

**PAIN
CONTROL**

**AND DRUG
POLICY**

**A TIME FOR
CHANGE**

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Dedication

This book is dedicated to the blameless victims of *War on Drugs* policy; especially to millions of pain sufferers in the US and their intimidated physicians, and to millions of displaced foreign peasants whose property is stolen and human rights are trampled over by exploiters of the illegal drug trade. It is also addressed to thousands of non-violent drug users worldwide incarcerated each year for choosing a path ranging from benign enjoyment to self-destruction.

FAMOUS QUOTES

On pain

Pain is a more terrible lord of mankind than even death itself.

Albert Schweitzer, *On the Edge of the Primeval Forest*. New York: Macmillan 1931, p 62.

The aim of the wise is not to secure pleasure, but to avoid pain.

Aristotle (384 BC – 322 BC).

On marijuana

There are 100,000 total marijuana smokers in the US, and most are Negroes, Hispanics, Filipinos, and entertainers. Their satanic music, jazz and swing, result from marijuana usage. This marijuana causes white women to seek sexual relations with Negroes, entertainers, and any others.

Harry J. Anslinger, Testimony to Congress in support of the Marijuana Tax Act, 1937.

Keep your Commission in line... [so] it not appear that the Commission's frankly just a bunch of do-gooders...[but]...if you're just a bunch of do-gooders that are going to come out with a 'soft on marijuana' report, I'll destroy it right off the bat.

Richard Nixon to Raymond P. Shafer, head of his Presidential Commission on Marijuana and Drug Abuse. Declassified Oval Office tapes from 1971-1972.

On prohibition, freedom, and liberty

Prohibition...goes beyond the bounds of reason in that it attempts to control a man's appetite by legislation and makes a crime out of things that are not crimes.

Abraham Lincoln. Speech to the Illinois House of Representatives, December 18, 1840.

I'd rather that England should be free than that England should be compulsorily sober. With freedom, we might in the end attain sobriety but in the other alternative, we should eventually lose both freedom and sobriety.

W.C. Magee, Archbishop of York, Sermon at Peterborough, 1868.

The only freedom which counts is the freedom to do what some other people think to be wrong. There is no point in demanding freedom to do that which all will applaud... There is no way of having a free society in which there is not abuse. Abuse is the very hallmark of liberty.

Quintin Hogg, British politician, *The Dilemma of Democracy*, Collins 1978.

Government exists to protect us from each other. Where government has gone beyond its limits is in deciding to protect us from ourselves.

Ronald Reagan, *The New York Times*, April 13, 1980.

On the DEA

DEA Success Update: Let's see. After 20 years of relentless federal Drug War activity, while the price of world-class marijuana has gone from \$60 an ounce to \$450, the price of quality cocaine has plummeted from \$125 a gram to \$30, and 30%-pure heroin has dropped from \$700 a gram to about \$100. Way to go, boys!"

High Times, Vol 236, April 1995.

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PREFACE

During my long career as a Hematologist-Oncologist, I witnessed the growing divergence between the enormous contribution of narcotics to pain management in the clinical setting and the entrenched perception of their lurking dangers. At issue is the belief that narcotics are extremely dangerous drugs that can easily and quickly turn an innocent and unsuspected victim into a drug abuser, at best, and into a crime-prone, self-destructing addict, at worst, whereas reality indicates otherwise. Indeed, the risk of addiction in populations taking narcotics as analgesics is extremely low in the absence of a prior history of drug abuse. As emphasized by the National Cancer Institute (NCI), *“Extensive worldwide experience in the long-term management of cancer pain with opioid drugs has demonstrated that opioid administration in cancer patients with no history of substance abuse is only rarely associated with the development of significant abuse or addiction”*¹. This strong endorsement of narcotics as non-addictive painkillers concludes, *“Although the lay public and inexperienced clinicians still fear the development of addiction when opioids are used to treat cancer pain, specialists in cancer pain and palliative care widely believe that the major problem... is the persistent under treatment of pain driven by inappropriate fear of addiction”*. My own professional experience over more than 30 years of clinical practice confirms this. Similarly, patients taking opioids for non-cancer pain have an extremely low risk of addiction. In three large studies involving 11,882, 10,000, and 2,369 hospitalized patients with no prior history of drug abuse who were administered opioids for chronic non-cancer pain, only 7 patients, or 0.03%, showed signs of abuse or addiction²⁻⁴. On the other hand, the vast majority of addicts are not criminals to be incarcerated or crime-prone victims of drugs or their genes who threatened their communities but undisciplined individuals who *chose* to use drugs for pleasure and lost control over their level of consumption⁵. Hence, the popular dread of narcotics is not based on evidence but an example of “*consent engineering*” that creates “*fear of just about anything after many years of intense propaganda designed to tame ‘the great beast’ by introducing panic*”⁶. The perception of drugs as “*the great beast*” of our time is reinforced by an obliging press, which confers legitimacy to detractors’ even most extravagant claims. Relentless promulgation of this view, a replay of *Prohibition*, provided a fertile ground for the emergence of unsound drug control policies, first in the US and then worldwide, that failed to achieve any of their goals. Indeed, neither drug production by producer countries nor drug supply, numbers of users, crime rates, or costs to society in consumer countries has decreased as a result^{7,8}.

Yet, drug criminalization has had enormous unintended consequences. It has fomented repression, crime, and corruption at home reminiscent of *Prohibition*, where gangs of foreign and homegrown hard-core criminals build empires while 1.85 million Americans were arrested for drug violations in 2005 alone, including 696,074 for marijuana possession⁹. To these grim home-based statistics must be added massive human rights violations, large-scale population displacements, and social decay linked to the lucrative illegal drug market pervasive in producer countries. In fact, perhaps drug policy’s “*best*” return on the \$500 billion “*investment*” through 2005¹⁰ has been to shift production from one region or country to another and to redirect traffic routes, justifying the view “*If you want to see money thrown at a problem to no good effect, you need look no further than America’s ‘war on drugs’*”¹¹. This is because, as long as consumer demand for illegal drugs remains unabated, traffickers and suppliers enjoy high profit

margins, drug users are willing to endure public ostracism and risk incarceration to get their “fix”, and illicit crop farmers have no realistic alternate sources of income, a sustainable disruption of the illegal drug market will not be achieved.

Another unintended but devastating consequence of narcotics control laws in the US is on patients with chronic or terminal illnesses associated with intractable, daily pain who benefit the most from their legitimate use of narcotics, especially because they are the most potent and the safest painkillers on the market. Indeed, millions of American pain sufferers are victimized by physicians’ reluctance to prescribe narcotics in appropriate doses for as long as necessary^{12,13}, in part to diminish their patients’ highly improbable risk of addiction but mainly to steer clear of possible entanglements with the DEA*. Indeed, the DEA aggressively persecutes narcotics-prescribing physicians for the flimsiest of reasons, ignoring what 30 State Attorneys General pointed out in their protest of its misguided policy: that drug diversion prevention should not hinder physicians’ ability, indeed duty, to provide “*the best pain relief available to alleviate suffering*”¹⁴ that only narcotics can offer. Likewise, many patients take less than the prescribed dose of narcotics or increase the dosing intervals enduring daily pain, often severe, for fear of addiction but also to avoid the prospects of having to justify a daily narcotics dose or a total supply deemed excessive according to unwritten and shifting criteria conceived by medically untrained DEA agents. The consequence of insufficient prescribing and inadequate medicating is an unprecedented pain management crisis of national scope where most pain patients are under treated and optimal pain control is seldom achieved. This is as unacceptable as it is unconscionable especially for terminally ill patients who, after months or years of a devastating and painful illness, die in pain.

President Richard Nixon launched the “*War on Drugs*” as a means to promote his political career claiming drugs are inherently addictive and foster a life of crime. Nixon’s “war” has been continued with renewed vigor by his successors despite the falsehood of the claims that set it in motion, its failure to achieve its goals, and its devastating if unintended consequences at home and abroad. Is so much suffering inflicted on so many by the *War on Drugs* justified by the harm drugs and drug offenders inflict on society? The answer to these questions is suggested by the portrayal of the average incarcerated American drug offender by a disaffected senior member of the drug enforcement establishment. “*Imagine yourself as a 20-year-old man in a mid-sized American city. Not only are you a high school dropout, you are, for all intents and purposes, illiterate. You are addicted to crack cocaine. Your only source of income is small-time thievery and drug pushing. Poverty, substance abuse, and failure have followed your family for three generations. You have no concept of a work ethic or of contributing to society. Your plans for the future go as far as this afternoon's score. However, instead of scoring crack, you are arrested for stealing a car phone and are carted off to jail - not an unusual circumstance for you. As a repeat offender, the judge sentences you to 18 months in state prison. What I have described is the average prison inmate. Not a grisly murderer. Not a predatory rapist. Just a young man with absolutely nothing going for him. This is the typical inmate received in Ohio's prison system over and over again, day after day, month after month, year after year*”¹⁵.

Yet, this book is not about the *War on Drugs* but about the interference of drug policy on American medical practice that led to a pain management crisis examined

* Drug Enforcement Administration

within broader historical, socioeconomic, and geopolitical perspectives. It will show that, in addition to penalizing millions of blameless American pain sufferers and hundreds of thousands of non-violent American drug offenders, and devastating societies in producer countries, drug policy has not, cannot, and will not reduce the supply of drugs on American streets or elsewhere as long as the illegal drug trade remains in place. Frontline Drug Wars documentary's headline said it best, "*From both sides of the battlefield, a 30-year history of America's war on drugs – a war with no rules, no boundaries, no end*" ¹⁶. Nevertheless, an end to the status quo is achievable albeit politically unpalatable. It requires overturning policies that created and sustain the black market for illicit drugs and handling drug use as a health issue rather than as a criminal matter. Hence, I will call for the decriminalization of illicit drugs, the dismantlement of all drug enforcement agencies and of their infrastructures, and the repeal of all drug laws. Such a thoroughly revisionist strategy, the only approach capable of solving the American pain management crisis and worldwide crime, corruption, and human rights violations associated with the illicit drug trade, is based on five compelling arguments drawn from available evidence. First, the *War on Drugs* was launched and is sustained by false claims. Second, criminalization of drugs gave rise to a highly lucrative black market that entices criminal elements and fuels crime and corruption in consumer countries and massive societal disruptions in producer countries. Third, drug policy implementation penalizes large segments of the population who use opioids for medical reasons or illicit drugs for pleasure, most often in moderation, briefly, reversibly, and without ill effects to themselves or to society. Fourth, the socially acceptable and legally permissible alcohol and tobacco each impose a much greater burden on society, in terms of economic and human costs, than all illicit drugs combined. Fifth, illicit drugs are not enemies to be vanquished, as in a "*war*", but manageable societal problems to be quantified, ranked, and compared to other social liabilities as a basis for developing appropriate public prevention and non-punitive interventional policies, and for allocating remedial resources.

It will be argued that current popular sentiment and the political environment complicate enormously the implementation of such a radical change in direction. In large measure this is because "*Drug war supporters have so demonized drugs, drug users, and drug war opponents that most public figures dare not raise questions*" ¹⁷ and, I would add, even risk their political career by proposing sweeping reforms of drug laws. However, de-criminalizing "*illicit*" drugs, de-demonizing users, and handling pleasure use of any substance as a health issue based on evidence of harm to society, rather than as a criminal behavior, is a drug policy worthy of enlightened societies guided by laws that punish criminal activity rather than repress harmless behavior. Undoubtedly, such a paradigm shift in drug policy requires the emergence of a new breed of judicious and bold legislators who, emulating policy-makers of the 1930s, will acknowledge past legislative errors and repeal the far more egregious and socially pernicious *War on Drugs*. Only then, will the US enjoy a drug policy worthy of its Constitutional principles and world governments be at peace with their own citizens.

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PART I

ALCOHOL PROHIBITION

Chapter 1

PROHIBITION: A HISTORICAL PRECENT

Today's attempt by the United States government to control drugs is a replay of Prohibition albeit with international scope and colossal human and financial resources at its disposal, but without Prohibition's constitutional anchor. Hence, by reviewing the failures and consequences of Prohibition it will become clear that the current drug policies and programs, drawn on similarly fallacious principles and unachievable goals, are destined to fail and, if left standing, will continue to cause harm to our nation and foster crime, corruption, and human rights violations abroad. Prohibition, ironically called "*the noble experiment*", refers to the period in American history when the manufacture, transportation, import, export, purchase, and sale of alcoholic beverages was prohibited, and also to the "*Temperance*" movement that sponsored such a policy. Prohibition began on January 17, 1920, when the eighteenth amendment of the constitution went into effect, and was abolished by Congressional passage of the "*Blaine Act*", on February 17, 1933, and became the first and only amendment ever repealed later that year with ratification of the twenty-first amendment. National Prohibition was the culmination of much earlier regulatory efforts at State level. Indeed, as early as 1905 Kansas, Oklahoma, and Mississippi had enacted "*dry*" laws and over the ensuing ten years, another 23 American States had joined in. Hence, between 1915 and 1920 over 60% of the US population was already under some sort of prohibition. Likewise, because the twenty-first amendment explicitly gives States the right to enact their own laws on the purchase, sale, and consumption of alcohol, Prohibition remained the law of the land in several States for years after its repeal, with Mississippi being the last State to finally repeal Prohibition, in 1967. Today, the last remnants of Prohibition are "*dry*" county and city ordinances, and widespread Sunday bans that compel consumers to stock up on week-days or to pay a Sunday visit to "*wet*" establishments located just outside dry jurisdictions.

However, the history of alcohol control in the United States reaches much farther in time. Its evolution and outcome are of interest to us as a study of a complex issue with personal, societal, financial, and religious overtones often difficult to reconcile that led to conflicting measures with unintended consequences. It must be observed that, contrary to popular belief, alcohol consumption was not frowned upon by Puritans as suggested by the 42 tons of beer and 10,000 gallons of wine they carried on their voyage to Massachusetts compared to 14 tons of water ¹. Likewise, production, sale, or consumption of alcoholic beverages was not forbidden in early colonial times, though drunken behavior and sales to Indians were unlawful. As intemperance and rowdy behavior by drunks upset the moral sensitivities of abstemious neighbors, colonial legislators passed laws attempting to curb excessive drinking. For example, in 1629 the Virginia Colonial Assembly ruled that "*Ministers shall not give themselves to excess in drinkinge, or riott, or spending their tyme idellye day or night*" ². Four years later the Plymouth Colony prohibited the sale of "*more than 2 pence worth of spirits to anyone but strangers just arrived*" ², and in 1637 Massachusetts ordered that no one should stay in a tavern "*longer than necessary*" ². Nevertheless, it became clear that while liquor consumption and human behavior were not easy to regulate they could become sources of revenue and were easy to enforce ³. Hence, license fees, taxes, and fines multiplied. Soon, production of most types of alcoholic beverages was taxed at the source, a sales

license fee was imposed, and selling to drunks or Indians or without a license, and drunkenness were subject to fines. However, attempts at prohibition did not appear until the following century, when notable politicians, physicians, and church leaders voiced concerns about real or perceived effects of alcohol. For example, in 1760 John Adams wrote that taverns were "*becoming the eternal haunt of loose, disorderly people...the nurseries of our legislators... [who]...by gaining a little sway among the rabble of the town...secure the votes of taverner and retailer and of all*"⁴. In 1785, Dr. Benjamin Rush, the Surgeon General of Washington's Continental Army, added health arguments to the claims of the Temperance movement, listing "*unusual garrulity, unusual silence, captiousness... an insipid simpering... profane swearing... certain immodest actions... and extravagant acts which indicate a temporary fit of madness*"⁵. He also circulated thousands of copies of an "*Intemperance Thermometer*" designed to gauge one's alcohol consumption restraint or lack thereof⁶. Likewise, most evangelical churches saw alcohol as the devil's tool and had their members sign a pledge of temperance. However, because a voluntary pledge left many uncommitted souls exposed to eternal damnation, churches became a driving force in the prohibition movement. Indeed, it is said that without the religious influence "*the temperance revolution of the past century would yet remain to be accomplished*"². As early as 1773, John Wesley was preaching for the prohibition of manufacturing and sale of alcoholic beverages; a demand echoed by the Presbyterian, Methodist, Universalist, and Baptist churches².

Non-religious groups also sprang up to discourage the use of spirits, such as the Free African Society, the Organization of Brethren, and the Connecticut Association of "*the most respectable farmers*", that culminated in the well organized American Temperance Society in 1826, The Congressional Temperance Society in 1833, and The Sons of Temperance in 1842². Their membership was mostly middle class, self-righteous, rural WASPs*, who believed their stock to be "*the most improved, hardest, and fittest*". With their combined evangelic zeal and Messianic vision they felt destined to bring the Kingdom of God to the United States, and alcohol had no place in it. Under Alexander Hamilton, a federal tax was included in the Revenue Act and the Second Congress of the United States enacted license fess and taxed anew the liquor industry. However, Pennsylvania farmers mobbed tax collectors and a 15,000 militia was called in to suppress what became known as the *Whiskey Rebellion*⁷. Liquor taxes were later repealed and the liquor industry enjoyed a tax-free period between 1818 and 1862, only to be taxed again in 1863 at a rate of 20 ¢ per gallon initially, which rose to \$2,00 per gallon by 1868⁸. Predictably, while tax rates went up, total collections did not due to massive tax evasion. Another consequence of high liquor taxes was the birth of the first industry lobby, the *United States Brewers Association*². After intense lobbying by the Association, Congress reduced the tax to 50 ¢ in early 1869 resulting in a dramatic rise in tax collections, from \$13.5 million in 1868 to \$45 million in 1969⁸. During this period, a wave of State prohibition laws were passed by several State legislatures, only to be vetoed by governors, declared unconstitutional by State supreme courts, or repealed by the same legislatures that had enacted them in the first place, suggesting that the majority of the people did not support prohibition laws. The US Army had adopted a *dry* stance in 1830, at least officially. But soldiers, who put their lives on the line, could not be asked to remain abstinent and were granted a daily alcohol allowance by their commanders. Drinking was generally condoned except while on guard duty or during battle. Additionally, during the Civil War alcohol was a surgeon's trusted friend that, since times immemorial, was used to clean battlefield wounds and to numb the senses

* White Anglo-Saxon Protestant

of wounded soldiers undergoing surgery. Once released from duty, most soldiers were more interested in resuming their lives than in becoming temperance advocates.

Nevertheless, the late 1890's saw another wave of prohibition laws, statutes, or constitutional amendments at State level, or local options that emerged from broad based activism over a variety of social issues. A common denominator was the evils of saloons that were denounced as hotbeds of corruption and vice. By 1895, this movement had evolved into the *Anti-Saloon League* ("*The league born of God*"²). Most of the League's claims were unsupported. Common denunciations included, "*Liquor is responsible for 19% of the divorces, 25% of the poverty, 25% of the insanity, 37% of the pauperism, 45% of child desertion, and 50% of the crime in this country*"⁹. With massive disinformation campaigns, the League was able to "*force closure of saloons, influence the election of dry candidates, and published its own periodicals*"¹⁰, including weeklies (*The American Issue* and *The New Republic*) and a daily (*The National Daily*), *The Scientific Temperance Journal*. The continuous barrage of propaganda began to sway public opinion about saloons and about alcohol in general. While most religious denominations espoused the League's views, the Episcopal, Lutheran, Catholic, and Jewish churches did not. As the issue of drinking and its effects on society and on the country moved further into the limelight, workers' unions and business interests weighted in the debate, mostly based on self-interest. Businesses viewed drinking as an impediment to productivity and wanted to "*keep God*" on their side. Henry Ford later declared, "*The country could not run without Prohibition; that is the industrial fact*". On the other hand, workers generally resented temperance laws they thought were directed at them. Yet, workers unions and the Socialist Party, both claiming to look after labor's interests, endorsed temperance laws as a means to advance their agenda. The latter declared, in 1908, "*Any excessive indulgence in intoxicating liquors by members of the working class is a serious obstacle to the triumph of our cause since it impairs the vigor of the fighters in political and economic struggle*". The Temperance movement was aided by widespread prejudice against immigrant populations, especially Catholics who arrived with their "*drinking intemperance*" to our Protestant shores at the turn of the 20th century, and by a wave of anti-German sentiment that swept the country before and during WWI^{*}. The latter was fueled by chauvinistic newspaper stories that Germany was attempting to addict the entire American population by spiking cosmetics with powder heroin, a powerful and mysterious opium derivative developed in 1898 by the German company *AG Bayer*. The fact that the United States Brewers Association, with members named Pabst, Schlitz, and Blatz, associated itself with the *German-American Alliance* to oppose the Temperance movement added fuel to the anti-German fire prevailing at the time that led to the *Wartime Prohibition Act*, passed in 1918. Self-serving politicians also embraced alcohol prohibition as a banner to seek notoriety and advance their careers and fortunes.

Perhaps the most prominent such profiteering figure was captain Richmond Hobson (1870-1937), an unlikely Spanish-American war hero¹¹. After escaping court martial for failing his mission^{**}, Hobson was decorated by President McKinley and began touring the country on behalf of the US Navy. Portraying himself as the champion of the forces of good that would save Western civilization from the scourge of Japanese military power, which he called the "*Yellow Peril*", he argued for American naval

* World War I

** The US Navy considered to court martial Hobson but decorated him instead

supremacy, as being "*the will of God*". At first, he was a very popular speaker attracting public and media attention but soon realized that a new, more immediate and public-arousing "*enemy*", was needed for his self-serving rhetoric to succeed. He identified alcohol, which he called "*The Great Destroyer*", as the target for his new crusade that would make him the best-paid speaker in America and win him a seat in the US Congress. His apocalyptic depiction of alcohol was just as reckless as the Anti-Saloon League's and that of many other prohibitionists. Based on statistics concocted for the occasion, he made claims such as: "*Alcohol is killing our people at the rate of nearly two thousand men a day, every day of the year*"... "*Ninety-five percent of all acts and crimes of violence are committed by drunkards*"... "*A hundred and twenty-five million white men today are wounded by alcohol*"¹¹ *. He argued that alcohol cost "*sixteen billion dollars*", a figure picked out of thin air that at the time represented 25% of the national budget. Ironically, passage of the 18th amendment put an end to congressman Hobson's anti-alcohol crusade but he soon found a new cause: heroin, a German product. The new "*greatest evil*", as he called it, had the advantage over home-produced alcohol of being a foreign import that could rally the public anti-German xenophobia around the emerging anti-drug sentiment. He published several books denouncing drugs, including "*Drug Addiction: A Malignant Racial Cancer*", in 1933. Half a century later, a similar approach would be espoused and refined by several unscrupulous politicians to launch the *War on Drugs*. For instance, Harry J. Anslinger, Commissioner of the US Bureau of Narcotics from 1930 to 1962, waged a press campaign during WWII** to convince the American public that Japan had mounted an "*Opium Offensive*" to addict the entire American population. During the Korean War it was the turn of Communist China to be smuggling massive amounts of heroin into the United States to "*weaken American resistance*", according to Anslinger. Indeed, the politics of narcotics legislation in the US that resulted in the *War on Drugs* is no less fascinating and tragic than *Prohibition's*, as briefly summarized in chapter 3, section 1.

The final drive that brought about the 18th constitutional amendment was spearheaded by the Anti-Saloon League and coordinated by The National Temperance Council. The League's petition was formally presented to Congress in 1913. The first congressional resolution failed to secure the two-thirds majority necessary to submit the amendment for State ratification. A second resolution didn't make it past the Judiciary Committees of both houses. Eventually, a resolution was passed by Congress and sent to the States for ratification in 1917². It stated, "*After one year from the ratification of this article the manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States and all territory subject to the jurisdiction thereof for beverage purposes is hereby prohibited*". Mississippi was the first State to ratify, on January 16, 1918. One year and eight days later, the ratification process was completed when Nebraska became the 36th State to ratify¹. Ratification took place in a national atmosphere of religious zeal when preachers, capitalizing on the 1918 influenza epidemics that killed over half a million Americans, blamed sin and the wickedness of an intemperate nation as the cause. On October 28, 1919, Congress enacted the *National Prohibition Act*, also known as the *Volstead Act* that made alcohol prohibition the law of the land beginning on January 17, 1920. Andrew Volstead, an ultra-dry congressman from Minnesota, successfully included wine and beer under the rubric "*intoxicating liquors*", intended by the drafters of

* The total US population in 1930 was 122,775,046¹²

** World War II

the amendment to target “*eighty proof*” liquors rather than beverages of lower alcoholic content, and his Act passed overriding President Wilson’s veto. A highly puritanical, albeit unrealistic, impact of Prohibition on society was expressed by Billy Sunday, a noted evangelist. He stated, “*The reign of tears is over. The slums will soon be only a memory. We will turn our prisons into factories and our jails into storehouses and comcribs. Men will walk upright now, women will smile, and the children will laugh. Hell will be forever for rent*”¹³. While the Anti-Saloon League and other promoters of the temperance movement were jubilant about their impressive victory, they probably could not have predicted the mayhem that would follow. Indeed, as the amendment went into effect, half a million dollars worth of liquor was stolen from Government warehouses, within a couple of years 20 Prohibition enforcement agents had been murdered, and there was more to come, much more. Herbert Asbury, a Prohibition historian describes the new national scene as follows: “*The American people had expected to be greeted, when the great day came, by a covey of angels bearing gifts of peace, happiness, prosperity and salvation, which they had been assured would be theirs when the rum demon had been scotched. Instead they were met by a horde of bootleggers, moon shiners, rum-runners, hijackers, gangsters, racketeers, triggermen, venal judges, corrupt police, crooked politicians, and speakeasy operators, all bearing the twin symbols of the eighteenth amendment; the Tommy gun and the poisoned cup*”¹⁴.

Prohibition ended for a variety of real or imaginary reasons. However, shared interests by Washington and the alcohol industry, both eager to protect their respective revenues, became a decisive anti-Prohibition coalition. In fact, Prohibition was an economic disaster for the Federal government for while excise taxes on alcohol amounted to 27% of the total tax revenues in 1917, they dropped to 1.7% four years later and remained at that level throughout the 1920s⁸. Additionally, while the Temperance movement’s strategy of voting only for “dry” candidates ensured the loyalty of elected representatives at a local level, national politicians were eager to reclaim generous campaign funds contributed by the alcohol industry, which also provided employment in their districts; both powerful arguments in favor of repeal. However, a major catalyst for the Prohibition repeal camp was Franklin D. Roosevelt’s acceptance speech before the National Convention of the Democratic Party held in Chicago in 1932. He stated *I congratulate this convention for having had the courage, fearlessly to write into its declaration of principles what an overwhelming majority here assembled really thinks about the 18th Amendment. This convention wants repeal. Your candidate wants repeal. And I am confident that the United States of America wants repeal*⁴. Roosevelt went on to win the Presidency; the repeal amendment was introduced February 14, 1933, approved by the Senate (63 to 23) and by the House (289 to 121) within a week, and ratified by the States later that year. The next few paragraphs succinctly describe the three major outcomes of Prohibition.

1. Alcohol manufacture and consumption:

Given the intended purpose of the 18th amendment, law enforcement and compliance should have brought down the manufacture and consumption of alcohol drastically. However, records show a very different picture; one that clearly indicates that the law was ignored or circumvented and liquor production and consumption continued almost unabated, albeit illicitly. In fact, the 1931 report by the Wickersham Commission, appointed by President Herbert Hoover, established to investigate conditions under Prohibition, concluded that the country had “*prohibition in law but not in fact*”. It also noted, “*The dries had their prohibition law and the wets had their liquor*”¹⁵. For example,

because wine was forbidden, wine makers switched to produce grape juice that after a few simple steps was converted to wine. Demand for the juice was such that the 97,000 acres planted with vines in 1919 grew to 681,000 acres by 1926¹⁶. The number of seized illicit distilleries exploded from only a few prior to Prohibition, to 95,933 in 1921, jumping to 282,122 in 1930. These seizures resulted in 34,175 arrests in 1921, jumping to 75,307 in 1928, with most being convicted¹⁷. In addition to bootlegged domestic production, liquor was smuggled across the Canadian border, from Belgium and Holland¹⁸ and many vessels stayed anchored outside US territorial waters easily accessed by entrepreneurial mongers. Saloons went underground as “*Speakeasies*”^{*} where the “*wets*” gathered to consume alcohol and indulge in other, often illegal, activities. It is estimated that up to 500,000 such establishments were in existence throughout the United States at the end of Prohibition¹⁷, double the number of pre-Prohibition saloons. During Prohibition, alcohol consumption rose by 11.64%¹⁹ and that of hard liquor increased from 1.46 gallons per capita during the 1910-1914 period to 1.63 gallons in the late 1920s, according to the US Department of Commerce and Statistics^{19,20}. Two prominent economists contest these estimates and contend that alcohol consumption actually dropped at the beginning of Prohibition^{17,21}. However, the downward trend in question had begun in 1910, was greater in the first year post-Prohibition, and subsequently reversed course despite rapidly rising resources devoted to enforcement¹⁷. Hence, claims that Prohibition was successful in reducing alcohol consumption are based on the interpretation of partial data, at best, or a deliberate distortion of the facts, at worst. On the other hand, spending on alcohol was higher after than before Prohibition as expected for an outlawed product. Additionally, the tenets of “*The iron law of Prohibition*”²² were fully at work during Prohibition: First, sales shifted from beer to more potent, profitable, and easier to conceal liquors²³ and the price of the bulkier beer increased by 700% whereas spirits rose only by 270%²⁴. Hence, most alcohol production and consumption was of liquors, distilled spirits, and fortified wines instead of equivalent amounts of beer and unfortified wine²⁴; a reversal from pre-Prohibition habits. Secondly, the potency of all alcoholic beverages rose by 150% according to some estimates. A notable example is the legendary “*White Mule Whiskey*”, a whiskey with a particularly strong “*kick*”²⁴. Thirdly, the lack of production standards led to home-distilled moonshine by amateurs and to often adulterated and unsafe beverages produced by unlawful enterprises. Health consequences were not far behind.

2. **Health effects:**

Adverse health effects observed during Prohibition resulted from increased alcohol consumption and from drinking more potent or adulterated liquors. Increased alcohol consumption during Prohibition occurred within three groups of patrons²⁵: the young, attracted by the lure of an illegal product; previous non-drinkers recruited by savvy marketers seeking to expand their base; and individuals resentful to be told by government not to drink. In addition, there were those who drank permissible, high-content alcohol products, such as the so-called *patent medicines*^{**} or medicinal alcohol (95% pure), the sale of which rose by 400% between 1923 and 1931, or sacramental wine. In 1925, the Federal Council of the Churches of Christ observed, “*The withdrawal of wine on permit from bonded warehouses for sacramental purposes amounted in round figures to 2,139,000 gallons in the fiscal year 1922; 2,503,500 gallons in 1923;*

* Illicit taverns or stores selling liquor during prohibition

** So-called because some of them had royal endorsement - also called *Nostrum*

and 2,944,700 gallons in 1924. There is no way of knowing what the legitimate consumption of fermented sacramental wine is but it is clear that the legitimate demand does not increase 800,000 gallons in two years”⁴. Young men and young women took up to drinking alcohol at an earlier age (20.6 and 25.8 years, respectively) after passage of the 18th amendment than before (21.4 and 27.9) or after its repeal (23.9 and 31.7)²⁶. One particularly serious adverse health effect of Prohibition was the progressive rise of alcoholic psychoses cases, as indicated by the following statement, “*These facts appear to indicate that since 1920, Prohibition [was] increasingly impotent as a means of preventing excessive use of alcohol to an extent productive of serious mental disorders and untimely death. 1920 marks the end of the decline and the beginning of the rise in the trends of alcoholic mental diseases and of deaths from alcoholism in the general population*”²⁷. This is confirmed by hospital admissions for alcoholic psychoses, which in 25 States and the city of New York rose from 485 in 1920 to 1380 in 1929^{27,28}. Likewise, death rates from alcoholism, which had decreased steadily from 5.8 cases per 100,000 population in 1916 to 1.0/100,000 in 1920, rose year after year subsequently, reaching 4.0/100,000 in 1928^{27,29,30}. Yet, these statistics actually understate the facts, as reported by New York’s Chief Medical Examiner, “*In making out death certificates (which are basic to Census Reports) private or family physicians commonly avoid entry of alcoholism as a cause of death whenever possible. This practice was more prevalent under the National Dry Law than it was in pre-prohibition time*”¹⁹. Finally, the ban and high price of liquor enticed a consumer segment to switch to tobacco, hashish, marijuana, and narcotics, bringing users into contact with another set of criminals³¹. Some might argue that statistics in the 1920’s and 1930’s were unreliable by today’s standards, and that some of the diagnoses of alcoholic psychoses and death from alcoholism at that time might have been mislabeled or mistaken. However, statistics were not less reliable during than before or after Prohibition. Moreover, what is unarguable and undeniable is the fact that no health benefits accrued from Prohibition, and that the inverse is the most accurate and rational interpretation of available data.

3. **Crime and corruption:**

The expectation of Temperance enthusiasts that Prohibition would usher in a world without crime and solve untold social ills, including poverty, was not to be. In fact, America had experienced a declining rate in serious crime over much of the 19th and early 20th centuries³¹. However, “*a major wave of crime appears to have begun as early as the mid-1920s... increased continually until 1933... when it mysteriously reversed itself*”³². For example, the incidence of homicides increased from 5.6 per 100,000 persons in the 1900-1910 period, to 10 per 100,000 in the decade of the 1920’s. Arrests for violating Prohibition laws increased across the board: 81% for DUI^{*}, 41% for drunkenness and disorderly conduct. Likewise, 13% more arrests were made for assault and battery and homicides and 9% for thefts and burglaries³², despite rising law enforcement budgets. As a result, local, State, and Federal prisons became overcrowded. For example, the number of federal convicts increased 561%, from 3,000 in 1914 to 26,589 in 1932, most of them for violations of Prohibition laws²⁵. In response to the exploding prison population, the Federal budget for penal institutions grew by 10-fold between 1915 and 1932²⁵. More ominously, given the high margin profits associated with the underground alcohol industry, much of production and distribution was taken over by organized criminal groups, often combined with gambling and prostitution. These groups resorted to violent crimes in order to protect their turfs and

* Driving under the influence

income, giving birth to infamous crime syndicates and also to street gangs, “a *criminal element that first surfaced during Prohibition*”³¹. By 1927, Al Capone controlled not only all illicit commerce in Illinois, from alcohol to gambling to prostitution, but also the majority of the politicians, most police commissioners, the mayor of Chicago, and the governor. But Illinois was not an aberration. “*Everyone from major politicians to the cop on the beat took bribes from bootleggers, moonshiners, crime bosses, and owners of speakeasies*”³¹, leading the Commissioner of Prohibition to conclude in 1931, “*the fruitless efforts at enforcement are creating public disregard not only for this law but for all laws. Public corruption through the purchase of official protection for this illegal traffic is widespread and notorious. The courts are cluttered with prohibition cases to an extent which seriously affects the entire administration of justice*”¹⁵. The Bureau of Prohibition had to be reorganized, without much success, to combat corruption in its midst. Finally, Prohibition presided over an enormous increase in the size and reach of the Bureau of Prohibition. Other Federal agencies, with expanded roles to backup the Bureau of Prohibition, also experienced a phenomenal growth. For instance, “*Between 1920 and 1930 employment at the Customs Service increased 45 percent, and the service's annual budget increased 123 percent. Personnel of the Coast Guard increased 188 percent during the 1920s, and its budget increased more than 500 percent between 1915 and 1932*”³¹. Thus, at the stroke of a pen, the 18th amendment turned drunkenness and petty offenses by a few into a nation where crime and corruption were rampant at all levels of society, the government, and the judicial system.

In conclusion, *Prohibition* was an unmitigated disaster as it failed to achieve its main goal of reducing alcohol consumption, had adverse health consequences for the public, and promoted, albeit unintentionally, an unprecedented rise in crime and corruption on a grand scale^{31,33-35}. Organized crime grew into regional empires and corruption permeated the government, law enforcement, and the judicial system and lasted throughout the *Prohibition* years, which in turn fostered general disrespect for the law. Tens of thousands of citizens were prosecuted and incarcerated for activities that were legal both before the enactment of the 18th amendment and after its repeal. This stimulated a phenomenal growth and reach of a repressive Federal government that failed to retrench with the end of *Prohibition*. “*The noble experiment*” clearly demonstrates that proscription of mutually agreeable exchanges is doomed to failure²⁷ primarily because arbitrary laws cannot regulate human behavior. Moreover, laws designed to protect people from themselves are an assault on individual and collective freedoms of the governed and on the prestige of government, as observed by Albert Einstein upon reaching US shores. “*The prestige of government - he said - has undoubtedly been lowered considerably by the prohibition law*”³⁶. With such credentials, future Federal undertakings, based on equally fallacious principles that parallel those that gave rise to *Prohibition*, would seem unlikely to emerge. Yet, the blueprint for the *War on Drugs* is a *déjà vu* copy of *Prohibition's* though the social disruptions and economic costs caused by the former are much greater at home and, given its unprecedented internationally reach, abroad.

PARTII

NEW DRUGS - NEW PROHIBITION

Chapter 2

THE LURE OF MIND-ALTERING SUBSTANCES

The purpose of this chapter is to illustrate the impact of drugs on ancient and modern societies, especially on their health, social fabric, and historical course, and how the drug trade was exploited by some colonial powers eager to enhance their geopolitical agenda of domination and to profit from the process. Our focus will be on poppy (*Papaver somniferum*), the source of the mind-altering substance with the longest recorded history and the most enduring and because, as the precursor of narcotics, it is central to this book's core themes: *pain control* and *drug policy*. Examples of early societal involvement with drugs, reviewed in section 1, were selected based on the reliability of available records and as a prelude to today's drug scene that confirms the enduring relevance of the old adage "*plus ça change plus ça reste la même chose*" (the more it changes the more it stays the same). They also demonstrate that the often repeated quote, "*those who ignore the lessons of history are bound to repeat its mistakes*" should be restated for the benefit of policymakers to, "*History repeats itself endlessly because its lessons are seldom learned*". However, in modern times drug abuse involves not only poppy but countless licit and illicit drugs and extends to ordinary substances, dietary products, and even intemperate behaviors, which will be addressed in section 2 of this chapter and in chapter 4.

1. **Poppy and Opium through the ages**

Poppy in antiquity. Poppy was known to man circa 5500 BC, as shown by poppy-adorned religious artifacts unearthed in Southern Spain. Archeological evidence suggests that a precursor poppy plant might have originated in Northwestern Africa, Spain, and southern France, but the plant seems indigenous to Asia Minor and Northern Mesopotamia, Persia and India, where it is still cultivated ¹. The wild strain of poppy growing in the Mediterranean basin is thought to be the forerunner, by centuries of breeding and cultivation, of *Papaverum somniferum*, the only species used to produce opium today. Fossil remains of poppy-seed cake and poppy-pods have been found in Neolithic Swiss lake dwellings, circa 2000 BC. The historical trail of poppy begins around 3400 BC with a Sumerian tablet unearthed at Nippur (south of modern Baghdad) inscribed in cuneiform script, "*Early in the morning old women, boys and girls collect the juice, scraping it off the notches [of the poppy-capsule] with a small iron* blade, and place it within a clay receptacle*" ². Moreover, they referred to poppy as "*the Joy plant*" for its euphoric effects, suggesting that poppy had gained certain popularity in Sumerian culture. Sumerians passed their knowledge on the cultivation of the plant and the extraction and use of opium to the Assyrians. Opium, the latex extracted from poppy, was likely the most powerful substance of the time as it had distinct sedative and calming effects in small doses, hypnotic properties in moderate doses, and rendered the user insensitive to pain in higher doses ^{3,4}. Hence, it is not surprising that the Babylonians adopted opium and in turn passed it to the Egyptians. The earliest record of poppy use in Egypt is found in the Eber papyrus (circa 3500 BC) where it is advised that the use of sap from the unripe poppy seedpod "*prevents the excessive crying of children*". Two millennia later, in the 1300s BC, the Thebes (modern Luxor) area of Upper Egypt became a major center of poppy growing, especially during the 18th-dynasty Pharaohs, from Tuthmosis IV (1419 - 1386 BC) through Tutankhamen "*King Tut*" (1333 - 1324 BC). *Poppy rhoeas* (red poppy), a variety imported from Asia Minor and the Palestine region that is closely related to *Papaver somniferum*, was grown in the gardens of pharaoh Tuthmosis III and in the temple of Amun at Karnak, and regularly depicted in vases, paintings, and ornaments of the time ^{1,5,6}. Traders, mostly Phoenicians and Minoans, took this lucrative crop they called "*opium thebaicum*", across the Mediterranean Sea into Greece, North Africa, and Southern Europe ⁷. These ancient people used poppy and hemp mainly for medicinal purposes and religious rituals, and there is no credible evidence of drug abuse among them. In fact, their languages did not include a term indicating abuse, dependence, or addiction. The Persians, who conquered much of Assyria and Babylonia, also inherited part of those civilizations' customs, though the first mention of opium (*malidéh or afium*) only occurs in circa 600 BC. Likewise, the Hebrews, living in an area where poppy and its extracts were known since antiquity, must have known and used poppy and opium. In fact, it has been suggested that a mixture of vinegar and poppy juice ("*rosh*" in Hebrew) was the drink given to Christ on the cross in order to alleviate His suffering ⁸.

Poppy and the ancient Greeks. The poppy culture became pervasive among the ancient Greeks. They portrayed their divinities Hypnos (sleep), Nyx (night), and Thanatos (death) covered with poppy capsules or carrying poppies on their heads, and similarly decorated the statues of Apollo, Pluto, Aphrodite, Isis, Demeter, and many other gods ². According to legend, Demeter, in despair over the seizure of her daughter

* Questionable translation for the iron age began around 1200-1300 BC

Persephone by Pluto, ate poppies in order to fall asleep and forget her grief. Archeological findings also unearthed poppy capsules depicted on Greek pottery, figurines, vases, coins, and jewelry. Their classical texts also bear testimony of poppy use. In fact, the first written mention of poppy in ancient Greece is found in Homer's Iliad (circa 800 BC), "...and as a poppy which in the garden is weighed down by fruit and vernal showers, droops its head on one side". In his other epic work, Odyssey, Homer mentions "*Nepenthes*", a substance assumed to derive from poppy, that Helen gave to Telemachus and his comrade to "*lull all pain and anger, and bring forgetfulness of every sorrow*". However, others have cast doubt on the nature of *Nepenthes*, claiming to refer to Helen's charms instead. Hesiod (circa 700 BC), wrote about a Corinthian town named *Mekonê* (poppy-town) for the extensive cultivation of poppy in the area, "... when the gods and mortal men were divided at Mekonê, even then Prometheus was forward to cut up a great ox and set portions before them, trying to beguile the mind of Zeus " ⁹.

Ancient Greeks also recognized the medicinal or healing properties of poppy. However, it is to be noted that while ancient Greeks included the word *pharmakon*, signifying drugs, the term had a positive (healing) and a negative (poison) connotation. In its positive connotation, *pharmakon* also applied to herbs of all kinds, especially exotic ones brought from the orient, whether used for healing by physician-herbalists, for household cooking, or for their fragrance. Additionally, in pre-Hippocratic times, when medicine was magical and the province of the gods and of physician-magicians, *pharmakon* referred to an incantation or a spell as often as it meant a physical substance. Like that of other ancient civilizations, the ancient Greek language lacked terms for drug abuse or addiction suggesting that such concepts and behavior were alien to them. Hippocrates (460-377 BC), the "*father of medicine*" repeatedly referred to the hypnotic, narcotic, and styptic* properties of opium and recommended its use for the treatment of various ailments ^{10,11}. He distinguished between the white, fire-red, and black poppy, and mentioned the nutritive properties of poppy seeds. Of interest is the use of poppy for euthanasia purposes among a segment of the Ancient Greek population, as described by Herakleides of Pontus (circa 340 B.C.) in his work "*On Government*" ¹¹. He described the "*Keian custom*" practiced in the island of Keos of the South Aegean Sea. "*Since the island is healthy and the population lives to a ripe old age, especially the women, they do not wait until they are very old for death to take them, but before they grow weak or disabled in any way, take themselves out of life, some by means of the poppy, others with hemlock*" ².

Centuries later, poppy and opium were still prominent in Hellenic culture. Pliny the Elder (AD 23-79) is credited to having been the first to use the word *opium* to describe the juice of the poppy ². Dioscorides of Anazarba (circa 100 AD) and especially Galen of Pergamon (Claudia Galena, 129-210 AD), two of the most renowned Greek medical practitioners described, prescribed, and recommended the use of poppy extracts and opium juice. Either could be taken internally or applied externally for their therapeutic benefits extended to a variety of illnesses and ailments. Galen, the second most famous physician of the ancient world after Hippocrates and the physician to three Roman emperors was a brilliant anatomist, philosopher and poet, and a most prolific writer with a corpus of 500 works. He bridged the Greek and Roman medical worlds and enshrined Hippocratic principles as the foundation of all medical knowledge that, with the collapse of Greco-Roman civilization after the fall of Rome in 476 AD, was preserved by Muslim translators until the Middle Ages. He listed the medical properties of poppy as

* Substance capable of stopping wound bleeding

follows, "[it]...resists poison and venomous bites, cures chronic headache, vertigo, deafness, epilepsy, apoplexy, dimness of sight, loss of voice, asthma, coughs of all kinds, spitting of blood, tightness of breath, colic, the lilac poison, jaundice, hardness of the spleen stone, urinary complaints, fever, dropsy, leprosy, the trouble to which women are subject, melancholy and all pestilences."

Poppy and the Muslims. Poppy was unknown in pre-Islamic Arab lands. It made its entrance into Arabia's drug armamentarium around 800 BC when Hjunayn ibn Ishaq and others ¹ translated Greek works or their Syriac versions into Arabic. In his seven-volume treatise "*Firdous al-Hikmat*", the first medical encyclopedia published in Arabic, Ali Ibn Rabban Al-Tabari (838 – 870), teacher of the distinguished physician Zakariya al-Razi (a.k.a Razes), recommended opium as ointment for external application and in tablet form for migraine and colds. The latter was administered in increasing daily doses until the desired effect was achieved. He also prescribed poppy seeds, along with psyllium, dandelion, and other seeds, for childhood coughs and consumption ¹². Tabari, Jabir ibn Hayyan, "*the most famous Arabic alchemist*", and other Muslim alchemists of the ninth century considered opium as a poison to be used as a remedy with extreme caution ¹³. The "*Medical Compendium*", by Sabtur Ibn Sahl (? - 869), utilized in the prestigious Adudi hospital in Baghdad, listed opium and poppy in tablet, powder, decoction, electuary *, enema, and other preparations for the treatment of various ailments, and as an antidote. In his *al-Qanun fi al-Tibb* (Canons of Medicine), Ibn Sîna (a.k.a Avicenna, 981 - 1037), philosopher, mathematician, astronomer, and the most famous physician of his time described how to extract opium from poppy. He warned, it "*dulls the intellect, impairs consciousness, thwarts good counseling, weakens digestion, and causes death by freezing the natural faculties*" ^{1,14}. Likewise, Al-Birûnî (973-1048), one of Avicenna's contemporaries and a famous astronomer, mathematician, physicist, physician, geographer, geologist and historian, cautioned that opium could cause death. "*I have seen - he wrote - a case where a person died from the use of an opium suppository. Therefore it should be used with extra care*" ¹. More importantly, he keenly observed and correctly interpreted the psychological implications of a new social phenomenon developing in the Muslim world. It is in all likelihood the first report of recreational use and abuse of a mind-altering drug. He wrote, "*People who live in the tropics or hot climates, especially those in Mecca, get into the habit of taking opium daily to eliminate distress, to relieve the body from the effects of scorching heat, to secure longer and deeper sleep, and to purge superfluities and excesses of humors. They start with smaller doses which are increased gradually up to lethal dosages*" ¹⁵. According to a current Muslim scholar, "*examination of historical evidences in Islam shows that abusers, seeking flight from reality, brought dangerous consequences upon the whole Muslim community and its cultural, religious, and economic life*" ¹. He further points out that this drug-permissiveness was possible because "*neither hemp nor opium was then known [in pre-Islamic Arabia]...no specific prohibition was made against their use in the Qur'an*".

The drug abuse phenomenon occurred at a time when Islam was expanding exponentially on the physical, political, and religious fronts, reaching India and even China to the East, controlling North Africa as far as Morocco, and ruling most of the Iberian Peninsula in Europe. The conquerors brought with them and propagated to the conquered peoples, especially converts to Islam, the good and the bad of their culture, including addiction to opium. Political unrest arising from religious sectarianism of all

* A medicine sweetened with honey

shades and colors that sprung up in the Muslim world compounded the social landscape and threatened the stability of the center government: the Caliphate. *Ikhwān al-Safā* (*Brethren of Purity*) and *Qaramitites* were two of the best known ideological societies that attracted large following and considerable political influence. Many of their adepts used drugs, presumably to withstand long hours of praying, meditation, and fasting leading to addiction in some. It has been observed that this and other practices represented a “*dreadful prostitution of religion [that] was often a cover for the pernicious influences of secret societies and the horrors of unbridled political ambitions*”¹⁶. Perhaps the most radical sect of Ismaili Muslims known for its extreme political dissidence and drug abuse was *Al-da'wa al-jadida* (the new doctrine) founded by Hasan-I-Sabbāh (1090 - 1124), also known as *Hashshashin*, or *Assassins* as they were known in the West. The name of the sect is said to mean *Hashish-eaters* or *hashish-smokers*, either because they “*would take hashish before missions in order to calm themselves... to turn themselves into madmen in battle...[or]...to show the neophyte the sensual pleasures awaiting him in the afterlife*”¹⁷. However, whether this is myth or fact has never been determined. Indeed, there are many stories connected with the *Assassins*, especially because their contacts with the Crusaders and the writings of Marco Polo awakened the imagination of European storytellers inclined to believe reports of wickedness among distant people of another race or religion, becoming part of Western folklore. They called themselves *Fedayeen*, “*one who is ready to sacrifice their life for a cause*” and were known for their blind obedience to their spiritual leader and for their use of murder to eliminate foes, especially of the *Abbasid* and *Seljuq* dynasties. Under the pretense of religious zeal, they engaged in conspiracy, murder, and terrorism, undermining the moral values of Islam¹. One Muslim scholar¹⁶ attributes the decline of the Muslim world after the thirteenth century in part to “*the addiction problem in a nation which subscribed very actively to the use and misuse of drugs since the 900s*”. However, this self-inflicted curse pales in comparison with the plight of the Chinese, eight centuries later, whose drug problem was imposed by a foreign power.

