Drug Addiction and the Open Society

Lee Harris

Today, despite America's three-decades-long national War on Drugs, we are still in the midst of what many have called a "drug epidemic." If we abandon our policy of "containment"—the long-term effort to reduce the production and consumption of drugs—how far would this epidemic spread through the general population? If most people, or even a substantial minority, became drug addicts whose whole existence revolved around getting their next fix, the prospects for our society would look bleak indeed.

Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy
By Theodore Dalrymple
Encounter ~ 2006 ~ 146 pp.
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The Cult of Pharmacology: How America Became the World's Most Troubled Drug Culture
By Richard DeGrandpre
Duke ~ 2006 ~ 294 pp.
$24.95 (cloth)

Is this, however, a realistic scenario? When we speak of a "drug epidemic," after all, we are employing a metaphor, one much abused by public health officials and the modern media. This is clearly not a classic medical epidemic, with a contagious disease spreading through the population. If my neighbor uses heroin, there is no danger that a stray heroin germ will float over the fence into my backyard, where I will acquire it by merely breathing it into my lungs. Still, our conventional wisdom about drugs and addiction asserts that we are right to speak of a drug epidemic. It views certain drugs, such as heroin, cocaine, crack, and methamphetamine, as if they were toxic agents capable of acting on an individual independently of his will. Our conventional wisdom insists that there are inherently dangerous and deadly drugs, just as there are inherently dangerous and deadly bacilli. Just as dangerous bacilli must be eliminated for the sake of the public welfare, so too must dangerous drugs.

Our conventional wisdom is often wrong, however—sometimes, so far off the mark that its version of the

truth turns out to be nothing more than ignorance, prejudice, and folly. An open society must be prepared to listen to those who offer a critique of its conventional wisdom—and our conventional wisdom about drugs and addiction should be no exception.

In *Romancing Opiates*, distinguished cultural critic Theodore Dalrymple focuses his attention on one particular drug, heroin, though he also explores the nineteenth-century use of opium by such literary figures as Samuel Taylor Coleridge. A psychiatrist at a large general hospital in a British slum, Dalrymple draws on his own personal experience and clinical observation of heroin addicts in order to support his iconoclastic approach to the problem of drugs and addiction. His brief and lucid book goes directly to its point in the first few pages: "*Romancing Opiates* seeks to expose the willful misconceptions, the lies and evasions, of the past two hundred years with regard to opiate addiction." Dalrymple believes this strong, even strident, language is warranted because the general public's "standard or received view of heroin addiction" is the result of "propaganda assiduously spread for many years by everyone who has concerned himself with the subject."

The same spirit of indignant iconoclasm pervades Richard DeGrandpre's *The Cult of Pharmacology*. DeGrandpre holds a doctorate in psychopharmacology, was a fellow of the National Institute on Drug Abuse, and wrote the 1999 book *Ritalin Nation*. Like Dalrymple, DeGrandpre does not believe that the standard ideas about drugs and addiction are honest mistakes made by people trying their best to solve human problems of great intrinsic complexity and difficulty. Instead, DeGrandpre argues that various powerful interest groups hoodwinked the public into accepting the orthodox view. These interests include: "The pharmaceutical industry, the tobacco industry, modern biological psychiatry, the biomedical sciences, the drug enforcement agencies, and the American judicial system."

Dalrymple also sees popular wisdom about drugs and addiction as the result of self-interested groups—though not the same self-interested groups enumerated by DeGrandpre. Dalrymple maintains that the "view of heroin addiction that is almost universally accepted by the general public…serves the interests both of the addicts who wish to continue their habit while placing the blame elsewhere, and the [addiction] bureaucracy that wishes to continue in employment, preferably forever and at higher rates of pay."

An iconoclast requires an icon, and the icon for both authors is referred to variously as the "received," the "standard," or the "orthodox" view of drugs and addiction. But does such an icon exist? Do we find in either America or England a monolithic

consensus about drugs and addiction from which only a few lonely voices dare dissent? If it comes to the question of legalizing drugs, the answer is no. There are many people, including people in positions of power, who find our current drugs laws wrong in principle; many others consider them grossly counter-productive, if not outright disastrous, in their social impact. Indeed, it might pose something of a challenge to find a roomful of people who would be willing to endorse, without cavil or reservation, current American drug policy. But if this is so, where is the dangerous icon that cries out to be shattered?

