the willingness-to-pay criteria standard is used in an economic analysis of welfare, the market for widgets should be valued at more than $100,000 per year. Consumers are actually paying that much for widgets each year, so it is known that they value widgets at least that much. The degree to which welfare exceeds expenditure depends on how much more than the competitive price consumers would be willing to spend for widgets.

In a competitive market, sellers are not able to discriminate among consumers with higher and lower reservation prices. Even consumers with an intense preference for widgets may buy at the equilibrium price, set by the marginal cost of production. What happens when the government declares widgets illegal and mounts a serious effort to curtail supply?

The price goes up. Moreover, the financial price understates the true price to consumers, who must now bear the search costs and the risk of prosecution, when they enter the underground economy. Consumption falls. That, after all, is the point of prohibition. Consumers who can no longer afford widgets reallocate their consumption to other goods or services. These alternative consumption choices ranked so low in the consumer's demand schedule that no purchase was made while widgets were available at market prices. Ergo the consumer surplus for these items is deemed negligible.

Suppose, in the example, an enforcement effort raises the price to $140 and that this 40 percent increase in price results in a 20 percent reduction in

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[77] The analysis that follows is a standard Kaldor-Hicks approach, measuring costs and benefits by willingness to pay. *See, e.g.*, EDITH STOKEY & RICHARD ZECKHAUSER, A PRIMER FOR POLICY ANALYSIS 134–58 (1978) (explaining the benefit-cost analytical framework used to evaluate public expenditure decisions).

[78] *See, e.g.*, John A. Powell, *Hostage to the Drug War: The National Purse, the Constitution, and the Black Community*, 24 U.C. DAVIS L. REV. 557, 566 (1991) (stating that "[c]ommon estimates of annual black market drug sales range from $80 to $100 billion a year" and that "[i]nterdiction strategies have, according to many experts, only served to promote 'hard' drugs").

consumption. The consumers on the demand curve between the $100 price and the $140 price cease consuming, thereby losing the consumer surplus of welfare over the price of widgets.

If the demand curve is linear, the lost-welfare triangle is $40 high (the difference between the pre-enforcement $100 price and the post-enforcement $140 price) and 200 units long (the twenty consumer-users who were consuming ten widgets a year).[79] The area under the triangle measures the lost welfare. In the example, the lost welfare amounts to $4,000.[80] The size of the welfare loss tracks the "success" of prohibition. If the price doubles to $200, cutting consumption 50 percent, the welfare loss is $25,000. (The triangle would be $100 high and 500 units long.)[81] If prohibition succeeded completely, eliminating consumption, the welfare loss would the value of the former market in toto—i.e., in excess of $100,000.

When illegal drugs are substituted for widgets, what happens to the analysis? The DEA estimates that Americans spend $67 billion annually on illegal drugs.[82] Put differently, the aggregated reservation price for current consumers is *more* than $67 billion. Not only do many current consumers stand willing to pay more than the current price for their drugs, but many other consumers would buy if prices (including the risks of consumption) fell.

There is no reliable method for estimating what American consumers would be willing to pay for legal drugs. Even the minimum estimate of $67 billion, however, is large enough to outweigh even massive external harms. There is no blanket prohibition on the sale or possession of automobiles, cigarettes, or alcohol, even though these products do play a causal role in massive external harms.[83]

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[79] *See infra* app. A.

[80] *See infra* app. A.

[81] *See infra* app. A.

[82] SPEAKING OUT, *supra* note 2, at 11. The DEA points out, without intentional irony, that "[i]f the money spent on illegal drugs were devoted instead to public higher education, for example, public colleges would have the financial ability to accommodate twice as many students as they already do." *Id.* How the vast opportunity cost of money spent on illegal drugs translates into a brief for raising prices is left unstated.

A more recent study suggests that the -0.4 estimate is not far off but may overstate elasticity. *See* Dhaval Dave, *Illicit Drug Use Among Arrestees, Prices and Policy*, 63 J. URB. ECON. 694, 711–12 (2008) (noting immediate elasticity of -0.09 for heroin and 0.17 for cocaine and that both numbers roughly double over time). Somewhat counter-intuitively, elasticity of demand may be high among hard-core addicts. For them, the budget constraint, not the demand curve, is the limiting factor on consumption.

[83] *See* Sylvia A. Law, *Addiction, Autonomy, and Advertising*, 77 IOWA L. REV. 909, 910 (1992) (noting that cigarettes and alcohol cause more deaths than all illicit drugs combined); *see also* Angela Lipanovich, Comment, *Smoke Before Oil: Modeling a Suit Against the Auto and Oil Industry on the Tobacco Tort is Feasible*, 35 GOLDEN GATE U. L. REV. 429, 429 (2005) (stating that automobiles "cause health harms, smog, climate change, and a hole in the earth's ozone layer").

Instead, responsible use is permitted, irresponsible users are held accountable in crime or tort, and the genuine costs are outweighed by consumer welfare.[84]

It is axiomatic, of course, that consumer welfare from illegal drugs is not counted. This is axiomatic because no reason can be given for it. The welfare gained by consumers is accounted for, whether arising from pornography, professional wrestling, violent video games, fast food, or hundreds of other vulgar and degrading, but quite authentic, pleasures.[85] Welfare is also counted for products that modify mental states directly, ranging from caffeine to alcohol to prescription drugs.[86] When a price increase forces a cocaine user to turn to alcohol, the difference between his reservation price for liquor and the market price is counted as welfare—even though he would prefer not to consume the liquor at all.

An illustrative comparison with so-called inhalants is possible. Common household products such as glue, spray paint, butane, hair spray and so on, when inhaled have powerful psychoactive effects.[87] They can also cause massive and irreversible brain damage.[88] Why is the possession of *these* dangerous drugs not illegal? Because their benefits outweigh their costs. That is to say, society counts the welfare over price derived from such bourgeois activities as model making, furniture refinishing, and home hair styling even when real and substantial, countervailing social costs are the result of self-induced euphoric intoxication.

In the case of inhalants, society implicitly holds users, rather than the product, responsible for bad outcomes, permitting the product to be sold so long as the benefits to responsible consumers exceed the social costs of abuse. Essentially, society refuses to take this approach to marijuana, cocaine, and heroin because it refuses to count these pleasures as a good. The value of intoxication, however, seems at least as authentic as that of rust proofing the lawn furniture. In the famous words of history's most famous cocaine user:

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[84] *See* Richard N. Pearson, *The Florida Medicaid Third-Party Liability Act*, 46 FLA. L. REV. 609, 619–20 (1994) (discussing the harms and utility derived from consuming cigarettes and alcohol).

[85] *See, e.g.*, Jonathan M. Proman, *Liability of Media Companies for the Violent Content of Their Products Marketed to Children*, 78 ST. JOHN'S L. REV. 427, 439 (2004) (discussing the utility of violent video games).

[86] *See* Noah Mamber, *Coke and Smack at the Drugstore: Harm Reductive Drug Legalization: An Alternative to a Criminalization Society*, 15 CORNELL J.L. & PUB. POL'Y 619, 620 (2006) (stating that "drugs" such as caffeine and alcohol are legal because their value is exclusively recreational).

[87] *See* Steven B. Duke, *Drug Prohibition: An Unnatural Disaster*, 27 CONN. L. REV. 571, 599 (1995) (arguing that only a few drugs are more harmful than household products such as paint and butane).

[88] *See, e.g.*, NAT'L INST. ON DRUG ABUSE, INHALANT ABUSE 6 (2005), *available at* http://www.nida.nih.gov/ResearchReports/Inhalants/Inhalants4.html#Risks ("The neurotoxic effects of prolonged inhalant abuse include neurological syndromes that reflect damage to parts of the brain involved in controlling cognition, movement, vision, and hearing. Cognitive abnormalities can range from mild impairment to severe dementia.").

> Life, as we find it, is too hard for us; it brings us too many pains, disappointments and impossible tasks. In order to bear it we cannot dispense with palliative measure. . . . There are perhaps three such measures: powerful deflections, which cause us to make light of our misery; substitutive satisfactions, which diminish it; and intoxicating substances, which make us insensitive to it. Something of the kind is indispensable.[89]

Was Dr. Freud's preference for cocaine so irrational, self-destructive, or misinformed as to wipe his consumer satisfaction off the books of social welfare?

The rejection of the addiction defense suggests that the answer is no. Courts reject the addiction defense because almost all recreational drug users remain rational moral agents whom society justly holds accountable for their choices. It follows that society should count *drug users'* consumer welfare just like everyone else's. Indeed it is counted whenever their preference schedule includes something other than illegal drugs, whether that schedule includes *The Jerry Springer Show* or a copy of the *Duino Elegies*.

IV. DISTORTING THE PROHIBITION DEBATE, PART II: COSTS AND BENEFITS OF PROHIBITION

A. Miscounting the Costs

Frequently undertaken with varying results, the project of estimating the cost of efforts to enforce prohibition typically takes the form of a financial accounting. In this case, however, the transfers from public funds to police officers, firms that build prisons, and so on, are not welfare-neutral transfers. If the money were spent elsewhere, it would benefit its new recipients no less than the current ones. The economic cost of these outlays is the opportunity to spend these same dollars on something better than the deliberate infliction of pain on fellow creatures.

A sly rejoinder might appropriate the analysis of consumer welfare and characterize the billions spent on enforcement as evidence of what electoral majorities are willing to spend *to prevent* drug consumption. Even if the rejoinder is granted, the $67 billion that consumers of illegal drugs are willing to pay greatly exceeds the $40 billion consumers of prohibition are willing to pay.[90] The $27 billion difference could cover many external costs.

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[89] SIGMUND FREUD, CIVILIZATION AND ITS DISCONTENTS (1930), *reprinted in* THE FREUD READER 722, 728 (Peter Gay ed., 1989) (citation omitted). The omitted footnote quotes the poet Wilhelm Busch: "'Wer Sorgen hat, hat auch Likör'" or "[h]e who has cares has brandy too." *Id.* at 728 n.4.

[90] *See, e.g.*, SPEAKING OUT, *supra* note 2, at 12 (estimating that total federal drug control spending in 2002 was less than $19 billion). Most of the enforcement costs fall on

There may be good reason not to count the preference for prohibition at all. Such "external preferences"—*A*'s willingness to pay *X* if *B* does as *A* wishes—pose a vexatious problem for preference-based approaches to measuring welfare.[91] If external preferences are counted, society risks dictatorship, either by the rich or by the state, because willingness to pay is bounded by ability to pay. If society refuses to count external preferences, it is difficult to explain the benefits of wilderness preservation or manned space flight, valued by many who will never visit the wilderness or fly in space.

Difficult as the issues may be in some instances, not counting preferences for inflicting violent injuries on others seems uncontroversial.[92] The resources spent on drug enforcement are not resources spent on actual changes in usage, as might be the case if the government offered bounties to young people who test negative for drug use. What taxpayers are consuming is not abstinence by fellow citizens, but institutional violence by police, prosecutors, and prison guards.

So viewed, the costs of enforcement are high. They are not as high as legalization proponents claim, however, because relaxation of prohibition will not solve the underlying problem of irresponsible use. Let us begin with the clearest case: use of drugs by minors.

The more available a product is to adults, the more access minors will have to that product.[93] To say, as legalization advocates do, that enforcement will remain in place for minors, is also to say that a large (and expensive) enforcement bureaucracy would remain in place after prohibition.[94]

Then there is the issue of taxation. If government wants to discourage consumption and raise revenue by taxing legal drugs, as is done with both alcohol

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states and localities. Estimates vary, but total government spending on drug control is probably in the range of $40 billion. *See* Drug Policy Alliance, Economic Consequences of the War on Drugs (2002), http://www.drugpolicy.org/library/factsheets/economiccons/fact_economic.cfm.

[91] The term "external preferences" appears to have originated in RONALD DWORKIN, TAKING RIGHTS SERIOUSLY 234–38 (1977) (arguing that a sadist's pleasure in his victim's suffering should be excluded from utilitarian calculations). For a good discussion of the issues, see Daphna Lewinsohn-Zamir, *The Objectivity of Well-Being and the Objectives of Property Law*, 78 N.Y.U. L. REV. 1669, 1677–86 (2003) (arguing for an objective approach to welfare).

[92] Adil Ahmad Haque, Lawrence v. Texas *and the Limits of the Criminal Law*, 42 HARV. C.R.–C.L. L. REV. 1, 28 n.128 (2007) ("It would be bizarre to count the pleasure a violent criminal takes in brutalizing another person as weighing against, rather than in favor of, punishment, and it is unclear why similarly malevolent preferences should be endorsed elsewhere.").

[93] *See* Ronald J. Krotoszynski, Jr., *Childproofing the Internet*, 41 BRANDEIS L.J. 447–48 (noting that minors' access to pornography increases as government regulation of adult access to pornography decreases).

[94] *See* Mary Pat Treuhart, *Lowering the Bar: Rethinking Underage Drinking*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y. 303, 304 (2006) (noting the millions of dollars spent annually enforcing prohibitions on underage drinking).

and tobacco, it will need enforcement to prevent the black market from undercutting the official price.

Finally, the truly dysfunctional individuals will make costly demands on the criminal justice system whether their drug of choice is illegal or legal. Most users can consume the illegal drugs without committing extrinsic crimes, even at current prices. As price falls, most of them will simply realize a positive income effect. But what about those irresponsible users, the ones located at the top-left corner of the demand curve?[95]

Cheaper drugs may enable some of them to function better while likely quickening the self-destructive trajectories of many others. When users commit extrinsic crimes, the criminal justice system will need to respond both by punishing the extrinsic crime and by monitoring conditions of release that will have the effect of leaving prohibition in place for thousands, quite possibly millions, of adults.

B. Miscounting the Benefits

Prohibition policy's focus on drugs rather than users induces one last, and large, distortion in assessing the costs and benefits of alternative drug policies. The distortion occurs when society confuses reductions in consumption of the product with reductions in the social harms with which the product is linked. Constricting supply to raise the price will decrease consumption, although demand for illegal drugs is relatively inelastic.[96] With great effort, however, the price can rise high enough to cause significant reductions in consumption.

If the harms of drug use exceeded the benefits, all things considered, and all consumption of the illegal drugs was equally harmful, a major reduction in consumption would advance public policy. But not all consumption is equally harmful. A minority of hard-core users are responsible for the majority of drug-related social costs.[97]

These users inhabit the northwest quadrant of the demand curve.[98] When price rises, the budget constraint may reduce their consumption, but they will still be using. For hard-core users whose consumption is set by the budget constraint, a 1 percent increase in price will reduce consumption 1 percent. A 50 percent increase

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[95] *See infra* app. A.

[96] *See, e.g.*, Peter Reuter, *Setting Priorities: Budget and Program Choices for Drug Control*, 1994 U. CHI. LEGAL F. 145, 155 n.37 ("No credible estimates of the elasticity of demand for illegal drugs, either singly or as a group, have been published. An analogy is often drawn to cigarettes, for which studies have established that the elasticity of demand at current prices is substantially less than one." (citing Edwin Mansfield, *Applied Microeconomics* 88 (W. W. Norton & Co. 6th ed. 1994) and Michael D. White & William A. Luksetich, *Heroin: Price Elasticity and Enforcement Strategies*, 21 Economic Inquiry 557, 557–63 (1983))).

[97] *See supra* note 66.

[98] *See infra* app. A.

in price, almost impossible to achieve let alone maintain, would mean daily users would become every-other-day users. It seems unlikely this would greatly reduce social pathologies such as ill health or crime.

Moreover, most hard-core users consume more than one drug.[99] For those who do change their preferences in response to a price increase, the income effect from any decrease in consumption of the drug of choice is likely to be spent on substitute intoxicants, such as alcohol, black-market prescription drugs, or some other illegal drug.[100]

Users who actually quit in response to a price increase are, by definition, marginal users. They inhabit the southeast quadrant of the demand curve.[101] Some of those who quit in response to a price increase might otherwise have become hard-core users in due time. This is the real payoff to enforcement. It is, however, a much smaller payoff than is suggested by statistics reflecting decreases in the number of total users.

Statistical study of illegal activity is, of course, difficult and uncertain. The available studies, however, indicate a distinctly limited price elasticity of drug-related harms, such as drug-related deaths or emergency-room (ER) visits. Dhaval Dave found the price elasticity of heroin-related ER episodes to be -.10 and the price elasticity of a cocaine-related ER episode to be -.27.[102] Bret Jonson Creech's study of drug-related deaths, after adjusting for regional differences, found the price elasticity of heroin-related deaths to be -.225, but this result was not statistically significant; a statistically significant price elasticity of cocaine-related deaths was -.471.[103]

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[99] *See, e.g.*, GOLDBERG, *supra* note 66, at 295 ("Most people in treatment use more than one drug. Nearly one in five people admitted into treatment inject two or more drugs. Multiple drug abuse seems to be dictated by drug availability rather than by desire for effects from a particular drug." (citation omitted)).

[100] On drug substitution generally, see Wayne E. K. Lehman et al., *Alcohol Abuse by Heroin Addicts 12 Years After Drug Abuse Treatment*, 51 J. STUD. ALCOHOL & DRUGS 233, 233 (1990) (analyzing a survey of 298 former heroin addicts that found that "[a]lmost one-fourth of the sample were classified as heavy drinkers in Year 12, and half had previously used alcohol in a substitution pattern"); *see also* Peter Reuter, *Hawks Ascendant: The Punitive Trend of American Drug Policy*, 121 DAEDALUS 15, 37 (1992) ("Marijuana prices are high by historical and internationals standards; indeed high enough to perhaps encourage more use of other drugs, such as alcohol and cocaine."); Jerome Skolnick, *Rethinking the Drug Problem*, 121 DAEDALUS 133, 146–47 (1992) ("As demand for particular drugs waxes and wanes based either on fashion or on interdiction, new drugs will be demanded by consumers and supplied by innovative entrepreneurs.").

[101] *See infra* app. A.

[102] *See* Dhaval Dave, *The Effects of Cocaine and Heroin Price on Drug-Related Emergency Department Visits*, 25 J. HEALTH ECON. 311, 330 (2006).

[103] Bret Johnson Creech, The Effect of Cocaine and Heroin Prices and Arrests on Cocaine and Heroin-Related Deaths 12 (July 28, 2000) (unpublished master's paper, East Carolina University), *available at* http://www.ecu.edu/cs-educ/econ/upload//bretcreech.pdf.

This is not surprising. The people causing most of the harm are the people who will be the last to quit consuming. They will deny their addiction, commit crimes to support it, and generally organize their lives around the drug.[104] Decreasing marginal consumption will reduce the number of experimental users, a few of whom would go on to dysfunctional extremes.[105] Hence, price has an impact, but only a diluted one, on the social harms that cause social concern with drug use.

Indeed, even these depressing figures probably overstate the degree of harm reduction attributable to marginal decreases in drug consumption. Fewer *drug-related* ER admissions, similar to fewer *drug-related* harms like extrinsic crimes, do not mean that those who have reduced consumption of illegal drugs in response to a price increase are *not* causing other social harms. Drug substitution by addicts is common.[106] If those dysfunctional users, bumped off the demand curve for cocaine by a price increase, turn to a prodigious consumption of alcohol, the social costs will not show up in drug-related statistics. These users-cum-alcoholics are likely to cause other harms that tend to offset those they would have caused had they continued to use their drug of choice.[107]

Increased prices are difficult to maintain over time. In fact, in real terms, the price of cocaine has fallen for decades.[108] If price falls, consumption tends to rise again as consumers respond to the increased incentives. A particularly sinister pattern is the development of nastier drugs in response to crackdowns on the old ones.[109] For instance, crack took off because it was a cheaper high than powder.[110]

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[104] *See* GOLDBERG, *supra* note 66; *see also* A. Morgan Cloud, III, *Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 725 (noting how addicts allow drugs to assume a central role in their lives and take precedence in their decision-making).

[105] *See* Cloud, *supra* note 104, at 746 (describing patterns of drug consumption by occasional and experimental users and noting that only some progress to full-blown addicts).

[106] *See supra* notes 99–100 and accompanying text.

[107] *See* Juan R. Torruella, *One Judge's Attempt at a Rational Discussion of the So-Called War on Drugs*, 6 B.U. PUB. INT'L L.J. 1, 9–10 (describing the societal harms caused by alcoholism).

[108] *See* Associated Press, *US Cocaine Prices Drop, DEA Data Shows*, MSNBC, Apr. 27, 2007, http://www.msnbc.msn.com/id/18355447 (stating the price of one gram of pure cocaine fell from $600 in 1981 to $135 in 2006).

[109] *See, e.g.*, Skolnick, *supra* note 100, at 145–46 (discussing the "drug hardening" phenomenon).

[110] *See Drug Testing in Schools: An Effective Deterrent?: Hearing Before the Subcomm. on Criminal Justice, Drug Policy and Human Resources of the H. Comm. on Gov't Reform*, 106th Cong. 68 (2000) (statement of George J. Cazenavette, III, Special Agent in Charge, New Orleans Field Division) (discussing prevalence of crack because it is cheaper than powder, easier to use, and its effects are more rapid and intense).

Similarly, crackdowns on domestic meth labs made a market for Mexican "ice," a more powerful version of the drug.[111]

The government is quite proud of an apparent, recent 15 percent increase in the retail price of cocaine.[112] Factoring in a three-point decrease to reflect the consumer price index of general inflation, that increase falls to 12 percent. If the elasticity-of-harm-numbers are right, a 12 percent price increase will cause an immediate 3 percent to 4 percent decline in cocaine-related ER visits, rising over time to a 6 percent decline, plus a 4 percent decrease in cocaine-related deaths.[113] It is not known whether these benefits are offset by the consequences of cocaine users' substitution of alcohol, prescription painkillers, or, for that matter, heroin.

In 2004 there were just under 10,000 deaths in the United States attributed to "narcotics and hallucinogens," including heroin, cocaine, and prescription opiates such as oxycodone.[114] Reducing that figure 4 percent (on the false assumption that all the drug deaths are cocaine-related and none heroin-related) would save 400 lives. Whether substitute consumption will offset this gain is unknown. In 2004 there were around 212 deaths from "nonopioid analgesics," including items like aspirin.[115] The figure for 2004 was up 54 percent from 1999, but increases in abuse of prescription painkillers appear to have played a larger role than cocaine in the change.[116] Lives saved from cocaine may be lost to other drugs.

The life of every person who dies prematurely is precious, unique, and irretrievable. One must ask, however, whether gains of this magnitude are worth the wealth and force used to produce them. On the debatable assumption that the current price hiccup is the product of enforcement, *tens of thousands of people* have been imprisoned, and *billions of dollars* have been spent, to achieve a modest and ambiguous result.

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[111] *See, e.g.*, Tim Craig, *Import of Methamphetamine from Mexico Offsets Local Progress*, WASH. POST, Apr. 13, 2007, at B7, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2007/04/12/AR2007041201180.html (noting that the crackdown on domestic meth labs was followed by importation of Mexican "ice," a more powerful version of methamphetamine).

[112] DEA, Drug Information, Cocaine Price/Purity Analysis, http://www.dea.gov/concern/cocaine_prices_purity.html (last visited Jan. 15, 2008) ("From January through June 2007, the retail (involving amounts up to ten grams) price per pure gram of cocaine increased 15 per cent, from $145.42 to $166.90.").

[113] *See* Dave, *supra* note 102, at 330.

[114] *Unintentional Poisoning Deaths — United States, 1999–2004*, 56 MORBIDITY & MORTALITY WKLY. REP. 93, 96 (2007).

[115] *Id.*

[116] *Id.* Unintentional drug poisoning mortality rates increased substantially in the United States during 1999–2004. Previous studies, using multiple cause-of-death data, have indicated that the trend described in this report can be attributed primarily to increasing numbers of deaths associated with prescription opioid analgesics (e.g., oxycodone) and secondarily to increasing numbers of overdoses of cocaine and prescription psychotherapeutic drugs (e.g., sedatives), and cannot be attributed to heroin, methamphetamines, or other illegal drugs.

Nor should the consumer-welfare loss from this arbitrary price increase be neglected. A 15 percent increase in the retail price of fast food would probably yield significant health benefits, but society does not crack down on McDonald's to achieve that benefit. Rather, the health costs are thought to be outweighed by consumer welfare as reflected in ability to pay.

Supply-side strategies take a long road to a small house. If social costs come from a minority of hard-core users, it makes sense to target them directly, rather than to continue investing vast amounts of wealth and force to change the behavior of people who are not causing problems in the first place. This is not difficult; if the drugs-cause-harm thesis has any truth at all (and it has some), the hard-core users will be prosecuted for extrinsic crimes or come to the attention of the mental health bureaucracy. What to do with them will be a vexatious question, but it will not be either more or less vexatious because drugs are legal or illegal. How to sentence a dipsomaniac and how to sentence a heroin addict present similar challenges, even though liquor is legal and heroin is not.

Enforcement must discriminate more finely among persons. Holding people responsible involves considerably *more* coercive social intervention with respect to two populations: minors and hard-core users.[117] Indeed, successful initiatives with these two groups are indispensable to whatever distant political prospects there may be for modifying prohibition.[118] If effective social control measures made it more difficult than it now is for young people to make irrevocable errors about habit-forming drugs while other measures made it more difficult than it now is for dysfunctional drug users to injure others, the group that remains—competent adults who do not cause harm—could press a strong argument for a new regime that is less repressive *as to them*.

The critical tool is drug testing. Properly used, this tool gives society the ability to impose, with substantial efficiency and modest cost, different legal regimes on different populations.

V. HOLDING PEOPLE RESPONSIBLE

A. Irresponsible Users: Children

No one advocates legalizing marijuana, cocaine, or heroin for juveniles. Even possession of alcohol or tobacco, allowed for adults, is an offense for minors. One

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[117] *See* OFFICE OF NAT'L DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, CURRENT STATE OF DRUG POLICY: SUCCESSES AND CHALLENGES 5–6 (2008), *available at* http://www.whitehousedrugpolicy.gov/publications/successes_challenges/successes_challenges.pdf (showing the prevalence of drug use among minors and hard-core users; citing that one in four 12- to 17-year-olds reported using drugs in the past year and that 20 percent of the drug-using population accounted for 70 percent of the total drug consumption).

[118] *See id.*

recurring theme in the defense of prohibition is the risk that relaxing prohibition would induce an epidemic of juvenile drug abuse.

Present policy toward minors has two primary components. One is the effort to drive up the price, hoping that kids, who do not have large sums of money, will be among the first priced out of the market.[119] The other is education: if kids are exposed to the facts, they will make wise choices when they confront temptation.[120]

The results have been disappointing. Youth drug-use numbers fluctuate but remain high by any standard. The DARE program is so bereft of measurable success that it has become notorious.[121]

Minors are, legally, not fully responsible moral agents. They may not vote, the younger ones may not drive or consent to sexual activity, and they are subject to compulsory education laws.[122] Their ability to enter contracts is limited, and

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[119] *See* Karen P. Tandy, DEA Administrator, Cocaine Price and Purity (Nov. 8, 2007) (transcript available at http://www.usdoj.gov/dea/speeches/s110807.html) (announcing that DEA measures had "attacked the financial underpinnings of the major cartels," resulting in an increase in the price of cocaine).

[120] *See* U.S. Dep't of Educ. Office of Safe and Drug-Free Schools, Programs/Initiatives, http://www.ed.gov/about/offices/list/osdfs/programs.html (last visited Jan. 15, 2008) (stating that the organization's mission is drug abuse prevention through education).

[121] On the lack of empirical evidence of effectiveness, see WILLIAM B. HANSEN, NAT'L INST. ON DRUG ABUSE, PREVENTION PROGRAMS: WHAT ARE THE CRITICAL FACTORS THAT SPELL SUCCESS?, http://www.nida.nih.gov/MeetSum/CODA/Critical.html (last visited Jan. 15, 2008). Hansen observes:

> The magnitude of the program notwithstanding, there is little evidence to support DARE as a viable or effective approach to substance abuse prevention. In a recent review by Ennett and colleagues (1994), 17 published and unpublished manuscripts documenting evaluations of DARE were examined. Of the 17, only 11 met minimal standards for methodological rigor and were used to form the basis of interpreting findings. None of these studies demonstrated any outcome effectiveness of DARE. The average calculated effect size reported was .06, indicating very small average effects. Overall, drug use among control schools and DARE schools was roughly equal. Several of these studies were longitudinal and found neither short- nor long-term results. Moreover, DARE has been most heavily institutionalized since 1990, a period during which drug use has been escalating.

Id.

[122] *See, e.g.*, Larry Cunningham, *A Question of Capacity: Towards a Comprehensive and Consistent Vision of Children and Their Status Under Law*, 10 U.C. DAVIS J. JUV. L. & POL'Y 275, 294–97, 334–36 (2006) (discussing the limits on minors' capacity to vote or drive); Elisa Poncz, *Rethinking Child Advocacy After* Romer v. Simmons*: "Kids are Just Different" and "Kids are Like Adults" Advocacy Strategies*, 6 CARDOZO PUB. L. POL'Y &

their liability for crimes is likewise limited.[123] Focusing on the responsibility of the user, there are very strong reasons for trying to do better at keeping the young from using drugs.

Drug testing techniques offer a powerful tool for directly achieving what institutional violence and official propaganda have failed to achieve indirectly. States could condition the issuance of drivers' licenses to minors on passing twice-a-year drug tests, administered on short notice.[124] Some kids might find ways to confound the test. However, drug tests seem to work tolerably well in the military, which operates largely with a young, albeit legally responsible, population.[125]

The United States has not yet undertaken this step because a majority of the country simply does not regard youthful use of marijuana as all that terrible. Parents do not want their kids to lose even a privilege like driving (let alone get sent to jail) for being merely naughty. These same parents often oppose any relaxation of prohibition because they *are* afraid that their kids might end up using cocaine or heroin.[126] To a degree, this response is good old-fashioned American hypocrisy, but it also reflects a rational policy preference. If the choice is, as so many perceive it, between slogging on with prohibition or allowing high school kids easy access to cocaine, persevering with prohibition and winking at marijuana use is not an unreasonable decision.[127]

ETHICS J. 273, 296–99 (2008) (discussing the limits on minors' ability to consent to sexual activity); Nat'l Conf. of State Legislatures, Compulsory Education, http://www.ncsl.org/programs/educ/CompulsoryEd.htm (last visited Jan. 15, 2008) (stating that "every state and territory requires children to enroll in public or private education or to be home-schooled").

[123] *See, e.g.*, Cunningham, *supra* note 122, at 287–94, 298–311 (discussing the limits imposed on minors in contracting and criminal liability).

[124] George Thomas and the author have both bruited this possibility. *See* Donald A. Dripps, *Terror and Tolerance: Criminal Justice for the New Age of Anxiety*, 1 OHIO ST. J. CRIM. L. 9, 41–42 (2003); George C. Thomas III, *Making Crime (Almost) Disappear* 17–19 (Rutgers Law Sch. (Newark) Faculty Papers, Paper No. 39, 2007), *available at* http://law.bepress.com/rutgersnewarklwps/fp/art39/.

[125] *See* William E. McAuliffe, *Health Care Policy Issues in the Drug Abuser Treatment Field*, 15 J. HEALTH POL. POL'Y & L. 357, 376 (1990) ("The military has conducted drug testing for some time now, and has reported great success in reducing the amount of drug use among the troops.").

[126] *See, e.g.*, Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 HAMLINE J. PUB. L. & POL'Y 117, 128 (noting that the National Federation of Parents for a Drug Free Youth opposed legislative rescheduling of marijuana, believing that it would lead to "youngster[s] trying marijuana, the gateway drug, and probably starting down the road that leads to nowhere but destruction").

[127] As Andrew Koppelman recently put it:

> The most potent grass-roots political force in the formulation of drug policy is parents who are concerned that their children will be seduced by the lure of drug use. These parents are not crazy, and their concern cannot be reduced to a desire to pass on their economic status to their children. They are

This fear of kids on hard drugs, combined with the perceived link between decriminalizing marijuana and greater juvenile access to hard drugs, is the chokehold that has paralyzed public policy for decades.[128] Policy makers have nursed it assiduously.[129] Opponents of the status quo have to engage this fear successfully if change is to become possible.

Mandatory testing of juveniles calls the bluff of the American middle class. It will not happen, no matter how compelling the facial logic may be. A different approach, however, might have a chance of freeing drug policy from the politics of fear. This approach is rooted in the idea of responsibility—this time, the responsibility of parents.

The government ought to undertake to provide a free, reliable, convenient, and confidential drug test for any minor child at the request of the child's parent or parents. This system could easily be administered through the schools. Parents could be mailed a consent form with a prepaid return envelope. They should also be given contact information so that, if they decline to consent at the start of the school year, they can change their minds during the year should behavioral changes or the like suggest the need for intervention. Parents whose children test positive can be referred to whatever public resources may be available for treatment.

Home testing kits are available now, but accurate testing poses a steep challenge for amateurs, and home testing virtually requires an angry confrontation between parent and child.[130] Normalizing testing, by subsidizing and bureaucratizing it, would make testing much more reliable and much more accessible. Simply *knowing* that the option is available might make parents less apprehensive about putting less reliance on the criminal law.

> trying to make their children into autonomous selves who are capable of choosing and pursuing real goods, and they are trying to ward off real hazards that can frustrate these goals.

Andrew Koppelman, *Drug Policy and the Liberal Self*, 100 NW. U. L. REV. 279, 285–86 (2006) (citation omitted).

[128] *See also* Carole Shapiro, *Law v. Laughter: The War Against the Evil Weed and Big Screen Reefer Sanity*, 29 OKLA. CITY U. L. REV. 795, 813–14 (2004) (describing the history of public policy "associating marijuana with hard drugs").

[129] *See, e.g.*, Press Release, Office of Nat'l Drug Policy Control, Statement from Deputy "Drug Czar" Scott M. Burns on Marijuana Decriminalization Efforts in New Hampshire, (March 19, 2008), *available at* http://www.whitehousedrugpolicy.gov/news/press08/031908.html ("Decriminalizing marijuana—the drug which sends the [largest number] of America's youth into substance abuse treatment and recovery—is a dangerous first step toward complete drug legalization.").

[130] *See* Sharon Levy et al., *A Review of Internet-Based Home Drug-Testing Products for Parents*, 113 PEDIATRICS 720, 724–26 (2004) (noting that testing procedures are complex and adolescents may see home testing as "invasive and a violation of their rights, potentially damaging the parent-child relationship").

Once such a system were up and running, the appeal to fear would have a plausible counter. Any parent worried about her child's access to marijuana, cocaine, heroin, meth, steroids, and the rest could monitor the child's use. Of course, parents would prefer that the state guarantee them that their child never be exposed to drugs, but the state cannot make that guarantee no matter how repressively it enforces prohibition. Testing programs target irresponsible use directly; they are justified by their immediate superiority to supply-side efforts at discouraging irresponsible use and also by their long-term tendency to free the decriminalization debate from the specter of a teenage drug epidemic.

B. Irresponsible Users: Addicts

Hard-core users who commit crimes or exploit the public health system are another, and very different, group of irresponsible drug users. If society rejects the addiction defense, as it is right to do, heavy users who commit extrinsic crimes are exposed to just punishment. If responsibility is taken seriously, this should also mark the limit of liability. Adults should not be subject to arrest or prosecution solely for offenses of possession and use of any recreational drug, heroin included.

When a user commits extrinsic crimes, he is by hypothesis one of that minority of users who cause substantial social harm. Crimes give the criminal justice system the opportunity to force users into treatment programs and to impose testing as a condition for avoiding incarceration. The role of drugs in causing the crime needs to be taken into account in setting the sentence, but it should not make possession simpliciter a ground for arrest. Marital discord causes crime, but the police are not sent out looking for unhappy marriages.[131] When a crime takes place against a background of marital strife, courts can, and often do, include in the sentence conditions designed to minimize future crimes by addressing the underlying cause.

This technique is currently employed with respect to drug possession: extrinsic crimes are used as the legal hook for imposing forced treatment.[132] The real debate between legalizers and prohibitionists is about whether to count low-level dealers, who are in the trade primarily to secure their personal supply, as users or dealers.[133] Any wider enforcement of the laws against simple possession would restrain the liberty of harmless persons and waste treatment resources on the socially functional.

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[131] *See* Ricardo Sabates, *Educational Attainment and Juvenile Crime*, 48 BRIT. J. CRIMINOLOGY 395, 404–05 (2008) (stating that marital discord experienced in childhood is a factor related to violent crime).

[132] For a critique of court-imposed drug rehabilitation, see generally Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783 (2008).

[133] *See* Jacob Loshin, *Beyond the Clash of Disparities: Cocaine Sentencing After* Booker, 29 W. NEW ENG. L. REV. 619, 635–36 (2007) (discussing how the Anti-Drug Abuse Act of 1986 intended that low-level dealers and users be given more lenient sentences than kingpins and mid-level dealers, which does not play out in reality).

With respect to health costs, society might decide to eliminate health services for drug-related health problems. This action is too cruel to accrue the necessary political support and might be met by calls from health zealots that smokers, drinkers, and meat eaters be cut off as well. The United States has tried simply to minimize the number of these hard-core users, but marginal price increases have not accomplished this goal very well.[134] The nation might be better off trying to directly reduce the harmfulness of hard-core use.

Needle-exchange programs (NEPs) are the obvious example. Opponents of NEPs are wrong about the value of the programs[135] but are probably right about the logical incompatibility of public benefits with criminality as a criterion for eligibility.[136] The next steps would be heroin maintenance and supervised use—the idea of setting up shooting galleries at public expense would likely produce visceral opposition.

The premise of opposition to NEPs and other managed-use approaches is that the manifest destructiveness of use deters many potential users.[137] Few would be eager to embrace the logic of this proposition either. Government agents might market heroin or cocaine laced with deadly poisons or, less effectively, substances that induce vomiting or incontinence. The risk that any given purchase might have been tainted would discourage use; but like cutting off medical aid, this strategy is too cruel to command public support.[138]

Recall that when consumption rises in response to falling prices, consumer welfare increases.[139] The non-price risks of illegal consumption, including the risks of arrest, overdose, HIV infection, and so on are costs added to the financial price. If use increases in response to harm reductions from managed use, consumer welfare would also increase.

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[134] *See supra* notes 112–114 and accompanying text (discussing the consequences of price increases).

[135] For a thorough review of research covering both laws against injection equipment and NEPs, see Scott Burris et al., *Lethal Injections: The Law, Science, and Politics of Syringe Access for Injection Drug Users*, 37 U.S.F. L. REV. 813, 821–47 (2003). A few studies have found that NEPs *increase* the rate of seroconversion in the cohort, but the author is inclined to agree with NEP proponents that, given the sample-selection problems involved, the weight of the evidence shows that needle access can reduce HIV infections without increasing drug use. *Id.* at 855–58.

[136] *See id.* at 874–76 (discussing political differences of opinion over NEPs).

[137] Ernest Drucker & Allan Clear, Harm Reduction in the Home of the War on Drugs: Methadone and Needle Exchange in the USA (unpublished manuscript), http://www.drug text.org/library/articles/drucker02.htm (last visited Jan. 15, 2008) ("[S]ome opponents of needle exchange have argued that it is imperative to keep drug use as unsafe as possible as a means of discouraging the behavior.").

[138] The uproar in the 1970s over spraying marijuana fields with the herbicide paraquat is illustrative. *See Panic Over Paraquat*, TIME, May 1, 1978, at 24.

[139] *See supra* Parts I.C, II.A–B, III.A–B.

An HIV vaccine might cause an increase in IV drug use; a general increase in income might do the same. Surely the world would be better off with the vaccine or the income, even with some increased use of hard drugs. Moreover, unlike maintaining a high price for illegal drugs by means of taxation, adding health and incarceration risks to the price subtracts from, rather than adds to, government resources.

If one could be sure that use would not increase, the case for public efforts to manage rather than punish addiction would be ineluctable. There is good evidence that NEPs do not lead to increased use.[140] This evidence suggests a strategy for managed use: experimental programs should be attempted, with one eye on harm reduction and the other on increased use. The life of heroin addicts is so unappealing that once-a-week supervised use is unlikely to lure many new users into addiction. But the question is an empirical one.

The rejection of the addiction defense is again illuminating. What if society agreed there should be an addiction defense, i.e., agreed that hard-core addicts are ill and have lost the capacity for behavioral control? Public safety would then call for incapacitation through civil commitment. If the government can adduce clear and convincing evidence that a user is a danger to himself or to others, the same balance that authorizes confinement of the mentally ill inclines in favor of committing drug addicts.[141] After some number of failed rehabilitation attempts, the result would be incapacitation, not further treatment.

Unlike supply-side efforts, expanded civil commitment would directly address the harms of irresponsible use. The government would need to prove by clear and convincing evidence that the addict was a danger to others (by reason of a record of committing drug-induced or drug-motivated crimes) or to himself (by reason of a record of drug-induced health problems, suicide attempts, and the like). There are good reasons to demand imposition of strict procedural safeguards on the process, but drug addiction does not, in principle, seem distinguishable from pedophilia. For users who really have lost behavioral control, the government should take the same coercive steps appropriate for the irresponsible.

The extraordinary expense this might occasion poses an obvious obstacle.[142] Civil commitment is costlier than prison; a rough-and-ready estimate is $100,000

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[140] *See* Burris, *supra* note 135, at 858 ("Studies have consistently shown that NEPs are not associated with increases in drug use.").

[141] *See* Addington v. Texas, 441 U.S. 418, 426–33 (1979) (holding that involuntary commitment of a mentally ill person requires a showing of clear and convincing evidence under the Fourteenth Amendment).

[142] *See* Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders*, 47 VILL. L. REV. 989, 1003 (2002).

> In sum, civil commitment to residential treatment facilities may be too prohibitively expensive to implement effectively. To have a meaningful impact, these programs required a year or more of secure residential treatment followed by long-term intensive probation or parole, with a realistic threat of re-

per person annually.[143] Committing 10,000 addicts would cost a billion dollars. There are tens of thousands of frequent heroin users,[144] and many more frequent cocaine users.[145]

The price of commitment can be deemed prohibitive only in reference to the expected benefits; the United States spends trillions of dollars on defense and health care.[146] If the price of committing half a million hard-core addicts ($50 billion) is thought too high, this implies that the costs of hard-core use, although real and substantial, are not of a scale that would justify such spending.

If that is the result, managed use, even at the risk of increased use, looks like a plausible alternative to present policy. Estimates of public expenditures to control drug supply vary, but total drug-control costs have been estimated at $40 billion.[147] Leaving civil liberties aside for the moment, as expensive as civil commitment is, that sum would suffice to civilly commit 400,000 addicts.

C. Responsible Users: Functional, Noncriminal Adults

An estimated 5 percent of the U.S. population uses illegal drugs every year.[148] After prodigious expansions, due to drug enforcement rather than to any rise in violent crime, the U.S. prison population has swelled to 1 percent of the

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> incarceration for absconding from the program or for serious instances of relapse. As such, the programs were viewed as untenable by policymakers and were abandoned.

Id. (citation omitted).

[143] This is the number usually given for committing sex offenders. *See* Monica Davey & Abby Goodnough, *Doubts Rise as States Hold Sex Offenders After Prison*, N.Y. TIMES, Mar. 4, 2007, § 1, at 1 ("The annual price of housing a committed sex offender averages more than $100,000, compared with about $26,000 a year for keeping someone in prison . . . .").

[144] *See* Office of National Drug Control Policy, Heroin Facts & Figures, http://www.whitehousedrugpolicy.gov/drugfact/heroin/heroin_ff.html#extentofuse (last visited Jan. 15, 2008) (estimating the number of past-month heroin users at 153,000).

[145] *See* Office of National Drug Control Policy, Cocaine Facts & Figures, http://www.whitehousedrugpolicy.gov/drugfact/cocaine/cocaine_ff.html#extentofuse (last visited Jan. 15, 2008) (estimating the number of past-month cocaine users at 2.1 million).

[146] *See* OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 2009, at 49, 68 (2008) (establishing a budget of $651 billion for the Department of Defense and $736 billion for the Department of Health and Human Services).

[147] *See supra* note 90.

[148] *See* SPEAKING OUT, *supra* note 2, at 2 (estimating that "[n]inety-five percent of Americans do not use drugs. This is success by any standards").

population.[149] As rejection of the addiction defense might suggest, most users remain responsible. They can—and do—refrain from extrinsic crime.[150]

The one strong reason not to decriminalize their lifestyle choices is the risk of a socially disruptive explosion in drug use.[151] Just as there is no political consensus favoring legalization, there is no political consensus for actual enforcement against those who consume illegal drugs in private without committing extrinsic crimes.[152] There is some hypocrisy in this arrangement, but also some common sense. A paper prohibition might be enough to prevent a huge upsurge in use, and actual enforcement would be very costly in terms of both liberty and resources.

