Fordham Urban Law Journal

Volume 28 | Number 1 Article 5

2000

Thinking About Drug Law Reform: Some Political Dynamics of Medicalization

Fredrick Polak

THINKING ABOUT DRUG LAW REFORM: SOME POLITICAL DYNAMICS OF MEDICALIZATION

*Fredrick Polak**

INTRODUCTION

Many people believe that medicalization offers the most reasonable approach to drug policy because it promises a dignified solution to the conflicting goals of prohibition and humane treatment of addicts.[1] The medicalization model, by encompassing in the medical domain some phenomenon or problem, allows medical considerations to be decisive in the interpretation of that problem and in the choice of measures to resolve the situation. With respect to drug use, medicalization can have a broad range of meanings and consequences. When it means providing normal, good quality medical care to drug addicts, including the prescription of illicit drugs, it should be applauded as a positive development.[2]

However, medicalization also may define regular, frequent drug use as a mental disorder; designate abstinence as the only acceptable treatment outcome; and/or recommend compulsory treatment for all users of illegal drugs, be they dependent or casual users. The latter three versions of medicalization demonstrate that, while the medicalization approach for drug policy seems more humane than repression of drug use, it risks becoming a form of repression itself.

One reason medicalization often is hailed as a more humane approach to drug policy than reliance upon the criminal justice system alone is because of the expectation that in the medical model, addiction no longer will be stigmatizing because it is considered a disease, and, hence, addicts no longer will be accused of being the cause of their problems. Another reason is that it still seems impossible to promote serious discussion of the more radical ap-

* M.D., psychiatrist, Department of Mental Health, Municipal Health Service of the City of Amsterdam, Netherlands, member of the board of the Dutch Drug Policy Foundation.

1. Although I prefer other terms, such as frequent users, problematic users, and compulsive users, I also use the word "addicts" to indicate that I mean the same loosely defined group of regular drug users.

2. Australian harm reduction advocate Alex Wodak sees medical prescription of illicit drugs as a successful and humane way of reducing the risks associated with such drug use. Alex Wodak, *Harm Reduction as an Approach to Treatment, in* PRINCIPLES OF ADDICTION MEDICINE 395 (Allan W. Graham et al. eds., 2d. ed., 1998).

proach of repealing drug prohibition and creating a set of legal regulations for the different groups of substances. Therefore, some proponents of legal regulation hope that medicalization may be an instrument in the transition to a legalized system, while other "legalizers" accept medicalization as the second-best alternative.[3]

On the other end of the political spectrum, some hard-core prohibitionists expect medicalization to leave punitive repression in place. One example of the rhetorical excesses to which this application of the medicalization paradigm can be taken is drug czar General McCaffrey's benevolently telling the American people that the war on drugs metaphor really is not appropriate (shortly before expanding the drug war in Colombia) and that fighting drug addiction can better be compared to fighting cancer.[4] What does this medical analogy mean? In surgery, cancers have to be eradicated, often along with a wide margin of healthy tissue, for safety. Further, chemotherapy kills many healthy cells. So here, the medicalization paradigm is used as a legitimization of collateral damage—no different than in a war. It provides the rhetorical cover for continuing the current repressive policies in the war on drugs.

On the whole, criticism of the medicalization approach—particularly from drug law reformers—is not welcome in the current climate of support for a policy of repression. This lack of receptivity to such criticism exists both among policy makers and the public at large. Some drug law reformers have advanced arguments that drug addiction is not a disease which requires a "cure," but a complex phenomenon, resulting from individual desires, and for which one must accept personal responsibility.[5] This seems to have alienated the public, thus diminishing the reformers' chances of progress through building public support.

---

3. In 1994, the Stichting Drugsbeleid (Dutch Drug Policy Foundation) published a report on the need for legalization which contained a proposal for the first phase of the transition to legal regulation. This system was based on the combination of controlled sales of "normal" doses of all presently illegal drugs to adults (the report recommended that the age requirement should be the same as for alcohol and cigarettes, which means sixteen or eighteen in most western countries) with medical prescription of larger doses of these substances to dependent people. NETHERLANDS DRUG POLICY FOUND., DRUG CONTROL THROUGH LEGALIZATION: A PLAN FOR REGULATION OF THE PROBLEM IN THE NETHERLANDS (1994), http://www.drugtext.org/reports/nlplan.