According to both Dalrymple and DeGrandpre, the dangerous icon is our fundamental way of thinking about drugs and addiction, not our ideas about what kind of drug policy our government should pursue. It is the conventional wisdom—not our consciously articulated ideas about what to do about drugs, but our unconscious and uncritical acceptance of the myth about the nature of drugs and their relationship to addiction. However, because Dalrymple and DeGrandpre each reject different features of the general consensus, it will be helpful to examine their positions separately. Despite the different routes they take to arrive at their conclusion, both end up with the same basic common-sense-defying message: Don't blame drugs for drug addiction.

Blaming addiction on the drug is exactly what the addict wants us to do, Dalrymple argues. If heroin renders the addict helpless to control his own fate and incapable of kicking his habit on his own, then obviously the addict will need outside help. Therefore, it is in the addict's self-interest for other people to see him as the victim of a medical condition for which the drug alone is responsible. It is in the addict's interest to have society blame the drug, heroin, instead of the addict who repeatedly chooses to use and abuse it. Thus, the first step on the road to sanity about drug addiction is to stop treating it like a medical condition and to begin looking upon it as a moral failing.

Dalrymple devotes the first of his three chapters to arguing that addiction cannot be blamed on opium or heroin. He offers evidence that it takes a lot of work to become a heroin addict—including a great deal of learning about how to perform self-injections, how to acquire the drug and its attendant equipment, and how to (illegally) make the money to pay for the drug. He tears to shreds the widespread popular notion that withdrawal from these drugs is a process so horrifying and ghastly that no one could possibly endure such agony voluntarily, citing the classic example of the large number of American soldiers who became hooked on heroin in Vietnam, but who, on returning home, never touched the stuff again. If they could quit cold turkey, then

why couldn't his slum addicts do the same? A glance at Dalrymple's index shows how much space he devotes to "withdrawal, alleged horrors of"—roughly twenty pages out of his 140-page book.

In his second chapter, Dalrymple leaves the slums behind and launches an attack on nineteenth-century English writer Thomas De Quincey, author of *The Confessions of an English Opium-Eater*. Dalrymple holds De Quincey responsible for popularizing the notion that opiates can unlock the secrets of the universe, as well as for creating the self-serving myths that opiate addiction is virtually impossible to defeat and that opiates can destroy the willpower of even the strongest man. Although Dalrymple skirts the fringes of the absurd in his efforts to connect De Quincey's romancing of opium to heroin use among contemporary addicts, his larger argument is plausible: that the myths De Quincey helped establish have blinded subsequent generations to the unvarnished truth about opiate addiction, whose real cause is nothing more than willful self-indulgence.

Dalrymple is a cultural conservative; he firmly believes that human beings should be held morally accountable for their actions. For him, addiction is not only "a moral weakness par excellence," but, even worse, the addicts themselves "tend to be bad people (if bad people are those who consistently behave badly).... Their lives are usually selfish and self-centered.... Addicts should therefore be stigmatized far more than they are." Heroin addicts must be dealt with like ethical agents who "have made a *conscious choice* of a criminal lifestyle" (emphasis added). Against this, the standard view treats addiction as though it were a medical disease over which the addict had no more control than lung cancer—an interpretation of addiction that leads to the policy of "harm reduction": If we cannot cure the patient, at least we can make him as comfortable as possible by reducing the adverse consequences of his "disease." For example, if we cannot get someone to stop shooting up heroin, we can at least provide him with clean needles, thereby reducing his chance of getting HIV or hepatitis B and C. Yet while this may be a humane treatment for the one individual, what about the larger effects of this risk-reduction approach on the society as a whole? "When self-indulgent actions, such as taking heroin, are deprived of some [of] their worst consequences, it is hardly to be wondered at that they spread like wildfire through a population. If consequences are removed from enough actions, then the very concept of human agency evaporates.... Harm reduction as a policy is inherently infantilizing of the population: it assumes that the authorities are, and ought to be, responsible for the ill-consequences of what people insist upon doing."