The real downside to retaining criminal prohibition is forgoing the tax and safety benefits of legalization. No one is going to pay tax on a transaction when reporting the transaction will lead to criminal prosecution. Nor can regulators monitor purity levels and needle disinfection when the activity to be regulated remains underground.

More needs to be known about the effect of lower prices. How much will use increase, and to what extent will new users turn out to impose genuine costs on society? If usage increased by a large number of persons, each using modest quantities on an occasional basis, the case for decriminalization would be very strong. It would then be clear that prohibition was frustrating a high volume of harmless consumer preferences. Taxation could keep a significant floor under price while yielding useful government revenue. Law enforcement resources could be retasked to higher uses. Testing programs could keep drugs out the hands of minors.

On the other hand, if falling prices and a relaxed official attitude led to a tripling in the number of in-the-past-week heroin and cocaine users, the case for prohibition would be strengthened. Even so, it is doubtful that the genuine costs of even dramatically increased use would outweigh the combined costs presently imposed in the form of lost consumer welfare and enforcement-related resource commitments.[153] The combined opportunity cost of enforcement ($40 billion or thereabouts),[154] and the value of even current consumer welfare ($67 billion)[155]

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[149] Adam Liptak, *More than 1 in 100 Adults Are Now in Prison in U.S.*, N.Y. TIMES, Feb. 29, 2008, at A14.

[150] *See supra* note 51 and accompanying text.

[151] *See* Kaplan, *supra* note 33, at 100 ("It is true that if the number of those dependent upon cocaine merely doubled, we would arguably be well ahead of the game, considering the large costs imposed by treating those users as criminals. But what if there were a fiftyfold increase in the number of those dependent on cocaine? We simply cannot guarantee that such a situation would not come to pass; since we cannot do so, it is the height of irresponsibility to advocate risking the future of the nation.").

[152] *See* Steven G. Calabresi, *Render unto Caesar That Which Is Caesar's, and unto God That Which Is God's*, 31 HARV. J.L. & PUB. POL'Y 495, 500–04 (2008).

[153] *See* Erik Luna, *Drug Exceptionalism*, 47 VILL. L. REV. 753, 794–95 (2002) (discussing the direct costs and opportunity costs associated with drug prohibition).

[154] *See supra* note 90 and accompanying text.

would justify decriminalization by the Kaldor-Hicks criterion[156] unless increased use began to threaten anarchy.

But to accept this kind of risk as a reason to not alter the status quo is to reject faith in freedom and responsibility. It is not enforcement but good sense and self-control that explain why cocaine, which fell in price for the last twenty years,[157] has not led to a social breakdown. Nonetheless, reasonable people cannot be certain of the effects that a policy change will cause, and a small risk of catastrophic error can justify adhering to present policies, however costly. If legalization of cocaine means over-the-counter sales and image-based advertising campaigns for competing brands,[158] the risk of catastrophic error is, of course, greater than if legalization means carefully recorded sales at high prices by regulated distributors.

There is very little risk in decriminalizing marijuana in a small number of states with large urban populations. Society could monitor the results and debate their implications. The other possible step is to move toward de facto decriminalization by de-emphasizing drug enforcement as such. Let prices fall while redirecting enforcement resources along the lines proposed for irresponsible users. If the government were to redirect supply-side enforcement resources toward a vigorous reaction to drug-related extrinsic crimes with compulsory treatment while acting aggressively and proactively to encourage, if not require, drug testing for minors, the welfare of responsible users would be advanced with limited risk of increased social costs.

Measured by the standards of a techno-fix like the polio vaccine, treatment programs are disappointing.[159] Success rates of 50 percent are thought impressive.[160] Compared to prison or civil commitment, however, drug treatment is

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[155] *See supra* note 90 and accompanying text.

[156] *See supra* note 77 and accompanying text.

[157] *See, e.g.*, Associated Press, *supra* note 108 ("The drug czar, John Walters, wrote Sen. Charles Grassley, R-Iowa, that retail cocaine prices fell by 11 percent from February 2005 to October 2006, to about $135 per gram of pure cocaine—hovering near the same levels since the early 1990s. In 1981, when the U.S. government began collecting data, a gram of pure cocaine fetched $600.").

[158] *Cf. Letter* from Norman Mailer to Marvin Gorson (April 11, 1968), *in* Norman Mailer, *In the Ring: Grappling with the Twentieth Century*, NEW YORKER, Oct. 6, 2008, at 61 ("I may have to come out for legalization [of marijuana] if the police keep harassing people and arresting them unnecessarily, but with all that I prefer it to be illegal for it gives a touch of spice to the smoking and saves us from the corporation being able to put vitamins in the hydroponically grown and hybrid hyped marijuana with filters. Not to mention all the psychedelic commercials we'll be spared.").

[159] *See, e.g.*, GOLDBERG, *supra* note 66, at 300 ("Despite the benefits of treatment, rates of illicit drug use by clients remain high. . . . Even when a person completes drug rehabilitation successfully, the compulsion to use drugs often reappears.").

[160] *See, e.g., Treatment, Education, and Prevention: Adding to the Arsenal in the War on Drugs: Hearing Before the S. Comm. on the Judiciary*, 107th Cong. 18 (2001) (statement of Alan I. Leshner, Director, National Institute on Drug Abuse).

cheap.[161] The programs therefore have high cost-benefit ratios. For many hard-core heroin and cocaine addicts, pushing them through the revolving doors of treatment programs when they commit extrinsic crimes may be the best anyone can do, all things considered. The reality of society's limited power to force people out of self-destructive life paths is no justification for making criminals out of millions of otherwise honest citizens while investing tens of billions of dollars in intrusive police tactics and an American gulag. If the best society can do, all things considered, is depressingly little, that little is still the best society can do, all things considered.

VI. CONCLUSION

This Article has argued that U.S. thinking about drug policy is inconsistent with the criminal law's rejection of any addiction defense and that the criminal law is right to reject that defense. Once society accepts that the choice to use drugs is not categorically different than the choice to consume many other consumer products with dangerous potentials and insidious long-term consequences, it is possible to see how misguided supply-side efforts have been. Supply-side enforcement wastes large quantities of resources with real economic opportunity costs, causes massive reductions in consumer welfare, and addresses the external costs of drug use inefficiently and indiscriminately. Society should instead measure the success of drug policy by the extent to which external harm is minimized and consumer satisfaction maximized, not by the number of users or the prevailing price of drugs.

This Article has argued that its methodological thesis points in the direction of some logical and, arguably, politically feasible reforms. Enforcement against users

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> Not just anything called treatment will do. For example, studies in states such as Delaware and New York have shown that comprehensive treatment of drug-addicted offenders, when coupled with treatment after release from prison, can reduce drug use by 50 to 70% when compared to those who are untreated. Treated offenders are also 50-60% less likely to end up back in prison. These findings hold true for at least four years after release. However, if the after-care component is left out, the effects of in-prison treatment are dramatically reduced. In addition, the treatment provided must be comprehensive. It must attend to all the needs of the individual and help return him or her to becoming a fully productive member of society. This means that a continuum of care is crucial for success, including offering treatment and services to individuals as they transition to the community.

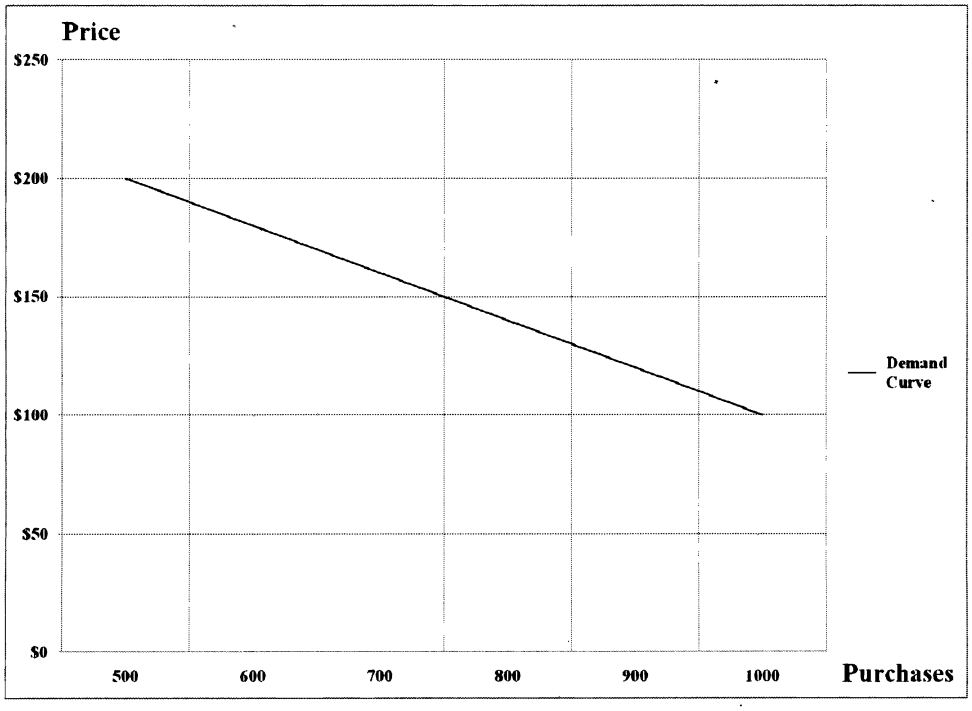
Id.

[161] *See, e.g.*, GOLDBERG, *supra* note 66, at 304 (noting that a 1996 study found the cost of outpatient cocaine treatment per person per year was $2,772, the cost of residential cocaine treatment per person per year was $12,467, and the cost of incarceration per person per year was $39,600).

should be predicated on the commission of extrinsic crimes, with the goal of using the threat of incarceration to coerce addicts into treatment. In turn, juvenile drug use requires proactive drug-testing programs, starting with a government guarantee that any parent who wants her child tested will have that option. Furthermore, supply-reduction efforts ought to be de-emphasized and prices left to drift downward, accordingly. Finally, the prudent step of decriminalizing marijuana and analyzing its effects in current social conditions can act as a bellwether for the legalization of other drugs.

The programmatic points are less compelling than the methodological one. After all, it is hard to find anyone who is openly against personal responsibility. Indeed, responsibility is a stock motif in the rhetoric of the moralistic right-wing of American politics.[162] Responsibility's mirror image, however, is freedom. If society insisted on responsibility in this area, it could increase human liberty with very good prospects of holding constant, or even reducing, the social costs of consumer behavior. And so I close by borrowing a truth from our conservative friends, adapted by one word to the case at hand: Drugs don't kill; people do.

APPENDIX A: WIDGET DEMAND CURVE



[162] FRANK HEARN, MORAL ORDER AND SOCIAL DISORDER 145 (1997).

PROSECUTORS AND DRUGS POLICY: A TALE OF SIX EUROPEAN SYSTEMS

Marianne Wade*

I. INTRODUCTION

The Symposium that this issue of the Law Journal documents is dedicated to a discussion of drugs and justice in the United States. It is hoped that with this contribution detailing the drug policy and the handling of related cases in several European jurisdictions an opportunity to reflect on certain issues from a different perspective and for discussion will arise.

The data presented here stem mostly from a study conducted by the author and a group of researchers across Europe seeking to explore the function of prosecution services within six criminal justice systems: England and Wales, France, Germany, the Netherlands, Poland and Sweden.[1] Though it was not a specific study focus, some interesting information concerning drug policy and the prosecution services' role within it was revealed for the countries involved and is recounted here.[2] The central study conclusion was that prosecution services across Europe play a key role in deciding how offences are dealt with. Considering that drug policy is a major issue within European criminal justice systems, it is not surprising that this research found prosecution services playing a particular role within drug policies of the studied countries.[3]

II. THE DEFINITION OF OFFENSES

First of all, one must note that there can be no discussion of a singular drug policy in the countries studied, the Netherlands providing one famous outlier. In fact, the borderless Schengen area went through an early rough patch as the French

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[1] The study was sponsored by the Fritz-Thyssen Stiftung and the AGIS programme of the European Commission. *See* Jörg-Martin Jehle, *The Function of Public Prosecution Within the Criminal Justice System: Aim, Approach and Outcome of a European Comparative Study*, *in* COPING WITH OVERLOADED CRIMINAL JUSTICE SYSTEMS: THE RISE OF PROSECUTORIAL POWER ACROSS EUROPE 3–12 (Marianne Wade & Jörg–Martin Jehle eds., 2006).

[2] For a broader range of information, see COUNCIL OF EUROPE, EUROPEAN SOURCEBOOK OF CRIME AND CRIMINAL JUSTICE STATISTICS (1999), *available at* http://www.europeansourcebook.org/sourcebook_start.htm [hereinafter SOURCEBOOK].

[3] *See* Marianne Wade, *The Power to Decide–Prosecutorial Control, Diversion and Punishment in European Criminal Justice Systems Today*, *in* COPING WITH OVERLOADED CRIMINAL JUSTICE SYSTEMS: THE RISE OF PROSECUTORIAL POWER ACROSS EUROPE 3, 67–77 (Marianne Wade & Jörg–Martin Jehle eds., 2006).

authorities apparently had great difficulties stemming the flow of drugs from the Netherlands.[4] There is, however, broad agreement amongst these six countries as to what substances are considered illegal narcotics and broad agreement that their trafficking, production, sale, possession and consumption should be illegal.[5] There is a varying degree of discussion as to the appropriateness of current legalization concerning certain commonly used narcotics associated with leisure activities in certain lifestyle groups.[6] By and large, however, serious political discussion is restricted to cannabis, and this remains so controversial that none of the jurisdictions involved have decriminalized the various behavioral forms related to its use.[7]

For those unfamiliar with continental European legal orders: in the mid-to-latter part of the twentieth century, the criminal law was often criticized as sanctioning too many forms of relatively harmless behavior with the stigma of criminal law.[8] Thus major reforms depenalizing a large number of more common and less serious offenses took place.[9] Rather than allowing such behavior to go entirely "unpunished" in the future, it was made subject to what are referred to as administrative proceedings.[10] Procedures therein are more regulatory in nature with lower standards of evidence and sanctions usually consisting of fines of a noncriminal nature (i.e., punishment will not be noted in a criminal record). Such procedures are usually carried out by the police under the authority of local

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[4] The multi-lateral Schengen Agreement was signed by 25 EU member states, Iceland, Norway, Switzerland and Lichtenstein (though Great Britain, Denmark, and Ireland have opted out of certain categories of cooperation). In 2003, it was integrated into the law or *aquis* of the European Union, and thus falls within the ambit of the European Court of Justice. It is best known for abolishing internal border controls between countries in Western Europe. For an introduction, see EUROPEAN UNION COMMITTEE, SCHENGEN INFORMATION SYSTEM II (SIS II), 2006-7, H.L. 49, at 7–8, *available at* http://www.publications.parliament.uk /pa/ld200607/ldselect/ldeucom/49/49.pdf.

[5] *See id.* at 35; Taylor W. French, Note, *Free Trade and Illegal Drugs: Will NAFTA Transform the United States Into the Netherlands?*, 38 VAND. J. TRANSNAT'L L. 501, 515–25 (2005).

[6] *See* French, *supra* note 5, at 515–25.

[7] *See, e.g., id.* at 521–22 (noting that the UK has only depenalised possession of certain drugs in limited quantities under certain circumstances). For the approach used in the Netherlands see *id.* at 515–17; *see also* SOURCEBOOK, *supra* note 2, at 14 (noting the Netherlands' liberal treatment of small-quantity possession).

[8] *See, e.g.*, Henk Jan van Vliet, *Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717, 722–25 (1990) (discussing the formation of drug policies in the Netherlands in the mid-to-late 20th century); *see also* French, *supra* note 5, at 515–17.

[9] *See, e.g.*, Jessica N. Drexler, Comment, *Governments' Role in Turning Tricks: The World's Oldest Profession in the Netherlands and United States*, 15 Dick. J. INT'L L. 201, 216–23 (1996) (offering the Netherlands as a model of decriminalization in the area of prostitution).

[10] *See* Wade, *supra* note 3, at 74–81.

administrations but may be appealed to the prosecution service.[11] The classic example is speeding tickets (at least those of a minor nature; see Figure 1). England and Wales have not formally decriminalized such offenses but subject them to very similar, automated proceedings; in other words, a type of procedural decriminalization.[12]

Figure 1: The Definition of Offenses[13]

	England and Wales	France	Germany	Netherlands	Sweden	Poland
Illegal Parking	C	C	A	A	A	O
Exceeding the speed limit	C	C	A	A/O	C	O
Driving under the influence of alcohol without causing danger or an accident	*	C	C/A	C	C	C
Driving under the influence of alcohol and causing danger to road traffic (driving recklessly)	C	C	C	C	C	C
Driving recklessly/ dangerously without influence of alcohol	C	C	C	C/O	C	O
Theft	C	C	C	C	C	C/O
Possession of small amount of cannabis/hash for personal use	C	C	C	O	C	C
Travelling with public transport without a ticket	C/A	A	C	O	C	O
Begging in a public place	C	*	*	O	*	O
Being "drunk and disorderly" in a public place	C	C	*	O	C	O
Prostitution[14]	*	*	C	*	*	*

C = Crime (subject to criminal proceedings) A = Administrative Offense (subject to noncriminal proceedings)

O = Offense against Order (subject to noncriminal proceedings)

* The behavior mentioned is not defined as an offense of any kind and not subject to criminal or administrative sanction.

[11] *See id.* at 30, 74–81.

[12] For more detailed discussion, see Wade, *supra* note 3, at 33–40; Marianne Wade et al., *When the Line is Crossed . . . Paths to Control and Sanction Behaviour Necessitating a State Reaction*, 14 EUR. J. CRIM. POL'Y & RES. 101, 101–22 (2008).

[13] All information stems from tables I.4.a.–k. of the respective study questionnaires available at http://www.kriminologie.uni-goettingen.de/pps/.

[14] Like the use of cannabis, this is an offence which is not criminalized directly in most cases but for which all surrounding types of behavior are criminalized. Thus it is, for example, a crime to live from the proceeds of prostitution, to incite prostitution, to solicit, etc. *See, e.g.*, Margarete von Galen, *Prostitution and the Law in Germany*, 3 CARDOZO WOMEN'S L.J. 349, 349 (1996) and table I.4.k. of the respective study country questionnaires available at http://www.kriminologie.uni-goettingen.de/pps/.

As Figure 1 demonstrates, the possession of cannabis for personal use, even in small quantities, is an offense in all of the European jurisdictions studied.[15] It may come as a surprise to those familiar with accounts of drug policy in Europe that the Netherlands—though it does not classify the possession of cannabis as a crime—features it as a punishable offense[16] that can, under certain circumstances, be depenalized entirely. Cannabis may be sold to and consumed by adults on premises that are classified by Dutch authorities as coffee shops free from the threat of punishment.[17] An operator or owner will avoid prosecution if she meets the following criteria:

- No more than five grams per person may be sold in any one transaction
- No hard drugs may be sold
- Drugs may not be advertised
- The coffee shop must not cause any nuisance
- The municipality has not ordered the establishment closed
- No more than 500 grams are in stock[18]

A breach of the law in relation to possession is also generally evaluated differently than it is in the rest of Europe. Possession is not a criminal offense, but rather is classified as a less serious "offense against order."[19] A comparative look at enforcement policy and sanctions for drug offenses[20] displays that the Netherlands cannot be described as having an exceptionally liberal drug policy in relation to the rest of Europe, though those familiar with certain quarters of Amsterdam will find this difficult to believe.

England and Wales (two countries which form one legal jurisdiction), where in recent years action has been taken following a long debate on the decriminalization of cannabis offenses altogether, provides another example of interesting policy. In the end, the decision was taken to effectively depenalize possession of small quantities and consumption so long as they cause no disturbance.[21] This was accomplished by downgrading the classification of cannabis products to the lowest category of narcotics, a category for which

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[15] *See supra* note 13 and fig.1.

[16] *Id.*

[17] *See* REITOX NAT'L FOCAL POINT, NATIONALE DRUG MONITOR, THE NETHERLANDS: DRUG SITUATION 18 (2006), *available at* http://www.emcdda.europa.eu/attachements.cfm/att_44964_EN_NR2006nl.pdf.

[18] *Id.*

[19] *See supra* note 13 and fig.1.

[20] *See* MARCELO FERNANDO AEBI ET AL., EUROPEAN SOURCEBOOK OF CRIME AND CRIMINAL JUSTICE STATISTICS—2006, at 49, 64, 110 (3d ed. 2006), *available at* http://www.europeansourcebook.org.

[21] *See* Sophie Goodchild, *The Met out of Step on New Cannabis Law; Drugs: London Police Chief Admits to Massive Amounts of Muddle Over*, THE INDEP. ON SUN. (London), Jan. 18, 2004, at 11.

enforcement action is rarely taken.[22] This was effectively the case for cannabis products before reclassification in any case.[23] The move was made, above all, to allow police to concentrate on the enforcement of laws relating to class A—the most serious—drugs.[24] Not surprisingly, this move caused great confusion and is now controversial as well as subject to heated debate surrounding potential reversal.[25] First, the lack of clarity in the law and the debate surrounding change led large portions of the population to believe that cannabis was being legalized.[26] At the same time, while the leading representative organization of chief police officers (ACPO) issued guidelines that police only step in and thus start the chain of prosecution in cases of flagrant use of cannabis products in public space (arresting only in aggravating circumstances—such as use outside schools—otherwise using powers to confiscate and issue warnings),[27] a significant number of police-force chiefs vowed to take a different path, imposing drug policy as they believe correct, causing widespread confusion among police officers.[28] The end result was that possession and consumption of cannabis remained legally

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[22] *Id.*

[23] *See* Jason Bennetto, *No Need to Alter Cannabis Law, Says Met Chief*, THE INDEP. (London), May 20, 2005, at 9 (stating that according to the Metropolitan Police Chief "arresting people for having small amounts of the drug [before reclassification] was a 'waste of time' because the courts usually gave people a caution or fine").

[24] *See* Nigel Morris, *Clarke to Reject Tougher Cannabis Law and Opt for Crackdown on Suppliers*, THE INDEP. (London), Jan. 19, 2006, at 4 (stating that "[t]he change from class B to class C . . . was designed to enable police to channel their efforts into tackling use of class-A drugs such as heroin and cocaine"); *see also* Sophie Goodchild, *The Met Out of Step on New Cannabis Law*, THE INDEP. ON SUN. (London), Jan. 18, 2004, at 11 (stating that "[t]he police have been instrumental in pressing for cannabis law reform so that officers can concentrate on targeting the supply and trafficking of class A drugs").

[25] *See* Bennetto, *supra* note 23, at 9 (stating that "[t]he legislation on cannabis is currently being reviewed and is widely expected to be reversed").

[26] *See, e.g.*, Jason Bennetto, *Cannabis Arrests Fall in London but Public and Police Are Confused*, THE INDEP. (London), Nov. 23, 2004, at 16 (stating that "civilians and law enforcers were still confused about the changes, prompting a growing number of confrontations with young cannabis smokers who believe the practice is legal"); Cole Moreton et al., *Special Report: Cannabis: As If Dope Smokers Weren't Confused Enough Already*, THE INDEP. ON SUN. (London), Mar. 20, 2005, at 4–5 (discussing the public perception that cannabis was being legalized).

[27] *See* Bennetto, *supra* note 26, at 16 ("Under the changes in the law, possessing the drug ceased to be an arrestable offence in most situations, but officers retained the power to arrest in aggravated circumstances, such as smoking dope outside schools or on the street. In most cases, the drug is supposed to be confiscated and users given a warning."). Though interestingly, ACPO is now among those calling for the old status to be reinstated. *See* Jonathan Owen, *Blunkett Goes Head-to-head with Government Over Plans to Raise Cannabis to Class B Status*, THE INDEP. ON SUN. (London), Feb. 3, 2008, at 2 (stating that the ACPO "is now calling for cannabis to revert to its class B status").

[28] *See* Jonathan Owen, *Top Policemen Want Cannabis Made Class B to End Confusion Among Forces*, THE INDEP. ON SUN. (London), Oct. 7, 2007, at 22 (discussing regional differences in policing the use and possession of cannabis).

punishable even though many members of the public thought otherwise.[29] Furthermore, police published enforcement guidelines indicating that they would intervene only in specific cases.[30] However, some police forces enforced a different policy.[31] In short, the reform ended in chaos and an increase in criminal justice discretion of which users in certain areas unexpectedly fell foul. To make matters worse, health concerns have emerged related to new breeds of highly potent cannabis plants and the damage they can cause to young people,[32] sparking a ferocious debate about what the law should look like.[33]

As it stands, possession and consumption of cannabis products is illegal in England and Wales. Whether and how strongly such offenses result in criminal justice action depends on the local police policy (there are forty-three forces in England and Wales) and, naturally, the resources a force is able to devote to enforcement.[34] A decision whether or not to enforce the law remains at the discretion of the individual police officer (though, naturally, she will risk a complaint or even a suit for malicious prosecution if she enforces the law unevenly without good reason). This is in line with the long-standing British tradition of powerful and highly trusted police officers.[35] This regulation also leaves discretion to define private premises with individual officers and has been the subject of some concerned comment from those who fear it could lead to further tension between police and minority communities.[36] Such communities, it seems, are less likely to be tolerant of their children consuming any intoxicating substances at all. Thus, these children are far more likely to commit such offences outside private premises and, thus, logically more prone to prosecution.[37]

As these few examples have shown, drug policy in European jurisdictions is by no means simple. Regulation on cannabis is also subject to debate given recent

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[29] *See supra* note 26 and accompanying text.

[30] *See* Goodchild, *supra* note 24, at 11 (discussing police guidelines for cannabis-related arrests).

[31] *See supra* note 28 and accompanying text.

[32] *See* Morris, *supra* note 24, at 4 (stating that according to the "mental health charity Sane . . . there was mounting evidence [that] cannabis, especially in its more toxic form of skunk, could cause long-term mental damage").

[33] *See* Owen, *supra* note 27, at 2 (discussing the debate regarding whether cannabis should revert back to class B status).

[34] *See, e.g.*, Nigel Morris, *Cannabis Arrests Fall Under Softly Softly Law*, THE INDEP., Jan. 29, 2005, at 9.

[35] The ACPO recommendation to arrest only where "users cause a policing problem" is not entirely reassuring to a mistrusting mind. Sophie Goodchild, *The Met Out of Step on New Cannabis Law; Drugs; London Police Chief Admits to Massive Amount of Muddle Over*, INDEP. ON SUN., Jan. 18, 2004, at 11.

[36] *See, e.g.*, Postings of Zaki Hashmi, Marion Fitzgerald, Newshost, and Paul Cavadino to http://news.bbc.co.uk/2/low/talking_point/forum/2118682.stm (July 12, 2002, 17:17 UK).

[37] *Id.*

scientific findings and the potency of new strains.[38] Such national debate is also reflected in more local structures as will be seen in an example from Germany below.

III. PROSECUTION INFLUENCE UPON POLICY

The prosecution study determined that prosecutors across Europe have a variety of options they can use in ending cases without taking them to court and indeed of imposing conditions or even punishment upon a suspected offender independently or highly independently of the courts.[39] In fact, the study determined that in France, Germany, the Netherlands, and Sweden, large proportions of cases are dealt with in this way.[40] This means that prosecutors in those countries have a direct role in imposing policy, including drug policy,[41] and it is of interest to see how they do so.

According to the study, prosecutors have the option to drop a case against a suspect even though they regard him as guilty on what the study broadly termed "public interest" grounds.[42] This means that a prosecutor regards some public concern to speak against prosecution and indeed to outweigh the interest in seeing the crime punished (e.g., the age of the offender, a minor offense causing no damage resulted from a genuine mistake, or—in Sweden—because the cost of prosecution is disproportionate to the potential gain). Furthermore, prosecutors have the option of making a conditional disposal, which means that they require the suspect—(again who they evaluate as being guilty)—to fulfill a condition in exchange for proceedings being halted.[43] In this way, prosecutors impose a quasi punishment without taking the case to court (though in Germany, except in very minor cases, court approval is required[44]).

Where prosecutors require a conviction to impose a fine or a short prison sentence (or where they or the guidelines of their managing unit view this as necessary), they may choose to use penal order proceedings.[45] These end in a conviction by court decision (except in Sweden where the prosecutor imposes

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[38] *See, e.g.*, EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION, AN OVERVIEW OF CANNABIS POTENCY IN EUROPE 21–42 (2003).

[39] *See* Wade, *supra* note 3, at 21–22.

[40] *Id.* at 90.

[41] *Id.* at 94.

[42] *Id.* at 65–68.

[43] *Id.* at 68–74.

[44] *Id.* at 109–10.

[45] *See id.* at 74–78 (discussing the application of penal order proceedings).

them individually),[46] but are subject to such low rates of rejection by the courts that the study categorized them as cases of effective prosecutorial adjudication.[47]

The study concentrated on mass crimes and so only directly posed questions to the use of such procedures in relation to cannabis possession for personal use.[48] Not surprisingly, this turned out to be one of the offenses for which public interest drops are used in Germany, and conditional disposal in England and Wales (cautions), France, the Netherlands, and Sweden (where penal orders were also used).[49] In France, conditional disposals are also frequently used to refer an addict to treatment.[50]

It is perhaps most interesting to compare prosecutors' actions in drug cases to those in other offense categories. Unfortunately, detailed statistical information as to what offenses prosecutors use their discretionary powers to resolve is not always available. Furthermore, the information available groups drug offenses together, meaning that a high rate of less serious offenses (as is to be assumed given how cannabis offenses are viewed in the jurisdictions studied) is mixed statistically with a number of serious offenses and differentiation is not possible.[51] Nevertheless, the figures can provide an impression of what policy is being pursued, albeit only a rough one.

A statistical comparison for England and Wales, the Netherlands, and Sweden follows:

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[46] *See* Robert Svensson, *Strategic Offences in the Criminal Career Context*, 42 BRIT. J. CRIMINOLOGY 395, 397 (2002) (noting that prosecutors in Sweden may issue fines).

[47] For a more detailed discussion of these forms and the allocation of power within the European criminal justice systems, see Eric Luna & Marianne Wade, *The Judge before the Judge* (forthcoming 2009).

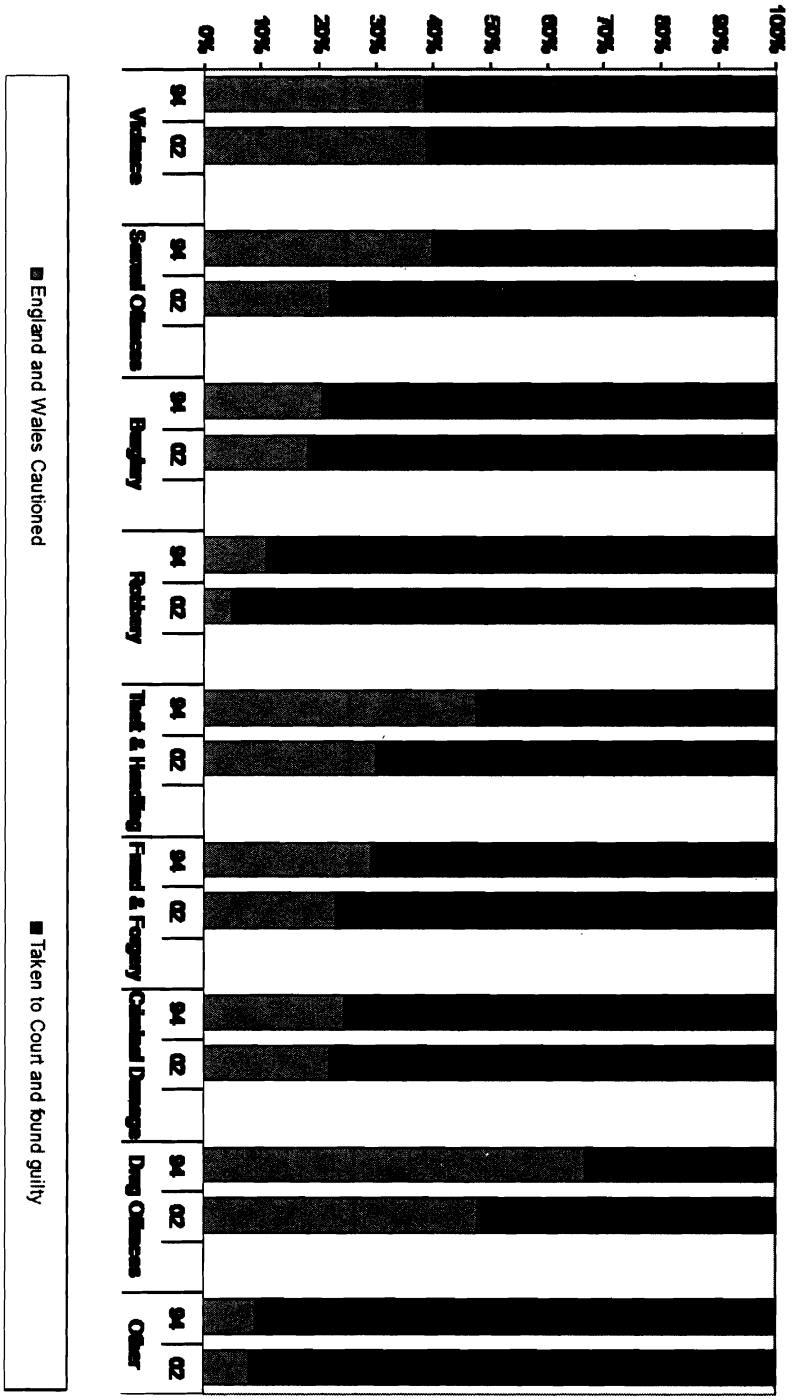
[48] *See* Wade, *supra* note 3.

[49] *See id.* at 68–71.

[50] *Id.* at 71, 72.

[51] *See id.* at 94 (noting that the drug offence category includes high proportions of less serious offences).

Figure 2: Cautioning in England and Wales 1994 and 2002



In England and Wales it is striking that the rate of cautioning for drug offenses—that is, of dropping a case against a suspect admitting his or her guilt, keeping only a record of this fact—is much higher than in relation to other offense groups in England and Wales.[52] Presumably, this proves that British police and prosecutors were probably pursing the kind of policy now advocated to depenalize possession of cannabis on condition that it is consumed in private premises long before this became official policy. Clearly, police and the prosecution service were ensuring that drug cases did not go to court, possibly taking advantage of one of the many programs introduced in recent years to help fight addiction rather than addicts via the English and Welsh criminal justice system.[53]

Drug offenses are quite clearly the offense category in which measures diverting cases out of the criminal justice system are regarded as appropriate in England and Wales.

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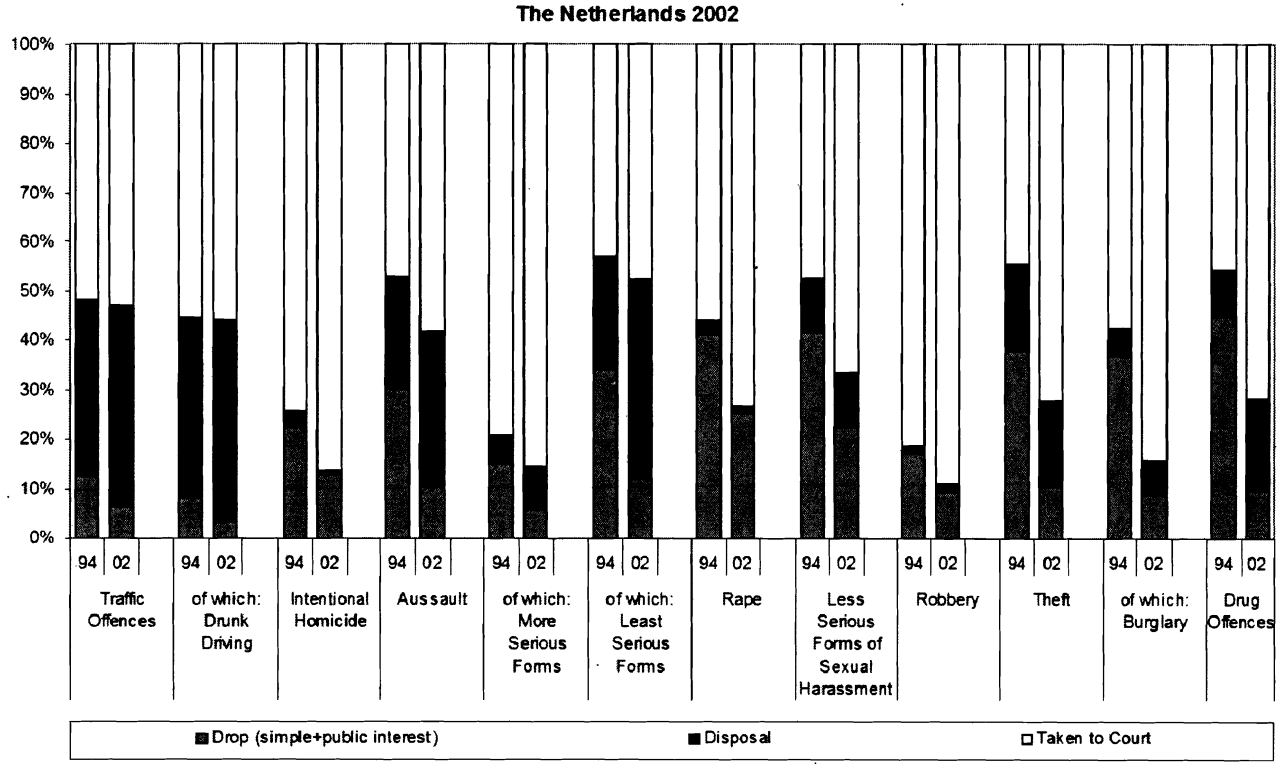
[52] *See supra* fig.2.

[53] *See, e.g.*, *Blair Unveils 'Tough' Anti-Drugs Package*, 4NI.CO.UK, Nov. 25, 2004, http://www.4ni.co.uk/news.asp?id=35605.

Figure 3: Diversionary Decisions in the Netherlands 1994 and 2002



The Dutch figures are very interesting, perhaps displaying the kind of tendency one might expect of the famously liberal Netherlands in 1994—with fewer than 50% of drug cases being taken to court (this presumably relating to serious offenses only), a large number of cases being dropped, and only a slim proportion meeting a prosecutorial discretionary "quasi punishment."[54] The 2002 numbers, however, are perhaps surprising, displaying a much higher rate of court involvement, a minimal tendency to drop (presumably then only in minor cases on policy grounds if not only restricted to evidentiary drops, which are included in these figures), and a high tendency to impose a condition when ending a case without taking it to court.[55] Assuming there were no major changes in statistical input practices,[56] this indicates a clear change of policy put into effect by the prosecution service. The statistics bear indication of this category of offenses being treated as the least serious with a high incidence of drops and a fairly slim category of cases subject to a condition being imposed in exchange for a disposal in 1994. This changes for 2002, though one should note that all offense categories see an increase in the rate of cases going to court, while most see a shift from drops in favor of disposals.[57] This is in line with executive policy decisions made in the nineties when the government took the line that a high rate of suspects facing no criminal justice system reaction at all was unacceptable.[58]

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[54] *See supra* fig. 3.

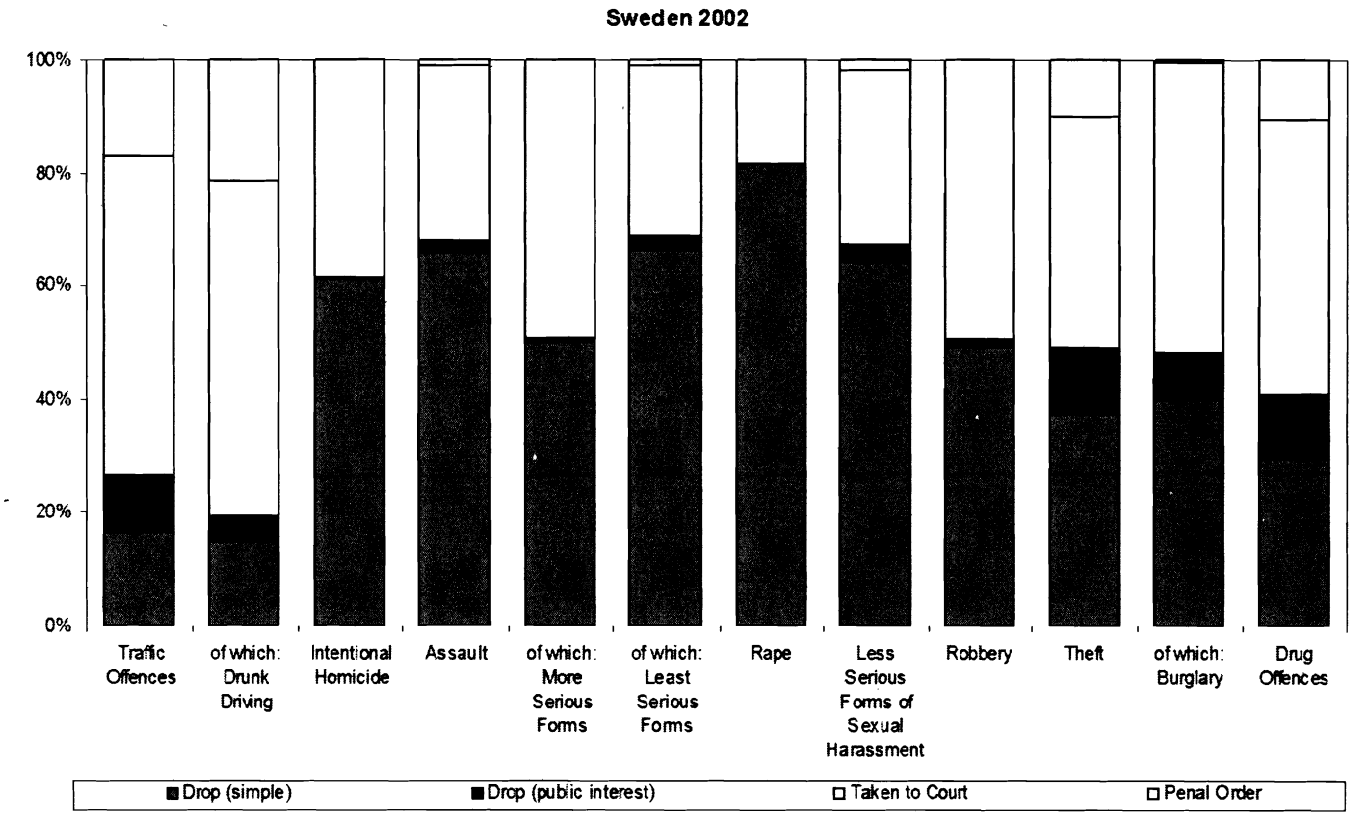
[55] *Id.*

[56] Theoretically, it is possible that a change in police behavior due to increased supervision of the police by the prosecution service has affected these statistics though there is no indication of this, see Martine Blom & Paul Smit, *The Prosecution Service Function within the Dutch Criminal Justice System*, *in* COPING WITH OVERLOADED CRIMINAL JUSTICE SYSTEMS: THE RISE OF PROSECUTORIAL POWER ACROSS EUROPE 237, 237–48 (Jörg-Martin Jehle & Marianne Wade ed., 2006).

[57] Jehle, *supra* note 1, at 246–48; *see also* Michael Tonry, *Crime, Criminal Justice, and Criminology in the Netherlands*, 35 CRIME & JUST. 1, 12–23 (2007) (discussing the changing trends in crime and punishment in the Netherlands).

[58] *See* PETER J.P. TAK, THE DUTCH CRIMINAL JUSTICE SYSTEM: ORGANIZATION AND OPERATION 53 (2nd ed. 2003).

Figure 4: Diversionary Decisions in Sweden 2002



The Swedish statistics for 2002 show a relatively low rate of simple drops (due to evidential insufficiency, etc.) being made, possibly because drug cases that tend to come to the prosecution service's attention are rarely accompanied by an offender not being known. A certain number of cases are dropped for policy reasons, with the majority of cases being taken to court (presumably the more serious). A similar proportion of cases as that dropped is subject to penal order proceedings; in Sweden these are equivalent to a conviction but are imposed entirely independently by the prosecutor and can be used to impose fines and conditional prison sentences (in which case, the offender can avoid a prison sentence by fulfilling certain conditions).[59] It would seem logical that prosecutors are using this path to impose treatment—as was indicated by the study findings.[60] The pattern of prosecutorial decision making bears clear resemblance to the other less-serious offense categories featured.

