CHAPTER 6

Drug and Alcohol Use

Scott Krueger was looking forward to balancing the challenging demands of an engineering major at MIT, early-morning crew practice, and an active social life at Phi Gamma Delta, one of the thirty fraternities at MIT. In the fall of 1997, however, the fraternity pledge passed out during a Greek Week celebration after downing sixteen drinks in an hour. When Krueger's fraternity brothers noticed he was having trouble breathing, they called an ambulance.

By the time rescue workers arrived, Krueger was already comatose. His blood alcohol level was later found to be more than five times the legal driving limit. A few days later, Krueger's distraught parents had him removed from life support. Krueger is only one of hundreds of college students whose lives are cut short or devastated every year as a result of drug and alcohol abuse.

Krueger's parents were awarded a $6 million settlement by the university. This unprecedented financial settlement and MIT's commitment to change the college conditions that contributed to Krueger's death have spurred other colleges to make similar commitments to create a safer and more secure campus environment for students.

WHAT IS A DRUG?

Drugs, for the purpose of this chapter, are defined as chemicals that enter the bloodstream and are easily transported to the brain, where they alter the way we feel, with predictable results. Alcohol, by this definition, is a type of drug. Drugs can be smoked, injected, snorted, or swallowed.

Drug abuse is defined as "taking a drug or drugs for purposes other than those for which the drug or drugs were intended, and/or the illicit use of a drug or drugs which can cause harm (not necessarily physical) to oneself and/or others."[1] One of the risks of alcohol and drug use is addiction. **Addiction** is "a behavioral pattern of drug use, characterized by overwhelming involvement with the use of a drug [compulsive use], the securing of its supply, and a high tendency to relapse after withdrawal."[2]

DRUG CLASSIFICATIONS

Classification	Drugs	Effects[3]
Stimulants	Amphetamines, cocaine, prescription diet pills, nicotine, caffeine	Alertness; a sense of power; enhanced performance
Depressants	Alcohol, anti-anxiety drugs, and sleeping pills containing benzodiazepine and barbiturates	Drowsiness and sedation
Opiates	Prescription painkillers, codeine, heroin, Demerol, methadone, morphine	Diminished or no pain; sense of euphoria
Hallucinogens	LSD, "magic mushrooms," peyote, MDMA ("ecstasy"), mescaline	Intensified perception and sense experience; hallucinations
Cannabinols	All forms of marijuana	Mellowness
Inhalants/ Solvents	Acetone, aerosol gases, glue, paint thinner, correction fluid	Giddiness and confusion
Performance enhancement	Anabolic and androgenic steroids	Increased muscle mass

THE HISTORY OF DRUG AND ALCOHOL USE

Alcohol is the most widely used drug in North America. Wine and beer have been used since ancient times for their pleasurable effects, in medicine, with meals, and in religious ceremonies. Even the *Mayflower* carried a good supply of "bere."

Distilled spirits were first produced in Europe about 1300 and were often referred to as "aqua vitae" because of their purported powers to prolong life. In 1606, alarmed by the increase in drunkenness, the British government made intoxication a statutory offense with the Act of Repression of the Odious and Loathsome Sin of Drunkedness.

Laws in the colonies were relatively lenient and geared primarily toward controlling drunkenness and disorderly conduct. A Connecticut law prohibited drinking for more than one-half hour at a time. A 1760 Virginia law prohibited ministers from "drinking to excess and inciting riots."

The temperance movement of the late nineteenth and early twentieth centuries was spearheaded by groups such as the Women's Christian Temperance Union (WCTU) and the Anti-Saloon League. The WCTU opposed drinking primarily because of its destructive effect on the family. The problem was also blamed on the influx of immigrants from Europe and Ireland, with their decadent drinking habits.

In 1919 the Eighteenth Amendment to the Constitution outlawed the sale and consumption of alcohol. Despite lack of unanimous support for the amendment, most prohibitionists thought that Americans would not violate their Constitution. They were mistaken. Although alcohol consumption declined during the first few years of prohibition, it began to climb again during the 1920s. Ratification of the Eighteenth Amendment ushered in an era of organized crime and a vast illegal liquor trade, known as "bootlegging," under the control of such notorious gangsters as Al Capone. The cost of trying to stamp out illegal drinking soared into the millions of dollars. It soon became apparent that prohibition was too unpopular and too expensive to enforce. The Eighteenth Amendment was repealed in 1933 by the Twenty-first Amendment, although some states continued to have local prohibition laws as late as 1966.

Alcohol consumption hit another peak about 1980. Once again the tide of public opinion turned against alcohol. This time it was the medical profession that led the crusade. Rather than denounce alcohol as a moral failing, as had the early prohibitionists, the medical establishment declared alcoholism to be a disease. The disease model continues to dominate attitudes toward alcohol use in the United States today.