Poppy in India and China. It is believed that opium was introduced to India by the armies of Alexander the Great (356 - 323 BC), and to China by Arab traders (circa 400 AD). In the 15th century, poppy was cultivated along the coast of India, mainly for medicinal purposes. At the time of the Mogul Empire, poppy was extensively cultivated and, as a State monopoly, became a profitable crop for trading with China and other eastern countries. During the reign of Mogul Jalaluddin Muhammad Akbar (1556 - 1605), the British and the Dutch conducted a lucrative opium trade between India and China. After the fall of the Mogul Empire, the monopoly over opium production and sale shifted to a group of merchants in Patna. However, a few years after the British conquered the province of Bengal in 1757, and on the order of Lord Warren Hastings, the Bengal's British Governor-General, the Indian opium production was transferred to the *British East Indian Company* (1773 -1833). As a tool of British colonial policy, the Company established a monopoly on the cultivation and sale of opium that was to oppress Indian peasants, turn millions of Chinese into addicts, and promote two wars. Faced with the social impact of opium on his people, the Chinese emperor had imposed a ban on opium smoking and trading in 1729. In order to circumvent the Chinese ban on opium importation, the *British East Indian Company* would purchase tea from Guangzhou (Canton) on credit and pay in Calcutta with Indian opium, leaving opium smuggling to third parties¹⁸. In 1799, the Chinese reiterated the ban on the importation of opium and in 1810 decreed, “*Opium has a very violent effect. When an addict smokes it, it rapidly makes him extremely excited and capable of doing anything he pleases. But before long, it kills him... We should also order the general commandant of the police*

and police-censors at the five gates to prohibit opium and to search for it at all gates. If they capture any violators, they should immediately punish them and should destroy the opium at once"¹⁹. The decree had little effect given the Chinese central government's lack of control over opium smuggling through southern ports thousands of miles away from Beijing, the strong demand by increasing numbers of Chinese users, and the greed of the *British East Indian Company* and of its surrogate smugglers. As a result, the amount of opium brought to China skyrocketed from 15 tons per year in 1730 to over 900 tons in the early 1820s to 4,000 tons in 1836. That year, an estimated 8 million Chinese had become opium addicts. Alarmed about the health and social problems caused by opium, the Emperor of China, Tao-kuang, appointed Commissioner Lin Tse-hsü to completely rid China from opium and opium addiction. Lin, an incorruptible official, established rehabilitation centers for addicts, banned all trading with western merchants demanding they turned over to him their opium stockpile, and had opium dealers arrested and publicly executed. He also blockaded the city of Guangzhou and surrounding towns where most of the opium trade took place. Although Charles Elliot, the British Chief Superintendent of Trade and British Minister to China, and other merchants complied by surrendering to Lin all remaining stockpiles of opium, many traders and British ships moved their illegal activities further south along the coast. Lin also wrote to Queen Victoria asking, "*I have heard that your country very strictly forbids the smoking of Opium... Why do you let it be passed on to the harm of other countries?*" to no avail.

On July 12, 1839, a group of drunken British sailors rampaged through the village of Kowloon, near Hong Kong, destroying a temple and killing Lin Weixi, one of the villagers. When the British rejected the Qing government's legal jurisdiction over their seamen and refused to sign a bond pledging not to smuggle opium, an infuriated Lin ordered all exported goods to the British be halted immediately. He also ordered the freshwater streams used by the British to be poisoned. This temporarily drove the British out of China only to come back in late August of that year with twenty-eight war ships that seized Hong Kong and easily defeated a second-rated Chinese navy. The first Opium War (1839-1842) had begun. Emperor Tao-kuang blamed Lin for the war and exiled him. In August 1842, China signed the vanquished nation-style treaty of Nanjing that committed the Qing government to cede Hong Kong "*in perpetuity*" and grant "*extraterritoriality*"^{*} to Britain, to open major Chinese ports to all traders, and to pay the British government a considerable indemnity. It included "*6,000,000 of dollars as the value of the opium which was delivered up at Canton in the month of March, 1839 and as a ransom for the lives of Her Britannic Majesty's Superintendent and subjects, who had been imprisoned and threatened with death by the Chinese High Officers... 3,000,000 of dollars, on account of debts due to British subjects... 12,000,000 of dollars, on account of the expenses incurred*"²⁰. The treaty of Nanjing paved the way for resuming and expanding the lucrative drug trade and opening up Chinese society to western missionary. A smuggler's chant of the time illustrates the treaty's outcome, "*Those were days to be remembered, when our good ship sailed away. From the old home port behind us, to Calcutta or Bombay; When we sold the Heathen nations runt and opium in rolls, And the Missionaries went along to save their sinful souls*"²¹. However, there was more to come, much more.

In the 1850s, the British eager to expand their hold on the China trade petitioned the Qing government to renegotiate the treaty of Nanjing. The British most notable

^{*} British subjects accused of crimes committed in China to be tried by British law

demands included opening all of China to British merchants, the exemption of foreign imports from internal transit duties, and its ultimate goal, the legalization of the opium trade. The Imperial court rejected the British new demands. In the same time-frame (October 8, 1856), Quing officials arrested 12 Chinese sailors after boarding the *Arrow*, a Chinese-owned, Hong-Kong-registered ship, suspected of piracy and smuggling for the British. The British authorities in Guangzhou demanded the seamen's immediate release on the grounds that the ship had been previously British-registered and that the British flag, they claimed was flown that day, had been desecrated. Concurrently, the British attacked Guangzhou finding no Chinese resistance. Moreover, based on the "*Arrow Incident*" report prepared by Harry Parkes, British Consul to Guangzhou, the British Parliament voted to assault China, asking France, the USA, and Russia to join in, marking the beginning of the second Opium War (1858-1860). France accepted, using as a pretext the execution of Father August Chapdelaine by Chinese authorities in Guangxi province. James Bruce, 8th Earl of Elgin * and Baron Jean Baptiste Louis Gros commanded the British and French armies, respectively. The USA and Russia chose to send no armies but dispatched envoys to Hong Kong to assist planning the assault on China. Guangzhou soon fell into the hands of the aggressors and was plundered, Ye Mingshen, governor of Guangdong and Guangxi provinces, was captured, and a puppet government was installed that would last 4 years. The defeat of China led to the lopsided treaties of Aigun and Tientsin. The former, signed with Russia on May 28, 1858, revised the 1689 Nerchinsky Treaty granting Russia additional territory bordering the Aigun River and the pacific coast establishing the modern borders of the Russian Far East. The latter, signed in June 1858, gave Britain, France, the US, and Russia certain navigation and travel rights, allow them to establishing diplomatic missions, and forced China to pay an indemnity of 2 million *taels* ** to each, Britain and France, plus 2 million *taels* to Britain as compensation for destruction of property. However, Chinese refusal to allow Western embassies in Beijing the following year, the capture and torture of Harry Parkes, and the murder of several members of his entourage were used as a pretext for a new Anglo-French military offensive. The allied forces captured and looted Beijing on October 6, 1860, and Lord Elgin ordered the Imperial Summer Palace be razed to the ground. Through the "*Convention of Peking*", the Chinese granted freedom of religion, consented once again to allow Western diplomatic missions in Beijing, and were forced to legalize opium trade and to pay a new indemnity to Britain and France, this time of 8 million *taels* each. Inexplicably, two weeks later, Russian envoy General Nicholas Ignatiev convinced the Chinese government to sign the "*Sino-Russian Supplementary Treaty of Peking*" that ceded to Russia an additional 300,000 squares miles of its territory.

* Whose father removed "*whole boatloads of ancient sculpture from Greece's capital city [including] a large amount of fifth-century BC sculpture taken from the Parthenon*" ²² and brought them to the British Museum where they now stand.

** A former Chinese monetary unit based on the value of 1 1/3 Oz (38 g) of silver

2. Drug abuse in the 21st century

Worldwide drug consumption. Today, the choice of illicit and licit drugs and other substances available for abuse is considerable. In addition to the everlasting marijuana, cocaine, and heroin it includes alcohol (beer, wine, distilled spirits), central nervous system stimulants (tobacco, caffeine, ritalin), hallucinogens (GHB*, LSD**, PCP***, ecstasy, ketamine, methamphetamine, rohypnol, mescaline, psilocybin), inhalants (glue, solvents, aerosols), and prescription drugs ranging from anabolic steroids to opioids. However, in modern societies addictive behavior has transcended drugs to embrace many activities that, to most people, are ordinary and routine such as eating chocolate or having sex. This fact must be taken into account when exploring the nature and the possible causes of addiction (chapter 4). According to the United Nations Office on Drugs and Crime (UNODC) World drug report 2006²³, *“The total number of drug users in the world is now estimated at some 200 million people, equivalent to about 5 per cent of the global population age 15-64. Cannabis remains by far the most widely used drug (some 162 million people), followed by amphetamine-type stimulants (amphetamines, 25 million people and ecstasy, 10 million people). The number of opiate abusers is estimated at some 16 million people, of which 11 million are heroin abusers. Some 13 million people are cocaine users”*.

Drug prevalence varies throughout the world (table 1). While cannabis and cocaine are the most abused drugs in North America (32% and 31% prevalence, respectively), opiates represent approximately 60%-65% of abused drugs in Asia, Oceania, and Europe, cannabis predominates in Africa (63%), and cannabis and opiates dominate the illicit drug market in Australia and New Zealand. Likewise, the prevalence of the five most common drugs varies widely by region and by country. Singapore is the country with the lowest prevalence of drug abuse, ranging from a low of 2 cocaine users to a high of 5 amphetamine users per 100,000-population aged 15-64. In contrast, Canada, Iran, Philippines, the USA, and Australia report the highest drug abuse

Table 1. Highest and lowest annual prevalence rates (%) of abuse in populations age 15-64²³.

Region	Cannabis	Amphetamines	Opiates	Cocaine	Ecstasy
Europe	0.80 - 11.3	0.01 - 1.5	0.05 - 1.2	0.02 - 2.7	0.10 - 2.5
North America	1.30 - 16.8	0.1 - 1.5	0.10 - 0.6	0.4 - 2.8	0.01 - 1.1
Central America	1.30 - 16.1	0.2 - 1.1	0.01 - 0.4	0.1 - 2.5	0.10 - 0.7
South America	0.50 - 5.6	0.1 - 0.7	0.01 - 0.6	0.3 - 1.9	0.10 - 0.3
Asia	0.004 - 6.4	0.005 - 6.0	0.004 - 2.8	0.002 - 0.03	0.004 - 0.8
Oceania	0.1 - 29.5	3.4 - 3.8	0.50 - 0.5	0.5 - 1.2	2.2 - 4.0
Africa	0.05 - 21.5	0.01 - 0.9	0.01 - 2.3	0.01 - 0.8	0.01 - 0.4

prevalence that averages 16.8 users per 100 population 15-64 for cannabis, 6.0% for amphetamines, 4.0% for ecstasy, and 2.8% for each opiates and cocaine,. These figures are not actual statistics but *“estimates by drug experts from each country”*²² reporting to the UNODC. Yet, if these estimates on *illicit* drugs sound ominous and would appear to justify the *War on Drugs* at the national and international levels, they pale in comparison to the higher prevalence and greater economic and human impact of

* Gamma hydroxybutyrate

** Lysergic acid diethylamide

*** Phencyclidine

abused *licit* substances. Indeed, as emphasized in the UNODC World Drug Report 2006, *"The picture is more bleak for licit psychoactive substances. Tobacco, a particularly addictive substance, is a case in point. About 28 per cent of the world's adult population is estimated to use tobacco, which exceeds, by far, the number of people using illicit drugs (4 per cent for cannabis and 1 per cent for ATS, cocaine and opiates combined)"*²². More ominously, *"with its 3,000-plus chemical components, including at least 43 carcinogens, tobacco is the leading preventable cause of disability and deaths in the US and the world. As a major contributor to the four leading causes of premature death (heart disease, cancer, strokes, chronic lung disease), cigarettes kill as many Americans as the next 10 causes combined...In the US, illnesses attributable to smoking accounted for 430,000 premature deaths in 1990, of which 189,700 were from cancer"*²⁴.

However, the most widely used and abused mind-altering substance worldwide is alcohol. In its Global Report: Alcohol Policy²⁵, *"The World Health Organization estimates that there are about 2 billion people worldwide [approximately 48% of the world's population age 15-64 the year of the report] consuming alcoholic beverages and 76.3 million with diagnosed alcohol use disorders. From a public health perspective, the global burden related to alcohol consumption, both in terms of morbidity and mortality, is considerable in most parts of the world. Globally, alcohol consumption causes 3.2% of deaths (1.8 million) and 4.0% of the Disability-Adjusted Life Years lost (58.3 million). Overall, there are causal relationships between alcohol consumption and more than 60 types of disease and injury. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries... Besides the numerous chronic and acute health effects, alcohol consumption is also associated with widespread social, mental and emotional consequences"*. In the next few pages, I will summarize trends in global and US illicit drug markets and compare their human and economic costs in the US to that of tobacco and alcohol.

Trends in global drug consumption²². According to the Executive Summary of the UNODC World Drug Report 2006, *"There is evidence that, over the last hundred years, it [the multilateral drug control system] has reduced and contained the drug problem at the global level. While tracking a trend over a century is difficult because there are few facts, some baselines can be found. The best is for the opium problem, because it was investigated at the Shanghai Commission in 1909"*. This statement is based on a *"world opium production estimated to have been at least 30,000 metric tons... [which] nearly a hundred years later... is down to about 5,000 metric tons"*, despite a nearly six-fold rise in the world population. However, a greater scrutiny of worldwide estimated drug production (called *"potential manufacture"* * for lack of firm data), seizure, and consumption for the most prevalent drugs reported in the same document reveals quite a different picture, as briefly outlined below.

Cannabis (162 million users estimated worldwide). Cultivation of cannabis herb (marijuana) is widespread worldwide, including in the homes of many consumers, especially Americans. The main sources of Cannabis resin (hashish) are Morocco, Afghanistan, and Pakistan. Data available from Morocco indicate that cultivation decreased from 120,500 hectares in 2004 to 72,500 hectares in 2005 to which a probable 30,000 hectares must be added for Afghanistan and an unknown cultivation

* Amounts of drug that *could* be manufactured from *estimates* of produced base product

area for Pakistan. *Potential manufacture* of cannabis resin in Morocco declined from 3,070 metric tons in 2003 to 2,760 metric tons in 2004 and 1,070 metric tons in 2005. Additionally, global seizures of cannabis herb and cannabis resin reached all time highs of over 6,000 and 1,470 metric tons, respectively, in 2004. Yet, despite official claims of sharply declining cultivation and production, and of increased seizures the same report acknowledges, "*cannabis use increased by more than 10 per cent at the global level* [since the early 1990s] ²².

Amphetamine-type stimulants (35 million users estimated worldwide). *Potential manufacture* of amphetamine-type stimulants was estimated at 480 metric tons in 2004, a sharp fall from 2000 levels. However, seizures declined by 53% from 2000 levels, to 19.5 metric tons. As a result, worldwide use increased by nearly 5% from 1992 to 2004.

Opiates (16 million users estimated worldwide). Between 1990 and 1997, worldwide poppy cultivation dropped from approximately 250,000 - 280,000 hectares to an average of 151,500 hectares over the period. Despite this sharp reduction in poppy cultivation, official figures revealed that improved cultivation techniques and better land irrigation helped maintain 2005 *potential manufacture* of opium at 4,600 metric tons, of which 4,100 metric tons came from Afghanistan. These production figures are little changed since 1993 except for 1994 and 1999 when opium production surpassed 5,500 metric tons and for 2001 when a strict ban by the Taliban regime almost eliminated Afghanistan's poppy cultivation. Global seizures of opiates (opium, morphine, and heroin) increased from approximately 10 metric tons in 1992 to 120 metric tons in 2004. However, these gyrations in cultivation area, production yield, and seizures had no impact on the street price of opiates. Indeed, between 1990 and 2004 the per-gram price for opium fell steadily from an average of (inflation-adjusted) US \$250 in the US and US \$420 in Western Europe to \$78 and \$157, respectively. As a result, opium use increased globally by approximately 0.3% annually between 1992 and 2005.

Coca and cocaine (13 million users estimated worldwide). Today, most coca leaves (54%) are cultivated in Colombia followed by Peru (30%) and Bolivia (16%). The total area under coca cultivation was 159,600 hectares in 2005; a level little changed since 2003 but much lower than a high of approximately 220,000 hectares reported for 1999 and 2000. Similarly, the *potential manufacture* of cocaine remained virtually unchanged over the last decade, at 910 metric tons. Seizures reached 588 metric tons in 2005, the highest figure ever. However, between 1990 and 2004 the street price per gram fell from an average of (inflation-adjusted) US \$175 in the US and US \$275 in Western Europe to \$87 and \$104, respectively. The net result is little change in cocaine use since 2002, after rising 0.3% annually in the previous decade.

Trends in US drug consumption. In nineteenth century America, the importation of opium was unregulated and its consumption unrestricted. Hence, a myriad of elixirs, tonics, potions, concoctions, liniments, and other remedies containing alcohol and/or opium and all sorts of other undisclosed ingredients inundated the market. Opium was very popular for its presumed medicinal properties, including as analgesic and hypnotic, to ward off fevers and to treat various illnesses, and to sooth teething infants among others. The recreational use of opium also rose alongside its medicinal use, from an annual per capita consumption of about 12 grains* in 1840 to roughly 52 grains towards the end of the century. As a result, addiction to opium also rose reaching a peak

* The smallest weight in the *troy* and *avoirdupois* systems; equivalent to 0.0648 grams

of 250,000 at the turn of the century in a total population of approximately 76 million; the highest rate ever reported in the US. Likewise, cocaine became very popular throughout the country in the first two decades of the twentieth century. However, all figures and quotes on recreational drugs and addiction were mere estimates by individuals or groups with a moral or prohibitionist agenda rather than the product of painstaking surveys as is the case today. At this writing (2007), solid data are available in the US on drug use and, to a lesser extent, abuse for different age groups albeit buried in a sea of unsubstantiated, exaggerated, or deceitful reports. Reliable data are gathered by Federal agencies and by other independent research groups. Perhaps the most thorough and authoritative drug use data collection in the US is generated from surveys conducted by the *Monitoring the future project* at the Institute for Social Research of the University of Michigan. These ongoing surveys, which began with the class of 1976 and cover use of *illicit* drugs plus alcohol and cigarettes by population cohorts ranging from 8th graders to adults age 45, are conducted biennially through age 30 and every five years for cohorts aged 35, 40, and 45. An analysis of their 2006 report²⁶ suggests the following conclusions.

*Teenagers and young adults exhibit the highest prevalence rates** for any *illicit* drug use. In 2007, the *annual* and *30-day* prevalence rates for *any illicit* drug use for the 18 to 26 year-old age groups ranged from 26% to 34%, and from 16% to 20%, respectively, dropping to 12% and 7%, respectively, at age 45 (figure 1).

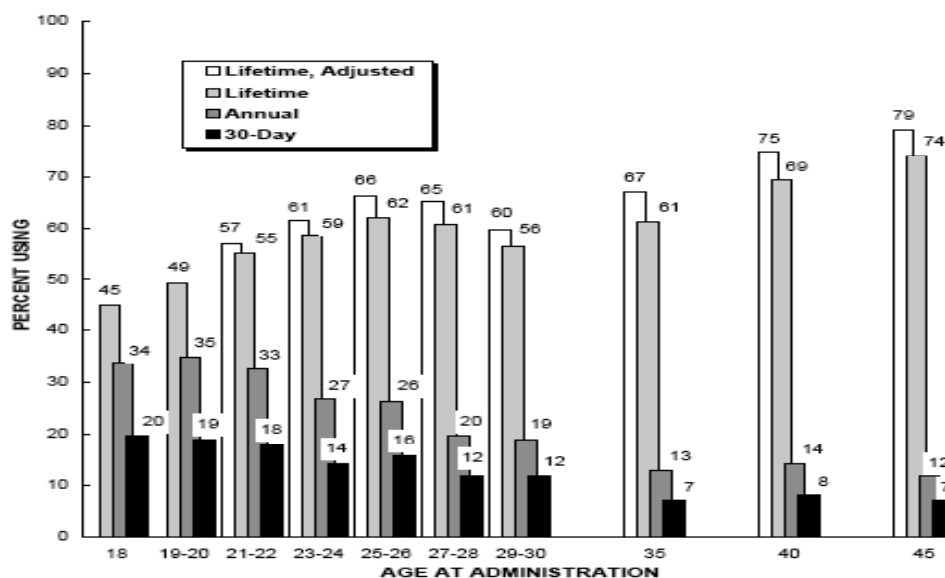


Figure 1. Any Illicit drug. Lifetime, annual, and 30-day prevalence rates by age group.

Marijuana is the single most widely used illicit drug in the US. In 2007, the *annual* and *30-day* prevalence rates for *marijuana* use by the 18 to 26 year-old age groups ranged from 25% to 33%, and 14% to 19%, respectively, dropping to 13% and 7%, respectively by age 45 (figure 2).

* Percentage of a cohort using drugs within the timeframe indicated

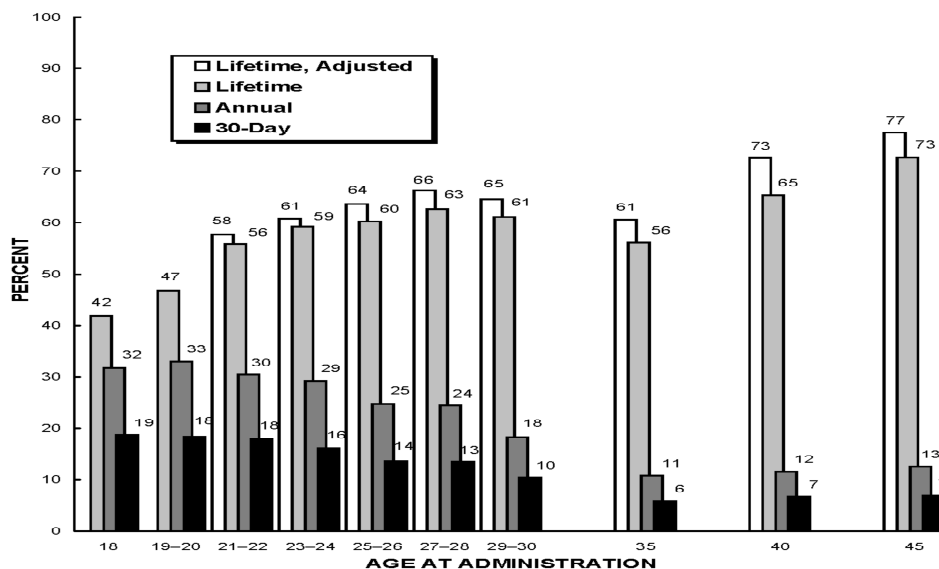


Figure 2. Marijuana. Lifetime, annual, and 30-day prevalence rates by age group.

Illicit drug use varies widely from year to year. After peaking in 1980-1982, the annual prevalence rates of illicit drug use (marijuana excluded) among 8th, 10th, and 12th graders and young adults (18 to 22) declined through 1992, after which they rose for teenagers and young adults but stabilized for the 35 to 45 age group (Figure 3). Annual prevalence rates for marijuana followed a comparable pattern, but for a much sharper rise in the decade of the 1990s (Figure 4). Indeed, as noted in the 2006 report, "During the 1990s, the annual prevalence of marijuana use tripled among 8th graders

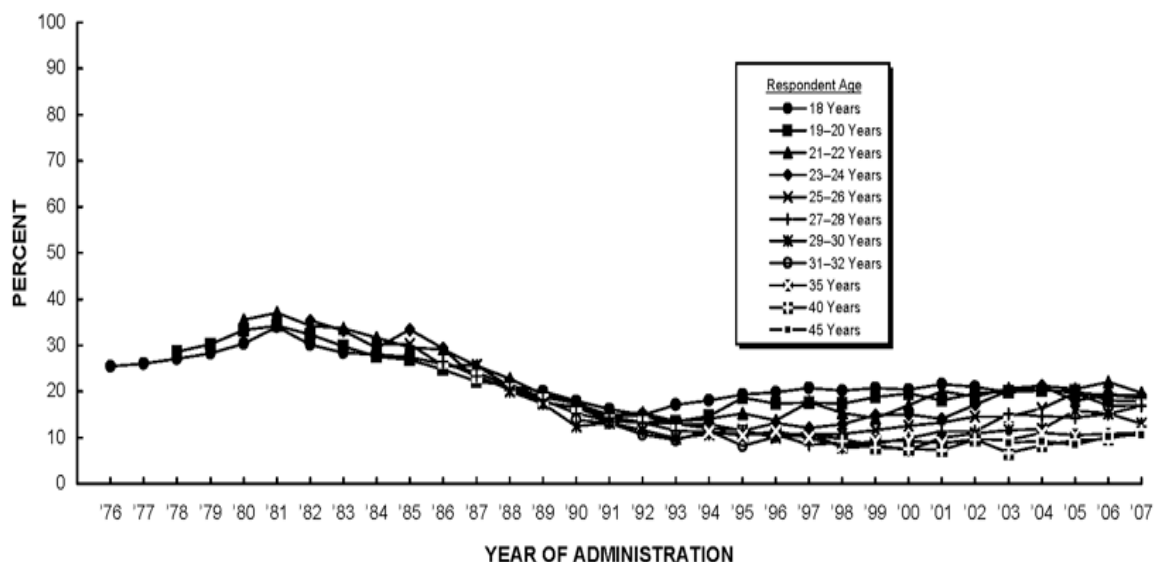


Figure 3. Illicit drugs other than marijuana. Trends in annual prevalence by age group.

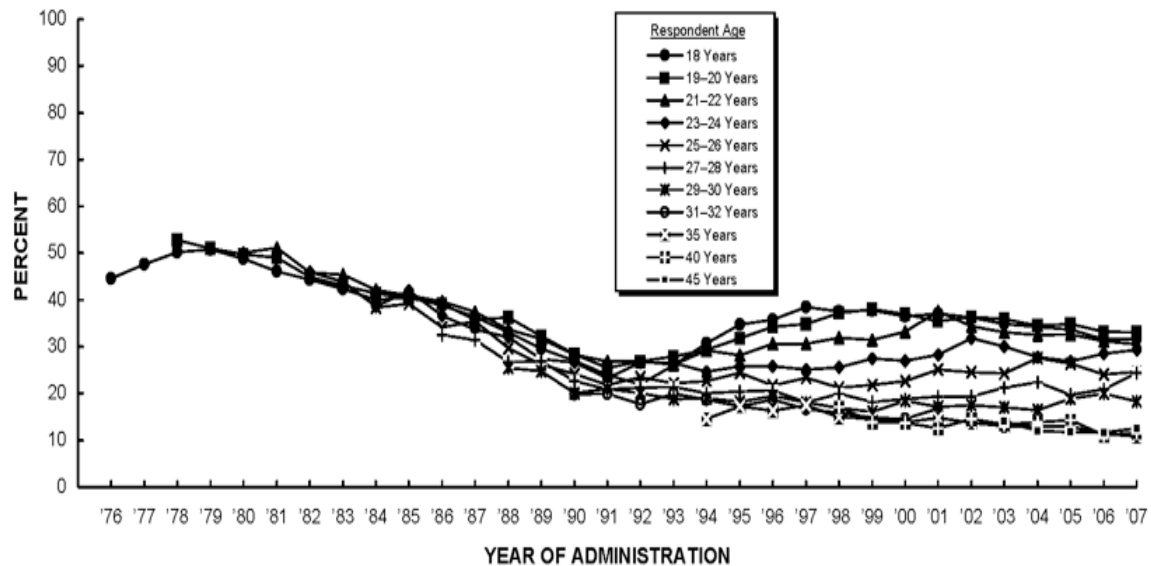


Figure 4. Marijuana. Trends in annual prevalence by age group.

(from 6% in 1991 to 18% in 1996), more than doubled among 10th graders (from 15% in 1992 to 35% in 1997), and nearly doubled among 12th graders (from 22% in 1992 to 39% in 1997). Among college students, however, the increase in marijuana use... was much more gradual"²⁶. As a result, peak rates occurred in 1996 for 8th graders, 1997 for 10th and 12th graders, 2001 for college students, and 2004 for young adults. Interestingly, use patterns do not rise and fall in tandem. For example, the *annual* prevalence for cocaine peaked in 1985-1986 at 12% to 24% for the 18 to 26 age group before falling over the next decade to approximately 5%. Similarly, the *annual* prevalence rate for MDMA* peaked in 2001 at 7% to 11% for the 18 to 24 year-old cohort before falling to less than 5% in 2005. In contrast, the *annual* prevalence rate for heroin remained stable at or below 1% for all cohorts since 1975, with only a slight rise between 1995 and 2001 for the 18 to 22 cohort. Remarkably, these variations in drug use patterns over three decades were independent of drug availability (increased) and street price (decreased).

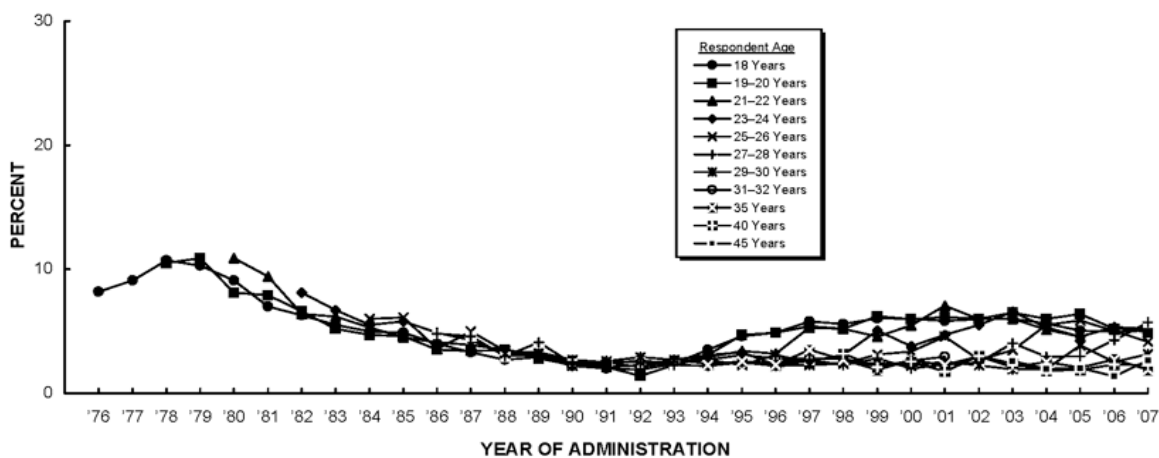


Figure 5. Marijuana. Trends in 30-day prevalence of daily use by age group.

* 3,4 methylenedioxymethamphetamine (ecstasy and other street names)

The 35 and over cohorts consistently exhibit the lowest prevalence rates for any illicit drug. In 2007, the *annual* prevalence rates for *illicit* drugs other than *marijuana* (figure 1) and for *marijuana* (figure 2) for the 35, 40, and 45 cohorts are the lowest of any surveyed age group, and has been so since these age groups were included in the surveys. Comparable findings apply to the *30-day* prevalence rates. Hence, high *annual* and *30-day* prevalence rates among teenagers and young adults do not predict drug addiction later in life. This is because *annual* and *30-day* prevalence rates represent casual, mainly "recreational", drug use rather than a "compulsion" associated with heavy use and addiction. However, while the *30-day* prevalence of *daily use*** is a better indication of heavy drug use, it also drops sharply with age for all illicit drugs. For instance, while the *30-day* prevalence of *daily use* of Marijuana in 2007 ranged from 4.5% to 6.5% between ages 18 and 24 it fell to approximately 2% by age 35 (Figure 5). Likewise, while one third of the over 35 surveyed age group admitted lifetime use of cocaine, only 1% reported use within the 30-day preceding the interview (Figure 6) and 0.1% used it daily (table 2).

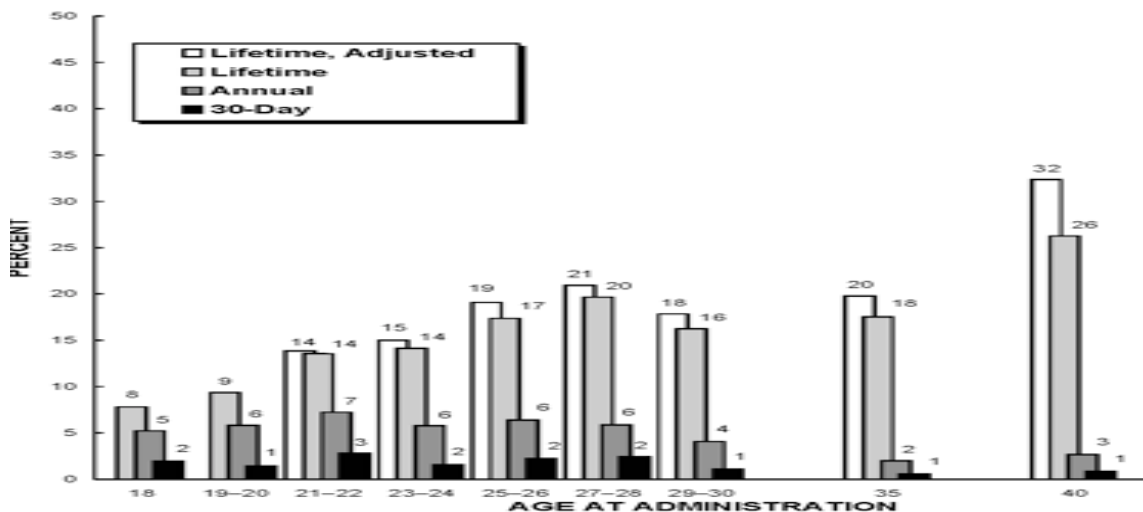


Figure 6. Cocaine. Lifetime, Annual, and 30-Day Prevalence by age groups.

Abuse of licit drugs is far more prevalent than of illicit ones and affects all ages. As stated, among all prevalence criteria, the "30-day prevalence of daily use" best describes the pattern likely to represent drug abuse that might lead to addiction. From available data, alcohol and tobacco abuse is generally defined as drinking 5 drinks of alcohol in a row within the 2-week period preceding the survey, and smoking ½ a pack of cigarettes or more daily, respectively. Using these criteria of abuse reveals that *alcohol* and *tobacco* abuse are a much greater problem than abuse of any *illicit* drugs. Indeed, as shown in table 2 *tobacco* and *alcohol* abuse by young adults far exceeded abuse of any *illicit* drugs in 2005, including Marijuana, the most prevalent, by 2.5- and 7-fold, respectively. Moreover and in contrast to *illicit* drugs, prevalence of *tobacco* (one half pack per day) and *alcohol* abuse (daily in the past 30-days) in 2007 remained age-independent and in fact increased slightly in the older age groups surveyed (figures 7 & 8).

** Daily use for 30 consecutive days

Table 2. Thirty-day prevalence of daily use of various licit and illicit drugs: Ages 19-26.

Licit & Illicit drugs	Percent
Marijuana	4.9
Cocaine	0.1
Amphetamines	0.1
Alcohol	
Daily	4.2
5-drinks in a row in past 2 weeks	37.0
Cigarettes	
Daily	19.6
Half-pack or more daily	12.5
Sample size (n)	5,400

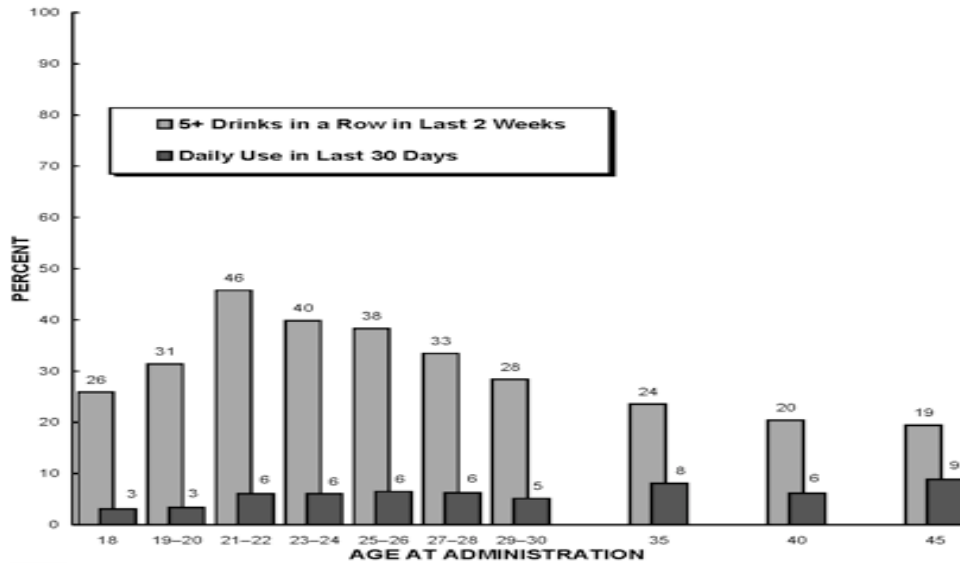


Figure 7. Alcohol use. 20-Week Prevalence of 5 or more drinks in a row and 30-day prevalence of daily use.

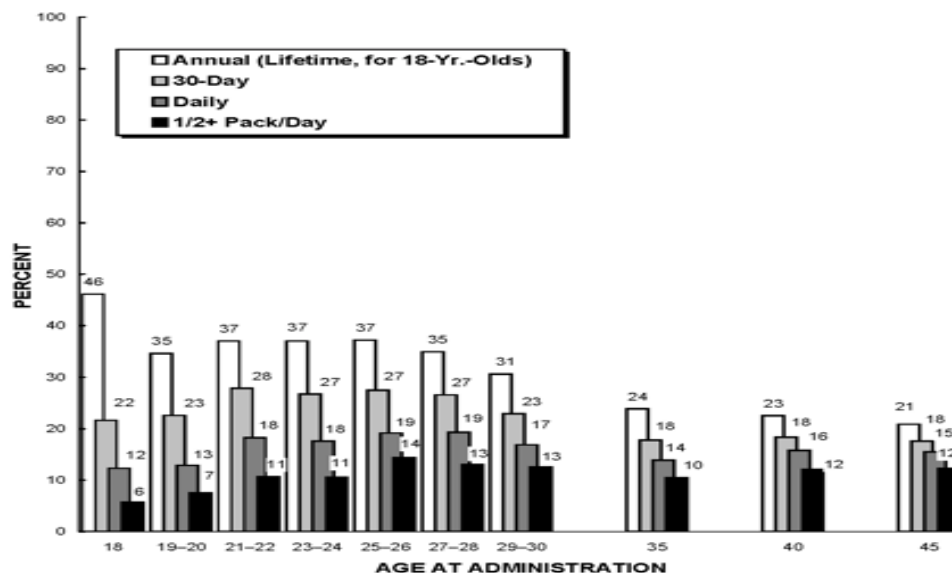


Figure 8. Cigarettes. Annual, 30-day, and half-pack-a-day prevalence rates.

Costs of illicit drug use in the US. Social liabilities (crime, disease, drugs, risks, hazards, or natural events) can be assessed by their economic and human costs. Economic costs include direct (e.g. disease treatment cost) and indirect costs (e.g. lost productivity). Human costs are judged by the *morbidity* (e.g. asthma caused by pollutants) and *mortality* (e.g. death from drug overdose) they cause. Mortality caused by a disease, risk, or natural event is reported in terms of actual deaths per year or per population group, or are calculated to reflect "*years of potential life lost*". Although all such data are mere estimates rather than factual figures, they serve to quantify, rank, and compare their costs to other social liabilities. The best annual cost estimates for all *illicit* drugs combined and for

Table 3. Economic & human costs (US, 1995-2001 data): *illicit* drugs, alcohol, & tobacco

Costs	All Illicit drugs	Alcohol	Tobacco
Human			
Deaths	19,102	75,000	440,000
YPLL*	NA	2.2 ¹	5.6 ¹
Economic	\$97.7 ²	\$148.0 ²	\$157.7 ²

1. Million life-years

2. Billions

alcohol and *tobacco* individually are shown in table 3, which derives from the Office of National Drug Control Policy. As shown, the number of deaths from all drugs (*licit* and *illicit*) in the U.S was 19,102 in 1999²⁷. In contrast, *alcohol-associated mortality* was estimated at over 75,000 annually between 1995 and 1999²⁷ and at over 440,000 for *cigarette smoking* in 2001²⁸. The same reports estimated the concomitant annual *years of potential life lost* at over 2.2 million for *alcohol* and 5.6 million for *cigarette smoking*. Finally, a study prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism estimated "*the total economic cost of alcohol and drug abuse was \$245.7 billion in 1992*"²⁹. Of this, \$97.7 billion was related to drug use and \$148.0 billion

* A statistical measure of premature death

to *alcohol* consumption. The total economic cost for *tobacco* use in the US has been estimated at \$157,7 billion in 1999 or \$3,391 for each of the 46.5 million smokers ²⁸.

In conclusion, humans have sought and used mind-altering substances since the dawn of time. Archeological findings and early recorded history seem to indicate that drug use was driven mainly by curiosity, as is the case today, but no records exist of untoward effects to users or their entourage and their languages had no word for addiction. However, two later societies appear to have suffered greatly from drug abuse: the Muslim world at the turn of the first millennium and the eighteenth century Chinese. To the former, it represented a self-gratification behavior that apparently permeated large segments of the population and contributed to the decline of that prosperous and advanced culture. To the latter, it became a curse fomented by a foreign power eager to enhance its geopolitical agenda of domination and to profit from the process. In modern America, mind-altering drugs are used by nearly 1 in 2 teenagers. It denotes natural curiosity, self-discovery, rebellion against "*grown-up*" rules, the lure of the "*forbidden fruit*", and the omnipresent albeit overrated '*peer-pressure*'; an excuse claim by the inattentive parents of every troubled youngster and the refuge of investigators at a loss to explain the causes of drug abuse. The natural history of drug abuse suggests that following peaks of problem behaviors in adolescence and early adulthood recovery is the norm for most users. Indeed, the high prevalence rates of drug use among teenagers decline progressively with age for all *illicit* drugs, whereas they increase slightly for *alcohol* and *tobacco* the two drugs that, despite exhibiting the highest morbidity and mortality rates and the highest cost to society, are *licit*. As a result, while about 5% of the global population age 15-64 use drugs (cannabis in 80% of cases), about 28% use *tobacco* and approximately 48% consume *alcohol* on a regular basis. As shown in table 3, the economic and human costs of each *alcohol* or *tobacco* in the US far exceed the costs of all *illicit* drugs combined. Moreover, as stated in the Lewin Group's report, even the comparatively low mortality rates attributed to *illicit* drugs included deaths caused by "*drugs, medicaments, and biologicals*". Likewise, the report explained, "*more than half of the estimated costs of drug abuse were associated with drug-related crime*"; an obvious consequence of the criminalization of drugs. In contrast, very little of the economic cost of *alcohol* or *tobacco* are related to crime because possession and use of both these substances are legal. Hence, on the bases of economic and human costs it is difficult to justify a *War on* [illicit] *Drugs* while the use and abuse of *alcohol* and *tobacco*, the two most deadly and costly substances to society, are *licit*. Moreover, *illicit* drugs are not enemies to be vanquished, as in a *War*, but manageable problems to be ranked alongside other societal liabilities aiming at developing appropriate public prevention or interventional policies, and for allocating resources for their implementation.

Chapter 3

THE POLITICS OF DRUG LEGISLATION

1. *A convoluted American political saga.*

A visitor from out of space or an idealistic observer from earth could imagine drug policy to have emerged after a careful review of all available evidence by policy makers, advised by experts in the legal, social, medical, economic, and other relevant realms, aimed at developing a far-reaching program likely to impact millions of lives. Yet, both would be wrong for political reality is far more cynical, as described in some detail in this section and next.

According to published data, the annual per capita opium consumption in the US rose steadily from about 12 grains in 1840 to approximately 52 grains towards the end of the century. Opium was popular as analgesic and hypnotic, to ward off fevers and illnesses, and to sooth teething infants, among many popular uses. Addiction to opium is said to have risen alongside, reaching a peak at the turn of the century estimated at 250,000 addicts in a total population of approximately 76 million; the highest rate ever reached in the US. It is said that there were tens of thousands of heroin addicts in New York City and that cocaine was massively consumed throughout the country in the first two decades of the twentieth century. However, such statistics are inherently unreliable and should be viewed with suspicion as they were driven by motives often disconnected from reality, as is still the case today, as I will demonstrate in this chapter. What is known with certainty is that the nineteenth and early twentieth centuries witnessed the unimpeded availability in America of a myriad of elixirs, tonics, potions, concoctions, liniments and the like containing alcohol and/or opium and all sorts of unknown and undisclosed ingredients. Indeed, the importation of opium in nineteenth and early twentieth century America was unregulated and its consumption unrestricted, and the status of medicine was chaotic. It has been described as follows: *“The United States had no practical control over the health professions, no representative national health organizations to aid the government in drafting regulations, and no controls on the labeling, composition, or advertising of compounds that might contain opiates or cocaine. The United States not only proclaimed a free marketplace; it practiced this philosophy with regard to narcotics in a manner unrestrained at every level of preparation and consumption”*¹. The main reason for this was the American form of government where mostly autonomous States were free to enact or not to enact regulatory drug laws. Because of this autonomy, State drug control initiatives with different goals precluded the emergence of uniform regulatory bodies and of nation-wide health groups suitable to regulate the manufacture, content, and distribution of drugs and other health products. For instance, the American Medical Association and the American Pharmaceutical Association, founded in 1847 and 1851, respectively, remained parochial, unorganized, and unrepresentative until WWI, lacking any authority to license or regulate practitioners. Likewise, American medical schools were unregulated and many were little more than diploma mills. Medical licensing, a State prerogative to this day, began in the late nineteenth century. However, efforts to raise health standards coupled with the Federal government exercise of its right to regulate

interstate commerce led to the Pure Food and Drug Act of 1906 that imposed modest labeling requirements for over-the counter drugs and certain health products.

As the Temperance Movement led to the enactment, on October 28, 1919, of the National Prohibition Act described in chapter 1, drug laws were not far behind, for drug addiction was being targeted in certain circles as a new cause for action. As a prelude to events of half a century later, physicians were finger-pointed and opium prescriptions were regulated though the manufacture of opium-containing "*patent medicines*" remained unimpeded and their sale ubiquitous. However, the road to what would years later become the federally based, led, and funded *War on Drugs* began with the acquisition of the Philippines through the Spanish-American War. Unlike American States that were and remain semi-autonomous, the Philippines came under the direct and sole control of the US Federal government. This was an opportunity for Congress to exercise its power and for its members to respond to public pressure and to the interests of influential constituents. At the time, Spanish authorities held a monopoly on the sale and distribution of opium in the Philippines, presumably destined to Chinese living in that country. William Taft, the newly appointed American Civil Governor of the Philippines continued the monopoly and earmarked profits of the opium trade to educate Filipinos. When American missionaries in the Philippines and religious organizations in the US learned of the project, they were outraged that "*tainted money*" from opium sales would be channeled to education and prevailed on President Theodore Roosevelt to order Governor Taft to kill the bill. The latter appointed The Philippine Opium Investigation Committee to explore how the "*opium problem*" was dealt with in Asian countries, and to make recommendations. Departing from the Committee's recommendations, the US Congress decreed to register adult non-Filipinos opium smokers allowing them a three-year opium supply that would be reduced gradually to zero over the final 6 months of the grace period. Non-medicinal opium was banned for all other inhabitants of the Philippines.

As mentioned earlier, at the end of the 19th century China had tried to free itself from British-imposed opium trade and was making vigorous efforts to address its opium addiction problem. In the meantime, Chinese laborers hired to build the Western States railroads were being mistreated and unhappy Chinese government, industrialists, and merchants were planning retaliatory measures. In order to placate the Chinese government and in attempts to reduce the flow of opium to the Philippines but not necessarily to the US, President Roosevelt convened in Shanghai the International Opium Commission, which led to the First International Opium Convention signed in The Hague, on January 23, 1912. It directed the "*Contracting Powers*" to "*bring about the gradual suppression of the abuse of opium, morphine, and cocaine as also of the drugs prepared or derived from these substances, which give rise or might give rise to similar abuses*"². The Convention was convened by the elected Presidents of the US, France, and Portugal, and the "*Majesties*" or "*Imperial Majesties*" of nine Kingdoms or Empires, ranging from "*His Majesty King of Italy*" to the pompous "*His Majesty the King of the United Kingdom of Great Britain and Ireland and of the British Dominions Beyond the Seas, Emperor of India*". In the meantime, the US government had passed the 1909 anti-opium law designed to placate China's outrage for the mistreatment of Chinese workers in the US. Dr. Hamilton Wright, newly appointed opium commissioner, proposed a Federal law to curtail the dispensation of narcotics to addicts using the government's power of taxation as a pretext to circumvent the States' autonomy on drug regulation. Republican Congressman David Foster of Vermont introduced, in April 1910, a bill to

that effect that included cocaine, cannabis, and chloral hydrate* in addition to opium. However, its passage had to await the Democratic majority of the Sixty-second Congress when it became the law of the land as the "*Harrison Act*", after Congressman Francis Burton Harrison of New York.

The Harrison Act was less draconian than the Foster bill for it accommodated both, demands from southern Congressmen eager to preserve racial segregation laws, and the lobbying pressure of the recently formed National Drug Trade Conference that represented drug trade associations. As a result, cannabis and chloral hydrate were dropped, penalties were reduced, record keeping was relaxed, and "*patent medicines*" containing small amounts of narcotics were allowed. It provided "*for the registration of, with collectors of internal revenue, and to impose a special tax on all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives, or preparations, and for other purposes*". The US Senate passed the Harrison bill in August 1914 and President Wilson signed it into law in December of that year. In 1902, the AMA** had labeled as "*highly addictive*" the new drug heroin (from the German *heroisch* - heroic) developed in 1898 by the German company AG Bayer that it marketed as a "*non-addictive painkiller*". Prior to enactment of the Harrison Act, heroin was being prescribed to treat morphine addiction. However, it became the recreational drug of choice in New York and other major cities, and was blamed for an increasing incidence in violence and crime. More ominously, it was rumored that heroin, mixed with cosmetics, was being smuggled from Germany in attempts to addict the entire American population. These were powerful arguments for prohibitionists and isolationists who rallied around Stephen G. Porter, the then Republican chairman of the House Committee on Foreign Relations, to stop all heroin production in the United States beginning in 1924. However, while the US government banned drugs at home, it was unable to convince the international community to do likewise at the Geneva's revised International Opium Convention of 1925, which dealt with cocaine as well as opium and was later monitored by the League of Nations' Permanent Opium Central Board. In fact, in a display of undiplomatic obstinacy over other nations' refusal to curb poppy and coca production the American delegation walked out of the conference. In addition to losing to the League of Nations its leading position in the global anti-drug movement it had gained in Shanghai and The Hague, the US was unable to join the League due to Senate opposition led by Henry Cabot Lodge of Massachusetts and other influential Republican Senators.

In addition to criminalizing opium and cocaine, the Harrison Act and set in motion a witch hunt that targeted physicians and pharmacists, especially those willing to prescribe maintenance narcotics to addicts; a practice the US Supreme Court ruled constitutional in 1916³. The net result was that fewer of them were willing to risk their livelihood and to face prison for prescribing or dispensing narcotics. Addicts, no longer freely maintained by prescription narcotics, turned to crime in order to support their habit, or so it was claimed. In response to this narcotics prescription vacuum and a perceived need for registering and assisting addicts rid themselves of their habit, several States and cities sponsored *narcotics clinics*. Today's methadone maintenance clinics are but a rebirth of this approach to the treatment of drug addiction. However, some clinics became indiscriminate narcotics distribution centers, selling heroin and morphine

* A hypnotic agent

** American Medical Association

to all comers. More ominously, the US Supreme Court reversed itself, on March 1919, in a five to four ruling that a narcotics prescription intended to supply maintenance doses to a "*mere*" addict could not be considered a true prescription given in the proper conduct of medical practice. Armed with these two powerful arguments, the Treasury Department proceeded to close down *narcotics clinics* and to arrest narcotics-prescribing physicians and narcotics-dispensing druggists unless pre-approved by a narcotics agent. As mentioned earlier, over 25,000 professionals were arrested and more than 3,000 were imprisoned. Whether as a result of the implementation of the *Harrison Act* or as a reflection of fluctuations in social mores, the number of addicts in the US is said to have dropped dramatically, though from an unrealistic and unsubstantiated high of one million cases "*estimated*" by a US Treasury Department committee in 1918.