4. *Shadow Wars and Conventions*, THE LEDGER, Aug. 1, 2000, at A6.

5. On this subject I recommend: Thomas S. Szasz, *Bad Habits Are Not Diseases: A Refutation of the Claim that Alcoholism is a Disease*, 2 LANCET, 83 (1972); THOMAS S. SZASZ, CEREMONIAL CHEMISTRY (Learning Publ'ns 1985) (1973); PETER COHEN, DRUGS AS A SOCIAL CONSTRUCT (1990); JOHN BOOTH DAVIES, THE MYTH OF ADDICTION (2d ed. 1997); STANTON PEELE, THE MEANING OF ADDICTION (1985).

Being aware of this difficulty, and acknowledging possible positive aspects of medicalization, I begin this essay by offering a few critical words on the position of the medical profession in drug policy.[6] Then, I will attempt to stimulate the drug policy debate by outlining certain negative political ramifications and social consequences of an abstinence-directed medicalization policy. I will argue that:

A. Making addicts responsible for their own cure and failure of treatment will result in more (coerced) treatment.
B. An obsessive fear of loss of control leads to a mistaken conception of drug dependence and to a failure to distinguish between controlled and problematic drug use.
C. There is a hidden link between medicalization and racial discrimination.
D. The medical addiction model facilitates tolerance towards "addictions" to consumer goods, diminishing personal responsibility.
E. Medicalization creates a new elite class that benefits from drug prohibition and is capable of creating new "patients."

THE POSITION OF THE MEDICAL PROFESSION IN DRUG POLICY

Doctors have both the responsibility for the treatment of people with dependency problems and the monopoly in prescribing some otherwise illicit drugs. Furthermore, doctors occupy a unique dual position in the drug policy debate: an official one, as individual medical experts and as professionals; and an unofficial one, as physicians to and friends of influential people. Although presidents and prime ministers typically are not experts on drugs, they do not accept automatically the recommendations of expert committees. Our leaders understand that experts can be found to support any number of opinions and viewpoints. For their own comfort, leaders informally may consult their private physicians, whose opinions they have learned to trust, and ask for their thoughts on the legali-

6. This text is not a scientific article, but a medico-political essay. There is little scientific evidence about many of the themes upon which I touch. As a psychiatrist, I have seventeen years of experience in general psychiatry in a system in which addicts were often shut out and referred to the categorical field of addiction treatment, and ten years of experience in addiction treatment in the public health system. I have some experience in medical organizational politics and in lobbying political parties. In this essay I did not try to pose as a scholar. I thought that I should stay close to my core business in drug policy, which is the link between psychiatry and medicine on the one hand, and politics on the other. From that position I have developed a critical view of what medicalization can do to alleviate drug problems.

zation of drugs. Unfortunately, most doctors suffer from the Clinician's Illusion.[7] Therefore, those doctors' answers are more likely to be, "Oh, no, that would be too risky," rather than, "Yes, that will have a beneficial effect on public health, not to mention the other areas that you know more about."

Some doctors do not believe that their medical responsibility is at stake in such a situation, and that a formal advisory function should accompany their medical expertise. This attitude may result in the situation in which doctors would have to collaborate in coerced treatment—with poor results—but not feel free to say that the medical argument for prohibition fails. One could call this the "half-medicalization" scenario. These doctors may assume that the decision to prohibit drugs is a political one, and the status of being a doctor does not render their opinion on national drug policy to be any more important than the opinions of other citizens. Nevertheless, every official text on drug policy contains medical arguments and health considerations that are advanced as important, if not essential, reasons for prohibition. Doctors, therefore, are in a unique position to understand and explain that many of the pro-repression health arguments, such as the risks of toxicity and addiction, are abused by proponents of prohibition. Doctors, both individually and collectively, should educate the public and the policymakers that there are no sufficient reasons to treat illicit drugs so differently from alcohol and cigarettes, and that health and medical arguments actually plead for legal regulation.