Attitudes toward drug use have followed a similar course. Hallucinogenic drugs have been used since antiquity both for pleasure and for religious purposes. Apparently, the techniques of ecstatic trances used by some Hindu yogis involved the use of drugs. The peyote cult of Mexico also used drug-induced ecstasy in mystical and religious rituals. LSD, which was popular in the 1960s, has been similarly credited with helping users get in touch with a deeper mystical wisdom. Marijuana also became popular in the late 1960s and 1970s. Much of the marijuana was imported from Jamaica, where the Rastafarians considered marijuana (ganja) to be the "wisdom weed" and used it in religious rites and for spiritual wisdom.

Drugs have also been widely used for medicinal purposes. Opium was available in a crude form prior to 1800 and was valued by physicians for its calming effect and as a cure for gastrointestinal illnesses. Morphine, a derivative of opium, became a popular painkiller after 1870. When heroin, a derivative of morphine, was introduced into medical practice in the late 1800s, it was actively promoted by the American Medical Association (AMA) and pharmaceutical companies as a cure for many ailments. The easy availability of these drugs in the late nineteenth century was accompanied by a substantial increase in the number of drug addicts.[4]

Cocaine was first isolated from the coca leaf in the mid-nineteenth century. It became popular as a general tonic and for sinusitis and hay fever. The exhilarating effects of cocaine made it a popular additive in medicine, soda, and wine. In the United States, blacks were blamed by prohibitionists for the "cocaine problem." Even though studies failed to confirm the widespread use of cocaine by blacks, the fear of an uprising of "euphoric" blacks was used, in part, to justify an era of lynchings and segregation.

LEGAL AND ILLEGAL DRUGS

State laws regulating the use of morphine and cocaine were first enacted in the United States in the 1890s. Federal prohibition of drugs was not attempted initially because it was thought to be unconstitutional. Libertarians, physicians, and the major

SECTION 1 OF THE EIGHTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION

[Adopted January 29, 1919]

Section 1. After one year from the ratification of this article the manufacture, sale, or transportation thereof into, or the exportation thereof from the United States and all territories subject to the jurisdiction thereof for beverage purposes is hereby prohibited.

pharmaceutical societies protested the outlawing of opiates, cocaine, and cannabis, substances they relied heavily on for symptom relief. Despite support for the medicinal use of drugs, by the mid-1920s the federal government moved to eliminate all heroin use.

The Pure Food and Drug Act of 1906 was the first federal legislation to regulate the use of opium. Because opium was imported from China, opposition to opium was used to reinforce anti-Chinese sentiment and the persecution of Chinese immigrants.

It is sometimes assumed that the division between legal and illegal drugs is based on rational criteria, but this isn't the case. Alcohol, nicotine (tobacco), and marijuana are currently the three most frequently used drugs in the United States. Yet marijuana, which rarely causes physiological addiction or serious illness, is illegal whereas alcohol and tobacco are not. According to an AMA study, tobacco is the number one "actual cause of death" in the United States; alcohol is number three. Tobacco kills one out of every three users, ending their lives prematurely by an average of fifteen years. Globally it is responsible for 5 million deaths a year, making it the leading cause of death in the world.[5] More than 80 percent of these deaths occur in the developing world in countries such as China, India, and Indonesia, where tobacco companies are aggressively marketing cigarettes in order to make up for lost revenue due to declining smoking in most industrialized nations.[6]

The abuse of legal over-the-counter or prescription drugs such as painkillers, inhalants, or solvents can also lead to addiction and serious health problems and are responsible for about 32.000 deaths a year, almost twice as many as illegal drugs. Indeed, marijuana has yet to be directly implicated as responsible in anyone's death.[7]

The most recent wave of antidrug laws comes at a time when the public is divided over the wisdom of drug prohibition. Does the state have a right to prohibit or protect adults from using drugs? Is drug abuse a moral, legal, medical, or religious issue? Which drugs should be prohibited and which allowed?

DRUG AND ALCOHOL USE TODAY

More than 25 million Americans currently use illicit drugs. Another 60 million are addicted to cigarettes and 40 million binge on alcohol.[8] Seventy-three percent of Americans believe that the drug problem in the United States today is "very" or

"extremely" serious, with women and people from lower-income families more likely to be concerned about the problem of illicit drugs.[9]

The use of illicit drugs by youth peaked in 1981, when 66 percent of American youth under the age of eighteen admitted to having tried illegal drugs.[10] When the George H. W. Bush administration declared an official "war on drugs," it had strong public support. Illicit drug use began declining during the 1980s. However, despite tougher laws and some initial victories, the success of the "war" was short-lived. During the mid-1990s, drug use began rising again, especially among young people. And marijuana has become ten to fifteen times more potent with the use of genetic engineering to alter the plant to make it resistant to attempts by drug agencies to destroy the crop through the use of pesticides.

