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ADVERSE LEGAL IMPLICATIONS OF HEROIN MAINTENANCE

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INTRODUCTORY NOTE

The following article was delivered at the National Conference on Drug Abuse held on December 7, 8, and 9, 1972 in Washington, D.C. The National Conference on Drug Abuse has granted permission to reprint the article. Subsequent to the delivery of this paper, Consumer Union published a report entitled *Licit and Illicit Drugs*. Authored by Edward M. Brecher, the work is the most comprehensive compilation of facts on drugs and drug problems in the United States that has been published. Of especial interest are the previously unpublished "British Columbia Study on Drug Addiction" and the chapter entitled, "The Heroin Overdose Mystery," which gives strong indication that heroin "overdose" deaths are not necessarily directly related to the illicit nature of procurement and administration. The work has not altered the views or conclusions set forth herein; it is the author's belief that *Licit and Illicit Drugs* buttresses and gives support to many of these views.

INTRODUCTION TO THE PROBLEM

With his usual adroitness for misleading understatement, President Richard M. Nixon has declared drug abuse a "national problem."[1] What Mr. Nixon could have said was that a conservative estimate of heroin addicts in this country numbers 559,000;[2] that drug addicts account for $2.4-billion annually in theft losses and account for 33 to 50 per cent of all property crimes in urban areas in America.[3] Law enforcement officials as diverse in approach and mentality as Haywood Starling, North Carolina's chief of the State Bureau of Investigation's operations division to Burton Roberts, Bronx County District Attorney agree that drug-related crimes

[1] See Marshall, "Heroin, The Source of Supply," *The New Republic*, July 24, 1971, p. 23.

[2] "World Opium Survey 1972," U.S. State Dept., the Central Intelligence Agency, the Bureau of Narcotics and Dangerous Drugs, Customs Bureau and the Treasury Dept. (Aug., 1972).

[3] U.S. House of Representatives, Select Committee on Crime, Heroin and Heroin Paraphernalia, H. Report No. 91-1808, Jan. 2, 1971, p. 13.

now account for the bulk of felonies committed in their respective jurisdictions.[4] Special courts in urban areas have been set up to handle narcotics and felonies.[5]

The overall cost of heroin addiction including crime losses, treatment and criminal process expenditures is $4.3-billion per year.[6]

The cost in human lives and suffering is immeasurable.

Most persons who have analytical dealings with the "drug scene" now concede that the problem is that of a contagious disease reaching epidemic proportions. The use of the phrase "contagious disease" has troubled certain persons in relation to narcotics abuse. The first point that must be accepted is that citizens in Central Europe in the 14th Century also had difficulty visualizing bubonic plague ("The Black Death") as a contagious disease.

Narcotics addicts, although generally characterized by a proclivity to boredom, inclined to passivity and frustration, are obviously never affected until introduced to the particular drug by another person, who is generally a user.[7]

The general profile of the heroin addict as young, urban, Black and disadvantaged does not account for the fact that some urban, Black and disadvantaged youths contract the disease and others don't. The parallel between exposure to the tubercule bacilli and introduction to heroin is not a mere game of analogies.[8]

Dr. Nils Bejerot, the Swedish psychiatrist, has pointed out that as late as the 19th Century, physicians refused to believe that epidemics were spread by microbes. Dr. Bejerot finds it similarly difficult to convince some of his colleagues of the reality of social contagion. Contagion occurs mainly among young addicts who enthusiastically proselytize among their peers. Dr. Bejerot would opt for quarantine to control the epidemic, which he views as the most serious spread of drugs in any culture in history.[9]

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[4] See *Raleigh News and Observer*, July 26, 1970, p. 3-A; also see New York Law Journal, Mar. 27, 1972, p. 30.

[5] See *New York Times*, Sept. 6, 1972, "Special Narcotics Court Opens," p. 35.

[6] *Op. cit.*, U.S. House of Representatives.

[7] Zimmering, Toolan, Safron, Renate and Wortis, "Drug Addiction in Relation to Problems of Adolescence," *Amer. J. of Psychiat.*; 1959, Vol. 109, p. 272.

[8] This statement is made notwithstanding the caveat concerning the possible attack upon analogies. See Beardsley, *Practical Logic*, p. 107.

[9] See *N.Y. Times*, May 14, 1972, "Psychiatrist Proposes Heroin Addict 'Villages,'" p. 41. Dr. Bejerot cites the recent British heroin epidemic and the widespread use of amphetamines in Japan after World War II, but points to America's increase of "geometric progression" as a challenge that "reaches into the soul of a civilization."

It cannot be gainsaid that narcotics abuse, and specifically heroin addiction, is based on personal contact between and among users. There is no demonstrated natural phenomenon that sets in motion a craving for the drug by the "dope fiend." The "craving," as it were, comes after the fact of infection, not before.