The crucial importance of doctors' opinions on the subject of drugs was underlined at the Eighth International Conference on the Reduction of Drug-Related Harm, March 1997 in Paris.[8] A hot topic at the conference was the resistance by French medical specialists, especially psychiatrists, to the introduction of harm reduction methods.[9] At the closing session of the conference, three French ex-ministers of health, Barzach, Kouchner, and Veil, accused the medical profession of systematically sabotaging necessary reforms.[10] Simone Veil even compared the potential role of doctors in the drug policy debate to that played by doctors in reaction to the scandal of HIV-infected transfusion blood, explaining

7. *Infra* note 14 and accompanying text.

8. Follea Laurence, *Le bilan encourageant de la politique de reduction des risques* [*A Report Encouraging a Policy of Harm Reduction*], LE MONDE, Mar. 29, 1997 (Societé).

9. *Id.*

10. *See id.*

that it had been general practitioners who successfully initiated policy changes in France to promote greater safety.[11] The ex-ministers painted a picture of negligence, abuse of power, self-interest and prejudice on the part of the medical community with respect to the issue of drug policy. For example, the results of the only French methadone project, the famous "25 places"[12] in Paris, were kept secret, probably because they were positive and provided support for continuing the project. Further, French psychiatrists who were considered specialists on the subject of drug use have long claimed that every addict should be treated and cured only psychotherapeutically.[13] Indeed, methadone prescription was not considered a therapy. These specialists expressed an unwillingness to explore literature from which they could have learned about other developments in the field. Even when they did peruse such studies, these specialists found excuses for rejecting the articles' findings, such as the belief that foreign articles were not reliable.

That doctors are publicly blamed by prominent politicians for the inferior French drug policy and for their indirect involvement in hundreds of AIDS and other drug-related deaths, provides a compelling reason for the profession to reexamine its role in the drug policy debate. Doctors are blamed not just for negligence, but also for their lack of knowledge and refusal to learn from experiences in other countries. Even in the most favorable analysis, prejudice accounted for this situation, because doctors confused their personal, ideological opinions with professional knowledge.

The background of this confusion is that the medical attitude towards drugs consists of a number of factors. I will discuss two of these factors. First, there is the specific problem of the "Clinician's Illusion,"[14] an epidemiological phenomenon described by the American epidemiologists Patricia and Jacob Cohen of which few doctors are aware. Doctors see users only in treatment, or via the police and the judiciary, which means they see a disproportionately large number of serious and chronic cases. Additionally, in medi-

11. *See id.*

12. *See* Follea Laurence, *Une conférence rehabilite le principe du sevrage des heroinomanes* [*A Conference Revives the Principle of Weaning Heroin Addicts*], LE MONDE, May 7, 1998 (Societé).

13. *See* Follea Laurence, *La politique de réduction des risques est une idée humaine et pragmatique* [*The Policy of Harm Reduction is a Humane and Pragmatic Idea*], LE MONDE, May 7, 1998 (Societé). *See also* Follea Laurence, *Le rôle ambigu du medecin face à l'entreprise de punition* [*The Ambiguous Role of Doctors in Prisons*], LE MONDE, Nov. 14, 1997 (Societé).

14. Patricia Cohen & Jacob Cohen, *The Clinician's Illusion*, 41 ARCHIVES OF GEN. PSYCHIATRY 1178 (1984).

cal conditions with great variability in seriousness and duration, such as drug dependence, doctors systematically underestimate the percentage of cases that are lighter or have a shorter duration.[15] In the case of drug use, the resulting "Illusion" would be a mistaken belief that drug use is predominantly chronic and life-threatening. Second, the war on drugs has created a media image of drug use that is excessively negative, and doctors, no less than the general population, are exposed to this distortion. The crucial point is that this distorted image, which begins as a general phenomenon, is seemingly confirmed by the impressions of doctors working under the influence of the Clinician's Illusion.