In the interim, another "*war*" loomed on the horizon and, this time, the target was "*marijuana*". As animosity towards Chinese laborers had galvanized public opinion against opium at the turn of the century, anti-Mexican prejudice of the early 1930s provided impetus that led to the *Marijuana Tax Act of 1937*. Mexicans had come to the US during the prosperous years of the 1920s to work as laborers in the fields of Southwestern and Western States. Many Mexicans grew and smoked marijuana; a benign custom initially tolerated, as it caused no ill effects in their adopted communities. However, as the Great Depression took its toll on the US job market Mexicans were finger-pointed as taking American jobs and engaging in drugs, violence, and crime. That was the classical and recurrent justification put forth by those who intuitively or on moral or religious grounds distrust minorities, especially if they exhibit physical, cultural, or behavioral traits that set "*them*" apart from "*us*", the majority. The fact that they smoked marijuana was used as a confirmation of their deviant nature and of their danger to others. At first, the Federal Bureau of Narcotics and its head, Harry J. Anslinger, former Commissioner of the US Bureau of Narcotics during *Prohibition*, were hesitant to get involved in banning a drug grown domestically as compared to opium and cocaine that were "*evil imports*". However, realizing he could expand the reach of his office and his personal power and driven by his racist zeal, Anslinger soon reversed course becoming the most outspoken and tireless, if deceitful, anti-drug campaigner. In speeches and articles, he described how "*Orientals*" used drugs to entice "*women from good families*" into brothels and how marijuana addiction was responsible for "*over 50% of violent crimes among 'Mexicans, Turks, Filipinos, Greeks, Spaniards, Latino-Americans, and Negroes'*" and had brought about "*an epidemic of crimes committed by young people*"⁴. While his racially inflammatory anti-drug rhetoric found no boundaries, he was providing morphine to the infamous senator Joseph McCarthy "*so that communists could not blackmail this great American senator for his drug dependency weakness*"⁵.

A fortuitous event took place that provided the US Bureau of Narcotics an opportunity to take action: the *Firearms Act* of 1934 that made it illegal to transfer a machine gun without the payment of a transfer tax. As soon as the US Supreme Court upheld the *Firearms Act* the Treasury Department requested and obtained from Congress a marijuana tax law, which became known as the *Marijuana Tax Act* of 1937. Under the Act, marijuana could not be sold, bartered, or given away without the proper Federal stamp. However, funds to implement the *Marijuana Tax Act* were not granted, and it remained an irrelevant piece of legislation until the 1960s when it became "*a law enforcement weapon directed against America's youth, the foreign-born, and non-conforming minorities*"⁵. Within the atmosphere of anti-drug paranoia of the 1930s and 1940s, there was an occasional voice of sanity. Suspicious of the US government claims on drugs, Fiorello La Guardia, mayor of New York City from 1934 to 1945, appointed a

special committee to conduct a thorough sociological and scientific investigation into the effects of marijuana use in New York City. After 6 years of research, the commission concluded that marihuana use created in the user a feeling of adequacy, relaxation, verbal disinhibition, self-confidence, sometimes anxiety, was not widespread among school children, was not associated with juvenile delinquency or major crimes, did not lead to hard drug use, and was more prevalent among Individuals of limited social adaptive capacity ⁶. Their findings echoed those of the British Indian Hemp Drug Commission of 1894 and of the Panama Canal Zone Report of 1925. Significantly, its findings were to be validated by four subsequent American and foreign studies on Marijuana (the *Advisory Committee on Drug Dependence and Cannabis* of 1968, the *Canadian LeDain Commission Report* of 1970, the *National Commission on Marijuana and Drug Abuse* of 1973, and the *National Academy of Science Report: Marijuana and Health* of 1982). The La Guardia report was strongly opposed by the Narcotics Bureau and by Anslinger who, true to form, attacked the integrity of the scientists involved in the study. Undeterred by his lack of medical, biological, or psychiatric training, he prepared his own unfounded version of "*The Psychiatric Effects of Marijuana Intoxication*", which inexplicably and inexcusably was published by the Journal of the American Medical Association ⁷. Disregard for the facts was Anslinger's trademark during his 32 years at the helm of the US Bureau of Narcotics as is further documented in an interesting book on the politics of America's *War on Drugs* ⁸. The book describes, "*During World War II, Anslinger waged a press campaign to convince the American public that Japan was systematically attempting to addict its enemies, including the American people, to opium, in order to destroy their civilization. Although there was no other evidence of the putative 'Japanese Opium Offensive', Coast Guard ships and Internal Revenue Service investigative units were directed to work with Anslinger's bureau. In 1950, during the Korean War, Anslinger again used the Hobsonian theme [from Richard Hobson's book: Drug Addiction-A Malignant Racial Cancer], leaking a report to the press that 'subversion through drug addiction is an established aim of Communist China', and that the Chinese were smuggling massive amounts of heroin into the United States to weaken American resistance*". Such misrepresentation of the facts, widely adopted and kept alive by drug enforcement agencies and drug prohibitionists of the time, continues to this day.

Anslinger's disregard for the facts and his targeting drugs as a springboard to promote his own political agenda would have a legion of intellectual successors over the years, most notoriously Governor Nelson A. Rockefeller, President Richard M. Nixon, his creation the DEA, and the CIA*, to name the most influential. "*Big Bill*" Rockefeller's great grandson, Nelson A. Rockefeller became a master manipulator of the media as the coordinator of inter-American affairs for President Franklin Delano Roosevelt, backed by a \$150-million budget to run a propaganda agency in Latin America. His approach was to distribute daily articles, editorials, and photographs of anecdotic or dramatic stories with titillating titles with the appearance of "*news*" to journalists not inclined to check the sources, motives, or politics behind the stories. While Rockefeller's mission ostensibly was to promote a positive image of America in that part of the world, his experience in manipulating the South American media proved invaluable in his subsequent political career at home. After delegates at the 1964 Republican convention rejected him, Rockefeller realized he needed to appeal to hard-line, law-and-order republicans and to ordinary citizens concerned about their family and property "*threatened by addicts*", according to polls he commissioned. Drawing on his South America experience, he

* Central Intelligence Agency

launched a media blitz proposing the most draconian anti-drug policies in America in order to win the Governorship of New York, which upon his election became known as the "*Rockefeller Drug Laws*" that took effect in May 1973. Rockefeller had boldly claimed that heroin was like an infectious disease that would spread to unsuspecting victims and declared that the "*epidemic of addiction*" in New York State had reached plague proportions that threatened the lives of innocent children. He played loose with statistics and with the size of the addict population and their cost to New York State taxpayers, according to the needs of the moment. He portrayed his anti-drug campaign as a "*treatment and rehabilitation program for addicts*", to appease his liberal supporters, while pushing for "*an all-out war on drugs and addiction*" to satisfy his right-wing patrons.

The Rockefeller Drug Laws established mandatory prison sentences for possession and sale of controlled substances based on the weight of the drug involved. The statutes mandated that anyone convicted of selling two ounces or more of heroin, morphine, or marijuana, or of possessing four ounces or more of these drugs, receive a minimum of 15 years to a maximum of life. As a result, the State's prison population and the costs involved escalated year after year. Yet, the Rockefeller Drug Laws failed to reduce the number of addicts and drug-related crime despite incarcerating thousands of drug offenders, imposing mandatory sentences that are longer than for rapists and murderers, choking prisons and the judicial system, incurring incarceration costs exceeding in-patient or outpatient addiction treatment costs (approximately \$30,000 vs. \$20,000, vs. \$5,000 annually, respectively). In 1977, the Committee on New York Drug Law Evaluations issued a highly critical report ⁹ on the Rockefeller Drug Laws. The Committee found that heroin use and heroin-related crime, the main issues that inspired the Rockefeller Drug Laws, were as prevalent in 1976 as they had been prior to enactment of the laws. It described the experiment as a "*dismal failure*" despite its high cost and the appointment of scores of additional judges to handle thousands of cases prosecuted under the new laws. It can be objectively concluded that, as all prior and subsequent prohibition statutes, the Rockefeller Drug Laws did not serve the interests of justice nor did they reduce drug abuse or drug-related crime in New York State.

Throughout the 1960's, Marijuana use was widespread on college campuses and among liberal circles as an expression of dissent and as a symbol of rebellion against the Vietnam War and the "*establishment*". During the Johnson and Kennedy administrations, public attitudes on drug control shifted from supporting punishment to one of "*laissez faire*", a view ignored by the Law Enforcement community. Indeed, while there were only 169 Marijuana felony convictions in 1960, Marijuana arrests rose to 188,000 in 1970 ⁵. During that decade, treatment of addicts was authorized by the "*Narcotic Addict Rehabilitation Act of 1966*", which provided voluntary, pretrial civil commitment, as well as forced treatment of convicted addicts. In 1968, the "*Alcoholic and Narcotic Addict Rehabilitation Amendments*" authorized funding of rehabilitation and treatment services by States and private organizations. Congress later enacted the "*Comprehensive Drug Abuse Prevention and Control Act of 1970*" that consolidated all previous Federal drug laws, acts, and statutes, including the Harrison Act, in order to regulate legitimate drug use and curtail importation and distribution of illicit drugs throughout the United States. Because it stratified mind-altering drugs into 5 "*classes*" according to their "*accepted medical use*" and "*substantial potential for abuse*", it has become known as the "*Controlled Substances Act*". It also included a relatively benign provision that lowered the maximum penalty for possession of an ounce of marijuana to one year in jail and a \$5,000 fine, with the option of probation or a conditional discharge at the judge's discretion. After President Nixon signed the Act in October 1971, it soon

became obvious that he planned an overall assault on the production, selling, and use of all illicit drugs. Under Nixon, drugs were catapulted to national prominence and drug policy became the political centerpiece of his administration.

From a very humble background, Nixon attended Duke University Law School on a scholarship and graduated among the top of his class. However, when his attempts to join prestigious New York law firms were dashed apparently for lack of connections he returned to Whittier, CA, his hometown. He espoused the fear of the time, *"the menace of international communism"*, and ran as the Republican nominee for the congressional seat held by Jerry Voorhis, a liberal Democrat, which he won in 1946. His adept exploitation of the national fear of Communism won him reelection to the US Congress (1948), a seat in the US Senate (1950), and the US vice-presidency (1952). After losing his bids first for the US Presidency to John F. Kennedy and then for the California Governorship to Pat Brown, Nixon's political career seemed to be over. However, he resurfaced in 1968 as the Republican nominee for the Presidency of the US, this time on a platform of *"Law and Order"*, inspired by the widely publicized success of Robert F. Kennedy, the Attorney General for the Kennedy Administration. However, once in office (1969 to 1974), the lack of jurisdiction and the powerlessness of Federal institutions to effectively curtail street crime became apparent to the Nixon administration. In fact, national statistics for crime, arrests, prosecutions, and convictions rose nationwide during 1969 and 1970, a fact that was not lost to a critical press. Hence, a new approach was needed for Nixon to fulfill his tough *"Law and Order"* campaign rhetoric. Some of his campaign trail slogans had included, *"In New York City more people between the ages of fifteen and thirty-five years die as a result of narcotics than from any other single cause"*¹⁰ and *"Doubling the conviction rate in this country would do more to cure crime in America than quadrupling fund for Humphrey's war on poverty"*⁵. Additionally, there was a perceived need to divert popular attention from the highly unpopular Vietnam War and to steer attention to domestic issues with popular appeal, and drugs seemed the obvious choice especially because of the high incidence of addicts among soldiers servicing in Vietnam. Besides, Governor Rockefeller was scoring major political points by waging a highly publicized war on the *"drug menace"* and on addicts few cared about.

Once again, the Hobsonian thesis that addicts cause most street crime, up to 75% according to one claim, provided the political cover and an easy way for reducing crime statistics, or so they thought. At first, the *Domestic Council*, a White House group created and used by John Ehrlichman to further his own political ambitions advocated to shift *"the burden for responsibility in controlling crime to the state and local governments, which have jurisdiction over local law enforcement"*. However, this obvious abdication of Nixon's campaign pledges was rejected by the White House, which opted for a triple anti-drug strategy instead. The strategy called for the Bureau of Narcotics to crack down on drug dealers and peddlers, the Department of Health, Education and Welfare to expand treatment programs for addicts, and the State Department to coax producer countries to curtail the production of drugs entering the US. In his Special Message to the Congress on Drug Abuse Prevention and Control, June 17, 1971, Nixon stated *"America does not grow opium-of which heroin is a derivative-nor does it manufacture heroin, which is a laboratory process carried out abroad. This deadly poison... is, in other words, a foreign import... No serious attack on our national drug problem can ignore the international implications of such an effort, nor can the domestic effort succeed without attacking the problem on an international plane. I intend to do that...It is clear that the only really effective way to end heroin production*

*is to end opium production and the growing of poppies”*¹⁰. In what would become a highly controversial international drug cultivation eradication program endorsed by each subsequent administration, he added, *“I am asking the Congress to provide \$2 million to the Department of Agriculture for research and development of herbicides which can be used to destroy growths of narcotics-producing plants without adverse ecological effects.”* Time Magazine reported, *“The Administration’s strategy has been to try to pinch off the drug routes before they reach New York, Miami or the Mexican border, the main U.S. entry points. The effort involves long, Le Carré-style work by dozens of globe-ranging narcotics agents, as well as diplomatic pressure on 57 countries that are concerned with the trade in one way or another. But the effort has been frustrating”*¹¹.

According to plan, Mexico was identified as the first target of *“Operation Intercept”*, as it presumably produced 85% of the heroin entering the US, and most of the marijuana, the claimed *“stepping stone”* to heroin addiction. That fictitious claim is now called a *“gateway drug”* by the drug enforcement establishment and prohibitionists for lack of objective evidence that marijuana is harmful to users or fosters crime. Soon, 2,000 customs and border-patrol agents were deployed along the Mexican border for what was touted as *“the country’s largest peacetime search and seizure operation by civil authorities”*. At first, the White House was pleased with the enormous media attention devoted to Nixon’s efforts to curtail drug availability at the border. However, because virtually no narcotics were intercepted over a 3-week period, *Operation Intercept’s* main purpose was now claimed to be to *“put pressure on Mexico and make its government more cooperative”*. Additionally, delays in border crossing by tourists and laborers alarmed both the Mexican government and the State Department concerned of international repercussions that might compromise its Latin American policies. This and increasingly critical press reports led to the quiet withdraw of *Operation Intercept*.

Now, another country susceptible to US bullying had to be found. CIA information indicated that most of the opium was grown in India, Afghanistan, Pakistan, Thailand, Laos, Burma, and Iran, with Turkey producing less than 10% of the total. India’s government, unfriendly to the US, would likely retaliate diplomatically and in the press to US pressure; The Shah of Iran, a close US ally, was not to be confronted; Afghanistan, Pakistan, Thailand, Laos, and Burma had central governments incapable of controlling poppy growing clans. That left Turkey by default; A NATO member and recipient of US aid and, it was claimed, the source of most of the heroin reaching Europe. When Ambassador William Handley demanded Turkish officials to drastically reduce the size of the poppy planted area, he was informed that tight distribution controls imposed by the Turkish government precluded much opium finding its way to illegal markets and that farmers from the plains of Afyon, where poppy had been planted for a millennium, depended from it for their livelihood. Indeed, poppy seeds provided cooking oil, protein-rich poppy husks were a source of livestock feed, leaves were used in salads, poppy stems furnished heating fuel, and the gummy juice of the unripened capsule served as painkiller. Turkish Prime Minister Süleyman Demirelviewed thought the demand to be evidence of American imperialism and of hypocritical double standard, for no action was demanded from other opium producing countries. Additionally, he feared his government might be toppled by a surge of popular protests should he complied with US demands. At most, Turkey would redouble its surveillance of poppy production and of its borders. However, Eugene Rossides a Greek-Cypriot American notoriously unsympathetic to Turkey who was in charge of all law-enforcement activities at the Treasury Department,

* North Atlantic Treaty Organization

pressured, with White House acquiescence, the recently created *Ad Hoc Cabinet Committee on Narcotics* to mount an all-out "crusade" against Turkey. The US Congress and the press were told that Turkey was responsible for 80% of all heroin reaching the US, a figure pulled out of thin air. Ambassador Handley, under considerable pressure from G. Gordon Liddy and other White House operatives to get quick results, was relieved when the democratically elected Turkish government was overthrown by the US-friendly military. An agreement was quickly reached: The Turks would suspend poppy cultivation after the harvest but ahead of the American presidential election in exchange for a \$100 million subsidy over a three year period offered by the US government to compensate Turkish farmers, which Eugene Rossides managed to reduce to \$30 million. The agreement was hailed in the American press as a major victory of President Nixon's crusade against drugs and crime, though its impact on worldwide opium production and on the amount of heroin on American streets was marginal at best. In the end, the ban was short lived and, in 1974, the Turkish government informed the UN it would license poppy cultivation for medical purposes; a program similar to one implemented in India two decades earlier. The UN approved and gave assistance to build a poppy processing plant and to control the program. In 1981, the US extended "*Special protected market status*" to Turkey and India that, to this day, obligates it to purchase at least 80% of narcotic raw materials produced by these two countries.

In the meantime, American intelligence had estimated that most of the heroin reaching the US came through Marseilles, France, where small labs converted Turkish morphine base into heroin. Hence, when President Nixon appointed former IBM executive Arthur Watson as Ambassador to France he urged him to "*clean up the heroin problem in France*". Upon arriving in Paris, Watson discovered that the French drug enforcement task force was small and nonchalant about heroin, which they considered an American rather than a French problem. He immediately began working to change that perception by planting stories in newspapers and television, as Rockefeller had successfully done in Latin America years earlier, about addiction in the streets and bars of Paris. While his campaign raised drug awareness of the French public, it had little impact on the US State Department that continued to press for concrete evidence of success including the seizure of clandestine drug laboratories that, in fact, were little more than a few hard to find converted kitchens. The US Embassy science attaché, Dr. Edgar Piret conceived the idea of "*sniffing out*" the fumes of acetic anhydrides, a chemical used in manufacturing heroin. Varian Associates, a California company that had developed a technique to chemically detect the presence of drugs in the urine of soldiers stationed in Vietnam, was given the contract for the "*heroin sniffer*", apparently underwritten by the CIA. Soon, a Volkswagen camper with a conspicuous "*sniffing*" snorkel mounted on its roof, rolled into Marseilles with an American agent inside charting the beeps signaling the location of drug labs, or so they thought. As it turned out, because acetic acid fumes from vinegar were indistinguishable from acetic anhydride's, the team had pinpointed the location of all the salad-serving restaurants, bistros, and kitchens in Marseilles but detected no drug labs.

Dr. Piret, sent back to the drawing board, came up with another approach perhaps after reading of Jean Valjean's escape through the sewers of Paris in Victor Hugo's *Les Misérables*. The idea was to test the effluent sewage emanating from drug labs for traces of drug processing chemicals. However, the multitude of sewer lines to be tested and the undesirable working conditions quickly led to another failure. Giving up on Dr. Piret's schemes, Ambassador Watson eventually prevailed on the French drug task

force to raid and seize a few drug labs, which was hailed by Washington, by a few touring Congressmen, and by the American media as a major break-through. The "*French connection*" also involved Auguste Ricord, a Corsican "*mafioso*" embroiled in the controversial theory about the assassination of President Kennedy¹². Accused in France of Nazi collaboration, Ricord had fled to Argentina settling in Uruguay where he engaged in prostitution and drug trafficking. Obsessed with Ricord, he presumed the kingpin of the "*French connection*", President Nixon eventually prevailed on General Alfredo Stroessner, Uruguay's dictator, to arrest and extradite Ricord to the US to serve a 20-year sentence for heroin smuggling¹³.

How was the Nixon White House able to convince the entire nation and Congress of the imminent dangers of drugs? Having run a campaign platform of "*Law and Order*", Nixon chose "*The drug menace*" as his target upon becoming President. He depicted addicts as medieval vampires, each of whom could "*infect*" at least 6 unsuspecting innocent victims including children, and exploited the public's fears to marshal support for his anti-drug policies. As part of his strategy to bolster his claim that the nation faced a "*national emergency*", his Administration disseminated alarming statistics suggesting that drugs threatened every American family. For instance, his 1971 request to Congress for emergency powers to deal with what he described as an "*uncontrollable heroin epidemic*" was accompanied by official statistics indicating that the number of heroin users had increased from 68,000 in 1969 to 315,000 in 1970 and 559,000 in 1971. Thus, at the stroke of a pen, the Bureau of Narcotics and Dangerous Drugs had managed to increase the number of drug users on American streets by 8-fold over a three-year period; a feat the most enterprising drug traffickers could only dream of. The method used to generate such statistics was ingenious, albeit deceitful. It was based on the "*tagged-fish-in-a-pond*" technique used to estimate the fish population in a pond. Briefly, fish caught are tagged and released back into the pond. The ratio of tagged-to-untagged fish caught subsequently is then used to estimate the total fish population before tagging. For example, if 1 in 100 fish caught the second time is tagged, the total fish population is estimated to be 100-fold the number of tagged fish released initially. That approach might be reasonable to estimate the fish populating a pond over a relatively short period, providing no intervening event occurred to disturb the tagged-to-untagged fish ratio. However, the technique is unsuitable for estimating the total number of drug users among the general population. First, users apprehended by police are not randomly distributed over the "*drug pond*". Second, previously apprehended users might be more or less susceptible to re-arrest. Third, street conditions vary from day to day depending on drug availability and demand, and from year to year according to changing enforcing procedures.

Interestingly, Nixon's claimed deteriorating drug use statistics between 1969 and 1971, if true, would have been an indictment of his own anti-drug policies and a failure to deliver on his campaign pledges, a thought not lost to John Ehrlichman and H. R. Haldeman, his closest advisors. They became concerned that increasing numbers of addicts would hurt Nixon's reelection and ordered all such figures be cleared by White House staff prior to their release to the press. Not surprisingly, subsequent "*tagged-fish-in-a-pond*" statistics revealed that after reaching a peak of 559,000 in 1971 the number of heroin addicts unexpectedly and precipitously dropped to 150,000; a clear vindication of Nixon's anti-drug crusade and a policy victory quickly trumpeted by his administration. Based on its "*tagged-fish-in-a-pond*" statistics, the Nixon administration put a price tag of US \$18 billion (\$88.5 billion in today's currency¹⁴) as the annual cost of drug-related street crime in America. The mathematical contortions necessary to arrive at such a

staggering figure are interesting to dissect. It was first decided that each heroin addict spent \$16,750 annually (\$83.400 in today's currency), most of which raised from 2 to 3 thefts (shoplifting, mugging, burglary, armed robbery, and so on) per addict per day. These stunning figures were welcome and obligingly reported by a mass media always bent on unconfirmed hyperbole. Scholarly work did not escape that trend. For instance, in the introduction to his 1972 book titled *"The Politics of Heroin in Southeast Asia"*¹⁵, the author alarmingly warned *"AMERICA* is in the grip of a devastating heroin epidemic which leaves no city or suburb untouched, and which also runs rampant through every American military installation both here and abroad. And the plague is spreading into factories and offices (among the middle-aged, middle-class workers as well as the young), into high schools and now grammar schools"*. A quarter of a century later, in the introduction of his 1998 book titled *"The Truth About Drugs"* the author cautioned, *"Addiction is a significant threat to civilization. There has never been a time in human history when so many lives have depended on finding the next dose in time"*¹⁶. However, a cursory analysis of Nixon's drug costs statistics proves them disingenuous at best or dishonest at worst. First, nowhere is the \$16,750 annual cost of heroin to be found from credible sources, except in Nixon's costs estimates included in his June 17, 1971 address to Congress. In it he further claimed, *"The cost of supplying a narcotic habit can run from \$30 a day to \$100 a day. This is \$210 to \$700 a week, or \$10,000 a year to over \$36,000 a year"*¹⁰. Second, 2 to 3 thefts per addict per day would result in over 1 million drug-related crimes each day; a figure that exceeded by at least 100-fold all US crimes reported to police in 1971-1972, as did the \$18 billion total annual cost of heroin. It is also interesting to note that no one within or outside the Nixon administration was too concerned about matching numbers being cited. Indeed, at \$16,750 apiece, 559,000 heroin users, the highest figure claimed by the Nixon administration would have cost the nation \$9.4 billion, not \$18 billion.

While these figures were being trumpeted by the Nixon's administration to bolsters its claim of imminent national danger, an interagency committee on narcotics and drug abuse contradicted them. It reported that no reliable figures on the number of US addicts or the cost of drug abuse or drug-related crime could be gathered and, *"If the misuse of drugs is viewed with proper perspective, it is not in actuality a paramount national problem.... However, because of the political significance of the 'Problem', visible, hard-hitting programs must be highlighted to preclude irrational criticism"*⁸. Emil "Bud" Krogh Jr., President Nixon's deputy for law enforcement before he was imprisoned for his role in the *"Plumbers' operations"*, was unhappy with the contradicting report. Hence, he ordered the Office of Science and Technology to analyze all available data on narcotics addiction and crime in the US. The task was assigned to the IDA^{**}. Professional IDA staff, used to the scientific method, first tested the widely spread belief that in order to support their habit addicts commit several thefts each day, which in turn accounted for most crimes in America. As luck would have it, a strike of shipyard workers that interrupted the heroin supply to eastern cities in the summer of 1972 provided the testing ground and an opportunity to assess the validity of the addict-crime link assumption. The strike dried out the heroin supply and quintupled the price of the little that remained. Under these circumstances addicts were expected to either increase their criminal activity in order to afford the higher cost of drugs or to rely on methadone-treatment programs in order to avoid the effects of withdrawal. Yet, crime rates did not

* Upper case in the original

** Institute for Defense Analysis

increase nor did enrollment in heroin-treatment programs suggesting that addicts were able to switch from heroin to other available and less expensive drugs or to simply abstain until heroin became more affordable. IDA analysts concluded, *“The little evidence available suggests that during a time of severe heroin shortage, addicts may not be willing or able to increase their crime commensurately with the price increase, and therefore they compensate by reducing their heroin consumption and/or substituting other drugs. Also the data do not suggest that entering treatment is the preferred option”*⁸.

In that same year, all Washington prison inmates were being routinely tested for opiate, amphetamine, and barbiturate use, providing IDA analysts the opportunity to test the validity of the assumption that addiction is drug-specific. Test results showed that the 20% pre-strike heroin use prevalence dropped close to 0% during the strike as amphetamine and barbiturate use levels rose from the single digits to nearly 20%⁸. Similarly, a study assessing the relationship between drug use and crime conducted by the Center for Criminal Justice at Harvard University on addicts enrolled in methadone-treatment programs demonstrated that while drug offenses decreased, robbery, assaults, and property theft actually increased while on methadone. Finally, one of the earliest and most thorough studies on drug use was conducted in 1971 on thousands of US servicemen stationed in Vietnam¹⁷. Using questionnaire responses and concomitant urine tests the investigators built an objective and reliable database for analysis. Additionally, a three-year follow up of 94% of the studied population enabled them to assess the subjects' drug use status once out of Vietnam and back into civil society. The study revealed that drug use was rampant in Vietnam-stationed servicemen: 90% drank alcohol, nearly 80% smoked marijuana, 38% and 34% used opium and heroin, respectively, and over 25% each used amphetamines or barbiturates. The study also found that *“the orderly sequence of substance use described as a Guttman scale, in which no one progresses to an illicit drug without having used the legal drugs, alcohol and tobacco, and no one progresses to a 'hard' illicit drug without having used a 'softer' illicit drug, had been turned topsy-turvy in Vietnam”*. Instead, a history of deviant behavior pre-service (e.g. fighting; truanting, drunkenness, arrest, and school expulsion) increased the risk of narcotics use before, during, and after Vietnam and accounted for adverse outcomes (e.g. crime, violence, unemployment, etc) commonly attributed to drug use. The follow up data showed that post-discharge, *“only 12% of those addicted in Vietnam had been addicted at any time in the 3 years since return, and for those re-addicted, the addiction had usually been very brief”*. Drug-addicted and drug-indulging US soldiers serving in Vietnam became drug-free as a result of a strict DoD ban on drugs, enforced by compelled urine testing and the threat of more disciplinary action for recidivists including an extension of their Vietnam tour of duty, rather than through treatment. Indeed, according to the report *“only a third of the men addicted in Vietnam received even simple detoxification while in service, and only a tiny percentage of Vietnam enlisted men went into drug abuse treatment after return”*.

Hence, four pivotal conclusions can be drawn from these various studies that dispel key myths underlying many of today's notions about drug use and invalidate misguided policies designed to curb it. First, the *“stepping stone”* theory of drug use and the stratifying drugs from *“soft”* to *“hard”*, while ingrained in popular folklore, has no basis in reality and has proven unfounded in large-scale studies. For instance, soldiers serving in Vietnam viewed marijuana as more of a problem than narcotics¹⁷ but were able to abandon either with the same apparent ease. Second, addiction to heroin did not compel addicts to increase their criminal activity in order to maintain their suddenly more

expensive habit. Conversely, supplying methadone to heroin addicts did not reduce their criminal penchant, except for drug offenses, suggesting that their drug addiction and criminal behavior are not causally related; a prior deviant behavior is, as concluded the Vietnam study. Third, the Vietnam study convincingly refuted the notion that an addict is doomed for life, as popularized by the slogan *"once and addict always an addict"* and by the notion that drugs *"change the average person into a slavish addict whose entire existence revolves around his daily dosage"* ¹⁵. Indeed, tens of thousands of US servicemen in Vietnam facing stern penalties for continuing to use illicit drugs were able to give them up by themselves most often without treatment and without relapsing. Fourth, heroin addicts are not inexorably dependent on heroin, as it is alleged. In fact, in the summer of 1972 incarcerated heroin addicts switched to other illicit drugs in order to ensure continuing pleasure. Conversely, many addicts succeed in freeing themselves from drugs by devoting themselves to a *"normal"* activity. For example, a study of 101 addicts recovered on their own after an average of 6 years of addiction and a 7-year average period of abstinence prior to study ¹⁸ showed that recovery was neither a spontaneous occurrence nor the outcome of a firm underlying resolve to abandon drugs, but a process triggered by a variety of motivations. Motivations ranged from the mundane, such as leaving a drug-using partner, to dramatic life crises when addicts face the uselessness of their own drug-driven lives. A common first step is a break with drugs and the drug scene and filling the void with a substitute endeavor, such as religion, family, work, and the like. For the most drug-dependent and socially cutoff addicts, the substitution was crucial for it became their *"life-line"*, though alcohol, marijuana, or tranquilizers were often used as a crutch to deal with interim craving. In contrast, addicts less immersed in drugs and those with a network of supportive relatives and friends found it easier to adapt as they were able to rebuild bridges to their own pre-drug lifestyle. However, completion of the process required addicts to also deal with the social stigma regardless of their drug-dependence level. *"Gaining recognition and acceptance from the non addict world often is a long and difficult process... [that requires perseverance in staying off drugs and in pursuing 'normal' activities that ultimately]... enable non addicts to trust the abstainer and, over time, to accept him and respond to him in 'ordinary' ways"*. In turn, this gives the ex-addict sufficient self-confidence to complete the recovery process ¹⁸. Switching is not limited to *illicit* drugs and can lead to another addiction when misdirected. The classic example is weight gain following smoking cessation when cigarettes are substituted by food, further arguing against the inherent addictive power of drugs and in support of the view that addiction is behavioral, as discussed in the next chapter.

Unhappy with the IDA Nixon thought that, through a new scientific commission of carefully selected like-minded members, he could prove the link between Marijuana and crime, despite the fact that neither the *Advisory Committee on Drug Dependence and Cannabis* of 1968 nor the *Canadian LeDain Commission Report* of 1970 had found such a link. Nixon appointed Governor Raymond P. Shafer of Pennsylvania, a former prosecutor known as a *"law and order"* governor to head his *"Presidential Commission on Marijuana and Drug Abuse"*. The Commission included a congressman and a senator from each party, and nine prominent citizens including the dean of a law school, the head of a mental health hospital, and a retired Chicago police captain. Anticipating the Commission would rubber-stamp his views on marijuana, Nixon continued to denounce it in public speeches and in private conversations and was outraged when he learned his commission might disagree. Recently declassified Oval Office tapes from 1971-1972 reveal that he summoned Shafer to the White House and urged him, *"Keep your Commission in line"*. He also warned him, *"You see, the thing that is so terribly important*

*here is that it not appear that the Commission's frankly just a bunch of do-gooders...[but]...if you're just a bunch of do-gooders that are going to come out with a 'soft on marijuana' report, I'll destroy it right off the bat"*¹⁹. However, to his consternation and anger, in its 1972 "*Marihuana: A Signal of Misunderstanding*" report²⁰, the Commission called for decriminalization of Marijuana. Its most compelling conclusion was, "*The actual and potential harm of use of the drug is not great enough to justify intrusion by the criminal law into private behavior*", and suggested "*a social control policy seeking to discourage marihuana use, while concentrating primarily on the prevention of heavy and very heavy use*". It also recommended that the distinctions between licit and illicit drugs be abandoned, finding that "*the use of drugs for pleasure or other non-medical purposes is not inherently irresponsible; alcohol is widely used as an acceptable part of social activities*". Expectedly, harsh criticism arose from Nixon and conservative quarters, including Anslinger who came out of oblivion to claim that enactment of the commission recommendations would result in "*a million lunatics filling mental hospitals and a couple of hundred thousands more deaths on the highways*"⁵. The Nixon tapes also reveal that Nixon's paranoid ideation and bigotry led to a grossly distorted view of history. For instance, in his May 13, 1971 meeting with John Ehrlichman and HR Haldeman²¹ he asserted that Aristotle, Socrates, and the last 6 Roman Emperors were gay, adding "*po-po-Popes were laying the nuns, that's been going on for years, centuries... it was homosexual. And finally, it had to be cleaned out. Now, that's what's happened to Britain, it happened earlier to France*". He concluded his diatribe stating "*You see, homosexuality, dope, immorality in general: These are the enemies of strong societies. That's why the Communists and the left-wingers are pushing the stuff, they're trying to destroy us.*" Predictably, the Nixon Administration ignored the *Shafer Report*, as it had previously ignored the IDA report and continued to promote an atmosphere of fear of drugs that ensured Congressional passage of extraordinary legislation and appropriations that launched the *War on Drugs*.

Under subsequent Democratic and Republican administrations, Nixon's anti-drug crusade continued to expand and took a global scope. For instance, early in his administration Jimmy Carter (1977-1981) attempted to relax penalties for Marijuana use advising Congress "*penalties should not damage the user more than pot itself*". However, his attempt failed in the face of fierce opposition from conservative detractors, parents' groups, opportunistic publications, and the law enforcement community eager to protect its turf. In fact, taking advantage of the outcry against President Carter's proposal, law enforcement was able to convince Congress to increase its *War on Drugs* budget. This episode suggests that opportunism and its very inability to control the illegal drug trade ensure the drug enforcement establishment's longevity and ever increasing budgets.

Escalation of anti-drug policies and budgets continued under President Ronald Reagan (1981-1989) whose moral conservative mind-set was not unlike President Nixon's and who viewed pot smoking as evidence of moral turpitude and social decay. Reagan emphasized a "*zero tolerance*" attitude on drugs at every opportunity, including White House ceremonies, public speeches, and State of the Union addresses that culminated in the Anti-Drug Abuse Act of 1986. The Act mandated minimum sentences for drug offenses and different penalties for selling cocaine and crack cocaine. Reagan also signed into law the Anti-Drug Abuse Act of 1988 that created the ONDCP* "*to set*

* Office of National Drug Control Policy

priorities, implement a national strategy, and certify federal drug-control budgets"²². To achieve his goals, Reagan enlisted "*the Navy, the Coast Guard, the Customs Service, The IRS, and the US Marshals Service as well as the DEA in his pot campaign*"⁵. The newly created White House Drug policy Office, with Carlton Turner at the helm, involved the Forest Service and the Bureau of Land Management with the sole purpose of eradicating marijuana grown on national forests. It is of interest, though unsurprising, that Reagan's Anti-Drug Abuse Acts were enacted on the heels of yet another scientific report titled, "*An Analysis of Marijuana Policy*" (1982)²³, conducted by the highly reputable National Academy of Sciences that confirmed the failure of Federal policy on drug control. It concluded, "*The ineffectiveness of the present federal policy of complete prohibition falls far short of its goal – preventing use*"...[hence]..."*we believe that a policy of partial prohibition is clearly preferable*"...[though]..."*Implementing such a policy...is unlikely to be effective in reducing marijuana use significantly below recent levels*". In a replay of Nixon's reaction to his own "*Presidential Commission on Marijuana and Drug Abuse*" report, Reagan dismissed the findings stating, "*we are making no excuses for drugs - hard, soft, or otherwise. Drugs are bad and we are going after them*"⁵. In a newspaper interview, Turner suggested marijuana to be a *gateway* to homosexuality, prompting Newsweek to proclaim, "*Reagan Aid: Pot can make you gay*"²⁴.

Drug repression continued unabated under subsequent administrations, as were the customary distortions of the facts and the hypocrisy involved. For example, William Bennett the drug "*czar*" under George H.W. Bush (1989-1993) was an habitual smoker^{*} and apparently a closet high-stake gambler²⁵. Ironically, he wrote about personal virtues in bestseller books such as *The Book of Virtues* and *The Moral Compass*. Bill Clinton's early Presidency (1993-2001) seemed to take a more tolerant approach to drug policy, especially marijuana. However, his initial inclination was doomed by rising rates of marijuana use among youth and soon, under General Jeffrey McCaffrey, his *drug czar*, the "*zero tolerance*" policy claimed more dollars, more arrests, more incarcerations, and longer sentences but no victories. Several additional drug policy initiatives were enacted between 1993 and 1997 that "*extended ONDCP's mission to assessing budgets and resources related to the National Drug Control Strategy*" and assigned it the responsibility of "*developing an outcome-measurement system*". The Reauthorization Act of 1998 gave the ONDCP additional responsibility over drug control policy and over its budget²². It is ironic, albeit tragic, that the President who did not "*inhale*" the marijuana he admitted smoked in his youth presided over the arrest of 5,144,000 pot-smoking Americans during his eight-year tenure²⁶. In fact, during the 1990s marijuana possession accounted for 79% of the growth in drug arrests²⁷. John P. Walters, George W. Bush's *drug czar*, expressed views on drugs that made General Jeffrey McCaffrey's and the President's own sound moderate. For example, Walters "*urged Congress for a South American drug policy of shooting down planes suspected of transporting drugs*"⁵, resulting in the downing of a plane carrying an American missionary in 2002. Likewise, in "*An open letter to America's Prosecutors*" dated November 1, 2002²⁸, Scott Burns, Deputy Director for State and Local Affairs of the ONDCP, urged them "*to take a stand publicly and tell Americans the truth*"... [because] "*no drug matches the threat posed by marijuana*". His recycled old "*truths*" that marijuana is harmful, addictive, violence inducing, and a gateway to hard drugs ignored the fact that each claim was contrary to scientific evidence, as was his claim that legalization would be a "*nightmare for America*". A critic of the War on Drugs, with broad experience as a judge of a State Court of Appeals, characterized the Bush administration's position on drugs as, "*for*

* A benign designation for a legal drug that changes to "*addict*" when referring to illicit drugs.

*Bush and Walters, the government's job is to save its citizens from hell"*⁵.

Today, *"The principal purpose of ONDCP is to establish policies, priorities, and goals for the Nation's drug control program. To achieve this, ONDCP is charged with producing the National Drug Control Strategy (NDCS). The Strategy directs the Nation's anti-drug efforts and establishes a program, a budget, and guidelines for cooperation among Federal, State, and local entities"*²⁹. Through fund allocations, the NDCS involves many US Departments and agencies, at a cost of 13 billion dollars in 2006 (table 4³⁰). In its 2007 report, the NDCS claims, *"The success of the President's National Drug Control Strategy demonstrates that a robust drug control policy can achieve measurable progress in reducing drug abuse"*. However, in the next sentence it also acknowledges that after 6 years into the *"President's first National Drug Control Strategy, a review of trends in drug use provides important **insights** * into what works in drug control"*; a meager outcome indeed for the enormous effort and cost involved, and the suffering needlessly imposed on large segments of the citizenry.

Table 4. National Drug Control Funding¹, 2006 (adapted from ref³⁰)

Department of Defense	1,086.6
Department of Education	489.8
Department of Health & Human Services	\$3,439.7
<i>National Institute on Drug Abuse</i>	998.9
<i>Substance Abuse and Mental Health Services Administration</i>	2,440.9
Department of Homeland Security	\$3,243.1
<i>Customs Border Protection</i>	1,635.3
<i>Immigration and Customs Enforcement</i>	382.3
<i>United States Coast Guard</i>	1,225.5
Department of Justice	\$2,674.9
<i>Bureau of Prisons</i>	62.6
<i>Drug Enforcement Administration</i>	1,890.8
<i>Interagency Crime and Drug Enforcement</i>	483.2
<i>Office of Justice Programs</i>	238.2
ONDCP	\$474.0
<i>Counterdrug Technology Assessment Center</i>	29.7
<i>High Intensity Drug Trafficking Area Program</i>	224.7
<i>Other Federal Drug Control Programs</i>	193.0
<i>Drug-Free Communities (non-add)</i>	79.2
<i>National Youth Anti-Drug Media Campaign (non-add)</i>	99.0
<i>Salaries and Expenses</i>	26.6
Small Business Administration	1.0
Department of State	\$1,156.9
<i>Bureau of International Narcotics and Law Enforcement Affairs</i>	1,036.0
<i>United States Agency for International Development</i>	120.9
Department of Transportation (<i>Natl. Highway Traffic Safety Administration</i>)	1.6
Internal Revenue Service	55.0
Department of Veterans Affairs (<i>Veterans Health Administration</i>)	376.7
Total	\$12,999.2

¹ In millions

* My emphasis

2. Global Drug Control: International Conventions.

Global drug control, initially the purview the League of Nations, is now coordinated by the United Nations Office on Drugs and Crime (UNODC), which along with the International Narcotics Control Board (INCB), is under the United Nations' Commission on Narcotics Drugs established in 1946. While the UNODC's primary mission is *"to educate the world about the dangers of drug abuse and to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, illicit crop monitoring and anti-money laundering programmes"*³¹, the INCB *"monitors compliance with the provisions of the international drug control treaties"*. Global drug control programs are based on three mutually supportive and complementary Drug Control Treaties. The first, called Single Convention on Narcotic Drugs of 1954 or *Single Convention "aims to combat drug abuse by coordinated international action"*. The second, called Convention on Psychotropic Substances of 1971 or *Psychotropics Convention "establishes an international control system for psychotropic substances"*. The third, called Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 or *Trafficking Convention*³¹ *"provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals"*. The three conventions embody the efforts of global governments to cooperate in the field of drug abuse control and provide the framework and the necessary tools for UN member States to address drug production, trafficking, and abuse problems individually and collectively. The three Conventions have been complemented by many drug-related *"Resolutions"* and *"Decisions"*, added since 1946³².

As is the case for American federal laws and the CSA, International drug control treaties emphasize the principle of maintaining a balance between controlling drug abuse and ensuring that controlled substances are available for medical use and research. To ensure achieving this balance in the US, the CSA gives the DEA authority to set production quotas for a number of opioids, stimulants, and sedative hypnotics intended for medical use, a stipulation also included in international treaties. Global quotas are arrived at based on each UN Member State's quarterly and annual statistical reports on the manufacture, use, import, and export of poppy-based medicines. Nothing in the international treaties should *"interfere with ethical medical practice in this country as determined by the secretary of Health and Human Services on the basis of a consensus of the American medical and scientific community"*³³. However, the INCB has rightfully admitted *"most developing countries lack the resources and expertise required for determining medical needs and adjusting drug supply to meet those needs"*³⁴. Hence, the vast majority of pain-suffering patients in underdeveloped countries have no access to opiates. For example, in 2005 to adequately treat *"end-stage HIV/AIDS and cancer patients in Latin America, 7.1 metric tons of morphine would have been needed, but just 600 kg of morphine was actually used, leaving 91% of these patients' pain needs un-met"*³⁴. Likewise, in 1978, the US Congress reaffirmed the principle that the availability of controlled substances *"for useful and legitimate medical and scientific purposes will not be unduly restricted"*. However, most American State laws do not achieve this balance. That imbalance and DEA policy implementation tactics interfere with medical practice and with pain management, in clear violation and defiance of Congressional intent, as will be described in chapter 5.

As of July 2007, 140 UN member States out of the current 192 are signatories to each of the three Conventions on drug control. Of the 15 East Asia States, 12 are

parties to the 1961 Convention, 11 are parties to the 1971 Convention, and 7 are parties to the 1988 Convention ³⁵. In compliance with the legally binding provisions of the conventions, signatory States assume the responsibility of developing and implementing drug control policies at home and of cooperating with each other and with UN bodies. Hence, while public policy choices often do not reflect public opinion and large segments of the population in several European countries favor relaxation of drug laws, drug decriminalization* or depenalization** ⁸, such changes would require amending international drug control treaties or a unilateral action by a member State which would be quickly challengeable. For example, when Portugal drafted a law reclassifying drug possession for personal use as an administrative rather than a criminal offense, the INCB opposed the change. It informed Portugal that its action was *“not in line with international drug control treaties, which require that drug use be limited to medical and scientific purposes and that States parties make drug possession a criminal offence”* ³⁶. In extremis, a signatory State could repeal its adherence to the Treaties. However, *“unilateral withdrawal from these Treaties would be a very difficult task because like most international treaties they are dominated by political groupings (in particular the USA) which will not, as yet, sanction rational, evidence-based changes in the ways in which the international illicit drug market is regulated. Such constraints make innovation difficult (as experienced by the Dutch) and rational debate elusive”* ³⁷. Indeed, any hope for amending international drug treaties requires US leadership and of its policy-makers whose decisions seem to follow the motto *“don’t confuse me with the facts; my mind is already made up”*. As a result, *“criminal law is ‘one-way ratchet’: it expands but does not contract”* ³⁸.

In the European Union, drug policy is not harmonized, falls under the responsibility of individual member States, and ranges from stern to lenient. For instance, while simple use is considered a criminal offense in 7 out of 25 member States (Cyprus, France, Finland, Greece, Luxembourg, Sweden, and Norway), it is handled as an administrative offense in 4 (Estonia, Spain, Latvia and Portugal) ³⁹, and recent legislation in Belgium, France, Luxemburg, and Portugal have downgraded penalties for personal use. In the Netherlands, a country perceived to have the most liberal drug laws, drug policy is based on two principles: hard drugs (e.g. heroin) are distinguished from soft ones (e.g. cannabis), and drug use is considered a health, not a criminal matter. While under the Dutch *“Opium Law”*, possession of any drug is punishable, article 11(5) provides that no penalties shall be applied when the quantities of hashish or marijuana in a person’s possession do not exceed 5 grams. Moreover, sale, possession, and use of cannabis in coffee shops are not liable to prosecution if the coffee shop does not advertise, sell *“hard”* drugs, cause public nuisance, sell to minors, or sell more than 5 grams per person per transaction. This non-enforcement of drug policy, that permits limited and controlled use of Marijuana the Dutch call *“Gedooogbeleid”* (policy of tolerance), is designed to depenalize possession and use of *“soft”* drugs while also complying with the letter of international drug control treaties ^{37,39}.

In contrast, the US has the most repressive drug laws with mandatory penalties, often more severe and lengthier than sentences imposed for the more reprehensible crimes of rape and murder. As a result, *“changes in sentencing law and policy, not increases in crime rates, explain most of the six-fold increase in the national prison*

* Removal of a conduct or activity from the sphere of criminal law

** Relaxation of the penal sanction provided for by law

population”⁴⁰. The following are some of the grim statistics⁴¹. In 2003, federally convicted drug offenders, whether for trafficking or possession, received prison sentences with the approximate same frequency (92.0%) as those assigned to perpetrators of violent crimes* (93.2%) and weapons offenders (92.3%)⁴², and their sentences were only marginally shorter (81.5 months) than those imposed for violent criminals (97.6 months) and for weapons offenses (84.0 months)⁴³. Moreover, because in any given year most federal arrests are drug-related, 56.7% of inmates in federal custody in 2003 were incarcerated for drug offenses compared to only 8.9% and 10.6% for violent and weapons offenses, respectively⁴⁴. Unsurprisingly, 33.5% of federal inmates were African-Americans who represented only 19% of the US population, and only 32.6% were high school graduates⁴⁵, whereas 88% of the general population and 80% of African-Americans graduated that year⁴⁶. The demographics and offenses of inmates of State prisons and local jails might differ from federal prisoners. However, suffice it to say that out of 14,094,186 Americans arrested in 2005, a staggering 4.7% of the total US population, the largest number (1,846,351) was for drug violations including 786,500 were for marijuana offenses²⁶, of which 81.7% was for simple possession⁴⁰. At the end of that year, 2,320,359 Americans were inmates of Federal, State, or Local prisons. In fact, with 5% of the world population the US accounts for 25% of its prisoners. The US Department of Justice said it best at the November 30, 2006 press release; “*One in every 32 adults was in prison, jail, or probation, or on parole at the end of 2005*”⁴⁷. These grim statistics led Humans Rights Watch to conclude, “*Putting a person behind bars is so common in the United States and so frequently imposed for minor conduct that it seems the country has lost sight of just how serious a punishment imprisonment is*”⁴⁸.

In conclusion, the Prohibition era had not yet ended when clamors were already been heard, mostly from the same players, that the new “scourge” of opium and related drugs were destroying American society. The obvious questions are: Why are failed anti-alcohol policies recycled to combat other mind-altering drugs? What motivates detractors to propose and implement policies to curtail a social conduct while others are allowed, independently of their impact on society? Why does society acquiesce to such policies? Why do such policies endure once shown to have failed and been counterproductive? While addressing these issues in detail is the domain of scholars in social and political sciences with greater expertise than my own, a few pertinent thoughts might be helpful. First, it is well documented throughout history that some people do not conform to majority rule or test the legally imposed limits of freedom. Within this group, there are those whose unconventional behavior is objected by the majority. Under such circumstances, objectors’ hasty reaction is to stigmatize the behavior and gather political support to criminalize the objectionable act and demonize the perpetrators. This is especially the case when the targeted activity is easy to stigmatize as being an “*out of main-stream*” practice of a minority especially foreigners, dissidents, the poor, the illiterate, and the underprivileged and disenfranchised who do not conform to the moral beliefs or social standards of the majority. Essentially, it amounts to identifying and targeting scapegoats for unrelated societal problems that serve to absolve and release inner feelings of inadequacy or guilt.

By portraying a certain category of drugs as *evil*, *sinful*, a *plague*, and other intensely evocative names, they became detractors’ quintessential target despite causing less harm to self and society than either alcohol or tobacco. That is, because

* Includes murder, forcible rape, robbery, and aggravated assault

the recreational use of some drugs by some members of society are objectionable to others, such drugs were outlawed despite evidence of non-harm to self and society and, since then, users and suppliers are stigmatized and persecuted. In contrast, while tens of thousands of Americans are injured and die in traffic accidents each year, few would advocate banning driving or cars because some drivers drive recklessly or under the influence of mind-altering drugs, potentially endangering themselves and others. For instance, 1,816,000 Americans were injured in traffic accidents in 2005 resulting in 39,189 deaths⁴⁹, including 15,238 alcohol-related (or 39%)⁵⁰ and 7,054 drug-related (or 18%)⁵¹. That leaves 16,897 deaths (or 43%) caused by sober drivers presumably in full control of their mental faculties. The proper response to this carnage on the roadways, adopted in most countries, is to penalize reckless driving whether associated with DUI, DUI-drugs*, or with neither rather than outlawing cars. The anti-drugs paranoia is such that while penalties for DUI and DUI-drugs are similar in the US⁵², the DUI penalty does not increase if alcohol is found in the driver's possession whereas drug possession would add a 5-year minimum jail sentence to a first DUI-drugs offender⁵² and a possible life-long incarceration for a recidivist. This is but one of the many examples of the inconsistencies in US penal law.