German statistics categorizing case endings by offense are not available. Ironically this is not because they do not exist. They do in the highly accurate *Strafverfahrensstatistik*, which are not accessible to researchers because the legislature failed to insert the necessary clause in the act of Parliament providing for the creation of this statistical register.[61] Fortunately, there is further knowledge in relation to drug cases because the Federal Constitutional Court made a vigorous recommendation in 1994[62] to the Länder (State) governments that they issue guidelines to their prosecutors to provide for equal application of the latter's diversionary powers in relation to drug offenses as well as to attempt to ensure similar policy nationwide.[63]

In Germany, drug offenses are regulated in a special law called the *Betäubungsmittelgesetz* (the act on anesthetising substances).[64] Section 31a of that act provides prosecution services with specific diversionary powers,[65] which usually take precedence over prosecutors' normal diversionary powers as lent to them by Section 153 onwards of the Criminal Procedure Code (both of these are federal laws but have application for the country as a whole because the

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[59] Jehle, *supra* note 1, at 74–75.

[60] *See* Wade, *supra* note 3, at 74–75.

[61] *See* Jehle, *supra* note 1, at 221 (stating that the statistics do not describe how the cases ended but only how many cases were ended using §153).

[62] The so-called Cannabis Decision. Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court] Mar. 9, 1994, 2 Entscheidungen des Bundesverfassungsgerichts [BVerfGE] 1577 (F.R.G.), *available at* http://www.drugdiscrimination.org /germancase94.htm.

[63] Rosalie Liccardo Pacula et al., *What Does It Mean to Decriminalize Marijuana? A Cross-National Empirical Examination* 9–10 (Ctr. for the Study of Law and Soc'y Jurisprudence and Soc. Policy Program, Working Paper No. 25, 2004), *available at* http://repositories.cdlib.org/csls/fwp/25/.

[64] Betäubungsmittelgesetz [BtMG] [Narcotics Act] July 28, 1981, BGBl. 1 at 681 (F.R.G.).

[65] *Id.* at 681, § 31a.

prosecution of crimes is a federal matter).[66] Section 31a of the *Betäubungsmittelgesetz* provides that a prosecutor may independently drop a case concerning a less serious crime (punishable by less than one year imprisonment as the minimum sentence) where the guilt of the offender can be viewed as minor, where no public interest in the prosecution is to be found (which is true where a case has not caused a disturbance to the legal order beyond the horizon of the accused's sphere), and the suspected offender has only committed the offense with a small amount of the narcotic for his or her personal use.[67]

The Federal Constitutional Court stated that these provisions are in line with the Constitution, but should be used even-handedly.[68] As a result, the Länder have issued guidelines to their prosecutors defining the terms of the possibilities for diversion.[69] The latest common guidelines came into force on October 1, 2007 and state that where an offense relates to no more than six grams of cannabis product for personal use, and where no endangerment of another person is at issue,[70] Section 31a powers may be used.[71] They also state that use is not foreseen for cases relating to other narcotics.[72] Any sign of dealing (e.g., the person is frequently caught with a small amount) will also exclude applicability of this regulation.[73]

Minor guilt is fundamentally to be assumed where addiction cannot be excluded and where nonaddict suspects are caught for the first or second time, or only after a significant gap in time (not in the previous year),[74] leading one to assume them to be an occasional user. If minor guilt is found in other cases, this may be grounds to use the regulations in Section 153 StPO onwards in order to ensure contact with institutions offering advice and therapy.[75] Endangerment is to

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[66] Strafprozeßordnung [StPO] [Criminal Procedure Code] Feb. 1, 1877, RGBl at 253, as amended, § 153.

[67] ROLAND SIMON ET AL., 2006 NATIONAL REPORT TO THE EMCDDA BY THE REITOX NATIONAL FOCAL POINT: GERMANY, DRUG SITUATION 2006, at 6 (2006), *available at* http://www.dbdd.de/Download/REITOX_D2006_E_Fin.pdf.

[68] Pacula, *supra* note 63, at 9.

[69] Tak, *supra* note 58, at 51–53.

[70] British police, on the other hand, have adamantly refused to set a limit to be regarded as indicative of possession for personal use to prevent dealers carrying amounts just below such guideline limits. In other words, they have refused to restrict their discretion to determine who they regard as a dealer and who a personal user. *See* Jason Bennetto & Harriet Walker, *Police Criticised for Ignoring Changes in Cannabis Laws*, THE INDEP. (London), Sep. 12, 2003, at 2.

[71] Richtlinien zur Anwendung des § 31a Abs. 1 des Betäubungsmittelgesetzes und zur Bearbeitung von Ermittlungsverfahren in Strafsachen gegen Betäubungsmittelkonsumenten [Guidelines for the application of Section 31a, Section 1 Narcotics Act and the Handling of Criminal Investigation Against Narcotics Consumers] (updated Oct. 25, 2007), *available at* http://www.vorschriften.saarland.de/verwaltungsvorschriften/vorschriften/05_0903.pdf.

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] *Id.*

be assumed if the drug was consumed in the presence of persons never having consumed drugs before, next to a school, etc.[76]

It is interesting to note, however, that the Länder display greatly diverging attitudes. While the Justice Ministry of Saarland emphasizes recidivism as less weighty in terms of preventing a diversion, the Brandenburg equivalent is unequivocal that the prosecution service may not use the laws to create an impression that "cannabis consumption is unproblematic," emphasizing the need to protect health—in particular that of children and adolescents.[77] Schleswig-Holstein presents yet another view, emphasizing that even a catalogue of associated offenses (including mild bodily harm, trespassing and theft) should not prevent cases against youths being diverted.[78]

In fact, the Länder also diverge in defining a small quantity: Hessen, Thuringia, Lower Saxony, Saxony, Saarland, Bremen, and Bavaria stick to the six gram definition,[79] but Northrhein-Westphalia advises prosecutors to divert cases involving up to ten grams (as well as very small quantities of other narcotics).[80] Rheinland-Pfalz also sticks to a ten gram boundary while Schleswig-Holstein and Hamburg set the limit at thirty grams (also regulating for smaller quantities of other drugs).[81] Baden-Württemberg, Saxony-Anhalt, and Brandenburg use the measure of three consumption units while Berlin has set a fifteen gram limit after a prolonged discussion of a thirty gram limit.[82]

There can be no doubt that a high incidence of prosecutorial drop and diversionary measures in accordance with the narcotics law is to be expected for cannabis-related offenses in Germany, and indeed in some of the more densely populated Länder, for possession of small quantities of other narcotics as well. Drops and disposals using the conventional criminal procedure code provisions may also be used for less serious cases relating to drugs other than cannabis, but these are likely to be the exception.

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[76] *See id.*

[77] *See* Morris, *supra* note 24, Rundverfügung der Ministerin der Justiz [Circular of the Minister of Justice] Richtlinie zur Anwendung der Opportunitätsvorschriften bei Verstößen gegen das Betäubungsmittelgesetz im Zusammenhang mit dem Eigenverbrauch von Cannabisprodukten [Directive on the Application of the Rules Opportunity for Violations of the Narcotics Act in Connection with the Captive of Cannibus Products] Vom 15. August 2006 (4630-III.19), *available at* http://www.landesrecht.brandenburg.de/sixcms/detail.php?gsid=land_bb_bravors_01.c.23868.de.

[78] *See* Instructions issued by the Ministries of Justice, the Interior and Family, Richtlinien zur Förderung der Diversion bei jugendlichen und heranwachsenden Beschuldigten [Policies to Encourage the Diversion of Juvenile and Adolescent Defendants] II 310/4210 - 173 SH - /1V 423 - 32.-11/V 350 - 3625.32 (SchlHA S.204) (Jun. 24, 1998), *available at* http://www.dvjj.de/download.php?id=502.

[79] *See* Press Release, Landespressestelle: Senat reformiert Cannabisrichtlinie [Land Press: Senate Reformed Cannabis Directive] (May 4, 2005) (on file with author).

[80] *Id.*

[81] *Id.*

[82] *Id.*

A. Findings

The results of the European prosecution study, as well as the above analysis of German guidelines, display a clear trend across Europe—prosecutorial discretion plays a major role in relation to drug offenses, in particular less serious ones. Cross referencing the statistical analysis with the major incidence of cannabis possession in relation to alternative procedural paths[83] certainly displays a trust in prosecutors to judge how to deal with (suspected) drug offenders.

The very high rate of disposal of drug cases in comparison to other offense types (even such as less serious bodily harm), discerned after such a metalevel look, begs a look at the grass-roots level to find out what prosecutors are actually doing. Are they in fact imposing a specific policy, and, if yes, what kind of policy are they imposing? Such questions are the basis for a major empirical study. A quick look at news headlines would lead one to believe that drug policy in the various study countries differs greatly and, thus, so too should related prosecutorial action. At this point, only a picture of the prosecutor's office of the town I live in can be presented. This does, however, display a very good example of how the study findings could be explained.

IV. PROSECUTION POLICY IN FREIBURG[84]

Freiburg im Breisgau is a mid-size city with a bustling population of over 200,000 swelled by students of the University and a never-ending stream of tourists drawn by the beautiful town in the midst of vineyards and at the edge of the Black Forest.[85] It lies in the so-called "three-country corner," the French and Swiss borders only a few miles away. While these borders certainly mean that Customs and Federal police presence is much higher than in other parts of Germany, it should be noted that all three countries are signatories to the Schengen agreement (Switzerland added as the only non-EU member only recently and is in the process of implementing all relevant measures).[86] This means that there are no hard borders in the area with frequent control of those passing—let alone a passport check of every person entering one or the other of the countries.[87] Usually one travels between the countries barely aware of a border's existence.

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[83] *Supra* note 3, at 67, 71 & 78.

[84] All information is based upon presentations made by prosecutors from the Freiburg office at a seminar in January 2008 and gained from interviews of six prosecutors in February 2008. The author would like to thank the Freiburg prosecution service for their kind and generous support.

[85] *See* Freiburg im Breisgau: Bevölkerung und Wohnen:l http://www.freiburg.de/servlet/PB/menu/1156563/index.html#AmtlicheBevoelkerungszahl (last visited Mar. 20, 2009).

[86] *Q&A Schengen Agreement*, BBC NEWS, Dec. 21, 2007, http://news.bbc.co.uk/2/hi/europe/4738063.stm.

[87] *Id.*

The prosecution service consists of thirty-two prosecutors supported by eight paralegal auxiliaries dealing with about 34,000 cases per year.[88] In 2007, 34,000 cases in which an offender was know were handed on to the prosecution service and about the same number of cases in which no offender was known.[89] Of the latter category, a minority will lead a prosecutor to insist on further and often complex investigation, but the vast majority will be dropped on grounds of evidential insufficiency, the police passing such cases on to have them closed and not anticipating an order to invest further resources in finding the perpetrator.[90]

In 2007, 3,200 persons were taken to court, 5,800 were dealt with by penal order (in most cases convicted via a written, in camera process), 1,300 disposed of conditionally and given a fine in accordance with Section 153 StPO, 3000 Section 153 (1) and 13,400 persons saw their cases dropped on evidentiary grounds.[91] Two thousand juveniles had their case dropped or were subject to diversionary pedagogic measures in accordance with the special law for juveniles.[92]

The Freiburg prosecution service is divided into six operative departments, one of which is a specialist drug section (Department 6).[93] The prosecutors there report their work as clearly marked by local political policy reporting that two central parks are "allowed" to be used as meeting places for addicts and places where drug sales take place.[94]

While they will periodically run operations there to ensure things do not get out of hand, they will never increase the pressure on dealers and buyers so far as to cause the scene to displace to another location.[95]

When cases are evaluated to decide whether to take them to court or not, prosecutors display a clear routine. They speak of categories of cases and standardized outcomes to be expected for various groups of offenders.[96]

Anyone caught trafficking—and a higher incidence is to be found in the region with couriers making their way from Amsterdam to Italy—will be taken to court and face a sentence predetermined by the guidelines followed by prosecutors across the country, depending on what type of and quantity of narcotics they were found to be carrying.[97]

Among users and dealers (to a certain extent), clear categorization of offenders takes place: if they are deemed to be drug addicts, cases against them will tend to be disposed of conditionally and they will be referred to addiction

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[88] Leitender Oberstaatsanwalt Peter Häberle Statistics for the Freiburg Prosecution Service 2007, 17.01.2008, see note 85.

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *Id.*

[93] Oberstaatsanwalt Zäh 17.01.2008, *supra* note 85.

[94] Staatsanwalt Allgeyer 17.01.2008, *supra* note 85.

[95] *Id.*

[96] *Id.* Confirmed in interview with Oberstaatsanwalt Maier, Staatsanwältin Jahnke, Staatsanwältin Dr. Rohr, Staatsanwalt Dr. Coen, *supra* note 85.

[97] Staatsanwalt Allgeyer 17.01.2008, *supra* note 85.

treatment.[98] If they fail to complete the treatment agreed upon, they will be taken to court and serve jail sentences.[99] Prosecutors are adamant that this policy is necessary, citing academic studies that indicate a high degree of pressure must be exerted upon addicts to force them to participate in treatment.[100] Any half-hearted attempt to impose therapy is apparently doomed to failure.

When addicts have been referred to treatment several times and have failed to complete a course of treatment, or repeatedly return to their addiction even after having completed therapy, and when medical staff report to the prosecution service that they can do no more, i.e., that the suspect is a resilient addict, prosecutors describe them as unsuitable subjects for the criminal process.[101] Policy in Freiburg is clearly marked by the fundamental assumption that addicts are in need of medical attention and have no place in prison.[102] A criminal justice treatment is appropriate only as part of a tactic to motivate an addict to accept and participate actively in treatment. An "untreatable" addict thus has no place in the criminal justice system. Nevertheless, an addict of this kind poses a considerable nuisance and threat to society because of his or her endless need to feed his or her habit. Thus the Freiburg prosecution service publicly advocates the introduction of a methadone scheme for addicts whom the criminal justice system has made all available efforts to lead to successful treatment so that those helpless few do not perpetually remain "clients" of the criminal justice system.[103]

Clearly a nonpunitive and utilitarian policy is pursued by the Freiburg prosecution service in relation to drug addicts with a fundamental belief that the drug problem cannot be suppressed entirely—that addiction will always produce suspects in need of help or, in the worst case, very proactive prevention strategies to prevent harm to society as a whole. Toward those who drive the supply chain—though they are described with some sympathy as terrified, young people at the very bottom of the supply hierarchy (and thus of no further use to the criminal justice system) because Freiburg only very rarely features anything other than a courier passing through—the Freiburg prosecution service follows the national policy of strict and firm repressive response.[104] At an official presentation of the prosecution service, one prosecutor explained the department's goal as being to ensure that the risk of discovery and prosecution remains high enough so that the drug phenomenon does not get entirely out of hand.[105]

Nonaddict users of milder forms of narcotics are also described as facing more relaxed policy, with full use being made of the procedural options avoiding court involvement for a first or second offense.[106] Interestingly, this is one area in

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[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Cf.* with guidelines and policy statements *supra* notes 77, 78 and 79.
[105] Staatsanwalt Allgeyer 17.01.2008, *supra* note 85.
[106] *Id.*

which the prosecution service, contrary to findings in other study areas, will treat youths more harshly following scientific findings that regular cannabis use hems their cranial development.[107]

Prosecutor drug policy in Freiburg thus displays all the features of prosecutorial discretion identified across Europe by the study. It is one model explaining the high proportion of cases not taken to court while simultaneously displaying that certain cases will always face a full criminal justice system reaction.

V. FREIBURG POLICY IN COMPARISON

While one cannot overemphasize that the Freiburg example is only one among many in Germany, let alone among all of the systems studied, it is interesting to note that major policy strands find echoes in a wider context.

These major policy strands are:

- a fundamental desire to control rather than combat the phenomena of drug crime entirely
- fundamental tolerance of low-level cannabis use except where there are serious health implications
- a nonpunitive attitude towards addicts
- a focusing of resources on a punitive response to suppliers rather than users

The policy decision to control rather than truly combat is reflective of the attitude across Europe.[108] Whether this phenomenon is of an ideological nature or due to a simple acceptance of a lack of resources, it is difficult to say. The French perhaps provide an exception here—going as far as to refuse to drop border controls at the Belgian and Luxemburg borders for a year after the Schengen agreement, which they had agreed to do, due to the (from the French perspective) lax Dutch narcotics policy.[109]

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[107] Staatsanwalt Allgeyer 17.01.2008, *supra* note 85.

[108] *See, e.g.*, Rick Steves, *Europe's Drug Antiwar*, L.A. TIMES, Oct. 12, 2007, at A.23 ("While each European nation has its own drug laws and policies, they seem to share a pragmatic approach. They treat drug abuse not as a crime but as an illness. And they measure the effectiveness of their drug policy not in arrests but in harm reduction."); Alan Travis, *The Drugs Debate: UK Out of Step as EU Takes New Approach to Problem: Emphasis Is Shifting Away from Jailing Users*, THE GUARDIAN, Feb. 17, 2000, at 4 ("The annual report of the EU's monitoring centre for drugs and drug addiction said that while most member states rejected extreme solutions such as full legalisation or harsh repression, there was increasing recognition that the prosecution and imprisonment of individuals with drug problems caused even greater difficulties.").

[109] *See, e.g.*, STEVE PEERS, EU JUSTICE AND HOME AFFAIRS LAW 44 (Oxford Univ. Press 2007).

Discussion of policy in Europe is rife with the tolerance of cannabis—the topics of legalization, prescription for medical use, etc. are subject to discussion in most jurisdictions.[110] Dutch policy naturally provides a focus for debate, though it does not always depict the situation in the Netherlands correctly.

The nonpunitive attitude toward addicts in Freiburg can be found further afield. German guidelines explicitly state that minor guilt for an offense (the precondition for a discretionary dropping of a case) is fundamentally to be assumed where addiction cannot be excluded while French prosecutors were given powers to divert cases ordering addiction treatment in the 1970s.[111] Practice in Britain is subject to great variation from police district to police district with radically different opinions being vocalized.[112] While some colleagues advocate a stauncher stance, refusing (at least publicly) to implement the official softer cannabis policy, one Chief of Police is causing public debate by calling for the legalization of all drugs, for the treatment of heroin addiction as a medical problem only, and for public effort and resources to be devoted to treatment and the avoidance of crime by addicts attempting to secure their next fix.[113] A focus on suppliers rather than users in order to prioritize the use of resources is also the current recommended political line in England and Wales.[114] Obviously a more lenient line taken toward addicts and users means a conscious dedication of resources to suppliers. In fact it is with specific reference to small time drug dealers that certain alternative measures to counteract the profitability of crime have been introduced in some of the study countries in recent years.[115]

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[110] *See, e.g.*, Isabel Conway, *Medical Marijuana Goes on Sale in Dutch Pharmacies*, THE INDEP., Sept. 1, 2003, at 9 (discussing medical marijuana in Dutch pharmacies); Press Release, Government of Berlin, Senat reformiert Cannabisrichtlinie [Senate Reforms Cannabis Guidelines] (Apr. 5, 2005), http://www.berlin.de/landespressestelle/archiv/2005/04/05/25436/.

[111] Marianne Wade, Marcelo Aebi, Bruno Aubusson de Cavarlay, Marc Balcells, Gwladys Gilliéron, Hakan Hakeri, Martin Killias, Christopher Lewis, Erika Roth, Paul Smit, Piotr Sobota, Ksenija Turkovic & Josef Zila, *When the Line is Crossed: Paths to Control and Sanction Behaviour Necessitating a State Reaction*, 14 EUR. J. CRIM. POLICY RES. 101, 114 (2008).

[112] *See supra* notes 34–36 and accompanying text; *see also* Jonathan Owen, *Top Policeman Wants Cannabis Made Class B to End Confusion Among Forces*, INDEP. ON SUN., Oct. 7, 2007, at 22 ("An IoS investigation has discovered that the penalties for cannabis possession vary widely across Britain. Some forces encourage the use of warnings, while others take a zero-tolerance approach and will arrest people found with the drug.").

[113] *See, e.g.*, *A Bold Attempt to Clear Clouds of Confusion*, THE INDEP., Oct. 15, 2007, at 32 (discussing the adoption of relatively radical views on drug policy by constables in North Wales, a rural region in the UK).

[114] *See* Nigel Morris, *Clark to Reject Tougher Cannabis Law and Opt for Crackdown on Suppliers*, THE INDEP., Jan. 19, 2006, News, at 4.

[115] Take, for example, the debate surrounding the introduction of the Asset Recovery Agency ("ARA") in the UK, a move that was quickly copied in the Netherlands, France and beyond. The purpose of this agency is to recover, by civil trial, assets that a person

VI. CONCLUSION

While it is not possible to conclude upon what basis and to which end prosecutors across Europe act in relation to drug cases, there are certain convincing indicators that they are involved in the implementation of policy that goes well beyond the boundaries of classic criminal policy in this realm. Where they can be statistically isolated, drug cases are seen to be subject to far higher rates of dropping and diversionary measures than most other offense types, and less serious drug offenses are subject to decriminalizing or depenalizing policy. The latter are also reported to form a major proportion of diversionary decisions made by prosecutors.

One German example indicates that prosecutors end up implementing political policy quite closely; ensuring strict punishment for all those caught committing more serious drug-related offenses (though this is not necessarily tied to the greatest investment of resources to make sure all such offenders are caught). Thus, a clear message of non-tolerance is conveyed. The prosecutors involved implement an entirely different policy in relation to users, also depending upon whether they are recreational users or addicts. Their primary concern are medically led considerations as to the best interests of the suspect backed up by a correspondingly more or less punitive prosecution policy. This conception of prosecutorial policy implementation is a good explanation for the patterns of prosecutorial behavior observed across Europe.

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possesses through illegitimate means. According to Jane Earl, former director of the ARA, this policy would hopefully take drug dealers "out of their local communities and help people feel good about their lives again" Robert Verkaik, *Gangster's Assets to Be Seized by New Agency*, THE INDEP., Feb. 24, 2003, at 8, *available at* http://www.independent.co.uk /news/uk/crime/gangsters-assets-to-be-seized-by-new-agency-598665.html.

IMAGINING THE ADDICT: EVALUATING SOCIAL AND LEGAL RESPONSES TO ADDICTION

Elizabeth E. Joh *

I. INTRODUCTION

Often we refer to *the* response to an unwanted addictive behavior, but of course there is no unified social or legal response. Instead, addictive or compulsive behaviors occasion a variety of social and legal responses: restrictive or prohibitive legislation, individual litigation, the emergence of advocacy groups, and the issue of expert opinion. Yet even if these responses do not originate from a single plan, they converge in a particular way. When a new "epidemic" of addictive behavior is identified, a narrative about that addiction emerges. Who are the addicts? What danger do they pose? Who bears responsibility for the problem? Even if these responses address the problem of addiction in very different ways, together they imagine the addict in ways that reinforce broader sympathetic or exclusionary attitudes towards the addicts themselves.[1]

Law and society respond to the problem of addictive behavior, and their responses in turn define and interpret the addict and addiction in question. Addiction characterizes the use of many substances, licit and illicit, and thus the characterization of the addict in these different settings suggests comparative discussion. The antismoking movement of the last forty years coincided with the steady and unmistakable decline of smoking among Americans.[2] On the other end of the spectrum, our illicit-drug policy has been

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[1] For a compelling study of how the media reinforced a narrative of blame and responsibility in the civil tort context, see Michael McCann et al., *Java Jive: Genealogy of a Juridical Icon*, 56 U. MIAMI L. REV. 113, 177 (2001) ("As is often the case in other legal domains such as criminal justice or welfare law, prevailing narratives tend[] toward blaming the victim for the painful injuries [that the victim] suffered and thus stigmatize[] her efforts to claim rights as a means of redress.").

[2] *See* Michael Janofsky, *25-Year Decline of Smoking Seems to Be Ending*, N.Y. TIMES, Dec. 19, 1993 (recognizing that smoking has been on the decline for decades).

pointedly critiqued as expensive, harmful, and ineffectual.[3] In each instance, the addict and his addiction were interpreted very differently.

Conventional legal scholarship largely underappreciates the sociolegal construction of the addict.[4] Addiction is, of course, a medically defined term, but in these responses, the addict represents much more than the set of physiological responses to a psychotropic drug. And while not all users of addictive substances become addicts, it is the portrait of the addict that forms the symbolic focus of public campaigns against their use. Using the examples of tobacco and illegal drugs—specifically, methamphetamine—this essay asks what insights might be found in comparing the characterization of the addict and his addiction in these different settings. Of course, there are enormous differences between tobacco and methamphetamine that resist an exact comparison between the two.[5] And the discussion of these two examples

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[3] Such critiques are too numerous to catalogue completely here. For some examples, see Donald A. Dripps, *Recreational Drug Regulation: A Plea for Responsibility*, 2009 UTAH L. REV. 117 (discussing benefits and costs of drug criminalization, including mismeasurements of both); Douglas Husak, *Predicting the Future: A Bad Reason to Criminalize*, 2009 UTAH L. REV. 105 (arguing that no good arguments exist for criminalization of drug use). This essay is not a call for the wholesale decriminalization of drugs: a perennial topic in the drug policy literature. *See, e.g.*, Jon Scott Batterman, *Brother Can You Spare a Drug: Should the Experimental Drug Distribution Standards be Modified in Response to the Needs of Persons with AIDS*, 18 HOFSTRA L. REV. 191, 195 (1990) (addressing the need to enable drug experimentation due to the emergent needs of dying AIDS patients).

[4] Law and society scholars, however, will be familiar with the questions and premises here. For representative works in this area, see generally PETER L. BERGER & THOMAS LUCKMANN, THE SOCIAL CONSTRUCTION OF REALITY: A TREATISE IN THE SOCIOLOGY OF KNOWLEDGE (1967) (finding that "reality is socially constructed and that the sociology of knowledge must analyze the processes in which this occurs"); Elizabeth Mertz, *A New Social Constructionism for Sociolegal Studies*, 28 LAW & SOC'Y REV. 1243, 1244–45 (1994) (discussing the "'moderate' social constructionist vision of law," in which there is "moderate skepticism regarding the fixed or natural character of categories"). In addition, scholarship in critical race and feminist theory has also discussed the socially constructed nature of race and gender. *See, e.g.*, Ian F. Haney Lopez, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 HARV. C.R.-C.L. L. REV. 1, 27 (1994) (arguing that "[r]ace must be viewed as a social construction. That is, human interaction rather than natural differentiation must be seen as the source and continued basis for racial categorization"); Carrie Menkel-Meadow & Shari Seidman Diamond, *The Content, Method, and Epistemology of Gender in Sociolegal Studies*, 25 LAW & SOC'Y REV. 221, 223 (1991) (observing that "social researchers have shown that gender is socially constructed out of cultural meanings as well as biological sex").

[5] Frank Zimring, however, provides an excellent comparison between tobacco regulation, on the one hand, and alcohol and illicit-drug regulation on the other. *See* Franklin E. Zimring, *Comparing Cigarette Policy and Illicit Drug and Alcohol Control*, *in* SMOKING POLICY: LAW, POLITICS, AND CULTURE 95–109 (1993) (categorizing tobacco, alcohol, prescription and illegal drugs as significant policy challenges regarding modern

cannot claim to offer definitive causal proof that policy failure or success turns upon the social construction of the addict. Rather, the modest goal of this essay is to depart from the question of how law can regulate behavior, and ask a question of a different sort: how do legal and social responses imagine the addict, and how might this knowledge help further our thinking about the problem of controlling addiction?

Part II compares and contrasts the contemporary social and legal responses to the problems of nicotine addiction and methamphetamine addiction.[6] While not meant to be an exhaustive review of these issues, this part highlights some of the most salient aspects of government responses, private advocacy, and media attention. Based upon this review, Part III observes some of the problems as well as the advantages of the two different approaches. There is unlikely to be one right answer to how we ought to respond to unwanted addictive behaviors, but by inviting comparison between two unlikely candidates, this essay provides a starting point that may be helpful in future thinking about social and legal responses to addiction problems.

II. TWO ADDICTIONS, TWO RESPONSES

Just because people use a substance in excess, and in some cases, become physiologically and psychologically addicted to it, does not always mean that government or privately organized groups respond in any serious way. And the type of response, ranging from tolerance to near total prohibition, may change over time. Alcohol is one such example of a substance that has been the changing focus of both the government and motivated private activism like the American Temperance movement.[7] The comparison of responses to both

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American life, public heath, and public order). Nor does this essay aim to present a comprehensive review of regulatory and social responses towards illicit drugs and smoking. In the latter case, there have been a number of book-length studies. *See, e.g.*, DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL (1999) (recognizing the link between drugs and modern social issues affecting schools, workplaces, and public health); RICHARD KLEIN, CIGARETTES ARE SUBLIME (1993) (proposing that open condemnation of cigarette smoking ensures the continuance of smoking); JOHN C. BURNHAM, BAD HABITS: DRINKING, SMOKING, TAKING DRUGS, GAMBLING, SEXUAL MISBEHAVIOR, AND SWEARING IN AMERICAN HISTORY (1993) (addressing the struggle between cultural and social forces underlying "bad habits").

[6] Tobacco use and attempts to regulate its use have a very long history, of course, but this essay will focus on government and social responses to nicotine addiction from the 1950s onward. *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SVCS., REDUCING TOBACCO USE: A REPORT OF THE SURGEON GENERAL 29 (2000) (describing 1604 anti-tobacco tract written by King James I).

[7] Indeed, the American social and regulatory response is a classic historical case of changing patterns of tolerance. Gusfield's study of the evolving aims and successes of the

tobacco and to methamphetamine addiction offers two very different responses, and two very different representations of the addict.

A. The Criminalization of Methamphetamine

In the 1990s, methamphetamine became the latest illicit drug to earn the title of "epidemic."[8] A synthetic variant of amphetamine,[9] methamphetamine had been provided to soldiers during World War II,[10] as well as prescribed to suppress appetite and to enhance energy in the 1950s.[11] Its inclusion under the Federal Controlled Substances Act in the 1970s largely criminalized methamphetamine.[12]

The primary legal response to methamphetamine addiction and use is, as with all other illegal drugs, near total prohibition.[13] Federal and state laws criminalize its possession, distribution, and manufacture.[14] Recent federal law has focused most particularly on reducing its supply through controlling the "essential precursor" materials necessary to manufacture it.[15]

American Temperance movement is an important study. *See* JOSEPH R. GUSFIELD, SYMBOLIC CRUSADE: STATUS POLITICS AND THE AMERICAN TEMPERANCE MOVEMENT 1–12 (1963).

[8] *See* Charlie Goodyear, *Concord Center to Study Drug Use: Methamphetamine Abuse Called Epidemic*, S.F. CHRON., Apr. 8, 1999, at A15.

[9] Methamphetamine is a stimulant that sharply increases dopamine levels in the brain. *See* Nat'l Inst. on Drug Abuse, *Methamphetamine: Abuse and Addiction*, *in* RESEARCH REPORT SERIES 3–4 (2006).

[10] *See* Steve Wiegand, *Simple Drug Unleashes Paranoia, Violence; Effects Linger*, SACRAMENTO BEE, Jan. 12, 1997, at A14.

[11] *See id.*

[12] Amphetamine and methamphetamine were included as Schedule II drugs under the Act as amended in 1971. *See Schedules of Controlled Substances, Amphetamine, Methamphetamine and Optical Isomers*, 36 FED. REG. 12,734 (July 7, 1971); Jean C. O'Connor et al., *Developing Lasting Legal Solutions to the Dual Epidemics of Methamphetamine Production and Use*, 82 N.D. L. REV. 1165, 1174–75 (2006). It can be legally prescribed for conditions such as narcolepsy and attention deficit hyperactivity disorder. *See* Nat'l Inst. on Drug Abuse, *supra* note 9, at 2.

[13] *See, e.g.*, Wiegand, *supra* note 10 (stating that law enforcement is "cracking down on distributors of pseudoephedrine-laden pills"); Steve Chapman, *'Crystal Meth' Crisis' Should be Taken With a Grain of Salt*, BALTIMORE SUN, Aug. 10, 2005, at 11A (observing that "fight against meth" focuses on seizure of home labs and restricting over the counter precursors). There are, however, efforts in some states to ensure that addicted defendants receive treatment during their incarceration. *See, e.g.*, Anthony Colarossi, *Cheap, Highly Addictive—Meth Makes Inroads in State*, ORLANDO SENTINEL, June 11, 2005, at B1 (discussing use of "specialized courts" using "teams of professionals" to help defendants addicted to methamphetamine).

[14] *See*, Wiegand, *supra* note 10.

[15] *See* O'Connor, *supra* note 12, at 1175.

The restriction of precursors is important because methamphetamine can be produced without pharmacological expertise, sophisticated equipment, or obscure ingredients.[16] The chief ingredient for its manufacture can be distilled readily from over-the-counter cold medicines containing pseudoephedrine, like Sudafed.[17] Limiting the amount of pseudoephedrine purchased and keeping track of purchasers is important because usable methamphetamine can be made with cold medicine and other commonly available chemicals,[18] a high school level knowledge of chemistry, and a readily obtained recipe from the internet.[19] About one hundred dollars worth of materials can be converted into one thousand dollars worth of methamphetamine in hours.[20] And unlike the distribution networks of other drugs like heroin and cocaine, methamphetamine is often cooked up in "mom-and-pop" labs by those who are addicts themselves.[21]

B. The Debased and Deviant Meth Addict

In the 1990s, stories emerged in the mass media depicting the use of methamphetamine as a national "scourge," "domestic crisis," "epidemic," and "the worst drug that has ever hit America."[22] In 2005, *Newsweek* magazine

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[16] *See* Anastasia Toufexis, *There Is No Safe Speed: Three Toddlers' Deaths Spotlight the Nation's Latest Drug Epidemic*, TIME, Jan. 8, 1996, at 37 ("Meth does not require huge, heavily guarded growing fields or sophisticated equipment.").

[17] Dirk Johnson, *Policing a Rural Plague*, NEWSWEEK, Mar. 8, 2004, at 41.

[18] *See* CELINDA FRANCO, CONG. RESEARCH SERV. REPORT FOR CONGRESS, METHAMPHETAMINE: LEGISLATION AND ISSUES IN THE 109TH CONGRESS, Order No. RS22325, at 3 (2005) (noting methods most commonly used require only "OTC [over-the-counter] cold medicines containing pseudoephedrine, and other ingredients including acetone, hydrochloric acid, sodium hydroxide, ether, anhydrous ammonia, cat litter, antifreeze, and drain cleaner").

[19] *See, e.g.*, John-Manuel Andriote, *Meth Comes Out of the Closet*, WASH. POST, Nov. 8, 2005, at F1 (describing ease of production); Toufexis, *supra* note 16, at 37 ("Just $4,000 in raw ingredients converts to 8 lbs. of meth worth $50,000 wholesale.").

[20] DANA HUNT ET AL., ABT ASSOCS., INC., METHAMPHETAMINE USE: LESSONS LEARNED 24 (2006).

[21] *See, e.g.*, Johnson, *supra* note 17, at 41 ("Makers of meth tend to be mom-and-pop operations simply making enough for personal use"); Hunt, *supra* note 20, at 40 (noting that unlike with other illicit drugs, "the meth producer . . . is quite often a consumer"); David J. Jefferson et al., *America's Most Dangerous Drug*, NEWSWEEK, Aug. 8, 2005, at 41–42 (describing mom-and-pop labs). A large portion of the methamphetamine market, however, is supplied by commercial "super-labs" in Mexico. *See, e.g.*, Andrew Buncombe, *The Crystal Craze*, THE INDEPENDENT, Apr. 21, 2006, at 38.

[22] *See, e.g.*, Buncombe, *supra* note 21, at 38 ("scourge"); Karine Ioffee, *Meth Stokes Crime*, RECORD (Stockton, CA), Mar. 31, 2006 ("epidemic"); Charlie Goodyear, *Methamphetamine Abuse Called Epidemic*, S. F. CHRON. Apr. 8, 1999, at A15 ("epidemic"); Jim Lynch, *County Combats Growing Meth Crisis*, SUNDAY OREGONIAN,

infamously described methamphetamine as "the most dangerous drug in America,"[23] even though surveys show that the use of cocaine and marijuana is significantly higher than use of methamphetamine.[24] In 2006, Montana governor Brian Schweitzer said of methamphetamine use in his state: "My God, at the rate we're going, we're going to have more people in jail than out of jail in twenty years."[25] These calls of alarm were used to describe a drug for which reported current use has ranged from 2–5 percent of the American population between 1993 and 2004.[26]

Although the drug was used among different socioeconomic groups, two portraits of the methamphetamine addict emerged that fueled and then justified a "crackdown" on methamphetamine at the state and federal levels. Rural America, according to these stories, bore the costs of a drug used predominantly among poor whites.[27] Newspaper series such as those in the

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Aug. 20, 2000, at A21 ("methademic"); *Methamphetamine: Instant Pleasure, Instant Ageing*, THE ECONOMIST, June 18, 2005, at 30 (noting that methamphetamine is "in the eyes of many, America's leading drug problem"); Toufexis, *supra* note 16, at 37 (quoting John Coonce, head of DEA meth-lab task force that "it's absolutely epidemic"); Steve Wiegand, *Meth More Dangerous Than Expected, Study Says*, THE SACRAMENTO BEE, Jan. 24, 2001, at A4 (quoting former U.S. Drug Czar Barry McCaffrey as saying methamphetamine was "the worst drug that has ever hit America").

[23] Jefferson, *supra* note 21, at 43.

[24] Hunt, *supra* note 20, at 16–18. The most recent National Survey on Drug Use and Health ("NSDUH"), which surveys Americans twelve and older who report use of illicit drugs, alcohol, and tobacco reports that in 2006 marijuana was the most commonly used drug (14.8 million past month users). Current cocaine use was reported by 2.4 million people. By contrast, in 2006 there were approximately 731,000 current users of methamphetamine, representing 0.3 percent of the population. The NSDUH report notes that use numbers for all three drugs have not changed significantly between 2002 and 2006. *Id.*

[25] Kate Zernike, *With Scenes of Blood and Pain, Ads Battle Methamphetamine in Montana*, N.Y. TIMES, Feb. 18, 2006, at 18.

[26] *See* Hunt, *supra* note 20, at iii. Methamphetamine use is far lower than reported use of marijuana or cocaine. *Id.* at 7.

[27] *See, e.g.*, Avi Brisman, *Meth Chic and the Tyranny of the Immediate: Reflections on the Culture-Drug/Drug-Crime Relationships*, 82 N.D. L. REV. 1273, 1309 (2006) (noting "meth still appears to be far more prevalent among Caucasians than African-Americans and Hispanics or Latinos"); Hunt, *supra* note 20, at iv (noting users tend to be "[w]hite and in their 20s and 30s"); Amit R. Paley, *The Next Crack Cocaine?*, WASH. POST, Mar. 19, 2006, at C1 (describing methamphetamine use as "a largely rural epidemic"); Margot Roosevelt, *The Cold-Pill Crackdown*, TIME, Feb. 7, 2005, at 56 (describing methamphetamine as problem of "rural America"); Noaki Schwartz, *Surge in Meth Use Takes Toll on Rural Children*, L.A. TIMES, May 7, 2001, at B1 (describing "horrific tales" "emerging from wind-blown motels, ranches and mobile home parks"); Toufexis, *supra* note 16, at 37 ("Meth has always been the poor man's cocaine.").

Oregonian[28] depicted gaunt methamphetamine addicts combining dangerous chemicals in mobile homes and in the trunks of cars.[29] And these same addicts exposed their children to these toxins, or worse still, neglected to feed them, while transforming their property into serious environmental hazards in the process.[30] Since a single pound of home-manufactured methamphetamine results in five to six pounds of hazardous waste, addicts running mom-and-pop labs were literally (as well as figuratively) generators of toxic waste.[31]

The second group of users focused on in the mass media was gay men who not only became addicted to the drug, but also engaged in risky sexual activity, thereby raising the specter of new outbreaks of AIDS and other sexually transmitted diseases.[32] Seeking clandestine events from internet chat

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[28] *See, e.g.*, Rob Bovett, *Meth Epidemic Solutions*, 82 N.D. L. REV. 1195, 1208 (2006) (calling *Oregonian* series a "watershed event"). For a critical review, see Angela Valdez, *Meth Madness: How the Oregonian Manufactured an Epidemic, Politicians Bought It, and You're Paying*, WILLAMETTE WEEK ONLINE, Mar. 22, 2006, http://wweek.com/editorial/3220/7368/ (noting that the *Oregonian* published 261 stories on methamphetamine in eighteen month period).

[29] Fox Butterfield, *Fighting an Illegal Drug Through Its Legal Source*, N.Y. TIMES, Jan. 30, 2005, at 20 (noting that while 80 percent of the drug is produced in large labs, the rest is "produced in small home laboratories or even in the trunks of cars").

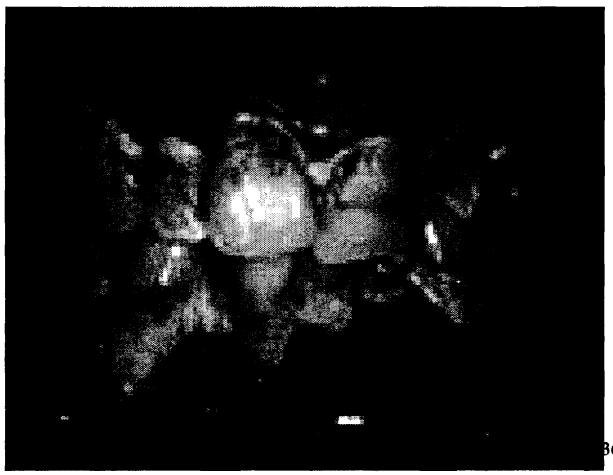
[30] *See, e.g.*, Paul Harris Crossville, *Tragic Orphans of U.S. Drugs Epidemic*, OBSERVER, Aug. 14, 2005, at 22 (describing parental neglect); Jim Lynch, *County Combats Growing Meth Crisis*, SUNDAY OREGONIAN, Aug. 20, 2000, at A21 (describing health and environmental risks of cleaning up methamphetamine labs); Patrick Rogers, *The Guardian*, PEOPLE, Nov. 25, 2002, at 99 (quoting police officers as naming children of addicts as "true victims"); Kate Taylor, *Meth Deals Death, Abuse to Children*, SUNDAY OREGONIAN, Aug. 22, 1999, at A1 (reporting that "meth menaces Oregon children like no other drug" according to child protection officials); Dan Weikel, *Looking Out for the Children*, L.A. TIMES, Apr. 7, 1996, at A18 (describing Butte County's efforts to protect children during methamphetamine lab raids).

[31] *See* Hunt, *supra* note 20, at 26 (describing hazardous waste byproducts of manufactured methamphetamine).

[32] *See* Christopher Heredia, *Dance of Death*, S. F. CHRON., May 4, 2003, at A1 (noting methamphetamine use reaching "epidemic proportions among gay and bisexual men"); Andrew Jacobs, *Crystal Meth Use by Gay Men Threatens to Reignite an Epidemic*, N.Y. TIMES, Jan. 12, 2004, at B1 (discussing the "emerging crisis" among gay men of methamphetamine abuse); David J. Jefferson et al., *Party, Play—and Play*, NEWSWEEK, Feb. 28, 2005, at 38 (describing "ugly underworld of meth-fueled sex"); *Meth Abuse Fueling Risky Sex Among Gay Men, Studies Show*, HOUSTON CHRON., Apr. 25, 2004, at A7 (describing "meth crisis among gay men"); Lorenza Munoz, *Positively Risky: Sex-Enhancing Drug May Expose New Generation of Gay Men to AIDS*, L.A. TIMES, May 11, 1995, at A12 (reporting concern that methamphetamine may be "promoting compulsive sexual behavior—and HIV infection—among gay men"); Stephen Smith, *Crystal Meth Threat Growing; Gays' Use in N.E. Fueling HIV Fears*, BOSTON GLOBE, Apr. 24, 2005, at A1 (reporting concerns of public health officials regarding increased risky sexual behavior among gay men due to methamphetamine use).

groups with the code words "party and play" or "PNP," these methamphetamine addicts, as news stories reported, engaged in a dangerous combination of snorting methamphetamine and engaging in unprotected sex with large numbers of anonymous partners.[33]

Perhaps the most striking image raised in depictions of methamphetamine addiction was that of the "meth mouth": an addict whose mouth was filled with rotting or absent teeth and open sores, due to the loss of saliva and the lack of personal hygiene that were byproducts of the addiction.[34] Pictures of those suffering from meth mouth like the one pictured below quickly circulated in the mass media and on the internet.[35]



[36]

Although methamphetamine use and possession had been criminalized before this heightened attention, the identification of the methamphetamine epidemic coincided with the introduction of state and federal laws designed to restrict legal sales of pseudoephedrine, widely available in over-the-counter

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[33] *See, e.g.*, Heredia, *supra* note 32, at A1 (reporting results of 2003 San Francisco Department of Health study documenting contribution of recreational drugs including methamphetamine contributing to rise of HIV transmission); Andrew Jacobs, *Battling H.I.V. Where Sex Meets Crystal Meth*, N.Y. TIMES, Feb. 21, 2006, at B1 (describing party-n-play as "cyberspace lingo for engaging in a sexual encounter enhanced with crystal methamphetamine").