NEGATIVE POLITICAL AND SOCIAL ASPECTS AND CONSEQUENCES OF AN ABSTINENCE-DIRECTED MEDICALIZATION POLICY

A. Making Addicts Responsible For Their Own Cure

Because addiction is currently defined as a disease, addicts must be "treated" (which in the United States is more often coercive than voluntary), and "cured" (which is defined as remaining abstinent). However, the well-known weakness of drug treatment is that a large majority of patients will not reach this goal. This is also true in the treatment of alcoholics and addicted cigarette smokers. Drug users often will fail to fulfill their conditions of probation or requirements set by a drug court, which results in incarceration or further coerced treatment. So, while it may seem as if under medicalization addicts are no longer accused of being the cause of their own problems (because addiction is defined as a disease), what happens when treatment fails? A consequence of the treatment paradigm, where abstinence is the dominant treatment goal, is that addicts *are* held responsible for their own "cure." When addicts are not cured on the orders of the state and the judicial system, they will be punished, and put in prison anyway—just as they would have been under a strict prohibition, or criminal justice appraoch. Forced treatment may appear more humane than straight incarceration, but in practice, for the majority of addicts who are not helped by treatment, or do not wish to be completely abstinent, this scheme will mean long stretches of lost freedom. This is be-

15. *Id.*; *see also* Freek Polak, *The Medicalization of (Problematic) Intoxicant Use and the Medical Provision of Psychoactive Drugs*, *in* DE-AMERICANIZING DRUG POLICY, THE SEARCH FOR ALTERNATIVES FOR FAILED REPRESSION 175, 179 (Lorenz Böllinger ed., 1994).

cause they suffer from a "disease" for which other addicts—alcoholics or cigarette smokers—are not treated involuntarily or punished, and, on top of that, for which treatment often fails. Since their "disease" is proclaimed intolerable, coercing them to be "cured" is considered ethical.

The argument is often advanced that without coercion there is insufficient incentive to enter treatment and, within a medical paradigm, not wanting to enter treatment is considered a symptom of the disease. However, this is an inversion of reality. Since voluntary treatment is scarcely available in the United States, for many people treatment is only accessible when they are incarcerated.[16]

B. An Obsessive Fear Of Loss Of Control And Failure To Distinguish Between Controlled And Problematic Drug Use

Inherent in the current medical conception of addiction in the United States is the importance of external control over an individual's drug use by the criminal justice system. This conception of addiction negates controlled use, which may be defined as self-imposed, regular, moderate, non-problematic use. Judging from movies and television, one gets the impression that the American people's belief in strong external control is linked to an obsessive fear of loss of personal control—to such a degree that it has become impossible for many to believe that people can indeed learn to use drugs moderately and responsibly. By extension, the negation of controlled drug use would lead to the idea that, without external control, there would not be many people other than alcoholics drinking alcohol. This is at odds with reality. It is well known from experience in more liberal countries and from historical, anthropological, and current epidemiological research that without professional help and on their own, more addicts learn to stop using drugs, or learn to use them in a controlled way that conforms to the conventional roles of productive citizens and parents, than do in treatment programs.[17]

In the United States, it is standard policy to call every form of use of illegal drugs either "abuse" or "addiction." In the United

16. *See* Lorri Preston, *New Treatments Further Complicate AIDS in U.S. Prisons*, AIDS WEEKLY PLUS, June 29, 1998 (discussing how prison inmates are likely to receive better treatment for AIDS while incarcerated than upon release).

17. Stanton Peele, *Can Alcoholism and Other Drug Addiction Problems Be Treated Away or Is the Current Treatment Binge Doing More Harm Than Good?*, 41 J. OF PSYCHOACTIVE DRUGS 375 (1988).

Kingdom, a similar ideology labels all drug use as "misuse." This shows that the current repression model of drug policy is not directed at problematic users or at addicts in general, but that it is aimed at all users of illegal drugs. The failure to distinguish between recreational and responsible drug use on the one hand, and problematic or "addictive" use on the other, gives prohibitionists the power to exert control over every user of illegal drugs, regardless of whether the use is moderate or excessive and regardless of whether it needs to be treated. In this respect, medicalization is different from criminal justice models only in that physicians will be in control of the policy and enforcement.