As previously described, while self-righteous groups initiated the anti-alcohol crusade that led to Prohibition, President Nixon spearheaded the anti-drug demonization campaign that set in motion the *War on Drugs*, fulfilling German philosopher Georg Friedrich Hegel's "*thesis-antithesis-synthesis*" road to power. It consists of deliberately contriving a social problem (*thesis*), devising a solution (*antithesis*), which leads to the ultimate goal of acquiring more power and control (*synthesis*)⁵³. Thanks to well orchestrated disinformation campaigns, both the anti-alcohol and anti-drug movements gained substantial support from large segments of society aided by politicians who, recognizing their ideological, rhetorical, and political usefulness, seized them as their own, misrepresenting facts when needed to fit their political agenda. However, unlike alcohol and tobacco that are strongly promoted and fiercely protected by powerful lobbies and generate substantial tax revenues for Federal, State, and local governments, anti-drug campaigns are lobby-orphan, tax-devoid, and non-partisan issues all politicians can agree and politically afford to support, regardless of their ideological persuasions, accounting for the latter's longevity and the former's early repeal. Moreover, failure to support policies alleged to protect *innocent children* from the *evils* of drugs would amount to political suicide. Hence, after demonization by the Nixon White House came the rhetoric by politicians who outdid and continue to outdo each other depicting the real, imagined, or fictitious *evils* associated with drug use, and portray themselves as "*tough on drugs*" to please their activist anti-drug constituencies. Never mind that numerous American and foreign scientific studies on the effects of drugs conducted between 1894 and 1982 have all disputed or dismissed the vast majority of presumed ill effects of drugs on users and their relationship to crime claimed by supporters of the *War on Drugs*. Advocates use disinformation, hollow rhetoric, and suggestive clichés *in lieu* of valid arguments for enacting ever-more punitive anti-drug laws and funding ever-expanding anti-drug law enforcement, prison infrastructure, and supporting personnel; all claimed essential to build a utopian "*drug-free America*".

This massive governmental infrastructure and the legion of supporting ancillary industries (e.g. training, research, and the like) accumulated over nearly a century of drug prohibition policies are fed by billions of dollars that reward all involved, buy their

* Driving Under the Influence (of drugs)

acquiescence if not their silence, limits debate, and perpetuates the *status quo*. In the meantime the “*drug-free America*”, as *noble* a goal as the one that inspired Prohibition, requires the incarceration of thousands of petty offenders, fosters crime resulting mainly from the criminalization of drugs, and victimizes tens of millions of American pain sufferers. Moreover, in waging its worldwide *War on Drugs*, the United States has set aside considerations of decency, human rights, and morality enshrined in its constitution and the foundation of its social fabric. Examples include American cooperation with an assortment of dubious regimes around the world including Mujahideen warlords, Panama’s Manuel Noriega, Peru’s Alberto Fujimori, Cuba’s Fidel Castro, and Burma’s military junta, among others. “*Such collusion reflects the frustration and desperation [and cynic disregard for the law] of U.S. officials as they have sought to stem the flow of illegal drugs into the United States decade after decade without meaningful, lasting success*”⁵⁴. To these we must add CIA’s involvement, directly or indirectly, in drug dealings in Southeast Asia and Colombia to fund its covert wars against the Marxist regimes of North Vietnam and Salvador^{55,56}.

While drug criminalization and user demonization began in the US, the movement spread globally as leaders and politicians worldwide recognized the political bonanza associated with anti-drug crusades. In fact, drug prohibition was one of the few things on which capitalist and socialist democracies, German Nazis and Italian Fascists, Communist USSR and China, Latin American dictatorships and anti-colonialist Africa could all agree. Moreover, prompted by the US, the UN forcefully spread and now supervises worldwide drug prohibition, giving anti-drug policies legitimacy worldwide and a staying power strengthened by legally binding international conventions that effectively dictate drug policies of 140 signatory countries. Although well intentioned, the UN’s current goal of a “*drug-free world*” is as unrealistic and unachievable as it is inane. In the meantime, a voluminous literature arising from a broad ideological spectrum that decries the abject failure of drug policy and condemns crime and corruption it causes at home and abroad is a clear indication that the clamor for change is mounting. However, meaningful change will require the emergence of strong leadership from American policy-makers with sufficient fortitude and resilience or pressure from an informed electorate to dismantle national and international policies that have raised havoc the world over for several decades and replace them by sound evidence-driven strategies. In the absence of central political leadership and given the expected legislative paralysis in this regard, several regional grassroots initiatives are slowly filling the vacuum. Perhaps the most groundbreaking is Arizona’s Proposition 200, also called *Drug Medicalization, Prevention, and Control Act of 1996*. The initiative called for probation and treatment for new non-violent drug offenders instead of incarceration, parole for those already in prison, and for doctors to be allowed to prescribe schedule I drugs. The initiative was approved by 65% of voters, despite fierce opposition by the Governor, the State legislature, the Congressional delegation, the DEA, and President Clinton. However, an undeterred Arizona legislature overturned most of the initiative the following year but voters reversed the changes in subsequent referendums, making it more difficult for legislators to tamper with future voter-approved initiatives. Arizona’s proposition 200 and INCB’s opposition to mild relaxations in drug laws by some European countries underscore the great difficulties and obstacles that lie in the path of overturning drug policy but also offer hope that it can be done.

PART III

ADDICTION: DISEASE OR BEHAVIOR?

Chapter 4

CURRENT THEORIES OF ADDICITON

The term “*addiction*” derives from the Latin “*addicere*”, meaning ‘*bound to*’ or ‘*enslaved by*’; a term and meaning that have become synonymous with impaired control over substance use, though non-substance-related disorders are increasingly been included as well. Today, the definition of addiction is as varied as the personal or professional interests or biases of its authors. English and medical dictionaries define addiction broadly as a “*persistent compulsive use of a substance known by the user to be harmful*”¹, a “*psychological or physiological dependence on a drug*”², or “*the loss of control over drug use, or the compulsive seeking and taking of drug regardless of the consequences*”³. In these and in most common definitions, the recurring theme is still “*drug*” or “*substance*”, reflecting a prevailing mindset that explains the focus of current research being centered on drug-brain interactions and viewing addiction as a brain disease. In a broader sense, addiction has been defined as, “*a recurring compulsion... often reserved for drugs but... sometimes applied to other compulsions, such as problem gambling and compulsive overeating*”^{4,5}. However, using words such as “*problem*” to define addiction adds confusion though professional organizations’ definitions might not be clearer. For instance, the American Psychiatric Association’s DSM-IV-TR^{*} nomenclature includes, not the specific term “*addiction*”, but the categories of “*Substance Use Disorders*”, “*Impulse Control Disorders*”, and “*Obsessive Compulsive Disorders*”. These disorders share some features including impulsivity and impaired control over use, and it has been suggested that certain Impulse Control Disorders such as compulsive gambling, compulsive shopping, compulsive computer use, and compulsive sexual behaviors are “*behavioral addictions*” or “*addictions without the drug*”⁶, implying that drug addiction is not the only “*real*” addiction and that all are behavioral. Likewise, the WHO’s ** International Classification of Diseases and Related Health Problems (ICD-10) lists Impulse Control Disorders under “*Habit and Impulse Disorders*”⁷ and includes drug abuse under “*Dependence syndrome*”. It defined the latter as “*A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state*”⁸. This bewildering array of classifications and definitions of compulsive, impaired use control, reward-seeking behaviors that interfere with major areas of life functioning compound their understanding and management.

Theories on the causes of addiction have been based on moral, biological, sociological, psychological, and social learning models, among many others. Consequently, addiction is said to be the domain of the police officer, the neurobiologist, the psychiatrist, the social worker, the priest, or the policy maker depending of the proponents’ point of view. Each stance can affect the income and fate of professionals

* Diagnostic and Statistical Manual of Mental Disorders, 4th edition

** World Health Organization

and organizations engaged in addiction prevention, control, or treatment, and the type of support offered to or punishment imposed on addicts. While it is not my purpose to reconcile these viewpoints through a “*grand unifying theory*”, I subscribe to the view that they can be reduced to two opposing camps: the *disease* vs. the *behavioral* model advocates. In addition to identifying the two core themes underlying all theories and definitions of addiction, these opposite views carry profound clinical, policy-making, and legal implications. Advocates of the *disease* model view addicts as “*victims*” of an alleged defective neurocircuitry implicated in drug abuse hence promote the development and use of drugs as the basis for its management. On the other hand, proponents of the *behavioral* model consider addiction a “*choice*” and promote behavior modification methods as the most suitable means to treat substance and non- substance abuse behaviors, at best, or incarceration, at worst. These two diverging views of addiction have divided the scientific community and the public at large to the point that each has become a dogma and as such, a non-negotiable polarizing issue to its proponents. In the next few pages, I will examine the pros and cons of each model in an objective and rational fashion.

1. ***The disease (victim) model:***

Although references to drunkenness as a disease can be found in ancient Egyptian and Greek writings, Scottish physician Thomas Trotter (1760-1832) is credited as the first to characterize excessive drinking as a disease in modern times. In America, drunkenness continued to be viewed as a condition that bridged morality and medicine. For instance, in his *"Inquiry into the effects of ardent spirits on the human mind and body"*⁹, American physician Benjamin Rush (1745-1813), considered the *"Father of American Psychiatry"*, introduced the idea that the loss of control characteristic of alcoholism was a disease *"induced by vice"* but caused by the *"inherent properties"* of alcohol. Likewise, in his *"Six Sermons on the Nature, Occasions, Signs, Evils, and Remedy of Intemperance"*¹⁰, reverend Lyman Beecher referred to *"intemperance"* as a *"sin"*, an *"evil habit"*, and *"a disease as well as a crime"*. However, of greater interest is Dr. William Sweetser's 1829 insightful argument that *"intemperance"* is *"a disease produced and maintained by voluntary acts, which is a very different thing from a disease with which providence inflicts us"*, though one that causes a *"morbid alteration"* of the body. This view would be resurrected in support of the disease theory of addiction over a century later, as discussed below. Likewise, doctor Samuel Woodward described *"intemperance"* as a *"physical disease which preys upon health and spirits ... making him a willing slave to his appetite"*¹¹. He also believed that heredity played a role in drunkenness. Swedish Physician Magnus Huss (1807-1890), who considered the condition as a chronic, relapsing disease first coined the term alcoholism, in 1849.

Hence, the disease concept of alcoholism was already taking shape in the middle of the 19th century, including the features of impaired control, craving, tolerance, and a presumed predisposition to drinking. Its biological, psychological, and social consequences also were being recognized. However, New York-born E. Morton Jellinek (1890-1963) was to propel the *"science of alcoholism"*, and the disease theory of alcoholism and by extension of drugs of abuse, to center stage. Jellinek's father, a Hungarian, had taken his family back to Budapest when young Jellinek was a pre-school boy. From his sister's account¹¹ we know that he first served as a captain in the Hungarian Red Cross in WWI before going bankrupt as a currency speculator. He reappeared in 1920 working for a steamship line in Sierra Leone under the name of Nikita Hartmann, then as a banana researcher in Honduras for the United Fruit Company before becoming a biostatistician at Worcester State Hospital in Massachusetts, in 1931. In 1939, age 50, he was hired to manage an Alcohol study called the Carnegie Project. According to his sister, he *"knew very little about alcoholism but he was interested so he got some books on the subject and spent a weekend in bed studying"*¹². Jellinek devoted the rest of his life to the field and earned the respect and admiration of his peers unaware that he had fabricated his degrees. Indeed, his claim to a Doctor of Science degree from the short-lived University of Tegucigalpa in Honduras was never substantiated and the *"Honorary"* prefix of a Doctor of Science degree he claimed the University of Leipzig bestowed upon him soon disappeared from his publications. Yet, he became an Associate Professor of Applied Physiology at Yale University (1941 - 1952) and subsequently a consultant on alcoholism to the WHO in Geneva. In 1958, he joined the Psychiatry departments of the Universities of Toronto and Alberta and, in 1962, moved to Stanford University where he died a year later.

Because alcohol was the most obvious drug of abuse in Jellinek's time and often ran in families, genetics was suggested as a possible cause, though according to this criterion child abuse and religion that also run in families would qualify as addictions. In

attempts to separate environmental from genetic factors, cohort studies of adopted children from alcoholic parents were compared to adopted children from non-alcoholic families. Some studies suggested up to a 3- to 4-fold increased incidence of alcoholism among the former ^{13,14}. However, such studies failed to account for non-genetic factors (e.g. ethnicity) that impact on incidence rates and could not explain how is alcoholism *inherited*. Subsequently, the focus shifted to the search for predisposing factors that confer the bearer an *inherited vulnerability* to alcoholism rather than a *predetermined alcoholic destiny*. Some of the metabolic defects claimed to predispose to alcoholism included: an inability of alcoholics to discriminate blood alcohol levels, which presumably leads to lesser effects from alcohol and to increased drinking ¹⁵; an altered alcohol metabolism associated with higher levels of acetaldehyde and related symptoms and with decreased drinking ¹⁵; or an aberrant brain circuitry that reinforces drinking ¹⁶. For instance, a mutant ALDH-2 gene protein that metabolizes acetaldehyde, a product of alcohol elimination, causes its tissue accumulation more slowly than normal inducing flushing, dizziness, and nausea, which is thought to reduce the risk of alcoholism in carriers. Indeed, approximately 50 percent of Asians born with this mutant gene drink less than their normal counterparts even after migrating to the US, suggesting that genetics might be the stronger predisposing influence in that population. However, children of immigrant Asian Americans drink more than their parents and the generational difference in drinking level is greater than that observed between carriers of the mutant and of the normal ALDH-2 gene. These findings conclusively prove that the drinking behavior of first generation Asian Americans is impacted more by environmental factors than by heredity. Likewise, sensitivity to blood alcohol levels, variations in alcohol metabolism, and abnormal brain circuitry in response to alcohol intake do not predict or correlate with alcoholism ¹⁷, nor do they differentiate the occasional or social alcohol user from an alcohol-dependent individual.

Another interesting historical episode on the presumed inheritance of deviant behavior is associated with Cesare Lombroso's now discredited theories described in his influential book "*l'Uomo delinquente*" ¹⁸ (the delinquent man). Born in Verona in 1835, Lombroso studied medicine in Pavia, Padua, Vienna, and Genoa and taught legal medicine and public hygiene at the University of Turin. His interest in psychology and psychiatry along with his studies on brain anatomy and physiology ultimately led to his anthropometric analysis of criminals and the mentally disturbed. Years of postmortem examinations and anthropometric studies of criminals, the insane, and normal individuals, convinced Lombroso that, contrary to the prevailing view that crime was a characteristic of human nature, he proposed the existence of the "*reo nato*" (born criminal) that was anatomically identifiable by certain physical stigmata^{**}. They included a sloping forehead, handle-shaped ears, high cheekbones, hawk-like noses or fleshy lips, prognathism^{***}, and excessively long arms. These physical features, he thought, indicated a throwback to a primitive form of humans whose behavior was inevitably contrary to the rules and expectations of modern civilized society. Not unlike some of today's researchers who seem convinced of the genetic basis of addiction, he reluctantly admitted the influence of the environment in the etiology of crime but continued to believe in the predominant role of "*predisposing*" organic and genetic factors. While Lombroso's notions gained many adepts throughout Europe, they were eventually

* The study of the measurement and proportions of the human body

** A mark or characteristic indicative of a disease or abnormality

*** A lower jaw that projects forward

discredited by Charles Goring in his book *The English Convict*, published in 1913, where he documented that anatomical differences found in criminals were minimal at best.

Since the decade of the 1960s, when illicit drugs began their ascent, addiction has become synonymous with drug abuse and its study expanded to include neuroscientists, molecular biologists, pharmacologists, psychologists, geneticists, and even circadian rhythm theorists. Inevitably, each discipline brings a special one-dimensional approach and conclusions to the study of addiction that confounds the understanding of this highly complex issue involving behaviors that transcend drug abuse. For example, it has been suggested that, “*all drugs of abuse converge on a common circuitry in the brain limbic system... [especially] ...the ventral tegmental area (VTA) of the midbrain... [and] ...their target in the nucleus accumbens (NAc). The VTA-NAc pathway is one the most important substrates for the acute rewarding effects of all drugs of abuse... [though] ...additional brain areas that interact with the VTA and NAc are also essential for acute drug reward and chronic changes associated with addiction*”¹⁹. From study results such as this, it is concluded that addiction is “*a chronic, relapsing brain disease... because drugs change the brain... and can lead to the harmful behaviors seen in people who abuse drugs*”⁴. However, even if drugs of abuse change brain chemistry reinforcing the reward circuitry that perpetuates the cycle of addiction, the question remains: what leads someone to use drugs in the first place. That is, what is first; behavior affecting the brain or brain changes that affect behavior? Likewise, if drugs *change the brain*, why is the vast majority of drug use transient and sporadic and why can most drug abusers who *choose to quit* do so, more often than not, without third-party assistance? In fact, no neurocircuits or neurotransmitters can compel anyone to abuse drugs for even the most drug-centered and self-destructive addicts retain a certain degree of control on how much drug they take at any given time, keeping some supply for the next *high*. Moreover, neurocircuitry and chemical reward theories of addiction are unable to account for the wide spectrum of addiction, ranging from not only licit or illicit drugs, prescription medications, and chemical products, but extending to non-substance based activities such as gambling and others that are normal, ordinary, and non-addictive for most people such as drinking coffee, eating, and having sex. Hence, “*addiction*” is linked to the individual, not to any intrinsic *addictive property* of the substance or activity abused, or their effect on the brain. Furthermore, the suggestion that the VTA-NAc pathway also mediates “*the acute positive emotional effects of natural rewards such as food, sex, and social interactions*”¹⁹ does not validate viewing addicts as victims of their brain chemistry.

The above arguments suggest that drug-receptor interactions theorized as the underlying mechanism for a self-reinforcing “*reward*” pathway blamed for addiction are at best simplistic, for they reduce behavior to simple neurobiochemical processes excluding free choice as a factor, or at worst seek to support preconceived notions intended to absolve drug abusers of responsibility. In fact, the reward pathway is an evolutionary brain circuit that reinforces behavior that makes us feel good and ensures our survival. Moreover, no brain pathways or neurotransmitters need be discovered to confirm what daily living teaches us: experiences are sought after if enjoyable and avoided if unpleasant. Seeking to recreate pleasurable experiences is a normal and common reaction of all living creatures from the lowest of worms to rodents to humans and is therefore incidental to the deviant and often self-destructing abuse behavior we call addiction. The issue is not whether seeking pleasurable experiences is reinforced

* Recurrent biological patterns claimed to influence drug efficacy, behavior, etc.

through a reward pathway, which it is, but what factors underlie the type of impaired control behavior that initially leads to drug seeking and later to compulsive use. In short, since chemical rewards have no power to dictate human behavior, the key question is what leads some casual users to become addicted whereas the vast majority doesn't; a pivotal step that neurobiologists cannot explain. Simply put, "*our brains do not make us do it*". Likewise, theorizing that opiates and other drugs of abuse are inherently addictive or that repeated exposure will inevitably lead to addiction, while ingrained in popular folklore, have no scientific basis. Indeed, some of the "*most addictive*" drugs of abuse induce tolerance and withdrawal symptoms (e.g. heroin), some induce one but not the other (e.g. cocaine, fentanyl), and others induce neither (e.g. Levo-Alpha Acetyl Methadol), suggesting that these properties are not central to addiction as it is claimed. Moreover, the notion that certain drugs are inherently addictive ignores the medical evidence that taking narcotics round-the-clock for months to years for pain relief does not induce addiction²⁰⁻²², and that most casual users of licit and illicit drugs do not become addicted²³ and those who do can give them up if they choose to. Finally, few would consider ordinary foodstuff as inherently addictive. Yet, it is undeniable that many individuals with "*compulsive eating disorder*" are in fact addicted.

Yet, a most forceful proponent of the disease theory of addiction is the National Institute on Drug Abuse (NIDA), the Federal agency whose mission is "*to lead the Nation in bringing the power of science to bear on drug abuse and addiction*", which it does by steering research on addiction through selective allocation of funds. It defines addiction "*as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain - they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs*"⁵. In an August 2007 online educational presentation, it likens drug addiction to several common *somatic* diseases on the basis that they all exhibit genetic and behavioral components and are not self-inflicted. It claims, "*Addiction, like heart disease, cancers, and type II diabetes, is a real and complex disease... no one chooses to be a drug addict or to develop heart disease... sometimes people do choose behaviors that have undesirable effects... addictive behaviors have clearly implicated both environmental and genetic influences*"⁴. These analogies were carefully chosen to convey a sense that if heart disease, cancers, and type II diabetes are acknowledged diseases despite being the unintended outcome of poor lifestyle choices (e.g. overeating, a sedentary lifestyle, and cigarette smoking -in the case of lung cancer-, respectively), addiction must also be classified as a disease. The parallel appears strengthened by invoking a genetic link based on the proposition that APOE^{**} and the μ -opioid receptor contribute to heart disease and heroin addiction, respectively. However, the comparison is inappropriate because there is no such a thing as *cancer* or *heart disease* but a diverse group of over 200 *cancers* and a plethora of *heart diseases* caused or contributed to by factors as diverse as heredity and behavior. Examples of the former include Hereditary, non-polyposis colorectal cancer^{***}, and Hypertrophic cardiomyopathy^{****}, respectively. Examples of behavior-related cancers and heart

* Related to the body

** Apolipoprotein-E, an apoprotein involved in heart disease

*** A hereditary type of cancer that affects mainly the colon and rectum

**** A familial thickening of the heart muscle

diseases include tobacco-induced lung cancer and atherosclerosis* linked to obesity, respectively. Moreover, the comparison would remain disingenuous even if it were limited to behavior-related heart diseases and cancers, as it steers the reader's attention to the *outcome* of addictive behavior in the case of the somatic diseases cited, to the addictive *behavior* itself in the case of drug abuse. The appropriate comparison should be between heavy smoking and heavy drug use; both being addictions albeit to products arbitrarily placed on opposite sides of the law, or between lung cancer and HIV infection; both being *disease* outcomes often associated with the addictive *behavior* of smoking and IV drug use, respectively. Similarly, overeating to the point of developing long-term health consequences, including morbid obesity, atherosclerosis, type II diabetes, or colon cancer is also a form of addiction albeit one not yet sanctioned by the politically-correct medical establishment or acknowledged by the public. To assert that addiction is a disease because drug users do not intend to become addicts is as ludicrous as claiming that heavy smoking is a disease because smokers don't plan to develop lung cancer. Smoking, overeating, and drug abuse are all addictions albeit with a different focus; the major difference being that the latter has been made into an illicit behavior. Likewise, to claim that the very existence of μ -opioid brain receptors proves or supports the genetic basis of heroin addiction is tantamount to suggesting that the human brain evolved such a receptor in anticipation of its usefulness as a mediator of heroin addiction centuries later. In fact, the term *opioid receptor* derives from neurobiological studies on narcotics²⁴ and is unrelated to the primary function of a receptor humans share with mice, rats, bullfrogs, chicken, cattle, and several fish species²⁵, suggesting an evolutionary function that certainly transcends addiction. Finally, it has been reported that "*genetic variants of the μ -opioid receptor OPRM1 play a role in pain perception and in the susceptibility to substance abuse*"²⁶. However, susceptibility does not mean inevitability and subscribing to this claim requires believing that, out of tens of millions of pain suffering patients taking opioids for pain relief, only 0.03% of them are endowed with this variant receptor and become addicted²⁰⁻²², an unlikely proposition indeed.

Sorting out the specific and individual effect of a multitude of factors impacting addictive, compulsive, or obsessive behavior, and indeed any human behavior, is a highly complex, uncertain, and daunting process. Moreover, limitations in the tools available for study, flaws in the design, methodology, analysis, or conclusions of many studies, and the mind-set and pre-conceptions of many addiction researchers are further impediments in the search for reliable answers. For instance, the authors of a recent study of the possible genetic bases of nicotine dependence and abstinence²⁷ concluded, "*the ability to abstain from nicotine has polygenic genetic components that overlap, in part, with those that contribute to vulnerability to nicotine dependence*". To put it simply, contrary to the authors' assertion, that means that the set of genes that predispose you to smoke also predispose you not to smoke! Hence, this study supports the view that to smoke or not to smoke is the result, not of genes, but of a conscientious decision - a choice - made by the smoker, albeit one that is influenced by a multitude of psychological, familial, social, environmental, and genetic factors, as are all human decisions. Similarly, a study report on the role of genetics in human sexuality claimed having found the "*gay gene*"²⁸. Given its social, political, legal, and eugenics** implications, the report and its lead gay author became highly controversial. The report

* Deposits of plaques within arteries, commonly know as "hardening" of arteries

** The science of improving genetic characteristics

identified a genetic marker in region 28 of the long or "*q arm of the X chromosome*"^{*}, shared by 33 (or 83%) of the 40 pairs of homosexual, non-twins brothers in which both members of each pair were gay and concluded that male homosexuality is X-linked. The Xq 28 marker, not itself a gene, is now known as "GAY-1". The report was initially hailed as the scientific foundation that supported prior claims of inherited sexual orientation based mainly on a prior study showing size differences of midbrains of homosexual young men and on several studies showing concordance^{**} in homosexual rates among monozygotic^{***} twins raised apart (100% concordance indicates a 100% inheritance). However, none of these studies are conclusive. First, many of the studied homosexuals with smaller midbrains died of AIDS^{****}, a condition that affects the brain. Second, concordance rates in identical male twin studies ranged between 0% and 100% suggesting flaws in subject selection or in the design, implementation, or interpretation of such studies. Finally, a linkage between homosexuality and the Xq28 region was not confirmed in a careful study of 52 gay male sibling pairs²⁹. In contrast to claims that link certain deviant behaviors to hypothetical "*genetic causes*", there are approximately 4,000 diseases directly linked to chromosomal changes or gene mutations^{*****} and can be inherited or acquired. Examples of the former include Ataxia Telangiectasia and Bloom syndrome. Acquired genetic mutations are caused by environmental "*mutagens*"^{*****} and take the form of microscopic structural chromosomal changes such as multi-copy (e.g. Down's syndrome), translocations (e.g. Burkitt's lymphoma), partial deletions (e.g. acute myelogenous leukemia), or point mutations (e.g. sickle cell disease)³⁰. Hence, it is evident that genetic mutations can and do cause disease and there are genetic components in everything we are and in everything we do. However, evidence to date shows that behavior is modulated by a myriad of non-genetic factors (e.g. educational, religious, social, familial, psychological, and environmental) superimposed to a non-specific and non-determining genetic makeup. Indeed, while genes govern the biological processes of all living organisms in a direct, predictable, and deterministic manner, they have a more circuitous and subtle effect on human behavior that influences rather than eliminates free will through difficult-to-assess gene-brain link. Simply put, "*our genes do not make us do it*".

* The female gene

** Sameness with regard to a particular trait or characteristic

*** Derived from a single ovum

**** Autoimmune Deficiency Syndrome

***** Alterations in DNA or gene sequences

***** Agents or substances that cause genetic changes

2. *The behavioral (choice) model.*

While drug addiction is not a disease and is not caused by genetic abnormalities or a compelling abnormal brain reward circuitry, it can be viewed as the outcome of a “process” that begins with an encounter with drugs followed by casual drug-use that can progress to drug abuse in certain individuals, often to the detriment of self³¹. However, this process, which is similar for any *substance of abuse* or *activity of abuse*, is not a continuum for something intervenes to lead few casual users to become addicted whereas most do not. Perhaps the best-known example is alcohol, the most indulged drug that a large segment of the population (48% worldwide) consumes casually, socially, or daily. While most consumption is moderate and without adverse effects, a minority of users become addicted (9.7 million Americans were alcoholics in 2001-2002³²) and suffer the medical, psychological, economic, and social consequences of their excessive drinking. Likewise, as discussed in section 2 of the previous chapter, the natural history of drug abuse suggests that following peaks of problem behavior in adolescence and young adulthood, unassisted recovery is the norm for most casual and not-so-casual users. Indeed, while the “30-day” prevalence rate* for any *illicit* drug use by the 18 to 26 year-old cohort exceeded 1 in 5 in 2005, it dropped to less than 1 in 10 by age 45, despite the fact that approximately 80% of them admitted lifetime experience with illicit drugs³³ (chapter 2, figure 1). Additionally, as discussed in detail in the next chapter, the prevalence rate of licit and illicit drug use among US servicemen during the Vietnam War was rampant (alcohol, 90%; marijuana, 80%; opium, 38%; heroin 34%; amphetamines and barbiturates, 25% each). However, a strict DoD** ban on drugs, enforced by compelled urine testing and the threat of more disciplinary action for recidivists including extending their Vietnam tour and a negative urine test required to be discharged from service were the main incentives, rather than treatment, for most users to abandon drugs. A three-year follow up study showed a relapse rate of only 12%, that in most cases was short-lived³⁴. Such extraordinarily high remission rate and continued abstinence contradict the still widely held belief that addiction is essentially irreversible, especially without treatment. These two studies, conducted 25 years apart, and many in between and since, demonstrate that most users “*mature*” out of their drug dependence or find sufficiently compelling motivations, often associated with love or religion, to override or compensate their cravings for drugs, and do so without professional or other assistance³⁵.

Users who become addicted and remain addicted constitute a very small subpopulation within the user population. Most, if not all, are trapped in personal, familial, and psychosocial problems that contribute to placing drug reinforcers*** in control of a significant portion of their behavior, which some neurobiologists call the “*hijacking*” of the reinforcement pathway by drugs³⁶. The reinforcing stimulus can be euphoria from drugs, a feeling of satiety from food, an expectation of financial gain from gambling, or an adrenaline rush from high-risk activities. Although such stimuli might not become preeminent while the activities in question remain moderate rather than all consuming, they can progressively escalate to eventually dominate behavior when competing activities within the available repertoire provide less potent reinforcing stimuli, especially in individuals with impaired self-control or with non-supportive environments.

* Rate prevailing within the timeframe indicated

** Department of Defense

*** Stimuli that increase the strength of behavioral responses

Alternatively, when exposed to reinforcers incompatible with drug abuse (e.g. marriage, drug-free employment, etc), addicts are able to substitute drugs for the new activity, achieving a more satisfying and often life-changing type of behavior reinforcement. As a corollary, it can be envisioned that the segment of the population that never tries drugs is made of individuals for who *drugs of addiction* or *activities of addiction* do not fit in their value system; a value system based on discipline and self-control that provides one or multiple reinforcers of non-deviant behavior.

Hence, the brain reward circuitry proposed by some neurobiologists as the cause of addiction is only a conduit common to most, if not all, reinforcing stimuli whether resulting from normal or deviant behavior. What determines whether casual or moderate use will become compulsive and eventually all consuming depends on the individual's access to, handling of, or adherence to alternative reinforcers and on his/her level of discipline and self-control. Motivation is pivotal to the type of reinforcement achieved and whether addiction will ensue. Consequently, relief of chronic pain accompanied by a greater sense of wellbeing and a higher level of functioning are both reinforcers of "*opioids-for-pain-relief*" seekers, whereas interference with major areas of functioning is the hallmark of compulsive seeking "*opioids-for-pleasure*". As a result, pain patients experience no euphoria from taking opioids, have no reasons to continue their use once pain is relieved, and very rarely become addicted²⁰⁻²². Similarly, it has been postulated that addicts who do not "*mature*" out of their addiction might not have access to alternative reinforcers, might not seek them out, or find them unsuitable replacement for the more potent reward derived from drugs or other deviant behavior. In either case, selection of reinforcers is a choice heavily dependent, not on genetics, but on personal, familial, and psychosocial factors, all of which contribute to forming an individual's personality, itself made of traits such as self-control, discipline, and willpower.

Self-control is the restraint exercised over one's own impulses, emotions, desires, and actions that are the foundation of behavior. Self-control, which embodies the concepts of character, will power, and discipline, is a personality trait that is learned mostly from parents but also from family members, teachers, friends and acquaintances, and from a variety of life experiences. Depending of the individual's environment, this learning process can lead to a strong or to an impaired self-control with positive or negative consequences, respectively. For instance, a child well nurtured by dedicated and loving parents in a stable family and social environments is likely to develop robust character traits suitable for making appropriate decisions emulating learned positive patterns of behavior conducive to personal success and to the avoidance of deviant choices later in life. In contrast, a child neglected by uncaring parents, themselves lacking strong character traits, and surrounded by a perfidious environment is unlikely to develop personality traits protective of the many life pitfalls, is less well prepared to face psychosocial challenges, and is therefore more likely to engage in deviant behavior later in life³⁷. One pioneering study that supports the importance and predictive value of early development in self-control is known as the "*marshmallow*" test³⁸ conducted in the 1960's by Walter Mischel to examine preschooler's ability to forego immediate gratification waiting instead for a larger but delayed reward. In the study, a group of 4-year olds were given a marshmallow and promised another if they would wait 20 minutes before eating the first one. Following the progress of each child into adolescence, via surveys of their parents and their teachers, the researchers found that ability (self-control) to delay gratification was both predictive of favorable personal

outcomes (e.g. higher SAT* scores and educational attainment and better social and cognitive competence), and protective against a variety of potential vulnerabilities later in life (e.g. lower drug use). Jellinek first described the concept of “*loss of control*”, in the context of alcoholism, as an inability to stop drinking leading to binge drinking. However, the concept has evolved to include the inability to refrain from substance use (or from engaging in other deviant behavior) and to terminate use or activity once begun. Yet, from Jellinek’s time “*loss of control*” is widely believed to be relative rather than absolute. That is, addicts are capable of exercising some degree of control over their behavior, at least some of the time³⁹. How “*loss of control*” relates to the behavior reinforcing effects of the stimulus, whether drug or activity, or to the addict’s expectation of pleasure from a particular impaired control behavior is largely unsolved and hotly debated.

Neurobiologists and electro-physiologists are now searching for neural correlates of self-control and of behavior that might explain how the brain assigns relative value to different incoming stimuli in order to select the most appropriate. For example, alcohol effects on the brain include impaired frontal lobe tasks as judged by PET** scans, by metabolic studies, and by a neuropsychological test battery designed to assess cognitive functions and processes⁴⁰. Frontal lobe dysfunction, whether associated with decreased or increased activity, has also been documented for many psychoactive agents. However, the key question is whether drug-induced frontal lobe dysfunctional changes predate abuse, which would support genetic predisposition, or are the result of abuse, which would not. That is, whether they are the cause or the result of impaired self-control. Partial recovery from chronic alcohol-induced frontal lobe dysfunction following an extended period of abstinence suggests dysfunctional frontal lobe changes to be, not the cause, but the result of impaired control and of abuse behavior. Hence, biological correlates of abuse are expected to complement our understanding of the neurobiological processes associated with the brain’s handling of reinforcing stimuli but are unlikely to account for addiction and other deviant behaviors.

In the meantime, “*behaviorists reject the prevalent neuro-scientific notion that drugs themselves are responsible for the development of addiction, and see addiction not primarily as a ‘brain disease’ but as a behavioral disorder that cannot be separated from the prevailing and historical contingencies of reinforcement*”³¹. Simply put, like any deviant behavior addiction is a deliberate “*choice*” that, while influenced by genetics, converges and mirrors an individual’s formal and informal education, and encompasses all previous life experiences. The notion that addiction is born of learned behavior and life experiences is not only common sense but has been corroborated by two decades of research⁴⁰⁻⁴⁷. Moreover, the behavioral model surpasses the disease theory of addiction in three major aspects. First, it accounts for the behavior of a majority of individuals who seek drugs and of the millions of casual users and pain patients who do not become addicted despite repeated or protracted drug exposure. Second, it provides a foundation for understanding and explaining all forms of addiction, whether substance or non-substance related. Third and most importantly, it promotes prevention, self-control, and treatment modalities aimed at restoring addicts’ discipline and willpower, empowering them to develop new behavioral patterns instead of perpetuating the myth that they are powerless victims, as embodied in the disease model of addiction. Hence “*solutions* [for

* Scholastic Aptitude Test

** Positron Emission Tomography

controlling addiction] *that do not take into account the basic motivations and propensities underlying addictive behavior are destined to failure*"⁴⁸.

In conclusion, scientific evidence shows that addiction cannot be blamed on an alleged intrinsic addictive power of drugs, on genetics, or on neurocircuitry reward pathways, and is not a disease or an indication of moral turpitude, as it is often claimed. There are at least three lines of reasoning that support the view that addiction is not substance-dependent but behavior-driven. First, an extensive repertoire of addictive behaviors extends well beyond drugs. Indeed, the addiction spectrum includes not only licit and illicit drugs (e.g. alcohol, narcotics), prescription medications (e.g. painkillers, tranquilizers), and chemical substances (e.g. inhalants, glues) but extends to a variety of dietary products (e.g. caffeine, chocolate), certain activities (e.g. internet browsing, gambling, exercise, sex), or even ordinary foodstuff, which the vast majority of the population indulges in moderation. Second, no substance or activity is intrinsically addictive. For instance, narcotics and foodstuff are not addictive when taken for pain relief and nourishment, respectively, but can become reinforcers of addiction when indulged for pleasure. Third, the vast majority of casual drug users do not become addicted and most who do eventually free themselves from their addiction, most often without help. Likewise, no specific genetic mutations or brain pathways have been identified that doom the carrier to addiction, and no chemical rewards have been shown to compel a casual user to engage in substance or non-substance abuse and become addicted.

In the words of a noted critic of the disease theory of addiction, "*The idea that addiction is a disease is the greatest medical hoax since the idea that masturbation would make you go blind.*"⁴⁹. However, addiction can lead to certain diseases and even to self-destruction as possible outcomes. Examples include liver cirrhosis from alcoholism, lung cancer from smoking, AIDS in addicts who share needles, and death from any of them. Equating cause to effect of addiction has been and continues to be exploited by proponents of the disease theory of addiction in part out of conviction but also driven by personal self-interest and to protect a multitude of highly lucrative businesses that profit from it. However, while addiction is not a disease addicts are not criminals to be persecuted and incarcerated as it is done the world over, or stigmatized as sinners. Indeed, addiction is not a crime (though certain drugs of abuse have been criminalized worldwide), nor is it a sign of moral or spiritual decay, or a sin (though it is so viewed in most religious circles). Rather, "*People take drugs because it makes sense for them to do so given the choices available, rather than because they are compelled by the pharmacology of the drugs they take*"⁵⁰. Indeed, evidence shows that addiction is a chosen behavior, just as are all choices that addicts and non-addicts make on a daily basis. In fact, everybody makes unwise choices in life that can lead to adverse outcomes such as addiction, a failed relationship, a disease, a financial loss, and even death. As in any decision-making, unwise choices most often are based on an analysis of available information that is influenced by personality traits of self-control, discipline, and willpower developed from one's life experiences superimposed to a non-determining genetic background. That being the case, three key questions arise: Should society enact social policies to prevent individuals from making unwise choices? When individuals make bad choices, should society intervene? When unwise choices lead to addiction, should addicts be held accountable? Abandoned to their fate? Treated and rehabilitated at society's expense? More on this later.

PART IV

PAIN CONTROL: NARCOTICS & THE DEA

Chapter 5

PHYSICIANS PREDICAMENT

1. The Specter of the DEA.

Today, physicians have at their disposal an array of pain medications ranging in strength from mild to powerful, with the most effective painkillers widely blamed for but rarely found associated with addiction. In the 1980's and 1990's some of these, especially narcotics, found their way to the black market with the occasional connivance of unscrupulous physicians. The public and Congress became acutely aware of the problem when a barrage of media reports claimed that diversion of OxyContin, an oxycodone-based opioid narcotic, was responsible for an outbreak of overdoses, deaths, and crime. Although many of these reports were exaggerated or unfounded, the DEA responded to critics in Congress and in the DOJ* by implementing an aggressive program to eliminate the diversion and illegal use of OxyContin and other narcotics. The DEA *"uses familiar law enforcement methods from the War on Drugs, such as aggressive undercover investigation, asset forfeiture, and informers"*¹. Its tactics, especially vigorous and well publicized when prosecuting physicians suspected of drug malfeasance, have had a chilling effect on legitimate narcotics prescriptions. Consequently, tens of millions of Americans suffer from untreated or under treated pain on a daily basis². Indeed, the American Medical Association reported that 97 million patients suffered from unrelenting pain in 1997 and most of them *"received inadequate care because of barriers to pain treatment"*³. Additional barriers include inadequately pain management training in medical schools, a shortage of pain medicine specialists, and reluctance on the part of many patients to take what they perceive to be addictive medications. However, it is clear that American physicians are frightened by the prospects of falling victims to Federal or State prosecutors eager to indict and convict *"licensed physicians for drug distribution, fraud, manslaughter, and even murder for the deaths of people who misused and/or overdosed on prescription painkillers"*¹. Likewise, restrictions on the production and distribution of narcotics imposed by national laws and international drug control treaties restrict their availability in non-industrialized countries. According to the WHO⁴, 80% of persons suffering from severe pain worldwide do not receive adequate treatment. The human cost of untreated or under treated *chronic*** pain includes depression, absenteeism, alcoholism, family disruption and violence, and suicide. The economic cost to society, including medical expenses and lost wages, is incalculable, but has been estimated to reach \$100 billion per year in the US alone^{5,6}.

Targeting physicians for prosecution is not a new phenomenon born with the DEA. The first Federal law that criminalized the recreational use of opium, morphine, and cocaine was the Harrison Act, passed in 1914⁷. This took place within the general thrust towards Prohibition by advocates of the Temperance movement, at a time when opiates were widely popular as medicinal and recreational drugs. They were thought to

* Department of Justice

** Pain that persists weeks to months

have tranquilizing, antidepressant, analgesic, and other properties that made them ideal for self-medicating a variety of ailments. They were sold at grocery stores as potions and elixirs, alongside beer and wine, and by itinerant salesmen roaming the countryside with a *shill*^{*} attesting to the astonishing properties of the boisterously promoted concoction. Examples of the most popular medicinal cannabis sold in the 1800s and early 1900s boasted eclectic claims⁸. "*Handy Corn Plaster*", manufactured by The Chamberlain Medicine Co. of Des Moines, IO, was formulated "*for hard and soft corns and bunions, guaranteed to give satisfaction or money refunded*". "*Doctor Macalister's Cough Mixture*", produced by John P. Lee of Chicago, IL, was promoted as "*the best remedy for coughs and colds of adults and for croup and whooping cough of children*". "*Dr Poppy's Wonder Elixir*" was advertised as "*the one bottle cure for Colds, Coughs, Rheumatism, Head tension, Gout, Shingles, Influenza and Arthritis...a glass in the morning is guaranteed to relieve symptoms and leaves a pleasant feeling that lasts all day*".

A plethora of *nostrums*^{**} or *patent medicines*, as these products were called, permeated American society in the mid- to late nineteenth century as they appealed to a public need left void by traditional medicine in an environment where no laws existed to regulate their content or curb claims of their curative properties. A notorious nineteenth Century peddler of patent medicines containing opium as the active ingredient was William Avery Rockefeller ("*Big Bill*") an eccentric man who made a quick fortune that enabled his only son, John Davison Rockefeller, to build an oil empire that made him the richest man in America⁹. However, muckraking journalists such as Samuel H. Adams, the General Federation of Women's Clubs, the American Medical Association, the American Pharmaceutical Association, and others exposed the worthless or harmful ingredients in most nostrums, the unfounded claims of their curative properties, and the manufacturers' deceitful advertising practices. At that time, Upton Sinclair published *The Jungle*, a shocking novel exposing the appalling living and working conditions and hopelessness of immigrant workers in Chicago and the lack of hygiene in meat packing plants. His novel includes episodes of workers falling into meat processing tanks and being ground, along with animal parts, and sold as "*Durham's Pure Leaf Lard*". Such exposés quickly captured public and Congressional attention and were instrumental in the passage of the first Federal Food and Drugs Act, in 1906. As could be expected, this act did not put quacks out of business; they still prosper today in a myriad of new schemes. However, it was the first attempt towards consumer protection legislation in the US.

Eight years later, the US Congress passed the Harrison Act, the first Federal law designed to regulate the medical use of narcotics by criminalizing their recreational use. Given possible opposition on constitutional grounds, the statute was masqueraded as a tax. The Act required anyone who "*produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives, or preparations, and for other purposes*" to register, obtain and fill out forms, and place and retain tax stamps on packages containing narcotics. Registered physicians, dentists, and veterinary surgeons were to keep records for two years "*of all such drugs dispensed or distributed, showing the amount dispensed or distributed, the date, and the name and address of the person to whom such drugs are dispensed or distributed...subject to inspection, as provided in this Act*". Any person who "*violates or fails to comply with any*

* An accomplice planted in the crowd pretending no association with the seller

** *Nostrum remedium* (our remedy): "*a patent medicine*" made of secret ingredients, produced by quacks

of the requirements of this Act shall, on conviction, be fined not more than \$2,000 or be imprisoned not more than five years, or both". To facilitate enforcement of the Harrison Act, possession of narcotics in any form other than the official tax-stamped package was sufficient evidence to authorize conviction unless the defendant explained the possession to the jury's satisfaction. Over the ensuing 25 years, tens of thousands of people were prosecuted for violations of the Harrison Act, and nearly 25,000 physicians were arrested, 3,000 were convicted and jailed, and thousands more lost their license and livelihood^{8,9}. This marked *"the US government... aggressive, unprecedented pursuit of physicians and their addicted patients"*¹.

In 1970, the Harrison Act was replaced by the Comprehensive Drug Abuse Prevention and Control Act, which included the Controlled Substances Act (CSA). The latter was to serve as the foundation for the *War on Drugs* that followed, including unleashing a new wave of prosecutions of physicians accused of drug malfeasance. The CSA, which classifies certain drugs (including all painkillers) into 5 "*Drug Schedules*" and establishes guidelines for their use, empowered the DEA to regulate all pharmaceutical Drugs, including prescription analgesics. Scheduled drugs range from Schedule I drugs, that have "*high potential for abuse*", "*no currently accepted medical use in treatment in the US*", and "*lack accepted safety for use of the drug... under medical supervision*", to Schedule V drugs that have "*low potential for abuse*", "*currently accepted medical use*", and "*abuse may lead to limited physical dependence*". Schedule I drugs includes heroin, which is used in much of Europe as a powerful pain reliever especially useful for managing terminal cancer patients. Ironically, *"under the DEA's interpretation of the CSA, a drug does not necessarily have to have the same abuse potential as heroin to merit placement in Schedule I"*¹⁰. This is how the DEA justifies listing Cannabis (Hemp), a plant from which *marijuana* and *hashish* are derived, alongside heroin despite its licit medical uses in some countries and in several American States and its lack of significant effects on health or crime rates. No prescriptions may be written for Schedule I drugs and non-violent street peddlers prosecuted for multiple offenses can face life-sentences¹. Schedule II drugs, which lists morphine, cocaine, and various formulations of opium among others, are available only by non-refillable prescriptions, their production is subject to quotas, and their distribution is controlled by the DEA, albeit incompetently.

In 1973, President Nixon created the DEA, under DOJ jurisdiction, as part of his Reorganization Plan No 2. Early on, the mission of the DEA was to *"bring to the criminal and civil justice system substances destined for illicit traffic in the U.S"*¹¹. But, by the late 1990s and early 2000s, the DEA came under criticism from Congress for having no measurable proof that the illegal drug supply and use in the US had declined under its watch. In the same time frame, the Inspector General of the DOJ claimed that a major problem of *"prescription drug abuse"* existed in the US, citing suspect statistics regarding the magnitude of the problem, and chastising the DEA for having failed to address it¹. For example, he cited the unverifiable figures of 6.4 million Americans having used painkillers illegally in 2001 whereas *"just over 4 million used cocaine"*¹. The DEA contributed to the disinformation campaign claiming *"people who abuse controlled pharmaceuticals each year equals the number who abuse cocaine: 2 to 4 percent of the US population"*¹², and were responsible for 25% of deaths from drug overdose¹². The media joined the chorus, contributing to an atmosphere of fear and hysteria about a supposed threat of a massive diversion of prescription painkillers by physicians who they likened to drug pushers. Included in the chain reaction, denouncing the dangers of the potent painkiller OxyContin, were high profile publications like Time magazine, US News and World Report, and The New York Times.

For instance, on January 2001 Time magazine reported that “*OxyContin may succeed crack cocaine on the street*”¹³. On February 2001, US News and World Report reported¹⁴ on the dangers of OxyContin, featuring a physician who purportedly supplied illegal narcotics to addicts and was responsible for a rise in crime in his community. The same month, the New York Times reported that 59 people had died of OxyContin overdose in Eastern Kentucky in 2000, and that the drug had set a wave of pharmacy burglaries, overdoses, and physician arrests¹⁵. WDSU Channel 6 of New Orleans ran 5 stories involving OxyContin, with titles such as “*Dad arrested in son’s OxyContin death*”, 4 of which were printed between April 10, 2001 and May 15, 2001¹⁶. And, on December 12, 2001, CBS’ “*48 Hours: Addicted*”, anchored by Dan Rather was followed the next night by MTV News and Docs’ “*True Life: I’m Hooked on OxyContin*”, hosted by Serena Altschul. The theme of both newscasts was, “*Dependency on prescription drugs like OxyContin is a mounting problem among young people and the general population, alike*”¹⁷. However, the most notorious example of unscrupulous media reporting was the now infamous five-part Orlando Sentinel series published October 19-23, 2003, titled “*OxyContin under fire*”, written by Doris Bloodsworth¹⁸. The articles, citing alarming though dubious statistics¹ and including photographs of “*innocent victims*”, and accompanying editorials, seemed designed to elicit maximum aversion towards OxyContin and sympathy for its “*victims*”. However, some of the *victims* had a prior history of drug abuse or addiction, as was discovered when the Sentinel stories unraveled and the paper retracted much of the information it had published¹⁹.

In response to the Sentinel series and without further inquiry, Florida Governor Jeb Bush proposed a bill that would create a prescription drug database to track and cross-reference the prescription drug records of all Florida citizens. Moreover, to make it harder for patients to abuse OxyContin, the Florida legislature also passed a law to stop paying for prescriptions exceeding 120 pills without prior approval from Medicaid. Howard Dean, governor of Vermont and a physician himself, also took advantage of the prevailing anti-OxyContin sentiment requiring that all prescriptions for that drug, written for 1,200 out of 128,000 patients enrolled in the State Medicaid and the Vermont Health Access Programs, be approved in advance²⁰. Other States that now curb OxyContin distribution to Medicaid recipients include West Virginia, Ohio, South Carolina, and Maine. Whether these State measures had the intended outcome is doubtful. As could be expected, many trial attorneys expecting a wave of law suits added OxyContin to the list of drugs their lucrative practices aggressively target. Yet, they appear to have misjudged the financial potential of OxyContin, for “*all 1,665 personal injury claims filed by individual plaintiffs have either been dismissed or abandoned*”, according to Purdue Pharma L.P., OxyContin manufacturer²¹. It is noteworthy that, long after the Sentinel and other OxyContin-related stories were exposed as inaccurate, exaggerated, or deceitful, some reporters and their editors continue to pound on a dead horse, unaware or oblivious of the generally accepted notion that the 2001-2003 media blitz on OxyContin was overstated, at best, or designed to increase newspapers sales, at worst. For example, in August 2004, the Boston Globe and the Ottawa Citizen published reports on OxyContin abuse or deaths, citing statistics out of context, or quoting alarming but uninformed statements by local officials^{22,23}. Likewise, in a book published in 2004²⁴ the claim is made that, “*whether prescribed by a physician as OxyContin or purchased on the street as ‘hillbilly heroin’, painkilling drugs are extremely effective in eliminating physical, emotional, and psychological distress. The problem is that these drugs are also incredibly addictive*”, a common misconception based more on popular folklore than on facts.

However, it must be observed that many in the media and law enforcement communities will feel vindicated by the plea agreement by Purdue Frederick Co., an affiliate of Purdue Pharma L.P., and three of its executives. They agreed to pay an aggregate of \$634 million for *“falsely claiming that OxyContin was less addictive, less subject to abuse, and less likely to cause withdrawal symptoms than other pain medications”*²⁵. This was the outcome of a 4-year investigation conducted by a consortium of eight State and Federal agencies. They included: the Virginia Attorney General’s Medicaid Fraud Control Unit, the FDA’s Office of Criminal Investigations, the IRS* Criminal Investigation unit, the Department of Health and Human Services, the Department of Labor, the Defense Criminal Investigative Service, the Virginia State Police, and the West Virginia State Police. The outcome of the witch-hunt triggered a series of grandiloquent pronouncements by law enforcement such as, *“It is unthinkable that purely for greed, addictive drugs were fraudulently marketed to the public, and in so doing threatened the health and safety of our citizens. Among those endangered were soldiers, sailors, airmen, marines, and their families, all of who avail themselves of the military health system. At a time when our military personnel and their loved ones are sacrificing so much, something like this is incomprehensible and grossly reprehensible”*²⁵. The media obligingly applauded the settlement but judged it insufficient because *“we were seeing a tsunami of opioid addiction in young people who had recreationally used OxyContin and had become rapidly addicted to this highly potent opioid. Soaring crime rates, multiple medical complications, an epidemic of intravenous drug abuse and Hepatitis C, a harrowing increase in overdose deaths and fractured families, overwhelmed the medical, legal and social systems that simply didn’t have the resources to meet the problems”*²⁶. Let the reader judge whether these are responsible and objective statements by law enforcement and the media.