That drug abuse is a national problem is axiomatic. The question remains, what are we doing to remedy the problem? "We" have made a well-publicized, though misdirected, effort toward buying up Turkish poppy crops for $30 million. Even at the time that the Turkey poppy buy was proposed, "we" had information that much of the heroin trafficked into the United States, came not from the Turkish source, but from Southeast Asia.[10] "We" have initiated various treatment programs that have worked to a degree, but have made no discernible in-roads into decreasing the American addict population.[11]

And now "we" have finally arrived at the threshold of maintenance programs, which do not purport to treat, but merely to appease the addict's "craving," thereby rendering him docile so that he does not present a criminal threat to the total community. This paper will develop as its primary theme the approach that heroin maintenance is not treatment and therefore a denial of treatment to diseased persons who could probably benefit from treatment. Tangentially, the paper will indicate that the proposed goal of eliminating the addict's need to engage in crime is not a demonstrable quality of such a program.

History of Opiates

The psychological effects of opium may have been known to the ancient Sumerians, circa 4,000, B.C., whose ideograph for the poppy was *hul* (joy) and *gil* (plants). The first undisputed reference to poppy juice were found in the writings of Theophrastus in the Third Century, B.C. The word opium itself is derived from the Greek name for juice; the drug being obtained from the juice of the poppy capsule. Arabian physicians early learned uses for opium and Arabian traders introduced the drug to the Orient and China, where it was employed mainly for the control of dysenteries. By the middle of the 16th Century the uses of opium that are still valid were fairly well understood in Europe.

[10] See Marshall, *op. cit.*; "Asian Drug Inflow Found Greater Than Realized," *N.Y. Times*, p. 3; McCoy, *The Politics of Heroin in Southeast Asia*, Harper & Row (1972).

[11] See *Dealing With Drug Abuse: A Report to the Ford Foundation* by the Drug Abuse Survey Project, Praeger Publishers (1972).

Paracelsus (1493-1541) is credited with compounding laudanum which remains in use today. In the 18th Century opium smoking became popular in the Orient. During that period, the use of opiates for their subjective effects was socially acceptable. The availability of opiates led to some over-use, but "opium-eating" (actually laudanum drinking) never became as prevalent nor as socially destructive as the use of alcohol.

In 1803, the German pharmacist Serturner isolated and described an opium alkaloid that he named morphine after Morpheus, the Greek god of dreams. Discovery of other opium alkaloids swiftly followed Serturner's discovery of morphine including diamorphine (heroin). In the middle of the 19th Century, the hypodermic needle was invented, leading to a wide-spread parenteral use of morphine and tended to produce a more severe variety of compulsive drug use. In the United States, the extent of the opiate use problem was accentuated by the wide-spread use of morphine to ease the pain of wounded Civil War soldiers and the ready availability of morphine for treatment of all ailments thought to involve the central nervous system. Little wonder that before the turn of the century, the bulk of narcotics addicts were little old white ladies in the South who had been introduced to morphine by over-accommodating physicians.[12]

American Narcotics Legislation

Narcotics legislation in the United States has taken a lurching path reminiscent of a "nodding junkie" proceeding down Lenox Avenue: unsure of its goals and purposes. The first law designed to combat illicit narcotics traffic was the Harrison Act which was enacted ostensibly as a tax proposal.[13]

The Act provided for a tax on any narcotic drug produced, imported or sold in the United States. The tax was upheld as a valid exercise of Congress' constitutional power to tax.[14] When the Harrison Act was first passed, many physicians interpreted it to mean that they could continue to dispense opiates to those who were already narcotics addicts as a "legitimate medical use" within the meaning of the statute. However, the Treasury Department interpreted the Harrison Act to label as unlawful any medical prescription of narcotics designed to satisfy the "hunger" of the addict.[15] This interpretation led to prosecution of physicians prescrib-

[12] *The Pharmological Basis of Therapeutics*, ed. by Goodman and Gilman, MacMillan & Company (N.Y.) 1971, p. 321.
[13] Int. Rev. Code §§ 4741-4786 (as amended).
[14] U.S. v. Jin Fuey Moy, 241 U.S. 394 (1916).
[15] Treas. Dec. No. 2809 (Mar. 20, 1919).

ing drugs to satisfy the demands of addiction, thereby forcing the addict to turn to illegal sources to obtain his narcotics.