[34] *See* ADA.org: A-Z Topics: Methamphetamine Use (Meth Mouth), http://www.ada.org/prof/resources/topics/methmouth.asp (last visited Feb. 17, 2009).

[35] *See* Crossville, *supra* note 30, at 22 (describing "meth mouth" as "one of the worst symptoms" of addiction). *But see* Jack Shafer, *The Meth-Mouth Myth: Our Latest Moral Panic*, SLATE, Aug. 9, 2005, http://www.slate.com/id/2124160/ (noting that same symptoms are associated with aging and other health problems not associated with methamphetamine use).

[36] *See* AMERICAN DENTAL ASSOCIATION, *supra* note 34.

cold medicines.[37] While prior federal law restricted and monitored the distribution of large amounts of pseudoephedrine, exempted from these requirements were the legal over-the-counter cold medications containing pseudoephedrine.[38] Though stolen or hoarded over-the-counter pseudoephedrine did not account for the bulk of the usable methamphetamine use in the country, it was the preferred source for mom-and-pop labs.[39] By tightening restrictions on the quantity and frequency with which these drugs could be sold, the Federal Combat Methamphetamine Epidemic Act of 2005 closed what was considered a loophole permitting home labs to exist.[40] Under the Act, not only must purchasers show picture identification and provide their home address, they are also limited to purchasing 3.6 grams per day, and nine grams every thirty days.[41]

These laws represented yet more criminal regulation over methamphetamine. The message behind this increased criminalization is clear. Prohibition as a regulatory measure carries with it a "moral simplicity":[42] what is prohibited is bad, and so are the people engaged in that prohibited behavior. Rather than a person to be pitied for the destructive effects exhibited on his body and on his life, the methamphetamine addict was construed as an immoral or amoral monster, whose addiction wreaked havoc upon children and property.[43]

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[37] *See* Hunt, *supra* note 20, at 5.

[38] *See id.*

[39] *See id.* at 33.

[40] *See* Combat Methamphetamine Epidemic Act of 2005, Pub. L. No. 109-177, 120 Stat. 256 (2006) (codified as amended in scattered sections of 21 U.S.C. and 42 U.S.C.); DRUG ENFORCEMENT ADMINISTRATION, GENERAL INFORMATION REGARDING THE COMBAT METHAMPHETAMINE ACT OF 2005 (2006), http://www.deadiversion.usdoj.gov/meth/cma2005.htm (discussing the changes made by the Combat Methamphetamine Act); O'Connor et al., *supra* note 12, at 1177 (describing prior federal law as permitting "blister pack exemption") (citation omitted).

[41] *See* Sarah Baldauf, *Vanished Behind the Counter*, U.S. NEWS & WORLD REP., Oct. 2, 2006, at 74; Combat Methamphetamine Epidemic Act of 2005 -Questions and Answers, http://www.deadiversion.usdoj.gov/meth/q_a_cmea.htm#13 (last visited Feb. 18, 2008). The Act does not, however, preempt similar state laws, which may be more restrictive than federal law. *See* Combat Methamphetamine Epidemic Act of 2005 § 711(g), 21 U.S.C. § 830(e)(1)(A)(i) (2006).

[42] *See* Zimring, *supra* note 5, at 104.

[43] If the adjective "monstrous" seems exaggerated, consider that in December 2005, Tennessee launched the nation's first online public registry, based upon sex-offender registries, of those convicted of methamphetamine crimes. *See* Sarah Childress, *Meth Epidemic: Tennessee's Registry*, NEWSWEEK, Jan. 30, 2006, at 9 (noting registry was first of its kind in the country); Theo Emery, *Registry Posts Names of Methamphetamine Makers Some Say Tenn. List Stigmatizes Offenders*, BOSTON GLOBE, Feb. 20, 2006, at A2 (noting registry modeled on sex offender registries); O'Connor et al.,

Police officials and policy makers spoke of the fear felt as methamphetamine reached their jurisdictions.[44] The result of a national survey of county law enforcement officials was cited in numerous media accounts.[45] Methamphetamine, according to 58 percent of respondents, represented the "biggest [drug] problem in [their] county."[46] Methamphetamine use was interpreted primarily as a threat to the moral and social order. The media focused most intensely on the abuse of the drug on marginal groups: poor whites and gay men engaged in high-risk sexual behavior.[47]

Some did raise doubts as to the accuracy of the term epidemic and the perception of crisis.[48] Others pointed out that most of the criminal laws addressing methamphetamine focused on interdiction and restricting access to precursor materials; little attention was paid to the addiction of users.[49] Yet these doubts remained on the periphery.

Sometimes the social and legal reaction to a group of people or an activity arises with a fervor out of proportion to what a disinterested perspective might conclude. These "moral panics"[50] have been described in this way:

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supra note 12, at 1188 (noting registries "function as public warnings, similar to sex-offender registries").

[44] *See, e.g.*, Cameron McWhirter, *Police: Worse Than Crack; Meth's Growing Popularity Forces Law Enforcement Officials Into a 'Crisis Mode*,' ATLANTA J. & CONST., Dec. 7, 2003, at A17 (quoting special agent of Georgia Bureau of Investigation as saying that on "a scale of 1 to 10, cocaine is a 2, crack was a 5, but meth is probably a 9 or 10").

[45] *See, e.g.*, Robert Crowe, *Meth Use and Related Problems Are on The Rise*, HOUSTON CHRON., July 18, 2005, at B1 (citing NACO survey).

[46] ANGELO D. KYLE & BILL HANSELL, NAT'L ASS'N OF COUNTIES, THE METH EPIDEMIC IN AMERICA: TWO SURVEYS OF U.S. COUNTIES 9 (2005), *available at* http://www.naco.org/Template.cfm?Section=Library&template=/ContentManagement/ContentDisplay.cfm&ContentID=17216. The results are from a survey given to 500 county law enforcement officials in forty-five states. *Id.* at 2.

[47] *See supra* notes 27, 32 and accompanying text.

[48] *See, e.g.*, Chapman, *supra* note 13 ("But it's not even clear that there is a meth epidemic . . . . Nor is meth all that addictive."); John Tierney, Op-Ed., *Debunking the Drug War*, N.Y. TIMES, Aug. 9, 2005, at A19 (arguing "there's little evidence of a new national epidemic from patterns of [amphetamine] drug arrests or drug use"); *see also* RYAN S. KING, SENTENCING PROJECT, THE NEXT BIG THING? METHAMPHETAMINE IN THE UNITED STATES 14–25 (2006) (pointing to interests of reporters, police, and others that led to exaggeration of methamphetamine abuse).

[49] *Cf.* Chapman, *supra* note 13 (noting that lab seizures did not reduce use or production, and that users "switched to meth smuggled from Mexico").

[50] The term "moral panics" is attributed to sociologist Stanley Cohen. *See* STANLEY COHEN, FOLK DEVILS AND MORAL PANICS 1 (3d ed. 2002) (defining a moral panic as period when a "condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media").

> When the official reaction to a person, groups of persons or series of events is *out of all proportion* to the actual threat offered, when 'experts' . . . *perceive* the threat in all but identical terms, and appear to talk 'with one voice' of rates, diagnoses, prognoses and solutions, when the media representations universally stress 'sudden and dramatic' increases (in numbers involved or events) and 'novelty,' above and beyond that which a sober, realistic appraisal could sustain . . . .[51]

The social and legal reaction to methamphetamine in the 1990s fits this thesis well. The police, government officials, and the mass media spoke with a unified voice about the existence of an epidemic.

C. Tobacco as an Addictive Health Hazard

The story of tobacco is quite different. Now it is commonly known that smoking is a public health hazard, and yet largely the smoker did not become demonized in the same way that the methamphetamine addict (or the cocaine or marijuana addict before him) did. Dramatic numbers are often cited as evidence of tobacco's dangers. Every year, more than 400,000 people in the United States die from health problems associated with cigarette smoking.[52] Smoking accounts for more premature deaths than *all* deaths resulting from illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders.[53]

The publication of the 1964 Surgeon General's Report on Smoking began a long process of social and legal change that resulted in the marked decrease of smoking by American adults.[54] While scientific evidence began to emerge in the 1950s linking cigarette smoking to problems like lung, mouth, and lip cancers now commonly associated with long-term smoking,[55] in 1964 about half of American men and almost a third of American women were smokers.[56] Over the next four decades, the smoking population dropped steadily and consistently.[57] In 2007, about 20 percent of American adults smoked

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[51] STUART HALL ET AL., POLICING THE CRISIS: MUGGING, THE STATE, AND LAW AND ORDER 16 (1978).

[52] B. Adhikari et al., *Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004*, 57 MORBIDITY AND MORTALITY WKLY. REP. 1226, 1226 (2008), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf.

[53] *See* Centers for Disease Control, Fact Sheet: Tobacco Related Mortality (2006), http://www.cdc.gov/tobacco/data_statistics/Fact_sheets/health_effects/tobacco_related_mortality.htm.

[54] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 33.

[55] *See id.* at 38.

[56] *See* Ronald Bayer & James Colgrove, *Children and Bystanders First: The Ethics and Politics of Tobacco Control in the United States*, *in* UNFILTERED 8, 10 (2004).

[57] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 33.

cigarettes.[58] The successful forty-year campaign to decrease cigarette smoking relied upon several factors, including: the emergence of scientific evidence about nicotine's harms, innovative litigation initiated by private actors and the states' attorneys general, and the rise of advocacy groups. These various resources gave rise to a complex portrait of the smoker.

D. The Smoker: Decision Maker, Victim, and Rights Violator

Public attitudes toward smoking and the smoker have changed significantly from the 1950s to the present day. Battles over how to regulate the smoking industry that took place in the courts and in the legislatures helped shape an evolving interpretation of the smoker and his responsibility for the harms of nicotine addiction. Also significant in this cultural interpretation were the efforts of antitobacco grassroots organizations and the emergence of mounting evidence of both nicotine's addictive qualities and the efforts of the industry to conceal that evidence.

1. Litigation: The Smoker as a Victim

From the 1950s onward, smokers turned to the courts as a venue for raising claims against the tobacco industry.[59] The hundreds of cases relied upon a number of different legal theories, during the course of which the smoker changed from an informed decision maker to a victim of deceptive industry practices. These lawsuits provided an opportunity for litigants and lawyers to not only present their legal claims, but also to offer the public a particular definition of smoking "in ways that affix blame and responsibility to their opponent."[60]

Until the 1990s, hundreds of individual smokers as plaintiffs repeatedly failed to bring successful claims against the tobacco industry, largely because of the legal theories underlying the cases.[61] The tobacco cases of the 1950s relied upon claims of negligence and implied warranty.[62] Because the tobacco industry avoided making health claims about their products and because of the health warnings mandated by the federal regulations of the 1960s, the implied warranty claims failed.[63] Because plaintiffs' attorneys could offer no evidence

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[58] *See* S.L. Thorne et al., *Cigarette Smoking Among Adults—United States, 2007*, 57 MORBIDITY AND MORTALITY WKLY. REP. 1221, 1221 (2008), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf.

[59] *See* Lynn Mather, *Theorizing About Trial Courts: Lawyers, Policymaking, and Tobacco Litigation*, 23 LAW & SOC. INQUIRY 897, 903 (1998).

[60] *Id.* at 918–19.

[61] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 225 ("By one count, 808 cases were filed between 1954 and 1984.").

[62] *Id.*

[63] *Id.*

of the tobacco industry's awareness of the potential harms of tobacco, the negligence claims failed as well.[64] During this "first wave" of tobacco litigation, the contest was less a battle of competing stories about the smoker than it was a battle of unevenly matched resources between tobacco companies and unorganized plaintiffs' attorneys.[65]

The success of asbestos litigation triggered the "second wave" of tobacco lawsuits in the early 1980s, but these cases did not fare well against well-financed defendants and unsympathetic juries either.[66] It was in this second group of cases, however, that a "full dress morality play" emerged in the struggle to assign blame for the smokers' injuries.[67] While plaintiffs' counsel turned toward new legal strategies, juries found persuasive defense arguments that smokers had freely chosen whatever risks existed (despite mild warning labels) and thus assumed some comparative fault.[68] In fact, lawyers for tobacco companies not only argued that the smoker made voluntary choices about smoking, but also in some cases presented evidence of individual claimants' supposedly risky lifestyles, with the suggestion that their lives were somehow immoral.[69]

The antismoking campaign of the 1980s was further complicated by a competing image of smoking as an act of personal freedom, not to be interfered with by government.[70] This "antipaternalism" created unlikely alliances. For instance, critiquing calls for radical restrictions on smoking advertisements, some civil rights advocates joined forces with the industry to defend the right of the smoker to be free from excessive government intervention.[71]

Two key events in 1994 made possible a "third wave" of tobacco litigation that was successful in assigning blame and responsibility for tobacco's harms to the industry itself. First, in headline-making news, the Federal Drug Administration (FDA) Commissioner David Kessler signaled his intention to assert his agency's jurisdiction over cigarettes.[72] Second, a

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[64] *Id.*

[65] *See id.*

[66] *Id.* at 226.

[67] Robert L. Rabin, *Institutional and Historical Perspectives on Tobacco Tort Liability*, *in* SMOKING POLICY: LAW, POLITICS, AND CULTURE 110, 124 (1993).

[68] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 226.

[69] *Id.*; *see* Mather, *supra* note 60, at 904 (describing tobacco companies' development of an "assumption of risk" argument in the 1980s).

[70] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 46.

[71] *See* Phillip J. Hilts, *Nader Assails A.C.L.U. on Tobacco Industry Gifts*, N.Y. TIMES, Jul. 30, 1993, at A12; *cf.* Bayer & Colgrove, *supra* note 56, at 8 (observing the "extent to which anti-paternalism suffuses popular and elite values" has affected public response to tobacco as a health threat).

[72] *See* Edwin Chen, *In Shift, FDA Says It Could Classify Nicotine as a Drug*, L.A. TIMES, Feb. 26, 1994, at 1.

national-television news-program report alleged that tobacco companies deliberately manipulated nicotine levels in cigarettes.[73] Both events sparked further media investigations and congressional hearings on the true knowledge and activities of tobacco companies.[74] Documents made public through leaks, litigation, and the FDA's attempt to regulate tobacco verified that tobacco companies did in fact know about the addictive properties of tobacco and deliberately manipulated their products.[75]

The emergence of this new factual evidence placed enormous pressures on the tobacco industry, which was now unable to deny awareness of the harmful properties of their product. Bolstered by these favorable facts, individual suits by injured smokers increased tremendously. In addition, two new types of cases became part of tobacco litigation: class-action suits and suits brought by third-party healthcare payers.[76] Of the latter group, the most significant cases were brought by the states' attorneys general, seeking reimbursement for costs to state Medicaid programs for tobacco-related health problems.[77]

Lawsuits brought by forty-six states' attorneys general reached successful settlement in 1997 and 1998.[78] The results of the settlement, the Master Settlement Agreement (MSA), exacted financial costs from the tobacco industry of $246 billion over twenty-five years.[79] The costs of the MSA were passed on to the smokers. This factor, along with increasing excise taxes imposed by the states in the 1990s, led to a dramatic rise in the price of cigarettes.[80] Between 1964 and 2000, the price of cigarettes had increased by 85 percent; more than 60 percent of the increase had occurred after 1997.[81]

At the same time that the tobacco industry experienced a dramatic change of fortune, the prevailing portrait of the smoker evolved from that of a voluntary decision maker to that of a victim harmed by an industry bent on deception.[82] While the movement to reduce cigarette smoking in the decades after the 1964 Surgeon General's report exhibited qualities of "moral zealotry"

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[73] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 229.

[74] *See id.*

[75] *See id.* at 229–30.

[76] *See id.* at 235–42.

[77] *See id.* at 238.

[78] *See id.* at 160.

[79] *See id.*

[80] More than any other factor, the costs of the MSA accounted for the dramatic rise in cigarette prices. *See* Bayer & Colgrove, *supra* note 56, at 34–35.

[81] *See id.* at 34.

[82] *See* Mather, *supra* note 60, at 934 ("Litigation thus challenged the public discourse about smoking, by providing new ways of defining the policy problem—ways that allocated blame and made moral judgments about fault and the responsibility of tobacco companies for the harm their product causes.").

that affixed blame to individuals,[83] much of the responsibility for smoking's harms came to be attributed to the tobacco industry rather than to individual smokers.[84] The revelations that tobacco companies engaged in a campaign of secret research, active manipulation, and public denials led to this change in public opinion.[85]

2. Regulation: The Smoker as a Rights Violator

The smoker was not entirely a hapless victim of the tobacco industry, however. Two noteworthy aspects of the antismoking campaigns of the 1980s and 1990s focused on the threats by smoking and the tobacco industry to innocent third parties: the nonsmoking public and children.[86]

It was not until the protection of children moved front and center that widespread support for advertising restrictions on tobacco existed.[87] The early studies linking smoking to numerous health problems led to calls for both warning labels and restrictions on tobacco advertising.[88] In theory, restrictions targeted the pervasive cultural influence of the tobacco industry in advertising and underwriting. Early regulations, however, were tepid. The mild warning required by the Cigarette Labeling and Advertising Act of 1965 was seen as a concession to the tobacco industry.[89] Growing calls for total bans on cigarette advertising emerged in the 1980s, but it was not until the 1990s that the necessary political support existed, with a focus on the industry's targeting of children.

It was the subject of children as innocent victims—and smoking as a "pediatric disease"—that became the focus of the FDA's much-publicized but ill-fated attempt to regulate tobacco.[90] The agency's 1996 final rule targeted in particular advertising and sales seemingly directed at the youth market.[91]

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[83] Sociologist Joseph Gusfield, for instance, describes the antismoking public health campaign as one in which the smoker "who persists in smoking is a victim of his or her own ignorance, stupidity, or lack of self-control." *See* Joseph R. Gusfield, *The Social Symbolism of Smoking and Health*, *in* SMOKING POLICY: LAW, POLITICS, AND CULTURE 49, 61 (1993).

[84] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 49.

[85] *See id.*

[86] *See* Bayer & Colgrove, *supra* note 56, at 10–27.

[87] *See id.* at 15.

[88] *See id.* at 10.

[89] *See id.* at 10.

[90] *See id.* at 17.

[91] *See Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents*, 61 Fed. Reg. 44,396–45,445 (Aug. 28, 1996).

Although the Supreme Court dead ended the FDA's efforts,[92] the view that smoking harmed defenseless children remained entrenched in antismoking campaigns.[93] Some of the basic ideas contained within the 1996 FDA regulations made their way into the Master Settlement Agreement between the industry and the states' attorneys general.[94]

Children were not the only nonsmokers whose rights had to be protected. Nonsmokers' rights groups pressed for restrictions or bans on smoking in public settings, as evidence emerged that second hand smoke, or environmental tobacco smoke, posed significant health hazards even to the nonsmoking public.[95] Grassroots activist groups such as the Group Against Smokers' Pollution pressed for restrictions on smokers because of the harm they posed.[96] Berkeley, California became the first local community to limit smoking in restaurants and other public places in 1977.[97] Over the next two decades, "negative zoning" of workplaces, airplanes, and other public or quasi-public places increasingly banned or severely restricted smoking.[98] By 1990, forty-four states restricted smoking in public places and workplaces; hundreds of cities and towns had done the same.[99]

Publicizing the harms posed to innocent third parties, the resulting wave of smoking restrictions, and the general downward trend in smoking among the upper and middle classes in particular contributed to a moral reinterpretation of the smoker.[100] As smoking has changed from a widely accepted social practice to an activity that is increasingly restricted and associated with known health threats, the smoker herself has become a somewhat stigmatized character.[101]

Yet the shift in focus to protecting nonsmokers' rights did not lead to wholesale demonization of the smoker. Negative zoning protects nonsmokers

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[92] The Court held that the FDA lacked authority to issue and enforce tobacco regulations. *See* FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120,126 (2000).

[93] *Cf.* Bayer & Colgrove, *supra* note 56, at 34 (noting that one of dominant themes of the anti-tobacco movement in the 1990s was "protection of young people").

[94] *See id.* at 18.

[95] *See id.* at 22.

[96] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 47.

[97] *See id.* at 198.

[98] *See* Zimring, *supra* note 5, at 100.

[99] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 47.

[100] *See, e.g.*, Bayer, *supra* note 56, at 34 ("Perhaps the most striking feature of the transformation in the epidemiologic profile of smoking has been its concentration among those of lower socioeconomic status."); U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 49 (noting that "as regulations against smoking become more widespread, the tendency to stigmatize smokers may increase"); Zimring, *supra* note 5, at 107.

[101] *Cf.* Zimring, *supra* note 5, at 106 ("The most significant shift in social attitudes toward smoking in the United States in the 1980s and 1990s is the developing tendency in many segments of public opinion and government to view cigarette smoking as socially deviant and morally wrong.").

from the harm caused by smoking in a stark and literal way, but smoking itself is not described as a threat to the moral or social order in the same way illicit drugs are so characterized.[102] Indeed, today nicotine addiction is touted by at least one manufacturer of a nicotine patch as more of an obstacle to achieving long-lasting beauty than anything else. The advertising campaign for Nicoderm CQ tells the smoker: "Every time you smoke, you damage your skin . . . . Quit now and discover the numerous benefits of healthy skin."[103] The Nicoderm website also prompts the smoker to take a "beauty assessment."[104]

The changing responses to smoking show that the public response to addiction need not be one dimensional or static. Unlike the monstrous methamphetamine addict, the smoker was a complex character in the public eye: a rational decision maker, a victim, a rights violator, as well as a public health problem.

III. OBSERVATIONS

This brief comparison suggests that the social and legal responses to addiction can vary widely depending on the substance. And as the case of tobacco shows, the social and legal response to an addictive substance can itself vary over time, depending on the extent of public concern. This part of the essay offers some observations about the distinct social and legal responses to methamphetamine and tobacco. First, the dominance of the police as experts on illicit and addictive substances exacerbates the demonization of the addict. Second, the resulting exclusionary stigmatization of the addict may be unnecessary, since the overall downward trend in cigarette smoking of the past forty years has occurred without this view of the nicotine addict. Finally, even if stigmatization is a desirable aspect of the regulation and response to methamphetamine addiction, one disadvantage is that its tendency is to distort and oversimplify the problem of addiction.

A. The Police as Experts

When an addictive substance like methamphetamine becomes regulated primarily through the criminal law, it is the police who assume the primary role as experts in defining and characterizing the problem of addiction.[105]

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[102] *See id.* at 108.

[103] *See* NicodermCQ, The Beauty of Quitting, http://www.nicodermcq.com/beauty/default.aspx (last visited Feb. 18, 2008).

[104] *See id.*

[105] *See* Zimring, *supra* note 5, at 102 (observing that "law enforcement is the dominant expertise consulted in the policy process" of criminally prohibited substances).

There are several aspects of this police dominance that may help us understand the interpretation of illicit drug addictions.

First, the assumption of expertise covers not just conventional areas such as investigation and surveillance, but also those in which the police may not have special competence such as drug-use trends, addiction issues, and drug prevention.[106]

Second, police, like other institutional actors, have understandable interests in drawing attention to problems that may receive increased financial and institutional support. The perception of an especially alarming criminal trend can trigger the release of federal and state funds for special attention outside of conventional police duties and expectations.[107]

Third and finally, any police interpretation of the problem of addiction must be understood as being interpreted through the institutionalized antagonism felt by the police about those targeted through the criminal law.[108] As a matter of training and occupational culture, the police officer meets potential lawbreakers, including addicts to illicit drugs, with a suspicion based in the basic moral message of the criminal law.[109]

These factors play important roles in the police interpretation, and then, in turn, media interpretations of crisis and alarm with regard to a perceived illicit-drug problem. A stark moralism tends to play a leading role in the perception of harm; other perspectives from public health and public policy, secondary roles. It should be no surprise, then, that those addicted to substances that are primarily regulated by the criminal law should be characterized as posing basic threats to morals and public order.[110] This was not the case with the antismoking initiative. The portrait of the smoker that emerged in the antismoking campaigns was complex: a person partially but

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[106] *Id.*

[107] *See, e.g.*, KING, *supra* note 48, at 15 (arguing that reported increases in methamphetamine drug lab seizures did not correspond to any reported increase in drug use and in "all likelihood" can be attributed to "expanded law enforcement efforts targeting methamphetamine production facilities in response to financial incentives"); Jack Shafer, *This Is Your County on Meth*, SLATE, Jan. 19, 2006, http://www.slate.com/id/2134392/ (arguing that "when reporters write stories based on [NACo surveys], it helps NACo shake the federal dollar tree for its 2,000-plus member counties").

[108] *See, e.g.*, JEROME H. SKOLNICK, JUSTICE WITHOUT TRIAL 44–45 (Macmillan 1994) (1966) (discussing the development of professionalized suspicion in the police officer's "working personality").

[109] *See id.* at 47.

[110] *Cf.* Zimring, *supra* note 5, at 108 ("In the temperance rhetoric that is the backdrop to drug and alcohol prohibition, the intoxication of drinkers and drug takers is itself a threat to morality and productivity." (citation omitted)).

not totally responsible for his addiction, and even to the extent blameworthy, not a pariah from the rest of society.[111]

B. Behavioral Change and Stigma

The comparison between tobacco and methamphetamine also suggests that changes in addictive behavior can be attributed to the addict with varying levels of blame and responsibility. Public attitudes toward the methamphetamine addict of the past twenty years can be characterized by *extreme exclusionary stigma*. It is the methamphetamine addict herself who was exclusively at fault for her problems. *Newsweek* magazine entitled one addict's harrowing experience as "Paying a Price for Pleasure."[112]

As a result of the successful antitobacco movement of the past half century, large-scale behavioral change was made possible without demonizing smokers.[113] Smoking has, however, become a stigmatized activity. As smoking has declined, particularly among the upper and middle classes, it has assumed the role of a "boundary marker" of class and status.[114] But nicotine addiction does not carry with it the opprobrium that methamphetamine addiction does. In part, this may be because smoking has "rarely been perceived as a feature of personal behavior that is *central* to someone's identity."[115] Significant, too, is the characterization of nicotine addiction as a medical issue subject to public health solutions.[116]

C. Division and Exclusion

One might ask why exclusionary stigmatization of the illicit-drug addict is wrong. After all, the very choice to criminalize methamphetamine represents a choice, in this view, that the criminal law and its denunciatory message is the most appropriate means of regulation. Media accounts of the horrors of methamphetamine addiction simply mirrored these legal choices. Indeed, given the significant harms of methamphetamine abuse, treating the problem through other means may not be socially or politically feasible.

There are problems with this perspective. First, exclusionary stigmatization—the sense that the methamphetamine addict was monstrous—distorts and oversimplifies the problem of addiction. Although addiction

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[111] *But see* Gusfield, *supra* note 83, at 65 (noting that "[i]n recent years, a variety of policies have been put in place that implicitly and symbolically create the definition of the smoker as pariah").

[112] Jefferson, *supra* note 21, at 46.

[113] *Cf.* Zimring, *supra* note 5, at 105 (observing that "criminal law may not be the only means of government policy capable of conveying and reinforcing stigma").

[114] *See* Gusfield, *supra* note 83, at 64.

[115] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 49 (emphasis added).

[116] *See id.*

reflects more than a bad person making bad choices, criminal punishment of the addict provides the appearance of an easy solution. Second, the criminal law focuses on individual responsibility to the virtual exclusion of structural or systemic problems that may contribute to illicit-drug addiction, such as poverty and joblessness. The antismoking campaign provides an easy contrast; while the smoker was a "responsible victim,"[117] she was also the victim of other forces, including once pervasive cultural mores about the social acceptability of smoking, as well as deceptive industry practices that preyed upon the physiology of nicotine addiction. Finally, as this essay has argued, public perceptions of addiction not only reflect regulatory choices, they also play a constitutive role in characterizing the problem by promoting some views of addiction and rejecting others.[118]

IV. CONCLUSION

Rhetoric means little to the addict. Addiction to substances like methamphetamine and nicotine requires practical and concrete solutions. Nevertheless, the public response that eventually emerges to a perceived widespread addiction is important precisely because of its rhetoric, imagery, and ideas. Some characterizations of addiction can be particularly harmful, portraying the addict as horribly deviant. Yet these views of addiction may not be necessary to achieve behavioral changes, as the history of the antismoking movement shows. Methamphetamine will not be the last illicit drug to animate public discussion and concern, but by studying our reactions to it we can inject some self-consciousness into the public discourse that will inevitably surround the next "epidemic."[119]

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[117] *See* Gusfield, *supra* note 83, at 61 (discussing the rhetoric of government and health organizations that created a "responsible victim" persona).

[118] *Cf.* Gusfield, *supra* note 83, at 54–60 (describing public acceptance of smoking risks in terms of sociology of knowledge, i.e. "the social construction of reality" (quotations omitted)).

[119] *Illegal Drugs: Speedy Decline*, ECONOMIST, May 3, 2008, at 35 (noting that demand for methamphetamine appears to be in decline since 2002).

HIGH SOCIETY: CALL TO ARMS
MARCH 13, 2008 SPEECH

Joseph A. Califano, Jr.*

If you wonder why I call our nation a high society, consider just one fact. Although we Americans are only 4 percent of the world's population, we consume two-thirds of the world's illegal drugs.[1] And that, my friends, is only the tip of the iceberg. HIGH SOCIETY is a book about the pervasive and pernicious role of alcohol and drug abuse in our country.[2] It shows how such abuse causes and aggravates just about every intractable problem our nation faces. And it calls for a revolution in our attitude about substance abuse and addiction and how we deal with it. What did Judy Garland, Mickey Mantle, President George W. Bush, Snoop Dogg, many mothers on welfare, Elton John, Rush Limbaugh, Natalie Cole, Jamie Lee Curtis, Don Imus, U.S. Supreme Court Justice William Rehnquist, most incarcerated felons and arrested juveniles, Janis Joplin, Frank Sinatra, Mel Gibson, millions of children and teens under twenty-one, Billy Joel, Joe Namath, Robin Williams, and former First Lady Betty Ford have in common? What attribute do most victims of cancer, heart disease, emphysema, accidents, and violence share? And what's the culprit in most assaults and homicides, incest, domestic violence, teen pregnancy, college date rape and campus racial incidents? Substance abuse and addiction.

We face many problems in America: entitlement programs that defy reform, rising healthcare costs, lousy urban schools, prisons bursting at the bars, state family courts and child welfare systems on the cusp of collapse, a bulging federal deficit threatening our economic prosperity and global supremacy, millions of people trapped in pockets in rural and urban poverty, and ample financing for terrorists. To solve these problems, we've passed many laws—thousands of them. We've spent billions of dollars; we've created hundreds of federal, state, and local law enforcements and social service agencies; parents, children, and spouses have offered countless prayers. We sent troops to Colombia and tried to stamp out poppy fields in Afghanistan, but the problems persist. Why? Because of our attitude about the sinister force that lurks behind them: abuse and addiction involving alcohol, tobacco and illegal and prescription drugs and our failure to counter that force.

On any given day, more than a hundred million Americans are taking some stimulant, antidepressant, tranquilizer, or pain killer, smoking, inhaling from aerosol or glue bottles, or self medicating with alcohol or illegal substances like

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[1] JOSEPH A. CALIFANO, JR., HIGH SOCIETY: HOW SUBSTANCE ABUSE RAVAGES AMERICA AND WHAT TO DO ABOUT IT, xii (2007).

[2] *See id.* at xii–xiv.

marijuana, cocaine, heroin, and methamphetamines.[3] Chemistry is chasing Christianity as the nation's largest religion. The millions of Americans, who daily take some mood-altering, pain-killing, or mind-bending prescription drug, abuse alcohol and illegal drugs, and smoke cigarettes, exceed the number who weekly attend religious services.[4] Indeed, millions of Americans who in times of personal crisis and emotional and mental anguish once turned to priests, ministers, and rabbis for keys to the heavenly kingdom now go to physicians and psychiatrists who hold the keys to the kingdom of pharmaceutical relief, or to drug dealers and liquor stores, as chemicals and alcohol replace the confessional as a source of solace and forgiveness.[5]

We have learned that chemistry makes parenting easier for mom and dad and teaching easier for Miss Brooks. Over the decade ending in 2005, the number of kids on Ritalin and Adderall or some other drug to treat Attention Deficit Disorder has exploded.[6] The age at which children begin to drink, smoke, and use marijuana is beginning to drop below thirteen years.[7] It is no longer surprising to read nine or ten year old kids smoking or drinking or snorting or swallowing some substance to get high. From its 1992 low during the last quarter century of 8.5 million, the number of Americans twelve and older who use illegal drugs has increased to nearly 20 million in 2007.[8] Similarly, despite slight decline since 2002, illegal drug use among twelve to seventeen year olds climbed from its quarter century low of 1.1 million in 1992 to 2.6 million in 2005.[9] And teen abuse of prescription opiates, stimulants, and depressants more than tripled between 1992 and 2003 rising to 2.3 million.[10] Indeed, teen abuse of prescription drugs over that period went up 212 percent.[11] The overall population in this country only went up 14 percent.[12]

Athletes thrive on all sorts of stuff: steroids, amphetamines, erythropoietin, and body-building creams. The medicine cabinet and chemistry lab are now common stops along the express train to professional stardom. Baseball players caught with their steroids showing, have for years swallowed greenies, amphetamine pills to maintain their energy over the course of the long season. The owners don't care so long as breaking records fill the seats at higher and higher prices and many fans look at today's athletes the way ancient Romans at the Coliseum viewed Christians fed to the lions—as hunks of fungible flesh served up to entertain with 400-foot home runs 350-pound bone crushing tackles.

Rock stars shake the rafters with eardrum-bursting anthems to drug and alcohol abuse. Musician, film, and television stars bounce in and out of drug and

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[3] *Id.* at 1.
[4] *Id.*
[5] *Id.* at 1–2.
[6] *Id.* at 2.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.* at 38.
[11] *Id.* at 161.
[12] *Id.*

alcohol rehab. Celebrities fill the pages of *People* and *US Weekly* with outrageous alcohol- and drug-fueled antics. And many physicians promiscuously prescribe mood-altering drugs to patients, particularly to girls and women. Indeed, many of the medical profession have pharmaceuticalized the normal stages of female life by prescribing mood-altering drugs for problems related to menstruation, marriage, motherhood, and menopause. Many psychiatrists replace the couch with chemistry—pushing pills to squelch patient guilt and anxiety.

The pharmaceutical companies and their Madison Avenue mavens christen new disorders and old ailments with catchy names and hawk pills to fill our television screens with happy and comforting images, promoting pills that promise uninterrupted hours of serene sleep, and clips of frolicking couples that have shed their social anxieties or physical pain thanks to the latest pill. They offer relief from restless leg syndrome and irritable bowel syndrome. In 2006, the Food and Drug Administration approved the first pill to specifically ease wintertime blues, or as pharmaceuticals promoters branded the condition as "SAD—Seasonal Affective Disorder."[13] That same year at their annual convention, psychiatrists dubbed road rage "intermittent explosive disorder" and authored as treatment antidepressant chemicals to target serotonin receptors in the brain.[14] Marketing of these drugs is so aggressive and the pace of drug approval so fast and furious that last year the American Medical Association called a moratorium on direct-to-consumer advertising in order to give doctors a chance to learn about new drugs before patients demand for prescriptions to ease their pain, bend their mind, or sleep through the night.[15]

The medications aimed to perfect the human condition are miracles of minor pharmacology. I applaud the scientific geniuses that have discovered them and the healthcare and marketing distributions that have made them available to help millions of our people. The problem lies not in these medications but in ourselves and how we view these pharmaceuticals and how we use them. We see them not just as palliatives when we as fallible human beings overindulge or suffer physical or mental illness despite our best efforts to stay healthy. Rather they have become a means to allow further abuse of mind and body. We use them to eat, work, play, and perform with abandon, uninhibited by any sense of personal responsibility as students cramming for exams or partying through the night, Wall Street bankers deal making around the clock, athletes chasing records, and parents and teachers trying to calm rambunctious children. If Moses were an American at the dawn of the twenty-first century, the tablets he would bring down from the mountain would be Vicoden and Valium, not a set of commandments to guide our conduct.

The anecdotal evidence is everywhere, even among society's most successful members. In the addictions of mega stars like Liza Minnelli, and in the collapse of athletic careers of professional super stars like Cy Young and award winner Dwight Gooden, in the destructed cocaine and heroin dependence of Eugene

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[13] *Id.* at 3.
[14] *Id.*
[15] *Id.*

Fodor, the first American to win Moscow's Tchaikovsky Violin Competition, in the problems of teen movie queen Lindsay Lohan and the antics of celebrities like Britney Spears, and the overdose deaths of pop cultural stars like Marilyn Monroe and Elvis Presley. Those who work the halls of national and state legislatures know how treacherous the lure of alcohol and pills can be in the cards of political success. We've seen this in political wives—Betty Ford, Kitty Ducacus, Joan Kennedy, and Cindy McCain—and in the long line of alcohol-abusing politicians, including Congressmen Patrick Kennedy, Jim Ramstad, and Mark Foley, as well as in Texas Governor Ann Richards, D.C. Mayor Marion Barry, and Ronald Reagan's top White House aide, Michael Deaver. And working as Lyndon Johnson's top domestic aide, I smoked four packs of cigarettes a day with mentholated cigarettes in one pocket and regular in the other so I could keep getting my nicotine fix even when my throat was raw. Incidentally, if any of you worked four years for Lyndon Johnson, you would smoke four packs a day too.

Is there an American without a family member, a friend who smoked himself to premature disability or death, from emphysema or lung cancer or heart disease? The celebrity morbidity list begins with Humphrey Bogart, Joe DiMaggio, and Nat King Cole, and it gets longer each day—a couple of years ago claiming the lives of comedic icon Johnny Carson and ABC news anchor Peter Jennings. The statistical evidence gives substance abuse and addiction its sinister status as public health enemy number one. Sixty-one million Americans are hooked on cigarettes;[16] 16 to 20 million are addicted to alcohol or abuse it.[17] More than 15 million abuse prescription drugs;[18] 15 million smoke marijuana;[19] 2.4 million use cocaine;[20] 600,000 crack;[21] hundreds of thousands are hooked on heroin;[22] more than 500,000 are methamphetamine users;[23] a million use Ecstasy and hallucinogens;[24] almost 2 million of our kids, twelve to seventeen years of age, have used steroids;[25] and 4.5 million teens abuse controlled prescription drugs like OxyContin, Ritalin, and Adderral to get high.[26]

The human misery that addiction and abuse cause cannot be calculated. The broken homes, the lives snuffed out in their twenties, the teenage mothers and absent fathers, women victimized by violence and rape, babies deformed by parents' smoking, drinking, or illicit drug use, children molested by fathers hopped up on beer or pot or cocaine, rural and Midwestern explosions from garages moonlighting as meth labs, abused children in such agony and despair that they

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[16] *Id.* at 5.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*

themselves resort to alcohol and drugs for relief, and children—yes, children—committing suicide. Substance abuse visits a special savagery on America's poor and minorities, but it spawns its tragedy far and beyond the disadvantaged. Three-quarters of illegal drug users work full or part time.[27] Heroin wrenched life away from Ethel Kennedy's son, David, in a luxurious Palm Beach hotel at the age of twenty-eight. And alcohol and drug addiction have touched many other members of that royal American family including Robert Kennedy, Jr., Matthew Kennedy, Michael Kennedy, Patrick Kennedy, Ted Kennedy, Jr., Joan Kennedy, Patricia Kennedy Lawford, and her son, Christopher. Alcoholism has devastated the Barrymore family, stunting the careers of patriarch, John, his son, John Jr., and threatening third generation Barrymore, Drew.

If we can't calculate the human misery and repair the broken hearts, we can put dollar signs on some costs of substance abuse and addiction. This year the financial bill is almost certain to hit $1 trillion in healthcare, lost productivity, disability, welfare, fires, crime and punishment, property damage from vandalism, interest on the federal debt, legal and court costs, family breakup, child abuse and the array of social interventions, public and private, to deal with the ravages of this scourge on addicts and abusers, their families and friends.[28] Half of the beds in many American hospitals hold victims of auto and home accidents, cancers, heart, cardiovascular diseases, liver, kidney, and respiratory ailments, and other illness and violence caused or exacerbated by tobacco, alcohol, and drug abuse.[29] Cigarette smoking, alcohol, and drug abuse have been pushing up state and local taxes and raiding government coffers for years to pay for Medicare and Medicaid costs. Americans crippled by smoking and alcohol abuse take home billions—billions—of dollars in Social Security and Veterans Disability payments.[30]

Drug and alcohol abuse crowd our prisons and clog our courts. Some 80 percent of juvenile arrestees and adult felony inmates committed their offenses while high, stole money to buy drugs, are drug and alcohol abusers or addicts, violated alcohol or drug laws, or share several of these characteristics.[31] Incidentally, alcohol is a much bigger factor in the criminal justice system than drugs. Many women remaining on welfare are hooked on alcohol and other drugs. At least 50 percent of the 3 million abused and neglected children in the child welfare systems are there because of substance-abusing parents.[32]

Alcohol and drugs are the prime suspects in the spread of AIDS and other sexually transmitted diseases.[33] Young Americans high on substances are far more likely to have risky sexual relations and with many partners. Most teen pregnancies

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[27] *Id.* at 6.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.* at 7.
[33] *Id.*

occur when one or both teens are high at the time of conception.[34] More than 5 million high school students—almost a third—binge drink at least once a month;[35] nearly half of the nation's college students binge drink and/or abuse illegal and prescription drugs.[36] Almost a quarter of our college students—a quarter of our full-time college students—meet the medical criteria for alcohol or drug abuse or addiction,[37] and the number of college women who admit drinking to get drunk has more than tripled over the past thirty years.[38] While president of Princeton University, Harold Shapiro called alcohol abuse, and I quote, "[t]he greatest single threat to the university's fulfillment of its mission,"[39] alcohol abuse is a deadly threat to students on the campus. Cruel courtesy of excessive alcohol drinking each year—700,000 students are injured, 100,000 are raped or sexually assaulted.[40] Think about this, thirty-two kids were killed by a crazy kid with a gun at Virginia Tech and we had national mourning. Every year on our college campuses, 1,700 students die from alcohol poisoning or alcohol-related accidents.[41]

America's children are at the greatest risk and not only from illegal drug dealers, but from nicotine pushers, cigarette companies, and beer and alcohol merchants as well. They all know that the younger individuals become illegal drug users, smokers, and drinkers, the likelier they are to get hooked on drugs, nicotine, and booze. Just think about this and the similarities here. We now have a new kind of heroin that started in Texas and is beginning to show up elsewhere called Cheese. Cheese is candy-flavored heroin. It's heroin with a strawberry flavor or a raspberry flavor so you can snort it and get a little bit of that flavor. R.J. Reynolds, two years ago, starting coming out with candy-flavored cigarettes—raspberry flavored and some other flavors. There was such an outcry that they finally backed down and took them off the market. Most recently Anheuser Busch came out with these little bottles called Spykes. Spykes is a 12.5 percent alcohol-content flavor to put in beer—chocolate flavor, other flavors. When they were accused of trying to appeal to kids they said, "No, no, this is for adults." But what thirty or forty year old guy watching a football game wants to put a little chocolate syrup in his beer to

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[34] *See id.* at 112 (arguing most teens "report they are usually drunk and high when they have unprotected sex").

[35] THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, TEEN TIPPLERS: AMERICA'S UNDERAGE DRINKING EPIDEMIC 1 (2003), *available at* http://www.casacolumbia.org/absolutenm/articlefiles/379-Teen%20Tipplers.pdf.

[36] THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, WASTING THE BEST AND BRIGHTEST: SUBSTANCE ABUSE AT AMERICA'S COLLEGES AND UNIVERSITIES 1 (2007), *available at* http://www.casacolumbia.org/absolutenm/articlefiles/380-Wasting%20the%20Best%20and%20the%20Brightest.pdf.

[37] CALIFANO, *supra* note 1, at 51.

[38] *Id.* at 7.

[39] *Id.*

[40] JOSEPH A. CALIFANO, JR., HIGH SOCIETY: HOW SUBSTANCE ABUSE RAVAGES AMERICA AND WHAT TO DO ABOUT IT, at xiii (2d ed. 2008).