Embolden by a clamor of public indignation against narcotics and physicians accused of diverting drugs to the black market, the DEA announced its newly deployed *“OxyContin Action Plan”* of 2001¹². This plan, like the Harrison Act, equated legal prescription drugs listed under Schedule II with illegal, non-prescription drugs included in Schedule I. This placed physicians on an equal footing with drug dealers making them legally responsible for the consequences of legitimate prescription drugs diverted by criminal elements. DEA’s commissioner, Asa Hutchinson, announced that given the threat of the new prescription drug epidemic his agency would reallocate resources from combating illegal drugs to fighting illicit prescription drugs, and that it would use its Asset Forfeiture Fund to help finance the new plan²⁷. His perverse logic was impeccable. Shifting the focus from hard to penetrate black markets of illegal drugs controlled by unknown and ever changing players, to a pool of easy to track, stable, registered, cooperative, record-keeping, tax-paying physicians with plenty of forfeitable assets, would help subsidize their own prosecutions, appease Congress, and validate the DEA’s own existence. It must be remembered that in the 1980s, prior to the *“prescription drug diversion”* scare, drug prohibitionists and the media portrayed crack cocaine as the *“the most addicting drug known to man”* that was quickly spreading to suburbs and schools and was responsible for most street crime, deteriorating social conditions, and for failing school grades. Politicians quickly adopted and amplified the unsubstantiated claims, using the issue as a rallying point to vote major budget increases for law enforcement, the prison system, and the military to save America’s children from the plague of crack cocaine. When the short-lived craze for crack cocaine ended, presumably because its extreme and vicious ups and down are undesirable to most users, politicians, the media,

* Internal Revenue Service

and law enforcement simply refocused their attention and their campaigns on other “*most addictive drugs known to man*”, mainly prescription narcotics. This new “evil” was an easier target to monitor and pursue, and provided law enforcement an opportunity to control narcotics prescriptions, even if the DEA continues to claim not to be in the business of regulating physicians; a State prerogative. However, this claim contradicts its requirement that physicians register and obtain a DEA license for the privilege of prescribing controlled substances that also serves as an agency’s tool to monitor prescribing patterns. Moreover, using “*all available enforcement tools*” to disrupt drug “*diversion, illegal sale, and abuse*”²⁸, where physicians play a “*primary*” role according to the agency, along with using revenues from license fees to investigate and prosecute targeted physicians, contradict its claims not to regulate and not to target physician. Another source of revenue for drug enforcement is the DOJ’s Asset Forfeiture Fund, which is financed by *Criminal, Judicial, and Administrative* forfeitures²⁹. The former is a perfectly transparent legal action invoked during the criminal prosecution of a defendant. It requires the indictment of the property and of its owner, a determination by a jury that the property is forfeitable, and a court order of forfeiture. *Civil judicial forfeiture* is an action brought in court against the property without charging the owner. More ominously, under the DOJ’s *Administrative forfeiture* guidelines, property can be seized by the federal seizing agency without judicial involvement. Administratively forfeitable property includes merchandise of prohibited importation, vehicles, and facilities used for the importation, transportation, and storage of controlled substances, and other property not exceeding \$50,000 in value.

However, if some features of the DOJ’s forfeiture program appear excessive, the DEA’s investigative tactics and *modus operandi* are even more questionable. Indeed, innocent targets are too often DEA’s focus, causing numerous abuses and miscarriages of justice that can wreck patients’ lives and destroy physicians’ careers. The tools it uses are multiple and all encompassing. They include redefining “*addict*”, “*drug dealer*” and “*drug distributors*”; aggressively using the asset forfeiture law at the arrest rather than the conviction stage of an investigation; offering leniency to arrested drug offenders in exchange for information incriminating physicians; character assassination; using SWAT teams indiscriminately; and even disavowing its own guidelines and positions when expedient to convict a suspects. Additionally, by defining addicts as, “*any individual...who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction*”³⁰, the DEA blurs the crucial distinction between “*addiction*” and “*physical dependence*”. Indeed, while an addict compulsively seeks pleasure from a drug despite adverse health or social consequences that frequently leads a deteriorated lifestyle, a pain patient is said to be “*physically dependent*” when taking a drug becomes necessary to relieve excruciating pain and to function with some semblance of normality. Another phenomenon, called “*tolerance*”, can develop when patients take opioids long-term. In such cases, increasing doses of medication are required to maintain the same level of pain control. Finally, *seeking or taking higher than prescribed doses of opioids, a condition that may be associated with tolerance and withdrawal symptoms, characterizes “pseudo-addiction”*. This seemingly aberrant behavior is the result of under treated pain, rather than an indication of addiction, and is eliminated by pain relief. Yet, *even physicians often confuse pseudo-addiction with addiction*. Patients taking opioids for pain control have extremely low rates of addiction³¹, even if physical dependence, tolerance, or pseudo-addiction develops. In addition, patients do not experience euphoria, a psychological effect of opioids sought and experienced by addicts, loss of control over use, do not exceed their prescribed dose after reaching adequate analgesia, and do not engage in other aberrant drug-

related behaviors that are hallmarks of addiction. Withdrawal symptoms from opioids occur in addicts unable to get a timely “fix” but not in pain patients, and are not life threatening as can be withdrawal from alcohol.

The DEA also played loose with its definition of OxyContin-related deaths, neglecting to inform the public that most of the 464 deaths it reported for 2000 and 2001 involved at least one other drug, precluding determination of which caused death. Indeed, the Journal of Analytical Toxicology reported that out of 919 deaths listed as “oxycodone deaths” over a three-year period, only in 12 was oxycodone detected alone in the system of the deceased³². Likewise, because possessing a drug in amounts exceeding a certain limit is a presumption of “*intent to distribute*”, many patients have been prosecuted as “*drug dealers*” and their physicians as “*drug distributors*”. Moreover, mandatory minimum sentences tie judges’ hands precluding their taking into consideration special circumstances of a case. Finally, because the DEA has criminalized prescription drugs, it makes no distinction between a homicide committed by a drug dealer in a turf war and an overdose death caused by a diverted prescription drug written in good faith to a legitimate patient. In both cases, the dealer and the physician could face life imprisonment.

With the expanding role of the DEA in the *War on Drugs*, so has exploded the use of SWAT* teams. Today, SWAT teams raid over 100 private homes daily and most of them involve drug offenses. *“These raids are commonly conducted late at night, or just before dawn, to catch suspects by surprise. Police sometimes deploy ‘flash grenades,’ then batter down or blow up doors with explosives. They then storm the home, subduing occupants, handcuffing them at gunpoint, sometimes pushing them to the ground”*³³. Such aggressive, confrontational raids are justifiable in response to violent crimes or to threats to the community, such as hostage situations. However, in the prosecution of drug cases agents frequently rely on law-breaking informers motivated by leniency for themselves rather than by objectivity. As a result, many SWAT raids *“have left a long trail of ‘wrong address’ frightened innocents, needless injury, and even death”*³³. On such episode occurred *“on the night of April 23, 1973, [when] Herbert Joseph Giglotto, a hardworking boilermaker, and his wife, Louise, were sleeping soundly in their suburban house in Collinsville, Illinois. Suddenly, and without warning, armed men broke into their house and rushed up the stairs to the Giglottos’ bedroom. Giglotto later recalled, ‘I got out of bed; I took about three steps, looked down the hall and I [saw] men running up the hall dressed like hippies with pistols, yelling and screeching. I turned to my wife: God, honey, we’re dead’. The night intruders threw Giglotto down on his bed and tied his hands behind his back. Holding a loaded gun at his head, one of the men pointed to his wife and asked, ‘Who is that bitch laying there?’ Giglotto begged the raiders, ‘Before you shoot her, before you do anything, check my identification, because I know you’re in the wrong place.’ The men refused to allow the terrified couple to move from the bed or put on any clothes while they proceeded to search the residence. As books were swept from shelves and clothes were ripped from hangers, one man said, ‘You’re going to die unless you tell us where the stuff is.’ Then the intrusion ended as suddenly as it began when the leader of the raiders concluded, ‘We made a mistake’ ”*⁹.

Another favorite DEA tactic is character assassination of arrested physicians through press releases as exemplified by Karen Tandy, DEA’s administrator’s reckless portrayal of the 42 physicians arrested in 2004. *“Those 42”, she announced, “were not*

* Special Weapons Assault Team

*arrested for prescribing too much medicine. They committed egregious criminal acts such as exchanging prescriptions for sexual favors or kickbacks”*²⁸. The DOJ's Asset Forfeiture Fund is financed by assets seized from suspects under investigation and is used to complement the funding of the DEA's Diversion Control Program and to reward State and local drug enforcement agencies that cooperate with the DEA¹. One example¹, is the \$220,000 seized from Dr. Eli Schneider before he was charged. Of that amount, \$50,000 went to the US Department of Health and Human Services, \$29,000 to the Cincinnati Police Department, \$24,000 to the Ohio Department of Health and Human Services, \$14,000 to the FBI, and \$3,752 to the Ohio Medicaid Fraud Control Unit. Not unlike war practices of yesteryear, the DOJ's forfeiture policy gives the conquering troops the authority to loot the conquered and share the spoils. This perverse financial incentive system contributes to the overly aggressive pursuit of well-off physicians by cash-short State and local police departments leading to numerous abuses. The following are three well-known and often cited prosecution examples¹ arising from the DEA's misguided and overzealous policies.

Richard Paey was a 45-year old wheelchair bound patient with chronic pain caused by a car accident and a botched back surgery. After moving to Florida, he elected to have his New Jersey physician mail him signed, undated pain prescriptions, some of which he photocopied and had filled. Although no evidence was presented in court that he sold any of the painkiller pills he purchased, he was charged with “*intent to distribute*” because the amount of narcotics found in his possession exceeded the statutory limit needed to be charged. Feeling that he was not a criminal, Paey refused a house arrest and probation and later a five-year jail sentence offered by the prosecution to avert a trial. Under the mandatory minimum sentencing guidelines, Paey received a 25-years sentence and a \$500,000 fine^{1,34}. “*Today, Paey sits in a Florida prison with a morphine pump, paid for by Florida taxpayers*”¹.

Dr. William Hurwitz is an example of a physician running afoul of the DEA¹. He was one of several dozen doctors, pharmacists, and patients caught in the DEA's “*Cotton Candy*” web. Dr. Hurwitz, who is Jewish, was arrested by a 20-agent strong SWAT team at his ex-wife's house in McLean, VA while visiting his children on Rosh Hashanah eve. He was jailed on a \$2 million bond. All his assets, including his retirement account, were seized essentially for being duped by some of his patients to write narcotics prescriptions that were later sold on the streets³⁵. Dr. Hurwitz was charged with “*conspiring to traffic drugs, drug trafficking resulting in death and serious injury, engaging in a criminal enterprise, and health care fraud*”³⁶. At the trial, his attorney was limited to present only 5 patients' testimonials whereas the prosecution was allowed 63 witnesses, including Dr. Michael Ashburn whose testimony was promptly refuted by 6 past presidents of the American Pain Society in a letter addressed to one of his lawyers on December 10, 2004³⁷. These pain experts took this unusual step because they felt “*deeply concerned that serious misrepresentations in the testimony provided by the government's expert, Dr. Michael Ashburn, will undermine the welfare of patients who suffer in chronic pain*”. The letter concluded “*In the past, each of us perceived Dr. Ashburn as a respected colleague and his selection as an expert by the government as understandable. We are stunned by his testimony. As leaders in this field, we feel compelled to correct the errors in his testimony, lest it be used in the future in a manner that worsens the national tragedy of untreated pain. We will try to correct the public record after the trial concludes and sincerely hope that the government and the court will consider this information now*”³³. Dr. Hurwitz was convicted of 50 of 62 counts, sentenced to 25 years in prison, and fined \$1 million³⁸. After the trial, the jury

foreman stated to the media that Dr. Hurwitz was “*sloppy*” and a “*bit cavalier*” in record-keeping rather than “*running a criminal enterprise*”³⁹, as accused. On August 15, 2006 the 4th US Circuit Court of Appeals ordered a new trial because the trial judge had “*effectively deprived the jury of the opportunity to consider Hurwitz's defense*” by failing to allow the jury to consider that Dr. Hurwitz “*acted in good faith*” in treating his patients⁴⁰. At issue were DEA guidelines that the agency disavowed at the time of the trial in order to prevent their introduction as evidence by Dr. Hurwitz’s defense attorney. The disavowed document included specific guidelines for “*Health Care Professionals and Law Enforcement Personnel*”⁴¹ enunciating what was and was not “*legitimate practice*”. Dr. Hurwitz’ retrial beginning on March 26, 2007 was characterized in the press as “*a battle over who sets the rules for treating patients who are in pain: narcotics agents and prosecutors, or doctors and scientists*”⁴². Using a tried and proven prosecutorial approach particularly effective with jurors, Dr. Hurwitz was portrayed as “*a drug trafficker... [who]... ignored clear 'red flags' that his patients were misusing and reselling the pills [prescribed] without a legitimate medical purpose... [and]... in its wake left destruction, devastation and death.*” The defense called on Dr. Russell K. Portenoy and Dr. James N. Campbell, two leading pain experts and past presidents of the American Pain Society who testified that Dr. Hurwitz was a knowledgeable physician and passionate advocate of pain control and that his pain prescriptions were “*within the bounds of medical practice*”. Yet, after deliberating 7 days, the jurors found Dr. Hurwitz guilty on 16 counts of drug trafficking each carrying a 20-year maximum sentence, exonerated him of 17, and were unable to agree on 16, which were then dismissed by the judge. On July 13, 2007, judge Leonie Brinkema dismissed a life sentence sought by prosecutors and sentenced Dr. Hurwitz to a 57-month prison term observing, “*an increasing body of respectable medical literature and expertise support those types of high-dosage, opioid medications*”. Having already served 2-1/2 years in prison, Dr. Hurwitz should be eligible for release at the end of 2008.

Another egregious example of the DEA’s strategy against pain-managing physicians is that of Dr. Frank Fisher^{1,43,44}. Dr. Fisher, a Harvard graduate whose California practice served a poor, rural area was charged in 1999 with multiple counts of fraud and drug diversion and 3 counts of murder. The latter included a patient who died of an unrelated car accident, a man who died after he took narcotics stolen from the home of one of Dr. Fisher’s patients, and a patient who died after her prescriptions had run out and Dr. Fisher was already in prison. According to Dr. Fisher’s own account⁴⁴, the car accident death “*was Rebecca Mae Williams, a 37-year-old who had suffered from incurable low-back pain. After exhausting alternative treatments, I had successfully controlled her pain with 80 milligrams of OxyContin twice a day, a dose that had allowed her to enjoy an active life. The day Becky died, she had taken her usual dose before going furniture shopping with her boyfriend. As their small truck rounded a curve, the driver's door flew open, and David, who was driving, fell out. The truck crashed into a tree, and the impact exploded my patient's heart, fractured her skull, broke her neck, and eviscerated her. Yet on the basis of an impossibly high level of oxycodone measured in a blood sample - later found to be contaminated - the county medical examiner asserted that Becky had died of a drug overdose*”. More was to come, as Dr. Fisher recalls: “*Before the criminal prosecution would conclude years later, I would be accused of murdering nine people, including several I had never even met*”. Dr. Fisher was described by the prosecutor and by the press as a mass murderer and a common drug pusher despite the fact that “*mindful of 'drug seekers' I had established a screening procedure... that turned away 60 percent of applicants without my even seeing them. Those accepted into the pain management program had access to a multidisciplinary*

*treatment team that included surgeons, physical therapists, chiropractors, and an acupuncturist. Each patient had to undergo regular psychological evaluation. And acceptance into the program didn't ensure continued treatment. Patients who could not follow the program's guidelines were discharged. By the time I was arrested, some 600 former patients were on the ejected list"*⁴⁰. His assets were seized and he was jailed on a \$15 million bond. At the preliminary hearings the government's medical expert stated, *"The majority of [his] patients were on doses that we had never seen before. Some of the doses we thought were incompatible with life"*⁴⁰. Seizing the opportunity, the defense attorney asked her to read aloud from the OxyContin product literature brochure that pure opioid agonists have no ceiling dose. Indeed, opioid narcotics have unrivaled analgesic properties with much lower toxicity than less efficacious alternatives, allowing their use long term and in high doses. The judge dismissed five murder charges, downgraded three to manslaughter, reduced the \$15 million bond to \$50,000, and released Dr. Fisher from prison; a bitter-sweet victory for, with no assets and now 50, he had to move in with his parents. At the trial that began on January 13, 2003, the prosecuting attorneys admitted not to have sufficient evidence to proceed and the judge dismissed all remaining charges. Yet, California Attorney General Bill Lockyer charged Fisher for an alleged \$150 "up coding" * theft from Medi-Cal". On May 18, 2004, a jury acquitted Dr. Fisher of that charge as well, with one of the jurors describing *"the whole thing as a witch-hunt"*. However, *"the criminal phase of my ordeal was over, but the state attorney general had one more gambit: to go after me through the state medical board. He failed there as well"*⁴⁴. Having faced charges ranging from Medicaid fraud to drug diversion to murder for six years, and after losing his medical practice and all his assets, and spending five months in jail, Dr. Fisher has found a new vocation. He is *"working to resolve the flaws in social policy that drive the pain crisis, with the hope that someday I will once again be able to treat patients with chronic pain effectively"*⁴⁴.

Skeptics might argue that these are anecdotal cases with little relevance to the overall picture that do not justify physicians' fear of the DEA. To reinforce skeptics' argument and offset its critics the DEA issued, on October 30, 2003, a "News Release" titled *"The Myth of the Chilling Effect: Doctors Operating Within Bounds of Accepted Medical Practice Have Nothing to Fear from DEA"*⁴⁵. In it, it asserts that since 1999 *"less than one tenth of one percent"* of physicians, or *"34 of the 963,385 doctors licensed in the US"* in 2003, were arrested for illegally prescribing narcotic painkillers. The actual percentage of arrested physicians, according to DEA's own data, would be 0.0035%. Eighteen months later, in a published rebuttal to critics, the DEA administrator stated, *"last year, DEA cases resulted in the arrest of 42 doctors... less than one arrest for every 23,000 DEA-registered physicians"*^{33,46}, or 0.0043%. These figures are disingenuous, misleading, and largely irrelevant to the issue of physicians' fears of the DEA and its effect on pain management. The reasons are four-fold, as shown by the analysis of the DEA's 2003 number of arrests claim. First, it is unclear where did the DEA's figure of *"963,385 licensed doctors"* originated. In fact, the number of *practicing* physicians probably did not exceed 700,000 in 2003 if only 720,290 physicians were DEA-registered two years later, according to the agency's own figures (see below). Second, 90% of physicians do not routinely treat chronic pain patients and, when they prescribe narcotics, it is on a sporadic basis, for short periods, and in low doses for the

* Altering a disease code to overcharge third party payers

** California's Medicaid agency

management of acute* or subacute** pain. Hence, arrested physicians might represent a tiny fraction of doctors in practice or with a narcotics license from the DEA but a large percentage of those who specialize in pain management and prescribe narcotics routinely. Indeed, it has been estimated, from three database sources, that the number of pain-treating physicians in the US range from 4,278 to 5,869 ⁴⁶. Therefore, the 34 arrested physicians represent 0.68% or 1 in 147 pain-treating doctors, rather than “one arrest for every 23,000 physicians”, claimed by the DEA. Even adding Medical Oncologists (8,397 with valid certificates in 2003 ⁴⁷) who treat cancer patients, most of whom will suffer chronic pain with disease progression ⁴⁸, the percentage of narcotics-prescribing physicians arrested (34 out of 14,266) would be 0.24%, or 1 in 412. Third, arrests made by DEA agents, in this case 34 physicians, is but a fraction of all arrests, most of which are carried out by State and local enforcement agencies working in partnership with the DEA. Fourth, as much as they fear arrest physicians dread the potentially devastating effect of a DEA investigation on their reputations, their finances, their lives, and on the lives of their patients, even if an arrest is never made. Indeed, according to one report ⁴⁶, “in 2001, the DEA carried 861 investigations of doctors” representing 17% (1 in 6) of 5,869, or 6% (1 in 16) of 14,266 pain-treating physicians. More recent DEA data reveals that the agency investigated 595 of “approximately 720,290 Medical Doctors (MDs) and Doctors of Osteopathic Medicine (DOs) registered with the DEA in 2005” ⁴⁹. Also, in 2005, there were 43 criminal dispositions against physicians, or a 50-fold greater than the “less than one tenth of one percent”, and 150 times the “one arrest for every 23,000 physicians”, claimed by the DEA.

Moreover, while these recalculated DEA figures expose the agency’s disingenuous handling of its own data, they do not begin to explain the intensity of physicians’ deep-seated fear of the agency. Indeed, what physicians dread is falling victim to the terrorizing tactics of the agency in its relentless pursuit of a case and, if arrested, the prospects of losing all their assets, their medical license, their malpractice insurance, and their livelihood, even if eventually acquitted, as was Dr. Fisher. The uselessness and hypocrisy of targeting physicians is revealed by the DEA’s own database which shows that most diverted narcotics destined to the black market in the US originate from sources other than physicians’ prescriptions, and that it does little to prevent or control it. In this regard, an analysis ⁵⁰ of the DEA’s “*Report of Theft or Loss of Controlled Substances*”, obtained through the Freedom of Information Act, sets the record straight on narcotics diversion. The report revealed that between 2000 and 2003 “almost 28 million dosage units of all controlled substances were diverted... primarily from pharmacies (89.3%), with smaller portions from medical practitioners, manufacturers, distributors, and some addiction treatment programs that reported theft/losses of methadone”. The six most stolen or otherwise diverted opiate analgesics were oxycodone (4,434,731 doses), morphine (1,026,184 doses), methadone (454,503 doses), hydromorphone (325,921 doses), meperidine (132,950 doses), and fentanyl (81,371 doses). The authors of the analysis concluded, “pain medications, regardless of schedule, are being stolen from the drug distribution chain prior to being prescribed, contributing to their illicit availability, abuse, and associated morbidity and mortality”. They opined, “If we accept uncritically that drug diversion stems only from prescriptions, we risk distorting our view of the medical profession and patients through a lens of substance abuse, which further weakens physicians’ desire to treat pain and worsens

* Sudden, brief, and severe

** Between acute and chronic

patient access to pain care". Finally, they advised, *"Diversion control efforts must target the correct sources and not subject law-abiding prescribers and patients to unwarranted scrutiny"*. Therefore, whether stolen from pharmacies or diverted at other points in the distribution chain, the vast majority of diverted prescription drugs have never been prescribed by a physician nor dispensed by a pharmacist and, in any event, represent but a minute fraction of illegal drugs on the streets, as reported by the White House ONDCP. For instance, *"between 1988 and 1995, Americans spent \$57.3 billion on drugs, broken down as follows: \$38 billion on cocaine, \$9.6 billion on heroin, \$7 billion on marijuana, and \$2.7 billion on other illegal drugs and on the misuse of legal drugs"*^{51,52}. *"Other illegal drugs"* referred to in the study included depressants, stimulants, inhalants, rohypnol, ketamine, PCP*, GHB**, LSD***, MDMA****, and scores of other illegal agents. As for the *"misuse of legal drugs"*, which referred to diverted prescriptions drugs, accounted for only 4.7% of the \$2.7 billion cited, or \$60 million, or 1% of the 57.3 billion total; hardly justifying being the DEA's favorite anti-narcotics drug enforcement target.

In conclusion, through the DEA, the US government is conducting an aggressive and unjustifiable campaign against pain-treating physicians. This is achieved by a multifaceted approach. It includes redefining the terms *"addict"*, *"drug dealer"* and, *"drug distributor"*, criminalizing opioid prescribing patterns coupled to a disinformation campaign to convince the public that, contrary to evidence, physicians are responsible for a *"major prescription drug problem in the US"*, and aggressively using the asset forfeiture law at the arrest rather than at the conviction stage of an investigation. Using drug dealers and other unreliable informers is the rule, as is reliance on *"no-knock"* SWAT raids of targeted physicians' and patients' homes. More ominously, SWAT incursions into the homes of innocent citizens, many of which botched³³, are often unauthorized, or misrepresented and in clear violation of the 4th amendment of the United States constitution. Indeed, the 4th amendment affirms, *"The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized"*. It also disavowed its very guidelines on narcotics when judged crucial to convict a suspect.

DEA's methods and tactics, coupled with its probably unconstitutional position that *"the Government can investigate merely on suspicion that the law is being violated, or even just because it wants assurances that it is not"*¹, suggest that abuses and miscarriages of justice are the norm rather than the exception and that most of them never come to light. In prosecuting physicians, the DEA is not bound by the usual rules of evidence and frequently thwarts the expectation of having expert medical testimony as protection against allegations that the physician's actions were *"outside the scope of legitimate practice"*. In fact, the DEA has brought charges against doctors even when prescriptions were not actually filled, leading to the conclusion that *"there seems to be no evidentiary standard at all that doctors can rely on to thwart a conviction"*¹. By heavily publicizing physician arrests, indictments, and convictions usually accompanied by character assassination, the DEA insures high visibility that fosters a public and

* Phencyclidine

** Gamma hydroxybutyrate

*** Lysergic acid diethylamide

**** 3-4 methylenedioxymethamphetamine or Ecstasy

Congressional perception that it is successfully addressing and protecting the public from a “*major drug problem*”. Never mind that the *War on Drugs* is being waged at enormous economic and human costs to the nation. According to the NIDA, “*More than half of the estimated costs of drug abuse [\$181 billion in 2002] were associated with drug-related crime. These costs included lost productivity of victims and incarcerated perpetrators of drug-related crime (20.4 percent); lost legitimate production due to drug-related crime careers (19.7 percent); and other costs of drug-related crime, including Federal drug traffic control, property damage, and police, legal, and corrections services (18.4 percent). Most of the remaining costs resulted from premature deaths (14.9 percent), lost productivity due to drug-related illness (14.5 percent), and healthcare expenditures (10.2 percent)*”⁵¹. Never mind that, despite these enormous costs and the involvement of an army of *DEA Special Agents* (5,296 in 2005) and countless State and local agents, drugs on American streets, including narcotics diverted from production facilities, warehouses, and in transit to distribution outlets rather than from physicians’ offices, have increased year after year since the DEA was created. Never mind that by making physicians scapegoats of its failed *War on Drugs* the DEA has managed to frighten them by the prospects of falling victims to overzealous Federal or State enforcement agents and prosecutors eager to convict.

While most practitioners are familiar with legal restrictions regarding prescribing controlled substances, most are unaware or rightfully distrustful of legal provisions designed to ensure that drug law enforcement not interfere with medical practice. Consequently, the number of pain-treating physicians has dwindled and those that remain err on the side of caution prescribing what they perceive to be acceptable to the DEA rather than what’s medically appropriate for their patients. As a result, tens of millions of Americans suffer from untreated or under treated pain on a daily basis. It seems clear that solving the pain crisis in America requires first acknowledging that pain control is a fundamental human right⁵³ and that millions of American pain sufferers must not be held hostage to an irrational drug policy based on misconceptions, self-serving attitudes, or outright deceptions regarding the “*dangers*” of illicit drug use to self or society. Acknowledging the veracity of these truths should lead to ending drug prohibition.

2. **DEA's Infringement on Standard of Care.**

Standard of Care in medicine is defined in general terms as, “*primarily a legal concept that refers to the level of practice that any average, prudent, and reasonable physician would provide under similar circumstances. It must reflect the art (consensus of opinion) and the science (peer-reviewed literature) of medicine*”⁵⁴. It is not necessarily the best or most advanced care available but one that is considered acceptable and adequate under similar medical and geographic circumstances. Thus, providing treatment that is inferior to the norm is unacceptable and unethical, and renders the physician guilty of negligence and potentially liable for malpractice. Although intuitively easy to understand, this definition of *Standard of Care* must be put in perspective. In primitive worlds, magicians, conjurers, or shamans probably provided equivalent level of rudimentary care to tribesmen suffering from similar ailments or complaints. However, medicine has evolved to become a highly complex, multifaceted discipline with thousands of diseases, each with variations and permutations, giving rise to specialties that group, study, and treat diseases classified by organ or type. For example, while Gastroenterology deals with diseases of the gastrointestinal tract, the liver, and the pancreas, medical Oncology addresses all types of cancers regardless of the organ or tissue of origin. Hence, the “*level of practice*” will depend on the physician’s training and level of expertise and the type of disease under treatment. For example, the “*level of practice*” exercised by a generalist treating a minor gastrointestinal ailment might be equivalent to that of a Gastroenterologist. On the other hand, because most generalists lack sufficient training and expertise in treating cancer, the “*level of practice*” expected from a medical Oncologist treating a cancer patient will be considerably higher than that anticipated from a generalist and, for *Standard of Care* purposes, should be compared only to that of other medical Oncologists. Hence, when referring to the specialists, the *Standard of Care* is defined as “*the level of practice that any average, prudent, and reasonable Gastroenterologist, Oncologist, etc...*” Additionally, *Standard of Care* must be “*acceptable and adequate under similar circumstances*”. That is, it must be based on the “*art*” and “*science*” of medicine in order to attain the outcome expected under similar circumstances, which might be as definitive as the cure of a disease or as modest as the control of a symptom.

In Pain Medicine, *Standard of Care* implies that an “*average, prudent, and reasonable pain-treating physician*” must prescribe analgesics in doses and for periods of time sufficient to ensure pain relief, always, and pain control, whenever possible. Hence, the determination of which analgesic drug to use, in what doses, and for how long to achieve pain control is not the DEA’s prerogative. Rather, it is the physician’s responsibility, indeed duty, based on each patient’s pain characteristics (type, cause, severity), adjusted according to personal, familial, psychosocial factors and the presence and type of co-morbidities* and their treatment. The history of medical malpractice in the US confirms that physicians enter into an unwritten but legally enforceable contract to provide *standard of care* to each patient; a contract that, in the case of pain management, is thwarted by DEA policy on narcotics.

How does the DEA interfere with the *Standard of Care* delivery by pain-managing physicians? As described earlier, the DEA has created an atmosphere of fear among pain-treating physicians that prescribing medically appropriate doses of opiates

* Concurrent diseases

might attract DEA's attention and wrath. Under these circumstances, most physicians opt to bypass opiates altogether, to prescribe them in doses acceptable to the DEA though insufficient to ensure adequate pain control, or to use other analgesics with inferior efficacy and greater toxicity (more on this in chapter 6, section 2). The DEA uses a variety of methods to alter the prescribing patterns of pain-managing physicians. For example, the DEA claims to distinguish between a prescription written for a "*legitimate medical purpose*" and one that is "*beyond the bounds of medical practice*". However, no guidelines or course of action exist for physicians to observe or for investigators or prosecutors to use as a guide for making that judgment objectively. This is particularly alarming given the fact that drug enforcement agents and jurors with no medical training find themselves the arbiters of what constitutes "*legitimate*" medical practice in a complex field of medicine that involves biological, psychological, behavioral, familial, and social components they do not comprehend and transcend enforcement policy.

Moreover, the DEA seems intent on blurring the legal-illegal boundary of what it deceptively calls "*legitimate practice*". This is strongly suggested by its disavowing its own document titled, "*Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals, and Law Enforcement Personnel*"⁵⁵ when it got in the way of Dr. Hurwitz' conviction, cited earlier. This document, compiled in collaboration with noted pain specialists and pain control advocates, offered reasonable pain management guidelines while curtailing drug diversion. Perhaps the DEA objected to a guideline that stated, "*for a physician to be convicted of illegal sale, the authorities must show that the physician knowingly and intentionally prescribed or dispensed controlled substances outside the scope of legitimate practice*". Or, to the assertion that prescribing narcotics to a patient with a history of drug abuse or not reporting patients suspected of abusing pain medications was not a violation of Federal law¹. Because of these and other "*misstatements of law and other statements*" the DEA repudiated the document, deleted it from its own website "*pending review*", and pressured the Pain and Policy Studies Group of the University of Wisconsin to do likewise⁵⁶. The DEA's reversal prompted the Liaison Committee on Pain and Addiction representing the American Pain Society, the American Academy of Pain Medicine, and the American Society of Addiction Medicine, to send a joint letter of protest. After refuting each of the arguments given by the DEA for its reversal, the letter concluded "*The interim policy statement 'Dispensing of Controlled Substances for the Treatment of Pain' is an unfortunate step backward largely because of the tone in which it is written, which promotes a return to an adversarial relationship between registrants and the DEA*"⁵⁷. Significantly, on January 19, 2005 thirty State attorneys of the National Association of Attorneys General sent a joint letter to the DEA complaining that the document withdrawal occurred without consultation. In part, the letter stated "*The Interim Policy Statement, 'Dispensing of Controlled Substances for the Treatment of Pain'... emphasizes enforcement, and seems likely to have a chilling effect on physicians engaged in the legitimate practice of medicine*". In a sharp rebuttal of DEA policy, the Attorneys General affirmed the group's position on pain control. It stated, "*As Attorneys General have worked to remove barriers to quality care for citizens of our states at the end of life, we have learned that adequate pain management is often difficult to obtain because many physicians fear investigations and enforcement actions if they prescribe adequate levels of opioids or have many patients with prescriptions for pain medications*". They also highlighted the DEA's tunnel vision by their statement "*There are many nuances of the interactions of medical practice, end of life concerns, definitions of abuse and addiction, and enforcement considerations that make balance difficult in practice. But we believe this balance is very*

*important to our citizens, who deserve the best pain relief available to alleviate suffering, particularly at the end of life*⁵⁸.

Other indications of possible *illegitimate medical practice* according to the DEA are “*red flags*”, which include, among others, “*patients who are poorly dressed or are seen without appointments... doctors licensed in various states or who dispense large amounts of narcotics from one office...or visits lasting less than 25 minutes*”. Each of these *red flags* is without merit for poorly dressing and being seen without an appointment might be more an indication of patients’ limited means and physicians’ benevolence rather than indications of illicit activity by either patients or physicians. Likewise, being licensed in various states and prescribing large amounts of narcotics relate to physicians’ evolving geographic practice preferences and to the needs of their patient population, respectively, rather than attempts to evading or braking the law, as assumed by the DEA. Finally, the DEA’s arbitrariness and disregard of available statistics in flagging office visits shorter than 25 minutes are highlighted by two large surveys conducted in 1998. Indeed, according to the National Ambulatory Medical Care Survey of the National Center for Health Statistics and the American Medical Association’s Socioeconomic Monitoring System, the average office visit lasted 17 and 21 minutes, respectively⁵⁹. Hence, based on this criterion, the DEA would consider suspect most office visits in this country.

Moreover, not only are DEA’s *red flags* egregious in themselves but so are the means used to elicit them. For instance, seeking whatever information to build a case investigators conduct surreptitious video surveillance of targeted physicians’ offices, search through their office and home trash, and often confront patients on their way to the physician’s office¹. Posing as pain patients, undercover agents befriend office employees in hopes of uncovering incriminating evidence against the physician. A frequent practice is to analyze physicians’ billing practices and prescribing history by painstakingly searching databases from Medicare and Medicaid, and from insurance and pharmaceutical companies. The DEA also has established a hotline for anyone to report anonymously doctors suspected of over prescribing. While such a tool is unlikely to be used by legitimate patients seeking pain relief, it is certainly useful to disgruntled patients and employees or rejected addicts. As a result, an atmosphere of distrust has emerged between patients and physicians. Patients must not appear too eager for more medication, a sure sign of addiction according to the DEA that must be reported by the physician, and physicians must be distrustful of every pain patient for fear of prosecution should a legitimate narcotics prescription be sold on the street. The latter is especially worrisome because prosecutors are not bound by the presumption of innocence principle and need not prove a doctor’s malicious intent or desire to profit from narcotics diversion to secure a conviction¹.

In conclusion, the DEA has introduced arbitrary and pliable rules of evidence to secure convictions. It includes intentionally blurring the boundary between “*the scope of legitimate practice*” and what it arbitrarily considers “*beyond the bounds of medical practice*” and applying unjustifiably aggressive investigative and prosecutorial tactics, including invoking the forfeiture law that effectively ruins targeted physicians and do so at the pre-trial stage. This climate of intimidation and of uncertainty, where presumption of innocence is not assured, has frightened many physicians out of pain-management altogether. Those who remain in the field prescribe narcotics in amounts that, deliberately or not, are designed more to protect themselves from falling afoul of the

DEA even if adequate pain relief is not achieve. Physicians who ignore these self-preservation precautions do so at their own peril, as the cases of Drs. Hurwitz and Fisher eloquently demonstrate. Likewise, many patients opt to not disclose to their physician the intensity of their pain not to arouse suspicion and run the risk of being reported as suspected addicts. Additionally, the DEA withdrew its support to a consensus document drafted by law enforcement representatives, health care practitioners, and patient advocates affirming, "*the prevention of drug abuse is an important societal goal that can and should be pursued without hindering proper patient care*"⁵⁵⁻⁵⁷. In so doing, it brought back the dark days of the Harrison Act of 1914 when every narcotics-prescribing physician was viewed as a potential law-breaker and every pain sufferer as a drug addict. Under these circumstances, where the DEA acts as a wedge between patient and physician and each is suspicious of the other's motives and intentions, *Standard of Care* delivery to chronic pain sufferers has been the casualty. The DEA's interference with *Standard of Care*, combined with the terror its aggressive prosecutorial tactics cause among pain-treating physicians, has triggered an unprecedented pain-management crisis where tens of millions of Americans suffer from untreated or under treated pain on a daily basis^{2,3}.

Can enforcement of drug laws by the DEA and *Standard of Care* delivery to pain patients be reconciled? It could be envisioned that the pain management crisis in America would be solved if the DEA targeted criminal elements within the drug culture and physicians engaged in activities truly "*beyond the bounds of medical practice*", according to clear and objective guidelines established by their peers. However, targeting physicians is easier and more financially rewarding and conveys to the public a sense of success and accomplishment through heightened media attention difficult to match by prosecuting drug dealers and drug peddlers. Moreover, the DEA shows no inclination to set "*legitimate medical purpose*" guidelines, preferring instead to keep physicians guessing. This is clearly the DEA's intention as demonstrated by its recent (2006) "*Policy Statement*"⁶⁰. In it, it states, "*However... it is not appropriate for DEA to address these questions in the form of a guidance document (or to endorse such a guidance document prepared by others)*". Another potential solution could be changes in or stern controls over DEA rules, procedures, and modus operandi to ensure fairness and adherence to the rule of law. However, adding layers of bureaucracy to an already bloated agency would compound rather than solve any problem, whichever it might be. A definitive solution to the pain crisis must take into account the political power and vested interests of diverse groups associated with the *War on Drugs* and the fact that the DEA has evolved into a nearly independent entity accountable for its acts only in retrospect and through court action. Hence, I contend that the pernicious status quo resulting from the DEA's very existence will endure until the US Congress, cognizant of the DEA's failures and abuses, and of its unachievable national and international mandates, musters the political will to abolish this ill-conceived, wrongly focused, and socially harmful Federal agency. Repeal of the 18th amendment provides a historic precedent for reversing similarly misguided policies intended to protect us from ourselves that brought havoc to our nation instead.

Chapter 6

PAINKILLERS

The IASP* defines pain as *"an unpleasant sensory and emotional experience associated with the actual or potential tissue damage"*¹, which emphasizes the nature of pain and its often ill-defined source. Pain can also be characterized by its intensity, as *mild, moderate* or *severe*, its duration as *acute, sub-acute*, or *chronic*, its character as *sharp, dull*, or *throbbing*, its anatomic basis as *nocioceptive*** or *neuropathic****, its pathological origin as *cancerous* or *non-cancerous*, and by many other criteria. However, while the medical literature is saturated with a bewildering array of articles addressing a multitude of pain-related issues in a variety of conditions and patient subsets, two overriding concepts emerge in the context of pain management and pain policy: *Acute* vs. *chronic* and *mild-to-moderate* vs. *moderate-to-severe* pain. Pain is said to be *acute* when it has a clear and time-definable onset arising from a sudden pathological event such as a toothache, a bone fracture, a myocardial infarction, etc. Hence, it is a symptom of disease or injury that disappears once the underlying cause is gone. In contrast, *chronic* pain, whether caused by cancer or by a non-cancerous illness, often persists for months or years beyond the period of healing and is considered a disease in its own right by the IASP and increasingly by other medical organizations.

Chronic pain is among the most prevalent, disabling, and costly afflictions worldwide. An analysis of 13 studies published between 1992 and 2002 from countries as diverse as the US, Israel, France, Turkey, Brazil, Australia, China, Nigeria, and many others showed that chronic pain afflicts between 10.1% and 55.2% of the population². In the US, it is estimated that *"over 20 million American employees miss 433 million work days [each year] due to pain, and indirect business costs have been estimated to be \$45 billion. The health care cost... has been estimated at \$885 billion. In a recent study that surveyed 1.2 million adults, 1 of 5 related that they had some form of chronic pain. Among those with chronic pain, approximately 40% reported that the pain had a 'major' impact on their lives, with half of those noting that they get depressed"*³ As cited earlier, the American Medical Association reported that 97 million patients suffered from unrelenting pain in 1997 and most of them *"received inadequate care because of barriers to pain treatment"*⁴. These grim statistics, and others cited elsewhere in this book, give credence to Voltaire's quip; *"Happiness is an illusion; only suffering is real"*. Two hundred and fifty years later, we have the means to provide adequate to excellent pain relief quickly and long-term to the vast majority (88%) of patients suffering from chronic pain⁵. Our failure to do so is a sad commentary on policy-makers of the past who initiated the *War on Drugs* based on political considerations (chapter 3) and on current ones who lack the political will to challenge erroneous notions about the dangers of narcotics, the causes of addiction, and other misconceptions and self-serving claims that sustain the *status quo*. Indeed, until *War on Drugs* policies are repealed, millions of American pain sufferers will go on suffering day after day, year after year.

* International Association for the Study of Pain

** Arising from inflammation, injury, or trauma

*** Arising from processes involving the peripheral or central nervous system

This chapter will outline the types of drugs available and commonly used for the treatment of *chronic vs. acute* pain, and compare their mechanism of action, efficacy, safety, and side effects. Other approaches to pain management such as neuroaxial, spinal, or transcutaneous nerve stimulation, acupuncture, cryotherapy, diathermy, physical therapy and other non-pharmacological modalities are outside the scope of this book. It must be emphasized at the outset that, contrary to acute pain, the pharmacological management of chronic pain is not a simple matter of prescribing a painkiller and escalating the dose or switching drugs until the desired response is achieved. Indeed, *chronic* pain is a highly complex, multifactorial, and multidimensional symptom that requires a detailed diagnostic workup to uncover its causes and the contributing or confounding impact of co-morbidities, as well as to understand each patient's psychosocial makeup that affects pain perception and response to treatment. Hence, it necessitates ample expertise on the part of the treating physician for selecting a management plan best suited to maximize pain relief for each individual patient. A review of the steps leading to a diagnosis and to the selection of an appropriate pain management plan is outside the scope of this book. Suffice it to say that a detailed medical, psychosocial, and pain history complemented by a thorough physical examination and by selective diagnostic testing, will expose the source(s) and cause(s) of pain and reveal underlying contributing factors, when present. For example, in certain cases a thorough workup will uncover an unsuspected pain-causing malignancy whereas in others, particularly in chronic pain cases, an underlying pain-exacerbating depression might be revealed. Hence, a patient feigning pain (a "*doctor shopper*") intent on misusing or selling opioids so obtained, will rarely dupe an experienced pain physician even if the pain characteristics are described skillfully because a negative diagnostic work up will raise suspicion. It must be emphasized, however, that the physician's interpretative task is complex for pain is a subjective symptom influenced by personal biological and psychosocial factors and its intensity often correlates poorly with objective findings. Alternatively, a dishonest patient already on opioids can feign inadequate pain control (a "*patient dealer*") in attempts to obtain an additional prescription meant to be sold.

The overall pain management plan must consider each patient's medical and psychosocial circumstances, taking into account the presence of co-morbidities and their treatment, and the type and cause of pain if it is to be effective. Its implementation must focus on the physician's proposed treatment goals, especially pain relief and function restoration whenever possible, and the patient's expectations that must be tempered if unrealistic. Benefits and risks of each proposed intervention must be addressed, and means to monitor outcome and to adjust course when needed must be instituted. The foundation of any pain management plan is painkillers complemented by antidepressants, neuromodulators, and the like that are useful as adjuvants* to treat depression, neuropathic pain, and other co-morbidities that often amplify the real or perceived intensity of pain. Pain painkillers include NSAIDs**, favored for treating *mild-to-moderate* pain, and opioids, best suited for the treatment of *moderate-to-severe* pain.

The WHO has described a 3-step ladder as a framework for pain management⁶. It is described as follows: "*If pain occurs, there should be prompt oral administration of*

* Agents that modify or enhance the effects of other agents

** Non-Steroidal Anti-Inflammatory Drugs

drugs in the following order: non-opioids (aspirin and paracetamol); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain. To calm fears and anxiety, additional drugs – adjuvants – should be used". In the next two sections, I will examine the pros and cons of this escalation ladder and whether it is appropriate and safe for the management of all types of pain. It is my contention that were it not for *War on Drugs* policies that stigmatize opioid analgesics, restricts their medical use, promotes and perpetuates the fear of addiction, and holds a Damocles sword on all pain management decisions, most patients with *chronic* pain would be treated with Step 3 analgesics (opioids) from the outset, supplemented by adjuvants, when needed. Such an approach, designed to address the currently unmet needs of most *chronic* pain sufferers, would provide both relief to the millions of patients with under treated pain and reduce the morbidity and mortality associated with the unwarranted use of non-opioid analgesics in that population. In fact, it is noteworthy that UN pain experts support this view for treating cancer pain, the most representative and most studied type of chronic pain. For instance, at its 1986 Meeting on the Comprehensive Management of Cancer Pain it was concluded, "*In patients with severe pain, morphine –a strong opioid- is the drug of choice*" ⁷. Likewise, a pain management symposium held in 2000 recommended, "*It's important to move beyond prescribing opioids for chronic pain and to encourage a comprehensive, interdisciplinary approach to improve patient outcomes*" ³. I will also demonstrate that, given the potency and safety profile of opioids, patients with severe chronic pain should not be exposed to NSAIDs as contemplated in the WHO's 3-step ladder but be treated with opioids from the outset and in sufficient doses administered for as long as necessary to provide optimal pain relief and functional restoration.

1. **Narcotics (Opioids).**

Narcotics can be defined as, “any derivative, natural or synthetic, of opium or morphine, or any substance that has their effect”⁸. However, most current definitions of narcotics were developed in the context of drug abuse, oblivious of their analgesic properties and of their medical uses. As a result, most definitions are prejudiced rather than objective using the noun *narcotics* as encompassing all illegally obtained or unlawfully possessed mind-altering drugs including opioids and non-opioid agents such as cannabis, cocaine, barbiturates and the like. One definition calls “*narcotic*”, “an addictive drug, such as opium, that reduces pain, alters mood and behavior, and usually induces sleep or stupor”⁹. It is disingenuous to define narcotics primarily as an “addictive drug” listing other side effects (“alters mood and behavior”, “induces sleep and stupor”) at par with its major property (“reduces pain”). Indeed, pain reduction is the hallmark of narcotics taken for legitimate purposes whereas other properties listed in that definition are side effects affecting only a rare medical user. In fact, as described in chapter 4, addiction and mind-alteration occur mostly in individuals who seek narcotics for their psychotropic effects whereas pain reduction, mostly without mind-altering adverse effects, is the outcome for individuals taking narcotics for pain relief. Another glaringly erroneous definition of narcotics can be found in the prestigious Encyclopedia Britannica. It defines narcotic as “a drug that produces... addiction (physical dependence on the drug)...”¹⁰, overlooking the fact that *addiction* and *physical dependence* are entirely different and unrelated phenomena, as described in the previous chapter. The WHO addresses the semantics of the nouns *narcotics* and *opioids* stating, “*Opioids are classified as narcotics because they have a potential for abuse*”¹¹. This nonsensical definition can be applied to licit and illicit drugs, to a spectrum of chemical substances, dietary products, and activities, and could even be extended to children and wives, who also have “*potential for abuse*”. The fact that most people do not abuse these agents or activities suggests that potential for abuse originates in the abuser, as elucidated in chapter 4. Hence, from a medical point of view and to avoid pejorative overtones, this class of analgesic agents is best called *Opioids* that can be defined as “*Analgesic agents best suited for the treatment of moderate to severe pain*”.

Opioids can be classified according to their origin, as endogenous (e.g. endorphins 1 and 2, which are produced by the body) and exogenous (opium alkaloids). The latter can be derived from the poppy seed (e.g. morphine, codeine, and papaverine) or produced semi-synthetically (e.g. oxycodone, hydromorphone, and heroin) or synthetically (e.g. fentanyl, meperidine, and methadone). Functionally, opioids are classified as morphine-like agonists*, partial agonists, or mixed agonist-antagonists, depending on their mechanism of action. In the US, the medical uses of opioids are restricted to the treatment of very specific clinical entities. In addition to their analgesic and anesthetic use, they can be used as cough suppressants (codeine and hydrocodone - only), to control diarrhea (opium - only), for the treatment of anxiety due to shortness of breath (oxymorphone - only) and for the treatment of narcotics addiction (methadone - only). In contrast, physicians are free to prescribe any non-opioid medication “*off-label*”. That is, for managing diseases and conditions other than those approved by FDA**. An extreme example of this policy is prescribing inefficacious chemotherapeutic agents *off-label* despite their meager contribution to 5-year survival

* Agents that bind morphine-like receptors and induce morphine-like effects

** Food and Drug Administration

(2.1% - 2.3%)¹² and to cure rates (2%)¹³, when prescribed for approved indications.

Mechanisms of action: Used appropriately, Opioids induce prompt and profound analgesia, with a potential for physical dependence and tolerance after chronic administration and for compulsive drug use in certain predisposed individuals. Opioid effects are exerted through their pharmacological actions on cell membrane receptors. There are three major types of opioid receptors (OR): μ (μ OR), κ (κ OR), and δ (δ OR) that are located on neuronal cell membranes of the brain, the spinal cord, and peripheral nerves, mostly of the gastrointestinal tract. When attached to spinal cord or peripheral nerve receptors, opioids interfere with the transmission of peripheral painful signals and block the psychological response to pain at the level of the limbic* brain system, thus diminishing pain perception. When bound to brain receptors, they trigger descending signals that inhibit incoming pain signals. In peripheral tissues such as joints, opioids reduce inflammation. Recent μ OR knockout mice** generated by gene-targeting technology have shown that the μ OR receptor is the molecular target for most morphine effects including analgesia, sedation, reduced blood pressure, itching, nausea, euphoria, decreased respiration, miosis (constricted pupils) and decreased bowel motility. The presence of μ OR is also required for some κ OR-mediated analgesic effects¹⁴. Moreover, antisense mutations*** and gene knockout mouse models support μ OR receptor functional multiplicity. The latter attribute, plus the dissimilar receptor selectivity and affinity of different opioids, and the varied psychosocial backgrounds among individuals, account for the range of side effects observed. κ OR is also involved in analgesia, but its activation also produces marked nausea and dysphoria. Hence, opioid receptors are a complex and incompletely understood system of multiple, interrelated, and functionally diverse molecules that mediate all opioid effects, whether therapeutic or undesirable.