The Jones-Miller Act prohibited the importation of narcotics not necessary for medical or scientific purposes.[16] A statutory presumption is created by the Jones-Miller Act that makes possession of "unexplained" narcotic drugs basis for conviction.[17]

The Narcotic Control Act imposes penalties for violations of any of a number of satellite drug control statutes.[18]

The federal government has subsumed many of the problems attempted to be covered by the various statutes mentioned under the recently enacted Controlled Substances Act.[19] The Controlled Substances Act lists approximately 150 substances in six separate schedules and covers such diverse drugs as heroin, marihuana, codeine and D-lysergic acid diethylamide (L.S.D.) Offenses punishable under the statute include:

(1) Manufacturing, distributing or possessing with intent to distribute controlled substances;
(2) Creating or distributing a counterfeit controlled substance; or
(3) Possessing a controlled substance.

State legislation concerning narcotics control have ranged from passage by 46 states of the Uniform Narcotic Drug Act in the mid-1950's to California's "status crime" statute, which made it a criminal offense to be a drug addict,[20] to the unfortunate fiasco created by the New York Narcotic Addiction Control Act of 1966.[21] The two-fold purpose of protecting society from the contagion of narcotic addiction and rehabilitating the addict, never came to fruition. The N.A.C.C. Act was designed to release the addict from a great deal of the opprobrium created by his being treated as a criminal rather than as a victim of disease. The program was effectively stymied by its proclivity for merely changing signs on prison gates.

It is now my turn for understatement decidedly not designed to mislead.

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[16] 42 Stat. 596 (1922), 21 U.S.C. 171-185.

[17] 21 U.S.C. 176 (a).

[18] Int. Rev. Code, §§ 7237-7238. "Satellite" statutes include the Marihuana Tax Act, Int. Rev. Code, §§ 4741-4786; The Opium Poppy Control Act, 21 U.S.C. 188; and The Vessel Seizure Act, 49 U.S.C. 781-788.

[19] 21 U.S.C. 801 *et seq.*

[20] See Robinson v. Calif., 370 U.S. 660 (1962).

[21] New York State Mental Hygiene Law (McKinney's Consol. Laws), Article 9, §§ 220 *et seq.*

The plethora of repressive federal and state legislation has not had any effect upon reducing the extent of the narcotic abuse problem in this country.

Treatment of Addiction

Narcotic Addiction

It is possible to describe all known drug use or abuse without employing the term addiction. The definition of addiction used here is somewhat arbitrary. The term addiction will be used to mean the behavioral pattern of compulsive drug use characterized by the overwhelming involvement with the use of the drug, the securing of the supply and a high tendency to relapse after withdrawal. In most instances it will not be possible to state with precision at what point compulsive use can be considered addiction. The term in this frame of reference cannot be used interchangeably with physical dependence. It is possible to be physically dependent upon drugs without being addicted and vice-versa.

Older views that all compulsive users of opiates or alcohol were morally weak persons who merely overindulged themselves have been largely replaced by the view that most of them have emotional disturbances that would have been manifested even in the absence of drug use. For some individuals the use of drugs may be an attempt to cope with this disturbance. The nature of the disturbance predisposing to drug use is not clear.

It has been suggested that individuals with widely differing problems use pharmalogical agents for different reasons. The neurotic may use the drug to relieve anxiety (negative euphoria); the psychopath to get a thrill (positive euphoria); and the psychotic to alleviate depression or suppress illusions. Considerable effort has been expended to find a constellation of common characteristics in compulsive drug users that would cut across the diversity of clinical diagnosis and that could be thought of as the addict or alcoholic personality. Although most narcotic addicts show a constellation of common features similar to alcoholics, they also exhibited some striking differences. Alcoholics tend to solve conflicts against aggression, dependency and sexuality by acting out in a pseudo-masculine fashion. Narcotic addicts prefer to handle such anxieties and conflicts passively by avoidance, rather than aggressive acts.[22]

[22] See Zwerling & Rosenbaum, "Alcoholic Addiction and Personality," in *American Handbook of Psychiatry*, Basic Books, Inc. (N.Y., 1959). Also see Zimmering, Toolan, Safron, Renate and Wortis, "Drug Addiction in Relation to Probelms of Adolescence," *Amer. J. of Psychiat.*, 1959, Vol. 109, p. 272.

Wickler and Rasor found that opiates suppress drug addicts' anxieties in a manner not accomplished by alcohol or barbiturates, thus permitting the user of narcotics to make a passive adaptation to his inner tensions.[23] There is some indication that there is cross usage of drugs among addicts, although materials on the subject are almost nonexistent.