Dalrymple appears to believe that if the addict had to face the

consequences of his actions—like catching HIV or hepatitis—then this fact would tend to preserve, rather than erode, his own sense of ethical agency. But setting aside the question of whether this is an acceptable policy for a morally self-respecting people to pursue, let us ask whether or not Dalrymple's prescription would be realistic as a policy approach. Would it actually work?

The addict, on Dalrymple's model, begins as a person who is already an ethical agent, but who is subsequently robbed of his capacity to make rational and mature decisions by the addiction bureaucracy. The addiction bureaucracy, according to Dalrymple, infantilizes addicts by treating their decisions "to inject themselves…like a natural fact that is independent of human volition, which is to say that they are not like you and me, who for good or ill make up our own minds about what to do and suffer the consequences." But here the question arises: *Are* they like you and me? When Dalrymple argues that heroin addicts in a slum make the same kind of decisions in the same kind of way as his average reader does, he is not making a moral judgment; he is advancing a dubious thesis about the social psychology of the addicts he treats. If these addicts were really like Dalrymple and most of his readers, would they have ended up like addicts at all?

Dalrymple is at his most unsympathetic and, far worse, at his most unrealistic, in his treatment of the excuses given to him by the heroin addicts he deals with. The addicts speak about their experience as if it were something that happened to them, something over which they had no control. They were hanging around with the wrong crowd, and before they knew it they got addicted. Or else "heroin was everywhere," and (once again) before they knew it they got addicted. Against this, Dalrymple insists that when slum kids drift into crime and addiction, they are making "the conscious choice of a criminal lifestyle," in exactly the same way that middle-class kids make a conscious choice to study medicine or accounting. The excuses that the addicts make for themselves are summarily dismissed as mere self-deception, or, worse, cheap appeals for the sympathy of suckers.

At issue here is not whether it is a good thing for people to take responsibility for their own actions. It *is* a good thing, and an open society vitally depends on the existence of a large number of people who do see their life choices as under their control. Indeed, an open society is doomed if enough of its members shirk off all sense of responsibility for their own actions. As a critic of contemporary culture, Dalrymple has been an eloquent spokesman for a much-needed return to a public ethic of personal responsibility. As a psychiatrist working in a slum, he knows all too well what happens

when most members of a community no longer even think of their own lives as something over which they have any effective control. Such an abdication of personal ethical agency does not simply injure the individual, but the entire community; it undermines the very foundations of a civilized and open social order. Yet while Dalrymple sees the problem with great clarity, the solution he proposes fails to convince, because it fails to grapple adequately with the problem of moral weakness.

If Dalrymple had limited himself to arguing that our culture should work to create individuals who have been habituated to mastery over their impulses and passions, he would have been on solid ground. But, instead, he begins by assuming that we all come into the world already equipped with the ability to make conscious choices about our lives, and to act like responsible ethical agents—and it is on this basis that he feels justified in stigmatizing the moral weakness of the drug addict. But which came first? If the drug induced the moral weakness, then shouldn't we blame the drug, as the addict asks us to? If the moral weakness was already there, before the drug use began, and if it explains the addict's inability to control his drug use, then what sense does it make to hold the addict responsible for his moral weakness? If a person has been trained to believe that he is helpless to control his own behavior, can you alter this fact by stigmatizing him or by making him face the adverse consequences of what Dalrymple calls his "conscious choices"? It is his very moral weakness that makes him impossible to help, because that moral weakness has long convinced him that he cannot help himself.

To accept the addict's account at face value does not require a bleeding heart. The problem of moral weakness was frankly recognized and brilliantly analyzed by the tough-minded Aristotle who put great emphasis in both his ethical and political theories on a psychological phenomenon he called *akrasia*. This Greek term literally means "without power," and it refers to a lack of mastery over the self—a state of helplessness in respect to one's appetites, passions, and impulses. It is defined in contrast to the concept of *enkrateia*, which represents the exact opposite kind of character—the person who has obtained mastery over himself, and who can control and regulate his passions and impulses. The dieter, for example, who follows his self-imposed regimen strictly and faithfully, is displaying *enkrateia*, while the dieter who goes off his diet because he cannot resist the lure of a strawberry milkshake is an example of *akrasia*.