By 1994 polls showed that approximately 19 percent of eighth graders, 36 percent of high school seniors, and 75 percent of people in their twenties had tried illicit drugs.[11] Unlike alcohol, daily marijuana use is increasing among teens. As of 2010 it was at its highest point in almost 30 years.[12]

Marijuana is the most widely used illicit drug in the United States. Nearly 69 million Americans over the age of twenty-one have used marijuana at least once.[13] Support for marijuana is growing. In 2011, for the first time, the majority of Americans supported legalization of marijuana with support being highest among young people.[14] Although marijuana was made illegal in 1937, medical marijuana under a doctor's prescription is currently legal in Canada, Belgium, Austria, Great Britain, the Netherlands, and in fifteen states in the United States. In 2005 the U.S. Supreme Court ruled that the federal government can block the backyard cultivation of marijuana,thus greatly limiting its availability for medical use. California and Nevada are also cracking down on growers of medical marijuana.

Canada legalized the use of marijuana for medical purposes in 2001, and in 2003 decriminalized marijuana possession, so small-time users do not face the threat of jail and a criminal record. People caught with 15 grams or less receive a citation and fine, similar to a traffic ticket. This move has created tension between Canada and the United States, where possession of even a small amount of marijuana is punishable by up to a year in jail. (See Case Study 6.) There is currently a bill (HR 5843) in Congress that, if passed, would permit the possession of small amounts of medical marijuana for personal use. Singapore, where the penalty for trafficking marijuana is death, has some of the toughest marijuana laws.

Possession of small amounts of marijuana has also been decriminalized in Spain, Russia, Greenland, most South American countries, and most parts of Australia. Although marijuana is technically illegal in the Netherlands, possession of less than 5 grams or five plants is not prosecutable. In countries such as Jamaica and India, where marijuana is used in traditional religious rites, its use is generally tolerated, though not legal.

Although the use of the drug peyote by Native Americans in religious rituals was legalized in the United States in 1994, the Rastafarians, a religious sect originating in Jamaica that uses marijuana in religious rites, have been unsuccessful so far in getting marijuana legalized in this country for religious purposes.

Cocaine is the second most popular illicit drug in the United States. White males, at 12 percent, are twice as likely to use cocaine as black, Hispanic, and Native American

males. African Americans, on the other hand, are more likely to use heroin. Because heroin-related offenses in the United States receive much more severe legal penalties than cocaine use or alcohol-related crimes such as drunk driving, blacks bear a disproportionate burden with respect to enforcement of drug laws. Blacks are also more likely than whites to receive convictions for similar drug-related offenses. A study in the state of Washington found that African Americans, who made up only 3 percent of the state's population, received nearly 20 percent of the drug sentences.[15] This disparity was attributed in part to racial profiling.

Tobacco, although legal, is one of the most deadly and addictive drugs. It is responsible for one in five deaths in the United States and one in every three worldwide. Tobacco use has declined by more than 40 percent since 1965, with the largest drop being among college graduates. Less than 20 percent of today's college graduates smoke compared to 30 percent in 1999.[16] People who smoke are also smoking fewer cigarettes, probably because of the greater restrictions on smoking in public places and the workplace as well as increased concerns about the health risks of smoking.

Alcohol is a drug that in moderation may have health benefits. Slightly under two-thirds of Americans drink alcohol—a figure that has remained relatively steady since 1940. Most Americans drink responsibly. Excessive alcohol use, however, has health risks. Alcohol is responsible for more than six times as many deaths—75,000 a year in the United States alone—as all illicit drugs combined. These include deaths due to accidents, violence, alcohol poisoning, liver disease, neurological disorders, cancer, and suicide.[17]

DRUG AND ALCOHOL USE AMONG COLLEGE STUDENTS

In 1984 the drinking age was raised from eighteen to twenty-one in the United States in an attempt to curb drunk-driving accidents. However, the drinking-age laws have had little effect on the actual drinking habits of college students. After dropping off from a high in the mid-1980s, drug and alcohol use among college students began to rise again in the 1990s. A 1997 *Time* magazine article described American colleges as "among the nation's most alcohol-drenched institutions."[18] American undergraduates in 1999 drank 4 billion cans of beer and spent an average of $446 on alcoholic beverages—more than they spent on soft drinks and textbooks combined.[19] Male college students are more likely to drink and to binge drink than are female students.[20]

Binge drinking, is defined as five or more drinks in a row for men and four or more for women. Although there has been a decline in binge drinking among young people since 2002, it is still a serious problem on many campuses in both the United States and Canada. According to the National Institute on Alcohol Abuse, 1,700 college students die each year from alcohol-related injuries, including automobile accidents. Members of fraternities and sororities are at the highest risk of excessive drinking, because intoxication is viewed as an acceptable aspect of Greek life.[21] The use of excessive alcohol has been responsible for the death of several fraternity initiates. (See Case Study 1.)