Contrary to popular belief, the professional pusher does not play the major role in introducing nonusers to marihuana or heroin. This is obviously not a matter of the pusher's scruples, but reflects the fact that the professional pusher feels safe only when selling to a known addict. Furthermore, solicitation is unnecessary. Illicit drug traffic is a seller's market. There are those who propose that if opiates were supplied through legitimate medical channels to addicts who cannot be rehabilitated there would be a virtual elimination of the illicit drug traffic (see infra.). The conclusion is highly unlikely. The illicit drug traffic is like any other black market; it is not necessary for its customers to have a physical need. The black markets in luxury items and consumer goods that flourished throughout war-time despite high penalties demonstrates this clearly. There will always be enough curious, frustrated and/or bored persons to provide a demand for illicit drugs that exceeds the supply.

Most users are introduced to the drug by other users. This is true both of the initial contact and subsequent contacts that lead to relapse after withdrawal. Although there are no statistics to support the notion, the most common pattern may be to use the drug once or twice and then, aware of the danger, avoid it thereafter.[24]

Means of Treatment

Methods of treatment of narcotic addicts would appear to be as diverse as the psycho-socio-economic types of addicts. There are advocates of both pure psychotherapy and total chemotherapy and a variety of camps in between. As narcotic-related crimes take on wider dimensions, pressures on national, state and local levels point to paths of least resistance. The drug-free therapeutic approach is eschewed in favor of methadone maintenance which in turn gives way to the simplest approach: heroin maintenance. The problem with the simplest expedient is its inherent failure prone nature. As the British program demonstrated, there are those heroin addicts

[23] Wickler and Rasor, "Psychiatric Aspects of Drug Addiction," *Am. J. Med.*, 1953, Vol. 14, p. 566.

[24] Robins & Murphy, "Drug Use in a Normal Population of Young Negro Men," *Amer. J. Publ. Health*, 1967, Vol. 57, p. 1580.

who exhibit criminal behavior both before and after heroin administration. The problem in these cases is obviously one of character disorder which is merely masked by the program of heroin maintenance.

The drug-free therapeutic programs are characterized by approaches which embody faith (Nation of Islam, Teen Challenge), encounter groups, isolation (Dr. Bejerot's recommended "Addict Villages") and plain psychotherapy.[25] Rehabilitation is often mentioned as an element of these programs, but is usually not present or of a limited nature.

Within the past two years, chemotherapy has received much of the publicity and most of the research funds directed toward the treatment of addiction.

A dramatic means of treatment of addiction involves the Rapid Coma Technique of Carbon Dioxide Therapy (C.D.T.). In a very limited clinical program (50 heroin addicts who had previously failed in some other treatment program; i.e., methadone, psychotherapy, hospitalization withdrawal, etc.), C.D.T. was found to be 70 per cent effective in rendering a complete cure. The treatment has been used for over 40 years in the adjustment of character disorders. There appears to be no indication of adverse side effects.

The technique involves forcible inhalation by the patient of a 75-80 per cent CO_2 mixture. The mixture induces unconsciousness in eight seconds with a full return to consciousness within 30 seconds of inhalation. The high concentrations of CO_2 tend to reduce the emotional tension in the central nervous system, with a concomitant loss of craving for any narcotic agent. Treatment lasts from six to eight weeks. The therapy is not habit forming, addictive nor dulling to the mental process.

Although the program has had demonstrated success, no federal aid has been advanced for research or implementation.[26]

Methadone maintenance is a relatively new treatment specifically for narcotics users. It is based on the hypothesis that as a result of repeated use of narcotics the addict has sustained a metabolic alteration such that narcotics produce a euphoria not experienced by non-addicts.[27] Although there are variations between programs, the treatments described by Dole and Nyswander consist of daily administration of methadone, 80 to 150

[25] The full range of narcotic treatment programs is set forth in a 1970 memorandum prepared by lawyers at Community Law Offices.

[26] LaVerne, "Carbon Dioxide Therapy," *New York Law Journal*, Mar. 28, 1972. See also Wickler and Rasor, *op. cit.*

[27] Dole, Nyswander and Warner, "Successful Treatment of 750 Criminal Addicts," *J. Amer. Med. Ass.*, 1968, Vol. 206, p. 2708.

milligrams per day orally in a fruit juice or vegetable compound, plus attempts at social rehabilitation. At this stabilization level, achieved by gradually increasing the dosage over a period of six to eight weeks, there is a very high degree of cross tolerance to all opiates so that the euphoric effects of even high doses of narcotics will not be felt. Dole and his co-workers have referred to this state as "narcotic blockade." Methadone treatment has had such an impact on narcotic addiction treatment in the United States that the number of programs utilizing this specific chemotherapeutic approach have increased from 50 to 434 in the past two years.[28]

The duration of action of methadone is such that the oral dosage need be given only once a day. Methadone has become an attractive treatment vehicle because it tends to make the addict more amenable to other forms of therapy. The recognized drawbacks to methadone maintenance include the fact that it too is an addictive drug, the effects of its long term use are not known with any certainty and there is evidence that some addicts can build a tolerance to the drug that vitiates the "blockade" effect. Other addicts in poorly supervised methadone programs sell their oversupply of methadone in order to get money for barbiturates, amphetamines or heroin. The poor supervision of several programs has permitted the drug to get into streets and create a new phenomenon: the methadone addict.[29] Several methadone overdose deaths have been recently reported around the country.