According to Aristotle, not all akrasia is the same. There is weakness (*astheneia*) and impetuosity (*propeteia*). Our lapsed dieter is an example of weakness. He has thought

out a plan of action that he thinks is the right thing for him to do, namely, to lose weight; he has even established a dietary routine to achieve his end. Yet he simply cannot resist the impulse to have a strawberry milkshake, in violation of the rules that he had set out for himself. He knows better, but this rational knowledge makes no difference to his actual conduct. He is too weak to control his appetites and his passions. He exists in a state of internal conflict: part of him wants to do the right thing, but that part is not strong enough to conquer the part of him that wants to do the wrong thing.

On the other hand, the impetuous person makes no attempt to curb and control his impulses and appetites. He simply acts, and does so without any internal agonizing over what choice to make, and indeed without any reflection or deliberation at all. Yet, for Aristotle, the impetuous person is capable of regretting his impulsive actions once he has committed them, though perhaps only in the way that the impulsive shoplifter regrets the fact that he has been caught red-handed. This regret, by itself, cannot bring about a change in the behavior of the impetuous person; he will continue to give in to his impulses and to be punished for them—like the criminal who, as soon as he is released from jail, returns to committing the same crimes that put him there in the first place. The impetuous person never learns.

Aristotle's analysis is helpful in seeing where Dalrymple's treatment of the addict falls short, since the concept of *akrasia* allows us to recognize that there will inevitably be large groups of human beings who will be unable to control their own lives—a group that will naturally exhibit all the signs of the impetuous personality. Large doses of testosterone coursing through the veins of young males will invariably lead to impetuous behavior, unless these boys have been subjected from a young age to a rigorous program aimed at habituating them to self-control, or *enkrateia*—and even then the success may be hit or miss. Kids who have been allowed to grow up feral cannot be expected to display self-control; self-mastery is a technique no one has taught them, so how could they have learned it? They will in fact lack the strength of mind to rise even to the level of Aristotle's weak man, since they will be ignorant of what constitutes right conduct. In Aristotle's political theory, such human beings are classified as "natural slaves" who must be governed by others because they are completely unable to govern themselves. Today we find Aristotle's theory objectionable, despite the fact that in even the most advanced societies many people are "enslaved" to drugs, to alcohol, to gambling, and to sex. Indeed, Aristotle could rightly point out that no society has ever existed that achieved the complete

elimination of the weak-willed and the impetuous, if only because each rising generation will consist of children who, by nature, lack the self-mastery that can only be achieved by the right upbringing—if even then.

Civilizing the young is one of the first duties of any society, though it is a duty that certain cultures have discharged with vastly more success than others. If there are many people in the society whose behavior is characterized by *akrasia*, or moral weakness, then the society, for its own good, has a right and an obligation to keep them from dangers to which they, by nature, are especially vulnerable. The sociological motive behind such puritanism is not a hatred of pleasure as such, but only of those pleasures that weaken the will and undermine self-control. Some pleasures are wholesome and acceptable, and should be encouraged. Other pleasures challenge not just individual self-control but the collective self-control of the whole community, threatening the ethical foundation of the society; such pleasures must be curbed. Lead us not into temptation, both for our own good and the welfare of the general society.

The rigid distinction between innocent and harmful pleasures happens to be a part of the cultural background of Anglo-American societies. It is of a piece with our puritan heritage. Yet, according to the main thesis of Richard DeGrandpre's book, it is also the source of immense evil. It is the ideological culprit that has led to America's fatal policy of the "differential prohibition" of drugs—our policy of dividing drugs into the innocent sheep and the wicked goats, or, as DeGrandpre prefers to put it, into angels and demons. Some drugs are legal, like Xanax and Prozac; others are illegal, like heroin and cocaine. Yet, as DeGrandpre points out, during the last century or so, there have been radical shifts in the substances subjected to differential prohibition. Once you could get cocaine in Coca-Cola at the corner drugstore (albeit in trace amounts). You could buy heroin from the same company, Bayer, from which you purchased aspirin. Heroin itself was originally introduced as a "cure" for morphine addiction: it began its life as an angel but fell from grace. At the same time, drug manufacturers have produced a variety of drugs that were peddled as beneficial for dealing with depression or anxiety, only to discover that many of them, like the barbiturates, could be both as addictive and as deadly as the demon drugs whose mere possession often incurs a considerable prison sentence. The result of this process has been to criminalize more and more drugs that were once quite legal, an escalating strategy of differential prohibition that has made America "the world's most troubled drug culture," as the book's subtitle puts it.