In addition to such problems as poor concentration, lower grade-point average (GPA), and health risks, binge drinking among college students is linked to intentional violence, including assault, homicide, rape, brawls, vandalism, and burglary, as well as being the victim of aggression, in part because being intoxicated makes the person an easier target for a predator.[22]

Of students who do not engage in binge drinking, the majority report problems caused by students who do. These problems ranged from unwanted sexual advances and property damage to having sleep or studying interrupted to assault. About half of all date rapes on campuses are associated with alcohol consumption.[23] Alcohol use is also a causal factor in suicide.

College drug use and binge drinking take a huge toll in terms of damage to health and cognitive functioning, violence, property damage, and liability costs to the fraternities and colleges associated with drunken parties. Would lowering the legal drinking age to eighteen make the problem of drinking on campus better or worse? Laura Dean-Mooney and John McCardell debate the wisdom of lowering the drinking age and the effect it might have on college campuses in their readings at the end of this chapter.

DRUGS IN SPORTS

Two weeks after the close of the summer 2000 Olympics in Sydney, Australia, the International Olympic Committee medical commission recommended that German wrestler Alexander Leipold be stripped of his gold medal. Leipold had tested positive for the steroid nandrolone after defeating American Brandon Slay in freestyle wrestling. Leipold denied taking the steroid and said he had no idea of how he could have tested positive. He is only one of forty-seven athletes who were suspended from the Sydney games for doping offenses, the highest number ever in the history of the Olympics. Apparently, mandatory drug testing has been ineffective. Both the 2004 and 2008 Olympics were also dogged by drug scandals and allegations of wrongdoing.

Anabolic steroids, such as nandrolone, are testosterone-based drugs that stimulate muscle growth and help athletes recover faster from injuries. However, use of these steroids also increases by fivefold the risk of heart attacks and strokes and may contribute to the development of liver disease.

Despite the harms associated with performance-enhancement drugs, their use in sports continues. Football is the toughest on drug use by professional athletes and hockey the most lenient, with basketball and baseball being somewhere in between the two.[24] According to one estimate, between 20 and 40 percent of major league baseball players were using testosterone-based drugs in 2000.[25]

In addition to steroids, growth hormones, and testosterone, blood doping is used by some athletes in sports that demand great endurance, such as cycling. Blood doping entails injecting a synthetic version of EPO, a hormone that stimulates the bone marrow to produce more red blood cells, which carry oxygen to the muscles. Because EPO is a naturally occurring substance in the body, it is difficult to detect through blood tests. In 2005, French authorities accused American cyclist Lance Armstrong, six-time winner of the Tour de France, of doping practices, an accusation that he denied.

College sports are also plagued by drug use. (See Case Study 3.) Peer pressure is a factor in the increased use of steroids by college athletes and young people who want to improve their appearance. The American College of Sports Medicine reports that more than 6 percent of high school and college athletes have taken steroids without a doctor's permission.[26] A policy at Duke University calls for unannounced drug testing, including tests for performance-enhancing as well as recreational drugs, for all college athletes. The first violation is handled by treatment and counseling, the third violation by permanent suspension from the team.

The use of performance-enhancing drugs raises several moral issues. Does the duty of self-improvement require that athletes refrain from using drugs that will harm their bodies over the long run? Is it fair that athletes who use these drugs have a competitive advantage? Should drug testing be mandatory, or does mandatory drug testing violate the autonomy of the athlete? Is the use of performance-enhancing drugs in sports inherently coercive since it puts pressure on athletes to use drugs if they want to win? In his reading at the end of this chapter, Thomas Murray opposes drug use in sports on the grounds that it is inherently coercive.

In addition to enhancing athletic performance, drugs can also be used to enhance personality. People may drink a glass of alcohol at a party to overcome social awkwardness and shyness, or use antidepressants to become a happier, less self-occupied person. (See Case Study 4.)

THE DISEASE MODEL OF ADDICTION

The therapeutic revolution in the mid-twentieth century involved relabeling certain behaviors, previously attributed to moral weakness, as diseases. The **disease model of addiction** views addiction primarily as an individual medical problem rather than a social or moral problem. According to this model, it is not lack of willpower or moral character that separates addicts from nonaddicts. Addiction is a pathological state. Addicts abuse drugs because they are ill; they are biologically different from nonaddicts. People who harm others or break the law while under the influence of alcohol or drugs should receive treatment, not punishment, because they were no more in control of what they did when "under the influence" than an epileptic having a seizure.