C. The Hidden Link Between Medicalization And Racial Discrimination

The number of blacks and Latinos in detention in the United States is disproportionately large,[18] but not because blacks and Latinos use more drugs. They are poorer, their use is more visible, and they are more often targeted by law enforcement.[19] The term "disproportionately" is used somewhat euphemistically here. To me, the number of minorities in detention is unbelievable.[20] Every American who is confronted with this reality will need to find some kind of justification for these racial disparities.

Today, genetic factors are cited to make it seem that there are sound reasons for this horrible situation. Unfortunately, there are many historical examples of medicalization providing the justification for sexist or racist policies. Drug use is systematically associated with aggression and criminality. The media has reported about genetic factors contributing to addiction, aggression, and criminality. These reports often are accompanied by images of minorities. This fallaciously implies that drug use is genetically determined. It suggests that genetic traits leading to addiction, aggression, and criminal behavior are more prevalent in some minorities than in whites, and that this is why so many minorities are incarcerated for drug offenses. This untruth perpetuates the idea that the U.S. drug problem is specific to African-American and Latino communities, rather than that it is a general social problem.

18. *E.g.*, Fox Butterfield, *Number in Prison Grows Despite Crime Reduction*, N.Y. TIMES, Aug. 10, 2000, at A10.

19. Steven B. Duke, *Commentary: Drug Prohibition: An Unnatural Disaster*, 27 CONN. L. REV. 571, 590-94 (1995) (discussing the disproportionate impact of the drug war on black and Hispanic communities).

20. *See* Butterfield, *supra* note 18 (noting that the incarceration rate for black men in their late twenties is almost ten times the rate for white men).

The contemporary popularity of genetic explanations for behavior has prompted many medical experts to provide information and give their views on various social problems. Medicalization should mean that doctors make their views heard, individually and as a group. When the social problems resulting from current drug policies are treated as personal medical problems, doctors should not through their silence lend tacit support to the current and fallacious genetic explanation for drug use or incarceration rates.

D. Tolerance Towards "Addictions" To Consumer Goods Diminishes Personal Responsibility

A significant portion of the U.S. population believes in the idea of addiction as a disease in which one cannot sufficiently control oneself. On the one hand, this leads to a hard approach towards drug addicts and an acceptance of punishing them for their lack of personal control. On the other hand, many people apply this concept to themselves in a remarkably softened way. A function of this conception of addiction is that it diminishes the burden of personal responsibility in our daily behavior. Of course, it does not completely eliminate personal responsibility, but it diminishes it to an important degree. This image of addiction, as a condition for which one is not completely responsible, has a peculiar attraction. The theme of addiction is often noticeable in ad campaigns for consumer goods. The addiction concept is so banal that addiction becomes something from which everyone suffers. This concept facilitates acceptance of one's weakness as a consumer, but at the same time allows for the belief that one's addiction is not as bad as that suffered by others. Mass consumption becomes an inability to resist the desire to buy a product, such as a piece of chocolate or a car, rather than a controllable urge. That is exactly what advertising is about—getting people to allow themselves to buy a specific article, which they want so badly, but do not really need.

E. Medicalization Creates A New Elite Class That Benefits From Drug Prohibition And Is Capable Of Creating New "Patients"

The rising status and influence of addiction medicine and addiction psychiatry provide for a new caste of professionals who profit from drug prohibition. The addiction medical elite make believe that the status of addiction as a brain disease is firmly established. In reality, the scientific discussion on the nature of addiction is far

from closed.[21] The National Institute on Drug Abuse ("NIDA") (a remarkable name: aren't they interested in drug *use*?) pays hundreds of millions of dollars per year for the construction of the unwarranted dominance of clinical biopsychopharmacological research.[22]

When the disease concept is not strictly reserved for medical conditions but is expanded to regular drug use and to other socially unacceptable behavior, repression and prohibition of deviant behaviors flourish. This is not a new idea, but in thinking about drug users, habitually or ritually called "abusers," it is generally not recognized that many regular users of alcohol and cigarettes also would be viewed as addicts if the substances they used were illegal. Because alcohol and cigarettes are still legal, drinkers and smokers can function as normal citizens, and the question of whether their pattern of usage should be called addiction does not seriously arise for most of them.