[41] *Id.*

make it taste better? They too have backed down and they are not selling them in this country incidentally, but they are selling in foreign countries, and there are candy-flavored cigarettes in the developing countries.

Marijuana poses a most serious risk to our kids. Twenty percent of twelve- to seventeen-year olds can buy marijuana within an hour, 40 percent can buy it within a day.[42] Today's marijuana is far more potent and dangerous than their parents' pot. There are more teens in treatment for marijuana dependence than alcohol and all other illegal drugs.[43] The director of the National Institute on Drug Abuse, Nora Volkow, says and I quote, "There is no question that marijuana can be addictive; that argument is over. The most important thing right now is to understand the vulnerability of young developing brains to these increased concentrations of cannabis."[44] The United Nations Drug Czar, Antonio Maria Costa, considers today's powerful marijuana as dangerous as cocaine and heroin.[45] And this understanding about it, if any of you noticed the reviews of the two books by the father and the son (the son who went through a lot of drug abuse and his father writing about it), his father writing about going to talk to the teachers at his son's high school[46]—David Sheff it was—he was saying his son is smoking marijuana and the teachers said, "Just forget about it. It's just a phase. Don't worry about it." And the kid almost destroyed his life with heroin and other drugs.

Most high school students and a quarter of middle schools report that drugs are used, kept, or sold at their schools.[47] Is it any wonder that in response to an open-ended question asking what their greatest problem is for eleven straight years in our CASA survey that the largest number of twelve to seventeen year olds responded drugs?[48] Every five years, substance abuse and addiction claim 3 million Americans, more people than have died in all our wars, auto accidents, and catastrophes combined.[49] More Americans die in a day from smoking than died in the entire year in 2005 in Iraq and Afghanistan,[50] and one in four of our people will have an alcohol or drug disorder at some point in their life.[51] Most of these people have parents, children, siblings, friends, and colleagues who suffer collateral damage.[52]

Now such is life in the high society. It doesn't have to be that way. It is so because conservatives, liberals, and moderates alike have become choruses of

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[42] CALIFANO, *supra* note 1, at 40.

[43] *Id.* at 122.

[44] *Id.*

[45] *Id.* at 121–22.

[46] Charles McGrath, *A Twice-Told Tale of Addiction: By Father, by Son*, N.Y. TIMES, Feb. 26, 2008, at E1, *available at* http://www.nytimes.com/2008/02/26/books/26meth.html?pagewanted=1&_r=1.

[47] CALIFANO, *supra* note 1, at 41.

[48] *Id.* at 42–43.

[49] *Id.* at 7.

[50] *Id.*

[51] *Id.* at xii.

[52] *Id.*

politicians, stage right, left, and center each calling for more of the same old programs chanting louder and louder in voices "If all the king's horses and all the king's men can't put Humpty Dumpty back together again, then give us more horses and give us more men." Substance abuse and addiction is the ugly elephant in the living room of American society and incidentally in this year's presidential campaign. Until we appreciate the weight of this elephant and accept its reality, until we accept our national and personal denial, we will continue to live with individual and family tragedies spawned by tobacco, alcohol, and illegal and prescription drug abuse. To suffer the failures that have limited the effectiveness of well-intentioned, public and private social initiatives, to waste taxpayer money and help finance the very terrorism that threatens our nation.

You know, there was a time in our history and it's not so long ago when smoking was cool, when seat belts were for sissies, and when AIDS was an accepted death sentence for gay sex. Today, our attitudes are profoundly different with powerful and beneficial consequences. Smoking has been cut sharply and so have the related deaths from lung cancer and heart disease. Auto safety measures have curbed the highway death and injury rate. And AIDS is recognized as a serious illness rather than as a social curse. In all three cases, we fundamentally changed our attitudes and as a result we took actions that greatly improved the quality of life for millions of our people. We can fundamentally change our attitude about substance abuse and addiction and mount a revolution and how to deal with it. There's ample press in such revolution, attitude and action.

In 1978, when I was HEW Secretary and I mounted the nation's first anti-smoking campaign, I declared the department's building smoke free. Employees demonstrated in opposition in front of the building and critics called the initiative one of "all smoke and no fire."[53] Yet today, thirty years later, there is universal acceptance of the dangers of second-hand smoking, and smoking. We moved from a nation where someone said "Would you like a cigarette?" to whether "Do you mind if I smoke?" and we're all happy to respond "You bet I do." A generation ago, in 1966, Lyndon Johnson proposed the Auto and Highway Safety Act.[54] Not only auto companies but drivers as well, scoffed at the use of seat belts and other safety measures. Today, the industry sells safety and just about every driver and most passengers buckle up before the car starts.[55] With an appreciation of the danger of AIDS and its fear's assault on and beyond the gay community, we have mounted an all-fronts medical research and safe-sex and abstinence education campaign that in a decade has dramatically changed the attitudes about the disease and its victims.[56]

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[53] *Id.* at xi.

[54] National Traffic and Motor Vehicle Safety Act of 1966, Pub. L. No. 89-563, 80 Stat. 718.

[55] CALIFANO, *supra* note 1, at xi–xii.

[56] *Id.* at xii.

This book, HIGH SOCIETY,[57] calls for a revolution in the way all of us as politicians and parents, physicians, teens, educators, entertainers, clergy, cops, corporations, judges, and lawyers perceive the threat that substance abuse and addiction poses and the obligation to protect our children. It is a call to sober up the high society to recognize that substance abuse and addiction is the nation's number one serial killer and crippler, and to acknowledge these fundamental realities. Substance abuse and addiction is a chronic disease of epidemic proportions with physical, psychological, emotional and spiritual elements that require continuing and holistic care. It is not a moral failing or an easily abandoned act of self-indulgence. Substance abuse is implicated in our nation's high healthcare costs, crime, social ills, and family breakup. There is a statistical and biological relationship between smoking, abusing alcohol, and marijuana use and between the abuse of those drugs and abuse of cocaine, heroin, prescription drugs, hallucinogens, and other substances.[58]

This problem is all about our children. Girls and boys are likely to use drugs for different reasons.[59] They exhibit use and abuse in distinct ways and suffer consequences in different ways. Individuals who have become addicts need all the carrots and sticks that can be mustered to achieve and maintain sobriety. And with the right mix of these incentives, millions can recover. Preventing substance abuse and addiction is a global problem that requires international as well as national leadership by our government. Accept those realities and you're led inexorably to the conclusion that in terms of public policy and parental conduct, it's time to think major surgery and abandon the iodine and Mercurochrome approaches of the past and the appalling political jargon that framed prior efforts. It's time to stop waging this war with cap pistols and mobilize all our people in modern science behind a national effort capable of defeating this scourge.

Our failure to understand the pervasive culpability of substance abuse has led to a misconception that the ineffectiveness of many domestic programs in achieving their objectives stems from some inherent floor or some contend the inability of the government to ever get it right. In fact, the limited effectiveness of many well-intentioned public and private initiatives stems from our refusal to recognize how substance abuse and addiction infect social problems we're trying to solve. Unfortunately, even in situations where substance abuse is seen to be culprit, we continue to shovel up the consequences rather than work to stamp out the causes. This shoveling up after the crime, the illness, the family breakup, rather than dealing with the root causes of substance abuse is the greatest failure of public policy and private philanthropy over the past fifty years. It's like telling someone whose hand is over a hot cooking flame that we have marvelous lotions to heal burns and miraculous surgical procedures to graft skin instead of saying turning off the gas and telling them not to put their hand over the stovetop. I'm talking cultural change, potent enough to cause a revolution in the nation's criminal justice,

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[57] *See* CALIFANO, *supra* note 1.
[58] *Id.* at xiii.
[59] *See id.* at 135–42.

medical, educational, and social service systems, in our foreign-policy priorities, and in the exercise of parent power for children and teens. We must end our denial, stamp out the stigma, rethink our concept of crime and punishment, reshape our medical system, and commit the energy and resources needed to confront this plague. Just a couple of examples: we should use our criminal justice system to get alcohol- and drug-addicted offenders into treatment and training. We can use punishment and the threat of punishment and the fact that we have more than a million users behind bars to get them off drugs and alcohol. If we only had a 10 percent success rate, the cost of treating all of them would be recouped within a year and thereafter the economic benefits, if they joined the workforce, would be about $10 billion annually.[60] To top it off, the reductions in crime would be the greatest in our history, since experts estimate that a drug addict commits between 89 and 191 crimes a year.[61] In healthcare, medical schools should establish a course in addiction is as essential for the future MDs as a course in anatomy. The National Institutes of Health spend $15 billion a year on research involving cancer, strokes, cardiovascular ailments, respiratory diseases, and AIDS.[62] They spend about only one tenth of that amount on substance abuse and addiction[63]—the largest single cause and exacerbator of that quintet of killers.[64] Judges and family courts, social workers, adoption and foster-care professionals should have compulsory training in substance abuse and addiction since 70 percent of the cases they'll have will involve it.[65] Welfare mothers with drug and alcohol problems should be required to enter treatment in order to receive their monthly checks. And the advertising and promotion of alcohol and tobacco aimed at children and teens should be eliminated. For example, beer and liquor merchants should not be permitted to advertise on television and not in radio shows and magazines where the proportion of underage audience exceeds its 15 percent share of the population. In foreign policy, we must accord drug abuse and addiction the kind of priority that we reserve for nuclear proliferation, terrorism, and commercial trade. We take all sorts of actions to keep biological contaminants and nuclear weapons out of our country, but we allow tons of illegal drugs in—marijuana, ecstasy, cocaine, heroin—and those drugs are killing and disabling millions of our citizens. And parents—prevention of substance abuse among children and teens is a mom and pop operation. Parents are key to a drug-free society. Why? Because a child who gets through age twenty-one without smoking, without using illegal drugs, without abusing alcohol—most will drink—is virtually certain never to do so.[66] Parents are also critical for getting drugs out of the schools. If asbestos is found in the school, parents raise hell and they wouldn't send their kids to school until all the asbestos is out of the ceiling. Yet these same parents send their kids to schools riddled with

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[60] *See id.* at 95.
[61] *Id.* at 95.
[62] *Id.* at 76–77.
[63] *Id.*
[64] *Id.*
[65] *Id.* at 7.
[66] *Id.* at 38.

drugs day after day. When parents feel as strongly about drugs in school as they do about asbestos in school, we'll have drug-free schools in this country.

Failure to revolutionize our culture and conduct on substance abuse and addiction is a decision to continue writing off millions of Americans to lives of debilitating illness, social dysfunction, and crime, and continue imposing on taxpayers exorbitant medical, social, and prison costs. Though substance abuse has touched almost every family and neighborhood, my years in public service and total emersion in the field recently convinced me that few Americans appreciate its complicity in just about every social problem we face, and even fewer believe we can do anything about it. The fact is we've never really tried creatively, sensibly, and aggressively to confront substance abuse and addiction. We can do it; the issue is whether we're willing to.

This book is my effort to inspire the will and show the way. We cannot create a Garden of Eden utterly free of drug and alcohol abuse, but we can save millions of lives, untold heartache, and billions of dollars by dramatically reducing the scourge. This book is a call to arms, a manifesto of actions we can take, a cry to fundamentally change the way we view and confront drug and alcohol abuse and addiction. With such a shift, we can improve the quality of life for our people and by example for others across the world. I'm calling for the same kind of defining change in attitude that we and—with our leadership—much of the world have experienced with respect to smoking and AIDS and indeed the environment. The sooner we change our attitude and accept responsibility to protect our children from drug and alcohol abuse, the sooner we will see in America where parents don't have to go to bed each night and fear that their teenage son or daughter will end up an alcohol or drug abuser or addict or a victim of reckless driving or sexual assault by some drunken friend.

In his monumental study of history, the brilliant historian, Arnold Toynbee, found that the great civilizations were destroyed not by an external enemy but from within.[67] "Civilizations," he wrote, "die from suicide, not by murder."[68] Of all the internal dangers our nation faces none poses a greater threat to our children and families and none is more complicit in domestic ills than substance abuse and addiction. This is our enemy within, and the judgment of history will be harsh if we fail to defeat that enemy, and deservedly so, when the stakes are our children and there is so much we can do to help them. Thank you.

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[67] *See id.* at 178.
[68] *Id.* at 178.

A GOVERNMENT INSIDER'S PERSPECTIVE ON THE WAR ON DRUGS MARCH 14, 2008 SPEECH

Scott Burns*

On behalf of the White House and on behalf of John Walters, the director of Drug Czar[1] of the United States, it's an honor to be here. It's been six years now that I've been at the White House, and looking at Scott Daniels, Scott Carver, Judge Boyden, Paul Boyden, and other friends, I'm reminded how I got there. I was sitting in my office as the Iron county attorney, and I was right in the middle of a really ugly sexual abuse case. I got a call and my secretary, Colleen—I think we had three lawyers and three secretaries in the office at the time in Cedar City—said, "It's the White House on the phone." I thought it was Jerry Woolmack, who was the detective that we were working on this case with, and we had been getting ready for days, marking exhibits. I thought he was being funny so I picked up the phone and said, "Jerry, you're such a ____," and I won't tell you what I said. The person hung up. So about an hour later, the Honorable Orrin G. Hatch called and said, "Scott, when the White House calls, you don't use a profanity and hang up on them."

I said, "Well, I get a lot of calls from the White House, Senator, but why would they be calling me?"

He said, "I put your name in to be the Deputy Director for State and Local Affairs at ONDCP."

I said, "Wow. I am honored. What is ONDCP? Is that part of HUD or—certainly not as big a deal as being the county attorney in Iron County, Cedar City, Utah?"

And he said, "No, it really is. Have you ever seen the movie *Traffic*?"

I said, "With Michael Douglas? Yeah. I get to be that guy?"

He said, "No, you don't get to be that guy, you get to be the guy's deputy." I said, "Well, is it as big a deal as being the Iron County attorney?"

He said, "You'd be in Washington. You'd be working at the White House. It's a huge deal. It's a much bigger deal."

I said, "Well, I'll think about it, but I'm not going to say 'yes' because like LMNO...ONDCP, okay whatever."

So I went through the process and a bunch of the boys—we meet for coffee everyday at 10:00—they'd be asking me, "Burns, is this a big deal?"

I said, "Orrin says it's a big deal—a bigger deal than county attorney. I get to go back to Washington—I've never been there. And they're going to have a Senate hearing and that's kind of a big deal." So I flew back and sure enough, there was the panel and they had CSPAN, and I thought, "Wow, this is a big deal." I found

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[1] Director of the Office of National Drug Control Policy.

out later that it was CSPAN 20 and it probably wasn't even plugged in, but I didn't know that. So we had the hearing and I remember my mouth was open, and there was Senator Kennedy and there was Senator Biden. I actually got to meet them and they asked me questions. I don't know how I did, but I answered them. I came home, and I couldn't wait to go to coffee that day to tell the boys what a big deal this was.

That morning, I remember I had three or four preliminary hearings and probably a speeding case, but I was in the shower at about 7:00 a.m., and my daughter Karlee, then ten, said, "Dad, you're wanted on the phone."

I said, "Honey, I'm in the shower. Take a message. Who is it?"

She said, "Hang on—It's *Time* magazine."

I said, "Tell them to wait. I'll be right there." *This is a big deal. This is a big deal.* I got out of the shower, grabbed a towel, and went over to the phone. In my best soon-to-be Michael Douglas's Deputy Drug Czar, probably going to have a Learjet, working at the White House, just had a Senate hearing, really big deal voice, I said, "This is Scott Burns."

And a woman said, "Scott Burns, for $19, you can have fifty-two weeks of *Time* magazine." So then I knew it wasn't a big deal—back to LMNOP.

It's been an honor to serve—coming down to the last ten months. I want to leave a considerable amount of time for questions, but I want to tell you something that I learned, having worked sixteen years at one foot off the ground, what it's like back in Washington D.C. at thirty or forty thousand feet. When we came into office, drug use was fairly high, and we had to make some fundamental decisions with respect to what would be the policy and how we would drive the numbers down. President George W. Bush was pretty serious about performance measures—they keep score back there—and he charged us with reducing drug abuse, especially among teens twelve to eighteen years old by 25 percent within the first five years. The strategy wasn't hard to figure out. We had to have prevention and education, and we had to have treatment and that included expanding treatment capacity. You had to have law enforcement, both domestically and internationally. The idea was to try and make those as balanced as possible.

One of the first issues that we faced, and I'm sure it came up in earlier panels, was: what are some of the things that we'll concentrate on? John Walters is a smart man; he's been around Washington for a long time. He worked as a deputy to Bill Bennett when he was the Drug Czar. He worked with him at the Secretary of Education and learned to go about things in a systematic way.

To put the challenge we were facing in perspective, there are about 300 million Americans living today. Of those, about 125 million use, and to some degree, abuse alcohol.[2] Approximately 50 million Americans still smoke, notwithstanding the education efforts and the media ads and stinky fingers and

[2] *See* Alcohol Abuse Statistics—Alcohol-Rehabs.org, Alcohol Abuse Information, http://www.alcohol-rehabs.org/alcohol-abuse.html (last visited Mar. 1, 2009).

breath and lung disease.[3] About 20 million abuse and illegally use drugs.[4] So that's the universe. What drugs? Of the 20 million, 75 percent marijuana.[5]

So we had to make a decision early on whether or not we were going to talk about and focus on marijuana. Of course we would talk about prescription drugs; of course we would talk about methamphetamines, cocaine, heroin, ecstasy, inhalants—all of the drugs abused that we know about that especially affect young people. But with sighs and rolled eyes and "oh my gosh, you don't get it. Marijuana? Why would you even talk about it?" We chose to address it. We did so primarily 1) because of the numbers and 2) because we believed and determined that it was a different drug than it used to be—so much so that it should be called marijuana 2.0. Those of you who have followed it know that the ditch weed of the '60s and '70s is 1 and 2 percent THC, the chemical in marijuana that gets someone high.[6] In my little town, I remember the rumors—somebody got a load of Maui Wowie or some other highly potent drug, and the THC content might be 3 or 4 percent. In the United States, the most recent studies we've got say it now averages 10 percent.[7] So it is ten times more powerful than the marijuana of twenty or thirty years ago. This is not Cheech and Chong dope—that's one.

Additionally, we determined that it used be a rite-of-passage drug. When people went off to school, went to college or law school, got their first job or joined the military, at 16, 17, 18, or 19—that's when Americans "experimented" or tried cannabis—marijuana. You cannot go into a treatment facility in this country and look a counselor in the eye and ask them, "The young people that you encounter come here suffering or dealing with an addiction to what?" And they will tell you 90 percent—I would almost say 100 percent—alcohol and marijuana. They don't wake up when they're twenty-five and slam meth or "you know I'd really like to try heroin." It all really starts with alcohol and marijuana. So we determined that we are going to talk about marijuana.

The second thing that we had to do is determine was what other commonly abused drugs we needed to concentrate on. And while I'm happy to tell you here today the good news—we just did a couple editorial boards—but for some reason when everything is in an epidemic or crisis, it's on the front page. But when there is good news, it's difficult to a) get people to believe it and b) print it or talk about it. There are great successes going on the United States right now. There are

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[3] *See* New York Times, Health Guide: Smoking and Smokeless Tobacco, June 19, 2008, http://health.nytimes.com/health/guides/specialtopic/smoking-and-smokelesstobacco/overview.html.

[4] *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, WHAT AMERICANS NEED TO KNOW ABOUT MARIJUANA: IMPORTANT FACTS ABOUT OUR NATION'S MOST MISUNDERSTOOD ILLEGAL DRUG 1, http://whitehousedrugpolicy.gov/publications/pdf/mj_rev.pdf (last visited Mar. 1, 2009).

[5] *See id.*

[6] *See id.* at 4.

[7] *See id.*

cocaine shortages in thirty-eight major cities of the United States.[8] There is a cocaine shortage and it has been going on for months and it is sustained. The prices are way up and some parts of the country have doubled per kilo and the purity is down.[9] There is a methamphetamine shortage in several areas and major cities of the United States.[10] The price is up and the purity is down.[11] I found out yesterday in Salt Lake City, we used to look at $650–700 an ounce for methamphetamine, the buys the police made within the last week were $1800 an ounce. So that's not 50 bucks or 100 bucks or 200 bucks an ounce, that is a sustained and dramatic increase in the price of that particular drug. The naysayers say it can't be anything that is policy driven or the good women and men in treatment, prevention, and law enforcement are doing; instead, they claim it's the euro. 'The euro is strong, the dollar is weak. All the dope from Mexico and Columbia is going to Europe.' That might be true, but if methamphetamine's price is up and purity is down and we know that meth is not the drug of choice or abuse in Europe yet, so there has to be something else happening.

We also decided we had to talk about heroin and ecstasy and all of the drugs of abuse. So how do we go about that? The prevention and education side of it had to be a media campaign. I'm disappointed to say that as much as we lean on Congress to increase the amount of funding—we got a $190 million media campaign and they are about the only antidrug ads you'll hear in America. There is no George Soros out there funding advertisements to dissuade young people to use drugs—it came from the government. We get a double match; we ran one ad in the Super Bowl for $100 million and 90 million viewers thought it was the best shot to reach Americans when parents and children co-view together. We get a $1 million free match for that ad and for every dollar that we spend in the media campaign. It has been cut now to $60 million.[12]

We also asked for an increase in treatment dollars. Again it's kind of frustrating. I was on the Hill a couple weeks ago testifying, there is this perception out there that this administration is heavy-handed on the supply side—helicopters to Columbia down into Mexico, dealing with the poppy in Afghanistan—when the reality is that every year at budget time, we ask for more and more money for prevention and education and treatment and fall short. We asked them to fully fund the media campaign; they didn't. The last couple of years, we asked for $40–50 million for drug courts. Drug courts work. We received I think one year it was $7 million, another year $9 million, so access to recovery is the precedence initiative to expand treatment in this country. Two or three years ago, we asked the question, "How many Americans wake up, look in the mirror, not forced by a court, not

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[8] *See* NAT'L DRUG INTELLIGENCE CTR., NATIONAL DRUG THREAT ASSESSMENT 2008, at 1–7 , (2007), *available at* http://www.usdoj.gov/ndic/pubs25/25921/25921p.pdf.

[9] *Id.* at 4.

[10] *See Id.* at 19–23.

[11] *Id.* at 22.

[12] *See* Bob Curley, Join Together, *Bush's 2009 Budget Cuts $198 Million from SAMHA*, Feb. 8. 2008, http://www.jointogether.org/news/features/2008/bushs-2009-budget-cuts-198.html.

under arrest, not having a warrant pending, and say 'I want treatment. I want help.'" We said, "In America, we should be able to take that person, that woman, that man, that young person, and provide them with treatment." We know of the 20 million illegal drug users in America, about 7 million suffer from the clinical definition of addiction; about 2 million are in treatment—so we have a 5 million treatment gap.[13] Part of the challenge we had is: how do you get the 5 million that meet the clinical definition of addiction into treatment? Some would say it takes a train wreck. They have to get arrested; they have to get into an accident; they have to encounter the criminal justice system because they don't believe that they have a problem.

We try to go about a number of ways of expanding capacity and funding treatment. Of the $200 million requested, we've received $100 million. I oversee a program called HIDTA—the High Intensity Drug Trafficking Area program and there are twenty-eight HIDTA offices across the country from Hawaii to Puerto Rico. There is one in Denver that has monies here in Salt Lake. I think you get about $2 million a year to bring law enforcement together. We asked for $198 million for that—that's on the supply side—and Congress gave us $230 million because they thought this law enforcement project would be more important. I always look them in the eye and say, "It is disingenuous to say that this administration doesn't care about prevention and education or treatment because those programs that we request more money are not funded and some of the supply side efforts that we don't ask for money are."

So we also try to reach those 5 million through a couple other innovative programs. We started a Screen and Breath intervention program and I'm proud to say that Brian Blake and I were in Vienna on Monday and Tuesday of this year at the International Drug Czar Conference. There are Drug Czars from all over. We introduced this program which I think was well received. How do we reach these people? We were able to get some of the medical coach change whereby physicians and healthcare providers will actually get paid for intervening and screening those people that come to them. Many times they know who is suffering from the disease of addiction whether it is cannabis or cocaine or methamphetamine or even alcohol abuse. So there is money now available to fund physicians and others to intervene when they encounter people in that setting. There are grants across the country and we're hoping to expand that program dramatically. It's a way of trying to reach people that are in need.

The other thing we have been talking about is student drug testing. Again, when they sent me out on this chore across the country, the groans went up and "violation of the Fourth Amendment," "now you're in our schools," "eleven year olds will be spread eagle on the floor with Doberman Pinschers and German

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[13] *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 4, at 1 (noting that 7.1 million people in the United States have an illegal drug dependence); Letter from Henry A. Waxman, Ranking Minority Member, U.S. Congress, to John P. Walters, Director of Office of National Drug Control Policy (Feb. 15, 2008), *available at* http://oversight.house.gov/documents/20080219093736.pdf.

Shepherds," "How dare this Bush Administration engage in another program like this?" The reality of it is and the genesis of promoting it came from a guy named Harry Connick. Harry Connick was the district attorney in New Orleans for over thirty years. He had seen generation after generation come through his office and prosecuted and dealt with family after family. And Harry Connick wanted to leave having done something better than having been a prosecutor. He believed that student drug testing was the answer, and he was promoting it for a couple of reasons. First and foremost, the debate about whether drug use is a sin or right or wrong. Those who espouse that—me included for many years—lost out to those that said it is a disease. These people suffer from the disease of addiction, and if we're going to look at it as a disease, which is a public health issue, Harry Connick said we should treat it as a disease. You don't catch the disease when you're thirty; you don't catch it when you're twenty. As we talked about earlier, you catch this disease when you're thirteen, twelve, or eleven, and you usually catch it in the school setting. The vector by which the disease spreads is from child to child. "Try it, you won't get in trouble. I have this drug. Come do it, it's fun. Nobody is going to know. Everybody does it." That is how the disease is spread. If we are going to treat it as a disease, then we need to find out those who have this disease. I don't know about you, but I have one child and when she went to school, I had to get a card and go around and she had to be tested for various drugs. They wouldn't let her go to kindergarten or first grade until she was tested for these things. So we have in an aggressive fashion gone across the country and I'm proud to say that it is increasing by leaps and bounds. Once school systems understand that it has to be anonymous, they cannot be punitive. If a child tests positive, unless the child or someone else discloses it—the family member, no one is to know and the idea is to get that young person into treatment. So that is another program that we have been pushing along with drug courts. As I said before, drug courts work. We have asked for an increase in funding for drug courts, and it looks better for this year.

The last thing I'll talk about is prevention and education back to the media campaign. It was interesting to me when they put this together, and we tried to get the best of the best of Madison Avenue and New York who donated their time to come in and tell us what we need to do to reach young people and deliver the appropriate message. Like I say, it was interesting; they do all these focus groups with these young people and with parents in trying to form these ads. This generation, these kids would tell us that the Baby Boomers, the people my age, really need to start acting like parents. "My dad embarrasses me, he turns his hat around backwards and picks me up at school and it's 'Yo, yo, yo, yo' he's trying to be cool in front of my friend. I don't want my mom to have a belly ring. My mom should not look like Britney Spears or have a tattoo on her ankle." It was interesting and that was in New York, Florida, Omaha, Calument Falls, Indian country, and Alaska. So that was one of the interesting things. These kids said "Make them act like parents." The other thing that we learned is that two things influence young people—and parents sometimes think they don't listen to them—that the most powerful motivator of young people were the parents and the second thing was their peers. I don't know if you saw them, but we did a whole bunch of

ads directed toward parents where "you need to know where their kids are, you need to be involved in their lives." We did a whole bunch of ads directed toward young people that had peer relationship messages and things, and we think they were fairly successful.

It's kind of a lead up to a couple of the ads that we're doing now, and I've talked about all the successes that we've had. Marijuana abuse among twelve to eighteen year olds is down 24 percent since 2001.[14] That's 860,000 fewer young people smoking marijuana in the United States.[15] Methamphetamine abuse is down 64 percent.[16] Cocaine is down; steroids are down; alcohol and tobacco are down.[17] This generation gets it when it comes to those drugs of abuse that the Baby Boomers used. Again, the interesting thing is if you saw *Little Miss Sunshine*, the girl is not using, but Allan Arkin, the Grandpa in the back, the Baby Boomers, continue to use.[18] Baby Boomers continue to use not only at rates they have historically, but increasing.[19] And now starting to plan for all kinds of issues dealing in geriatric care settings, what do we do when grandpa is eighty-two and jonesing? I mean, these are issues that are real because we haven't been able to reach that population.

Down, down, except in one category and that is prescription drug abuse.[20] I had a chance to meet with the governor and the Utah Attorney General Shurtleff and this great meth task force that has been formed here along the Wasatch Front and across Utah talking about the successes they've had in methamphetamine here in Utah. Two hundred seventy-two labs in 1999; down to three last year.[21] From 272 to 3 is phenomenal. Fewer drug endangered children; fewer issues in labs exploding and exposing law enforcement officers to toxic chemicals, but what is up is prescription drugs across the country. And Utah last year was number one per

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[14] *See* John P. Walters & Margaret Spellings, *Strategies for Success: New Pathways to Drug Abuse Prevention*, OFFICE OF NAT'L DRUG CONTROL POL'Y, Fall/Winter 2007, at 1, 3 *available at* http://www.randomstudentdrugtesting.org/newsletter/fall_winter_07/pdf/sfs_fallwinter07.pdf.

[15] *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, 2008 DRUG CONTROL STRATEGY 57 (2008), http://www.ncjrs.gov/pdffiles1/ondcp/221371.pdf.

[16] *See Study: Teen Drug Use Declining; Painkillers Still Popular*, CNN.COM, Dec. 11, 2007, http://www.stoprxdrugabuse.org/2007_Dec_11_Study_painkillers_still_popular.pdf [hereinafter CNN.COM].

[17] *See id.*

[18] *See Baby Boomers Continue Recreational Drug Use in Senior Years*, JOIN TOGETHER, June 3. 2008, http://www.jointogether.org/news/research/summaries/2008/baby-boomers-continue.html.

[19] *See id.*

[20] *See* CNN.com, *supra* note 16.

[21] *See* DEA Briefs & Background, Drugs and Drug Abuse, State Fact Sheets, Utah, Mar. 2008, http://www.justice.gov/dea/pubs/state_factsheets/utah.html.

capita.[22] I think from the most recent survey we've got with the exception of Oklahoma, Arkansas and I want to say Tennessee, Utah is in the top four.

So part of the media campaign that we recently launched is directed toward prescription drug abuse, especially among young people. I would not think it is any surprise to you, but part of the reason is they don't want to inject, they don't want to snort, they don't want to smoke, but if it comes in a pill, it comes from the medicine cabinet, it comes from the doctor, it can't be as dangerous as those other drugs; it's an easier fix than some of the other challenges we've had because we've learned that 60 to 70 percent come from the medicine cabinet at home and for free. We are the drug dealers. So we are now engaged in a campaign to educate Americans to purge their medicine cabinet, get rid of old, unwanted or unused drugs. If you have painkillers, Oxycontin, Vicoden or Lortab, Percocet, or drugs like Soma or Xanax, I promise you, your fourteen- or sixteen-year-old knows every one of them. They get on the internet and type in "I.D. this pill" and those that have a scanner and use them—my daughter showed me how to do it—can hold the pill up and it can tell you what it is. It will tell you that you can boost it if you drink two glasses of wine; or if you take this one, it will bring you down, and they go to parties and they trade them and buy them and sell them and it's becoming normalized. There's a great article in the *New Yorker*, and some people say New York leads the country when it comes to trends that come out. I want to say it came out five or six months ago, talking about what is going on in New York now. The article essentially said, "Your mother-in-law is coming over this weekend: Valium. Hard day at work: two Lortab. Just finished exams: two Vicodens and a martini." In social settings in New York, prescription drugs are traded back and forth as if somebody were ordering a cocktail or beer and some would say that is a trend to come. If that's true the burden is upon us to get out in front of that.

On the treatment side again, some of the prevention and education was an attempt to expand capacity to fund better than we can. We're never going to fund everything, but have more money available. Somebody said the other day, "When is the federal government going to do more?" And I used the example of New Mexico and it's probably a bad one, but you know it's true. They sent me down there to try and talk to Governor Richardson. In New Mexico, they receive an Access to Recovery Grant, which is about $22 million from the federal government over three years. New Mexico, they get drug free community grants which are between $100,000–$125,000 a year for communities to come together and discuss the drug issues in their city or town. They had eleven of them so that is eleven-plus million dollars a year. You get $2 million in Salt Lake City. In New Mexico, they get an excess of $8 million for their High Intensity Drug Trafficking Area program. New Mexico sought and obtained a Screen and Brief and Intervention grant, which was about $8 million. That was the federal government

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[22] *See Utah No. 1 in Prescription Drug Abuse*, DESERET MORNING NEWS, March 6, 2007, at B10 *available at* http://findarticles.com/p/articles/mi_qn4188/is_20070306/ai_n18722437.

side of it—there is more, like all the SAMHSA Block Grants that every state gets, but the only drug issue that the New Mexico legislature and the governor were dealing with was to legalize marijuana. From a federal perspective, to build a building to have medical marijuana available, to have the state of New Mexico to oversee and dispense cannabis—at some point there has to be a discussion with respect to melding and blending policies on the state level and local level and the federal level with respect to what is it that you want. Do you want treatment dollars? Do you want prevention money? Do you want law enforcement through the HIDTA and all those things? But in the same breath, you're saying what we really want to do is make more cannabis, more marijuana available in the state of New Mexico. So that debate is always on and it's on in every state.

The last thing with law enforcement, and I could talk about efforts against every category of drug—what are we doing about heroin, especially in the Northeast? What about cocaine along the border? What about methamphetamine? We have seen great strides as I said earlier with respect to methamphetamine, but it still flows into the United States and comes from Mexico. But I think it is a good example how policy follows the program, and I had the opportunity to see it. When I first got there, the super labs in Central Valley, California and along the coast were ubiquitous. Super labs produce ten pounds or more in a twenty-four hour cook, and some of those were twenty, thirty, forty, fifty, a hundred pounds in a twenty-four hour cook.

We found out that all the pseudoephedrine was coming from Canada. You'd go to the lab site or you'd go to the dump site and you'd find these French or Canadian pill bottles and/or if you hit the lab, thousands and hundreds of thousands of fedrine and pseudoephedrine pills. So we had a discussion with the Canadians. The Drug Czar of the United States went there, I went there, and others went there and we sat down with them. We found out Health Canada doesn't really track fedrine and pseudoephedrine. They know it's imported; they have no idea where it goes. We told them, "You're killing us. You're poisoning the United States. This methamphetamine is a bad thing." They weren't dealing with it; they're starting to now. We said, "it's a very bad thing in Utah and every other state in the United States—you need to help us out." And the RCMP and others did. They understood that it is an issue. We ramped up interdiction efforts along the border and pretty soon we cut down on their importation; we sealed off the psuedoephedrine coming in from Canada to the United States. And for a minute, drug labs went down, but then there was an indication—we saw almost a ton of psuedoephedrine going north to south. Why would we have pseudoephedrine going from the United States down into Mexico? That was kind of the canary in the mineshaft in knowing that that is where it moved. It was moving to Mexico.

The other thing that happened is we put pseudoephedrine behind the counter. The Federal government was slow, I'll admit, and Congress would not pass a law that would do that. Oklahoma started; they put it behind the counter and within months they had about an 80 percent reduction in meth labs. Iowa followed, then Arkansas, then Oregon, and then the Combat Meth Act passed. Labs have gone in the United States from 17,500 in 2004—this last year it will be under 4,000 and

closer to 3,000.[23] That is a dramatic decrease in cutting off the pseudoephedrine. But it's gone to Mexico and it continued to flow into Salt Lake City and other cities across the country.

So two years ago we sat down with the Mexicans. We went to the border and again, we went through the same educational process that we did with the Canadians. We showed them, "This is a lab." We showed them, "This is a person on meth and you've all seen the photos as they progress. It's all a horrible, horrible drug." We talked about how many licit tons they need to treat the colds and asthma of Mexicans—"Is it a 125 metric tons, is it 100?" Medina Mora, the attorney general and consultation with President Calderón finally said, "You know what, we'll use phenylephrine." As of January 1, 2008, Mexico no longer imports any ephedrine or psuedoephedrine products into their country. Period. And on January 1, 2009, it will be a federal crime for anyone to possess or have ephedrine or psuedoephedrine.[24] That is a remarkable step and gesture on behalf of that country and speaking of that, this President Calderón is the real deal. This guy is serious about taking his country back. We've heard that before, but actions speak louder than words. He sent 25,000 troops to Tijuana and disarmed corrupt cops.[25] He sent 25,000 federal troops to Juárez, and took guns away from corrupt cops there.[26] He is going after the cartels; he knows who the leaders are. They are hunting them down; they are extraditing more to the United States than they ever have. Ten years ago we got one or two if we were lucky. Last year, eighty-three were extradited to the United States.[27] And if they don't kill him and he's allowed to continue to do what he's doing—and I promise you, every day people wake up trying to figure out a way to take him out because he is serious about it—I think we'll continue to see much better cooperation and efforts in stemming the flow of drugs that come from Mexico and from South America and Colombia up into the United States.

You might be thinking, "Well big deal. So you cut it off in Mexico, then it will just go somewhere else." Well, it is a big deal if we're having shortages and price and purity success rates, and it is a big deal if we now know there are five countries that make pseudoephedrine and fedrine and there are only seven companies that make it. Somebody came up with a great idea and said, "Let's go visit them." So we flew to India and we flew to China and we went to Germany,

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[23] *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, 2008 DRUG CONTROL STRATEGY 42 (2008), http://www.ncjrs.gov/pdffiles1/ondcp/221371.pdf.

[24] *See* NAT'L DRUG INTELLIGENCE CTR., NATIONAL DRUG THREAT ASSESSMENT 20099–16 (2008), http://www.usdoj.gov/ndic/pubs31/31379/31379p.pdf (noting that use of ephedrine or psuedoephedrine is to be banned in Mexico by 2009).

[25] *See Police Disarmed in Mexican Town*, BBC NEWS, Dec. 29, 2007, http://news.bbc.co.uk/2/hi/americas/7163818.stm.

[26] *See Drug Gang Publishes Police Hit List*, NEWS.COM.AU, May 27, 2008, http://www.news.com.au/story/0,23599,23766007-23109,00.html (noting that President Calderon sent 25,000 troops to Juarez, Mexico, to quell the local drug war).

[27] *See* Stephanie Hansen, *Mexico's Drug War*, COUNCIL ON FOREIGN RELATIONS, Nov. 20, 2008, http://www.cfr.org/publication/13689/.

and we sat down with those companies. We went to the United Nations and obtained a resolution to track it, just like you would any other controlled substance. Africa, ironically is now one of the biggest importers and nobody knows why until somebody figured out it's because they're just sending it there now to stage it and then try and bring it in illicitly either into Mexico or the United States to make methamphetamine. But it is a big deal because if they move and we make the appropriate move to stop them and drug use continues to decline as it does now, then those are success rates.

I'm old enough and others are old enough to remember when cocaine was delivered to the United States. Cargo planes took off from Medellín or Bogotá and landed in the United States—would fly right into the United States and dump out kilos and hundreds of tons of cocaine in the United States. It doesn't happen anymore. Next, they came up through the border, what we're dealing with now, and we're making a difference. The federal Mexican army are the gatekeepers at the border. There would be something like five gatekeepers along the border and they took bribes to allow loads to come through. The Mexican army would get between $50,000 and $100,000 to step away from the road for an hour. You had one hour to bring the load through and then they come back. If you don't get it through within that hour, you get another $50,000 to $100,000 depending on the price of the gatekeeper. Those days are over with President Calderón. Up on the wiretaps and other sources of information, they're now saying, "We got to figure something else out" because it has become so hard to get past the Mexican army and now the American border and it is too difficult to get it by.

The newest trend is submersible submarines, which cost two to three million to make. We have Intelligence and we have the DEA, and had the pleasure of spending the last couple of days with them and they're on it. They'll discover these subs and "Should we take it out?" "No no, wait until they spend two or three million to have it made" and just before they start to bring the load, they will interdict the men. So we continue to have check and counter-check; we continue to use best efforts on the supply, and the law enforcement side. And whether anyone wants to believe it or not, from the National Household Survey, whether it is a Democratic administration or Republican, that has been our report card for the last twenty-five or thirty years; that's what we look at to determine rates of use. Again, with the exception of prescription drug abuse, every category is down among our young people, I'm proud to stand up and say that.

JUDD AND THE JURY: HOW THE UTAH SUPREME COURT DEALT A BLOW TO THE CONSTITUTIONAL RIGHT TO A JURY TRIAL BY ALLOWING A CAP ON PAIN AND SUFFERING DAMAGES

Adam Weinacker*

I. INTRODUCTION

Your health care provider has injured you. Hypothetically, the extent of your injury or who you are does not matter. It is of no import whether you lost vision, mobility, or brain function. The law cares not whether you are a newborn or a senior citizen. In fact, you could be a baby whose negligent delivery will affect the way your brain and body function for the rest of your life.[1] You could be a mother of three with severe brain damage, memory loss, and paralysis as a result of your negligently performed jawbone surgery.[2] It may be difficult to imagine, but you also could be left without a leg as a result of medical malpractice.[3]

In Utah, all that matters is whether a jury decides your pain and suffering is worth more than $400,000, plus a bit more for inflation.[4] That is the ceiling for noneconomic damages in Utah when it comes to medical malpractice. Why? Because the legislature has said so.[5] If a jury were to assess your damages for pain and suffering—or what the Utah Supreme Court has interestingly termed damages for the "diminished capacity for the enjoyment of life"[6]—at more than $400,000, your award would be reduced to meet the cap.

Such limits on noneconomic damages have taken hold across the country, with legislatures in almost every state attempting to rein in a perceived medical malpractice crisis through tort reform.[7] Damages caps have been called the

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[1] *See* Judd v. Drezga, 2004 UT 91, ¶ 2, 103 P.3d 135, 137.

[2] *See* Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 526–27 (Va. 1989).

[3] *See* Kevin J. Gfell, Note, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 775 (2004) (describing the effect of Maryland's cap on noneconomic damages on Gilford Tyler).

[4] *See* UTAH CODE ANN. § 78B-3-410(1)(b)–(c) (2008).

[5] *See id.* § 78B-3-402 (describing the legislative intent behind the limit on damages).

[6] *Judd*, 2004 UT 91, ¶ 4; *see also* Gordon L. Roberts & Sharrieff Shah, *What Is Left of* Berry v. Beech*—The Utah Open Courts Jurisprudence?*, 2005 UTAH L. REV. 677, 691 (calling the court's phrasing "a rather bland way of describing pain, suffering, permanent brain damage, and severe disability.").

[7] *See* Stephen K. Meyer, *The California Statutory Cap on Noneconomic Damages in Medical Malpractice Claims: Implications on the Right to a Trial by Jury*, 32 SANTA CLARA L. REV. 1197, 1198 (1992) ("The professional liability insurance crisis of the last two decades prompted all but one state to prescribe reform legislation aimed at remedying

"darling of tort reformers,"[8] and state legislatures have enacted caps despite questionable evidence that caps result in malpractice premium relief.[9] Despite the doubtful efficacy of caps, legislatures have enacted them with seemingly utilitarian motives: reduce the compensatory damages of a few seriously injured patients to the alleged financial benefit of society.[10] Consequently, damages limits have faced various state constitutional challenges from injured individuals, including attacks under equal protection, due process, separation of powers, and open courts provisions.[11] One of the more intriguing attacks, however, is that limitations on damages invade an injured person's right to a trial by jury. In Utah, the right to a trial by jury is "inviolate."[12] Despite this language, the Utah Supreme Court recently held that reducing a jury's damages award does not compromise the "inviolate" nature of the constitutionally guarded institution.[13]

The 2004 decision of *Judd v. Drezga* quickly cast aside the idea that a cap on noneconomic damages in malpractice cases may violate the right to a trial by jury.[14] In doing so, the majority subscribed to questionable persuasive authority.[15] The *Judd* majority provided no historical analysis of the jury's role or of Utah's own constitutional provision, and the court based its holding on imperfect

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the unmanageable insurance rates levied against health care services."); Robert S. Peck, *Violating the Inviolate: Caps on Damages and the Right to Trial by Jury*, 31 U. DAYTON L. REV. 307, 307–08 (2006) (describing the "irrationality" and "nonsensical approach to law" of the tort-reform movement); *see also* David M. Gold, *Trial by Jury and Statutory Caps on Punitive Damages: Lessons for Alabama from Ohio's Constitutional History*, 31 CUMB. L. REV. 287, 289 n.13 (2001) (focusing on punitive damages and caps imposed in many states).