Efficacy: Opioids are the most efficacious painkillers for treating *moderate-to-severe* somatic and inflammatory pain. Because of their efficacy, they offer sufferers of chronic pain, whether from cancer and chronic illnesses, the best hope for a more functional lifestyle. This assertion is supported by my own 30-plus years of clinical practice and by most experienced pain experts. For instance, in a recent review article on pain management¹⁵ opioids are characterized as *“the most potent and effective analgesics available and have become accepted as appropriate treatment for acute and cancer pain”*. The critical importance of opioid analgesics is highlighted in the following WHO statement, *“Although there are many drug and non-drug pain treatments, the opioid analgesics such as codeine and morphine are **absolutely necessary****** for the management of pain due to cancer. When cancer pain is moderate to severe, **there is no substitute for opioids*******...”*¹¹. Likewise, according to educational guidelines from NCI***** *“Opioids, the major class of analgesics used in management of moderate-to-severe pain, are effective, easily titrated, and have a favorable benefit-to-risk ratio”*¹⁶.

* Brain structures involved in emotion, motivation, and emotional association with memory.

** Laboratory mice where a gene is inactivated ("knocked out") in order to study its function.

*** A mutation that alters a gene so as to produce a truncated product.

**** Emphasis in the original

***** My emphasis

***** National Cancer Institute

Likewise, pain experts also view the use of opioids as a medical imperative to treat chronic non-cancer pain. The American Society of Anesthesiologists articulated a widely held view on the subject. It stated, *"To deny a patient with chronic pain the right to aggressive, clinically proven treatment using a combination of opioids... is simply unforgivable and unacceptable. The argument against the proper use of opioids in chronic pain is debatably a non-argument, which flies in the face of scientifically proven, objective, rational treatment modalities for the chronic pain patient"*¹⁷. However, despite forceful endorsements such as this, opioids are unjustifiably controversial and their medical use generally inadequate. In too many cases, they are used reluctantly and only after exhausting the less efficacious non-opioid painkillers, resulting in under treatment of pain and in needless suffering, morbidity, and mortality. The reasons for this attitude are multifactorial including: 1. Physicians' cursory knowledge of basic analgesic pharmacology. 2. Poorly informed medical regulators, as revealed by a 1991 survey of State medical board members¹⁸. Astonishingly, the survey found that most preferred aspirin and acetaminophen alone or in combination with codeine for managing *moderate-to-severe* pain and failed to distinguish addiction from physical dependence. Additionally, 14% felt that prescribing opioids for chronic cancer pain was legal but should be discouraged while 5% believed the practice to be illegal, and 33% stated they would investigate opioid prescribing for non-malignant pain as an illegal practice. So much for the level of medical and legal erudition of arbiters of medical practice who often are called upon to investigate complaints against their peers' standard of care or medical ethics; 3. Patients' unwillingness to take drugs purported to induce addiction at the first contact, fear that acknowledging pain is admitting disease progression, concern of being suspected of drug-abuse behavior rather than seeking pain relief, stoicism, and religious considerations; 4. Drug policy and punitive laws designed to control *narcotics* diversion to the detriment of pain relief; 5. An inadequate health care system that leaves 40 million-plus Americans uninsured and, for the remainder, focuses primarily on acute disease management failing to recognize the importance of palliative measures for alleviating chronic suffering and for improving quality of life; 6. Reimbursement policies that do not cover the cost of prescription drugs or cover the more expensive parenteral administration of analgesics through pumps, blocks, and epidural injections for hospitalized patients, but fail to cover oral analgesics taken at home.

Despite these shortcomings, chronic pain management is slowly improving as revealed by the rise in medical use of opioids since 1990. According to a recent report¹⁹, *"From 1990 to 1996, there were increases in medical use of morphine (59%; 2.2 to 3.5 million g), fentanyl (1,168%; 3,263 to 41,371 g), oxycodone (23%; 1.6 to 2.0 million g), and hydromorphone (19%; 118,455 to 141,325 g), and a decrease in the medical use of meperidine (35%; 5.2 to 3.4 million g)"*. Significantly, this rise in the medical use of opioids was not accompanied by a rise in drug abuse. Indeed, the same report observed, *"During the same period...reports of abuse decreased for meperidine (39%; 1,335 to 806), oxycodone (29%; 4,526 to 3,190), fentanyl (59%; 59 to 24), and hydromorphone (15%; 718 to 609), and increased for morphine (3%; 838 to 865)"*. Hence, contrary to unsubstantiated claims by drug policy advocates, increased medical use of opioids does not increase diversion. Regrettably, palliative care for the terminally ill, especially pain management, remains grossly underutilized in the US, as illustrated by Medicare expenditures. For instance, out of \$210 billion total Medicare payments in 1998, only 1% was for hospice care whereas 28% went for acute care of hospitalized patients and for high-tech interventions during the last year of life, half of it in the last two months²⁰. This misguided end of life care is but a reflection of Western medicine's focus on aggressive, expensive, and mostly futile interventions while overlooking cost-effective

palliative measures, especially pain relief, that have the greatest impact on quality of life when it is the most needed.

Mild opioid agonists include codeine, hydrocodone, and the atypical opioid tramadol. Their major disadvantage is a dose-dependent toxicity that severely limits dose escalation. Moderate opioid agonists include meperidine and propoxyphene. Meperidine was the opioid of choice for many years based on its perceived greater safety, lesser risk of addiction, and better antispasmodic effect in treating pain associated with biliary^{*} spasm and renal colic^{**}. However, it has fallen out of favor in recent years due to its low potency, short duration of action, the unique neurotoxicity (seizures and other neuropsychological effects) of its metabolites^{***}, and because presumed advantages were proven illusory. Propoxyphene, a relatively weak opioid, is available in the US as a pure preparation or in combination with acetaminophen. However, both opioids exhibit short action and toxicity that limit their use in the management of chronic pain. In fact, the staying power of propoxyphene is likely due to *"concern about oversight and censure [that] may be a factor in the extensive use of propoxyphene (Schedule IV drug) rather than oxycodone and hydrocodone"*²¹.

Morphine is the international gold standard opioid for treating *moderate-to-severe* pain, to which all others are compared. It should be chosen from the outset for managing *severe* pain. Morphine was first isolated from opium by Friedrich Wilhelm Sertürner in 1805. Sertürner named the bitter white crystalline alkaloid after the Greek god of dreams, *Morpheus*. Morphine is available as short- and long-acting formulations, as are other narcotics, greatly facilitating chronic pain management. In addition to its efficacy in controlling *moderate-to-severe* pain, another major benefit of morphine and morphine agonists, such as hydromorphone, codeine, oxycodone, hydrocodone, methadone, levorphanol, and fentanyl, is their lack of efficacy ceiling with increasing doses. That is, their doses can be escalated until adequate pain relief is achieved. Morphine, oxycodone, hydromorphone, fentanyl, and methadone are the strongest and most

Table 5. Opioid analgesics most widely used in the US (2005).

Generic name	ARCOS ¹	Brand name	Morph Eq ²	Oral Dose	Parenteral Dose
Morphine	1,297	MS Contin	1:1	15-30 mg Q3-4 ³	2-10 mg
Meperidine	1,267	Demerol	1:10	50-100 mg QD	10-50 mg
Oxycodone	756	Oxycontin	1:1	5-10 mg BID	N/A
Hydromorphone	53	Dilaudid	5:1	2-4 mg Q3-4	0.5-2 mg
Fentanyl	16	Duragesic	100:1	N/A	25-50 mcg ⁴
Methadone		Dolophine	1:2	5 mg TID ⁵	2.5-5 mg

1. Drug amounts (g/100,000 population) flowing from manufacture to sale or distribution

2. Morphine equivalent

3. Every 3 to 4 hours

4. Micrograms

5. Three times daily

prescribed opioids in the US (Table 5). In contrast, partial agonists, such as buprenorphine are subject to dose efficacy ceiling where dose escalation increases toxicity without augmenting the level of analgesia. Opioid with agonist-antagonist

* Relating to bile ducts or the gallbladder

** Severe pain produced by passage of a kidney stone through the ureter

*** Breakdown products of metabolism

activities, such as pentazocine, butorphanol, dezocine, and nalbuphine activate one type of opioid receptor while blocking or remaining neutral to others. Therefore, they can precipitate withdrawal and other symptoms in patients taking opioid agonists concomitantly. Their analgesic efficacy also is limited by a dose-related ceiling effect.

General principles of administration²²: Relief of chronic *moderate-to-severe* pain requires an opioid given in a fixed-schedule, round-the-clock, day after day for as long as necessary. As stated earlier, there is little evidence of the clinical superiority of one opioid over another regarding analgesic efficacy and/or side effects. However, most physicians are more familiar with morphine and tend to initiate therapy with this opioid in its short-acting oral formulation. The analgesic effects of short-acting oral opioids such as morphine, hydromorphone, codeine, and oxycodone begin within 30 minutes and last 4 hours approximately. Hence, they are administered every 4 hours. Oral administration is generally preferred because it is convenient and inexpensive, followed by the rectal or trans-dermal routes. Parenteral methods such as subcutaneous, trans-mucosal, intravenous, and intra-spinal administration are useful in special circumstances. The initial daily dose, chosen according to pain severity and the opioid selected can be increased on a daily basis by 25% to 50%, if necessary, until pain relief is adequate, or intolerable side effects develop. Because they have no maximum or ceiling dose, "*the appropriate dose of morphine agonists is whatever amount of opioid medication is necessary to control pain with the fewest side effects*". As with any pain medication, the goals of opioid treatment are to relieve pain, to enhance functional ability, and to improve quality of life within the context of tolerable side effects. Should tolerance develop, switching opioids becomes an option. Selecting a new opioid is empirical and the dose equivalence* for the new agent should be reduced by 25% to 50% initially to ensure safety. After the switch, patients should be monitored closely as the new opioid dose is escalated for maximum analgesic effect. Contrary to widespread belief, a prior history of substance abuse does not preclude using opioid analgesics but suggests caution when prescribing and careful patient monitoring to prevent abuse.

Once pain relief has been achieved, patients are usually switched to a controlled-release or slow-release formulation. The analgesic effect of controlled-release formulations of morphine and oxycodone, available in the US, begins in 1 hour, peaks in 2 to 3 hours, and lasts for 12 hours. Hence, these formulations are usually taken at 12-hour intervals, except for 10% to 20% of patients who require an 8-hour schedule. Fentanyl, a strong trans-dermal morphine agonist, is an excellent controlled-release alternative for sustained, long-term pain management. Its analgesic effect begins approximately 12 hours after the application of the morphine-containing patch, peaks in 24 to 48 hours, and lasts for approximately 72 hours. Therefore, patches are replaced every 72 hours except in a small subset of patients who require new patches every 48 hours. Patients who have reached a stable dose can occasionally develop pain exacerbations referred to as "*breakthrough pain*". Breakthrough pain is easily and rapidly controlled with intravenous or short-acting oral opioids, given as a supplement to the regular fixed-schedule opioid. The recommended dose is the equivalent of 20% of the calculated equianalgesic** total daily dose.

* Dose based on prior need and relative potencies of new and old painkillers

** Equivalent analgesic power

Side effects. Considering the efficacy and strength of opioid analgesics and their usefulness in chronic pain management, their side effects are relatively mild and seldom life-threatening and addiction is not one of them. Side effects include, in decreasing order of frequency, constipation, nausea and vomiting, neurotoxicity, and less commonly pruritus, respiratory depression, and sexual dysfunction.

Constipation. Opioid analgesics impair gastrointestinal peristalsis*. As a result, opioids prolong the gastrointestinal transit time, which promotes dehydration of stools as they slowly move down the intestine, making their evacuation difficult. Hence, constipation in one degree or another occurs in virtually all patients taking opioids on a chronic basis, especially morphine. Unconfirmed reports suggest that fentanyl and methadone might cause less constipation than oral morphine^{23,24}. Drinking plenty of fluids is often advised in order to maintain a good level of hydration. However, while encouraging good systemic hydration is reasonable as it reduces stool dehydration, in practice, it is seldom successful in fully reversing opioid-induced constipation. Measures that are more effective include, the use of stool softeners (e.g., docusate sodium), mild osmotic agents (e.g., milk of magnesia, 70% sorbitol solution, lactulose,) lubricants (e.g., mineral oil), bulk-forming laxatives (e.g., psyllium), or mild cathartic laxatives (e.g., senna). More severe constipation can benefit from stimulant cathartics (e.g. bisacodyl), enemas, or the physical removal of impacted stools. Rare cases can advance to a pseudo bowel obstruction or mechanical ileus**. Unlike analgesic tolerance, constipation tolerance does not develop and patients will remain constipated for as long as they take opioids. This is the main reason for patients abandoning opioid therapy.

Nausea. Nausea occurs in approximately one-third to two thirds of patients taking opioids long term²⁵ and is related to decreased intestinal motility, dopamine stimulation or, less frequently, to increased vestibular sensitivity. However, regardless of cause, most patients develop tolerance to nausea after a few days or weeks. Management of nausea in patients with persistent nausea requires constipation relief, including measures outlined above or the use of agents such as metoclopramide or domperidone that increase gastrointestinal motility and have anti-dopamine effects. In cases of motion-induced nausea, antihistamines or anti-emetics can be helpful. Patients with refractory nausea might benefit from switching from one opioid agent to another.

Central nervous system. Opioids can stimulate or inhibit the central nervous system, especially in the elderly. Stimulation, a rare occurrence, can induce hallucinations, generalized myoclonus***, occasionally hyperalgesia****, allodynia*****, or rarely delirium²². Alternatively, inhibition can trigger lightheadedness, drowsiness, or confusion. A popular myth is that opioids can cause patients to become "zombies", unable to function. Experience indicates that neurological side effects are usually temporary and long-term opioid therapy is usually associated with a normal level of thinking and functioning. The risk of developing neurotoxicity is greater in the elderly and in patients taking high doses of opioids, whose opioid dose was recently increased, or with chronic dehydration, renal impairment, and other co-morbidities. In these clinical

* Wave-like muscle contractions of the intestinal tract that move food along.

** Bowel obstruction

*** Repetitive muscle spasm

**** Extreme sensitivity to pain

***** A condition that should not evoke pain but does

circumstances, the culprit appears to be the accumulation of opioid metabolite, a suggestion supported by animal and clinical studies. Neurological symptoms usually subside after 3-5 days on a constant opioid dose. However, in cases of persisting neurotoxicity dose reduction, changing the route of administration, or switching to a different opioid agent are strategies worth trying. If this fails, a multidimensional approach might be required that includes managing contributing factors such as interfering drugs and underlying co-morbidities or the pharmacologic treatment of the actual neurological symptoms. The latter includes the use of sedatives (e.g. haloperidol, methotrimeprazine, and chlorpromazine), anxiolytics (e.g. lorazepam), psycho stimulants (e.g. caffeine, dextroamphetamine, or methylphenidate), and other psychotropic drugs.

Respiratory depression. Respiratory depression, a rare event, is more likely to occur when opioid-naïve patients are first started on opioids, when opioids are given parenterally, or the doses are rapidly escalated, especially in patients whose advanced disease or age make them vulnerable. However, most patients receiving long-term opioid therapy quickly develop tolerance to these agents' respiratory-depressant effects. Additionally, opioid-induced respiratory depression is easily and quickly reversed by the administration of naloxone, an opioid antagonist (table 6).

Sexual dysfunction. Decreased libido and feminizing effects have been known for centuries to occur in men addicted to heroin, though its causes were poorly understood. Recent studies have revealed low blood testosterone levels in sexually dysfunctional men on long-term methadone treatment for opioid addiction. However, as increasing numbers of chronic pain sufferers are being treated with opioids, sexual dysfunction is being reported more frequently in the context of opioid analgesia. Its management consists of empiric measures such as reducing or eliminating opioids when possible, or adding non-opioid or adjuvant analgesic agents to the pain management regimen. Testosterone replacement therapy, in men, can be beneficial.

Table 6. Drugs to be avoided for the treatment of cancer pain ²²

Class	Drug	Rationale for NOT Recommending
Opioids	Meperidine (Demerol)	Short-lived 2-3 hrs analgesia. Risk of CNS toxicity.
Agonists/antagonists	Pentazocine (Talwin)	Risk of withdrawal in opioid-dependent patients.
	Butorphanol (Sterol)	Analgesic ceiling. Risk of psychotomimetic effects.
	Nalbuphine (Nubian)	
Partial agonist	Buprenorphine (Buprenex)	Analgesic ceiling. May precipitate withdrawal.
Antagonists	Naloxone (Narcan)	Reverses life-threatening agonists complications
	Naltrexone (ReVia)	BUT may precipitate withdrawal.
Combination preparations	Brompton's cocktail	No better than single-opioid analgesics.
	Meperidine, Promethazine, & Chlorpromazine	Lower efficacy than other analgesics.
		High incidence of adverse effects.
Anxiolytics	Benzodiazepine (e.g. Alprazolam, Xanax; Diazepam, Valium; Lorazepam, Ativan)	OK for some neuropathic pain.
		Additional sedation to patients on opioids limits neurologic assessment.
Sedatives	Barbiturates	Analgesic properties not demonstrated.
	Benzodiazepine	Added sedation limits opioid dosing.

Urticaria and pruritus. Opioid-induced urticaria and itching are usually short-lived and respond to treatment with antihistamines or by switching to opioids that do not release histamine such as oxymorphone or fentanyl.

Other adverse effects and precautions. Other adverse effects can occur in patients with co-morbidities taking medications that potentiate opioid effects through pharmacologic synergism, the accumulation of opioid metabolites, or frailty associated with age and preexisting illnesses. Limitations and cautions to the use of certain opioids, especially for the management of cancer pain, are listed in table 6.

In conclusion, opioids are strong analgesics best suited for the treatment of *moderate-to-severe* pain, whether from cancer or from non-cancer causes. Their high benefit-to-risk ratio suggests that they are some of the safest drugs on the market despite unjustifiable fears of addiction; a notion that is aggressively promoted by the DEA, State and local drug enforcement agencies, reinforced by detractors and self-serving politicians, and obligingly disseminated by an uncritical media.

Let us sum up the evidence. The incidence of addiction in patients taking opioids long term for analgesic purposes has been reported to range between 0.3%²⁶ and 24%²⁷. The discrepancy is caused by including tolerance and physical dependence, which is listed as criteria for drug abuse in the *Diagnostic and Statistical Manual III-R*, adding pseudo-addictive behavior as true addiction. Today, there is a consensus among pain experts that “*aberrant drug-taking behavior from cancer pain management is generally related to a premorbid history of drug addiction*”²⁸. This has been interpreted to mean that addiction among patients taking opioids long term is similar to that found in the general population adjusted for age. Indeed, drug abuse is less prevalent among older adults and the elderly than among younger population subsets. For instance, in 2004 drug use “*within the last 12 months*” by American high school seniors (85.9%) compared to the “*older*” population subsets (15%)²⁹. Likewise, 2002 arrests for marijuana possession decreased with increasing age, from 969 (per 100,000) teenagers 15 to 19, to 366 for young men 24 to 29, to 162 for men 34 to 39, to 35 for adults 50 to 54, and 7 for the 60 to 64 age group³⁰. Finally, according to the latest survey report from the Institute for Social Research of the University of Michigan³¹, the *thirty-day* prevalence rate for “*any illicit drug*” peaks at 17% to 23% for the 18 to 26 age group falling to 9% by age 45 (chapter 2, figure 1).

Hence, a 5.9% and 3.9% incidence of drug abuse [mainly benzodiazepine] among elderly patients hospitalized or consulting psychiatric services, respectively, reported in a small German study³² might reflect the true addiction prevalence *expected* in that age population. However, the prevalence of opioid addiction in *chronic pain* sufferers, whether from cancer or other causes, is actually much lower than observed in the population at large or in the elderly. In large measure, this is due to these patients’ motivation for taking opioids: a desire to obtain pain relief rather than to achieve a hedonistic experience. Therefore, addiction *resulting* from chronic opioid treatment for pain is actually much lower than is being cited, especially by detractors. Indeed, in three large studies^{26,33,34} involving 24,251 hospitalized patients with no prior history of drug abuse who were administered opioids for chronic non-cancer pain, only 7 patients, or 0.03%, showed evidence of abuse or addiction. These studies establish conclusively that when taken for analgesic purposes by patients without prior history of drug abuse opioids are non-addictive, a judgment endorsed by pain expert, health organization, medical societies, and other knowledgeable sources.

Hence, perhaps the National Clearing House* should justify its uninformed and misleading 2006 guidelines titled, "*Opioid guidelines in the management of chronic non-cancer pain*"³⁵. It recommends, "*prior to embarking on a regimen of opioids the physician must determine, through actual clinical trial or through patient records and history, that non-addictive medication regimens and/or interventional techniques have been inadequate or are unacceptable for solid clinical reasons*". In a veiled condemnation of physician practices it warns, "*important issues in opioid therapy for the treatment of chronic pain revolve around the appropriate use of prescription opioids. Consequently, adherence monitoring is crucial to avoid abuse of the drugs and at the same time to encourage appropriate use*". Suspecting a potential addict in every patient it suggests, "*Adherence monitoring is achieved by screening tests, urine drug testing, and periodic monitoring*". Emulating DEA's anti-physician posture, such "*guidelines*" hold good pain management hostage to drug enforcement and coerce practitioners to regard all chronic pain sufferers as potential addicts. The absurdity and capricious implementation of drug policy impose restrictions on the manufacture, distribution, and prescription of opioid analgesics to the detriment of millions of American pain sufferers. Once in place, such policies and laws acquire inertia of their own that insures their longevity and the unending violation of individual freedoms and of the fundamental and inviolable right to pain relief. Only their repeal will give meaning to the maxim "*Pain is inevitable; suffering is optional*" and empower pain sufferers and their physicians, not the DEA, to exercise that option.

* An agency of the US Department of Health and Human Services

2. Non-opioids

Non-opioid painkillers include all NSAIDs plus acetaminophen because of its similar analgesic properties despite lacking anti-inflammatory effects. NSAIDs are the most widely used drugs of any kind worldwide³⁶⁻³⁸, the most often over prescribed, the most misused³⁹, and the most frequent cause of iatrogenic^{*} pathology. Between the mid-1980s and early 1990s, 70 million prescriptions for NSAIDs were dispensed yearly in the US³⁶, 20 million in Great Britain³⁷, and 10 million in Canada³⁸. Aspirin, probably the least expensive and most popular NSAID, accounts for more than 30 billion tablets dispensed each year in the US at a cost in excess of \$1 billion. These figures, which do not include over-the-counter self-medicating purchases so prevalent in the US, have risen considerable since. NSAIDs are efficacious and safe analgesics when used for short periods to treat *acute mild-to-moderate* pain. However, frequent or protracted use of NSAIDs is associated with serious and even life-threatening side effects, especially in frail individuals and the elderly, making them unsuitable for the long-term management of *chronic* pain. Aspirin has the distinct advantage of helping prevent heart attacks and colon cancer in addition to its analgesic and antipyretic properties. Yet, like other NSAIDs it can cause life threatening gastrointestinal side effects and idiosyncratic^{**} allergic reactions in small subsets of patients that would probably preclude FDA approval of the drug in today's tightly regulated drug environment according to a former FDA commissioner⁴⁰.

Mechanisms of Action. Based on their mechanism of action, NSAIDs are classified as nonselective and selective (table 7). Non-selective NSAIDs, the most commonly prescribed, inhibit prostaglandin synthesis via blocking the activity of both COX-1^{***} and COX-2^{***}. Prostaglandins are ubiquitous substances involved in inflammation and platelet aggregation and have been implicated in cardiovascular and inflammatory diseases, and even in cancer. COX-1 is present in most tissues particularly platelets^{****}, stomach, and kidney. As a “housekeeper” enzyme, it maintains the integrity of the gastric mucosa, is necessary for platelet aggregation, and influences kidney function making its pharmacological inhibition undesirable. On the other hand, Cox-2 is a “constitutive” enzyme found in kidney, brain, testicular, and tracheal epithelium though it is predominantly induced by inflammation with levels rising up to twenty folds, rendering its pharmacological inhibition desirable.

NSAIDs include more than 30 drugs and each has a slightly different chemical structure, which results in different anti-COX-1 and anti-COX-2 activities, metabolic pathways, and side effect profiles. Studies in guinea pigs have demonstrated a direct correlation between the COX-1 to COX-2 inhibition ratio and side effects of several NSAIDs studied: The lower the COX-1 inhibition the fewer the side effects. For example, in a recent study⁴¹ meloxicam, an NSAID with a lower-than-average incidence of side effects, had a COX-1/COX-2 inhibition ratio of 0.33, whereas indomethacin, an NSAID with a higher-than-average incidence of side effects, had a ratio of 122. Based on that knowledge, a new subclass of NSAIDs called “coxibs” was developed to selectively inhibit COX-2 with the expectation of eliminating COX-1-associated side effects. Three

* Unintended result of treatment

** Peculiar to an individual

*** Cyclooxygenase-1 and cyclooxygenase-2

**** Blood cells necessary for vascular integrity and clotting

coxibs were approved by the FDA: celecoxib, valdecoxib, and rofecoxib. However, rofecoxib was withdrawn from the market on September 30, 2004, after greater-than-expected serious thromboembolic* events were detected in patients taking the drug long-term and at higher-than-usual doses as part of a cancer prevention trial. As

Table 7. Common nonselective and selective NSAIDs, daily dose, and NNT⁴².

Nonselective NSAIDs	MRTD² (or usual daily dose)	Mean NNT¹
Acetaminophen	50	3.5 - 3.8
Aspirin	67	4.4
Choline Mg trisalicylate	ND ³ (1,000 mg Q6 hrs ⁴)	ND
Diclophenac	3.75	2.3
Ibuprofen	40	2.4
Indometacin	ND (25 mg Q6 hrs)	ND
Naproxen	ND (250 mg Q6 hrs)	2.3
Mefenamic acid	21	ND
Meloxicam	ND (7.5 mg QD ⁵)	ND
Piroxicam	ND (20 mg QD)	2.7
Selective Coxibs		ND
Celecoxib	6.7	2.8
Valdecoxib	Withdrawn from the market	1.6
Rofecoxib	Withdrawn from the market	1.9

1. Number needed to treat (see text)

2. Maximum Recommended Therapeutic Dose in mg/kg/day (not determined - ref 43)

3. Not determined

4. Every 6 hours

5. Daily

an aside, this is yet another failed cancer *chemoprevention*** study that confirms my view that "*the mechanism of action of chemopreventive agents are ill-defined and their long-term side effects can counteract their anticipated cancer preventing benefits...*"¹³. On April 7, 2005, valdecoxib also was withdrawn from the market after the FDA ruled that the drug's overall risks outweighed its potential benefits. Whether celecoxib and other COX-2 inhibitors are safer is a question that must be ascertained given their marginally greater efficacy and only slightly lower gastrointestinal side effects than nonselective NSAIDs despite their higher cost. As a result, non-selective NSAIDs are still the favored analgesics for acute *mild-to-moderate* pain, especially combined with agents that protect the gastric mucosa.

Efficacy. Ascertaining the efficacy of NSAIDs is complicated by differences in NSAIDs doses, study design, execution, or analysis of the many studies undertaken. However, the "*Oxford league table of analgesic in acute pain*" provides a useful tool to assess relative efficacy of the most common NSAIDs. The Oxford table is based on reviews of randomized, double-blind, single-dose studies in patients with *moderate-to-severe* pain, assessed uniformly. Essentially, for each NSAID studied the table lists the number of patients requiring treatment (*number needed to treat* or NNT) for one of them to achieve 50% pain relief over 4-6 hours. According to the study⁴², the NNT (table 7) ranged from 1.6 for Valdecoxib (40 mg), to 2.3 for naproxen (440 mg) and ibuprofen (400 mg), to 3.8 for paracetamol [acetaminophen in the US] (1,000 mg), to 4.4 for aspirin

* Occlusion of a vessel by a clot originating at a distant site

** The use of drugs in attempts to prevent cancer or reduce recurrences

(650 mg), to 5.3 for tramadol (75 mg). It must be stressed that while NNT provides a measure of NSAIDs' average relative potency their efficacy is influenced by the medical, psychological, and social makeup of each individual, the type and severity of the underlying disease, and the presence of co-morbidities. In addition to NNT, the choice of a NSAID must take into consideration its risks, discussed below under *side effects*.

General principles of administration. According to WHO's widely adopted "use of analgesic guidelines"⁶, patients with *mild-to-moderate* cancer pain should be treated "by the ladder". The sequence is described as follows: "*The first step is a non-opioid. If this does not relieve the pain, an opioid for mild to moderate pain should be added. When an opioid for mild to moderate pain in combination with a non-opioid fails to relieve the pain, an opioid for moderate to severe pain should be substituted. Only one from each of the groups should be used at the same time. Adjuvant drugs should be given for specific indications*". Implied in the WHO's "ladder" is the low potency of NSAIDs relative to opioids, hence the need to add an opioid to adequately treat many cases of *mild-to-moderate* pain. Therefore, it stands to reason that such agents would be inefficacious for the management of most cases of *moderate-to-severe* pain. Moreover, as described below their potentially life-threatening side effects profiles make them unsuitable for long-term administration required for the management of *chronic* pain, for which they have proven inefficacious⁴⁴. Consequently, NSAIDS should be restricted to treat *acute mild-to-moderate* pain.

However, ignoring the evidence NSAIDS are the drugs of choice for the treatment of all types of pain regardless of severity and anticipated duration. This is confirmed by surveys showing NSAIDs to be the most common analgesics sold both in America, whether over the counter (63%) or by prescription (29%)³⁹, and worldwide, according to consumption statistics cited earlier. Acetaminophen is usually favored as the initial painkiller because, unlike NSAIDs, it is not associated with gastrointestinal complications. However, it can cause liver or kidney damage especially at doses higher than 4 grams per day. There is wide variation in the way patients respond to NSAIDs. An individual may respond well to some NSAIDs and not to others, develop side effects to some NSAIDs but tolerate others well. Likewise, recommended doses may be optimal in one case but either too high or too low in another. Hence, physicians must proceed cautiously by "*trial and error*" to identify the most appropriate NSAID and the optimal dose for each patient. If the level of pain relief and quality of life outcomes, set by patient and physician, are not met after several weeks of NSAIDs administration, an opioid should replace rather than be added to the NSAID regimen, as advocated by the WHO. Finally, great caution should be exercised in patients with a prior history of gastrointestinal ulcers or bleeding, or with a low platelet count. All patients should be advised of the risks and monitored closely for signs or symptoms of complications though ulcers can be asymptomatic at the onset.

Side effects. The most frequent and clinically significant side effects of NSAIDs are gastrointestinal (dyspepsia*, gastric or duodenal ulcer with or without perforation, and bleeding), followed by kidney damage and anaphylaxis**. Asthma exacerbation and erectile dysfunction occur infrequently.

* A sensation of stomach discomfort

** Hypersensitivity reaction resulting from prior exposure

Gastrointestinal side effects. Although NSAIDs are well tolerated generally, gastrointestinal side effects occur in a small but significant percentage of patients, resulting in substantial morbidity and mortality. The risk of gastrointestinal complications of NSAIDs, assessed by a meta-analysis⁴⁵ of 527 high quality studies published between 1985 and 2003 involving 5,325 patients receiving NSAIDs for a period of 5 to 1,825 days, put the average relative risk (RR*) of NSAIDs-induced gastrointestinal complications at 1.54. Indometacin exhibited the highest risk of the group (RR = 2.25) and ibuprofen the lowest (RR = 1.19), with other NSAIDs ranging between RR 1.43 and 1.83. The risk was time-, dose-, and drug-dependent, with indometacin triggering side effects as early as 7 days while the others required 2 to 3 months of therapy at their recommended doses. Patients developing ulcers, bleeding, or perforation, were older on the average than patients with minor or no gastrointestinal complaints. The mechanisms responsible for NSAIDs' gastrointestinal complications have not been elucidated fully but involve both local and systemic factors. Local factors include mucosal injury caused by the acidic properties of NSAIDs and by alteration of the gastric mucus. Systemic factors include inhibition of endogenous prostaglandin synthesis, which leads to decreased epithelial mucus and mucosal blood flow, and epithelial proliferation. Together, these NSAIDs effects impair mucosal resistance to injury⁴⁶, which in turn allows tissue damage by exogenous factors such as gastric acid, pepsin, bile salts, ethanol, NSAIDs themselves, and other noxious agents. Once tissue damage has taken place, COX-1 inhibition of platelet aggregation, which begins the process of plugging vascular leaks, promotes bleeding at the sites of tissue injury.

In the US, at least 10% to 20% of individuals taking NSAIDs develop dyspepsia, 1% to 2% exhibit serious gastrointestinal complications requiring hospitalization (e.g. ulcer or gastrointestinal bleeding), and 5% to 10% of these die as a result. Ulcers and gastrointestinal bleeding are often not preceded by symptoms, which make these complications the more serious and unpredictable. Older age, prior history of peptic ulcer or of gastrointestinal bleeding, higher NSAID dose and treatment duration, concurrent use of corticosteroids, anticoagulants, alcohol or smoking, and the presence of co-morbidities and their treatment increase the risk for serious NSAID-induced gastrointestinal side effects⁴⁷⁻⁴⁹. Most deaths from NSAID-related gastrointestinal complications occur in elderly persons, particularly women. Hence, given the seriousness of the gastrointestinal complications of NSAIDs, prevention is crucial. It should include avoidance of NSAIDs altogether or choosing an analgesic agent without gastrointestinal side effect (e.g. acetaminophen) for individuals at risk, or the concomitant administration of agents to protect the mucosa from injury. Examples of the latter include H2 receptor agonists (e.g. cimetidine, ranitidine, or of famotidine), or proton-pump inhibitors (e.g. omeprazole) to patients not especially vulnerable.

While the incidence of serious NSAIDs-induced side effects mentioned above is relatively low, it nevertheless translates into very high levels of morbidity and mortality when extrapolated to the entire NSAIDs-medicated population. Indeed, based on the 70 million prescriptions⁵⁰ and 30 billion over-the-counter tablets sold annually in the US, it is estimated that over 100,000 individuals are hospitalized each year for serious gastrointestinal complications costing in excess of US \$2 billion and 16,500 deaths^{47,51}. The magnitude of the problem has been characterized as follows⁴⁶: *"If deaths from gastrointestinal toxic effects of NSAIDs were tabulated separately in the National Vital Statistics reports, these effects would constitute the 15th most common*

* Relative risk of NSAIDs compared to controls

cause of death in the United States. Yet, these toxic effects remain largely a 'silent epidemic,' with many physicians and most patients unaware of the magnitude of the problem. Furthermore, the mortality statistics do not include deaths ascribed to the use of over-the-counter NSAIDs". Data from other countries reveal similar statistics ^{52,53}. For instance, a recent survey of 83% of the 269 Spanish National Health System hospitals ⁵² was conducted "to determine mortality associated with hospital admission due to major gastrointestinal (GI) events and NSAID/aspirin use". It found "the incidence of hospital admissions due to major GI events of the entire (upper and lower) gastrointestinal tract was 121.9 events/100,000 persons/year, but those related to the upper GI tract were six times more frequent. Mortality rate was 5.57%... and 5.62% ...in study 1 and study 2, respectively. Death rate attributed to NSAID/aspirin use was 15.3 deaths/100,000 NSAID/aspirin users. Up to one-third of all NSAID/aspirin deaths can be attributed to low-dose aspirin use".

Other severe side effects. It is estimated that prolonged exposure to NSAIDs account for 11% to 13% of all cases of end-stage renal disease and 26% of all cases of severe drug-induced anaphylactic^{*} reactions ⁵³.

In conclusion, based on WHO's widely adopted "Use of analgesic guidelines" ⁶, patients with *mild-to-moderate* cancer pain should be treated "by the ladder". Cancer pain is often used as a benchmark for comparison purposes because many clinical cancer studies, testing numerous variables in a multitude of combinations and permutations, enable greater consensus about its management than that of non-cancer pain. Additionally, a diagnosis of cancer conjures up the "finality of death" that "justifies" a presumed risk of addiction to opioids, whereas that risk is felt to be disproportionate if the patient is expected to recover or not to succumb to the illness causing pain. Hence, the widely adopted "by the ladder" approach recommends the use of a non-opioid drug first, adding a mild opioid if this fails, followed by further escalation through stronger opioids plus adjuvant agents, when needed. Using NSAIDs to treat *mild-to-moderate* pain regardless of cause, particularly if *acute or sub-acute*, beginning with the most efficacious and best tolerated (e.g. Ibuprofen and naproxen), is indeed appropriate. However, NSAIDs should not be used for the management of *chronic* pain, whether from cancer or other causes. The main reasons are three-fold. First, the relatively weak analgesic potency of NSAIDs usually requires dose escalation or the addition of or switching to an opioid to manage *moderate-to-severe* pain. Second, most patients with *chronic* pain are individuals at greater than average risk for serious gastrointestinal side effects given their frailty or age, or the presence of co-morbidities frequently treated with medications that contribute to or potentiate NSAIDs' side effects. Thirdly, the frequency of potentially severe and life-threatening side effects increases with escalating NSAIDs doses and long-term administration, which is required for the successful management of *chronic* pain.

Another unsupported practice is adding NSAIDs to an opioid regimen for managing *moderate-to-severe* pain, based on an alleged "opioid-sparing effect" of NSAIDs. However, reports of opioid sparing ^{54,55} describe random effects probably related to variable accumulation of opioid metabolites resulting from NSAIDs-induced renal impairment ⁵⁶. Likewise, NSAIDs-opioid combinations do not reduce opioid side effects but preclude dose escalation because of the potential for increased toxicity from the NSAIDs component of the combination ^{16,57}. Hence, unless necessary to treat opioid-

* A potentially fatal form of shock caused by a severe allergic reaction

intolerant patients, a questionable indication, relying on an alleged *opioid-sparing* effect of NSAIDs or NSAID-opioid combinations are nonsensical practices born out of an unjustified fear of addiction, inexperience, or self-delusion. Indeed, addiction in pain patients is extremely rare, μ -agonists (morphine-like) with no ceiling dose need no *sparing*, and NSAIDs cause far more frequent and serious complications than opioids, they supposedly *spare*, including thousands of deaths each year. Hence, adding potentially lethal NSAIDs to more potent and far safer opioid-based regimens solely for the purpose of reducing the opioid dose seems a bizarre notion that has no place in the practice of evidence-based medicine of the 21st century.

PART V

GEOPOLITICS: CASUALTIES OF THE DRUG WAR

The *War on Drugs* has received considerable attention and rightfully generated widespread condemnation over the years. Critics include celebrities ranging from libertarian socialist intellectual, Noam Chomsky to conservative author and commentator, William F. Buckley, from financier and philanthropist George Soros to former US Secretary of Labor, State, and Treasury, George Shultz, and economist and Nobel Prize winner, Milton Friedman ¹. However, most critics have concentrated on the destructive effects of the *War on Drugs* on American society almost entirely overlooking its geopolitical and socioeconomic impacts at the international level. Therefore, in order to raise awareness on the devastating impact of *War on Drugs* policies overseas, especially on producer countries, I will describe in some detail the plight of Colombia, supplier of 80% of the global cocaine demand, and of Afghanistan, provider of over 90% of worldwide opium market. This stunning concentration of illegal crop production in these two countries is no accident. They both benefit from favorable climactic and geographic conditions and are cursed by chaotic political and legal infrastructures for which the highly lucrative black market of illicit drugs, initiated and sustained by the criminalization of drugs, is a godsend. Indeed, this irresistible and unmatched road to riches funds guerillas, insurgent groups, terrorists, and common criminals, often with the complicity of regional leaders. By supplying consumer countries' insatiable demand for drugs by whatever means, these groups bring devastation to their countries' underclass and corruption to their political and judicial systems. However, while demand drives supply in all commercial exchanges, including drugs, placing a large share of blame on consumer countries, producer countries especially Colombia and Afghanistan must assume responsibility for chronically dysfunctional institutions underlying their current dire sociopolitical and socioeconomic conditions.

Chapter 7

COLOMBIA

As the main producer of cocaine destined to supply an unabated demand in countries of consumption, mostly the USA and West European nations, Colombia has been devastated by an unimaginable level of corruption that reaches far and wide, and by violence on the rural poor caught between warring factions focused on protecting their turf and sources of income. Social dislocations include 3.4 million peasants, or 13.1% of the rural population, displaced between 1985 and 2004 ², with over 400,000 in 2002 alone, after being robbed of their land and possessions by guerillas and counter-guerilla groups, creating *“the gravest humanitarian situation in Latin America”* ³. Political disruptions result mostly from the ongoing collusion with such groups of a large number of conniving congressmen, the Liberal party, and at least two former presidents ⁴. From a historical and socio-economic standpoint, cocaine trafficking was propelled to a business of massive proportions by the *“Medellin cartel”*, which dominated the trade in the 1970s. After the assassination of its founder and leader, Pablo Escobar, the *“Cali cartel”* became the predominant cocaine exporter through the 1980s but its dismantlement in 1995 opened the door for the drug trade to become one of the major funding activities of insurgent guerillas and counter-guerilla groups, along with kidnapping for ransom and extortion. As a result, Colombia is often viewed as a *“narco-democracy”* where the impact of drugs permeates the economy, the ruling class, the political and judicial systems, and the every day lives of ordinary Colombians.

Yet, while Colombia is considered one of the most violent countries in the world, its violent history preceded narco-trafficking. It can be traced back to the period of *“La Violencia”* ^{*} (The Violence) that gave rise to insurgent left-wing movements of the 1950s and right-wing armies of the 1980s, all of which eventually funded by drug trafficking, leading to massive human rights violations and drug-related crime. However, to pretend that Colombia has brought onto itself all the social and political ills it now faces is tantamount to ignoring the impact of War on Drugs policies and of American foreign policy on its internal affairs. The former has fostered a highly lucrative worldwide black market of illicit drugs that provide guerilla and counter-guerilla armies an irresistible incentive to abandon their initially altruistic goals of bringing social justice to the masses and protection from the rich and powerful, becoming narco-trafficking enterprises instead. In turn, this metamorphosis opened the door for American foreign policy of overt or covert intrusion in Central and South American affairs to become a player in Colombia's 50 yearlong internal conflict. Indeed, *“U.S. intervention in Colombia [currently through ‘Plan Colombia’] is accepted because of its ostensible anti-drug objectives, but its effects extend beyond the sphere of drug control”* ⁵. In this section, I will describe in some detail major historical and political events that led to the decades-old Colombian conflict and how the drug trade impacted its major players and shaped today's Colombian society.

* A period from 1946 to 1965 characterized by armed confrontation between the two main political parties

1. ***From ‘La Violencia’ to self-defense armies***⁶

While Colombia experienced four civil wars between 1895 and 1902, the last one lasting 1,000 days (*Guerra de los Mil Días*^{*}), the period known as *La Violencia* began in 1946 when Mariano Ospina Perez, candidate for the Conservative party^{**}, won the presidential election. This electoral victory was due, in large measure, to the split of the Liberal party between a moderate wing, led by the official candidate Gabriel Turbay, and a radical faction headed by populist Jorge Eléicer Gaitán. The assassination of Gaitán on April 9, 1948 ignited the April 1948 Revolution in Bogota^{***} and other major cities, and the uprising of disenfranchised peasants leading to rural violence by guerrilla groups of liberal leaning, especially in the “*llanos orientales*” (western plains) and in coffee growing areas of the Andes mountains. Conservative counter-revolutionary bands called “*los pájaros*” (the birds) also roamed the countryside. The polarization intensified under the government of President Laureano Gomez, whose uncontested election had been boycotted by the Liberals. The Gomez regime, supported by the Catholic Church and the US, viewed uprising peasants as Communist insurgents and intensified their repression, resulting in violent confrontations between Liberal and Conservative camps and between peasants and landowners.

Armed peasant groups of Liberal or Communist persuasion organized themselves mostly for self-defense against the violent incursions of the national Army. For instance, one of the Communist-leaning groups founded “*ciudad roja*” (red city), in Viotá, one of the first Communist-inspired armed communes, with similar settlements soon to follow. In 1953, Gomez was overthrown by a military coup led by General Gustavo Rojas Pinilla, who first dispatched the Army to reclaim lands occupied by peasants but later changed tactics promising an unmet agrarian reform and issuing a general amnesty with government aid for belligerents willing to lay down their arms. Thousands accepted the offer. However, many of the demobilized men were subsequently killed in an escalating cycle of revenge and Gomez sympathizers, released from prison, renewed their hostilities against peasants, forcing them to take up arms again. In 1955, Rojas Pinilla responded by launching a massive Army offensive against armed peasants that became known as the “*Guerra de Villarica*”. This caused a massive exodus of armed peasants towards Marquetalia, Ríochiquito, El Pato, Guayabero, El Duda, and El Ariari where they founded new settlements, loosely called “*independent republics*”. Like Viotá, these settlements were more a means of self-defense (*autodefensas*) than a prelude to an overthrow of the central government. Hence, *la Violencia* was a combination of political inter-party fight for power and a peasant revolt for social justice. This explains why the 1957 “*Frente Nacional*” (National Front) pact subscribed by the two major parties to alternate the presidency and other high-level governmental positions as a means to end the political conflict. However, by failing to address inequities and injustices toward the peasant population, the pact was unsuccessful in ending the armed conflict in rural areas.

In the meantime, while leftist *autodefensas* had accepted Rojas Pinilla’s amnesty, their Communist counterparts under the leadership of “*Charro Negro*” and Manuel Marulanda Vélez, refused. Theirs remained a minuscule *autodefensas* with little

^{*} Thousand-day War

^{**} Colombia has two major political parties: Liberal (left-leaning) and Conservative (right-leaning)

^{***} Also known as “*Bogotazo*”

relevance to the national life or politics for several years. However, on May 27, 1964 the government of President Guillermo León Valencia launched a massive assault, by 16,000 infantrymen backed by airpower, on the “*independent republic*” of Marquetalia where Marulanda had retrenched with his 48-armed *autodefensas* peasants. Their instructions were to destroy the insurgents within three weeks. In response to the attack, Marulanda’s *autodefensas* became an outright revolutionary army that two years later would be renamed “*Fuerzas Armadas Revolucionarias de Colombia*” or FARC (Revolutionary Armed Forces of Colombia), this time with the stated aim to overthrow the government. While the FARC evolved into the largest Colombian insurgent force, it lost its early political ideology becoming instead a guerilla group caught up in a vicious cycle of narco-trafficking, kidnapping for ransom, and extortion with the tacit compliance of a terrorized rural peasantry.

Other insurgent groups emerged during this period. They include the “*ELN*” * or National Liberation Army inspired on Communist and Cuban ideology and on “*Liberation theology*”; The “*EPL*” ** or Popular Army of Liberation, a Marxist-Leninist insurgency that was demobilized in 1991; The “*M-19*” *** or Movement April 19th, an insurgent group that gained notoriety through a series of daring urban raids. The most infamous were the Dominican Embassy occupation, in 1980, and the ill-fated takeover of the Palace of Justice in 1985 where over one hundred people died, including eleven Supreme Court judges. In exchange for a full government pardon, the group laid down its weapons, in 1989, and joined the country’s political system; and the “*AUC*” **** or United Self-defense Forces of Colombia, better known as “*Paramilitares*”. As the name indicates, these armies were organized, with overt or tacit support of the Colombian Army, for self-protection against guerilla attack, kidnappings, and extortion. In contrast to the FARC and ELN, the AUC are not a unified organization with a central command, as its name implies, but a collection of semi-autonomous regional groups that are infamous for their gratuitous and brutal violence, massive violations of human rights, and for their close association with many local and national politicians.

2. Guerrilla and counter-guerrilla armies: Origins and evolution

In addition to a host of criminal gangs and hired guns, Colombia confronts two Marxist guerilla movements that remain operative today: the FARC and the ELN, and their sworn enemy, the AUC. The first two groups rose in the mid-1960s in reaction to the State’s neglect of the underclass, abuses by the ruling elite, and the desperate socioeconomic conditions of Colombian peasants abandoned to live a subsistence-level existence without access to education, health care, sanitation, electricity, or even running water. Americans and Europeans, used to minimum hourly wages ranging from US \$5.75 to up to Euro 11.00 (US \$16.00 at current exchange rate), respectively, might find such appalling living conditions difficult to comprehend.

Yet, 50 years later the plight of most Colombians has changed little. Indeed, “*in the year 2000 no more than 0.4 percent of the landowners owned 61.2 percent of the arable land, while 57.3 percent of the landowners were small-scale peasants owning just*

* Ejército de Liberación Nacional

** Ejército Popular de Liberación

*** Movimiento 19 de Abril

**** Autodefensas Unidas de Colombia

1.7 percent of the land”⁷. In the same time-frame (2002), unemployment in the 7 largest cities averaged 15.6% and 48% of Colombians in the “workforce” were street vendors or held sporadic menial jobs⁸. More recently (2006), official figures indicated that nearly 50% of Colombians still lived below the poverty line (US \$3.30 per person, per day)^{8,9}, ranking 34th poorest country in the world¹⁰, a slight improvement from 2002 levels. The same sources⁹ indicated that nearly 15% of Colombians lived in misery in 2006, surviving on less than US \$1.50 per person, per day. The AUC, whose original purpose was to protect wealthy landlord from the FARC and the ELN acting as surrogates of the Colombian Army, were demobilized in March 2005 (see caveat under AUC heading). However, although the FARC’s and ELN’s original commitment to social justice was justifiable and their motives altruistic and the AUC’s defensible at the outset, these groups became decidedly criminalized, which along with their abhorrent *modus operandi* have undermined their credibility and support in Colombia and internationally. Indeed, they engage in wanton violence and massive human rights violations, mostly against the segment of the population they claim to represent, supporting their “cause” through narco-trafficking, kidnapping for ransom, and extortion of businesses and of individuals. As a result, all three have been branded “terrorist organizations”, by the USA, the European Union, and other nations.

Fuerzas Armadas Revolucionarias de Colombia (FARC).

Origins. Following the carnage at Marquetalia by the Colombian Army in 1964, Communist *autodefensas* dispersed only to regroup as the “*Bloque Sur*” (Southern Bloc) later renamed FARC, under the joint leadership of Manuel Marulanda Vélez (real name, Pedro Antonio Marín) a.k.a “*Tirofijo*” (Sureshot), its commander, and Jacobo Arenas, its Communist ideologue. Arenas chronicled the attack in a book titled, “*Diario de la Resistencia de Marquetalia*” (Diary of the Marquetalian resistance). The FARC’s initial force of 350-armed men grew slowly until 1982 when, at the “*Seventh Guerrilla Conference*”, it developed its first “*Strategic Plan*”. The plan outlined incremental goals to be reached through the “*Ejército del Pueblo*” (The People’s Army), meant to seize power “*sometime in the 1990s*” using legal as well as illegal means of struggle. The Conference was a turning point in the FARC’s struggle, as it provided a forum to fine-tune policies and plans to achieve their dual goals of seizing power and creating a Socialist State.

At its peak, the FARC reached an estimated 12,000-18,000 fighters, including 20 to 30% of children as young as 9 years of age. They were organized into five “*bloques*” and two joint commands that operated throughout Colombia’s territory though, as of late, they have been both plagued by desertions and relegated to southeastern sanctuaries by the Colombian Army. Some children-fighters are forcibly recruited but 3 in 4 join voluntarily, not for ideological reasons, but as a means to escape poverty and unemployment, the lure of the uniform, or in response to parental rejection or abuse¹¹. A typical case, described by Amnesty International, reveals these children’s tragic lives, “*My father abused me [sexually] from the age of five. He didn’t want me to study or talk to anyone. Just work milking the cows. My mother knew nothing. He gave the orders. My father came looking for me but I didn’t go back. The FARC gave me an AK-47 with three ammunition magazines, clothes and boots. He [the father] couldn’t hurt me any more*”¹². Recruits are trained to fight and kill without gender distinctions: women are not spared hardships and have the same opportunities as men to become field commanders, and many do. However, sexual harassment and abuse are the rule, as reported by girl recruits who have managed to escape. For instance, Human Rights Watch reports, “*When girls join the FARC, the commanders choose among them... the women have the*

final say, but... when you're with a commander, you don't have to do the hard work... you get away with stuff [and] enjoy privileges. So, most of the prettiest girls are with commanders...you see lots of commanders with young girls. Commander Topo was fifty-two. He had a sixteen-year-old girlfriend. This is typical" ¹³. As for pregnancies, "Even girls as young as twelve are required to use contraception, often by having an intrauterine device (IUD) inserted by guerrilla nurses. While the AUC-ELN seem more willing to tolerate pregnancies... FARC-EP girls are almost invariably made to have abortions if they get pregnant" ¹³. Amnesty International quotes Janet, a 12-year old FARC recruit, "As soon as you get there, they give you coils and injections. Any girl who gets pregnant has to have an abortion" ¹².