Under current prohibition policies, medicalization creates its own patients. Many drug users officially are considered and treated as addicts. However, under a legal regulation regime, they generally would be viewed as regular, heavy users, and not as addicts. There are at least two reasons for this categorization:

First, the most widely used psychiatric diagnostic system is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* ("DSM").[23] This system uses two criteria which are strongly context-dependent in the definition of substance dependence, and as a result, many users of illicit drugs will be included in this definition primarily because of the illegal status of their drugs, not because of any physical or mental impairment.[24]

---

21. *See* PSYCHOLOGICAL THEORIES OF DRINKING AND ALCOHOLISM (Kenneth E. Leonard & Howard T. Blane eds., 2d ed. 1999) (mentioning a range of theories on alcohol and drug dependence, supported by a steady stream of research that claims to increase the understanding of mechanisms of addiction); *see also* STANTON PEELE, DISEASING OF AMERICA (Jossey-Bass 1999) (1989) (criticizing the American treatment system).

22. NAT'L INST. ON DRUG ABUSE, CURRENT NIDA RESEARCH CENTER GRANTS, NIDA NOTES, January/February 1996, (listing current recipients of NIDA research center grants) http://165.112.78.61/NIDA_Notes/NNVol11N1/Currentgrants.html; *see also* Arthur Allen, *The Drug War's Tweedledee*, SALON.COM (Oct. 10, 2000), *at* http://www.salon.com/health/feature/2000/10/10/nida/index.html.

23. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994).

24. In the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, three of seven criteria are needed for the "diagnosis" of "Substance Dependence." *Id.* at 176-79. The DSM gives the following formulations for criteria 5 and 6—criterion 5: "a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting

When doctors espouse the view that drug dependence is a disease, they should at least point out to the general public that most drug users are normal, healthy people and that, if addiction is a disease, it is a very special kind of disease. Few diseases exist in which the patient can decide to say, at almost any point during the course of the disease, "All right, I am fed up with this disease. I am going to be cured from now on." This does not fit the medical model. It can only be explained by the combined influences of psychological, social, and biological factors on drug users, and on the course and development of usage patterns. This shows the necessity of applying the biopsychosocial model to drug dependence discourse.

Second, the penal system, and especially the drug courts, refer large numbers of users to treatment systems after an arrest for possession or sales, not because of addictive behavior. To its discredit, the treatment system in general accepts these "patients." Of course, under prohibition, the "patients" also profit from this situation, because it offers them a milder type of punishment than incarceration.

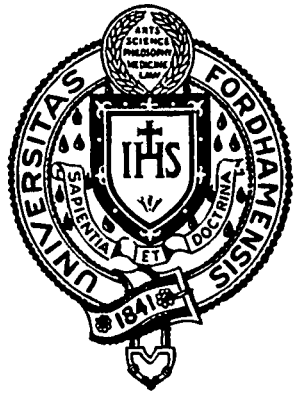
CONCLUSION

When drug prohibition and the abstinence paradigm are kept in place, medicalization will mean even less voluntary and more coerced treatment, which is ineffective for most people, and no freedom for recreational or other forms of controlled drug use. The most important political consequence of this kind of medicalization is that it allows for the continuation of excessive control over all drug users by the criminal justice system.

The medical profession carries an important part of the responsibility for not informing the general public about the effects of drugs and the nature of drug use, and for keeping in place a system of drug prohibition which has proved to be harmful to public health and especially to minorities. Doctors should explain that drug prohibition lacks a scientific foundation and that public health would be better served by legal regulation.

---

multiple doctors or driving long distances)" and criterion 6: "important social, occupational, or recreational activities are given up or reduced because of substance use." *Id.* at 178. For the "diagnosis" of "Substance Abuse," one of four criteria suffices. Criterion 3 is as follows: "recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)." *Id.* at 182.


ARTS
SCIENCE
PHILOSOPHY
MEDICINE
LAW
IHS
SAPIENTIA
ET
DOCTRINA
UNIVERSITAS
FORDHAMENSIS
1841