[8] Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 515 (2005).

[9] *See* Ferdon *ex rel.* Petrucelli v. Wisconsin Patients Compensation Fund, 2005 WI 125, ¶¶ 118–66, 284 Wis. 2d 573, ¶¶ 118–66, 701 N.W:2d 440, ¶¶ 118–66 (concluding that caps on damages have little effect on lowering malpractice premiums and reducing health care costs for patients); *but see* U.S. GENERAL ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 41 (2003) ("A cap on noneconomic damages may decrease insurers' losses on claims by limiting the overall amount paid out by insurance companies, especially since noneconomic damages can be a substantial portion of losses on some claims.").

[10] *See* James L. "Larry" Wright & M. Matthew Williams, *Remember the Alamo: The Seventh Amendment of the United States Constitution, the Doctrine of Incorporation, and State Caps on Jury Awards*, 45 S. TEX. L. REV. 449, 538 (opining that statutory damages caps are based on utilitarianism).

[11] *See* Peck, *supra* note 7, at 311.

[12] UTAH CONST. art. I, § 10.

[13] Judd v. Drezga, 2004 UT 91, ¶ 35, 103 P.3d 135, 144–45.

[14] *Id.*

[15] *Id.* ¶ 34; *see also infra* Part IV.A–B (explaining why the Utah Supreme Court erred in relying on the *Etheridge v. Medical Center Hospital* opinion).

analogies when Utah case law would have provided a cleaner approach with a different outcome.[16] Had the *Judd* majority provided more analysis and been more faithful to the history of the jury trial in Utah and in the United States, it would not have tread upon a constitutional provision meant to protect against legislative encroachment and the desires of businesses such as health care providers.

Part II of this Note provides background of the Utah Health Care Malpractice Act and its intended effect of reducing malpractice premiums in Utah. This part provides a synopsis and analysis of *Judd v. Drezga*, the first Utah Supreme Court case to hold that caps on noneconomic damages do not violate Utah's right to a jury trial.

Part III of the Note offers a historical perspective of article I, section 10 of the Utah Constitution. During the adoption of the constitution, delegates zealously guarded the jury trial right, and aspects of the *Judd* decision stand for propositions that weaken the institution the delegates so venerated. In addition to the historical support of a strong jury right, Utah has consistently put the measure of damages within the dominion of the jury.

With these points in mind, Part IV analyzes the weaknesses of the *Judd* decision and its reliance on a questionable Virginia decision. An argument is made that the *Judd* majority relied on inapt comparisons and that the Virginia decision failed to recognize the importance of the jury right in its own state.

Part V juxtaposes *Judd* and its reliance on Virginia precedent with a more thoughtful approach from the Washington Supreme Court. Additionally, Part V argues that Chief Justice Durham's dissent in *Judd* was more faithful to the jury trial right in Utah and provided an approach that is more justifiable with the provision's historical context.

II. THE UTAH HEALTH CARE MALPRACTICE ACT AND *JUDD V. DREZGA*

In 1976, the Utah legislature enacted what is now known as the Utah Health Care Malpractice Act (the Act) in an effort to combat rising insurance premiums.[17] Citing a substantial increase in judgments and settlements in the health care arena, increased costs to patients and care providers, and the "possible unavailability of malpractice insurance" for some providers, legislators decided "to protect the public interest" by reining in malpractice damages awards.[18] A key component of achieving this legislative goal was the enactment of a cap on noneconomic damages—those for pain, suffering, and inconvenience—in malpractice actions (the Malpractice Cap).[19] Legislatures across the country have targeted

[16] *See infra* Part III.B.

[17] *See* UTAH CODE ANN. §§ 78B-3-401 to -422 (2008). For the 1976 version of the Act, *see* UTAH CODE ANN. §§ 78-14-1 to -17 (2004).

[18] *Id.* § 78B-3-402(1)–(2) (describing the legislative findings, declarations, and purpose of the Act).

[19] *See id.* § 78B-3-410. The Act also prohibits plaintiffs in malpractice actions from specifying dollar amounts for prayers for damages in their complaints. *Id.* § 78B-3-409.

noneconomic damages in the name of tort reform, likely because limiting economic damages would be politically unpopular and because noneconomic damages are more indefinite in nature.[20]

As it currently stands, the Malpractice Cap limits a plaintiff's recovery for noneconomic damages to $400,000 for causes of action arising after July 1, 2001.[21] Thus, if a jury awarded $1,000,000 for pain and suffering to a plaintiff injured within the past seven years, a court would reduce the award by sixty percent to comport with the Malpractice Cap.

The Utah Supreme Court upheld an even more drastic reduction in *Judd v. Drezga*.[22] There, Dr. Gregory Drezga's negligent delivery of Athan Montgomery resulted in Athan's severe brain damage.[23] In addition to $1,022,735.30 in economic damages for Athan's current and future medical expenses, the jury awarded Athan $1,250,000 in noneconomic damages for his "reduced life experiences and expectations."[24] The trial court then reduced Athan's noneconomic damages to the $250,000 allowable under the Malpractice Cap at that time.[25] On appeal to the Utah Supreme Court, Athan's mother, Heidi J. Judd, brought a spate of constitutional challenges,[26] one of which argued that the Malpractice Cap violated Athan's right to a jury trial under article I, section 10 of the Utah Constitution.[27]

The Utah Constitution's jury-trial provision states:

> In capital cases the right of trial by jury shall remain inviolate. . . . In other cases, the Legislature shall establish the number of jurors by statute, but in no event shall a jury consist of fewer than four persons. . . . A jury in civil cases shall be waived unless demanded.[28]

Although the term "inviolate" is linked to the right to a jury in capital cases, before *Judd* the Utah Supreme Court interpreted the provision to guarantee the

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[20] *See* Kelly & Mello, *supra* note 8, at 516–17.

[21] Causes of action arising before July 1, 2001, are subject to a $250,000 cap. UTAH CODE ANN. § 78B-3-410(1)(a). The Malpractice Cap also applies differing inflation formulae for injuries arising after July 1, 2001, depending on the exact date of injury. *Id.* § 78B-3-410(1)–(2).

[22] Judd v. Drezga, 2004 UT 91, ¶¶ 39–40, 103 P.2d 135, 145.

[23] *Id.* ¶ 2.

[24] *Id.*

[25] *Id.* ¶ 3. Athan's injuries occurred before July 1, 2001, and thus were subject to the $250,000 cap. *Id.*

[26] *See id.* ¶ 7 (listing challenges under the Utah Constitution's open courts, uniform operation of laws, due process, and separation of powers provisions).

[27] *Id.*

[28] UTAH CONST. art. I, § 10.

right to a jury in civil cases.[29] Delegates at the constitution's founding also had little doubt about the importance of the civil jury trial right.[30]

In its analysis of the Malpractice Cap's implications for article I, section 10, the *Judd* court held the cap constitutional.[31] In the court's first holding regarding statutory limits on a jury's assessment of damages,[32] the majority provided a mere four paragraphs of analysis as to why Athan's right to a jury trial remained intact, despite an eighty percent reduction in his award of noneconomic damages.[33]

The majority recognized two lines of "analytically simple and reasonable" case law with respect to damages caps and their effect on the right to a jury trial.[34] One line of reasoning, embodied in Washington's *Sofie v. Fibreboard Corp.*, posits that it is the province of the jury to make a factual assessment of a plaintiff's damages, and the legislature may not tamper with the result.[35] A second line of reasoning, illustrated in Virginia's *Etheridge v. Medical Center Hospital*, concludes that juries have no ultimate authority to award damages to a plaintiff.[36] The mere fact that the jury assesses damages is sufficient to satisfy the constitutional jury-trial right.[37]

Of the two lines of reasoning, the *Judd* majority chose the *Etheridge* viewpoint.[38] Although it found the reasoning in both cases to be "analytically simple and reasonable,"[39] the *Judd* majority provided little analysis as to why one was superior or was a particularly better fit for Utah. The court applied no historical analysis of the evolution of Utah's article I, section 10, or of the importance of the jury trial in American history. Additionally, it provided almost no discussion of why the *Sofie* court's reasoning was flawed or inapplicable in

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[29] *See* Int'l Harvester Credit Corp. v. Pioneer Tractor and Implement, Inc., 626 P.2d 418, 421 (Utah 1981) ("Today we squarely hold that the right of jury trial in civil cases is guaranteed by Article I, § 10 of the Utah Constitution."); *see also* Abdulkadir v. W. Pac. R.R. Co., 318 P.2d 339, 341 (Utah 1957) ("We are in accord with the idea that the right of trial by jury should be scrupulously safeguarded.").

[30] *See infra* notes 46–62 and accompanying text.

[31] *See Judd*, 2004 UT 91, ¶ 32.

[32] In *Condemarin v. Univ. Hosp.*, Justice Durham addressed the problems damages caps pose with respect to article I, section 10. 775 P.2d 348, 365–66 (Utah 1989). Although Justice Durham argued that an "absurdly low" cap on damages infringed "egregiously" on the right to a jury trial, no majority holding was made on that point. *Id.*

[33] *See Judd*, 2004 UT 91, ¶¶ 32–35.

[34] *See id.* ¶ 33.

[35] *See id.*; Sofie v. Fibreboard Corp., 771 P.2d 711, 719 (Wash. 1989) ("[T]he Legislature cannot intrude into the jury's fact-finding function in civil actions, including the determination of the amount of damages.").

[36] *See Judd*, 2004 UT 91, ¶ 33; Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 529 (Va. 1989) (stating a party "has no right to have a jury dictate through an award the legal consequences of its assessment").

[37] *See Judd*, 2004 UT 91, ¶ 35.

[38] *Id.* ¶ 33.

[39] *Id.*

Utah. From the opinion, it appears the *Etheridge* opinion is correct merely because it is.[40]

Chief Justice Durham highlighted many of the flaws in the majority's analysis in her vigorous dissent.[41] After detailing the importance of the right to trial by jury,[42] Durham noted, "[o]f what use is such a right if the legislature has the power to nullify the jury's function by imposing arbitrary limits on the jury's impact on the result of a case?"[43] The *Judd* majority had no adequate answer for this. Chief Justice Durham's dissent incorporated the analysis the majority failed to supply, and her reasoning was more faithful to the history of the jury trial in the state of Utah.[44]

III. HOW THE *JUDD* COURT WENT ASTRAY

A. The History of Article I, Section 10

In holding that the Malpractice Cap does not violate the constitutional guarantee to a jury trial, the *Judd* majority did not delve into the history of article I, section 10.[45] If it had, it would have discovered that delegates at the state constitutional convention held the jury right in high esteem. The original text of the proposed right to a jury trial read:

> The right of trial by jury shall remain inviolate, but the Legislature may provide for a jury of any number less than twelve, in courts not of record, and for a verdict by nine or more jurors on civil cases in any court of record and for waiving the jury in civil cases where the consent of the parties interested is given thereto in open court.[46]

It should be noted that the original provision did not specify the right to a jury in capital cases as being inviolate, but instead referenced the broad "trial by jury." The eventual adoption of the language stating that the right to a jury in capital cases is inviolate does not reflect the idea that the legislature can erode the civil

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[40] *Id.* ¶ 34 (stating that the *Etheridge* case was correct, but citing *Etheridge* for that proposition). The *Judd* majority did, however, attempt to link the case to Utah precedent, but that attempt also was problematic. *See infra* notes 74–78 and accompanying text.

[41] *See id.* ¶¶ 50–59.

[42] *See id.* ¶ 50 (quoting the U.S. Supreme Court's observation that the right of a civil jury trial is "a safeguard too precious to be left to the whim of the sovereign, or, it might be added, to the judiciary" in Parklane Hosiery Co., Inc. v. Shore, 439 U.S. 322, 343 (1979)).

[43] *Id.* ¶ 51.

[44] *See infra* Part V.B.

[45] *See Judd*, 2004 UT 91, ¶ 32–35.

[46] *See* 1 OFFICIAL REPORT OF THE PROCEEDINGS AND DEBATES OF THE CONVENTION ASSEMBLED AT SALT LAKE CITY ON THE FOURTH DAY OF MARCH, 1895, TO ADOPT A CONSTITUTION FOR THE STATE OF UTAH 258 (1898) [hereinafter PROCEEDINGS].

jury. It instead reflects the delegates' concern with protecting the twelve-person jury system for capital cases.[47]

Indeed, adoption of the article generated substantial debate among delegates as to the appropriate number of jurors needed in criminal and civil arenas, and whether allowing for fewer than the traditional dozen jurors would save the state money.[48] Outside of that limitation, however, there was almost no debate questioning the importance of juries to the legal system, in both their civil and criminal capacities.[49] One statement during the proceedings expressed what seemed to be the overwhelming sentiment of delegates with respect to juries:

> I do not believe that the jury system is a work of barbarism in any sense. I believe it has been a part of the bulwark of human liberty from the days in which our English forefathers battled for human rights down to the present time.
>
> It is the only branch of the judicial system which is in touch with the people. . . . It is the jury drawn from the body of the people, who, in times past, have stood out against the aggressiveness of courts and executive, in the defense of liberty, and for the protection of human rights.[50]

Among other characterizations, delegates described the jury institution as being as venerated as "a broken-down old wall covered with ivy,"[51] as one of the "last holds"[52] the people have against government oppression, and as a protection from the "tentacles" of corporations ready to "suck the life-blood of the citizen."[53] Of course, these concerns—especially the last one—have direct application to the legislature's attempt to protect the health care industry at the expense of injured patients. The delegates' comments reflect what has been a long history of veneration for the jury system.[54]

The *Judd* majority opined that article I, section 10 "identifies only the right to jury trial in capital cases as 'inviolate,' and gives the legislature some authority to regulate other jury trials, *at least* as to the number of jurors."[55] This statement, while true on its face, dangerously flirts with the proposition that there is wiggle room in section 10 beyond limiting the number of jurors in civil trials. The court's

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[47] *See infra* notes 58–62 and accompanying text.

[48] *See* PROCEEDINGS, *supra* note 46, at 258–62, 274–96, 492–95.

[49] *Id.*

[50] *Id.* at 260 (providing a statement by Delegate Varian on March 21, 1895).

[51] *Id.* at 262 (Delegate Goodwin).

[52] *Id.* at 281 (Delegate Varian).

[53] *Id.* 287 (Delegate Evans).

[54] *See* Wright & Williams, *supra* note 10, at 497 ("History plainly shows that the civil jury trial was long guaranteed under English law and was even more jealously defended by the colonies.").

[55] Judd v. Drezga, 2004 UT 91, ¶ 32 n.3, 103 P.3d 135, 144 n.3 (emphasis added).

use of the phrase "at least" implies that the language of the provision may allow for further legislative encroachments on and regulation of the jury system. In that respect, it devalues the constitutional framers' discussion of the provision[56] and shows little allegiance to prior case law interpreting it.[57]

It is clear from the debates that "inviolate" was attached to capital-case juries to emphasize that those juries ought to consist of twelve jurors, not that civil juries should be subject to more regulation than a reduction in jurors. At one point, a delegate commented, "The right of trial by jury shall remain inviolate; we all agree upon that part, but in civil actions the jury shall consist of nine in district courts."[58] At the adoption of the jury-trial provision, delegates understood juries to consist of twelve men and require a unanimous verdict.[59] Thus, the jury right was to remain "inviolate,"[60] but the Legislature was granted the narrow ability to restrict the number of jurors in civil trials. One exchange between delegates at the 1895 convention casts light upon the issue:

> Mr. CREER. Why, Mr. Evans, do you suggest striking out the first part, "the right of trial by jury shall remain inviolate?"
>
> Mr. EVANS (Weber). The only reason for that is this, that when we say the right of trial by jury shall remain inviolate, *that means a jury of twelve men with a unanimous verdict.* That has a well understood, definite, common-law meaning.
>
> Mr. CREER. I would not have that, it seems to me—
>
> Mr. EVANS (Weber). *Except where the exceptions are expressed.*
>
> Mr. CREER. They are expressed here. That is why I prefer having this in, to secure that right. It shall remain inviolate.
>
> Mr. EVANS (Weber). As long as this method or this form of jury is in the bill of rights, *it does remain inviolate; it is in the Constitution and cannot be changed without changing the Constitution.*[61]

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[56] *See* PROCEEDINGS, *supra* note 46, at 258–62, 274–96, 492–95 (demonstrating substantial debate surrounding the adoption of article I, section 10, but almost exclusively regarding the appropriate number of jurors).

[57] *See* Int'l Harvester Credit Corp. v. Pioneer Tractor and Implement, Inc., 626 P.2d 418, 421 (Utah 1981) (holding that "the right of jury trial in civil cases is guaranteed by Article I, § 10 of the Utah Constitution").

[58] PROCEEDINGS, *supra* note 46, at 290 (quoting a statement by Delegate Eichnor).

[59] *See id.* at 494 (putting the term "inviolate" into context); *see also Int'l Harvester Credit Corp.*, 626 P.2d at 420 ("The word 'inviolate' as used in the first sentence was intended to provide for the continued use of the common law jury composed of twelve persons who could convict only by unanimous verdict.").

[60] In attempting to define "inviolate," the Washington Supreme Court has noted that "*Webster's* defines 'inviolate' as 'free from change or blemish: PURE, UNBROKEN . . . free from assault or trespass: UNTOUCHED, INTACT.'" State v. Smith, 75 P.3d 934, 940 (Wash. 2003) (quoting WEBSTER'S THIRD INTERNATIONAL DICTIONARY 1190 (1993)).

[61] PROCEEDINGS, *supra* note 46, at 494 (emphasis added).

Thus, the inclusion of "inviolate" in reference to criminal juries emphasizes the protection of the twelve-person, unanimous, common-law system, but as Delegate Evans pointed out, the mere inclusion of the jury-trial right in the Utah Constitution is enough to secure it.[62] The inclusion of "inviolate" is for clarity, but its placement should not reflect poorly upon the civil jury. The Utah Supreme Court recognized this in 1981, noting the "virtually unanimous intention on the part of the framers of the Constitution to preserve a constitutional right to trial by jury in civil cases and in noncapital criminal cases" and delegates' "repeated reference to the intention to insure the underlying right of trial by jury."[63]

The *Judd* majority's language can be read to imply that the use of "inviolate" in article I, section 10 may leave civil juries open to regulation beyond the number of jurors. This implication overlooks the history of the provision. The statement was also unnecessary commentary with respect to the court's established jurisprudence that article I, section 10 guarantees a right to a jury in civil trials. After all, the court must not "give a strained meaning to the terms of our Constitution which would result in dispensing with an institution that has the sanction of the centuries."[64] It is an institution to which the people cling, and "they have an affection for it; they feel that as this government is constructed and as the pressure is growing stronger and stronger every day against them and their acts, and this one of the last holds that they have [sic], it is upon the jury that they rely, not upon the court."[65]

B. In Utah, the Jury Has Dominion over Determining Damages

It is well-established in U.S. jurisprudence that juries, as finders of fact, are charged with making a factual assessment of a party's damages.[66] This role of the jury is deeply ingrained in Utah, as well. The Utah Supreme Court has held consistently that "under our constitution the amount of the verdict is a matter *entirely within the province of the trial court and jury*, the same being a question

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[62] *See* Hyatt v. Hill, 714 P.2d 299, 302 (Utah 1986) (Howe, J., concurring in the result) ("The intent of framers was that in capital cases, the jury should continue to consist of twelve jurors and the verdict had to be unanimous. As to non-capital cases, the right to trial by jury was assured without such restrictive language.").

[63] *Int'l Harvester Credit Corp.*, 626 P.2d at 419.

[64] *Id.* at 420.

[65] PROCEEDINGS, *supra* note 46, at 281 (comment by Delegate Varian).

[66] *See* Dimick v. Schiedt, 293 U.S. 474, 486 (1935) (noting that juries as fact-finding bodies occupy a "firm . . . place in our history and jurisprudence" and that parties are entitled to a jury's assessment of damages under the Seventh Amendment of the U.S. Constitution); *see also* Peck, *supra* note 7, at 320–27 (discussing the overwhelming history of juries as assessors of damages).

of fact."[67] Since before Utah's statehood and well after, juries have held a position as the final arbiters of damages.[68] In 1952, the Utah Supreme Court commented on its faithful protection of the jury's right to make findings of fact:

> Both our constitutional and statutory provisions assure trial by jury to citizens of this state.
>
> Courts, as final arbiters of law, could arrogate to themselves arbitrary and dangerous powers by presuming to determine questions of fact *which litigants have a right to have passed upon by juries*. Part of the merit of the jury system is its *safeguarding against such arbitrary power in the courts*. . . . The court does have a duty and a responsibility of supervisory control over the action of juries which is just as essential to the proper administration of justice as the function of the jury itself. Nevertheless, we remain cognizant of the vital importance of the privilege of trial by jury in our system of justice and *deem it our duty to zealously protect and preserve it*.[69]

This language is strong, and supplies contrary argument to the *Judd* majority's holding that the Legislature may cap damages, limiting a jury's finding of fact. Indeed, the *Judd* court could not overlook Utah's consistent adherence to the jury as finder of fact and assessor of damages. The majority recognized "that damages are a question of fact, and that questions of fact are distinctly within the jury's province."[70] The court's reasoning as to why the Malpractice Cap does not infringe on the jury's province, however, was problematic.

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[67] Palmquist v. Mine & Smelter Supply Co., 70 P. 994, 995 (Utah 1902) (emphasis added).

[68] *See, e.g.*, Biswell v. Duncan, 742 P.2d 80, 86 (Utah Ct. App. 1987) ("Case law overwhelmingly concludes that whether punitive damages are awarded is generally a question of fact within the sound discretion and province of the jury."); Harrison v. Denver & R.G.W. Ry. Co., 27 P. 728, 729 (Utah 1891) (stating it is the jury's province to assess damages and determine whether they are awarded); Daniels v. Union Pac. Ry. Co., 23 P. 762, 762–63 (Utah 1890) (stating that in tort cases, "[i]t is peculiarly the province of the jury to estimate the damages").

[69] Stickle v. Union Pac. R. Co., 251 P.2d 867, 871 (Utah 1952) (emphasis added).

[70] Judd v. Drezga, 2004 UT 91, ¶ 34, 103 P.3d 135, 144 (citing Ricks v. Budge, 64 P.2d 208, 213 (Utah 1937)).

IV. *JUDD* AND *ETHERIDGE*: STRANGE BEDFELLOWS

A. Problems with Judd

In finding that the Malpractice Cap did not infringe on the right to a jury trial, the *Judd* majority relied on analysis in *Etheridge v. Medical Center Hospital*.[71] First, the court came close to begging the question by asserting that the *Etheridge* court's reasoning was best because it was correct.[72] Further, the court attempted to tie the *Etheridge* holding—that a court may apply law to limit damages after a jury's verdict—to a Utah case that applied in only the loosest sense to the issue at hand.[73] In support of the Malpractice Cap and a judge's ability to apply law to a jury's factual findings, the court cited language in *Ricks v. Budge* stating, "While the law cannot . . . determine with absolute certainty what damages, if any, plaintiff may be entitled to, still those are questions which a jury *under proper instructions from the court* must determine."[74]

One problem with citing *Ricks* this way is that the ellipses leave out the important phrase "measure with exactness such suffering."[75] Including this phrase acknowledges that laws such as the Malpractice Cap are incapable of measuring pain and suffering in any nonarbitrary fashion. One could argue that this is why the right to a jury trial is constitutionally protected—to provide case-by-case damages determinations in the name of fairness.

More importantly, it is unclear how a jury's consideration of "proper instructions from the court" equates to a judge's postverdict application of a damages-limiting statute. First, the imposition of instructions and the limitation of damages differ temporally—one happens before the verdict, and one happens after. Second, the two differ substantively. Instructions serve as a legal framework under which a jury may apply its findings.[76] Instructions have a bearing on whether a jury will be legally capable of finding a party liable,[77] but they do not disregard a jury's factual findings as a damages cap does. In fact, jurors are never informed of the

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[71] *See id.* ¶ 33–34 (citing Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 529 (Va. 1989)).

[72] *See id.* ¶ 34 (indicating that *Etheridge* was correct (citing *Etheridge*, 376 S.E.2d at 529)).

[73] *See id.*

[74] *See id.*

[75] *Ricks*, 64 P.2d at 213.

[76] *See* Don Musser, *Instructing the Jury—Pattern Instructions*, *in* 6 AM. JUR. TRIALS: PRACTICE STRATEGY CONTROLS 928 (Roy Miller et al., eds., 1967) ("Those who believe in the preservation of trial by jury are endeavoring to enhance its efficiency and effectiveness by improving the methods of informing laymen of the law applicable to the facts of the cases they are sworn to decide.").

[77] *See* 75A AM. JUR. 2D *Trial* § 920 (2007) ("The fundamental function of jury instructions is to set forth what the jury must believe from the evidence in order to return a verdict in favor of the party bearing the burden of proof.").

Malpractice Cap through instructions, so they are unaware of its effect on their finding of noneconomic damages.[78]

Instead of drawing such an analogy, the *Judd* majority could have easily looked to the state's established jurisprudence recognizing the jury as having dominion over damages. In discussing remittitur, the court recognized this constitutional protection explicitly in 1914, stating:

> Both parties . . . are *entitled to the unprejudiced judgment of the jury.* That is *exclusively within their province.* Their power and discretion, when properly exercised and when they have been properly directed as to the measure of damages and the mode of assessing it, *may not be interfered with merely because the court above or below may think the amount rendered is too large*, or even may think it appears to be larger than the evidence apparently or fairly justifies. A court, vacating a verdict and granting a new trial by merely setting up his opinion or judgment against that of the jury, but usurps judicial power and *prostitutes the constitutional trial by jury.*[79]

In Utah, the determination of damages is exclusively within the province of the jury. Even in the case of remittitur, a judge may not disturb a jury's damages calculation unless a test is met.[80] In that case, the reduction in damages is in response to a jury's abuse of the process and the damages award's trampling of a party's rights.[81]

It may be said that remittitur provides an argument in favor of the Malpractice Cap, demonstrating that a jury's award may be disrupted.[82] Indeed, a judge's

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[78] No part of the statute states a jury cannot be told of the cap. *See* UTAH CODE ANN. §§ 78B-3-401 to -422 (2008). However, nothing in the *Judd* opinion indicates jurors were told their noneconomic damages award would be limited. *See Judd*, 2004 UT 91, ¶¶ 3–7; *see also* Michael S. Kang, *Don't Tell Juries About Statutory Damage Caps: The Merits of Nondisclosure*, 66 U. CHI. L. REV. 469, 469 (1999) ("[S]ome statutes that provide for caps also prohibit notifying the jury about the existence of these caps.").

[79] Jensen v. Denver & R.G.R. Co., 138 P. 1185, 1192 (Utah 1914) (emphasis added); *see also* Mel Hardman Prods., Inc. v. Robinson, 604 P.2d 913, 918 (Utah 1979) ("When the matter of damages is in dispute, it is an issue upon which the parties are entitled to a jury trial, the same as on other disputed issues of fact.").

[80] *See* Stamp v. Union Pac. R.R. Co., 303 P.2d 279, 282 (Utah 1956) (reducing damages where the "award made by the jury has no basis in fact" and "is so excessive as to be shocking to one's conscience and to clearly indicate passion or prejudice").

[81] *See id.* (holding that the jury's award was "without all reasonable bounds for the detailed injury").

[82] *See* Kelly & Mello, *supra* note 8, at 521 (noting that some courts justify damages caps as a form of remittitur).

ability to reduce damages dates far back in Utah.[83] Of course, the reduction of damages in cases of remittitur rests on the jury's lack of evidence to support its factual finding, and a prevailing party is given the option of a new trial.[84] In this respect, it differs greatly from damages limitations such as the Malpractice Cap. Additionally, judicial remittitur does not violate the right to a jury trial because it belongs to the judicial branch, allows for case-specific review based on sufficiency of evidence, is tightly controlled, and it strongly favors jury verdicts.[85] Some courts have noted that remittitur would not pass constitutional muster if plaintiffs were not given the option of a new trial.[86] As previously stated, it must not be used to prostitute the constitutional jury-trial right, a danger which the Malpractice Cap, as a broad, inflexible measure, vividly presents.

Along with remittitur, some have used a judge's ability to award double or treble damages to undergird the constitutionality of reducing a jury's assessment of damages.[87] While this seems a convincing argument, it overlooks various differences between a damages cap and treble damages. For one, a damages cap provides an arbitrary noneconomic damages award that applies irrespective of a jury's factual finding.[88] Treble damages consider the jury's factual assessment and multiply damages based on that finding.[89] Additionally, treble damages are primarily punitive in nature and are provided for by statute when the legislature creates causes of action.[90] Providing for treble damages in a statutorily created cause of action is distinct from reducing damages for a cause of action recognized at common law when the right to a jury trial was constitutionally established.[91] Additionally, one must consider Utah's constitutional protection of an injured person's ability to obtain a remedy, as discussed below.[92]

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[83] *See* Kennedy v. Oregon Short-Line R. Co., 54 P. 988, 989 (Utah 1898) (upholding trial court's finding that a jury award was excessive and should be reduced if plaintiffs did not agree to a new trial).

[84] *See id.*

[85] *See Judd*, 2004 UT 91, ¶ 58 (Durham, C.J., dissenting).

[86] *See, e.g.*, Chester Park Co. v. Schulte, 166 N.E. 186, 190 (Ohio 1929) (stating that "reduction under such circumstances invades the province of the jury").

[87] *See* Arbino v. Johnson & Johnson, 880 N.E.2d 420, 431–32 (Ohio 2007) (arguing that if treble damages are constitutional, decreasing a jury's award using a legislative cap cannot be unconstitutional).

[88] *See* Phillips v. Mirac, Inc., 685 N.W.2d 174, 196–97 (Mich. 2004) (Cavanagh, J., dissenting).

[89] *Id.*

[90] *See Arbino*, 880 N.E.2d at 450 (O'Donnell, J., dissenting).

[91] *See* Sofie v. Fibreboard Corp., 771 P.2d 711, 721 n.6 (Wash. 1989) (noting that the jury trial right is far more guarded in common law actions).

[92] *See infra* notes 111–115 and accompanying text.

B. Why Etheridge *Was a Poor Choice for Utah and Virginia*

The *Judd* court's holding that the Malpractice Cap does not violate article I, section 10 was based substantially on the statement in *Etheridge* that "although a party has the right to have a jury assess his damages, he has no right to have a jury dictate through an award the legal consequences of its assessment."[93] Like the *Judd* court, the *Etheridge* court supplied little historical context for its holding supporting a $750,000 cap on noneconomic damages, [94] and its analysis was also flawed in many ways.

Article I, section 11 of the Virginia Constitution states, in part: "That in controversies respecting property, and in suits between man and man, trial by jury is preferable to any other, and ought to be held sacred."[95] It should be noted that the language of Virginia's provision differs from Utah's article I, section 10. The Alabama Supreme Court, in criticizing *Etheridge*, noted that Alabama's jury-trial provision is "materially distinguishable" from Virginia's.[96] Much like Utah, Alabama guarantees "[t]hat the right of trial by jury shall remain *inviolate*."[97] Thus, under the Alabama court's analysis, Utah's provision also would be materially distinguishable from Virginia's. The *Judd* majority made no effort to determine whether the two state provisions were different in any meaningful way.

In elucidating what Virginia's provision means with respect to a damages cap, the *Etheridge* court attempted to draw a distinction between the role of the jury and the role of the court.[98] The jury's role is confined to resolving disputed facts, the court stated, and this role is best illustrated by the "case stated" responsibility of the jury at the time of the state constitution's adoption.[99] "The 'case stated' was a trial device employed to bypass the jury when only undisputed facts remained in a case."[100] This analysis supports the argument that judges apply the law.

The *Etheridge* court reasoned, however, that because juries are finders of fact, and because a trial court applies the law, the sequence of events in applying a damages cap satisfies the right to a jury trial.[101] Aside from this chronology

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[93] Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 529 (Va. 1989).

[94] *See id.* at 528–29.

[95] VA. CONST. art. I, § 11.

[96] *See* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156, 163 (Ala. 1991).

[97] ALA. CONST. art. I, § 11 (emphasis added).

[98] *See Etheridge*, 376 S.E.2d at 528–29.

[99] *Id.* at 529.

[100] *Id.*; *see also* BLACK'S LAW DICTIONARY 229 (8th ed. 2004) (defining "case stated" as "[a] formal written statement of the facts in a case, submitted to the court jointly by the parties so that a decision may be rendered without trial"). Both definitions seem comparable to the present-day summary judgment motion, but with both parties agreeing to the facts at issue.

[101] *See Etheridge*, 376 S.E.2d at 529. At least one commentator has referred to this idea as the "splitting theory." *See* Matthew W. Light, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 WASH. & LEE L. REV. 315, 332 n.108

argument, the *Etheridge* court did not indicate why it was permissible for the court to encroach on the jury's findings. Furthermore, its "case stated" comparison is not on point. In a case stated, "all questions of pleadings and forms of procedure are waived."[102] The case is presented to the judge because facts are no longer in dispute, and the jury's role is unnecessary.[103] While the case stated indicates judges are arbiters of the law, it is unclear how this supports the contention that a legislature-created "matter of law" allows for a jury's damages findings to be curtailed when the right to a jury trial is constitutionally protected. A case stated further complies with a plaintiff's right to waive a trial by jury.[104]

An additional problem with respect to Utah jurisprudence is that, in wrapping up its reasoning, the *Etheridge* court stated, "Significantly, the common law never recognized a right to a full recovery in tort."[105] This point relies on the judicial assessment in Virginia and by the U.S. Supreme Court that law-making bodies may abolish rights and that "[a] person has no property, no vested interest, in any rule of the common law."[106] Of course, here the rule of common law would be a person's ability to seek a remedy in tort. Some have viewed the statement as pure dicta and questionable with respect to the jury-trial right,[107] but it helps express an argument that is frequently leveled in support of damages caps: Legislatures may abolish or limit common law causes of action, so they must be able to limit the amount of damages available in medical malpractice cases.[108] What the *Etheridge* court did not state, however, is that many state constitutions protect a plaintiff's right to seek a remedy for injuries and restrict legislatures' ability to abolish remedies and causes of action.[109]

(2001) (citing *Etheridge* as adopting "splitting theory," which postulates that juries may assess damages, but judges must apply the law and cap damages if required by law).

[102] 89 C.J.S. *Trial* § 1022 (2008).

[103] *Etheridge*, 376 S.E.2d at 529.

[104] *See* UTAH CONST. art. I, § 10 ("A jury in civil cases shall be waived unless demanded.").

[105] *Etheridge*, 376 S.E.2d at 529 (citation omitted).

[106] Duke Power Co. v. Carolina Envtl. Study Group, Inc., 438 U.S. 59, 89 (1978) (citation omitted).

[107] *See* Wright & Williams, *supra* note 10, at 527–28 (arguing that *Duke Power Co.* did not address the right to a jury trial and also hinged on Congress's substitution of a reasonable remedy for victims of a nuclear accident).

[108] *See, e.g.*, Franklin v. Mazda Motor Corp., 704 F. Supp. 1325, 1331 (D. Md. 1989) ("The power of the legislature to define, augment, or even abolish complete causes of action must necessarily include the power to define by statute what damages may be recovered by a litigant with a particular cause of action."); Phillips v. Mirac, Inc., 651 N.W.2d 437, 442 (Mich. Ct. App. 2002) ("Where the Legislature can abolish a cause of action, it necessarily follows that it can limit the damages recoverable for the cause of action."); *but see* Wright & Williams, *supra* note 10, at 528 ("The proposition that a legislature may abolish a cause of action entirely is certainly not at all a settled rule . . . .").

[109] *See* Mondou v. New York, N.H. & H.R. Co., 223 U.S. 1, 50 (1912) ("Rights of property which have been created by the common law cannot be taken away without due

The Utah Constitution contains such a provision. Under article I, section 11—the open courts clause—"[a]ll courts shall be open, and every person, for an injury done to him in his person, property or reputation, shall have remedy by due course of law, which shall be administered without denial or unnecessary delay."[110] The Utah Supreme Court has recognized this provision as not merely procedural, but as imposing a "'*substantive* limitation on the legislature to abolish judicial remedies in a capricious fashion.'"[111] "In other words, the open courts clause provides more than procedural protections; it also secures substantive rights, thereby restricting the legislature's ability to abrogate remedies provided by law."[112] While the Utah Supreme Court has recognized that the right to a remedy in tort is not a vested right, it has stated that article I, section 11 affords protections to injured people.[113] Additionally, the court has stated:

> Necessarily, the Legislature has great latitude in defining, changing, and modernizing the law, and in doing so may create new rules of law and abrogate old ones. Nevertheless, the basic purpose of Article I, section 11 is to *impose some limitation on that power for the benefit of those persons who are injured in their persons, property, or reputations* since they are generally isolated in society, belong to no identifiable group, and rarely are able to rally the political process to their aid.[114]

Neither the Virginia Constitution nor the Washington Constitution contains a clause similar to Utah's open courts provision.[115] It is thus significant that the *Judd* majority did not call into question or clarify the *Etheridge* analysis on this point when Utahans have a constitutionally protected right to a remedy.[116] Clearly, the

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process; but the law itself, as a rule of conduct, may be changed at the will . . . of the legislature, unless prevented by constitutional limitations." (citations omitted)).

[110] UTAH CONST. art. I, § 11.

[111] Laney v. Fairview City, 2002 UT 79, ¶ 30, 57 P.3d 1007, 1016 (quoting Craftsman Builder's Supply v. Butler Mfg., 1999 UT 18, ¶ 36, 974 P.2d 1194, 1204).

[112] Tindley v. Salt Lake City School Dist., 2005 UT 30, ¶ 13, 116 P.3d 295, 299.

[113] *See* Berry v. Beech Aircraft Corp., 717 P.2d 670, 675–76 (Utah 1985) (stating that "'no one has a vested right in any rule of law,'" but the legislature is limited in abrogating laws meant for the benefit of the injured (quoting Masich v. U.S. Smelting, Ref., & Mining Co., 191 P.2d 612, 624 (Utah 1948)).

[114] *Id.* at 676 (emphasis added); *see also* Condemarin v. Univ. Hosp., 775 P.2d 348, 360, 368 (Utah 1989) (recognizing the "right to recover for personal injuries as an important substantive right" and citing persuasive authority supporting the protection of injury remedies). For a discussion of the deterioration of the *Berry* test and the declining status of the open courts clause, *see* Roberts & Shah, *supra* note 6.

[115] *See* VA. CONST. art. I, §§ 1–17; WASH. CONST. art. I, §§ 1–35.

[116] The *Judd* majority did hold, however, that the Malpractice Cap did not violate the open courts clause. 2004 UT 91, ¶ 18 (holding that the Malpractice Cap eliminated a social or economic evil and was reasonable, satisfying the test for abrogating a remedy). The court's extreme legislative deference on this point should be, and has been, the subject of

Utah Legislature does not have carte blanche to abolish causes of action where the rights of injured individuals are concerned.[117] Furthermore, even if one entirely ignores the open courts clause, it is still logically flawed to state that the ability to abolish a cause of action inherently implies a legislature's ability to limit damages. Article I, section 10's guarantee of a trial by jury is not a cause of action; it is a constitutionally guaranteed right.[118] It does not logically follow that a legislature's ability to do away with a cause of action implies its ability to encroach on a long-protected dominion of the jury.

Not only did the *Judd* majority not look at Virginia's jury-trial provision, but the *Etheridge* court itself failed to recognize the historical significance of the jury trial in its own state. At the time of the adoption of the Seventh Amendment of the U.S. Constitution, some viewed the right to a jury trial as unnecessary.[119] Patrick Henry, at the Virginia Constitutional Convention, argued vehemently to the contrary:

> Trial by jury is the best appendage of freedom. . . . We are told that we are to part with that trial by jury with which our ancestors secured their lives and property. . . . I hope we shall never be induced, by such arguments, to part with that excellent mode of trial. No appeal can now be made as to fact in common law suits. *The unanimous verdict of impartial men cannot be reversed.*[120]

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other scholarly review. *See* Roberts & Shah, *supra* note 6, at 692 (opining that the *Judd* court's analysis "reduces the *Berry* doctrine to the cleverness of the legislative gloss, a game that the Legislature and clever defense lawyers will win" and that it employed a weak form of heightened scrutiny). With respect to the *Etheridge* decision, however, it is enough to note that its implication that a state may abolish causes of action at will does not apply in Utah. In this respect, article I, sections 10 and 11 in Utah are uniquely intertwined.

[117] In fact, the test for abrogating a remedy requires the legislature to supply a reasonable alternative remedy of substantially equal value; or it must justify the abrogation by demonstrating a "clear social or economic evil to be eliminated and [that] the elimination of an existing legal remedy is not an arbitrary or unreasonable means for achieving the objective." *Berry*, 717 P.2d at 680.

[118] *See* John Zevalking, Comment, *Cast Adrift: The Patently Unjust Shift of Healthcare Costs to Those Who Can Least Afford Them is Constitutionally Intolerable*, 24 T.M. COOLEY L. REV. 347, 377–78 (highlighting the logical inconsistency of equating the power to abolish a cause of action with the power to curtail a jury award).

[119] *See* Galloway v. United States., 319 U.S. 372, 398 (1943) (noting the views of Alexander Hamilton). The Seventh Amendment states, "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law." U.S. CONST. amend. VII.

[120] *Galloway*, 319 U.S. at 398.

As a result of similar, widespread sentiment, Virginia was a leading proponent of a jury trial protection in the Bill of Rights.[121] In fact, its Declaration of Rights has been called the "parent" of the constitutional amendments.[122] Perhaps the *Etheridge* and *Judd* courts failed to take a historical perspective because history is protective of the jury trial right.

V. SUBSTANCE, NOT SHADOWS: *JUDD* SHOULD HAVE CHOSEN THE OTHER "REASONABLE" LINE OF REASONING

A. Why Sofie *Was a Better Choice for Utah*

In choosing to subscribe to *Etheridge*, the *Judd* court declined to adopt the Washington Supreme Court's expansive and thoughtful analysis in *Sofie v. Fibreboard Corp.*[123] Unlike Virginia's jury trial provision, Washington's provision contains language similar to Utah's, stating, "[t]he right of trial by jury shall remain inviolate," and provides for reduction of the number of jurors in courts not of record.[124] With respect to a state damages cap and its effect on this provision, the court held that although the legislature may shape litigation, "it must not encroach upon constitutional protections. In this case, by denying litigants an essential function of the jury [awarding damages], the Legislature has exceeded those limits."[125] This point clarifies the muddy analysis in *Judd.* The *Judd* majority failed to recognize that the legislature is free to redefine elements of a claim and shape litigation, but it may not encroach upon constitutional protections.[126] In short, "the legislature may pass measures which affect the way a jury *determines* factual issues" but it may not twist a jury's findings of fact.[127]

Whereas the *Etheridge* court described the state damages cap as merely law that a judge applies after a jury has performed its constitutional function, the *Sofie*

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[121] *See* Lisa Litwiller, *Has the Supreme Court Sounded the Death Knell for Jury Assessed Punitive Damages? A Critical Re-examination of the American Jury*, 36 U.S.F. L. REV. 411, 414–15, 423 (2002) (noting the right of trial by jury dating back to the Virginia Company, and later the state's "sweeping" proposed language protecting the jury right); Wright & Williams, *supra* note 10, at 525 (calling it an "unfortunate twist" that the Virginia Supreme Court has not done more to protect the jury trial right).

[122] *See* Wright & Williams, *supra* note 10, at 503–04.

[123] *See* Judd v. Drezga, 2004 UT 91, ¶ 34, 103 P.3d 135, 144; *see also* Sofie v. Fireboard Corp., 771 P.2d 711, 723 (Wash. 1989) (criticizing courts that have upheld damages caps for not engaging in a historical analysis of the right to a trial by jury).

[124] WASH. CONST. art. I, § 21. The *Sofie* court also notes that four other courts with jury-trial provisions similar to its provision—and, thus, Utah's—have invalidated caps on damages. 771 P.2d at 724.

[125] *Sofie*, 771 P.2d at 719.

[126] *See Judd*, 2004 UT 91, ¶ 34 (commenting briefly that "[t]he damage cap enacted by the legislature represents law, similar to an element of a claim to which the trial court must comport the jury's factual determinations.").