DeGrandpre asks whether any of this makes sense. Are we right to

blame the drugs themselves, especially considering our tendency to change our minds about which drugs are good and which are bad? More to the point, how much genuine scientific evidence do we have that it is the drug that is really responsible for addiction? Consider what would appear to be the slam-dunk case against nicotine.

In 1988, C. Everett Koop, President Reagan's surgeon general, concluded that smoking cigarettes was addictive, but went on to locate the source of the addiction, the drug known as nicotine. Yet, as DeGrandpre points out, if nicotine is what makes smoking so hard to quit, why don't people simply chew nicotine gum with their morning cup of coffee, or, to get a quicker and more powerful dose, use nicotine spray—perhaps taking spray breaks during the workday? Still worse, consider the effects of the campaign undertaken by Food and Drug Administration Commissioner David Kessler in the 1990s to prove that smokers became so helplessly addicted to the drug nicotine that they no longer had any control over whether or not they continue to smoke. Yes, such a campaign might help lawyers win millions for their "hopelessly" addicted clients, but what then becomes of the other FDA campaign—the one aimed at getting smokers to stop smoking? If smokers are powerless to resist the allure of nicotine, what is the point of urging them to stop?

If DeGrandpre had limited himself to probing the paradoxes and pitfalls of our current approach to drugs, all would be well. He goes badly astray, however, when he tries to offer a sweeping general theory of how America became "the world's most troubled drug culture," and makes a set of utterly extravagant claims about American drug policy that can most charitably be described as severe rhetorical overkill.

The target of DeGrandpre's fury is what he calls "the cult of pharmacology," a kind of quasi-but-not-quite conspiracy that is supported by an ideological system that he calls pharmacologicalism—an octosyllabic tongue-twister DeGrandpre employs to stress its resemblance to other despicable *-isms*, including racism, Edward Said's Orientalism, and, most astonishing of all, Nazism.

One may well ask in what way America's drug attitudes and policy is akin to Nazism, and DeGrandpre provides the answer: "Like the angel drug and the demon drug, the Aryan and the Jew were constructed as distinct and distinguishable categories that gave meaning to and thereby excused extraordinary political, social, and scientific measures." Well, it is true that the Nazis divide people into good and bad, like we divide drugs into good and bad, but this is hardly a useful comparison. Making distinctions between good and bad things is a necessary and basic part of our survival in the world. Of

course, the specific divisions we choose to assign may be wrong and we may wish to revise them; or they can be used viciously, as in the case of Nazism or racism. But it is downright bizarre to assume that there is something inherently pernicious about dividing objects into good and bad, harmless and dangerous, useful and hazardous.

DeGrandpre's conclusion should come as no surprise: If "differential prohibition" is an evil on the order of Nazism, then the right course would be to stop demonizing certain drugs as being inherently evil or dangerous or socially destructive. True, some people can't handle them, but, as DeGrandpre points out, some people cannot handle gambling either. In short, it is wrong to continue to blame drugs. They do not cause addiction. Addiction is rather a matter of setting, the user's personality and background, and the meaning assigned to certain substances by powerful, self-interested, sinister groups. This is precisely the conclusion that Dalrymple has led us to, though by a different route: Blame the addict, not the drug.

Despite the various compelling arguments advanced in both books, this conclusion remains troubling for a number of reasons. To begin with, let us examine the case of two remarkable individuals, one cited by DeGrandpre, the other by Dalrymple.

William Halsted was an American doctor whom DeGrandpre calls "one of the greatest of surgeons in American history, perhaps even the father of modern surgery." In 1892, Halsted became the first professor of surgery at Johns Hopkins Hospital; he later introduced the use of rubber gloves when operating on patients, and went on to organize "new fields of medicine, including orthopaedics, otolaryngology, and urology." Yet Halsted had been using morphine from the age of twenty-two, and remained a morphine user for well over the next half-century. A study made of him in 1942 reported that Halsted "found that his addiction caused him little inconvenience.... Sometimes he went for a few days, or even weeks, without the drug, but then 'suddenly the overpowering desire would come.'"