Condition aversion techniques have been tried in both alcoholism and other forms of drug abuse. This usually involves the administration of an emetic agent, apomorphine or emetine, followed shortly thereafter by the pharmological agent so that nausea will occur soon after the drug is ingested. The taking of the drug then becomes a conditioned stimulus which produces a sensation of nausea. Cyclazocine, a narcotic antagonist, has been used to create an anxiety producing paralysis that is then linked with drinking or drug use.[30]

A projection for the distant future involves the use of psychoactive chemical agents in a protein vehicle to be used as an immunizing agent. The agent would be similar to a measles vaccination, which would then ward off any euphoria by subsequent narcotic ingesting.

[28] Glasscote, Sussex, Jaffe, Ball and Brill, *The Treatment of Drug Abuse*, The Joint Information Service (Washington, D.C. 1972), p. 37.

[29] *Dealing With Drug Abuse, op. cit.*, p. 114.

[30] Martin, Gorodetsky & McClane, "An Experimental Study in the Treatment of Narcotic Addicts With Cyclazocine," *Clin. Pharmac. Ther.*, 1966, Vol. 7, p. 455.

Heroin Maintenance

Of the many things that heroin maintenance may be, it is obviously not treatment of the disease of narcotic addiction. The primary thrust of heroin maintenance proposals in this country is articulated by Professor Packer as an approach to "decriminalizing" heroin.[31] The approach is at best naive and at worst a genocidal attack upon those in the predominantly Black aspect of the drug subculture who are addicted to heroin. As indicated, there is no evidence that the illicit drug traffic would "dry up almost at once" (Prof. Packer's phrase) if heroin is made legally available to the addict. The most telling argument against Packer's very abstract reasoning is that if legal heroin did cut into the black market traffic, the price of the illegal heroin would drop and the addict would find it more convenient to go back on the street than appear at the heroin clinic five to six times per day (the number of injections necessary to maintain an addict). Implicit, I hope, in Prof. Packer's position to gift addicts with heroin is the supplying of the legal drug to "certifiable" addicts only. This does leave a fertile field for the illicit market: the non-certifiable addict, or the non-user.[32] In response to the query concerning uncertified minors who use drugs, Packer exhibits a horribly inordinate degree of naiveté when he reports that, ". . . I very much doubt that a traffic would spring up in supplying minors. The 'pusher' would be reduced to hanging around school yards."[33]

Those who advocate heroin maintenance as the panacea for our narcotics problems (The A.B.A., John Lindsay, Howard Samuels, Herbert Packer, The Vera Institute, Ira Glasser, Jim Vorenberg, impressive array, eh?) point to the British maintenance scheme as the model for any projected American program.

The British maintenance system grew out of an attitude following World War II that drug addiction was a disease and not a crime. Physicians treated the disease by administering dosages to drug addicts that would prevent mental or physical anguish based upon withdrawal. In 1960, there were 94 known heroin addicts in the British Isles. By 1968, the number had increased to 2240, plus 542 persons addicted to other narcotics, and included 764 adolescents.[34] The figures are obviously not stag-

[31] Herbert Packer, "Discriminalizing Heroin," *The New Republic*, June 3, 1972, p. 11.

[32] See Zimmering, *et al.*, *op. cit.*

[33] Packer, *op. cit.*

[34] Bean, "Social Aspects of Drug Abuse: A Study of London Offenders," 62 *Jour. Crim. Law*, 80 (1971).

gering by American notions, but it does point up the fact that the British drug epidemic continued unabated despite efforts to legalize the traffic. Similarly narcotic related crimes increased significantly during the period. Some blame was attributed to a rather loose administration of the program. Physicians' records were not closely scrutinized until patterns of excess came to light. In 1968, stringent restrictions were placed on dispensing heroin, so that only those physicians licensed to do so by the Secretary of State were permitted to prescribe heroin or cocaine.[35] In spite of the concerted crackdown on drug users and pushers within the past year, the illicit traffic continues to flourish.

It must also be noted that the British heroin maintenance project makes no pretense at treatment or rehabilitation, an inherently self-contradictory approach, since they concede that addiction is a disease.