The disease model of addiction was first articulated in the 1940s by Elvine M. Jellinek of the Yale Center of Alcoholic Studies.[27] It has since become the official view of both the AMA and the World Health Organization (WHO). In 1956 the AMA recognized drug addiction as a "chemical dependency" and, therefore, a disease like diabetes or cancer. In 1977 the AMA added alcoholism to its list of illnesses, defining it as "an illness characterized by significant impairment that is directly associated with persistent and excessive use of alcohol. Impairment may involve physiological, psychological, or social dysfunction." Although abstinence may arrest the disease of addiction, the disease itself can never be cured because it is biologically based. Advances in genetics lend weight to the disease model of addiction and the idea of the "addictive personality."[28] (See Case Study 2.)

Alcoholics Anonymous (AA) is based primarily on the disease model. A fundamental assumption of the AA Twelve Steps program is that healing can occur only

when alcoholics admit their powerlessness over addiction and turn the healing process over to a "higher power." The "one disease [addiction], one treatment [abstinence]" approach of AA currently dominates the medical field. (See Case Study 5.)

THE MORAL MODEL OF ADDICTION

Addiction, according to the **moral model of addiction,** is a freely chosen vice. In his reading at the end of this chapter, Psychiatrist Thomas Szasz questions the validity of the medical model and calls for a return to the moral model. Resisting or overcoming addiction is simply a matter of willpower. The religious view that alcoholism is a sin, the prohibition legislation of the early twentieth century, and the "Just Say No" campaign are all based on the moral model of addiction.

Most positions on addiction lie somewhere between the two extremes. Although AA is based primarily on the disease model, accepting moral responsibility for one's actions is also a key part of the recovery process. Similarly, most supporters of the moral model acknowledge that there are social, personal, and genetic factors that make it more likely that certain people will become addicts. However, unlike predispositions to other diseases, such as breast cancer and diabetes, a person who is genetically predisposed to addiction can avoid it altogether by avoiding the substances that may lead to addiction. Therefore, people who harm others while under the influence of alcohol or drugs should be held morally responsible for their choices and actions. Under the moral model, punishment is an appropriate response to drug-related crime.

THE PHILOSOPHERS ON DRUG AND ALCOHOL ABUSE

Aristotle rejects the disease model of addiction. According to him, virtue entails acting according to reason. People who are drunk are "acting in ignorance." Thus, addicts give up their essential humanity by giving up control of their actions. We need have no sympathy for a person whose health is destroyed by excessive drinking or drug abuse. Unlike a person whose illness is involuntary, a drunkard is responsible for his ignorance "since it was open to him to refrain from getting drunk."[29]

Although Aristotle would probably not object to the use of drugs and alcohol in moderation, Buddhists are morally opposed to any use of drugs or alcohol because a "clear and composed mind" is necessary to achieve moral perfection and enlightenment. According to Buddha, all human suffering is caused by people whose minds are confused and their reason dulled.

Muslims are also opposed to the use of alcohol and drugs. Alcohol use is a moral failing. According to Muslim philosophy, "When a person drinks he becomes intoxicated; when he is intoxicated he raves; and when he raves he falsely accuses."[30]

Libertarians favor a permissive policy on drug and alcohol use. John Stuart Mill opposed the U.S. prohibition laws of the 1850s as an unjustified interference with people's liberty. He wrote, "Over himself, over his own body and mind, the individual is sovereign."[31] Although Mill acknowledged that drug or alcohol users can harm others

by rendering themselves incapable of working, this does not justify prohibiting drugs, because society can afford to absorb these losses for the sake of liberty.

THE MORAL ISSUES

Virtue Ethics and the Good Life

Virtue ethicists encourage us to improve our character through self-examination and the practice of virtuous behavior. Addiction interferes with our ability to engage in philosophical self-examination and to seek the higher good.

Virtue, in most cases, requires us to seek the mean between excess and deficit. The doctrine of the mean requires that we use our reason to discern where the mean is for us. According to the disease model, the use of any amount of a drug is excessive for addicts. For other people, moderation may be appropriate and consistent with the good and virtuous life. Studies at Harvard University have found that light and moderate drinkers are healthier and live longer than total abstainers. Morphine is another drug where excess for one person may be a deficiency for another. Although it can be addictive, to refuse a dying cancer patient morphine because of fear of addiction is to err on the side of deficiency.