William Wilberforce, an Englishman who lived a century before Halsted, played a pivotal role in bringing about one of the world's greatest ethical achievements: he worked tirelessly for the emancipation of slaves, not just in British colonies, but around the world, and he was instrumental in ending the horrors of the Atlantic slave trade. His contemporaries admired his eloquence; Boswell famously described watching the diminutive Wilberforce give a speech: "I saw what seemed a mere shrimp mount upon the table; but as I listened, he grew, and grew, until the shrimp became a whale." Thanks to

his patience and persistence, the abolitionist cause eventually won out in Parliament. Yet, as Dalrymple notes, Wilberforce died an opium addict.

Halsted and Wilberforce certainly do not fit into the categories of the weak-willed or impetuous man. Can their addictions be summarily dismissed as mere self-indulgence, or do they offer evidence that certain substances possess an occult hold over even the strongest of us? When Halsted spoke of the times when he tried to quit morphine, but found himself seized by "the overpowering desire" for the drug, was he simply propagating more pharmacological lies, as De Quincey is supposed to have done, or was he genuinely possessed by a desire over which he had no control?

Earlier we discussed the case of the weak-willed fellow who set out to follow a rigorous diet plan, but found himself seduced by the temptation of a strawberry milkshake. When dealing with our lapsed dieter and his strawberry milkshake, our common sense tells us that it would be silly to blame some sinister power in the milkshake. Instead, it makes more sense to say that he lacked the strength of will; or, as Aristotle would say, that he was weak. But can the same thing be said about other substances, like opium, cocaine, or alcohol? It was the immensely strong-willed Samuel Johnson who, when asked why he never touched wine, replied: "Abstinence is as easy for me, as temperance would be difficult." But why would temperance have been so difficult for Johnson to achieve? It makes no sense to blame it on his lack of willpower, since he was strong enough to abstain from wine completely, and, as he said, quite easily.

Johnson's quip about abstinence and temperance makes sense when it is a question of spirituous beverages, but what about strawberry milkshakes? We can understand a man who abstains from drinking strawberry milkshakes—but what about a man who cannot drink strawberry milkshakes in moderation, and who goes on a weekend-long strawberry milkshake binge? Is such a man even imaginable? If one finds pleasure in a strawberry milkshake at all, one can find it *only* in moderation: drink three of them in a row as an experiment if you doubt the truth of this observation. But the same thing cannot be said about the pleasures of alcohol, and by extension, the pleasures of opium, cocaine, crack, and methamphetamine. While it is true that some people can use these drugs moderately, the way many of Johnson's contemporaries could drink wine moderately, the fact remains that there are many otherwise strong-willed people who begin taking alcohol and drugs and discover, too late, that they cannot control their desire to take more and more—a problem which, as we have seen, does not afflict even the most self-indulgent lover of strawberry milkshakes.

In short, the chemical nature of the temptation *does* matter.

Yet let us suppose, for the sake of argument, that both Dalrymple and DeGrandpre are correct in telling us not to blame the drug. Let us grant that there is not really a little devil lurking in the bottom of the bottle of Demon Rum, nor any fiendish agent in a gram of opium or cocaine. Let us cheerfully discard all such unscientific myths and cease to demonize certain substances as inherently dangerous. At the end of this orgy of demythologization, what have we gained? For most of my life, I have believed all the dubious myths about heroin; I had erroneously thought that I could become hopelessly addicted if I had any dealing with this infernal substance at all, and in consequence of my illusions I have never even thought about trying something so horrible. Yet as I was reading Dalrymple's dismissal of these self-serving lies and willful misconceptions about heroin, I couldn't keep from thinking: "Where can I get some!"

Is it possible that one of the causes of the modern drug epidemic is that more and more people have ceased to subscribe to the idea that certain substances are inherently destructive of our strength of will, and have therefore been tempted to taste the erstwhile forbidden fruit? If scientific knowledge leads us to abandon such myths as that of Demon Rum, Demon Heroin, and Demon Cocaine, is it altogether clear that our increased sophistication will be advantageous to the welfare of both present and future generations? Some irrational fears are obviously bad; others may serve an immensely useful social purpose. Carrie Nation's crusade against Demon Rum may raise smiles on our faces today, but have we developed a more effective technique at getting people to resist the temptation of forbidden fruit than scaring the hell out of them?