[127] *Sofie*, 771 P.2d at 722.

court distilled the consequences of a damages cap to their essence: "At issue in the Sofies' case is a statute that directly changes the outcome of a jury determination. The statute operates by taking a jury's finding of fact and altering it to conform to a predetermined formula."[128] Whether this was appropriate depended on "the right as it existed at the time of the constitution's adoption in 1889."[129] History guided the *Sofie* court, whereas the *Judd* and *Etheridge* decisions did little investigation into the background of the jury right. Much like Utah courts' consistent declaration that damages are the peculiar province of the jury,[130] Washington too put the measure of damages squarely before the jury.[131]

The *Sofie* court addressed the *Etheridge* decision, as well, calling it "poorly reasoned."[132] It criticized the contention in *Etheridge* that there was no encroachment on the jury's province because the cap applied after the jury's assessment of damages.[133] At its core, the *Etheridge* analysis is a judicial sleight of hand. In a rebuke of the reasoning supported in the Virginia case, the *Sofie* court noted that Washington's "constitution deals with substance, not shadows."[134] The court added, "In other words, a constitutional protection cannot be bypassed by allowing it to exist in form but letting it have no effect in function."[135]

It is clear that *Etheridge* and *Sophie* have opposite views of the effect of damages caps on the right to a jury trial. *Etheridge* stands for the proposition that as long as law is applied after a jury has served its fact-finding duty, it does not matter whether the law limits those findings.[136] On the other hand, *Sofie* stands for the more commonsense viewpoint that the jury has always been left to determine damages and that to allow a legislature to apply a uniform cap to noneconomic damages strips away the effect of juries' factual findings.[137] In essence, one cannot say that because a certain procedure has been followed that the heart of the system has not been compromised. Merely because a jury has been given the opportunity to determine damages does not mean its function is still intact if damages awards are significantly reduced by legislative fiat.

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[128] *Id.* at 720.

[129] *Id.* at 716.

[130] *See supra* notes 67–70 and accompanying text.

[131] *See Sofie*, 771 P.2d at 716.

[132] *Id.* at 724; *see also* Wright & Williams, *supra* note 10, at 532 (stating the *Etheridge* court "mischaracterize[d] the trial by jury as merely an anachronistic procedural formality").

[133] *Sofie*, 771 P.2d at 724.

[134] *Id.* (quoting State v. Strasburg, 110 P. 1020, 1023 (Wash. 1910)).

[135] *Id.*

[136] Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 529 (Va. 1989).

[137] 771 P.2d at 716.

B. Defending the Inviolate: Why Chief Justice Durham Was Right

In her *Judd* dissent, Chief Justice Durham was able to see through the majority's logical shadows and address the substance of article I, section 10. Among other arguments, she employed a parade-of-horribles analysis.[138] One possible ramification of the majority's adherence to *Etheridge* is that "the legislature could establish maximum (or minimum) recoveries in virtually every civil case without implicating the nature of the underlying right to jury trial. Such an argument, in my view, is absurd."[139] Additionally, the chief justice noted:

> Of what use is [the right to a jury trial] if the legislature has the power to nullify the jury's function by imposing arbitrary limits on the jury's impact on the result of a case? Presumably, if the legislature declared that, in actions for defamation, any damages awarded by the jury should be reduced to the sum of $1.00, the majority, under its logic here, would uphold the statute as not affecting the right to a jury trial.[140]

This form of "one-size-fits-all" legislation disregards the facts of cases and the extent of individuals' injuries, nullifying two key functions of the jury system.[141] Creating an inviolate right to a jury trial cannot mean that the historically protected province of the jury to decide damages may be cast aside because the legislature perceives a problem with malpractice premiums.

Further, Chief Justice Durham was faithful to case law holding that it is a fundamental aspect of tort law that an "injured party is entitled to recover fair and adequate compensation."[142] She also noted the understanding at the time of statehood that noneconomic damages were within the sole province of the jury.[143] Her dissent was consistent with the constitutional delegates' view of the importance of the jury trial, and she offered more than the four paragraphs of analysis the *Judd* majority provided when it came to analyzing a constitutionally protected institution.[144]

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[138] *See* Judd v. Drezga, 2004 UT 91, ¶¶ 50–51, 103 P.3d 135, 148.

[139] *Id.* ¶ 50; *see also* Wright & Williams, *supra* note 10, at 524 (discussing the converse problem of establishing a minimum damages award in malpractice cases).

[140] *Judd*, 2004 UT 91, ¶ 51.

[141] *Id.* ¶ 54; *see also* Wright & Williams, *supra* note 10, at 523 (stating that in reducing a jury's damages assessment via legislative cap "the two main purposes for the jury's finding of fact are rendered nugatory").

[142] *Judd*, 2004 UT 91, at ¶ 53 (quoting Rosenthal v. Harker, 189 P. 666, 667 (Utah 1920)).

[143] *Id.* ¶ 52 (citing Fenstermaker v. Tribune Publ'g Co., 45 P. 1097, 1099 (Utah 1896)).

[144] *Id.* ¶¶ 50–59.

VI. CONCLUSION

The *Judd* court identified two "analytically simple and reasonable"[145] schools of thought with respect to the right to a trial by jury. In choosing one, it failed to adequately analyze the history behind Utah's right to a jury trial. The debates among delegates at the state constitutional convention clearly indicate that the right to a jury trial was to be left alone aside from a permissible tinkering with the number of jurors.[146]

Instead of looking to the convention or relying on the plethora of cases that state that damages are within the constitutional dominion of the jury, the *Judd* majority followed an opinion based on dissimilar constitutional language and sleight-of-hand reasoning.[147] If Utah's constitution is to be more than shadows, article I, section 10 must protect a jury's findings of fact. It is suspect reasoning to argue that the jury need only assess a party's damages for the jury to perform its function. Of what use is this assessment if it is to be subsequently curtailed?

At the very least, the *Judd* majority failed to perform careful analysis regarding a key provision of the Utah Constitution, providing a mere four paragraphs explaining why the Malpractice Cap does not violate a right central to the American judicial system and, more particularly, to Utah's judicial system.[148] If the *Etheridge* reasoning is, in truth, the better fit for Utah—a contention this Note has questioned at length—then Utah's injured are entitled to a more thorough explanation. It will not do to state that the Malpractice Cap is like an instruction to the jury or like an element of a claim, when in fact it is much more than that and has considerable real-world implications for seriously injured individuals. The *Judd* majority should not have so quickly circumscribed a key jury function when the constitution's founders spent so much time drafting protection for the jury trial and when the court has, from the time of the Utah Territory, zealously guarded the jury's role of assessing damages.

As a final note, perhaps most interesting is the *Judd* court's lack of analysis of the word "inviolate." It is possible the majority did not want to address its definition, instead implying that it is possible only juries in capital cases deserve the utmost protection.[149] Likewise, the *Etheridge* court chose not to delve into its constitutional protection of the jury as "sacred."[150] The *Sofie* court, however, took careful notice of what "inviolate" means in its constitutional context:

> The term "inviolate" connotes deserving of the highest protection. Webster's Third New International Dictionary 1190 (1976), defines

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[145] *Id.* ¶ 33.
[146] *See supra* Part III.A.
[147] *See supra* Part IV.A–B.
[148] *Judd*, 2004 UT 91, ¶¶ 32–35.
[149] *Id.* ¶ 32 n.3.
[150] *See* Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 528 (Va. 1989).

> "inviolate" as "free from change or blemish: pure, unbroken . . . free from assault or trespass: untouched, intact . . . ." Applied to the right to trial by jury, this language indicates that the right must remain the essential component of our legal system that it has always been. For such a right to remain inviolate, it must not diminish over time and must be protected from all assaults to its essential guarantees. In Washington, those guarantees include allowing the jury to determine the amount of damages in a civil case.[151]

In Utah, the right to a trial by jury is inviolate. History shows it, and prior to *Judd* the court had recognized it. Unfortunately for Athan Montgomery and other malpractice victims whose pain and suffering damages exceed $400,000, it is now acceptable for the Legislature to declare, in the name of tort reform, that the jurors who heard the evidence and carried out their duties were just too generous.

Inviolate, indeed.

[151] Sofie v. Fibreboard Corp., 771 P.2d 711, 721–22 (Wash. 1989).

VALIDATING VICTIMS: ENFORCING VICTIMS' RIGHTS THROUGH MANDATORY MANDAMUS

Steven Joffee*

I. INTRODUCTION

The American criminal justice system "has long functioned on the assumption that crime victims should behave like good Victorian children—seen but not heard."[1] As a result of this assumption, for centuries, crime victims and their families have been excluded from participation in criminal proceedings, often leaving them secondary victims to the very system to which they had turned for justice.[2] In an effort to end this tradition, in October 2004, the United States Congress enacted the "the most sweeping federal victims' rights law in the history of the nation,"[3] the Scott Campbell, Stephanie Roper, Wendy Preston, Louarna Gillis, and Nila Lynn Crime Victims' Rights Act (CVRA).[4] This historic piece of legislation was specifically designed to provide crime victims with substantive and procedural rights enforceable in federal criminal proceedings.[5] To ensure that these rights are not capriciously denied, the CVRA also grants crime victims the right to appeal any district court decision denying them any one of these rights through a writ of mandamus, which the Act requires appellate courts to "take up and decide."[6] Congress's use of this seemingly mandatory "take up and decide" language in conjunction with the term "mandamus," a traditionally discretionary writ,[7] has caused much debate among United States circuit courts regarding the appropriate standard of review for these appeals, currently resulting in a four-circuit split.[8] This Note resolves this debate through the use of statutory interpretation. Part II briefly discusses the history of the crime victims' rights

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[1] Kenna v. U.S. Dist. Court, 435 F.3d 1011, 1013 (9th Cir. 2006).

[2] *See* Matthew B. Riley, Note, *Victim Participation in the Criminal Justice System:* In Re Kenna *and Victim Access to Presentence Reports*, 2007 UTAH L. REV. 235, 236.

[3] Jon Kyl et al., *On the Wings of their Angels: The Scott Campbell, Stephanie Roper, Wendy Preston, Louarna Gillis, and Nila Lynn Crime Victims' Rights Act*, 9 LEWIS & CLARK L. REV. 581, 583 (2005).

[4] 18 U.S.C. § 3771 (2006).

[5] *See* Kyl et al., *supra* note 3, at 583.

[6] *See* 18 U.S.C. § 3771 (d)(3).

[7] *See* BLACK'S LAW DICTIONARY 984 (8th ed. 2004) (defining mandamus as "[a] writ issued by a superior court to compel a lower court or a government officer to perform mandatory or purely ministerial duties correctly"); *see also* United States v. Malmin, 272 F. 785, 789 (3d Cir. 1921) (explaining that "ordinarily a writ of mandamus is not demandable, as a matter of right, but is awarded in the discretion of the court").

[8] *See infra* Part III.

movement and provides a general overview of the 2004 Crime Victims' Rights Act. Part III explores the four-circuit split that has emerged over the CVRA's standard of review and briefly discusses the prevailing arguments on each side of the issue. Finally, this Note concludes by arguing that the CVRA's enforcement provision entitles crime victims to ordinary appellate review of district court decisions denying their rights and offers some potential solutions for resolution of the current circuit split.

II. THE CRIME VICTIMS' RIGHTS ACT: HISTORY AND OVERVIEW

A. History of the Crime Victims Rights Movement

As justification for the exclusion of crime victims from the criminal justice process, the American justice system long treated crimes as acts committed against the community, rather than against individual victims and their families.[9] Consequently, "rather than affording victims such basic guarantees as the right to be heard, the right to be present at criminal proceedings, and the right to be treated with fairness and dignity, the system . . . treated victims as nothing more than useful tools for the reporting and prosecution of criminal offenses."[10] Thus, as Senator Feinstein noted, "[i]n case after case . . . victims and their families, were ignored, cast aside, and treated as non-participants in a critical event in their lives . . . by prosecutors too busy to care enough . . . , judges focused [solely] on defendant's rights, and . . . a court system that simply did not have a place for them."[11]

The results of this treatment were often terrible, leaving crime victims and their families "secondary victims" to the flawed criminal justice system.[12] Such was the case following the 1977 murder of Wendy Preston, a twenty-three-year-old woman who was viciously murdered in her parents' Florida home.[13] Soon after Wendy's killing, the state of Florida informed her grieving parents that they would not be notified of criminal proceedings in the case, because the state, and not the family, was being considered the victim of the crime.[14] Similarly, after Louarna Gillis was murdered in 1979 as part of a gang initiation process, not only was her family not notified of the proceedings in her case, but they were also later barred from entering the courtroom when they attempted to attend the trial of their daughter's killer.[15]

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[9] *See* Kyl et al., *supra* note 3, at 583.

[10] Riley, *supra* note 2, at 236 (citing DOUGLAS E. BELOOF ET AL., VICTIMS IN CRIMINAL PROCEDURE 11–18 (2d ed. 2006)).

[11] 150 CONG. REC. S4262 (daily ed. Apr. 22, 2004) (statement of Sen. Feinstein).

[12] *See id.*

[13] *See* Kyl et al., *supra* note 3, at 582.

[14] *Id.*

[15] *Id.*

In an effort to end this secondary victimization, the crime victims' rights movement began to take shape in the mid-1970s when advocates began calling increased public attention to the justice system's poor treatment of victims and their families.[16] The efforts of these early advocates began to gain considerable impetus in 1981 "when Ronald Reagan became the first president to publicly acknowledge the [important] role of the victim in the criminal justice system."[17] As part of this historic call for reform, President Reagan issued a proclamation calling for the first National Victims' Rights Week and, later, established the President's Taskforce on Victims of Crime ("Taskforce").[18] After conducting extensive hearings throughout the country, in 1982, the Taskforce concluded that the American "criminal justice system ha[d] lost an essential balance . . . depriv[ing] the innocent, the honest, and the helpless of its protection . . . [and] transform[ing] [crime victims] into a group oppressively burdened by a system designed to protect them."[19] Upon demanding that "[t]his oppression . . . be redressed,"[20] the President's Taskforce provided multiple solutions and reforms to fix the country's flawed system.[21] "In its most sweeping recommendation,"[22] the Taskforce proposed an amendment to the United States Constitution designed to protect crime victims by giving them the right "to be present and . . . heard at all critical stages of judicial proceedings."[23] Recognizing the difficultly of "obtaining the consensus required to amend the United States Constitution,"[24] the victims' rights movement instead turned its focus toward creating a federal statute designed to create substantive rights for crime victims.[25] In 1982, this objective was achieved through Congress's passing of our nation's first federal victims' rights statute, The Victim and Witness Protection Act (VWPA).[26] Specifically, the VWPA granted crime victims the right to make victim-impact statements at sentencing hearings and provided for increased victim restitution.[27] In the years following the

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[16] *See* Paul G. Cassell, *Treating Crime Victims Fairly: Integrating Victims into the Federal Rules of Criminal Procedure*, 2007 UTAH L. REV. 861, 865.

[17] Kyl et al., *supra* note 3, at 584.

[18] *Id.*

[19] Cassell, *supra* note 16, at 865 (quoting PRESIDENT'S TASK FORCE ON VICTIMS OF CRIME: FINAL REPORT 114 (1982)); Kyl et al., *supra* note 3, at 584 (citations omitted).

[20] Cassell, *supra* note 16, at 865 (citations omitted).

[21] *See id.*

[22] *Id.* at 866.

[23] *Id.*; *see also* Paul G. Cassell, *Recognizing Victims in the Federal Rules of Criminal Procedure: Proposed Amendments in Light of the Crime Victims' Rights Act*, 2005 BYU L. Rev. 835, 842 ("The Task Force proposed adding to the Sixth Amendment's protections for defendants' rights a provision allowing crime victims to be present and heard: 'Likewise, the victim, in every criminal prosecution shall have the right to be present and to be heard at all critical stages of judicial proceedings.'" (citations omitted)).

[24] Cassell, *supra* note 23, at 842.

[25] *See id.* at 843.

[26] *See id.*

[27] Kyl et al., *supra* note 3, at 584–85.

enactment of the VWPA, Congress sought to expand the scope of these provisions through additional legislation[28] in the Victims of Crime Act of 1984,[29] the Victims' Rights and Restitution Act of 1990,[30] the Violent Crime Control and Law Enforcement Act of 1994,[31] and the Victim Rights Clarification Act of 1997.[32]

While these statutes initially appeared to advance the goals of the victims' rights movement, they failed to include procedures for the enforcement of the rights they provided and ultimately each statute proved to be largely ineffective.[33] Nowhere was this failure more obvious than during the 1997 trial of Oklahoma City bomber Timothy McVeigh, during which a district court judge forbade victims wishing to provide impact statements at sentencing from observing any of the prior proceedings in the case.[34] Following the media coverage and public outrage concerning this event,[35] victims' rights advocates renewed their efforts to create a federal constitutional amendment.[36] However, after several attempts to amend the constitution failed,[37] the movement shifted its focus toward creating a comprehensive federal statute that could overcome the shortcomings of previous attempts to codify federal rights for crime victims.[38] This objective was finally

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[28] *See* Cassell, *supra* note 23, at 843.

[29] Victims of Crime Act of 1984, Pub. L. No. 98-473, 98 Stat. 2170 (codified as amended at 42 U.S.C. §§ 10601–03 (2006)) (creating a crime victim fund and the Department of Justice Office for Victims of Crime).

[30] Victims' Rights and Restitution Act of 1990, Pub. L. No. 101-647, tit. V, 104 Stat. 4820 (codified as amended at 42 U.S.C. § 10601 (2006)) (creating a comprehensive bill of rights for crime victims in the federal criminal justice system including: the right to be treated with fairness and respect; the right to be notified of all court proceedings; the right to confer with the government's attorney; and the right to attend all court proceedings).

[31] Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, 108 Stat. 1796 (codified as amended in scattered sections of 18, 21, 28 & 42 U.S.C. (2006)) (mandating restitution for sexual assault, domestic violence, to abused and sexually exploited children).

[32] Victim Rights Clarification Act of 1997, Pub. L. No. 105-6, 111 Stat. 12 (codified as amended at 18 U.S.C. § 3510 (2006)) (clarifying for judges a crime victims right to attend court proceedings even if the victim intends to give impact testimony at sentencing).

[33] *See* Kyl et al., *supra* note 3, at 586.

[34] 150 CONG. REC. S4261 (daily ed. Apr. 22, 2004) (statement of Sen. Feinstein).

[35] *See* Jo Thomas, *New Law Forces a Reversal in Oklahoma Bombing Case*, N.Y. TIMES, Mar. 26, 1997, at A18.

[36] *See* Cassell, *supra* note 16, at 867.

[37] *See* Cassell, *supra* note 16, at 867–70 (discussing the crime victims' movement's numerous attempts between 1996 and 2004 to gain congressional support for a crime victims' rights amendment to the United States Constitution); *see also* Paul G. Cassell, *Barbarians at the Gate? A Reply to Critics of the Victims Rights Amendment*, 1999 UTAH L. REV. 479, 479–82 (providing a more detailed history of the efforts to enact a federal crime victims' rights amendment).

[38] *See* Cassell, *supra* note 16, at 868–69.

achieved in 2004 when President George W. Bush signed into law the Crime Victims' Rights Act.[39]

B. Overview of the Crime Victims' Rights Act

In a conscious effort "to correct . . . the legacy of . . . poor treatment of crime victims in the criminal process,"[40] and overcome the failings of previous legislation, the Crime Victims' Rights Act was specifically drafted to bring together three critical components: "rights, remedies, and resources,"[41] in an effort to guarantee crime victims substantive and procedural rights enforceable in federal courts.[42] Specifically, this unprecedented piece of legislation provides crime victims, whom the Act defines as "person[s] directly and proximately harmed as a result of the commission of a federal offense or an offense in the District of Columbia,"[43] with the following eight enumerated rights:

> (1) The right to be reasonably protected from the accused.
> (2) The right to reasonable, accurate, and timely notice of any public court proceeding, or any parole proceeding, involving the crime or of any release or escape of the accused.
> (3) The right not to be excluded from any public court proceeding, unless the court, after receiving clear and convincing evidence, determines that testimony by the victim would be materially altered if the victim heard other testimony at the proceeding.
> (4) The right to be reasonably heard at any public proceeding in the district court involving release, plea, sentencing, or any parole proceeding.
> (5) The reasonable right to confer with the attorney for the Government in the case.
> (6) The right to full and timely restitution as provided in law.
> (7) The right to proceedings free from unreasonable delay.
> (8) The right to be treated with fairness and with respect for the victim's dignity and privacy.[44]

Additionally, in what might be described as the Act's most essential component, the CVRA provides for enforcement of these rights through a writ of mandamus that the court of appeals must "take up and decide" within seventy-two hours of

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[39] *See* 18 U.S.C. § 3771 (2006).
[40] Cassell, *supra* note 16, at 880 (citations omitted).
[41] 150 Cong. Rec. S4262 (daily ed. Apr. 22, 2004) (statement of Sen. Feinstein).
[42] *See* Kyl et al., *supra* note 3, at 583.
[43] 18 U.S.C. § 3771(e).
[44] *Id.* § 3771(a)(1)–(8).

receipt of a victim's petition.[45] As previously noted, Congress's use of the phrase "take up and decide," in conjunction with the term "mandamus," has raised much debate concerning the appropriate standard of review for appeals brought under this provision. On one side of the debate, judges and lawyers argue that by using the term "mandamus," Congress could have intended nothing other than its traditional meaning,[46] while the opposing side argues that Congress intended the words, "shall take up and decide," to transform the traditionally discretionary mandamus standard into a mandatory standard requiring ordinary appellate review.[47] The remainder of this Note discusses these opposing viewpoints and attempts to resolve this debate.

III. CIRCUIT CONFUSION: THE CURRENT DEBATE

The confusion discussed above has created a four-circuit split between the Second and Ninth Circuits and the Fifth and Tenth Circuits on the issue of whether appeals brought by victims under the CVRA's enforcement provision are to be reviewed according to the discretionary standards associated with traditional mandamus petitions, or rather under an expedient form of ordinary appellate review.[48] The following discussion briefly explores the various opinions of the four circuit courts that have ruled on this issue.

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[45] *Id.* § 3771(d)(3).

[46] *See in re* Antrobus, 519 F.3d 1123, 1129 (10th Cir. 2008); Response of the United States to Petition for Rehearing or Rehearing En Banc at 8–13, *in re* Antrobus, 519 F.3d 1123 (10th Cir. 2008) (No. 08-4002).

[47] *See* Kenna v. U.S. Dist. Court, 435 F.3d 1011, 1017–18 (9th Cir. 2006); Petition for Panel Rehearing with Suggestion of Rehearing En Banc at 4–11, *in re* Antrobus, 519 F.3d 1123 (10th Cir. 2008) (No. 08-4002).

[48] *See infra* Parts III.A–B. In further demonstrating the complexity of this issue, it is worth mentioning that the Fourth Circuit Court of Appeals has twice discussed the CVRA's standard of review; however, finding that the petitioners in both cases were not entitled to relief regardless of the standard of review, the court has twice chosen not to rule on the issue. *See in re* Brock, 262 F. App'x 510, 512 (4th Cir. 2008); *see in re* Doe, 264 F. App'x 260, 261–62 (4th Cir. 2007). The Court in *in re Doe* stated:

> Normally, petitions for mandamus are subject to an extraordinarily stringent standard in order to prevent them from becoming a substitute for appeal.
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> . . .
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> However, mandamus petitions filed under the CVRA are not necessarily subject to this stringent standard of review. In creating the CVRA, Congress specifically chose a mandamus petition as the appropriate vehicle for appellate review of an order denying a crime victim's assertion of a right protected thereunder. Because the use of mandamus in this context results from a deliberate legislative choice and not adroit or devious pleading, it is not clear that a petitioner under the CVRA should be subjected to the same stringent standard of review as traditional petitioners. At least two other circuits have

A. The First Approach: The CVRA Calls for Mandatory Mandamus Review

In 2005, approximately one year after the CVRA was signed into law, the United States Court of Appeals for the Second Circuit became the first federal court to address the appropriate standard of review for appeals brought under the CVRA's enforcement provision.[49] The court began its opinion by noting that "[u]nder the plain language of the CVRA . . . Congress has chosen a petition for mandamus as a mechanism by which a crime victim may appeal a district court's decision denying relief sought under the provisions of the CVRA."[50] However, in distinguishing the CVRA's use of the term "mandamus" from more traditional usage, the court explained that "petitioner[s] seeking relief pursuant to the mandamus provision set forth in [the CVRA] need not overcome the hurdles typically faced by a petitioner seeking review of a district court determination through a writ of mandamus."[51] Upon recognizing the nondiscretionary nature of the CVRA's mandamus procedure, the court proceeded to address the appropriate standard of review for appeals brought under this provision.[52] After explaining that "for purposes of standard of review, decisions of judges are traditionally divided into three categories, denominated questions of law (reviewable *de novo*), questions of fact (reviewable for clear error), and matters of discretion (reviewable for 'abuse of discretion'),"[53] the court concluded its discussion of the issue by holding that "a district court's determination under the CVRA should be reviewed for abuse of discretion."[54]

> found that CVRA petitioners should not be so constrained and each has applied a normal abuse of discretion standard to CVRA mandamus petitions. We need not decide the issue today, however, because Petitioner would not be entitled to relief even under the lower standard.

Id. (citations omitted).

[49] *See in re* W.R. Huff Asset Mgmt. Co., 409 F.3d 555, 561–63 (2d Cir. 2005).

[50] *Id.* at 562.

[51] *Id.*

[52] *See id.* at 562–63. Under traditional standards,

> [a] writ of mandamus may issue only if (1) the petitioner has "no other adequate means" to attain the desired relief; (2) the petitioner has demonstrated a right to the issuance of a writ that is "clear and indisputable;" and (3) the issuing court, in the exercise of its discretion, is satisfied that the writ is "appropriate under the circumstances."

In re Dean, 527 F.3d 391, 394 (5th Cir. 2008).

[53] *In re W.R. Huff Asset Mgmt. Co.*, 409 F.3d at 562 (quoting Pierce v. Underwood, 487 U.S. 552, 558 (1988)).

[54] *Id.* at 563.

Following the Second Circuit's first-impression decision, the Ninth Circuit returned to the same issue in its 2006 decision, *Kenna v. United States District Court*.[55] Prior to bringing his appeal, the appellant in this case, W. Patrick Kenna, had fallen prey to Moshe and Zvi Leichner, a father-and-son team who swindled numerous victims, including Mr. Kenna, out of almost $100 million in a foreign investment scam.[56] After exercising his right to be heard at the sentencing of the first defendant, Moshe Leichner, Mr. Kenna again attempted to give impact testimony at the later sentencing of Moshe's son Zvi.[57] However, instead of allowing Mr. Kenna to exercise this guaranteed right,[58] a district court judge denied the request, stating that he had previously listened to the victims at the father's sentencing, reviewed their impact testimony, and did not foresee "anything else that could possibly be said."[59] Outraged that "the judge was [not] taking into consideration the victims in the case,"[60] and armed with the CVRA's enforcement provision, Mr. Kenna turned to the Ninth Circuit Court of Appeals to challenge the district court's ruling forming the basis of the above-mentioned appeal.

In an opinion written by Judge Alex Kozinski, the Ninth Circuit began its analysis by addressing the substantive meaning of the CVRA's "right to be reasonably heard" provision, and then turned to a discussion of the appropriate standard of review for decisions denying victims this right.[61] To begin this discussion, the court first explained that while they ordinarily "apply strict standards in reviewing petitions for a writ of mandamus" and "grant the writ only when there is something truly extraordinary about the case,"[62] such strict application was not required, "because the CVRA contemplates active review of orders denying victims' rights claims even in routine cases."[63] Rather, under the "unique regime" created by the CVRA, appellate courts "must issue the writ whenever [they] find that the district court's order reflects an abuse of discretion or legal error."[64]

While the Second and Ninth Circuits' opinions vary slightly in their articulation of the types of error that will result in the grant of a writ of mandamus under the CVRA, their opinions agree that through the CVRA's enforcement provision, Congress intended to modify traditional mandamus standards to create a

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[55] 435 F.3d 1011, 1017–18 (9th Cir. 2006).

[56] *Id.* at 1012.

[57] *Id.* at 1013.

[58] *See* 18 U.S.C. § 3771 (a)(4) (2006) (granting crime victims "[t]he right to be reasonably heard at any public proceeding in the district court involving release, plea, sentencing, or any parole proceeding").

[59] *Kenna*, 435 F.3d at 1013.

[60] Emma Schwartz, *Giving Crime Victims More of Their Say*, U.S. NEWS & WORLD REP., Dec. 24, 2007, at 28.

[61] *Kenna*, 435 F.3d at 1016–17.

[62] *Id.* at 1017.

[63] *Id.*

[64] *Id.*

unique appellate procedure allowing for expedient, mandatory, and active review of decisions denying crime victims' rights.[65]

B. The Second Approach: Mandamus Means Mandamus

More than two years after *Kenna*, the Tenth Circuit Court of Appeals turned to the CVRA standard of review issue in the 2008 case *in re Antrobus*.[66] The facts underlying this appeal involved the February 12, 2007 shooting at the Trolley Square shopping mall in Salt Lake City, Utah, where a man opened fire at random targets, killing five people.[67] Among the victims of the shooting was Vanessa Quinn, the daughter of Sue and Ken Antrobus, appellants in this appeal.[68] On that tragic day, Vanessa went to Trolley Square to meet her husband of four years to purchase a long-awaited wedding ring they had been unable to afford at the time of their marriage.[69] As she anxiously rounded a corner headed toward a jewelry store, eighteen-year-old Sulejman Talovic gunned her down with a .38 Special handgun, killing her instantly.[70] Following the shooting, police investigators learned that Talovic had purchased the .38 Special eight months prior to the shooting, when he was only seventeen years old, from a man named Makenzie Hunter.[71] After Mr. Hunter pleaded guilty to the unlawful "transfer[] of a handgun to a juvenile," Vanessa's family "sought to have [her] declared a victim of [his] crime so that they, on her behalf, could assert certain rights provided by the CVRA."[72] However, much to their dismay, a district court judge denied their request, finding that Vanessa was not a direct victim of Hunter's crime.[73] Unhappy with this decision, the Antrobuses filed a petition for mandamus with the Tenth Circuit Court of Appeals.[74]

Upon turning to the relevant standard of review issue, the Tenth Circuit began by observing that to receive a writ of mandamus, "[p]etitioners must show that their right to the writ is 'clear and indisputable.'"[75] Following this assertion, the court proceeded to explain that while "Congress could have drafted the CVRA to provide for 'immediate appellate review' or 'interlocutory appellate review,'

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[65] *See supra* notes 49–54, 61–64 and accompanying text.

[66] 519 F.3d 1123, 1124–25 (10th Cir. 2008).

[67] *Id.* at 1124.

[68] *Id.* at 1123–24.

[69] Ben Winslow, *Quinn's Husband Hopes to Turn his Grief into a Force for Good*, DESERET NEWS, Feb. 16, 2007 at A19.

[70] *See id.*

[71] Aaron Falk, *Parents Appeal for 'Victim' Status*, DESERET NEWS, Sept. 23, 2008, at A1.

[72] *Antrobus*, 519 F.3d at 1124.

[73] *Id.* at 1125.

[74] *Id.* at 1124.

[75] *Id.* (quoting Allied Chem. Corp. v. Daiflon, Inc., 449 U.S. 33, 34 (1980)).

something it has done many times,"[76] they instead made use of the term mandamus,[77] "a well worn term of art in our common law tradition."[78] In an attempt to interpret the CVRA's use of this term, the court referred to the United States Supreme Court's 1951 ruling in *Morissette v. United States*, in which the Court stated that:

> [W]here Congress borrows terms of art in which are accumulated the legal tradition and meaning of centuries of practice, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken and the meaning its use will convey to the judicial mind unless otherwise instructed.[79]

Applying this "rule," the court explained they saw "no reason to suppose that the use of the word mandamus in the CVRA has anything other than its traditional meaning,"[80] thus holding that petitions made under the Act's enforcement provision are to be reviewed under traditional mandamus standards.[81]

Just two months later, the Fifth Circuit became the fourth federal court to address the CVRA's standard of review in *in re Dean*.[82] Rather than attempting to interpret the CVRA's enforcement provision, the court simply began its analysis by stating they were "in accord with the Tenth Circuit for the reasons stated in its opinion."[83] Applying the Tenth Circuit's standard, the court found that the lower court had violated the victims' rights by failing to confer with them before reaching a plea agreement.[84] However, rather than enforcing those rights, the court explained that, because "[t]he decision whether to grant mandamus is largely prudential," they felt "the better course [was] to deny relief," and leave it to the district court who denied the victim's rights in the first instance, to "carefully consider their objections and briefs as th[e] matter proceed[ed]."[85]

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[76] *Id.*

[77] *Id.*

[78] *Id.* at 1127.

[79] *Id.* at 1124 (quoting Morissette v. United States, 342 U.S. 246, 263 (1952)).

[80] *Id.* at 1129.

[81] *See id.* at 1129–31.

[82] 527 F.3d 391, 393–94 (5th Cir. 2008).

[83] *Id.* at 394.

[84] *Id.* at 394–96 ("With due respect for the district court's diligent efforts to do justice, we conclude that, under the specific facts and circumstances of this case, it was contrary to the provisions of the CVRA for the court to permit and employ the *ex parte* proceedings that have taken place—proceedings that have no precedent, as far as we can determine.").

[85] *Id.* at 396.

IV. RESOLVING THE DEBATE: THE CASE FOR MANDATORY MANDAMUS AND POTENTIAL SOLUTIONS

A. The Case for Mandatory Mandamus

For several reasons, the Second and Ninth Circuits were correct in their conclusion that the CVRA's enforcement provision entitles crime victims to ordinary appellate review of district court decisions denying any of their eight enumerated rights. While it may be difficult for some to suppose that Congress intended its use of the term mandamus to have anything "other than its traditional meaning,"[86] through the use of statutory interpretation, the following discussion demonstrates that this was precisely the case.

The starting point for any sound statutory-interpretation analysis begins in the statute's "plain language."[87] This basic insight was made clear by the United States Supreme Court in its declaration that "the meaning of a statute must, in the first instance, be sought in the language in which the act is framed."[88] Thus, "when the statutory language is clear on its face, and its words 'neither create ambiguity nor lead to an entirely unreasonable interpretation,' an inquiring court must apply the statute as written, and 'need not consult other aids to statutory construction.'"[89] However, "when the statutory language chosen by Congress is unclear, or capable of more than one reasonable interpretation, it is proper for a court to consult extrinsic sources, such as legislative history, for guidance."[90] Beginning with the CVRA's plain language, the Act's enforcement provision states that when a "district court denies the relief sought [by a crime victim], the movant may petition the court of appeals for a writ of mandamus," which "[t]he court . . . *shall take up and decide* . . . within 72 hours."[91] That four circuit courts have found these words to have different substantive meanings makes clear that this language is "capable of more than one reasonable interpretation," making it appropriate to turn to the canons of statutory construction to resolve this issue.[92] Rather than attempt such an analysis, the Tenth Circuit focused solely on the Act's use of the word "mandamus," and promptly ended its analysis by assigning the word its traditional meaning.[93] Although courts do often interpret Congress's use of terms of art

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[86] *See Antrobus*, 519 F.3d at 1129.

[87] For a detailed explanation of the "plain meaning" rule of statutory interpretation, see NORMAN J. SINGER, SUTHERLAND'S STATUTORY CONSTRUCTION § 46.01 (6th ed. 2000).

[88] *See* Caminetti v. U.S., 242 U.S. 470, 485 (1917).

[89] Passa v. Derderian, 308 F. Supp. 2d 43, 51 (D.R.I. 2004) (quoting Atlantic Fish Spotters Ass'n. v. Evans, 321 F.3d 220, 224 (1st Cir. 2003)).

[90] *Id.* at 5152.

[91] 18 U.S.C. § 3771(d)(3) (2006) (emphasis added).

[92] *See Passa*, 308 F. Supp. at 51–52.

[93] *See In re* Antrobus, 519 F.3d 1123, 1127-30 (10th Cir. 2008).

according to their traditional usage, an important exception to this technique, one which the Tenth Circuit seemingly ignored, is readily apparent in various courts' application of this rule. For example, in *McDermott International, Inc. v. Wilander*,[94] the Supreme Court stated that, "*[i]n the absence of contrary indication*, [a court] assume[s] that when a statute uses such a term [of art], Congress intended it to have its established meaning."[95] Similar language was expressed in the Supreme Court's opinion in *United States v. Trans-Missouri Freight Ass'n*, in which it expressed:

> [t]he well-settled rule is that where technical words are used in an act, and their meaning has previously been conclusively settled, by long usage and judicial construction, the use of the words *without an indication of an intention to give them a new significance* is an adoption of the generally accepted meaning affixed to the words at the time the act was passed.[96]

Thus, while courts may interpret terms of art according to their traditional meaning when the legislature has not expressed a contradictory intent, when such intent *is* expressed, further analysis is required.

Additionally, courts have made clear that statutory interpretation is to be a "holistic endeavor,"[97] in which courts "must not be guided by a single sentence or member of a sentence."[98] Rather than focusing solely on the CVRA's use of the word "mandamus," one needs only to continue reading a few words more to find a manifestation of Congress's intent to modify this term in the words "shall take up and decide."[99] While greater specificity likely would have helped prevent the current confusion associated with this clause, Congress's use of the word "shall" indicates its intent to transform the traditionally discretionary standard associated with mandamus into a mandatory and expedient form of appellate review. In fact, according to the Supreme Court, legislative use of the term "shall," "normally creates an obligation impervious to judicial discretion."[100]

Additional support for this interpretation can be found in another often-cited rule of statutory construction that "requires [that] every part of a statute be presumed to have some effect and not be treated as meaningless unless absolutely

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[94] 498 U.S. 337 (1991).

[95] *Id.* at 342 (emphasis added).

[96] 166 U.S. 290, 353 (1896) (emphasis added).

[97] Koons Buick Pontiac GMC, Inc. v. Nigh, 543 U.S. 50, 60 (2004) (quoting United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd., 484 U.S. 365, 371 (1988)).

[98] U.S. Nat. Bank of Or. v. Indep. Ins. Agents of America, Inc. 508 U.S. 439, 455 (1993) (quoting United States v. Heirs of Boisdore, 49 U.S. (8 How.) 113, 122 (1850)).

[99] 18 U.S.C. § 3771(d)(3) (2006).

[100] Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach, 523 U.S. 26, 35 (1998) (quoting Anderson v. Yungkau, 329 U.S. 482, 485 (1947)).

necessary."[101] Similarly, the Supreme Court has suggested that "provision[s] that may seem ambiguous in isolation [are] often clarified by the remainder of the statutory scheme . . . because *only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law.*"[102] With regard to the CVRA's enforcement provision, only two permissible interpretations exist, either Congress intended to import traditional mandamus standards or, alternatively, they sought to modify those standards by creating a mandatory, nondiscretionary, mandamus procedure. Assuming the correctness of this proposition, it readily becomes clear that only a nondiscretionary writ of mandamus would produce a substantive effect compatible with the rest of the CVRA because, "[w]ithout the right to seek appellate review and a guarantee that the appellate court will hear the appeal and order relief, a victim is left to the mercy of the very trial court that may have erred[,]"[103] leaving any rights afforded by the statute mere "rhetoric."[104] This was precisely the result of the Fifth Circuit's holding in *in re Dean*, in which the court recognized that victim's rights had been violated, but, through their discretion, chose to deny the victim's relief.[105]

Beyond the plain language and spirit of the CVRA, further support for this mandatory mandamus standard can be found in the legislative statements of the statute's two cosponsors, Senators Jon Kyl and Dianne Feinstein.[106] While the use of legislative history in statutory interpretation has become somewhat controversial in recent years,[107] "[w]hen aid to construction of the meaning of words . . . used in the statute, is available, there certainly can be no 'rule of law' which forbids it use . . . ."[108] Rather, it is entirely appropriate for courts to turn to legislative history to resolve perceived ambiguity.[109] Additionally, courts have made clear that statements made by sponsors of legislation "deserve[] to be accorded substantial

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[101] Cal. v. Arias, 195 P.3d 103, 109 (Cal. 2008); *see also* Comm'r. v. Ewing, 439 F.3d 1009, 1014 (9th Cir. 2006) (stating that "the basic principle of statutory construction [is] that 'a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant.'" (quoting Planned Parenthood of Idaho, Inc. v. Wasden, 376 F.3d 908, 928 (9th Cir.2004))).

[102] *Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. at 371 (emphasis added) (citations omitted).

[103] Kyl et al., *supra* note 3, at 620.

[104] *Id.* at 617.

[105] *See In re* Dean, 527 F.3d 391, 394–96 (5th Cir. 2008).

[106] *See* 150 CONG. REC. S4269 (daily ed. Apr. 22, 2004) (statement of Sen. Feinstein & Sen. Kyl); 150 CONG. REC. at S10912 (daily ed. Oct. 9, 2004) (statements of Sen. Kyl & Sen. Feinstein).

[107] For more discussion of the controversy surrounding the use of legislative history, see WILLIAM D. POPKIN, STATUTES IN COURT: THE HISTORY AND THEORY OF STATUTORY INTERPRETATION 248 (1999).

[108] Koons Buick Pontiac GMC, Inc. v. Nigh, 543 U.S. 50, 66 n.1 (2004) (citing United States v. Am. Trucking Ass'ns., Inc., 310 U.S. 534, 543–44 (1940)).

[109] *See* Toibb v. Radloff, 501 U.S. 157, 162 (1991) ("[A] court appropriately may refer to a statute's legislative history to resolve statutory ambiguity . . . .").

weight in interpreting the statute[s]."[110] A look at the statements of the CVRA's sponsors plainly demonstrates that Congress intended to grant crime victims ordinary appellate review through the CVRA's enforcement provision. As Senator Kyl clearly explained:

> [The] provision [that courts "shall take up and decide"] is critical for a couple of reasons. First, it gives the victim standing to appear before the appellate courts of this country and ask for review of a possible error below. Second, while mandamus is generally discretionary, this provision means that courts must review these cases. Appellate review of denials of victims' rights is just as important as the initial assertion of a victim's right. This provision ensures review and encourages courts to broadly defend the victims' rights.
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> Without the right to seek appellate review and a guarantee that the appellate court with hear the appeal and order relief, a victim is left to the mercy of the very trial court that may have erred. This country's appellate courts are designed to remedy errors of the lower courts and this provision requires them to do so for victims' rights.[111]

Clearly, the intent of Congress was not to create a discretionary standard whereby courts could deny crime victims the rights guaranteed to them by the CVRA, but rather, as the Act's legislative history makes clear, to rigorously safeguard these rights by requiring that appellate courts "take up and decide" crime victims' appeals using ordinary, nondiscretionary, appellate review.

B. Potential Solutions

Because of the four-circuit split, the United States Supreme Court should grant certiorari to resolve this issue. Alternatively, Congress should amend the language used in the CVRA to provide a more understandable explanation of the standard of review the Act intends to provide. For example, leaders in the crime victims' rights movement have suggested the following amended language to avoid further litigation on this issue:

> If the district court denies the relief sought, the movant may petition the court of appeals for a writ of mandamus. The court of appeals may issue the writ on the order of a single judge pursuant to circuit rule or the Federal Rules of Appellate Procedure. The court of appeals shall take up and decide such application forthwith within 72 hours if necessary to protect the movant's rights and in any event within 30 days after the petition has been filed and shall issue the writ when, after a de novo

[110] Fed. Energy Admin. v. Algonquin SNG, Inc., 426 U.S. 548, 564 (1976).
[111] 150 CONG. REC. S10912 (daily ed. Oct. 9, 2004) (statement of Sen. Kyl).

> review, it finds any legal error or a clear factual error applying ordinary standards of appellate review. In no event shall proceedings be stayed or subject to a continuance of more than 30 days for purposes of enforcing this chapter. If the court of appeals denies the relief sought, the reasons for the denial shall be clearly stated on the record in a written opinion. This section 3771 shall be liberally construed to effectuate its purposes.[112]

While this language may seem to be somewhat of a departure from the CVRA's original language, it appears to spell out in more detail what the drafters of the CVRA intended, something apparently necessary in light of the current circuit split. This is especially true given the fact that the Second and Ninth circuits, both of whom agreed that the CVRA modified the traditional mandamus standard, have reached slightly different solutions for the standard of review for reviewing such petitions.