Confucius believed that government bears the primary responsibility for promoting virtue in citizens. The purpose of laws is to make it easier for people to be virtuous. James Q. Wilson argues that if drugs are legal, many people will prefer the pleasure of drug excess over treatment and virtuous behavior. Douglas Husak counters that it is not the place of government to impose on citizens an ideal of human excellence. It is up to each of us to responsibly determine our own concept of the good life.

Human Dignity and the Categorical Imperative

Kant's categorical imperative states that we should never use ourselves as a means only. Addicts debase themselves by using themselves as a means only—to get a fix through drugs or alcohol. Addiction is tempting because it "fixes" our disquiet and malaise. Addiction distracts us from our lives and relieves us of the burden, the frustration, the boredom, and the search for meaning in our lives. Addiction *becomes* the meaning of life. Because drug abuse and addiction prevent us from being fully human, they are incompatible with human dignity.

As rational moral agents, we are responsible for our choices and actions. The disease model is problematic in that it places the burden of "curing" addiction on physicians rather than on the individual, thus allowing addicts to abdicate personal responsibility for their behavior. Passing off responsibility for our destructive and disrespectful behavior is inconsistent with human dignity and freedom.

Autonomy, Liberty Rights, and the Principle of Noninterference

Autonomy involves our ability to make free choices. Both Szasz and Husak argue that prohibiting recreational drug use violates our autonomy. The "right of self-medication," Szasz writes, is a fundamental right. Enforcement procedures are not

only futile, but an infringement on people's liberty rights. They reject the disease model of addiction. Drug addicts are autonomous, because any person of "reasonable firmness" can stop using drugs.

Not everyone agrees that adult drug users are acting autonomously. Murray maintains that the use of performance-enhancing drugs in sports is "inherently coercive." In sports, in which one's professional success may ride on using performance-enhancing drugs, the pressure to use these drugs may seriously compromise the athlete's autonomy. Like Major League Baseball, the National Football League and the National Basketball Association have banned many performance-enhancing drugs, but they balk at mandatory blood testing, saying that making players give blood violates their privacy.

The principle of noninterference states that interference with adults' free choice must be justified. However, most drug and alcohol addicts begin as children. In the United States, the average age is twelve for the first use of alcohol and thirteen for the first use of illicit drugs.[32] Judges in both Massachusetts and Iowa have upheld a school's right to search students for drugs, ruling in *Iowa v. Marzel Jones* (2003) that the school's interest in maintaining "a controlled and disciplined environment" overrules a student's right to privacy.

Pleasure

Pleasure is the most common reason college students give for using alcohol and drugs.[33] According to some utilitarians, the use of drugs for pleasure is not necessarily at odds with the good life and may even contribute to it. However, they draw the line at drug use that interferes with living the good life.

Paternalism and Harm to Self

Paternalism permits interfering with people's choices for their own good. Drugs and alcohol can be harmful to self. The life of an average alcoholic, for example, is fifteen years shorter than that of a nonalcoholic.[34]

The belief that drug and alcohol abuse is a disease promotes a paternalistic approach to drug and alcohol regulation. Indeed, according to the Centers for Disease Control, smoking shortens one's life by more than ten years. Laws prohibiting alcohol and tobacco use by children are generally based on the principle of paternalism. Given that so many untimely adult deaths involve tobacco and alcohol abuse, however, shouldn't paternalism extend to adults as well? If adults use these and other drugs in a manner that is harmful to themselves, isn't their "decision" to do so by definition irrational and, hence, not a free and autonomous choice?

Prohibition based on paternalism can come into conflict with the principle of autonomy. The use of coercion—even "well-meaning" coercion—in an attempt to regulate a person's character is an affront to human dignity and freedom. Should we prohibit drugs for all because drugs seriously impair the autonomy of some? The belief that people use drugs "against their will," that they have "lost control of their lives," or that drug users are "morally deficient" is demeaning. It may be better to let addicts continue harming themselves rather than deny them at least some control over their lives.

Furthermore, because people do not like to be told what to do, paternalism can backfire. There was a dramatic increase in drug use, especially among young people, following President Bush's declaration of war on drugs. Studies also suggest that raising the drinking age from eighteen to twenty-one throughout the United States may actually have exacerbated the bingeing problem on campuses. In addition to the lure of forbidden fruit, students are now more likely to drink in private places like their dorms and fraternities or in bars that are lax in checking for proper ID.[35]

Nonmaleficence and Preventing Harm to Others

One of the most common arguments for drug prohibition is protection of public health and safety. Although restrictions based on paternalism are often considered an affront to personal dignity, most people acknowledge that coercion is justified to prevent people from harming one another.