Manuel Marulanda, the legendary founder of the FARC-EP led the group for 44 years, assisted by his military commander Jorge Briceño, a.k.a. "Mono Jojoy", until his cardiac death on March 26, 2008, age 78. The FARC-EP claims to be an insurgent Marxist-Leninist army that represents the poor in a struggle against Colombia's wealthy elite. Its agenda includes expropriation of multinational corporations, nationalization of natural resources, wealth redistribution, and an agrarian reform to dismantle large estates. It fiercely opposes US interference in Colombia's affairs, particularly "Plan Colombia". Through decades of operations, the FARC-EP became one of the toughest and most disciplined leftist guerillas in the world, and Marulanda one of the best guerilla commanders and strategists. In the late 1980s, the FARC-EP attempted an insertion into the country's political life through a political party, the "Unión Patriótica" (Patriotic Union). However, right-wing death squads, sponsored by drug traffickers with links to government security forces, decimated the party by murdering thousands of its members including its 1990 presidential candidate ¹⁴. This convinced Marulanda that the road to power was by force rather than through the ballot box, marking the beginnings of a particularly violent decade.

The FARC-EP operate through military and paramilitary means. Conventional military tactics include hit and run attacks against the Colombian Army using state of the art machine guns, rocket launchers, AK-47 rifles ¹⁵, and land mines. On a recent website's "War bulletin" heading ¹⁶, they declared "On the 16th of the current month, units from the FARC's southern bloc activated mines against six anti-narcotic police cars in the Mirabeles vereda * of the municipality of Hormiga, in the province of Putumayo **, destroying two cars, killing two policemen and wounding 19". However, as is the case elsewhere most land mine victims are innocent civilians, including children unaware of the danger lurking in their own backyards ¹⁷. Paramilitary operations are wide-ranging. They include blowing up economic targets such as oil pipelines, electric and water facilities, kidnapping military personnel for political gain and civilians for ransom, murdering known or suspected opponents, meddlesome journalists ^{18,19}, human rights activists, and holders of or candidates to public office ²⁰, and conducting indiscriminate massacres of populations suspected of cooperating with the enemy (mainly the AUC).

Their weapons of choice when attacking towns, police stations, and other paramilitary targets include car bombings and crude but gruesomely lethal mortars made of shrapnel-filled gas canisters that, given their inaccuracy, frequently kill more civilians than enemy fighters, as was the case of a 2002 attack on a church in the Chocó

* Administrative rural area

** Colombia is divided into 32 administrative "Departamentos", referred to as "Provinces" in this book

province that killed 119 people including 45 children. As reported at the time ²¹, *“Chocó is Colombia's poorest province. A jungle region populated by Afro-Colombian and indigenous communities, it has coasts on two oceans and shares a border with Panama, which obviously places it close to the Canal Zone. This strategic location is particularly attractive to armed groups, who use the area as a corridor for drug trafficking and to smuggle weapons. This has sparked a deadly struggle between the Revolutionary Armed Forces of Colombia (FARC) and the United Self-defense Groups of Colombia (AUC). Each of these groups wants to control the area... On April 21, 2002 four hundred (400) members of the AUC arrived in Vigía del Fuerte and ousted the FARC... At 6:00 a.m. on Wednesday, May 1, approximately 2,000 FARC guerrillas launched an attack... to regain control. Finding themselves under attack, the AUC took refuge in Bellavista... the people of Bojayá [county] took refuge in the church, the parish house, and the health post [the only solid buildings]... [On] May 2, at about 10:15 in the morning, the FARC launched a propane gas cylinder against the building [the church]. Full of metal shards and explosives, the cylinder broke through the thin roof and exploded on the altar. The shingles from the roof and wooden chairs inside the church were converted into shrapnel, killing many of the [300] people who had sought refuge in the building. The fighting went on for five days. The bodies of the victims were exposed to the inclemency of the tropical sun and the water for three days, before they could be recovered for burial... The stench was so horrible that it was difficult even to approach the church”*.

President Andrés Pastrana Arango (1998-2002) visited the area on May 9th, 2002, promising reconstruction aid that never materialized and, say critics ²², he exploited this especially gruesome episode at the national and international level. To that effect, he made a number of statements to the Colombian press, radio, and television, and embarked on a vigorous diplomatic offensive especially aimed at the EU*. A week after the incident he met Javier Solana, EU High Representative for the Common Foreign and Security Policy, in Madrid Spain, to make the case that *“omission of the FARC from the EU's terrorist list sent the message that Europe tolerates these terrible and cowardly attacks”*. A few days later, the Foreign Ministers of the then fifteen EU member nations meeting in Luxembourg added the FARC to its terrorist list. The initial EU reluctance to act was more pragmatic than philosophic or political. Indeed, *“Stigmatizing a group or an individual as ‘terrorist’ - as Ariel Sharon does with regard to the Palestinians, as Russia does with the Chechens, and as Turkey does with the PKK - is an effective means of excluding it from the political arena. You use the term with groups with which you do not want to negotiate”* ²³. Five years later, awaiting reconstruction, electricity, and running water the townspeople re-baptized their town “Se verá” (we’ll see). Quizzed about the lack of progress, the nonchalant project manager disdainfully declared, *“we know they can live without electricity as they didn’t have it before. As for water, they’ll have tanks to fill with rainwater”* ²⁴.

The FARC favors collective over individual kidnappings for obvious financial reasons. An example with a deadly outcome occurred on April 11, 2002 when a FARC “commando” (squad), disguised in military uniform, entered the regional assembly of the Valle del Cauca province and evacuated the building under the pretext of a bomb threat, kidnapping 12 “diputados” (municipal officials) ²⁵. They became part of a group of high-profile hostages the FARC hoped to exchange for hundreds of their comrades held in Colombian prisons. Six years later, on June 18, 2007, the FARC announced *“11 assembly members of the Valle del Cauca that we had retained in April 2002 died as a*

* European Union

result of crossfire when a non-identified military group attacked the camp where they were held" (cited in ²⁵). Yet, a forensic investigation of the 11 cadavers, conducted by the *Cuerpo Técnico de Investigaciones* (Technical investigational group) of the Fiscalía General de la Nación (Nation's Attorney General) under the watchful eye of the OEA's* International Forensic Commission, revealed a very different picture. The 11 *diputados* had been shot 4 to 15 times each, some at short range and from behind. Ninety percent of the bullets recovered from cadavers were from Russian-made AK-47, the rifle favored by the FARC, and 10% from Israeli-made "Galils" ²⁶.

Sources of income. Funding a large organization such as the FARC requires substantial and steady revenues. Initially, the FARC was able to get political and financial assistance from the Soviet Union. However, in 1985 Carlos Lehder, a notorious Colombian "narco" **, introduced them to the booming drug business marking a shift in their source of income. More recently, some FARC financial and logistical support comes from Venezuela's leftist President Lt. Col. Hugo Chávez facilitated by a long, unprotected 1,375-mile border with Colombia. Evidence cited includes Chávez' virulent attacks on US policy in Latin America, especially "Plan Colombia" also opposed by the FARC, and his choice of Diego Serna, a FARC member, as bodyguard during his May 2001 visit to Colombia, who asserted to Cambio*** that Chávez was in frequent and secret contacts with the FARC leadership. The Venezuela-FARC connection acquired credence when the Colombian Air Force captured a Venezuelan plane loaded with munitions destined to the FARC ²⁷, by accusations of collusion between the Chávez government and the FARC made by retired Lt. Col. Jesús Urdaneta, Venezuela's former secret-police chief, and by a video recording of meetings between Venezuelan military leaders and FARC commanders. The Chávez-FARC connection was confirmed by a wealth of electronic documents discovered in Raul Reyes' computers retrieved after the March 1, 2008 bombardment, by the Colombian Air Force, of a FARC camp hidden in Ecuadorian territory. However, the FARC derives most of their income from the drug trade, kidnappings, and extortion. They are involved at all levels of drug production, transportation, and exportation from areas under their control. They also tax every stage of the drug business, from the chemicals needed to process coca leaves into cocaine and poppy into heroin. Extortion takes the form of kidnapping for ransom, which they have turned into a fine-tuned business, and of taxing individuals and businesses presumed to making more than a million dollars a year.

Total revenues from these criminal activities make them probably the richest guerilla group in the world. It is estimated that in 2003 total income was 2,100 billion pesos (over US \$1 billion at the then exchange rate), 88% of which drug related, more than the ELN's and AUC's combined. Total outlays for that year were 546 billion pesos, including a measly 2,000 pesos (approximately US \$1,00) daily to feed each combatant and each hostage ²⁸. Although ransom money accounts for less than 10% of the FARC's revenues, the enormity of that crime, the family and society disruptions it causes, and the appalling conditions in which hostages are kept day after day, year after year attract international attention and condemnation of its practitioners, mainly the FARC and the ELN. For instance, a recent article titled "Colombia: Secuestros, S.A." (Colombia: Kidnappings, S.A.), reports "Extortion of rich and poor alike has grown to become one of

* Organization of American States

** Drug baron

*** A magazine published by Nobel laureate Gabriel García Márquez

the most lucrative practices of the FARC and the ELN, where the amount of the ransom is assigned based on the apparent worth of the kidnapped" ²⁹. Accurate figures on the number of kidnappings are difficult to come by, as are other Colombian crime statistics, because victims' families do not report many such cases, guerillas or criminal gangs do not boast of their criminal activities, official statistics can be of dubious accuracy ³⁰, and data gathering NGO's * have their own sources, ways of investigating, and focusing interests. However, it is generally agreed that until recently Colombia had the dubious distinction of holding the world record on reported kidnappings, reaching 3,706 in 2000 ³¹ (3,572, according to another source ³²), or approximately 10 each day, more than 50% of them committed by the FARC-EP and the ELN ^{31,52}.

Kidnappings take two forms: "*secuestros*" and "*pesca milagrosa*" **. While the former usually takes place in urban settings against pre-selected civil or political targets, the latter consists of blocking major roadways and selecting targets whose physical vehicle, appearance, or dress denotes wealth and therefore a potentially sizeable ransom. The fear is such that people traveling by car anywhere in the country pay particular attention to traffic fluidity because more than a few minutes without incoming traffic might indicate a road blockade ahead and an ongoing "*pesca milagrosa*". A variant of the *pesca milagrosa* follows commando-style attacks on apartment buildings, restaurants, and other places where people assemble. A particularly reprehensible form of kidnapping involves minors, as young as 4 years of age; the age of a case reported by the Colombian and international press on December 4, 2007. Common criminals are also engage in kidnappings either directly or as informants. In the latter case, they identify potential targets and sell the information to their guerilla contacts for a fraction of the ransom eventually charged by guerilla captors. Once a kidnap occurs, euphemistically called "*retención*" *** , a ransom is demanded from relatives accompanied by a threat of execution should the demand not be met within the specified deadline, or the police be contacted. Victims of political kidnapping are held hostage not for ransom but for political gain or to pressure the government into a prisoner exchange.

Ingrid Betancourt was the most famous hostage held by the FARC. A Colombian politician, Ms. Betancourt was a former senator, anti-corruption activist, and founder of the "*Green Oxygen*" political party. She was kidnapped on February 23, 2002 along with Clara Rojas while attempting to enter the demilitarized FARC stronghold of San Vicente del Caguán in the Caquetá province against President Pastrana's warning that the government could not guaranty her safety. Because of her dual Colombian-French citizenship and her book "*La rage au Coeur*" **** , a bestseller in France, she became a "*cause célèbre*" and the focus of efforts towards her release by Prime Minister, *Dominique de Villepin*, and French President, *Nicolas Sarkozy*. In her book, she denounced corrupt Senate colleagues and the partial funding of Ernesto Samper's presidential campaign by the Cali drug cartel, which triggered an investigation that landed Fernando Botero, his campaign manager and son of the celebrated "*fat motifs*" painter and sculptor, in prison. Ms. Betancourt remained captive over six years, a fate endured by hundreds of hostages held in the jungles of Colombia, until her liberation on July 2, 2008 by Colombian intelligence units in a spectacular, daring, and bloodless

* Non-government organizations

** Miracle catch

*** Retained

**** *Until Death Do Us Part* in the English version

rescue operation that freed 11 hostages, including three Americans.

Yet, until recently Colombia had shown impotence against the hostage tragedy. In efforts to fill the void several radio stations offer airtime for hostage relatives to send messages of hope to their captive love ones. “*Voces del Secuestro*” (Hostage Voices), the oldest such program, was founded in 1994 by Herbin Hoyos Medina, a former kidnap victim himself. As of December 7, 2007, the website of the program’s parent company listed, alphabetically, 4,200 hostages³³, along with dates and circumstances of their kidnapping. During a TV interview held on December 4, 2007, Mr. Hoyos indicated that 14,000 Colombian families have participated in his broadcast since its inception. How do the FARC justify Kidnappings as a source of revenues? The answer was provided by Rodrigo Granda, a leading member of the FARC released from a Colombian prison, in an interview dated October 2, 2007³⁴. “*Of course... a war requires funding... a war imposed on us by wealthy Colombians ... hence they have to finance the war they set off. That is why the FARC retains people and charges a reward [for their freedom] that is in fact a tax*”. He also justified extortions as follows, “*The New State that we are building has decided on a tax for peace. That means that any person or enterprise conducting business in Colombia with profits in excess of a million dollars annually must pay a tax equivalent to 10% of their profits... If they fail to do so, of course they are retained and imprisoned until they comply with their obligations*”. As for kidnappings of politicians and the military, “*in the conduct of military operations, some [State] officers or soldiers fall in our hands and are currently retained as prisoners of war... as some of ours fall in the hands of the enemy... prisoners of war are kept for humanitarian exchange that we hope will take place shortly*”. Finally, after a protracted and hesitant preamble Granda explained the FARC’s drug involvement as follows, “*We are not, in any way, shape, or form, narco-traffickers. We don’t get involved in the production, transport, of exportation of narcotics. Our organization has implemented charging a tax to buyers of coca paste in the areas... were we operate... retaining [non-complying] persons also helps, it must be said, to finance the FARC but is not decisive*”.

FARC-Government tug-of-war: 1998-2002. During his presidential campaign, Andrés Pastrana pledged to end the decades-old internal conflict and met with Manuel Marulanda in June 1998; a tactic that won him the election. Shortly after taking office, he granted the FARC, unilaterally and without preconditions, a Switzerland-size *Zona de Despeje* (Demilitarized zone) in the Caquetá province that was to last 90 days. The negotiations had an inauspicious beginning. They were carefully planned by the government “*as a spectacle that ranked the FARC at par with the government where President Pastrana was to sit at the negotiating table side-by-side with Manuel Marulanda, head of the FARC. The diplomatic corps and high-profile personalities were invited to the event and each received a white hat. A band was contracted for the occasion... [but] Marulanda did not show up*”³⁵. Eventually, negotiations began between both sides in the town of San Vicente del Caguán only to break up ten days later on FARC accusations that the Government had not clamped down on the AUC. From that point on accusations, counteraccusations, and provocations by each side characterized the mutual posturing that led to multiple interruptions of the peace negotiations and to their final collapse. For instance, the Government established military checkpoints around and surveillance flights over the demilitarized area while the FARC hijacked a civilian airplane on January 30, 2001, and kidnapped and executed Consuelo Araujo Noguera, the attorney general's wife. The “*coup de grâce*” came when the FARC hijacked a civilian airplane in order to abduct a congressman, leading Pastrana to declare an end of the negotiations, in January 2002.

In the interim (between late 1998 and early 2002), the FARC had control over the political, judicial, educational, and security affairs of a 42,000 square kilometer area (approximately 16,200 square miles). The FARC used this safe-heaven as a springboard for guerilla activities and as a hostage hideout. They used the truce to acquire weapons, and to recruit and train combatants in the manufacture and use of sophisticated explosives, with the assistance of three Irishmen known in Colombia as “*Los tres monos*” (The three blond men). *Los tres monos* (Martin John McCauley, James William Monaghan, and Niall Connolly) were IRA* explosives experts who, according to Interpol, had entered Colombia under the names of John Joseph Kelly, Edward Joseph Campbell, and David Bracken, respectively. On February 15, 2002, they were charged of entering the country with false passports and of training the FARC, and were sentenced to seventeen-year prison terms, along with fines in excess of US \$200,000, each. However, they managed to flee Colombia on September 15, 2005 and, despite an international arrest warrant, are back in Ireland claiming their innocence pending a Colombian government extradition request³⁶. The FARC also renewed their weaponry with the cooperation of Vladimiro Montesinos, Peru’s spymaster during the Presidency of Alberto Fujimori (1990-2000). As disclosed at his trial, “*Skimming off money that the CIA intended for use in Peru’s anti-drug trafficking efforts, Montesinos set up a major arms deal in the Middle East that funneled 10,000 AK47 rifles to left-wing FARC guerrillas in Colombia, thereby fomenting the very uprising that America has pledged \$1.3 billion to stamp out*”³⁷. The rifles had been parachuted into the FARC *Zona de Despeje*, in 1999³⁸. On June 24, 2001, Montesinos was arrested in Venezuela, extradited back to Peru, and convicted of arming the FARC and other crimes. On September 21, 2006, he was sentenced to several multi-year prison terms to be served consecutively. Hence, aided by foreign renegades the FARC was able to withstand the larger, better-equipped, and American-backed National Armed forces. In 2005 alone, they conducted attacks in Iscuandé and La Cruz, Nariño province, Mutatá, Antioquia province, Tame, Arauca province, Teteyé, Putumayo province, Atánquez, César province, Sipí and San Marino, Chocó province, San José del Guaviare, Guaviare province, and Vista Hermosa, Meta province, killing, maiming, or kidnapping hundreds of soldiers, policemen, and civilians³⁹.

Canjes Humanitarios ** *saga: 2002-2007*. The inauguration of the newly elected rightist President Álvaro Uribe Velez, on August 7, 2002, was greeted by the FARC with gas canisters full of dynamite and mortar attacks against the “*Casa Nariño*” (Presidential Palace) and the “*Capitolio*” (seat of Congress). Several grenades had been launched earlier that day against the Military School and two unexploded car bombs and assorted explosives were found in Bogotá. One of the canisters exploded in “*El Cartucho*”, an area of tin-houses inhabited by mendicants and drug addicts, located near the targeted buildings, where most of the 16 deaths, including 3 children, and over 30 injuries occurred⁴⁰. This marked the inauspicious beginnings of a thorny relationship. It has been characterized by a never ending barrage of communiqués from both sides about “*Canjes Humanitarios*” that captured international attention thanks to Ingrid Betancourt, the FARC’s most “*canjeable*” prisoner, and to the involvement of two presidents. On one side was Hugo Chávez, the leftist President of the “*República Bolivariana de Venezuela*” and a FARC supporter, and on the other Nicolas Sarkozy, the newly elected rightist President of France, seeking Betancourt’s release. Although endless posturing by both

* Irish Republican Army

** Humanitarian prisoner exchange

sides raises questions about their willingness to negotiate, history shows that even in the mayhem of Colombian politics such exchanges are possible, if infrequent.

For instance, the “*Acuerdo de Remolinos del Caguán*”, under President Ernesto Samper, freed 70 policemen and infantrymen held by the FARC. Likewise, the “*Acuerdo de los Pozos*” of 2001, under President Andrés Pastrana, led to the exchange of 310 policemen and soldiers, including 42 in poor health, for 15 imprisoned FARC guerillas. More recently, on Christmas day of 2006, 29 policemen, 10 soldiers, and 3 intelligence agents were released by the ELN. Since 1996, 4,152 of the 6,790 persons kidnapped by the FARC were freed through prisoner exchanges or payment of ransom, albeit after years of captivity³². The most prized hostages, such as Ingrid Betancourt, are held the longest and without giving evidence of life in expectations of extracting the most concessions from the government or the highest ransom from relatives. In fact, there is little of *humanitarian* in these exchanges, especially as it concerns the FARC. For instance, until the rescue of Ingrid Betancourt and the Americans, the FARC claimed 47 politicians and members of the military or police forces as “*canjeables*”. This excluded 700-plus hostages to be held for ransom until the extortion process plays out, regardless of duration and the physical and psychological suffering inflicted onto the hostages and their families. Shortly after Álvaro Uribe became President, the FARC demanded that any prisoner exchange would have to take place in a demilitarized zone in Colombian territory, where 47 political and military “*prisoners of war*” would be exchanged for several thousand FARC fighters held in Colombian prisons. The Uribe government ruled out a demilitarized zone but countered by demanding a cease-fire, the freedom of all hostages, assurances that freed FARC members would not rearm; preconditions that were promptly rejected by the FARC. A year later, a failed Military rescue attempt led to the assassination of several “*canjeables*”, including the Governor of the Antioquia province, an ex-minister of Defense, and nine military personnel. Hence, the FARC’s insistence on being acknowledged as an insurgent army confronting an unjust an oppressive Colombian government, rather than a terrorist organization, is hollow.

The year 2004 was marked by the capture of Ricardo Palmera, a.k.a “*Simon Trinidad*” and of Nayibe Rojas, a.k.a “*Sonia*”, both prominent members of the FARC, and by attempts by the Colombian Catholic hierarchy, national and international organizations, and hostage families to pressure both sides of the conflict. Throughout the year, the Colombian government offered to release groups of imprisoned guerillas with certain preconditions that were rejected out of hand by the FARC, insisting on a demilitarized zone to conduct the negotiations and demanding the release of *Simon Trinidad* who had been extradited to the USA. In late 2005, President Uribe extended an olive branch to the FARC by proposing a meeting along with assurances that, during the negotiations, all FARC representatives would be guaranteed safe-conduct nation-wide and that the government would refrain from any military or police action in the negotiation area. At his request, the Embassies of Spain, France, and Switzerland initiated an exploratory mission to the municipalities of *Florida* and *Pradera*, Province of *Valle del Cauca*, an area the FARC wanted demilitarized. The group formulated a proposal guaranteeing safety for all negotiators, which was quickly approved by the Government but rejected by the FARC as another of Uribe’s pre-electoral ploys. In early 2007, the escape first of ex-minister Fernando Araujo, during a Military rescue attempt, and later of police officer Jhon Frank Pinchao, who gave grim accounts of the fate of his captive comrades, galvanized hostage families and the international community into pressuring the Colombian government for a humanitarian exchange. As a good will gesture, President Uribe released a group of imprisoned FARC members and, at the

request of the French government, Rodrigo Granda the highest ranked FARC prisoner. The FARC dismissed the Government's overtures and made additional demands ironically coinciding with their own communiqué announcing that 11 of the 12 assembly members of the Valle del Cauca they held hostages "*died as a result of crossfire when a non-identified military group attacked the camp where they were held*". President's Uribe's response was predictable: Prisoner exchanges would take place at a non-demilitarized site and military rescue missions would continue, which unsurprisingly incensed hostage families fearing botched attempts, especially Yolanda Pulecio, mother of Ingrid Betancourt, who redoubled her high profile international campaign in favor of a humanitarian exchanges. Eventually, President Uribe agreed to a 42 square kilometer (16.2 square miles) "*Zona de Despeje*"* in the municipality of Pradera instead of the 802 the FARC demanded.

In the meantime, a video ⁴¹ of an emaciated and visibly dejected Ingrid Betancourt, seated on a rudimentary stool, was intercepted by Colombian intelligence and released to the press, along with a 12-page letter addressed to her mother and children, dated October 24th, 2007. In it, she wrote "*Mamita, I am tired, tired of suffering... I have tried to escape on several occasions... I have tried to maintain hope...but mamita, now I have given up... life here is not life... It is a gloomy waste of time. I live, or survive, in a hammock hanging from two poles, covered with mosquito netting and a canvas overhead, which serves as a roof, allowing me to think that I have a house. I have a shelf where I keep my equipment, that is my backpack with clothes, and a Bible that is my only luxury*" ⁴². Her despondent look and heart wrenching account of what constitutes the hopelessness of a kidnapped victim held in the Colombian jungle caused international consternation, many headlines and expressions of support worldwide, but no results. Predictably, outsiders exploited the Government-FARC standoff for political or personal gain. For instance, on December 9, 2007, the FARC announced it would release Ingrid Betancourt's old running mate Clara Rojas, her 3-year old son Emanuel born in captivity, and Consuelo Gonzalez, a former Congresswoman kidnapped in 2001, to Venezuela President Hugo Chávez or his designee. This was orchestrated as "*a gesture to Chávez*" for his acrimonious firing by President Uribe as a mediator of prisoner exchange negotiations. Eager to reclaim his status as mediator and as a champion of human rights, Chávez organized "*Misión Emanuel*". This obscene media circus, based on the exploitation of suffering hostages and their families, involved presidential emissaries from Argentina, Brazil, Cuba, Ecuador, France, and Switzerland, the International Committee of the Red Cross, and Oliver Stone, an American filmmaker. Wearing the red beret and fatigues of his paratrooper days, Chávez and his international entourage arrived at *Villavicencio*, in the Meta province, along with two Russian-made MI-172 helicopters, where they were greeted by a barrage of reporters eager to make the most of such a high profile international media event.

After three days of high expectations and widely broadcast pronouncements by Chávez, Nestor Kirchner, former President of Argentina, and others, the FARC called off the release claiming insufficient guarantees for the safe transport of the hostages. The same day, President Uribe exposed the FARC's duplicity. Emanuel could not possibly be released for, separated from her mother in 2005, he had been handed over, at 11 months of age, to child welfare workers in San José de Guaviare in a FARC-dominated zone of eastern Colombia, by José Gomez, a peasant farmer who introduced himself as the child's great-uncle. The malnourished infant, given the name Juan David Gomez,

* Cleared (demilitarized) zone

had been rushed to the *Instituto Colombiano de Bienestar Familiar* (Colombian Institute for Family Welfare), in Bogotá, for fracture-reduction surgery and treatment of leishmaniasis*, and then referred to foster care. Chávez promptly accused Uribe of "dynamiting a rescue mission that involved observers from five leftist Latin American governments". True to form, the FARC declared that they had placed Emanuel in the care of "honest persons" in Bogotá but was kidnapped by the Colombian government before the hostage release could be finalized⁴³. The following Thursday, Clara Rojas and Consuelo Gonzalez were finally released by the FARC and promptly flown to Caracas to meet Chávez, their "savior". In a video taken at the time of the hostages release and broadcast by "Globovisión", a TV station, Venezuela's Justice Minister, Ramón Rodríguez Chacín, is heard expressing encouragement to the rebels and support for their struggle. Consuelo Gonzalez had brought letters from eight co-hostages to their families. In one, Ingrid Betancourt was said to be so weak at one time that she had to be carried in a hammock during a routine move from one camp to another. In another, Colonel Luis Mendieta, held hostage since 1998, described his weakness to be such that he had to drag himself through the mud to relieve himself in privacy.

In his televised annual "*Informe de Gestión*" to the National Assembly (equivalent to the American President's State of the Union address), delivered one day after the hostage release, Chávez took full credit and urged the governments of Colombia and of all nations to remove the FARC and the ELN from their terrorist list. In his view, "*The FARC and the ELN are not terrorist groups; they are armies, real armies that occupy a space in Colombia. The FARC and the ELN must be given recognition. They are insurgent forces that have a political and Bolivarian project, and that is respected here*". Forty-eight hours later, on January 13, 2008, "Frente 57" of the FARC kidnapped 6 tourists in the town of Nuquí, Chocó province⁴⁴. Four days later, the overwhelmingly pro-Chávez Venezuelan National Assembly declared the "belligerent" nature of the "insurgent" groups FARC and ELN, which the bill characterized as "*Liberation movements or States unwilling of [foreign] domination*", and rejected the "*unilateral [terrorist] lists imposed by the government of the US*". On February 5, 2008, coinciding with a Gallup poll showing a 96% disapproval of the FARC, hundreds of thousands of Colombians held protest marches in 115 cities around the world demanding "*No more kidnappings, No more violence, No more FARC*". This was Oscar Morales' brainchild using "Facebook" to launch a virtual community he called "*un millón de voces contra las Farc*" (a million voices against the FARC) that Carlos Andrés Santiago converted into a march⁴⁵. Such a massive condemnation of the FARC by the Colombian citizenry shows that they have lost all public support. And, although a negotiated settlement is viewed in some quarters as the only road to peace, President Uribe's firm policies for reclaiming his nation from terror have already changed Colombia's security landscape.

Neighbors' complicity confirmed. A few minutes into March 1, 2008, the Colombian Air Force bombarded and Army units later raided a FARC camp setup on Ecuadorian territory, less than two miles from the Colombian border. The attack was made possible by eavesdropping on a conversation from a mobile phone known by intelligence units to belong to Luis Édgar Devia, a.k.a "Raul Reyes", a member of the FARC "Secretariat" in charge of finances and public relations. In the attack, Raul Reyes and 17 of his comrades were killed, triggering a diplomatic crisis between the two countries. When President Uribe informed Rafael Correa, President of Ecuador, of the bombardment of the FARC camp in a telephone call broadcast on TV, the latter seemed

* A tropical parasitic disease produced by leishmania, a protozoan organism transmitted by sandflies.

at a loss on how to react, not unlike President George W. Bush's blank stare when informed of the "9-11" attack while visiting the Emma E. Booker Elementary School. However, the next day he broke diplomatic relations with Colombia in unison with President Chávez who, although not involved in the dispute, also deployed approximately 6,000 of his 57,800 men-strong army along the Northeastern Colombian border and threatened war should Colombia violate Venezuelan sovereignty. Five days later, Daniel Ortega, President of distant Nicaragua and a political ally in his global crusade against "*El Imperio*"^{*}, also broke diplomatic ties with Colombia. A mere 24 hours later, he, Chávez, and Correa, agreed to close the chapter and re-establish diplomatic ties at the "*Grupo de Río*" meeting held in the Dominican Republic on March 6th, 2008; a record worth the Guinness Book of World Records. At the meeting, President Uribe defended the attack arguing sarcastically, "*I reject the portrayal of our legitimate right to fight a terrorist organization as a massacre of angels clad in pajamas that [certainly] were not preparing [to celebrate] Easter*"⁴⁶. He also disclosed information mined from *Raul Reyes*' computers (three laptops, two external hard disks, and two USB memory sticks) that corroborated Chávez' and Correa's support of the FARC⁴⁷. Yet, Uribe failed to convince his Latin-American peers that attacking the FARC's camp in Ecuadorian territory was justified by Chávez' and Correa's allowing the use of their territory by a foreign terrorist organization as refuge and as a springboard from which to wage war against Colombia. That justification is implicit in UN Resolution 1373 of 2001 that requires all member States to cooperate in the fight of terrorism and to deny support for any terrorist organization. In the end, Colombia was condemned almost unanimously but for one supporting vote from the USA and one abstention from Canada, forcing Uribe to pledge to never again "*violate his neighbors' sovereignty*", thus averting a potentially serious diplomatic crisis.

The episode served to bring attention of the international community to Venezuela's and Ecuador's complicity with Colombia's terrorist groups. Raul Reyes' computers exposed the complicity's extent and duration⁴⁷. For instance, the FARC appears to have held secret meetings with representatives of the Chávez and Correa governments, to have received financial support from Chávez, to be considering business transactions and investments in Venezuela with Chávez' approval, and to have contributed US \$100,000 to Correa's presidential campaign. More ominously, if confirmed, is the revelation that the FARC were negotiating the purchase of Uranium from an intermediary offering 50 kilos "*but who can deliver a lot more*". Reyes' computers also contained instructions on how to build a "*dirty bomb*". It is up to President Uribe to play these cards adroitly and, if the weight of the evidence warrants it, seek UN support to declare Chávez' Venezuela and Correa's Ecuador as terrorism-sponsoring States, which would isolate the FARC and cut-off their vital lifelines. Once isolated, dwindling resources and relentless pressure from the Colombian Armed forces would accelerate the current rate of desertions from its ranks and eventually destroy the myth of the FARC's "*invincibility*" that attracts and sustains its combatants. Some experts already see evidence of implosion in the assassination, three days after the camp attack, of Iván Ríos a.k.a "*Darío*", the youngest member of the FARC "*Secretariat*", by his security chief, "*Rojas*", who collected the bulk of the US \$2.5 million reward for his boss' head. Hence, within a week and for the first time in its forty-year existence the FARC lost two of its nine-member high command. More ominously for the FARC's negotiating power and survival, was the July 2, 2008 rescue of Ingrid Betancourt and

* "*The Empire*", as Chávez calls the US

three Americans, in a meticulously executed, bloodless, and cunning operation conducted by Colombian intelligence units. These severe blows in quick succession, the incriminating contents of *Raul Reyes'* computers, and the increasing defections among its ranks suggest that the FARC's demise can finally be contemplated.

Ejército de Liberación Nacional (ELN).

The ELN became the second largest guerilla group in Colombia, with approximately 4,000 to 5,000 combatants at the height of its power. In its 42 years of existence, the ELN has survived murderous infighting, an increasing Army firepower including a near fatal defeat, hostile encounters with the FARC, and the relentless onslaught of the AUC. The ELN is viewed more as an insurgent group than the FARC with a nationalist, anti-imperialist, and anti-oligarchic political agenda. For instance, in August 2002, Colombian Vice President Francisco Santos declared, "*The ELN is an armed party and not an army, as the FARC describes itself, which facilitates the negotiating process with this guerrilla group*"⁴⁸. Likewise, the ELN is said to have adopted Che Guevara's "*foquismo doctrine*"; a theory that a nucleus of dedicated revolutionaries can awaken a critical mass within the population sufficient to succeed in its power struggle toward a just society. Yet, notwithstanding the Colombian Vice President's rhetoric designed to assuage its leaders in anticipation of peace negotiations, and the ELN claims to look after the welfare of the poor and disenfranchised, its activities and tactics parallel the FARC's. Like the FARC, it uses kidnapping for ransom, extortion, and to a much lesser extent drug money as the main sources of revenue, and engages in the murder of opponents and in indiscriminate massacres to intimidate populations it wants to subdue and exploit. For instance, of the 23,401 persons kidnapped between 1996 and September 2007, 23% are attributed to the ELN against 29% to the FARC⁴⁹, despite a combatant force one fourth its size. Homicides and massacres committed by the ELN through the years have also been disproportionate to its size. In the next few pages, I will review the evolution of the ELN along the four major periods of its history: rise and expansion (1964-74), crisis (1974-80), restructuring (1980-90), and strategic adaptation and peace talks (1990-2002), and assess its present status.

Rise and Expansion. The ELN was founded in 1964 by left-wing students and intellectuals, labor activists, and Catholic radicals that were inspired by Fidel Castro's revolution that overthrew Cuba's dictator Fulgencio Batista in 1959. In fact, Fabio Vásquez and Víctor Medina, its first leaders, trained in Cuba in 1962 along with 60 Colombian university students. Hence, the choice of *San Vicente de Chucurí* in the *Santander* province as its first camp is not surprising given that province's history of Communist upheavals, its being the seat of one of the country's earliest leftist *autodefensas* during *La Violencia* period, and its sympathetic leftist oil sector trade unions bent on insurrection. The initial group of 30 members, recruited in the *Santander* province, grew very slowly to only 350 twenty years later. From the beginning, its "*cri de guerre*" was "*Liberación o muerte*" (liberation or death). On January 7, 1965, the ELN launched its first attack, against the police station of *Simicota*, a town in *Santander* province, from which emerged the "*Manifiesto de Simicota*", and later the "*Declaración Programática*" (Declaration of Programs). The latter delineated the ELN's political platform. In essence, it contemplated a democratic government by and for the people, elimination of large estates and allocation of land to peasants, protection of national industries, and developing a communications infrastructure, a popular credit system, affordable housing, and free education and health care for all. It also called for separation of church and State with freedom of worship and of expression, an anti-

imperialist foreign policy based on mutual respect, and the establishment of a people's army. However, early Cuban-style Marxist leaning was tempered when Camilo Torres Restrepo, a Catholic priest, university professor, and sociologist from an elite Colombian family joined the group in 1965. Torres, who had gained national attention as the leader of "*Frente Unido*" (United Front); a popular left wing movement opposing the *Frente Nacional*, was a believer in the radical new ideas of liberation theology calling for a Christian-Communist solution to Colombia's rampant corruption, extreme poverty, and social inequity. Although Torres died in February 1966, during an ambush of an Army Unit, he remained a symbol for the group, inspiring like-minded priests including Domingo Laín and Manuel Pérez, two Spanish priests who went to Colombia in 1969 to join the ELN. The former was killed in combat in February 1973. The latter, nicknamed "*El cura Pérez*" (Pérez the Priest), was at first sidelined by Fabio Vásquez who followed a strict *foquismo doctrine*, but eventually would exert a decisive influence on the group's ideology and direction.

From Crisis and Decline to Resurgence. The 1970s marked a period of decline marred by ideological, political, and leadership crises, and by counterinsurgency campaigns launched by the Colombian Army, which severely reduced its military capacity and political relevance. Additionally, in September 1973, ELN commanders committed the serious tactical blunder of stationing 100 fighters near Anorí, Antioquia province; an area where the Army was very active. Quickly encircled, 28 fighters were taken prisoner and 21 killed, including two brothers of Fabio Vásquez, the ELN's commander-in-chief. Shortly after Vásquez abandoned the group and fled to Cuba, in November 1974, *El cura Pérez* assumed joint leadership of the ELN along with Nicolás Rodríguez Bautista, a.k.a "*Gabino*", until his death of malaria in 1998. From his leadership position, *El cura Pérez* was able to reshape the ELN ideology along Camilo Torres' goal of fusing revolutionary fervor with Christian values of social justice, introducing a new sense of purpose and direction. Hence, after a decade of stagnation in size, funding, and political relevance, the 1980s witnessed a resurgence led by the shared leadership of *El cura Pérez* and Nicolás Rodríguez. Together, they reorganized the group giving it a more dynamic and responsive decentralized command structure, better relations with trade unions, and new sources of revenue extorted from domestic and multinational oil companies exploiting oilfields in the provinces of Arauca, Norte de Santander, and César. Their new strength and confidence was demonstrated by several high profile operations including the assassination of José Ramón Rincón Quiñones, the Army's Inspector-General, and a major force in counterinsurgency operations.

In 1983, the ELN held its first national conference named "*Reunión Nacional de los Héroes y Mártires de Anorí*" (National Meeting of the Heroes and Martyrs of Anorí), where it was decided to recruit more fighters and expand operations beyond the Northeastern and Northwestern territories. As a result, the group grew to over 2,000 combatants and, by 1990, was conducting operations in more than 20 "*Frentes de Guerra*" (War Fronts), including urban areas. Sabotage of the country's electrical and oil infrastructures remained its main strategy. Yet, they continued to suffer numerous casualties at the hands of the Army, which it sought to counterbalance by merging with other insurgent groups and by trying to join the political process. For instance, they merged with the M-19 and the EPL, a dissident FARC faction. When that failed, they spearheaded the creation of the larger "*Simón Bolívar Guerrilla Coordinating Group*" and later launched a political movement called "*Union Camilista*" (UC-ELN) integrated by ELN with *MIR-Patria Libre* members. Both attempts at consolidation failed.

Strategic adaptation and peace talks. Since the mid-1990s, the ELN was confronted by an increasingly powerful and militant AUC, especially in the Bolívar province, an area of coca production and trafficking the AUC's "*Bloque Central Bolívar*" (Central Bolívar Bloc) controlled and used as a trafficking base. In contrast, at its Second National Congress of 1989, the ELN had adopted a stance of "*Deslinde categórico con las mafias del narcotráfico*" (definitive disengagement from narco-trafficking mafias) *vis a vis* illicit crop cultivation, processing, and trafficking. It viewed involvement in illicit drugs as fostering corruption, impunity, violence, the growth of paramilitarism, and the emergence of a "*narco-bourgeoisie*" that was taking control over leading political positions at the regional and national levels. In the interim, the M-19 and the EPL had signed peace agreements with the government and were either demobilizing or fully participating in democratic politics. The defection, in 1991, of the dissident FARC member of the *Simón Bolívar Guerrilla Coordinating Group* weakened the coalition, forcing the ELN to seek negotiations with the government that began in Caracas, Venezuela moving later to Tlaxcala, Mexico. Subjects discussed were broad, never went past procedure, and the government ended contacts. This, and the increasing confrontations between the FARC and the ELN led to the collapse of the *Simón Bolívar Guerrilla Coordinating Group*.

In 1996, the UC-ELN held its Third National Conference, where it proposed the creation of a "*National Convention*" to unite "*all sectors of national opinion, social movements, political organizations, economic associations, the Church, intellectuals, the Left, democrats, and patriots*" ⁵⁰. The Convention would serve as a forum to discuss political, social, and economic issues of concern to all Colombians, especially the underprivileged. In addition to the Convention, the ELN demanded a demilitarized "*Zona de Encuentro*" (Meeting Zone) of approximately 7,600 square kilometers in the municipalities of Santa Rosa, Simití, San Pablo, and Morales, as preconditions for peace negotiations. These demands met with fierce opposition by a coalition of politicians, cattle ranchers, and the AUC. Hence, When President Andrés Pastrana initiated peace negotiations with both the ELN and the FARC, in October 1998, he rejected the *Zona de Encuentro*, focusing instead on the stronger FARC apparently assuming the ELN would be an easy militarily prey after reaching an agreement with the FARC. While preliminary contacts were taken place between the ELN and the National Peace Council and the National Conciliation Commission, in Viana, Spain and Würzburg, Germany, the ELN continued its policy of hostage taking and extortion. In 1998 alone, the ELN is said to have collected US \$84 million in ransom and US \$255 million in extortion money ^{51,52}. It continued the so-called "*gramaje*", a protection tax levied from coca and poppy growers. Hence, the government suspended peace talks. In retaliation, the ELN bombed an oil pipeline in the Antioquia province on February 1999, killing more than 70 people, and launched a series of mass kidnappings in quick succession. The latter included the hijacking of an Avianca commercial airliner, on April 12, 1999, that was forced to land in Simití, Bolívar province, with its 46 passengers and crewmembers who were promptly hidden in the jungle, and the kidnapping of 140 parishioners attending mass at Cali's La María church the following month. Eighty parishioners were released within a few hours with the help of the Army but 63 were retained and held hostage for ransom.

These audacious operations that far exceeded acceptable guerilla behavior even in a country regularly shaken by violence, brought strong national and international condemnation, including the excommunication of participants in the La María assault, by Cali's Archbishop, Monsignor Isaías Duarte. On 30 July 1999, an eclectic group of citizens, called the *Civilian Facilitating Commission*, was formed to negotiate the release

of the remaining Avianca and La María hostages and to seek a peace settlement. However, meetings held in Colombia, Cuba, and Venezuela between 2000 and 2002 got nowhere, as did efforts by the “*Group of Friends*” (Cuba, France, Norway, Spain, and Switzerland) chosen jointly by the ELN and the government as “*facilitators*”. Despite the “*Agreement for Colombia*”, signed on November 24, 2001, to implement a transition agenda designed to bridge negotiations with the upcoming new administration, President Pastrana announced, on May 31, 2002, the collapse of the negotiations. In the meantime, the ELN and representatives from various sectors of Colombian society had signed the “*Convention of Geneva*” that banned kidnapping children, the elderly, and pregnant women; a ban that was soon ignored by the ELN.

The ELN and Uribe. During the mandate of President Uribe, massive spraying of coca plantations in the Caquetá and Putumayo provinces and successful Army assaults against the FARC forced the group to redeploy to the southern provinces of Cauca and Nariño where the ELN had a strong presence. This caused increasingly frequent confrontations between the FARC and the ELN. While the ELN anti-drug stance allowed a negotiated non-belligerent coexistence between the two guerillas in the beginning, economic necessity forced the ELN to increasingly rely on drug revenues to sustain itself; a change in tactics that triggered a fierce competition for coca growing areas and trafficking routes, and open warfare with the FARC. At one point, *Mono Jojoy* instructed his troops that the ELN was as much an enemy of the people as was the government. As a result, increasingly frequent armed confrontations in shared territories led to hundreds of casualties on each side. In the meantime, President Uribe reinitiated negotiations with the ELN, as part of his strategy to end the half a century old conflict and to integrate the various guerillas into the political process. To this end, he submitted to Parliament a constitutional reform proposal that, among others, would create additional seats at the municipal and provincial levels to be reserved for defecting guerilla members “*committed to peace*”, and several seats to Parliament intended for “*special representatives for peace*” appointed by the President.

Exploratory talks began in Havana, Cuba, in December 2005. Negotiators for the ELN included Francisco Galán, released for that purpose after serving 13 years of a 20-year prison sentence, Antonio García, and Ramiro Vargas. Spokesmen for Colombia included Carlos Restrepo, Colombia’s High Commissioner for Peace and Ambassador to Cuba, and Julio Londoño. International observers from Switzerland, Norway, and Spain were also present. High on the government’s agenda were bilateral ceasefire, cessation of hostilities, and the release of all hostages. The ELN sought legal political status, amnesty for its imprisoned members, and integration of the group into the national political process. As a counterbalance to his belligerent policy towards the FARC, President Uribe’s offer of an olive branch to the ELN was predicated on his desire to show flexibility, especially to a Democrats-controlled American Congress unlikely to rubber-stamp Plan Colombia without evidence of substantive progress. Additionally, the ELN’s apparent renunciation of violence made it a better choice than the FARC as a partner for peace negotiations. For instance, at the conclusion of the fourth round of talks in Havana, Nicolás Rodríguez Bautista, ELN commander, declared, “*We reaffirm that political action is what is most important at the moment*”. His statement was followed by decreased guerilla activity. However, the talks fizzled when the two sides disagreed on a talks’ framework, on details of a cease-fire, and on a hostage-prisoner exchange. Nevertheless, talks were to re-start in late December 2007 under the auspices of Venezuelan President Hugo Chávez as facilitator. Peace talks were rekindled by the arrest in Bogotá, on January 7, 2008, of Carlos Marín Guarín, a.k.a

"Pablito", an ELN commander responsible for the 1992 murder of a Catholic bishop in the Arauca province and for more than 200 attacks on the US-owned Caño Limon oil pipeline in northern Colombia. In fact, according to Defense Minister Juan Manuel Santos, "*we know that on various occasions (Guarín) prevented the ELN's central command from signing a peace treaty with the government*"⁵³. On April 3, 2008, President Uribe invited ELN Spokesman Francisco Galán to meet at the presidential palace for new peace talks. However, in a press communiqué hours after the meeting the ELN disavowed Galán as their spokesman. A few weeks later, the ELN's Central Command issued a communiqué⁵⁴ proposing a three-point plan towards a "*National accord*" that included their old standby call for a "*Constitutional National Assembly*" previously rejected by the government.

Autodefensas Unidas de Colombia (AUC) or Paramilitares.

The use of civilian armies by local chieftains, wealthy landlords, political parties, and the Armed forces has a century-long tradition in Colombia. Today, such groups are known as *Autodefensas* or *Paramilitares*. While the name *autodefensas* reflects their initial purpose *vis a vis* guerilla armies, the pejorative *paramilitares* exposes the military links of these semi-autonomous armed groups that "*are among the most brutal human rights violators in the world today*"⁵⁵. Their origins can be traced back to 1962 but they have evolved through three periods shaped by guerilla activity, inner corruption, and politics: *Official Paramilitarism*, *Private Paramilitarism*, and the *AUC* of the last twenty years⁵⁵. In the next few pages, I will briefly review their history and their collusion with the nation's military and political establishments so profoundly harmful to Colombia's democratic institutions. Their involvement in the drug trade, in massacres of poor rural populations, and in massive violations of human rights also will be outlined.

Official Paramilitarism.

In 1962, General Alberto Ruiz Novoa, Commandant of the Armed Forces, proposed "*Plan Lazo*" (Plan Rope) following recommendations by the visiting US Army Special Warfare unit led by General William Yarborough. The US team recommended the creation of "*select civilian and military personnel [groups] for clandestine training in resistance operations*". This marked the beginnings of a new alliance between the United States, intent on preventing the spread of communism throughout Latin America, and the Colombian military anxious to neutralize real or perceived "*internal enemies*". General Ruiz' *Plan Lazo* gained legal status when, in 1965, Presidential Decree 3398 authorized "*the organization and tasking of all of the residents of the country*" to face emerging insurgent groups. The decree gave rise to *Law 48* three years later. *Law 48* allowed the Defense Ministry "*to support, when it considers convenient... [armies] to be considered as being for the private use of the Armed Forces*". These armies were charged to "*organize the civilian population militarily so that they may defend themselves against guerrilla actions and assist combat operations*". Military manuals of the time stressed that they "*should remain in military hands at all times*". This abrogation of governmental jurisdiction and lack of civilian control that began during the administration of President Guillermo León Valencia continues to this day giving the Colombian Armed forces virtual autonomy in handling issues considered of *public order*. From the outset, Official Paramilitary groups operated not in self-defense but offensively against *guerrillas* and "*guerrilla supporters*", a stretchable term that included social protesters, government critics, trade unionists, community organizers, leftist politicians, and human rights activists. However, despite being an arm of the Colombian military, these groups had little impact on the insurgent armies of the 1960s, but are viewed as precursors of the more active and more effective Private Paramilitary armies of the 1970s and 1980s.

Private Paramilitarism.

While *Official Paramilitarism* was an extension of the Colombian Military allowed by law, *Private Paramilitarism* grew out of the necessity of wealthy Colombians, especially owners of large estates, to protect themselves and their families from guerilla kidnappings for ransom and extortion. They too benefited from Military backing but in a more subtle and covert way. The origins of private paramilitary armies can be traced back to the early 1980s when newly rich “*narcos*” invested in large estates, especially cattle ranches. These “*narco-ganaderos*” became the new oligarchs, hence enemies of guerilla groups and justifiable and highly profitable targets for kidnappings. The Ochoa family, that would dominate the Colombian drug scene after the death of Pablo Escobar, reacted swiftly after the kidnapping of Martha Nieves Ochoa, a family member, by declaring an all-out war against guerillas, especially the M-19. To that effect, 223 drug traffickers met in Cali, in December 1981, to launch a paramilitary group they named “*Muerte a Secuestradores*” or MAS (Death to Kidnappers). It consisted of 2,230 armed men, backed by prominent members of the Medellín and Cali drug cartels and by members of the National Army. Their mission was to “*execute without mercy any person linked to any kidnapping*”.

Over the following decade, “*hundreds of paramilitary organizations based on the MAS model were founded*”⁵⁶ with the tacit support of the Armed Forces. Captain Oscar de Jesús Echandía of the Bárbula Battalion, stationed in Puerto Boyacá, province of Santander, launched the first such group in 1982. Funding came from local politicians, businessmen, ranchers, and representatives of the Texas Petroleum Company, and counted with the logistic support of the Military. Another MAS-inspired self-defense organization was the “*Autodefensas Campesinas de Córdoba y Urabá*” or ACCU (Peasant Self-Defenses of Córdoba and Urabá) that was founded by Carlos and Fidel Castaño, as a reaction to the murder by the FARC of their wealthy landowner father. The Castaños were heavily involved in the drug trade marking the auspicious beginning of today's AUC. Many other Military-backed groups sprang up throughout the country reaching 163 in 1988 according to the then Minister of Government, César Gaviria. They became known collectively as “*autodefensas*” for their aim was primarily to protect their bosses from leftist guerrilla violence and extortion unopposed by a perennially underfunded, understaffed, inefficient, and corrupt Colombian police and judicial systems, but also to chase them out of their territory. Because *the enemy of my enemy is my friend*, the *autodefensas* were tolerated by the State and often assisted by the Military. In time, these scattered private armies coalesced into the AUC, a loose federation led by Carlos Castaño until he resigned the position in 2001. Like the MAS before them, the AUC were in essence the Military arm of the Colombian elite intent on preserving their socio-economic privileges against guerillas and leftist groups or any other force for change.