Consider conventional treatment for heroin addiction: the controlled, medical administration of opiate substitutes like methadone or buprenorphine. Its track record, as Dalrymple argues, leaves much to be desired, though it is highly questionable whether he is correct to blame conventional treatment for causing an increase in drug use. Yet if this form of treatment does no positive good, can our society really be expected to reject the policy of "harm-reduction" in order to pursue the wan and rather utopian hope that heroin addicts can be shamed out of their lifestyles by being further stigmatized by people with whom they have virtually nothing in common? True, by not providing clean needles, and refusing to take care of them when they get a deadly disease, the number of addicts would be decreased by a grisly process of elimination, but at an enormous cost to our own collective moral decency. The policy of harm-reduction, which Dalrymple

assails, may do little good for the addicts, but at least it preserves the humanity of the society that adopts it; the same cannot be said for a policy of letting people die unnecessarily from HIV and hepatitis.

This brings us to the final question: Can we solve our drug problem by simply legalizing drugs?

Both authors correctly point out that the very attempt to outlaw dangerous substances from a society automatically creates a black market for them. This was demonstrated during Prohibition in the United States and, as DeGrandpre argues, the escalating differential prohibition of drugs in America has resulted in a very troubling drug culture indeed: the number of inmates in our jails and prisons who are there on drug charges is an ample demonstration of this sad fact. But here, too, there may be something to be said for our conventional wisdom. In fighting a normal epidemic, the goal is not just to cure those who have it already, but to keep it from spreading to those who don't. If we can save a substantial number of people from becoming drug addicts by locking up those already addicted, such a policy might be favored by a utilitarian calculus: to save many we must penalize a few. Unfortunately, given the very nature of the problem, it is impossible to discover the number of those who are saved from drug addiction out of their fear of imprisonment, or even by the mere difficulty of obtaining drugs due to their illegalization. Yet the fact that we can never quantify this number with any pretence of precision does not mean that this factor should be ignored. An open society may be less threatened by imprisoning those who cannot handle their freedom than by permitting them to exercise it at other people's expense.

At the end of his book, Dalrymple debates the pros and cons of legalizing heroin use, and comes out in favor of keeping heroin illegal. He clearly sees that this question, like the question of legalizing the use of any other currently illegal drug, is not as straightforward as many people would like to think. Should it be sold openly on street corners, or should it be prescribed only by doctors? Should it be limited to registered addicts, or offered to the general public? Such questions, Dalrymple argues, cannot be intelligently decided by an appeal to "a simple universal principle by which all important questions may be answered." In the debate over legalizing drugs, the relevant simple universal principle is the one cherished by libertarians and given its classic expression in John Stuart Mill's *On Liberty*: "The only purpose for which power may be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." Against this laissez-faire moralism, Dalrymple

argues that "no man, least of all a drug addict, is an island; we all live in society with other men. It is hard to discover activities that affect only the person who undertakes them. And while it is certainly possible for opiate addicts to lead otherwise normal lives, the fact is (and is likely to remain) that the great majority of them do not…they impose costs on others, often very heavy ones."

Dalrymple's own experience with heroin addicts showed him that their addiction entailed quite considerable social costs. The vast majority of addicts committed crimes other than the use of illegal drugs: they stole things and robbed people. There was a costly addiction bureaucracy set up to "treat" them, or at least to pretend to. Yet, earlier in the book, Dalrymple undermines his own anti-legalization position by asserting that "heroin-taking is more a consequence of than a cause of criminality, and the decision to take heroin, whether in prison or outside, is therefore the conscious choice of a criminal lifestyle.…A criminal mentality causes heroin addiction more than heroin addiction causes criminality." But if this is true, the heavy cost imposed on society by the heroin addict arises not from the heroin addiction, but from the addict's previously established criminal lifestyle. In that case, the principle of punitive parsimony would suggest that it was sufficient to punish the criminal activity of the addict, and to leave alone those heroin users who do not commit crimes. If heroin itself is not the cause of criminality, then what is the point of outlawing it? The heavy social costs imposed by the addict come not from the heroin but from his criminal lifestyle. Thus there is no need, by Dalrymple's argument, to repudiate Mill's principle, since Mill would clearly agree that the state's power may be rightfully exercised over those who steal and rob. Furthermore, by legalizing heroin, there would be no need for an addiction bureaucracy to treat addicts: those who committed crimes would be dealt with by the existing penal system, while those able to lead somewhat ordinary lives would be simply left alone.