Wilson argues that the harms of legalizing drugs outweigh those of prohibition. Drug abuse, he points out, is hardly a victimless crime. It is associated with health problems, reduced job productivity, family violence, crime, fetal alcohol syndrome, drug-addicted newborns, and suicide. Many of these costs are passed on to society. Twenty percent of Medicare funds go to the treatment of problems stemming from alcohol and drug abuse.

Prosecuting and punishing drug-related crimes cost taxpayers more than $30 billion a year. In 2005, 53 percent of inmates in federal prisons and 20 percent of those in state prisons were drug offenders.[36] The majority of drug-related criminal charges in the United States involve marijuana. Of these, two-thirds are for simple possession.[37] Indeed, there is a marijuana-related arrest in the United States every 38 seconds, with marijuana-related arrests outnumbering those for all violent crimes.[38]

Husak supports legalizing recreational drugs. Harm to others is a powerful argument for working toward decreasing drug and alcohol abuse, but it is not obvious that legal prohibition is the best solution; drug education may be more effective. Making drugs illegal forces up their price, thus encouraging users to resort to crime to pay for their habit. Much of the street violence in our cities is attributable to the illicit sale of drugs rather than to the actual effects of the drugs themselves. In addition, drug prohibition can bring young people seeking drugs into contact with the criminal element.

There are also hidden costs of illegal drug use and alcoholism in terms of domestic violence and the breakup of families. In addition, the cost of health care for alcoholics is more than double that for nonalcoholics; much of this cost is borne by taxpayers and employers. Smokers also use more medical resources and have longer hospital stays than nonsmokers. Indeed, lung cancer has now become the leading cause of cancer deaths in women.

CONCLUSION

Drug and alcohol use raises two concerns. The first relates to virtue ethics: We have a personal responsibility to abstain from harmful drugs or drugs that are addictive. If addiction is a disease, virtue dictates that addicts or potential addicts are morally

SUMMARY OF READINGS ON DRUG AND ALCOHOL USE

Szasz, "The Ethics of Addiction." People who abuse drugs and alcohol are not sick and should be held morally accountable.

Wilson, "Against the Legalization of Drugs." Drugs should be illegal because the harms of legalizing drugs outweigh the harms of prohibition.

Husak, "A Moral Right to Use Drugs." There is nothing inherently wrong about using recreational drugs; therefore, they should be legal for adults.

Dean-Mooney and McCardell, "Two Takes on the 21 Drinking Age." A forum on whether or not the drinking age should be lowered to eighteen.

Murray, "Drugs, Sports, and Ethics." Drug use in sports is immoral because it restricts the free choice of competing athletes.

responsible for avoiding drugs and/or alcohol and for seeking a cure, or at least avoiding situations in which they could harm others. On the other hand, the moderate use of certain drugs may actually enhance the good life. Knowing the difference between excess and moderation involves the development of wisdom and character.

The second issue relates to social policy. Some philosophers maintain that drugs should be prohibited. Most people agree that harm to others is a strong justification for restricting drug use; however, they disagree over the best means to achieve the objective of minimizing harm.

THOMAS SZASZ

The Ethics of Addiction

Thomas Szasz is a professor emeritus of psychiatry at the State University of New York Upstate Medical Center and author of several books on psychiatry, including *The Myth of Mental Illness*. In this article Szasz rejects the disease model of addiction. Citing John Stuart Mill's principle of no harm, Szasz argues that drug laws do not respect the right of citizens to exercise control over their own lives. Therefore, all prohibition laws should be repealed, at least for adults.

Critical Reading Questions

1. What is the World Health Organization definition of drug abuse? Why does Szasz maintain that this definition is a moral rather than a medical judgment?

"The Ethics of Addiction," *Harper's Magazine* 244 (April 1972): 74–79.

2. According to Szasz, what "propaganda" is used by proponents of the disease model of addiction to justify the prohibition of drug use?
3. Why does Szasz reject the prohibition argument that some drugs are dangerous?
4. According to Szasz, why do people become addicted? Why does Szasz reject the prohibition argument that drug addiction is different from addiction to other substances?
5. According to Szasz, what are the primary reasons people take drugs? Which of these reasons is identified with "drug abuse"?
6. What arguments does Szasz use to support his position for the legalization of drugs?
7. On what grounds does Szasz argue that the "right of self-medication" is a fundamental right? Should there be any limitations on this right?
8. Why does Szasz support the prohibition of drug and alcohol sales to minors?
9. What are the two principal methods of legitimizing policy in the United States? How have these two methods been used to legitimize the prohibition of drugs?
10. On what grounds does Szasz reject the current medical concept of drug abuse and drug treatment programs?
11. According to Szasz, why are we in need of a "medical reformation"?
12. On what grounds does Szasz argue that we have a constitutional right to use drugs and alcohol?
13. How does Szasz use John Stuart Mill's philosophy to support his position?