In a study of London drug offenders Bean found that a greater percentage of the group admitted to participating in property crimes and crimes of violence after having taken drugs. Bean's conclusion was that there was no evidence of any reduction in criminality after taking drugs, because, "The relationship between drug taking and criminality is complex."[36]

Putting aside the moral issue, that denying affirmative treatment to a narcotic addict is in the long run debilitating and possibly fatal, the reality is that heroin maintenance has never worked to reduce criminality. The 1919 New York maintenance program was too short lived to form the basis for any conclusion, although the American Medical Association's 1921 Committee on Narcotic Drugs report indicated that the program helped spread addiction.

An interesting side note on the subject is that British medical personnel are now talking about moving from heroin maintenance to methadone.

It was once thought that high morbidity among drug users in the United States was due solely to the contamination and the widely fluctuating purity of the drugs obtained from illegal sources. It now appears that qualitatively similar problems, including overdose deaths, occur when pure drug is available for intravenous administration.[37]

Although much has been made of the fact that the number of newly registered addicts in England has decreased since the 1968 restrictions,

[35] *Ibid.*; Dangerous Drugs Regulations, Stat. Instr. 1968, No. 416.
[36] *Ibid.*, p. 86.
[37] Bewley and Ben-Arie, "Mobidity and Morality From Heroin Dependence: Study of 100 Consecutive In-patients," *Br. Med. J.*, 1968, Vol. 1, p. 727.

little attention has been given to the increase in arrests for illegal possession of narcotics and other drug related offenses.[38]

Tort Liability for Failure to Treat

Notwithstanding protestations by Vera Institute spokesmen, Howard Samuels, Ira Glasser, et al., that the threshold purpose of heroin maintenance is its use as a lure for heroin addicts to be placed in other treatment programs, it obviously must be conceded that heroin maintenance is not treatment (see "Treatment of Addiction," *supra.*). And during the period that treatment is being withheld from the addict (the Vera proposal suggests up to six months), there is liability on the part of the physician or agency withholding such treatment.

The question arises as to the degree of honesty with which the program is projected. If the addict is advised that a maintenance approach is not treatment for his (or her) affliction, but merely a feeding of the drug hunger, and accepts the "man's" free smack, then he has given up to his "Jones" and assumed the risk. There is an entirely different story presented by the addict who legitimately wants to be cured (or at least alleges that he does) and interprets the initial stage of maintenance as part of his "treatment." The problem presented in the situation (which would be the majority of cases, since the Vera proposal projects initially to work only with those who have failed in methadone maintenance programs) is one that involves deliberate denial of known alternatives of treatment in favor of a course that cannot be designated "treatment." (A similar problem is raised in relation to the Tuskegee (Alabama) Syphilis Study.)[39]

Consent to the mode of "treatment" does not invalidate any possible claim for relief by the untreated addict placed in a maintenance program. It is well settled that a lack of full and honest disclosure of risks and alternatives vitiates consent of patients vis-à-vis physicians and surgeons.[40]

A further problem affecting consent encountered in a program which has governmental sanction concerns the degree of coercion, perceived or actual, inherent in a situation where there is a vast disparity of bargaining power.[41] (The 112th Street junkie versus the City of New York looks

[38] Bean, *op. cit.*

[39] "Syphilis Victims in U.S. Study Went Untreated for 40 Years," *New York Times*, June 26, 1972, p. 1.

[40] Wilson v. Scott, 412 S.W.2d 299 (1967).

[41] Miller's Mutual Fire Ins. Assn. of Alton v. Parker, 65 S.E.2d 341 (1951); Nagah v. Stockfleth, 4 N.W.2d 766 (1942).

like a problem of obviously unequal footing.) The facts may well indicate that the addict who gave his "consent to be treated" in the maintenance project had several criminal charges pending against him, or worse, was being considered for a period of civil commitment.

Of greater moment to the addict who wishes to press a claim for relief based on failure to treat his illness are problems concerning possible governmental immunity from tort liability and modes of establishing standards of care in narcotic addiction treatment. While both problems appear difficult on the surface, neither is insurmountable and therefore could present embroilments not anticipated (or at least not discussed) by the advocates of heroin maintenance. These, then, are not the primarily social and/or moral questions of permitting the continued spread of a contagious disease, but the very real adverse legal implications in denying treatment to the victims of that disease.

This paper will not deal with the probable liability of private institutions (i.e., Vera Institute of Justice) in tort actions premised on failure to treat, since private, albeit charitable or research oriented, institutions are generally not exempt from such liability under New York law and the private portion of the project is proposed as the experimental forerunner to the governmental program.[42]

Governmental Immunity

The common law rule of sovereign immunity is stated by Mr. Justice Holmes in *Kawanankoa v. Polyblank*:

> The sovereign is exempt from suit not because of any formal conception or absolute theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends.[43]

A noble concept when it comes to dealing with the English monarchy, but does it reflect in any manner the tenets of democracy which the Founding Fathers allegedly embraced in order to make government more responsive to the people?