V. CONCLUSION

Through the 2004 Crime Victims' Rights Act, the United States Congress intended to end the long-standing tradition of excluding crime victims and their families from the American justice system.[113] As part of this historic effort to give victims a voice in criminal proceedings, the CVRA was enacted to guarantee victims eight enumerated rights enforceable in federal courts.[114] Although Congress intended to avoid the capricious denial of these rights by giving victims the ability to seek a writ of mandamus, to be granted using ordinary standards of review, their lack of specificity failed to make this clear and has resulted in much confusion. As a result of this confusion, the Fifth and Tenth Circuits have held that the enforcement of victims' rights is subject to the discretion of appellate courts,[115] ultimately rendering the right provided to victims in the CVRA mere rhetoric. To resolve this debate and end the further victimization of crime victims, the United States Supreme Court should grant certiorari to decide the issue, or alternatively, Congress should amend the statute to make the appropriate standard of review more clear. Only by resolving this issue will the rights provided to crime victims in the CVRA be guaranteed, ensuring that victims will never again be treated "as good Victorian school children—seen but not heard."[116]

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[112] E-mail from Steven J. Twist, Adjunct Professor of Law, Arizona State University College of Law, to Paul G. Cassell, Professor of Law, S.J. Quinney College of Law (Oct. 6, 2008, 09:39 MST) (on file with author).

[113] *See supra* notes 40–44 and accompanying text.

[114] *See* 18 U.S.C. § 3771(a)(1)–(8) (2006).

[115] *See supra* notes 81–85, and accompanying text.

[116] Kenna v. U.S. Dist. Court, 435 F.3d 1011, 1013 (9th Cir. 2006).

COMPENSATING DEFRAUDED INVESTORS WHILE PRESERVING THE SEC'S MISSION OF DETERRENCE: A CALL FOR CONGRESS TO COUNTERACT THE TROUBLING CONSEQUENCES OF *STONERIDGE*

Adam Reiser*

I. INTRODUCTION

In *Stoneridge Investment Partners, LLC v. Scientific-Atlanta, Inc.*,[1] the U.S. Supreme Court ruled that there is no private cause of action against aiders and abettors to a securities fraud.[2] Instead, the Court ruled that only the Securities and Exchange Commission (SEC) could pursue civil damages against aiders and abettors.[3] This Note reviews the history that led to *Stoneridge*, and argues that *Stoneridge* leaves defrauded investors[4] with little or no remedy against the aiders and abettors who wronged them.[5] Additionally, *Stoneridge* presses unfavorable side effects on the SEC, most notably forcing the SEC to take on an overly broad role as a collector of civil damages at the expense of the SEC's primary mission to deter securities fraud. The Note concludes by making several recommendations for changes in federal securities law that will 1) provide adequate compensation to defrauded investors, 2) preserve the SEC's mission as a deterrent agency, and 3) enable Congress to continue its pursuit of curbing vexatious securities litigation against secondary actors, a primary reason *Stoneridge* was decided as it was.[6]

II. BACKGROUND

A. Events Leading to Stoneridge

Stoneridge traces its roots to Section 10(b) of the Securities and Exchange Act of 1934 (the Exchange Act), which makes it illegal "[t]o use or employ, in connection with the purchase or sale of any security . . . any manipulative or deceptive device."[7] Since the passing of the Exchange Act, Congress has delegated

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[1] 128 S.Ct. 761 (2008).

[2] *Id.* at 773.

[3] *Id.*

[4] The terms "investor" and "shareholder" will be used interchangeably.

[5] *See* Texas & P. Ry. Co. v. Rigsby, 241 U.S. 33, 39 (1916) (asserting that every wrong must have a remedy).

[6] *See Stoneridge*, 128 S.Ct. at 771.

[7] *Id.* at 768.

substantial federal securities lawmaking power to courts,[8] a result of which has been a judicially created private cause of action against parties engaging in securities fraud.[9]

For sixty years, courts unanimously applied this private cause of action to both the primary actors who orchestrate a securities fraud and to the secondary actors who aid and abet it.[10] In 1994, however, the Court rejected the reasoning of every circuit court that had previously ruled on the issue[11] by holding that the private cause of action in securities frauds applied exclusively to primary actors.[12] The Court reasoned that because the term "aider and abettor" did not appear in the text of the Exchange Act, there was no private cause of action against aiders and abettors.[13]

Congress seemed to view the *Central Bank* holding as an invitation to curb the problems of vexatious securities litigation that were constantly being voiced by corporate lobbying efforts. In passing the Private Securities Litigation and Reform Act of 1995 (the Reform Act), Congress not only adopted *Central Bank's* sharp break from longstanding precedent by affirming that there is no private cause of action against aiders and abettors, but took further steps to protect business interests by introducing a tightened pleading requirement[14] and barring discovery

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[8] Jill E. Fisch, *The Scope of Private Securities Litigation: In Search of Liability Standards for Secondary Defendants*, 99 COLUM. L. REV. 1293, 1307 (1999).

[9] J.I. Case Co. v. Borak, 377 U.S. 426, 430–33 (1964).

[10] *See* Richard J. Pierce, Jr., *The Supreme Court's New Hypertextualism: An Invitation to Cacophony and Incoherence in the Administrative State*, 95 COLUM. L. REV. 749, 760 (1995) (explaining that from 1934 to 1994, "no court had suggested any doubt" that the Exchange Act applied to aiders and abettors).

[11] Jill E. Fisch, *Retroactivity and Legal Change: An Equilibrium Analysis*, 110 HARV. L. REV. 1055, 1104–05 (1997).

[12] Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A., 511 U.S. 164, 177 (1994).

[13] Strict textualism is uniquely controversial when interpreting federal securities law because Congress deliberately drafted the federal securities laws broadly to grant courts liberal discretion to adjust the law to meet the rapidly changing complexities in the federal securities arena. *See* Fisch, *supra* note 8, at 1306–07. Congress has consistently recognized the legitimacy of federal common law in the securities field by repeatedly passing amendments that approve of judicial decisions. As a result, commentators have argued that "whole areas of securities regulation have little or no origin in the text of the statute, but rather are the creations of federal common law." *Id.* at 1307–08; *see* Steven Thel, *Section 12(2) of the Securities Act: Does Old Legislation Matter?*, 63 FORDHAM L. REV. 1183, 1198–1200 (1995).

[14] James D. Cox & Randall S. Thomas, *SEC Enforcement Heuristics: An Empirical Inquiry*, 53 DUKE L.J. 737, 741 n.14 (2003) ("Exchange Act section 21D(b)(2) provides that when scienter is required in private securities litigation the plaintiff must 'state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind.'" (quoting 15 U.S.C. § 78u-4(b)(2) (2000)).

until the defendant's motion to dismiss has been resolved.[15] Congress also specifically increased protections to aiders and abettors in the Reform Act by replacing joint and several liability with proportionate liability.[16] Perhaps as a Congressional effort to show it had not completely forgotten investor interests, the Reform Act granted the SEC the exclusive right to pursue civil damages from aiders and abettors to a securities fraud.[17]

However, the business-friendly tone that Congress projected in the Reform Act quickly changed pitch when Enron, WorldCom, and other major securities scandals of the late nineties rocked corporate America, defrauding investors of billions of dollars. Congress responded by passing the Sarbanes-Oxley Act of 2002 (SOX), "the most sweeping reform since the Depression-era securities laws."[18] This Note does not attempt to give even a cursory overview of the densities of SOX, but does focus on one change to federal securities law that SOX introduced: in expounding upon the Reform Act's designation of the SEC as the exclusive collector of civil damages from aiders and abettors, section 308 of SOX ("the Fair Fund Provision") grants the SEC the authority to distribute the civil penalties it collects from aiders and abettors to injured investors.[19] The Fair Fund Provision will be discussed at length later in this Note. The next section discusses the most significant post-SOX securities law development: *Stoneridge v. Scientific Atlanta.*

B. Stoneridge

Stoneridge is the primary progeny of *Central Bank*, and also the product of a ten year circuit split that disputed the level of participation required to upgrade an aider and abettor to a primary violator.[20] In *Stoneridge*, Charter Cable Company

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[15] *Id.* at 741.

[16] Fisch, *supra* note 8, at 1304.

[17] *Id.*

[18] Lawrence A. Cunningham, *The Sarbanes-Oxley Yawn: Heavy Rhetoric, Light Reform (And It Just Might Work)*, 35 CONN. L. REV. 915, 917 (2003).

[19] Previously, any civil penalty was placed in the U.S. Treasury. Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, § 308, 116 Stat. 745, 784 (codified at 15 U.S.C. § 7246 (Supp. V 2005).

[20] Though *Stoneridge* dealt with the difference between primary and secondary liability, it also provided the Court an opportunity to discuss the divisive policy considerations swirling in the contemporary securities arena. Stoneridge Investment Partners, LLC v. Scientific-Atlanta, Inc., 128 S.Ct. 761, 770–73 (2008). Barbara Black notes that

> [t]hirty Amicus Curiae briefs were filed in *Stoneridge* by a variety of individuals, organizations, and entities, equally divided in their support for the plaintiff and the defendants. There was disagreement within the executive branch of the federal government as to what position the Solicitor General should take. The SEC voted (not unanimously) to file an *amicus curiae* brief in support of the plaintiff, the Treasury Department urged support for the

(Charter) arranged "fake sales" with Scientific-Atlanta, Inc. (Atlanta).[21] Though the sales appeared on Charter's financial statements, they never actually occurred.[22] Hence, investors viewing Charter's financial statements were led to believe that Charter had sold more goods than it actually had, prompting them to make investment decisions under fraudulent precepts. Stoneridge Investment Partners (Stoneridge), one of Charter's private investors, sought civil damages from Atlanta for its role in the fraud.[23] In a 5-3 decision[24] (Justice Breyer recused himself), the Court, adhering to both *Central Bank* and the Reform Act, held that Atlanta was only an aider and abettor to the fraud and, consequently, only the SEC could pursue civil damages.[25]

III. ANALYSIS

A. Finding Balance Between Investor Protection and Free Markets

Stoneridge confronts the unavoidable conflict between minimal market regulation and adequate investor protection. This section analyzes contemporary arguments made by advocates for freer markets and weighs these against arguments advocating heightened regulation and investor protection.

1. Contemporary Arguments for Freer Markets

The business lobby has recently argued that SOX has suffocated free enterprise, referencing reports by these three organizations to back its claim: the Committee on Capital Market Regulation,[26] the Commission on the Regulation of U.S. Capital Markets in the 21st Century,[27] and McKinsey and Company.[28] The

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defendants, and President George W. Bush himself reportedly decided that the Solicitor General would file an *amicus* brief in support of the defendants' position.

Barbara Black, *Stoneridge Investment Partners v. Scientific Atlanta, Inc.: Reliance on Deceptive Conduct and the Future of Securities Fraud Class Actions*, 36 SEC. REG. L.J. 330–31 (2008). The Court responded by devoting the lion's share of its holding to setting forth policy considerations that, in its view, mandate against extending the scope of the private remedies against aiders and abettors. *See Stoneridge*, 128 S.Ct. at 770–73 (2008).

[21] *Stoneridge* 128 S.Ct. at 766 (2008).

[22] *Id.*

[23] *Id.* at 767.

[24] Justices Kennedy, Thomas, Scalia, Alito and Chief Justice Roberts voted in the majority. Justices Stevens, Ginsburg, and Souter dissented. *See id.* at 765.

[25] *Id.* at 774.

[26] James D. Cox, Randall S. Thomas, & Lynn Bai, *There Are Plaintiffs And . . . There Are Plaintiffs: An Empirical Analysis of Securities Class Action Settlements*, 61 VAND. L. REV. 355, 358–60 (2008).

[27] *Id.*

reports focus on one central theme: how the plaintiff-friendly atmosphere of U.S. securities markets places them at a competitive disadvantage to foreign markets.[29] Companies considering an Initial Public Stock Offering (IPO) are becoming increasingly more likely to offer their IPOs in less-regulated markets, particularly the London Stock Exchange.[30] The reports noted that the heavy SOX-imposed disclosure requirements have created heightened exposure to litigation and consequently caused many companies to steer their IPOs overseas.[31]

Such concerns were certainly on the mind of the *Stoneridge* majority. Justice Kennedy, writing for the Court, remarked that one of the Court's cases from the 1970s, *Blue Chip Stamps v. Manor Drug Stores*,[32]

> provides a further reason to reject [plaintiff Stoneridge's] approach. In *Blue Chip*, the Court noted that extensive discovery and the potential for uncertainty and disruption in a lawsuit allows plaintiffs with weak claims to extort settlement from innocent companies . . .[o]verseas firms with no other exposure to our securities laws could be deterred from doing business here. This, in turn, may raise the cost of being a publicly traded company under our law and shift securities offerings away from domestic capital markets. [33]

2. Contemporary Arguments for Investor Protection

Many investors, still in the angry wake of the Enron and WorldCom scandals, feel that *Stoneridge* is an unjustifiable restraint on the increased regulatory power Congress desired in SOX.[34] The investor lobby can also point to *Stoneridge*'s reference to *Blue Chips Stamps*[35] as an unjustifiable use of judicial precedent at the expense of Congressional intent. The concerns the Court noted in *Blue Chip Stamps*—drawn-out, expensive discovery for meritless litigation—were explicitly

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[28] *Id.*

[29] *See id.*

[30] For example, the Committee Report emphasized a widely reported news account that 24 of the 25 largest IPO's in 2006 took place in markets outside of the United States. *Id.* at 358–59. Additionally, the McKinsey Report notes that global IPO's taking place in the United States in 2006 were barely one-third the level they were in 2001, while European exchanges saw a 30 percent increase during this same period. *Id.* at 359. Finally, the Chamber report notes that the U.S. market share of world-wide listings has decreased nineteen percent since 1997. *Id.*

[31] *See id.*

[32] 421 U.S. 723 (1975).

[33] Stoneridge Inv. Partners, LLC v. Scientific-Atlanta, Inc., 128 S.Ct. 761, 772 (2008).

[34] Indeed, one commentator remarked that because of *Stoneridge*, the Enron defendants "got out of jail free." Steven J. Mintz, *U.S. Supreme Court Rejects "Scheme Liability"*, LITIG. NEWS, May, 2008, at 1.

[35] *Stoneridge*, 128 S.Ct. at 772.

addressed by, and indeed were the prime reason for passing the Reform Act.[36] Hence, while there may be compelling reasons to refrain from granting a private cause of action against aiders and abettors, the Court cannot justify doing so on the reasoning set forth in *Blue Chip Stamps* unless it is prepared to argue that the Reform Act has not been successful, an argument that conflicts with current legal scholarship.[37]

Investors can also argue that the contemporary securities arena leaves them with an unjustifiably weak civil remedy against aiders and abettors. *Stoneridge* reasons in a way that almost sounds as if the Court believed that Congress intended no remedy at all against aiders and abettors.[38] Congress not only provided such a remedy in the Reform Act when it designated the SEC as the sole civil damages collector against aiders and abettors, but reaffirmed and strengthened this remedy in SOX when it allowed the SEC to distribute the damages it collects to defrauded investors.[39] Hence, the issue is not whether Congress intended to provide a civil remedy against aiders and abettors, but whether the remedy it has designated—SEC civil collection—is adequate in the current securities landscape.[40] The next section addresses this issue.

B. The SEC as the Investor's Sole Civil Remedy against Aiders and Abettors

Congress likely designated the SEC as the sole collector of civil damages against aiders and abettors because it felt the SEC would be less likely than private investors to pursue vexatious litigation,[41] a primary concern the Reform Act aimed to curb.[42] While it is almost certainly true that fewer vexatious claims have been

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[36] *See* Fisch, *supra* note 8, at 1304.

[37] *See* Cox,Thomas, & Bai, *supra* note 26, at 358 (arguing that the Reform Act has been successful).

[38] *See Stoneridge*, 126 S. Ct. at 769 (stating that "[t]he § 10(b) implied private right of action does not extend to aiders and abettors"). The Court offers only a few lines discussing the remedy the SEC provides against aiders and abettors. In reading the Reform Act's declaration that there is "no private cause of action," the Court overemphasizes the words "no cause of action" and underemphasizes the word "private." *See id.* Congress desired a remedy against aiders and abettors to a securities fraud; it simply provided this remedy through the public sphere.

[39] *See* Black, *supra* note 20, at 325 (stating that "[i]n enacting SOX in 2002, Congress explicitly authorized the SEC to collect funds to compensate investors for their losses").

[40] Though *Stoneridge* expounded on policy considerations that are arguably flawed, the Court correctly deferred to Congressional intent in making its overarching holding that the cause of action against aiders and abettors should not be extended. *See* Wilder v. Virginia Hosp. Ass'n., 496 U.S. 498, 509 n.9 (1990) (stating that "Congress rather than the courts controls the availability of remedies for violations of statutes").

[41] *See* Black, *supra* note 20, at 337 (stating that "[p]erhaps Congress had confidence that the agency, unlike private parties, was less likely to bring unmeritorious claims").

[42] *See* Fisch, *supra* note 8, at 1295 (stating that the Reform Act "dealt with perceived abuses by revising a variety of procedural and substantive aspects of private litigation").

filed against aiders and abettors since the passing of the Reform Act, this benefit has come at a high price. The SEC should not be designated as the sole party able to pursue civil remedies against aiders and abettors because: 1) the SEC's primary mission is to deter fraud, not compensate investors;[43] and 2) the Fair-Fund Provision, widely asserted by the business lobby as a more than adequate weapon for compensating victims of securities fraud,[44] does not apply to aiders and abettors the same way it does to primary violators. Each of these premises will be discussed in turn.

1. The SEC's Primary Mission is to Deter Fraud, Not Compensate Investors

The SEC shoulders the responsibility of deterring securities fraud throughout the United States,[45] a task commentators have noted far exceeds its available resources.[46] To best use its limited resources, the SEC has historically refrained from viewing the collection of civil damages as one of its principal objectives. [47] However, the Reform Act's designation of the SEC as the exclusive collector of civil damages from aiders and abettors[48] suggests that Congress desires that the collection of civil damages be a primary function of the SEC. The SEC's reluctance to embrace the collection of civil damages as one of its principal objectives likely reflects its awareness of the dangers to investor protection that would result if the SEC is forced to split its energies between deterring fraud and

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[43] *See* How the SEC Protects Investors, Maintains Market Integrity, and Facilitates Capital Formation, http://www.sec.gov/about/whatwedo.shtml (last visited Mar. 30, 2009) (stating that in the securities context, the "SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing, and protecting against fraud").

[44] Black, *supra* note 20, at 338.

[45] Some of the ways the SEC deters securities fraud include the use of cease and desist orders and injunctions, issuing releases that give guidelines and examples of legal and illegal financial reporting actions, counseling companies on why their proposed actions would be illegal, and working with the Department of Justice to prosecute securities fraud criminally. *See* How the SEC Protects Investors, Maintains Market Integrity, and Facilitates Capital Formation, http://www.sec.gov/about/whatwedo.shtml (last visited Mar. 30, 2009).

[46] *See* Cox & Thomas, *supra* note 14, at 756 (noting that "by far the greatest limiting factor in federal enforcement actions is the resources the SEC can commit to these efforts"); *see also* Black, *supra* note 20, at 338 (stating "the SEC does not and never will have the necessary resources to investigate and bring enforcement actions against every securities violator, much less pursue every enforcement action that may result in recovery for investors").

[47] *See* John D. Ellsworth, *Disgorgement in Securities Fraud Actions Brought by the SEC*, 1977 DUKE L.J. 641, 644 n.15 (stating that according to a 1968 speech by SEC Commissioner Richard B. Smith, "[t]he Commission attempts to avoid being a collection agency for injured investors" (quotations omitted)).

[48] Fisch, *supra* note 8, at 1304.

acting as a civil damages collection agency. Two main arguments reveal why the SEC's designation as the exclusive collector of civil damages from aiders and abettors conflicts with its primary function of deterring securities fraud and consequently prevents it from adequately providing the civil remedy against aiders and abettors to which defrauded investors are entitled.

First, cases that generate the deterrent effects the SEC seeks are typically against large, highly visible primary actors like Enron and WorldCom,[49] not against smaller aiders and abettors who often only appear on the fringes of the crime scene the public views when the fraud is uncovered, but who nevertheless may be just as culpable as the primary actors. While the SEC likely wishes to pursue these aiders and abettors, in order to send the broad deterrent messages it desires, the SEC, simply put, has bigger fish to fry.

The problems associated with the SEC's deterrence-driven focus on primary violators—at the expense of suits against aiders and abettors—are compounded when viewed in the light of a circularity problem recent commentary has noted occurs in securities litigation. This circularity problem is as follows: A fundamental precept of corporate governance is that ownership is separated from management.[50] Ownership in public companies is maintained through individual shares available to the public at large. When investors are defrauded and later file suit, the damages they receive come out of the pockets of the company's current shareholders, a classic case of "robbing Peter to pay Paul."[51] Even worse, when the defrauded investors continue to hold stock in the company at the time a class action suit is filed for the company's past fraudulent conduct, the investors are in a real sense suing themselves, a phenomenon commentators have called "robbing Peter to pay Peter."[52]

Pursuing civil damages from aiders and abettors is an especially valuable remedy because the circularity problem is not present. Because it was the primary actor's investors who were defrauded—not investors of the aiding and abetting party—lawsuits against an aider and abettor do not harm any investors who themselves were victims of fraudulent securities conduct.[53] Hence, the SEC's

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[49] *See* Cox & Thomas, *supra* note 14, at 759 (stating that "[t]he SEC gauges its enforcement priorities by the message the action sends to the industry and public . . . and the visibility the SEC enjoys in combating such abuses").

[50] *See* Travis S. Souza, Note, *Freedom to Defraud:* Stoneridge, *Primary Liability, and the Need to Properly Define Section 10(B)*, 57 DUKE L.J. 1179, 1201–02 (2008).

[51] *See* Black, *supra* note 20, at 331 (discussing the principal flaw in securities fraud class actions).

[52] *Id.*

[53] It is sensible that the investors of the aiding and abetting party share some of the burden the lawsuit produces. Though they, unlike the investors of the primary violator, will not be entitled to any of the damages a successful law suit would provide, they also were not exposed to the lost investment the fraud created. The lost investment of securities frauds far outweigh the typical damages or settlement amounts securities lawsuits bring, a

original mission of deterrence conflicts with its recent mandate to act as a civil damages collection agency against aiders and abettors. The SEC's pursuit of primary violators gives the preferable deterrent, but not compensatory effect. Its pursuit of secondary violators gives the preferable compensatory, but not deterrent effect.

Pursuing both objectives has created a type of "mission schizophrenia" at the SEC. The SEC traditionally did not recognize the collection of civil damages as one of its primary objectives.[54] Shortly after SOX was enacted, however, SEC Chairman Harvey Pitt noted the agency's "principal goal of taking care of innocent investors and trying to make them whole when they have been defrauded."[55] Current SEC leadership has continued this tone by often boasting of the large settlement and judgment amounts the SEC has returned to investors since the passing of SOX.[56]

However, in its 2004–2009 Strategic Plan, which sets forth the SEC's vision, mission, and strategic goals, the SEC described its mission as threefold: "to protect investors; maintain fair, orderly, and efficient markets; and facilitate capital formation."[57] It also articulated four goals: enforce compliance with federal securities laws, sustain an effective and flexible regulatory environment, encourage and promote informed investment decision making, and maximize the use of SEC resources.[58] Nowhere in the report was the returning of money to investors explicitly mentioned as part of the SEC's mission or goals.

The second reason that transforming the SEC into a compensatory agency conflicts with its mission of deterrence is that in order to make a deterrent presence

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point that will be discussed in greater detail later in this Note. *See infra* note 90 and accompanying text.

[54] *See* Ellsworth, *supra* note 47, at 641 (noting that it was not until "[r]oughly a decade ago the [SEC] first argued in federal court for the right to seek restitution of the ill-gotten profits of securities law violators").

[55] Harvey L. Pitt, Chairman, SEC, Remarks before the U.S. Department of Justice Corporate Fraud Conference (Sept. 26, 2002), www.sec.gov/news/speech/spch585.htm.

[56] *See* Christopher Cox, Chairman, SEC, Opening Remarks to the Practicing Law Institute's SEC Speaks Series (Feb. 9, 2007), http://sec.gov/news/speech /2007/spch020907cc.htm ("In 2006, we continued to order record monies to be returned to harmed investors . . . . $50 million in McAfee; $50 million in Tyco; $55 million in Hartford; $153 million in Security Brokerage . . . . [D]uring my 80-week tenure with the Commission, we have distributed over a billion dollars to injured investors."); *see also* Press Release: SEC Announces $316 Million Fair Fund Distribution to Investors Harmed by Fraud at Time Warner, July 9, 2007, *available at* http://www.sec.gov /news/press/2007/2007-131.htm ("With this distribution, the Commission will have distributed over $2 billion in Fair Fund monies since the 2002 passage of the Sarbanes-Oxley Act, demonstrating our continued resolve to return money to injured investors where appropriate.").

[57] SEC, 2004–2009 STRATEGIC PLAN 4 (2004), *available at* http://www.sec.gov /about/secstratplan0409.pdf.

[58] *Id.* at 5.

felt in all areas of securities fraud,[59] the SEC settles cases unusually quickly so it can allocate more resources to areas in which it is less represented.[60] Spreading itself thin over a large number of cases is one of the reasons commentators have argued that the SEC is a less effective remedy than private litigation.[61] Viewed in the light of *Stoneridge*, defrauded investors wishing to collect from the fraud's aiders and abettors can likely expect less in settlement and judgment awards than private litigation may have brought them, or worse still, when the SEC does not pursue the case, no compensation at all.[62]

In addition to the lower settlement amounts the SEC obtains, the Fair Fund Provision limits the SEC's ability to distribute civil damages to investors more when it seeks the funds from aiders and abettors than when it seeks the funds from primary violators. The differing application of the Fair Fund's civil damages distribution policy to aiders and abettors and primary violators is the focus of the next section.

2. The Fair Fund Provision Does Not Apply to Aiders and Abettors the Same Way It Does to Primary Violators

The Fair Fund Provision allows the SEC to distribute the civil penalties it gathers from securities law violators to investors.[63] Prior to the passing of SOX, all

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[59] SEC policy seeks to ensure that enforcement actions are not over- or underrepresented in the different areas of SEC regulation. *See* Black, *supra* note 20, at 343. Consequently, it seeks to dedicate no more than 40 percent of its resources to any one category "so as to maintain a 'presence' in every area it regulates." *Id.* (quoting SEC, 2006 PERFORMANCE AND ACCOUNTABILITY REPORT 6 (2006), *available at* http://www.sec.gov /about/secpar/secpar2006.pdf); *see also* Cox & Thomas, *supra* note 14, at 753 ("[A]ny priority setting inherently means that not all cases for which the SEC has a potential substantive dog in the fight will be engaged.").

[60] *See* Black, *supra* note 20, at 343.

[61] See Cox & Thomas, *supra* note 14, at 779 ("[E]ven after the enactment of the Fair Fund provision, the SEC is not armed in most instances with authority to recover from wrongdoers sums equal to those that can be recovered in private suits. Thus, even when there is a SEC enforcement action, the private suit provides a more encompassing remedy for the injured investors.").

[62] *Id.*

[63] The SEC has the option of pursuing civil damages from violating parties through both disgorgement and civil penalties. Disgorgement involves returning to investors the profits the violator obtained as a result of its fraud. Civil penalties, as their name implies, are instruments the SEC can use to invoke monetary punishment for conduct it feels is particularly egregious. *See* SEC, *The Investor's Advocate: How the SEC Protects Investors, Maintains Market Integrity, and Facilitates Capital Formation*, http://www.sec.gov /about/whatwedo.shtml (last visited Mar. 30, 2009) ("First and foremost, the SEC is a law enforcement agency. The Division of Enforcement assists the Commission in executing its law enforcement function.").

civil penalties were placed into the U.S. Treasury.[64] The Fair Fund Provision has been widely declared by the business community a sufficiently adequate tool to compensate injured investors, thus making private civil suits unnecessary.[65] While Congress has not responded to the business community's plea to abolish private litigation against primary violators,[66] the Reform Act's prevention of civil suits against aiders and abettors was not overruled by investor-friendly SOX.

(a) The Overlooked Mechanics of the Fair Fund Provision

Though the Fair Fund Provision has in its six-year existence been a powerful instrument for the SEC in its collection of civil damages from primary violators,[67] its ability to compensate investors decreases significantly when used to retrieve funds from aiders and abettors. For civil penalties to be distributed to injured investors, the Fair Fund requires the violator to have disgorged a profit.[68] If the violator has no profit that can be disgorged but has still been levied a civil penalty, the civil penalty, as it was pre–Fair Fund Provision, is placed in the U.S. Treasury.[69]

The Fair Fund Provision typically creates no obstacles when the SEC is pursuing a case against a primary violator. The SEC can generally show at least some profit that was gained as a result of a primary violator's deceptive acts, and even in those rare cases when it cannot, the SEC has attached a nominal one dollar disgorgement value to ensure that the civil penalty is given to investors.[70] Interestingly, this practice does not appear to be contested by primary violators or questioned by courts.[71]

But *Stoneridge*'s authoritative affirmation that only the SEC can pursue civil damages from aiders and abettors[72] coupled with its sharp, business-friendly categorization of what constitutes aiding and abetting as opposed to primary

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[64] *See* Black, *supra* note 20, at 318.

[65] Black, *supra* note 20, at 338.

[66] *See* Stoneridge Inv. Partners, LLC v. Scientific-Atlanta, Inc., 128 S. Ct. 761, 773 (2008) (noting that private civil litigation against primary actors is still legal in the U.S.).

[67] *See supra* note 56 and accompanying text.

[68] *See* Black, *supra* note 20, at 327.

[69] *Id.* at 318, 327.

[70] *Id.* at 330.

[71] *Id.* This is most likely because primary violators, for public relations and good-will purposes, would rather see the civil penalty returned to their own defrauded investors than to the U.S. Treasury; courts are reluctant to question an act that both compensates investors and is also preferred by company management.

[72] 128 S. Ct. 761, 771 (2008) ("Aiding and abetting liability is authorized in actions brought by the SEC but not by private parties.").

acting[73] will likely lead aiders and abettors to question the Fair Fund Provision's odd disgorgement requirement, and require that the SEC show a bona fide profit that the aider and abettor can disgorge before the SEC can distribute an accompanying civil penalty to the investor.

As noted previously, securities-fraud litigation suffers from an investor-harming circularity problem—the pains of a lawsuit are borne by the company's current, innocent shareholders. This circularity problem is worsened when the money is placed in the Federal Treasury. Rather than the "robbing Peter to pay Paul" problem, which at least allows the defrauded investors to be compensated—even if it comes at the expense of the current shareholders—when the civil penalty is placed in the Federal Treasury, the suit creates a problem of "robbing Peter to pay Uncle Sam." Both the defrauded investors and the current investors are harmed (though the government benefits). Because companies have interests in compensating anyone who has invested in the company—both those who may have been defrauded in the past and particularly the current shareholders—primary violators have strong incentives to ensure that civil penalties are given to investors. The SEC gladly accommodates this interest.

Aiders and abettors do not share this incentive. When suits are filed that include claims against aiders and abettors, any profits that either the aider and abettor or the primary violator disgorge, as well as any accompanying civil penalties levied against them, are given to the shareholders of the *primary violator*[74] (or to the Federal Treasury if there was no profit disgorgement). Investors of the aider and abettor receive nothing.

Additionally, aiders and abettors, in sharp contrast to primary violators, not only receive no benefit when civil penalties are returned to investors, they actually have an incentive to direct civil penalties to the Federal Treasury. The SEC takes great pride in returning funds to investors, particularly by using the Fair Fund provision because of the Fund's specific earmark as a tool to strengthen the SEC's compensatory abilities. As noted previously, Congress, courts, and the SEC itself often point to the large sums of money the Fair Fund provision has returned to investors when critics question whether SOX is protecting investors the way it was designed to.[75] Hence, the SEC has been pressured to put money where Congress's, courts, and the SEC's mouths are.

As *Stoneridge* takes root in securities-fraud litigation, and both courts and aiders and abettors become accustomed to the high bar that must be met for a deceptive party to be classified a primary violator rather than an aider and abettor,

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[73] *See* Souza, *supra* note 50, at 1206 (arguing that *Stoneridge* has created a standard that will allow many culpable actors to be tried only as aiders and abettors when sound policy suggests they should be tried as primary violators).

[74] This is because only investors who actually purchase or sell a security have standing in a securities lawsuit, and can consequently reap the damages any lawsuit brings. *See* Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723, 754–55 (1975).

[75] *See supra* note 56 and accompanying text.

and because *Stoneridge* authoritatively affirms that only the SEC can pursue civil damages agains those classified as aiders and abettors, deceptive secondary actors will likely take careful measures to 1) ensure that they can, at most, be classified as aiders and abettors;[76] and 2) require that the SEC show bona fide profit disgorgement—not the nominal one-dollar runaround the SEC has attached to primary violators—before a civil penalty can be distributed to investors. In regard to this second *Stoneridge* fallout, aiders and abettors have reason to argue for civil penalties being returned to the Treasury because it blunts the effects of the Fair Fund provision. This in turn will frustrate the SEC, likely causing it to focus its efforts on parties that will not challenge the Fair Fund's disgorgement requirement—which will in all likelihood be primary violators for the reasons mentioned above.

Hence, to keep SEC investigation away and thereby get themselves off the civil-liability hook entirely, those parties who regularly involve themselves as secondary actors in securities actions may need only establish a track record showing that civil penalties drawn from them are often placed in the Federal Treasury instead of being given to investors; they can effectively do so by challenging the Fair Fund's odd disgorgement requirement. The next section focuses on why aiders and abettors are in a better position than primary violators are to prevent the SEC from proving their role in the fraud provided a profit that can be disgorged, which consequently directs civil penalties away from investors and into the treasury.

(b) Aiders and Abettors' Convenient Path to Thwarting the Disgorgement Requirement

Aiders and abettors can more easily show that they received no profit from a fraudulent securities action because securities frauds are typically designed to make profit for the party that is selling the security, which in almost all cases is the primary violator.[77] Courts have been inconsistent in their categorization of

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[76] This will not be discussed in this Note because of the commentary already published on this issue. However, it should be mentioned that *Stoneridge* significantly heightened the bar of deceptive conduct a party must reach to move from aider and abettor to primary violator. *See* Souza, *supra* note 50, at 1206 (arguing that *Stoneridge* has created a standard that will allow many culpable actors to be tried only as aiders and abettors when sound policy suggests they should be tried as primary violators).

[77] Barbara Black notes how

> it is hard to identify any 'profits' or 'ill-gotten gains' in the absence of the entity's sale of its securities. The SEC does not appear ever to have argued that the definition of 'profits' includes the increase in the entity's value resulting from increased market capitalization or improper accounting practices. Indeed, requiring a corporation to disgorge amounts other than assets received by the corporation would raise serious questions about inflicting undue harm on the

disgorged profits and application of accompanying civil penalties. For example Big Four accounting firm KPMG was ruled to have made $10 million in ill-gotten profits for its fraudulent audit of Xerox and was consequently slapped with a $10 million civil penalty.[78] But another Big Four accounting firm, Deloitte & Touche, was ruled to have gained no profit that could be disgorged in its fraudulent audit of Adelphia, though Deloitte's deceptive accounting practices and corrupt relationship with its client were likely of a similar brand as KPMG's.[79] Consequently, the entire $50 million civil penalty taken from KPMG was placed in the Federal Treasury.[80]

Interestingly, the facts of *Stoneridge* provide an excellent example of how hazy the line of securities fraud profit making can become when dealing with secondary actors. In *Stoneridge*, the only fraudulent act performed by secondary actor Atlanta was an agreement to record on its financial statement goods that were never actually purchased from primary actor Charter.[81] The sales showed up on Charter's financial statements as income, leading investors to believe Charter was making more money than it actually was.[82]

However, careful accounting practices made the sales show up as a wash on Atlanta's financial statements.[83] Hence, during the time of the fraud, Atlanta showed no profit as a result of its aiding and abetting Charter's deceptive act. Though Atlanta may have conducted past business with Charter by which it gained profits, and though it certainly anticipated a future business relationship with Charter, the Fair Fund provision can arguably be construed as requiring profit disgorgement only when a defendant has actually profited from a sale of a security during the time of the fraudulent act, not just by assisting another defendant in the fraudulent sale of its securities.[84] Hence, any civil penalties the SEC obtains from Atlanta,[85] who neither sold nor purchased securities in the fraud, will likely be placed in the Federal Treasury.

Stoneridge has thus paved the way for aiders and abettors to avoid the civil penalties drawn from them from being given to investors because aiders and abettors can more easily prove they made no profits during the time of the fraud.

> corporation or, more pertinently, its innocent shareholders who did not benefit from the fraud.

Black, *supra* note 20, at 322.

[78] *See id.* at 329 n.82.

[79] *Id.*

[80] *Id.*

[81] *See* Stoneridge Inv. Partners, LLC v. Scientific Atlanta Inc., 128 S.Ct. 761, 766-7 (2008).

[82] *See Id.* at 766.

[83] *Id.* at 766–67.

[84] Black, *supra* note 20, at 322. ("[I]t is hard to identify any 'profits' or 'ill-gotten gains' in the absence of the entity's sale of its securities.").

[85] This is assuming the SEC chooses to file suit against Atlanta.

Hence, secondary actors can keep the SEC away by successfully proving that 1) they are only aiders and abettors, a task *Stoneridge* has made much easier[86] and 2) they disgorged no profits during the time the fraudulent act occurred, a task that is much easier for aiders and abettors and something they may press in order to force the SEC—knowing any civil penalties it collects from an aider and abettor who disgorged no profit will not pad its Fair Fund provision—to settle more quickly and for less or to avoid pursuing the case altogether. The next section offers solutions to this problem by recommending changes to federal securities law that will 1) allow investors to obtain their deserved remedy against aiders and abettors; 2) allow the SEC to maintain its mission as a deterrent, rather than a compensatory, agency; and 3) allow Congress to continue to liberate financial markets by curbing vexatious securities litigation.

(c) Potential Solutions

As noted previously, any change to federal securities law invites opposition from either the business or investor lobby, and sometimes from both. This section proposes three moderate changes that will increase investor protection while keeping the costs imposed on the business community to a minimum.

(i) Create a Federal Agency Whose Sole Purpose Is to Collect Civil Damages

The United States' designation of the SEC as both a civil damages collection agency and the primary deterrent agency against federal securities fraud is at odds with international securities standards.[87] A primary reason this two-pronged mission may have developed is because of a congressional desire to maintain some level of control over the amount of private securities litigation occurring in the United States. Any power the SEC obtains in the private litigation arena is indirectly passed along to Congress.

Creating a separate federal agency responsible only for civil damages collection would allow Congress to maintain its hand in the private litigation arena without suffering the negative impacts of combining deterrent and compensatory functions. A lighter remedy for this problem may simply be to sharply divide the SEC enforcement division into compensatory and deterrent subdivisions, each with management and staff that play no role in the mission of the other subdivision. This would remove the obstacles that are inevitably created when SEC staff are forced to juggle compensatory and deterrent objectives under the umbrella of one mission statement.

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[86] *See* Souza, *supra* note 50, at 1206.

[87] *See* Black, *supra* note 20, at 319.

(ii) Require Civil Suits Against Aiders to Meet Even Higher Standards than Those Required by the Reform Act

The Reform Act has been praised by commentators as a success.[88] If Congress is concerned with innocent secondary actors being exposed to excessive litigation, which certainly was a concern of the *Stoneridge* court, passing legislation that further heightens the plaintiff's burden is a more effective remedy than relying on the SEC's limited resources and separate agency objectives to keep the number of law suits and settlement amounts obtained from secondary actors at congressionally desired levels. Congress should not use the financial constraints of an executive agency to achieve an objective that should be achieved through legislation.

(iii) Amend the Fair Fund Provision to Allow the SEC to Distribute Civil Penalties to Investors Without Showing Disgorgement

Congress should amend the Fair Fund provision to either allow the SEC to distribute civil penalties to investors without showing any disgorgement, or, if Congress insists on some showing of disgorgement, require that only one party in the suit—in all likelihood the primary violator—disgorge a profit to trigger the distribution of civil penalties to investors. There is no sensible reason for requiring that a violator disgorge a profit before civil penalties can be distributed to investors. Perhaps, as one commentator noted, "Congress may have viewed ill-gotten gains as the equivalent of restitution and seen disgorgement as a proxy for investor harm, so that distribution of the penalty to investors would not be a windfall recovery."[89]

> However, if this is the case, Congress significantly overestimates the compensatory abilities of a securities lawsuit in relation to the harm securities frauds cause investors. Commentators have noted that it is the nature of financial fraud violations that the harm caused as a consequence of misrepresenting the firm's performance or financial position is often greater than any profit violators take home . . . . Even though [civil penalties] can be considerable, with the largest penalty now authorized reaching $25 million...this amount can pale when compared to the harm proximately caused by the defendants' violation.[90]

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[88] Cox, Thomas, & Bai, *supra* note 26, at 358.

[89] Black, *supra* note 20, at 327.

[90] Cox & Thomas, *supra* note 14, at 756. The SEC has also noted that "financial fraud violations may cause huge investor losses that dwarf, by several orders of magnitude, any profit that violators made." *Id.* at 755–56; *see also* John C. Coffee, Jr., *Reforming the Securities Class Action: An Essay on Deterrence and Its Implementation*, 106 COLUM. L. REV. 1534, 1545 ("Settlements recover only a very small share of investor losses. NERA

Additionally, as argued previously, aiders and abettors have an incentive to direct their civil penalties to the Federal Treasury, rather than to the defrauded investors of the primary violator. If the SEC can distribute civil penalties to investors regardless of whether or not the party disgorged a profit (or if at least some party in the suit disgorged a profit) aiders and abettors no longer have this incentive. Civil penalties levied against aiders and abettors will end up where they should—with the injured investor. A primary benefit of these final two recommendations is that they skirt the circularity problems that have become so troublesome in securities litigation.[91] When an aider and abettor is successfully sued, the primary violator's investors who held stock at the time of the fraud are not harmed (robbing Peter to pay Peter) nor are the company's current shareholders (robbing Peter to pay Paul). And by amending the Fair Fund Provision to allow civil penalties to be distributed to investors regardless of whether profit was disgorged, the "robbing Peter to pay Uncle Sam" problem is solved as well.

IV. CONCLUSION

Stoneridge reveals the problems that arise when judicial inconsistency crosses paths with congressional acquiescence. Sharply departing from an era when federal courts were viewed as capable of interpreting securities laws in the light of current policy considerations,[92] a practice to which Congress has consistently acquiesced,[93] *Central Bank* inexplicably employed a strict textual approach to the Federal Securities Act.[94] The Reform Act, which expounded on *Central Bank* by designating the SEC as the exclusive collector of civil damages from aiders and abettors,[95] indirectly allows Congress to rely on the SEC's limited resources and separate agency objectives to keep the number of law suits and settlement amounts at congressionally desired levels.

As a result, the SEC is pulled in two separate directions, forcing it to choose between either sacrificing part of its mission to deter fraud or to forgo suing many culpable aiders and abettors. *Stoneridge*, the latest judicial affirmation of the Reform Act, justified its holding by noting that the SEC's power to pursue civil remedies from aiders and abettors "is not toothless."[96] While the SEC may not be

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Economic Consulting annually prepares a table showing the ratio of settlements to investor losses, and between 1991 and 2004, this ratio has never exceeded 7.2%. . . .").

[91] *See* Black, *supra* note 20, at 7 ("[T]he concern over circularity of damages is absent in actions against outside actors.").

[92] *See* Fisch, *supra* note 8, at 1293.

[93] *See Id.* at 1307.

[94] *See* Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A., 511 U.S. 164, 177 (1994).

[95] Stoneridge Inv. Partners, LLC v. Scientific-Atlanta, Inc., 128 S.Ct. 761, 771 (2008).

[96] *Id.* at 773.

"toothless," the constraints it faces as a government agency charged with deterring all federal securities fraud often prevent it from adequately "putting down the bite," leaving defrauded investors with little or no remedy against the aiders and abettors who wronged them.

Compounding the problem is Congress's and the Court's belief that the Fair Fund Provision is a sufficient tool to compensate injured investors, seemingly not recognizing that the Fair Fund Provision's enigmatic disgorgement requirement will likely be challenged more vigorously by secondary actors in light of *Stoneridge*. This note has proposed some moderate solutions—creating a new federal agency that would focus entirely on civil damages collections or at minimum dividing the SEC enforcement division into compensatory and deterrent subdivisions, heightening the plaintiff's burden for suits against aiders and abettors, amending the Fair Fund provision to allow civil penalties to be returned to investors without the showing of disgorgement—that would restore some of the remedial measures available to investors without overly burdening the business community. The *Stoneridge* dissent noted that "investor faith in the safety and integrity of our markets *is* their strength. The fact that our markets are the safest in the world has helped make them the strongest in the world."[97] In the face of an economic crisis that has driven investor confidence in financial markets to historical lows, the need for a regulatory system capable of providing an effective remedy to every injured investor has never been greater.

[97] *Id.* at 779.