AN ARGUMENT IN FAVOR OF LETTING AMERICANS TAKE ANY DRUG THEY WANT TO TAKE

To avoid cliches about "drug abuse," let us analyze its official definition. According to the World Health Organization, "Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: 1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, 2) a tendency to increase the dosage, and 3) a psychic (psychological) and sometimes physical dependence on the effects of the drug."

Since this definition hinges on the harm done to both the individual and society, it is clearly an ethical one. Moreover, by not specifying what is "detrimental," it consigns the problem of addiction to psychiatrists who define the patient's "dangerousness to himself and others."

Next, we come to the effort to obtain the addictive substance "by any means." This suggests that the substance must be prohibited, or is very expensive, and is hence difficult for the ordinary person to obtain (rather than that the person who wants it has an inordinate craving for it). If there were an abundant and inexpensive supply of what the "addict" wants, there would be no reason for him to go to "any means" to obtain it. Thus by the WHO's definition, one can be addicted only to a substance that is illegal or otherwise difficult to obtain. This surely removes the problem of addiction from the realm of medicine and psychiatry, and puts it squarely into that of morals and law.

In short, drug addiction or drug abuse cannot be defined without specifying the proper and improper uses of certain pharmacologically active agents. The regular administration of morphine by a physician to a patient dying of cancer is the paradigm of the proper use of a narcotic; whereas even its occasional self-administration by a physically

healthy person for the purpose of "pharmacological pleasure" is the paradigm of drug abuse.

I submit that these judgments have nothing whatever to do with medicine, pharmacology, or psychiatry. They are moral judgments. Indeed, our present views on addiction are astonishingly similar to some of our former views on sex. Until recently, masturbation—or self-abuse, as it was called—was professionally declared, and popularly accepted, as both the cause and the symptom of a variety of illnesses. Even today, homosexuality—called a "sexual perversion"—is regarded as a disease by medical and psychiatric experts as well as by "well-informed" laymen.

To be sure, it is now virtually impossible to cite a contemporary medical authority to support the concept of self-abuse. Medical opinion holds that whether a person masturbates or not is medically irrelevant; and that engaging in the practice or refraining from it is a matter of personal morals or life-style. On the other hand, it is virtually impossible to cite a contemporary medical authority to oppose the concept of drug abuse. Medical opinion holds that drug abuse is a major medical, psychiatric, and public health problem; that drug addiction is a disease similar to diabetes, requiring prolonged (or lifelong) and careful, medically supervised treatment; and that taking or not taking drugs is primarily, if not solely, a matter of medical responsibility.

Thus the man on the street can only believe what he hears from all sides—that drug addiction is a disease, "like any other," which has now reached "epidemic proportions," and whose "medical" containment justifies the limitless expenditure of tax monies and the corresponding aggrandizement and enrichment of noble medical warriors against this "plague."

PROPAGANDA TO JUSTIFY PROHIBITION

Like any social policy, our drug laws may be examined from two entirely different points of view: technical and moral. Our present inclination is either to ignore the moral perspective or to mistake the technical for the moral.

Since most of the propagandists against drug use seek to justify certain repressive policies because of the alleged dangerousness of various drugs, they often falsify the facts about the pharmacological properties of the drugs they seek to prohibit. They do so for two reasons: first, because many substances in daily use are just as harmful as the substances they want to prohibit; second, because they realize that dangerousness alone is never a sufficiently persuasive argument to justify the prohibition of any drug, substance, or artifact. Accordingly, the more they ignore the moral dimensions of the problem, the more they must escalate their fraudulent claims about the dangers of drugs.

To be sure, some drugs are more dangerous than others. It is easier to kill oneself with heroin than with aspirin. But is also easier to kill oneself by jumping off a high building than a low one. In the case of drugs, we regard their potentiality for self-injury as justification for their prohibition; in the case of buildings, we do not.

Furthermore, we systematically blur and confuse the two quite different ways in which narcotics may cause death: by a deliberate act of suicide or by accidental overdosage.

Every individual is capable of injuring or killing himself. This potentiality is a fundamental expression of human freedom. Self-destructive behavior may be regarded as sinful and penalized by means of informal sanctions. But it should not be regarded as a crime or (mental) disease, justifying or warranting the use of the police powers of the state for its control.

Therefore, it is absurd to deprive an adult of a drug (or of anything else) because he might use it to kill himself. To do so is to treat everyone the way institutional psychiatrists treat the so-called suicidal mental patient: they not only imprison such a person but take everything away from him—shoelaces, belts, razor blades, eating utensils, and so forth—until the "patient" lies naked on a mattress in a padded cell—lest he kill himself. The result is degrading tyrannization.