The carry over of the doctrine of sovereign immunity is, in a word, interesting. The principal factor to be noted is that few states have fully broken away from the immunity rule. New York is the one state that has more completely broken away from the rule than any other state. While everyone agrees that an across the board doctrine of state tort liability

[42] 25 ALR 2d 29, 170, Sect. 39.
[43] 205 U.S. 349 (1906).

is not only socially desirable, but also legally defensible, there are usually three arguments raised in opposition to any change of the general status. The first embraces the rather archaic language about sovereignty and the nature of law, which is usually contradicted by modern legal facts, including the Federal Tort Claims Act, the New York statute and statutes from foreign jurisdictions which permit suits against the state.[44] Legislative and judicial inertia is listed as the second impediment to change. The third position goes to the general impecunious nature of most state treasuries. The fear is voiced that unlimited tort liability would divert needed funds from nearly bankrupt public coffers.

While most states generally adhere to the rather strict line of no tort liability being placed on the "sovereign," only four (Alabama, Arkansas, Illinois, and West Virginia) have actually incorporated this doctrine into their constitutions. Many states, including the above four, permit special legislation for tort claims based upon recommendations made by investigatory agencies. The relief awarded is made in the form of a direct appropriation to the claimant. This practice avoids total injustice while maintaining the shibboleth of "sovereign immunity."[45]

Although many states still maintain the facade, if not the reality, of tort immunity, municipalities, which will be saddled with the responsibilities of heroin maintenance,[46] are usually not extended such broad immunity, so that the onus of any tort liability growing out the projects will fall squarely on the cities.

Under the English common law, the creation of a corporation, with no distinction between private and public corporations (i.e., municipalities) involved a voluntary and inviolable contract between the Crown on the one hand and the incorporators on the other. The special privileges granted by the charter were regarded as consideration for the assumption of tort liability by the corporation.[47] The distinction between "public" and "private" corporations is more frequently drawn in American than English law.

The American case decisions follow *Bailey v. City of New York* which

[44] See 28 U.S.C. 1346, 2406, 2680.

[45] For a categorization of states which permit degrees of tort liability See Leflar and Kantrowitz, "Tort Liability of States," 29 *N.Y.U. Law Rev.* 1363 (1954).

[46] For various political reasons, the cities will be the ones shouldering the responsibility of heroin maintenance projects. It is difficult to imagine state legislators from Carthage, Claytown, Fredonia or Gouverneur, New York or Roxboro, Valdese, Kenansville or Bryson, North Carolina pushing for statewide heroin maintenance programs.

[47] Lynn v. Turner, 1 Comp. 86, 98 Eng. Rep. 980 (K.B. 1774).

held the municipal corporation liable in tort only for the exercise of its "private" (or "proprietary") functions, as distinguished from its "public" functions.[48] The decision was absolutely reactionary and extremely confusing since it limited liability of municipal corporations to one class of functions in contradiction to the generally accepted English view that applied tort liability to all corporations without regard as to dichotomy of functions.[49]

"Proprietary" functions have been found to exist in situations where the municipal corporation performs some service that would otherwise have been performed by a private corporation. Operation of hospitals, medical clinics, fire departments and county fairs have all fallen within the ambit of proprietary functions.[50]

The fact that the proprietary service or function may be dispensed *gratis* is immaterial. Once the municipality provides the services, tort liability attaches.[51]

Malpractice in the Treatment of Narcotic Addicts

The general rule applicable to standard of care to be exercised by physicians and surgeons concerns the skill and care that is possessed by similar professionals in the same or similar communities.[52] Once the standard of care has been established, recovery for malpractice is allowed where there has been a showing by either expert testimony or matters within the common knowledge of laymen that the breach of the standard was the proximate cause of injury.[53]

Governmental subdivisions must also conform to rules of standard of care in the offering of medical treatment. A municipal corporation has no discretion to establish a hospital and then run it negligently.[54]

While there are many medically accepted modes of treatment of nar-

[48] 3 Hill 531, 38 Am. Dec. 669 (N.Y. 1842).

[49] Barnett, "Foundations of the Distinction Between Private and Public Functions in Respect to the Common Law Tort Liabilities of Municipal Corporations," 16 *Or. Law Rev.* 250 (1936).

[50] Stolp v. City of Arkansas City, 303 P.2d 123 (1956); Hyde v. City of Lakewood, 175 N.E.2d 763 (1961); McPhee v. Bay City Samaritan Hosp., 159 N.W.2d 880 (1954); Guidi v. California, 262 p. 2d 3 (1953).

[51] Barnes v. Gardner, 9 N.Y.S.2d 785.