The libertarian position seems inevitable once we have decided that drugs are not the cause of drug addiction. If opiate users can be divided into those who would be criminals anyway and those who end up brilliant surgeons like Halsted and eminent humanitarians like Wilberforce, then it obviously makes far more sense to lock up the criminals for their criminal behavior, and not for their heroin use. But this argument can be turned on its head: If strong and confident men like Halsted and Wilberforce can become hopelessly addicted to a drug, then might this not be an argument for doing everything possible to keep it out of the hands of adolescent boys, slum addicts, the weak-willed, the impetuous, the self-indulgent, the depressed—in short, to treat it in the

same way you would treat a dangerous strain of plague that threatened to sweep through entire populations? Yes, some people will be immune to the plague, but it remains a plague all the same. The obvious fact that some people can use these substances without undermining the foundation of the open society does not mean that their widespread promiscuous use among the general population will prove equally innocuous.

Mill argued that the prohibition of opium imports into China was an "objectionable…infringement of liberty…of the buyer." This was a straightforward, if unappetizing, application of his "simple universal principle." But would Mill have stood by his simple principle if he had foreseen the consequences of its application in this case? By the time the Communist Party came to power in 1949, there were approximately 20 million opium addicts in China. Chairman Mao, no student of Mill, decided that the only answer to the problem was ruthlessness. As Dalrymple writes, Mao gave the Chinese opium addicts "a strong motive to give up and the rest of the population a strong motive not to start. He shot the dealers out of hand, and any such addicts who did not give up their habit. The carrot for addicts was life and the stick was death. It would not be going too far to say that, within a mere three years, Mao produced more cures than all the drug clinics in the world before or since, or indeed to come. He was the greatest drug worker in history."

Immediately after making this observation, Dalrymple writes that "the point of this story is not to advocate a repetition of Mao's methods on our soil, but to demonstrate that, when a motive is sufficiently strong, not merely some, but many, indeed millions, of addicted people can abandon their addiction, without the whole paraphernalia of the help that is necessary on the standard view of the problem." But what kind of substitute for mass executions is available to the open societies of the West in dealing with our drug problems? Out of our limited box of tricks, how do *we* devise motives that are "sufficiently strong" to get addicts to kick their habit, but which fall short of lining them up against a wall and shooting them?

Herein may well lie one of the great advantages that highly authoritarian forms of government have over open and liberal society. They are in a position to crack down on social epidemics, like drugs, in ways that are far more effective, because far more brutal, than any option available to societies like Dalrymple's England or DeGrandpre's America. If so, what a fascinating paradox to present to Mr. Mill—those societies that most closely followed his "simple universal principle" could eventually be undone by their excess of liberty; in which case, the epitaph of the open society might well be taken from Dalrymple's

assessment of the addicts he dealt with in the British slum: "Freedom was bad for them, because they did not know what to do with it."

Open societies cannot be open to everything. Even if it were possible to draw with great precision the line between what is harmful only to me and what is harmful to others, no society can tolerate a population that is committed to enslaving itself to drugs, just as no democracy can permit itself to be liquidated by a majority vote. What often goes unnoticed about Mill's simple universal principle—unnoticed by even Mill himself—is that he stipulates that his rule applies to "member[s] of a *civilized* community" (emphasis added). But in order to have a civilized community in the first place, the members of such a community must obtain a high degree of self-mastery over their impulses and urges. The weak-willed and the impetuous, as Aristotle recognized clearly, cannot by themselves create a civilized community—and even if they find themselves in the midst of it, they will have no capacity to sustain it. Indeed, because of their own weakness, they will weaken the community of which they are a part, often to the point of endangering its capacity to remain free and open.

In sum, an open society has no realistic choice but to concern itself with the harm that people do—not just to others, but to themselves. It has not only a right but a *duty* to do this. The question is not whether it should exercise this duty, but only how and under what circumstances. With respect to drugs and addiction, the conventional wisdom may have much still to learn—but it is closer to the truth than those who seek to overthrow it.

Lee Harris *is the author of* The Suicide of Reason: Radical Islam's Threat to the West, *published this summer by Basic Books.*