[52] See Thaggard v. Vafes, 119 So. 647; Dunn v. Beck, Nelson v. Harrington, 40 N.W. 228. See also 61 Am. Jur. 2d 244.

[53] Hundley v. St. Francis Hospital, Weinstien v. Prostkoff, 191 N.Y.S.2d 310, revd. on other grounds 13 App. Div. 2d 539, 213 N.Y.S.2d 571 (1959); Hawkins v. McCain, 79 S.E.2d 493 (1954). See also Klein v. Arnold, 203 N.Y.S.2d 797 (1960); Gray v. Weinstien, 42 S.E.2d 616 (1947).

[54] United Airlines v. Wiener, 335 F.2d 379 (1964, 9th Cir.), City of Miami v. Oates, 10 So. 2d 721. *Cert. denied* 379 U.S. 951.

cotic addiction (see "Treatment of Addiction," *supra.*), heroin maintenance is not listed among them. Physicians who have worked with addicts, including Dr. Jerome Jaffee, head of the Special Office for Drug Abuse Prevention, are generally appalled at the use of heroin maintenance as a basis for any so-called medical treatment. Where a physician, in the exercise of his best judgment, follows an *alternative* course of treatment sanctioned and approved by competent medical authority he cannot be held liable because he failed to pursue another and different sanctioned approach.[55] When that physician fails to follow an approved mode of treatment, malpractice is established.[56]

In the setting, we can point to heroin maintenance as a course which does not adhere to accepted modes of treatment. There is no indication that the continued use of narcotics by the addict results in a cure, but in fact results in a high degree of alteration in the addict's metabolism, thereby building tolerance and requiring greater dosages.[57] It cannot be ruled, as a matter of law, that a drug addict has assumed the risk in a situation where medical assistance results in continued addiction. Where a patient, being treated with morphine, and suspecting that the narcotic was in fact being administered (she felt "pretty high quite often") became further addicted, a jury was free to find malpractice on the part of the physician for continuing the patient in an addictive state. *King v. Solomon.*[58]

Physicians who administer medications to patients known to be unusually susceptible are generally held prima facie liable for malpractice.[59] There can be no gainsaying the obvious: narcotic addicts are persons who are susceptible to the adverse effects of analgesics. Once a physician has accepted this premise, he cannot shield himself from any liability for the complications attendant upon administration of the narcotic—including, but certainly not limited to, overdose deaths.

Failure to administer any treatment, when methods of treatment are known, constitutes medical malpractice. In *Ramberg v. Morgan,* the plaintiff's intestate was struck by an automobile and lost consciousness. The police surgeon examined the man, found no contusions, lacerations, dislocations or broken bones. Finding no external evidence, the surgeon diagnosed the state of unconsciousness as intoxication. The patient was

[55] Wooten v. Curry, 362 S.W.2d 820 (1962), 93 ALR 2d 307.
[56] McHugh v. Audet, 72 F. Supp. 394 (D.C. Pa. 1947).
[57] See Footnotes 22 and 23 *supra.*
[58] 81 N.E.2d 838 (1948).
[59] Parrish v. Clark, 145 So. 848 (1933); Stokes v. Dailey, 85 N.W.2d 745 (1957); Rotan v. Greenbaum, 273 F.2d 830 (C.A., D.C. 1967).

not given any medical treatment for several days, until an x-ray determined that he had suffered fractures of the sutures of the parietal and occipital bones. The jury could consider this omission of treatment as the basis for malpractice.[60] Questions of proof aside, a physician who withholds treatment engages in a rather serious breach of duty owed to his patient.

Conclusion

I would be less than honest if I did not voice the obvious: I do not support heroin maintenance as the answer to this nation's drug problem. The "decriminalizing" gambit does not in any way address itself to the problems confronting narcotics addicts found in possession of illicit narcotics. The "decriminalization" will just extend to those persons under the projected maintenance programs. A more honest, meaningful approach would involve the actual decriminalizing of all narcotics possession laws (other than for purposes of sale) concomitant with rehabilitative programs. As pointed out, there is no positive, objective indication that a heroin maintenance program will have any salutary effect upon trends in criminality.

I am not advocating an onslaught of legal actions by addicts in maintenance programs who do not receive "treatment"; the possibility of an avalanche of law suits by such a group is remote. The possibility of the disruptive effect of a handful of suits on heroin maintenance programs is very real. The addict who envisions himself aggrieved by the programs' palliative effect is not without decided recourse. Third parties who are injured by addicts who have received their "fix" at the official dispensary may also have possible claims for relief against the clinic or its officials. This problem has not been touched upon at all in this paper, but it strikes me as being a whole new "can of worms."

[60] 218 N.W. 492 (1928). Plaintiff failed in this matter because he was unable to prove proximate cause of death.