The last twenty years.

The AUC counted with approximately 15,000 fighters before it was demobilized in 2005. At first, they operated in the Magdalena Medio and Urabá regions of the Antioquia province but their success in expelling guerrillas from these regions encouraged their expansion to virtually the entire Caribbean and Pacific Coasts, and parts of the Eastern Plains. Their military structure consisted of army “*Bloques*” led by autonomous local commanders coordinated through a central Supreme Commander; Salvatore Mancuso being the last. They were most infamous for their cruelty and unspeakable savagery in massacring civilian populations suspected of helping the

* Narco-ranchers

guerilla. The AUC perpetrated most massacres and were responsible for the majority of displaced populations countrywide; 40% of the total between 1995 and 1997 and 46% of between 2000 and 2001, against 28% and 12%, respectively, for the FARC and ELN combined ⁶¹. In 2002, the year with the most displaced population (412,553), the AUC was responsible for 26% of the total against 19% for the FARC and ELN combined ⁶¹. Recently, the AUC changed tactics from indiscriminate massacres to selective assassinations. Hence, AUC's murders from massacres, that averaged 886 per year during 1996-2002 and peaked to 2,367 victims from 352 massacres carried out in 2000-2001, decreased to a yearly average of 227 during the 2002-2006 period. In contrast, selective assassinations remained practically unchanged, from a yearly average of 895 in the 1996-2002 timeframe, to 833 for the 2002-2006 period. In contrast, they accounted for a relatively small fraction of the total number of extortive kidnappings. For instance, between 2002 and 2005, 4,650 individuals were kidnapped nationwide, of which 2,456 or 52.8% were attributed to the FARC and ELN combined, against 385 or 8.2% to the paramilitaries ⁶⁰. It is noteworthy that the Colombian Military is implicated in many assassinations, massacres, and human rights violations attributed to the AUC, as described in the following pages. For instance, out of the total number of murders or *forcible disappearances* reported between 2002 and 2006, 74.5% are attributable to the Army; either directly (12.1% or 752 victims) or indirectly (62.4% or 3,887 victims), against 25.5% or 1,588 victims attributed to the FARC and the ELN combined ⁶⁰.

Modus operandi seen from within. The microcosm of AUC's activities, *modus operandi*, and coordination with the Colombian Army emerge from the diary of a former AUC commander ⁵⁸ recovered from the vehicle he abandoned to escape an ambush set up by former allies. His narration begins, "*When I joined the AUC... there was no money for food, uniforms, medicines, and much less for munitions*". "*One day we stopped at a farm asking for something to eat. We were told to come back... the next day, 'Monoleche' asked the 'Indian' and Germán to fetch some bananas and yuca* from the farm... When they didn't return, 'Monoleche' entered the farm only to discover a sickening scene: The 'Indian' had been chopped up ('picado') and the pieces scattered around the yard... Germán's beheaded body had been tied to a tree trunk... ten FARC men came out of the house and started shooting but Fidel outmaneuvered them killing seven*". Then he explains how their fortune took a turn for the better, "*A rancher was very helpful to us. With his help, most farmers paid us for guerilla protection, as did owners of banana plantations, buses, trucks, even banana exporters... we brought armaments on their returning ships*".... "*One day we were approached by Elías, a man who traded coca from Puerto Raudal and Valdivia, two towns in Antioquia province. He was interested in shipping through the Urabá gulf **, and offered a share of the profits [in exchange for free passage]. Business with Elías went well... a month later, he brought us 3 million dollars -incredible- we didn't know what to do with so much money!*".

He describes how they ran towns under their control to collect taxes, analyze and discipline townspeople, and to coordinate operations with local Army and police units to avoid confrontations. "*We levied taxes on everyone and everything that made money*"... "*in urban areas, shops, restaurants, hotels, butcher shops, pool halls, and jewelries paid 50,000 to 100,000 pesos monthly (approximately US \$35 to \$70 at the then exchange rate); gasoline stations, between 100,000 and 200,000 pesos; cattle ranches, 500,000 to*

* Tapioca

** Under AUC control

700,000 pesos, according to size. Truckers paid 50,000 each time they crossed [our territory] and transporters of merchandise, 1,000,000 but 5,000,000 if they carried coca". Town mayors were forced to assign public works contracts to AUC sympathizers, retaining 30% of the contract value: 10% for themselves and 20% for the AUC. Cooperating Army and Police commanders were paid 10 million pesos per year.

He also narrates his rise through the ranks, how he made a fortune, and the deadly confrontations within AUC ranks, but is silent about massacres. *"I made friends with Miguel Arroyave who, thanks to me, met with Carlos Castaño in Nudo de Paramillo and came back as commandant of the Meta and Guaviare [provinces]. He told me 'here are 2 million dollars. You can stay or retire; no problems'... [with that money] I bought two ranches: one in El Dorado the other in San Martín, and invested in farms around my hometown. I was a millionaire; enough for the rest of my life, but greed took over. I was used to having subordinates and to be called 'sir', and I stayed"...* *"Miguel infiltrated and manipulated the politics of the Llanos"...* He informed the Buitragos [local AUC commanders] that all decisions had to be approved by him. In other words, he proclaimed himself commander-in-chief; an unacceptable situation for Héctor Buitrago and his sons 'Caballo' and 'Martín Llanos'... The war began... Miguel summoned his allies to San Pedro de Armería... from Casanare came 500 men under my command; 'Macao', commandant of bloc Central Bolívar, sent 1,500 men; Guillermo Torres added 200 from Meta, and 'Cuchillo' came up with another 500 men from Guaviare... Daily encounters resulted in scores of dead in both camps... While planning 'Operación Punto Final', Belisario proposed to bring a witch from San Martín to pray for combatants so that bullets wouldn't penetrate their bodies. We knew of cases where that had been effective... The witch began the ritual of praying while sprinkling the men with aromatized herbal water giving each man a bit of graveyard earth to carry in his pocket... According to her, no bullet on earth could now penetrate their body"... *"The next day, at 6 AM, 'Pólvora' ordered 'Voluntario', second in command, to send his men shooting standing up in a formation we call 'curtain-like'... By 10, we already had 65 dead and 48 wounded... I met with Miguel and told him about our losses... He replied 'don't worry, tell me where they are for a politician friend of mine has already contacted the Air Force to launch a bombardment'... adding 'wait and see, those sons of bitches don't know what's coming to them'..."* *"About forty minutes later two 'Tucano' planes and four 'Arpía' helicopters began bombing 'La Cooperativa' **... we could see machinegun fire and 500-pound bombs and missiles exploding on the ground"...* *"At about 4 PM, Belisario called euphoric announcing, 'Commandant, we did it. Nothing remains standing there. They are all dead'... Miguel was overjoyed, 'we beat those sons of bitches. The General that helped me is the kind of people we need on our side'. No sooner had he spoken that 'Pólvora' called in frantic, 'those sons of bitches of the Air Force turned against us. They dropped a bomb as big as a cow'. Miguel immediately called the 'General' and the attack promptly stopped"...* *"To celebrate, Miguel ordered a party and told me 'to those who excelled, give them a girl, a bottle of whiskey, and pay for everything they consume'... Wilson found 50 women... I said, '50 is too few because that would be only one to 20 men... and, if the Central Bolívar [men] join in, one for 40 men'... When the women arrived, there was quite a stir. We had to post a guard to control them and to raffle turns with the girls".*

* Vast eastern plains

** The farm where Buitragos' men had retrenched

Massacres and AUC-Military collusion. Though well known, the AUC-Military links were confirmed by commanders of both organizations and by numerous NGOs *. A noted example acknowledged by the Military is the massacre (4 or more murders at one time according to the Ministry of Defense) of Mapiripán, Meta province, between July 15 and 20, 1997. Fighters used chainsaws and machetes to murder, throat-slit, behead, dismember, and disembowel at least 49 civilians, though many bodies thrown into the river could not be counted. The episode began when two planeloads of paramilitaries arrived at the of San José del Guaviare airport, on July 12, 1997, and marched through several Army checkpoints before reaching the town of Mapiripán. According to a witness account, “200 ACCU soldiers arrived in the town on July 15, [and] searched for peasants who had taken part in a department-wide protest over the poor economic conditions in Meta. These people and others were rounded up and taken to the town slaughterhouse where soldiers tortured them and then slit their throats. One victim, Antonio María Herrera, was hung from a hook, and ACCU members quartered his body, throwing the pieces into the Guaviare River. Leonardo Iván Cortés, a town judge, repeatedly contacted the local security forces during the massacre, pleading for help. He reported, ‘each night they kill groups of five to six defenseless people, who are cruelly and monstrously massacred after being tortured. We can hear the screams of humble people begging for mercy and asking for help’. The judge made a total of eight phone calls but neither the police nor the Army showed up or investigated until after the paramilitaries had left; strong evidence of military acceptance of paramilitary activity” ⁵⁶. When summoned by the “Unidad Nacional de Fiscalías de Derechos Humanos” (National Unit of Prosecutors for Human Rights) for his presumed role as author-by-omission in the Mapiripán massacre, retired General Jaime Alberto Uscátegui, ex-commandant of the 7th Brigade, avowed the Army’s involvement. He also revealed that the Army knew of the AUC march on Mapiripán and that, after the massacre, it had mounted a massive retaliatory maneuver to crush the FARC unit dispatched to punish the AUC for operating on their turf ⁵⁷.

Another indiscriminate and savage massacre perpetrated by the AUC in collusion with the Army occurred in February 2000, ⁵⁷. At 6:00 AM of February 16th, 2000, the “*Bloque Norte y Anorí de las ACCU*”, led by Emanuel Ortiz, ex-FARC-EP member who had defected to the AUC along with 15 of his men, stopped a car traveling between El Salado and Carmen de Bolívar, Bolívar province. They slit the throat of five passengers scattering their bodies on the road, and “disappeared” the other two. These actions took place in an area controlled by the *Batallón de Fusilleros de Infantería de Marina, Mafim-3* of the First Brigade, led by lieutenant colonel Harold Mantilla. A few hours later, the same group executed 42 peasants in Ovejas, Sucre province, 39 of whom were tortured before their throat was slit. They also burned several houses with the acquiescence of the *Batallón de Fusilleros de Infantería de Marina, Bafim-5*, of the First Brigade. On February 18, 2000, the same AUC group returned to Carmen de Bolívar where they executed 46 more peasants by beheading, hanging, shooting, or beating, often in front of their wives and children. A hooded member of the group pinpointed, one by one, townspeople to be killed. They also raped several women while celebrating their exploits drinking and dancing to “*vallenato*” ** music through the afternoon of the following day when, according to eye witness accounts, they were informed of the arrival of the *Infantería de Marina* and left town leisurely. Colonel Harold

* Non-Government Organizations

** Popular music of African and peasant Colombian roots

Mantilla, far from admitting involvement, claimed the dead resulted from a confrontation between the AUC and the FARC.

Another instance, reported by Amnesty International ⁵⁹ describes, “*Between 1 and 7 May 2003, soldiers from the army’s Navas Pardo Battalion of the Brigade XVIII, wearing AUC armbands, reportedly entered the indigenous reserves of Betoyes - Julieros, Velasqueros, Roqueros, Genareros and Parreros - in Tame Municipality, Arauca Department. According to reports, on 5 May in Parreros, armed men raped and killed 16-year-old Omaira Fernández, who was pregnant, before ripping open her belly... in front of everyone. The bodies of the girl and the baby were thrown in the river. During this incident, three members of the indigenous community were killed. In Velasqueros, three young girls were raped. According to witnesses, a contingent of men had been parachuted into Parreros from [Army] helicopters... they were paramilitaries who live in the battalion [Navas Pardo] with the soldiers*”. Likewise, during his January 2007 deposition before the “*Fiscalía General de la Nación*”, in compliance with AUC demobilization rules, AUC’s supreme commander Salvatore Mancuso made shocking revelations. He disclosed his organization’s reliance on the Army and police for training, weapons, and transportation, and how on many occasions they were given lists of populations to be massacred or the names of individuals to be assassinated.

Foreign trainers. The AUC has received training and support not only from the Colombian Armed forces but also from Israeli, German, and American mercenaries. While public information about German and American trainers is scant, involvement of retired Israeli Lt. Col. Yair Klein and his associate, Lt. Colonel Amatzia Shu’ali has come to light in some detail. In the 1980s, Klein founded a paramilitary mercenary firm called “*Hod He’hanitin*” (Spearhead Ltd.) that trained Medellín cartel members, MAS groups and the AUC. This establishes a strong Israeli presence in both the Colombian Armed forces and the AUC. Indeed, while the former have obtained military hardware and anti-terrorist training from the official Israeli Military establishment, mercenary ex-members of that institution have trained many Colombian death squads. In 1989, Colombian authorities charged Klein, along with several other former Israeli officers, of arming and training drug lords running international cocaine cartels. Supporting evidence included a video he used to instruct death squads found in the house of a Medellín cartel drug lord. He is also suspected of involvement in the downing of a civilian airliner in November of 1989. An extradition request was not honored by Israel but, in 1990, an Israeli court convicted Klein to a fine of US \$13,400 and a one-year prison term for smuggling arms and military hardware destined to Colombian terrorist groups. In 1999, he was imprisoned in Sierra Leone for smuggling arms to rebels of the Revolutionary United Front. Initial charges were scaled down and eventually dismissed after behind the seen pressure from Israel. Klein has also been active in El Salvador, Guatemala, and Russia, where Interpol arrested him in August 2007. It remains to be seen whether he will escape a new extradition order outstanding for him to stand trial in Colombia. The US has been accused of aiding the AUC indirectly, through *Plan Colombia*, despite listing it as a terrorist group. One of the arguments advanced is the US-financed aerial fumigation of coca fields that focuses almost exclusively on FARC-controlled areas despite the fact that most of the coca trade is controlled by the AUC, accounting for 70% of their revenues. Additionally, considering that 71% of American aid under *Plan Colombia* (\$2,34 out of \$3,29 billion between 2004 and 2007) was earmarked for the Colombian military despite well-known AUC-Military links, it has been argued that the groups’ ideology takes precedence over narco-trafficking in the implementation of American anti-terrorist policy, at least in Colombia.

Para-politics: A scandal of national scope. Military support, the cornerstone of Official Paramilitary armies of the 1960s, was said to have declined in recent times and to represent isolated episodes from rogue military units, marking the AUC's fading relevance. That perception was shattered by revelations that AUC influence reached into the deepest corridors of Colombian power, including the legislative and executive branches of government and its intelligence apparatus. Incriminating evidence was found in the confiscated laptop computer of "Jorge 40", a notorious AUC commander, and was complemented in disclosures by Rafael García, a former informatics chief at the "Departamento Administrativo de Seguridad" or DAS^{62,63} turned informer, describing how the AUC manipulated local and national elections, controlled politicians, and infiltrated the DAS. Yet, the para-politics scandal acquired national proportions when it was revealed that scores of politicians had met, in Santa Fé Ralito in July 2001, to pledge allegiance to the AUC central command. Based on these revelations, a host of Colombian politicians have being incarcerated or are being investigated by the "Corte Suprema de Justicia" (American Supreme Court equivalent), the "Fiscalía" (Office of the Prosecutor General), and other judicial authorities for colluding with paramilitary forces. At this writing (July 2008), "32 out of 102 senators and 25 of the 166 representatives" are suspected of collusion with the AUC (as are numerous governors, mayors, and members of local assemblies and city councilors). Eighteen senators and twelve representatives are incarcerated and four have been sentenced after pleading guilty"⁶⁴.

Rodrigo Tovar Pupo, a.k.a *Jorge 40*,⁶⁵ is the son of a military officer who grew under the tutelage of his uncle, a former governor of the César province. An Army General of the first brigade recruited him in 1996, along with other members of prominent local families, to participate in a plan to fuse all private armies into a unified force. *Jorge 40* and the others met with Carlos Castaño and Salvatore Mancuso who would become supreme commanders of the newly constituted AUC. While *Jorge 40* soon became a local leader, his quest for power clashed with Hernán Giraldo's and Jorge Gnecco's, two local AUC leaders who controlled access to the northern seaports from which cocaine was shipped to the USA and Europe. An unrelenting war with the former ensued leaving hundreds of dead. Summoned to a meeting by *Jorge 40*, Giraldo's naked body was found riddled with bullets on his way to the meeting. *Jorge 40* also ordered the kidnapping of six members of the Gnecco family while others fled the country or were barred from office by the *Procuraduría General de la Nación*. With both rivals out of the way, *Jorge 40* was now in control of the seaports of the Magdalena and Guajira provinces and hence of the lucrative drug business from these region. *Jorge 40*'s now famous computer also detailed drug dealings. Surprisingly, most of the thrice weekly cocaine shipments went, not to the USA, but to Europe, mainly Belgium, Holland, and France, hidden within banana crates or furniture, or carried by "mules"⁶⁶. "Each banana crate carried up to 200 grams of cocaine and each sea container contained 1,080 crates, which amounts to transporting 140 to 180 kilograms [per container]"⁶⁵. At least one furniture exporter was involved in the drug trade; hiding cocaine within furniture destined to Madrid, Spain and to several US destinations. Shipping clearance required payment of 1,500,000 to 1,800,000 Colombian pesos (approximately US \$750 to \$900) per kilo of cocaine to anti-narcotics agents stationed at the seaports of Santa Marta and Cartagena. "Mules" traveled thrice weekly in groups of four to Caracas,

* Colombia's CIA equivalent

** The Colombian Congress consists of 102 Senators and 166 Representatives

*** A hired courier of illegal drugs

Venezuela or Madrid, Spain carrying 5 to 10 kilos each hidden in their luggage. Upon arrival, members of Venezuela's "*Guardia Nacional*" and of Spain's "*Guardia Civil*" on the narco-traffickers' payroll greeted them. "*Each kilo [of cocaine] sells for US \$2,500 in Venezuela. The mule and the Commandant of the Guardia each are paid a percentage*"⁶⁵. According to the same source, the margin of benefit for cocaine shipped to Spain was 900 to 1,000 euros per kilo (approximately US \$1,350).

However, *Jorge 40's* ambitions extended well beyond the drug trade. He also wanted to control the public purse strings, which required the connivance of politicians and public office holders, a feat that was facilitated by his enormous military and economic power that kept everybody in check. A meeting was held at Pivijay, César province, in December 2001, attended by ranchers and politicians to carve out a strategy to ensure the election of friendly politicians to the Senate and House of representatives. It was decided to divide the Province into three sectors: two where only AUC-friendly candidates would be on the ballot box, and a third one where competition was allowed. Means to ensure compliance ranged from economic assistance to AUC-sponsored candidates, to kidnapping and murdering unfriendly candidates. An example of the latter is the well-publicized assassination of an ex-mayor aspiring to a Congressional seat without AUC approval. Because of the manipulation of the electoral process and intimidation, two AUC-sponsored candidates were elected to the Senate and three to Congress from that province that year. Election of provincial Governor the following year was also influenced by the AUC, which led to the withdrawal of two candidates under AUC pressure leaving Hernando Molina Araújo unopposed to win the governorship in 2003, only to be investigated by the Supreme Court on allegations of malfeasance as were several other members of the Araújo clan.

Rafael García, a long-standing member of the AUC's *Bloque Norte*, commanded by *Jorge 40*, became Chief of informatics at the DAS and promptly deleted AUC files from DAS computers. On November 21, 2006, after 18 months of silence following his arrest, García began a deposition before the Colombian *Corte Suprema de Justicia* that would last 3 days. He accused Jorge Noguera, his former boss and ex-DAS Director, of long-term collusion with the AUC especially with *Jorge 40* and Hernán Giraldo; a scandal now known as "*DAS-Gate*". Prior allegations of wrongdoing had forced Noguera to resign from the DAS directorship and García's revelations forced his resignation from his new post as Colombian consul in Milan, Italy. According to García, Noguera maintained contacts with both, José Gélvez Albarracín, a.k.a "*El canoso*" (Grey-hair man), the political chief of Hernán Giraldo's "*Resistencia Tayrona*" group and with Álvaro Pupo, *Jorge 40's* cousin. The relationship with the former had begun when both worked in Álvaro Uribe's first Presidential campaign in the Magdalena province, which was headed by Noguera. Álvaro Pupo reportedly acted as go-between Noguera and *Jorge 40* and, according to García, "*on one occasion, through him [Pupo] DAS agents sent to Jorge 40 a list of union members and professors that were subsequently murdered*"⁶⁵. García also described lucidly and in great detail AUC's widespread penetration in State institutions, their manipulation of the electoral process, the influence they exerted over many national politicians and local elected officials, and their control over the revenues of many northern cities and municipalities. Many of his accusations were already known or were confirmed subsequently. As a result of García's deposition, "*within two weeks, four congressmen and four 'diputados' were arrested, an order of capture was issued against a former governor of the Sucre province, and an ex-Director of the DAS was called to testify*"⁶⁵.

Yet, more explosive than García's disclosures were revelations of a secret accord signed between Colombian politicians and elected officials and the AUC central command. On July 23, 2001, eleven congressmen, two governors, three mayors, and an assortment of elected officials, thirty two in all, met at the AUC's central command center near Santa Fé Ralito with Salvatore Mancuso, supreme AUC commander, "*Don Berna*", its inspector general, and *Jorge 40*, commandant of its "*Bloque Norte*". The purpose of the meeting was to approve an AUC program designed to "*re-founding the homeland*" through a "*new social contract*". At the meeting, Mancuso circulated the secret document for each participant to sign. While the document did not contain seditious statements, it nevertheless sealed a pact between a group of Colombian elected officials and a criminal enterprise already known to be responsible for most massacres of innocent victims and for the displacement of hundreds of thousands of peasants each year. That day, "*part of the Colombian State settled its destiny with one of the most terrifying organizations in recent history...*"⁶⁶. Hence, far-fetched excuses concocted by participants facing indictment by the *Corte Suprema de Justicia* five years later were quickly dismissed and, at this writing, except for one that fled the country, most are in prison charged with aiding, supporting, or participating in criminal activities⁶⁷.

AUC Demobilization: Fact or fancy? Demobilization of AUC armies, authorized by legislation approved in 2002, 2003, and 2005, is a commendable goal that was designed to Disarm, Demobilize, and Reintegrate (DDR) these groups and to end massive human rights violations and other egregious crimes they committed against defenseless civil populations. The history of DDR of irregular armies in Colombia dates back to Dictator General Gustavo Rojas Pinilla's successful amnesty of 1953, followed by President Belisario Betancourt's "*Ley de Amnistía no condicionada en pro de la paz*" (Law of unconditional amnesty towards peace) that succeeded in demobilizing 700 guerrilla members from the FARC, the ELN, and the M-19. However, subsequent Presidential initiatives were unsuccessful including Virgilio Barco's (1986-1990) "*Iniciativa para la paz*" (Initiative for peace) designed to dismantle guerillas, Cesar Gaviria's (1990-1994) reduced sentences for drug traffickers, and Andrés Pastrana's (1998-2002) peace negotiations with the FARC, mentioned earlier. Soon after Álvaro Uribe took office in August 2002, the AUC leadership announced its willingness to participate in peace negotiations with his government on condition that none of its members would face prison time or extradition to the United States. In view of President Uribe's favorable response, on November 29, 2002, the AUC proclaimed a unilateral ceasefire. In July 2003, the Colombian government and the AUC signed the "*Acuerdo de Santa Fé de Ralito para contribuir a la paz de Colombia*" (Santa Fé de Ralito accord towards peace in Colombia), with the expectation that the process would be completed by December 31, 2005.

The legal framework for the demobilization of the AUC and other illegal armed group rests on Law 418 of 1997, extended and amended by Law 782 of December 2002, later revised by Decree 128 of January 2003, and finally complemented by law 975 of July 2005, also known as "*Ley de Justicia y Paz*" (Justice and Peace Law). Yet, the resulting directive "*still failed to meet international standards on truth, justice and reparation*"⁶⁸. Law 782 bars "*persons who participated in acts of barbarism, terrorism, kidnapping, genocide, or homicides committed outside combat or against defenseless victims*" from participating, which if complied with would have excluded most AUC combatants. After several attempts to reach a balance between necessary incentives to attract combatants and justice for their victims failed because of domestic and

international outcry, Decree 128 was enacted. Decree 128 confers “*pardon, conditional suspension of the execution of a sentence, a cessation of procedure, a resolution of preclusion of an investigation or a resolution of dismissal*” but only to those that committed “*political and related crimes*”. It also delineates economic and social benefits for demobilized combatants. And, acquiescing to demands from the AUC high command, Law 975 prohibits extradition of members of illegal armed groups accused of “*political*” offenses such as rebellion and sedition, albeit allowing it for narco-trafficking and other criminal offenses. In their aggregate, these DDR laws represent an alternative approach to conventional justice and is designed to balance accountability, punishment, retribution, and forgiveness in a process of post-conflict healing and recovery. Comparable approaches were adopted in El Salvador, Argentina, and South Africa, among others, to confront their past in hopes of establishing the foundations for a better future. By their very nature, alternative justice approaches to national conflict resolution trigger controversy and contentious debate and lead to imperfect outcomes and to numerous abuses, especially when applied unevenly, as in Colombia’s case.

Decree 128 cleared the way for the demobilization process to begin and, on November 25, 2003, 874 members of the “*Bloque Cacique Nutibara*”, an infamous AUC urban unit operating in Medellin, Antioquia province, laid down their arms. Yet, no demonstrable reduction in crime occurred in Medellin the following year, and 160 members of the AUC’s “*Bloque Cacique Nutibara*” were pardoned in December 2004 despite being actively investigated by the Office of the General Prosecutor for human rights violations, making a mockery of decree 128. In the first 30 months of the DDR process, over 30,000 AUC combatants have demobilized collectively and over 3,000 demobilized individually*, though only 17,000 weapons were turned in. However, procedural flaws and haphazard application of the law have tainted the entire process raising questions about each facet of the DDR and whether justice is being served and the desired outcome is being reached. According to a recent Amnesty International report ⁶⁹, “*Since 2003, paramilitary groups, responsible for the vast majority of human rights violations in Colombia for over a decade, have been involved in a government-sponsored ‘demobilization’ process. More than 25,000 paramilitaries have supposedly demobilized under a process, which has been criticized by Amnesty International and other Colombian and international human rights groups, as well as by the OHCHR ** and the IACHR ***. The process is lacking in effective mechanisms for justice and in its inability to ensure that paramilitary members actually cease violent activities*”. Moreover, the DDR process doesn’t record combatants’ group affiliation, precluding ascertaining whether AUC groups are fully or partially demobilized. Additionally, while human rights violators are not eligible to certain benefits under DDR laws, the General Attorney responsible to make that determination only checks its records to establish whether the demobilization applicant is under investigation or has been convicted of human rights violations. Likewise, combatants are not debriefed which prevents gathering information on AUCs’ structures, crimes, financing, illegal assets, and other critical information, and enables murderers and violators of human rights to escape prosecution and retain illegally obtained property while depriving victims of just compensation. For instance, only 24,000 out of 5,000,000 hectares seized by AUC groups between 1998 and 2006 from over 3 million displaced peasants were restituted. Finally, DDR laws do not

* Figures difficult to reconcile with the 14,000-15,000 active AUC combatants estimated by most observers.

** United Nations’ Office of the High Commissioner for Human Rights

*** Inter-American Commission on Human Rights

incorporate appropriate safeguards to ensure full re-integration of demobilized AUC combatants into civilian society leading many of them to form or join gangs of common criminals and resume criminal activities.

Amnesty International has identified several flaws in the application of Law 975 that have led to several major negative outcomes. They include, *“Providing de facto amnesties for paramilitaries and guerrillas responsible for serious human rights abuses and violations. Perpetuating impunity for human rights abusers and violators thereby undermining the rule of law in Colombia. Failing to guarantee the effective dismantling of paramilitary structures by focusing solely on individual combatants. Failing to expose those Colombian security forces, government officials, and private citizens who have supported and benefited from the activities of the paramilitary. Failing to establish a full and independent judicial process to oversee the demobilization process. Neglecting to respect the rights of victims of human rights violations and abuses to truth, justice, and reparation”*. Another criticism of the DDR process is that *“Colombia’s paramilitary groups have agreed to dismantle their military arm, but the process is only legitimizing their network of political power and country-wide control of land, as well as the suppression of anyone who threatens their rule”* ⁷⁰. It must be recognized that *“with Colombia’s transitional justice process scheduled to proceed over the next eight years, this examination [of the DDR process] has only just begun”* ⁷¹. However, even an impeccable DDR process flawlessly implemented would not achieve peace in Colombia as long as the drug trade remains in place.

Chapter 8

AFGHANISTAN

As the world's main opium supplier devastated by a quarter-century of civil war and by outside military interventions that wrecked the country's economic and political infrastructures, a weak and corrupt central government imposed by foreign powers, and a resurgent Taliban, Afghanistan poses complex challenges to its neighbors and to the world community. It has become the focal point where the *War on Drugs* and the *War on Terror* collide. Indeed, many current and former warlords utilize opium trade income to maintain their hold on power and to enrich themselves and, when US-friendly or allied to the central government, to fund anti-Taliban military operations. However, regardless of their current allegiance many warlords are former Mujahideen or Mujahideen supporters who would not hesitate to re-align their loyalties should their source of revenue be threatened, especially by a foreign power. Additionally, many of them are now integrated into the mainstream political process or have developed key political connections that brought about a symbiotic relationship between the illicit drug trade and the government. Likewise, a resurging Taliban exploits the opium trade as a major source of revenue, especially now that it tries to both regain power it lost following the US-led invasion in October 2001, and to expel foreign troops stationed in their country since.

Like Colombia, Afghanistan plays a prominent role in the worldwide illicit drug trade and, like Colombia, is the target of American intervention. In Colombia, to stem the flow of illicit drugs to the US and in Afghanistan, first to oust the Taliban from power ostensibly for refusing to hand over Osama bin Laden, the alleged mastermind of the 9/11 attack, and now to sustain its imposed but fragile democracy. However, they differ fundamentally in that in Colombia's case the illicit drug trade has caused massive disruptions in the social fabric of the country, whereas in Afghanistan's it has turned the country into a major battlefield of the US-led *War on Terror*, allegedly to stop the export of terrorism by radical Islamists. Additionally, Colombia's dynamic and decisive current leader, building on long-standing albeit imperfect democratic institutions, and enjoying overwhelming approval from the citizenry and American military and financial support, is well underway to regain control over the whole of his country. His ultimate success would end half a century of guerilla and counter-guerrilla conflict that, in the last two decades, has been funded by the drug trade. In contrast, the future of Afghanistan as a thriving democracy looks bleak ⁷² despite massive financial, military, and logistic support, and good intentions from the USA and ISAF*. Factors that contribute to the country's economic, social, and political stagnation include a weak central government whose authority is tenuous outside Kabul, the country's capital, a meager GDP ^{** 73} that compels reliance on foreign aid, and the lack of a democratic infrastructure and of a well-functioning civil society that now faces a resurging Taliban. In the next few pages, I will briefly delineate events that have shaped today's Afghanistan outlining the role of geopolitical interests, including America's, and sketch Afghanistan's place in today's confrontation between Islam and the West.

* NATO-led International Security Assistance Force

** Gross Domestic Product

1. **The early days - Prying by the British Empire**^{74,75}.

In 1747, Ahmad Shah Durrani unified the Pashtun tribes in what is today Afghanistan and conquered additional territory that, at the height of his power, included all of today's Pakistan and parts of India and Iran. Initially, the new country served as a buffer between the British and Russian empires but as Ahmad Shah Durrani's domain started to disintegrate, the British took advantage of the wars of succession by installing ex-Shah Shuya as the head of a puppet government in Kabul, replacing Dost Mohammed who was supported by Russia. This marked the first in a series of moves and ploys used by Britain and Russia, known as the "*Great Game*", that were designed to expand their respective sphere of influence. However, Shuya was unable to gain support from Afghan tribal chiefs who rose up against him and the British, leading to the first Anglo-Afghan war of 1831-1842. The second Anglo-Afghan war (1878-1881) erupted when Lord Lytton, Viceroy of India and a loyal promoter of the *Forward Policy* formulated by British Prime Minister Benjamin Disraeli (1804-1881), delivered an ultimatum to Emir Sher Ali to accept a British mission in Kabul. Ali's refusal led the British to invade, in November 1878 and, nearly unopposed by an ill equipped and poorly trained Afghan army, quickly occupied half the country. This led to the *Treaty of Gandamak* that stopped the British advance and installed a British Regent in exchange for payment of annual subsidies. However, less than a year later 2,000 unpaid Herati^{*} mercenaries stormed the "*Residency*"^{**} killing the entire British garrison. In retaliation, Lord Lytton sent an army that massacred hundreds of Afghans indiscriminately, which rallied 10,000 tribesmen to march on Kabul forcing the British to anoint Abdul Rahman Khan as Emir who, ironically, was backed by Russia. Hence, while the British were able to crush a second-rated Afghan army in both Anglo-Afghan wars they were ultimately expelled by tribal warfare, as would be the Soviet army a century later.

British Imperial wars were temporarily halted when William Gladstone (1809-1898) regained the position of Prime Minister in April 1880 with anti-war campaign slogans such as, "*The sanctity of life in the hill villages of Afghanistan, among the winter snows, is as inviolable in the eyes of Almighty God as can be your own*". Yet, in 1893 Abdul Rahman Khan was forced by the British Indian government to agree to the "*Durand Line*" as the boundary between Afghanistan and the then British India; a 1610-mile line that now demarcates the border between today's Afghanistan and Pakistan. Because the *Durand Line* was drawn arbitrarily through Pashtun territory, it continues to be a source of tension between Afghanistan and Pakistan. While the growing power of Germany forced an end to the *Great Game* through the *Anglo-Russian Convention* of 1907, the third Anglo-Afghan War was launched by Amanullah Khan, the new king of Afghanistan, in May 1919 when the British refused to acknowledge Afghanistan's independence. However, hostilities lasted only a month given British reluctance to re-engage in new war as WWI had just ended and Afghanistan's feeling the pressure of British air bombardments on Kabul and Jalalabad⁷⁵. Under the *Convention*, Afghanistan regained control of its foreign affairs, usurped by the British in 1878, and established diplomatic relations from the Soviet Union, Iran, Britain, Turkey, Italy, and France. King Amanullah Khan attempted to import reforms that Kemal Ataturk had instituted in Turkey. They included western clothing, secular education, the unveiling of women, and banning slavery and forced labor. A constitution, civil rights, a legislative assembly, and

^{*} From the ancient city of Herat in the Western province of the same name

^{**} British seat of power

a court system were established. However, such changes were too much and too quickly instituted for many tribal chiefs and religious leaders and, forced to abdicate in 1929, Amanullah Khan went into exile with his family, vowing never to return.

2. Events leading to the Soviet invasion.

The following 5 decades were marked by regional power struggles, short-lived attempts to relax censorship and to emancipate women, shifting geopolitical alliances and confrontations, especially with Pakistan, and to a civil war that led to the Soviet invasion. For instance, when Mohammed Daoud Khan became primer minister (1953 – 1963) he severed diplomatic relations with Pakistan and turned to the Soviet Union to equip and train the Afghan army and to aid in the development of the country's infrastructure⁷⁶. As his economic policies proved disastrous, King Zahir Shah, Daoud's cousin, ousted him and took control of the government. He instituted a parliamentary democracy with a constitution (1964) that enshrined equal rights for women including the right to vote and to an education. Wearing of the veil was made optional. However, King Zahir Shah was deposed in 1973 by his former Prime Minister and cousin he had sacked ten years earlier, supported by officers of the Afghan army and by the *Khalq* (masses) faction of the PDPA*. Daoud abolished the monarchy, named himself President, and ran a repressive regime with arbitrary arrests and executions, lessened the country's dependence on the Soviet Union, and squashed the growing Islamic fundamentalist movement *Jamiat-i Islami*** . Its leader, Burhanuddin Rabbani fled to Pakistan along with Gulbuddin Hekmatyar and Ahmad Shah Massoud, where they received support to fight the Daoud government. These men would become leaders of the Mujahideen*** forces that evicted the Soviets⁷⁶.

At the time, Afghanistan was one of the poorest and most underdeveloped countries in the world, with per capita GNP**** of \$70, ranking it 73rd among 83 underdeveloped countries, according to the World Bank⁷⁸. Many Afghans became impatient with his rule. Discontent was covertly encouraged by Pakistan where Daoud's doctrine of "*Pashtunistan*" or unification of all Pashtuns living on both sides of the "*Durand Line*" was viewed with great alarm. If ever realized, annexation of Pashtun lands would cut deeply into Pakistan's Northwest Frontier Province, home of millions of Pashtuns⁷⁹. Unrest led to the PDPA seizing power on April 27, 1978 through a military coup d'état spearheaded by a group of sympathetic Afghan soldiers. Daoud, his family, and thousands of ordinary citizens died, and Nur Muhammad Taraki was installed as President, ending two centuries of control of the country by the Durrani clan. Taraki's aim was to "*uproot feudalism*" in Afghanistan by implementing reforms to expand social services, education, women's and religious rights, and to strengthen Afghanistan ties to the Soviet Union. However, such measures caused violent opposition by wealthy landlords and chieftains and by the Muslim religious establishment that included many Mullahs holders of large estates. Opposition turned into open rebellion that by early 1979 had spread to 24 of the 28 Afghan provinces.

* People's Democratic Party of Afghanistan (communist party)

** Islamic Society, a Mujahideen party akin to Pakistan's *Jamaat-e Islami* and Egypt's *Muslim Brotherhood*

*** Plural of *Mujahid* or a person involved in *Jihad* (struggle)

**** Gross National Product

3. ***The Soviet-Afghan war (1979-1989).***

In March 1979, a faction of the Afghan army led by Ismail Khan massacred 100 Soviet advisers stationed near Kabul. The Afghani government crackdown was unable to control the situation despite reportedly killing 10,000 Afghan dissidents. President Taraki and Prime Minister Hafizullah Amin repeatedly urged the Russian leadership to send troops and assistance but were initially rebuffed. As revealed by transcripts of the *Russian Presidential Archive*, the *Ministry of Defense Archive*, and from published memoirs of participating Soviet officers and politicians ⁸⁰, USSR* leaders were very reluctant to send troops and instead dispatched military equipment in the spring and summer of 1979. However, after repeated requests, 20 in all, from the PDPA and the Afghani government, and alarmed by the overthrow and assassination of President Taraki by his Prime Minister Amin, in September 1979, the Politburo decided to send a "*Limited Contingent of Soviet Troops*" to Afghanistan against the strong objections of the military high command. Arguments debated included the wider geopolitical implications of the situation in Afghanistan, the regional impact of the Iranian revolution, and perceived U.S. ambitions in that part of the world. The latter was based on reported cooperation between Amin and the CIA, an argument promoted by Yuri Vladimirovich Andropov, KGB** Chairman, who controlled the flow of information to the ailing General Secretary, Leonid Ilyich Brezhnev. Regional geopolitical events that also influenced the Soviet leaders' decision included the overthrow of Mohammad Reza Pahlavi, Shah*** of Iran, on February 1979, the US-sponsored Israel-Egypt peace treaty in March 1979, and the US military support of Saudi Arabia and North Yemen royalist against Communist factions. Soviet ideologues, unacquainted with tribal societies ways and unaware of the preeminent role of Islam in Afghan society and believing that all countries were ripe for socialism, also played a major role in the Politburo change of mind.

In November-December 1979, Soviet troops stormed across the Amudarya River in tanks and armored personnel carriers and thousands more were flown into Kabul, Bagram, and Shindand air bases accompanied by Babrak Karmal, one of the founders of the PDPA and leader of its *Parcham* (Banner) faction. Within days, Karmal was installed as the new President of the Soviet-backed Democratic Republic of Afghanistan, after Amin's assassination. Early on, the mission of the *Limited Contingent*, initially made of reservists, was to take control of major urban centers, military bases, and strategic installations. However, it was unable to pacify the country and, far from being viewed as a friendly force, it was seen as an "*infidel*" foreign invader; a perception that united Afghans as no local or national issue could, turning a civil war into a war of liberation. Powerless to control the rebellion, President Karmal demanded the Soviet Army to intervene. Hence, Soviet troops "*found themselves pulled into the internecine war in Afghanistan and began to fulfill tasks related to suppression of the rebel movement, which initially did not figure in the USSR plans at all*" ⁸¹. Soviet forces were facing guerilla warfare where massive ground-air offensives undertaken periodically proved ineffective against hit and run guerilla tactics by a myriad of small groups of Mujahideen fighters with knowledge of the terrain, logistic support from local populations, and armed with sophisticated equipment supplied by the West. The Soviet Army brass quickly realized that given their lack of counterinsurgency training and military equipment

* Union of Socialist Soviet Republics

** *Komitet Gosudarstvennoy Bezopasnosti* (Soviet's intelligence services in Russian)

*** *Shahanshah* or King of Kings

inadequate to fight guerilla warfare, compounded by shifting directives coming from the Soviet Politburo, a military solution was not in the cards. Hence, *“the issue of troop withdrawal and the search for a political solution was discussed as early as 1980, but no real steps in that direction were taken, and the Limited Contingent continued to fight in Afghanistan without a clearly defined objective”*⁸⁰.

In the meantime, the USA was increasing its support of the Mujahideen and other anti-Communist factions. In fact, American involvement in Afghanistan preceded the Soviet invasion as later revealed by Robert Gates⁸², a 26-year veteran of the CIA and Director (1991-1993) under President George H.W. Bush, and by Zbigniew Brzezinski, American National Security Advisor (1977-1981) under President Jimmy Carter. In a 1998 interview with *Le Nouvel Observateur*⁸³, Brzezinski revealed that the US began supporting the Mujahideen well before the Red Army invaded Afghanistan. He stated, *“According to the official version of history CIA aid to the Mujahideen began during 1980, that is to say, after the Soviet army invaded Afghanistan, 24 Dec 1979. But the reality, secretly guarded until now, is completely otherwise. Indeed, it was July 3, 1979 that President Carter signed the first directive for secret aid to the opponents of the pro-Soviet regime in Kabul. And that very day, I wrote a note to the president in which I explained to him that in my opinion this aid was going to induce a Soviet military intervention... We didn't push the Russians to intervene, but we knowingly increased the probability that they would”*. When asked if he regretted anything, he replied, *“Regret what? That secret operation was an excellent idea. It had the effect of drawing the Russians into the Afghan trap and you want me to regret it? The day that the Soviets officially crossed the border, I wrote to President Carter. We now have the opportunity of giving to the USSR its Vietnam War. Indeed, for almost 10 years, Moscow had to carry on a war unsupportable by the government, a conflict that brought about the demoralization and finally the breakup of the Soviet empire”*. When pressed, *“do you regret having supported Islamic fundamentalism, having given arms and advice to future terrorists?”*, he replied, *“What is most important to the history of the world? The Taliban or the collapse of the Soviet empire?... Some stirred-up Muslims or the liberation of Central Europe and the end of the cold war?”*. Indeed, President Carter's July 3, 1979 directive had authorized funding of anti-Communist guerrillas in Afghanistan, enabling the CIA to launch *“Operation Cyclone”* that would channel billions of dollars and sophisticated equipment, including 500 to 2,000 US-made FIM-92 Stingers*, to support the Mujahideen's anti-Soviet struggle using the Pakistani government as a conduit.

Brzezinski's approach went much beyond Afghanistan. His grand strategy, adopted by his successors, was to destabilize the Soviet Union by supporting Islamic fundamentalism not only in Afghanistan but also in all predominantly Muslim Soviet republics in Central Asia. This was to be achieved by financing and arming the Mujahideen, especially Hekmatyar, which were conveniently classified as *“freedom fighters”*, and broadcasting a daily barrage of anti-soviet propaganda through US-run and funded *Radio Free Europe* and *Radio Liberty*. Subsequent American administrations continued to back the Mujahideen in words and deeds. For instance, in his Proclamation 5034 designating March 21st, 1983 as *“Afghanistan Day”*, President Ronald Reagan stated *“The tragedy of Afghanistan continues as the valiant and courageous Afghan freedom fighters persevere in standing up against the brutal power of the Soviet invasion and occupation...”*⁸⁴. In his radio address that day, he invited his audience *“to watch the courageous Afghan freedom fighters battle modern arsenals with*

* Surface-to-air missiles that are shoulder-fired by a single operator

simple hand-held weapons is an inspiration to those who love freedom"⁸⁵. Yet, the CIA went beyond Afghanistan's "freedom fighters" in its backfired efforts to counter the Soviets. Apparently dissatisfied at infighting between rebel Afghan factions, it sought to recruit better anti-Soviet fighters from the wider Muslim world to join the Afghan Jihad, which it funded through Pakistan's ISI; a program that was approved by CIA Director, William Casey. "So, [Osama] bin Laden, along with a small group of Islamic militants from Egypt, Pakistan, Lebanon, Syria and Palestinian refugee camps all over the Middle East, became the 'reliable' partners of the CIA in its war against Moscow"⁸⁶. In time, thousands of Muslims radicals from scores of Muslim countries were trained in Pakistan in bomb making, guerrilla warfare, and other terrorist activities. Ironically, most never took part in the Afghan struggle and those that did returned to their country of origin after the war where they organized terrorist groups or engaged in individual acts of violence. Though unforeseen or ignored by the CIA, the danger of that policy was not lost to regional leaders. For instance, Pakistani Prime Minister Benazir Bhutto warned President George H. W. Bush, "You are creating a *Frankenstein*", and Richard Murphy, assistant secretary of State for Near East and South Asian relations during the Reagan administration, opined "We did spawn a monster in Afghanistan. Once the Soviets were gone... [people trained and/or funded by the USA] were looking around for other targets, and Osama bin Laden has settled on the United States as the source of all-evil. Irony? Irony is all over the place"⁸⁷.

On the Soviet side, mounting casualties, the success of FIM-92 Stingers in neutralizing its air superiority, the staggering economic cost, and the loss of support at home increased the pressure on the Soviet leadership to end the quagmire. In fact, upon becoming General Secretary of the Communist Party in March 1985, Mikhail Sergeyevich Gorbachev proposed ending the Afghan conflict within a year; at the most two⁸⁸. As a result of the initial Politburo deliberations, the size of the *Limited Contingent* was increased to approximately 118,000 men and the day to day duties of fighting the Mujahideen was transferred to Afghan forces, which were built up in manpower and military capability. If this precursor of America's "troop Surge" in neighboring Iraq twenty years later is any indication, the orderly end of the Iraq war and the prospects for a self-sustaining democracy in that country is indeed bleak. The PDPA leadership feared the proposed Soviet withdrawal for it was aware of the lack of motivation within the Afghani army and worried about the high level of desertions. In fact, Gorbachev had made it clear to President Karmal that there was no going back. He informed the Politburo, at its October 17, 1985 meeting that he had warned Karmal, "by the end of the summer of 1986 you'll have to have figured out how to defend your cause on your own. We'll help you, but with arms only, not troops. And if you want to survive you'll have to broaden the base of the regime, forget socialism, and make a deal with truly influential forces, including Mujahideen commanders and leaders of now-hostile organizations. You'll have to revive Islam, respect traditions, and try to show the people some tangible benefits of the revolution"⁸⁸. In May 1986, Karmal was replaced as party leader and was ousted as President six months later. Haji Mohammad Chamkani, the new interim President (1986-1987) instituted a policy of national reconciliation that neither increased support for the new Moscow-backed Kabul regime nor brought about a truce with insurgents. Moreover, the real power behind the seen was Mohammed Najibulla who succeeded him as President (1987-1992). In the meantime, Soviet troop withdrawal continued as planned and was completed by February 1989.

4. *The aftermath of the Soviet-Afghan war.*

Aside from the economic and human costs on both sides, the Soviet-Afghan war unleashed serious and long-lasting geopolitical consequences, mainly terrorism and an illicit drug trade that in turn gave rise to ill-conceived policies and counterproductive strategies to combat each. The political scenario of the post-Soviet era is dominated by alliances, dissensions, and confrontations among the numerous Mujahideen factions vying for power. One of the most notorious players is Gulbuddin Hekmatyar, leader of the Islamic *Hezb-e-Islami* * he founded in 1975 to oppose Daoud's rule. Hekmatyar, who allied himself to and fought every other Mujahideen group over the years, was strongly backed by Pakistan dictator General Muhammad Zia-ul-Haq ⁸⁹, Saudi Arabia, and the CIA during the Soviet-Afghan war, each to further their own country's strategic interests. By some accounts ⁹⁰, he was responsible for countless deaths, assassinations, and human rights violations. For instance, after the Red army's withdrawal, Hekmatyar's forces fired thousands of scud rockets at Kabul where nearly 2,000 civilians died and 500,000 fled the city. Given these chaotic local circumstances, western annalists expected the PDPA regime to soon collapse especially given American and Pakistani support of the Mujahideen, but it was able to survive thanks to its military strength. In fact, the Red army had left behind scores of jet fighters and attack helicopters, and thousands of tanks and armored personnel carriers. Additionally, Soviet aid was renewed thanks to President Najibullah's socialist reforms, reaching \$3 billion in 1990. Moreover, President Najibullah counted with the support of pro-government militias especially Abdul Rashid Dostum's 40,000 men-strong *Jozjani* militia. Hence, a military operation, planned by Robert B. Oakley, American ambassador to Pakistan, and by Pakistani General Hamid Gaul, head of ISI **, to hasten the demise of the PDPA regime by capturing Jalalabad and make it the temporary seat of a provisional pro-western government was a failure. This ill-conceived campaign that the Mujahideen had opposed, caused the death of approximately 3,000 of its fighters, the sacking of General Hamid Gaul by Pakistani Primer Minister Benazir Bhutto, and revived the Afghani army's morale and the resolve of the Kabul government.

Yet, what foreign plotters could not achieve was accomplished by internecine fighting between the Khalq and Parcham factions of the PDPA and by a collapsing Afghan economy that became increasingly depended on Soviet largesse, though it was curtailed in 1991 by Boris Yeltsin, the first President of the Russian Federation. As a result, food, fuel, and materiel shortages caused massive desertions from the army and the eventual defection of *Jozjani* militia and of a number of government factions to the Mujahideen. In the meantime, Ahmad Shah Massoud and Abdul Rashid Dostum, later joined by Sayyed Mansour, had formed a coalition of militias that controlled nine north and northeast provinces and became known as the "*Northern Alliance*". Witnessing the disintegration of his fragile government, Najibullah attempted to reach a compromise with Massoud under the auspices of the UN ***. However, talks broke down, his government collapsed, and he sought refuge at the UN compound in Kabul where he lived until he was dragged out of the compound by the victorious Taliban, castrated, brutally murdered on September 28, 1996, and his blood-soaked body was hung "*from a Kabul lamp post with his genitals stuffed in his mouth*" ⁹¹. The Massoud-Dostum coalition

* Islamic Party

** Pakistan's Inter-Services Intelligence agency

*** United Nations

came apart and fighting among different ethnic and religious factions broke out in many parts of the country leading to thousands of people being detained, tortured, and killed. Warring factions included the Saudi-backed Pashtun Wahabi *Ittehad-e-Islami* and the Iran-supported Shi'a *Hezb-e-Wahdat* *. Hekmatyar again shelled Kabul, which led to a new wave of deaths and destruction. After Burhanuddin Rabbani, leader of the *Jamiat-e-Islami* party, became President (1992-1996), his forces and Hekmatyar's engaged each other resulting in renewed shelling of Kabul by the latter and thousands of new victims before a cease-fire, brokered by Pakistan and Saudi Arabia, took hold in March 1993. Under the treaty, which unraveled two months later after new fighting broke out between Massoud and Dostum militia, Hekmatyar became Prime minister. As the factional fighting continued unabated, the Taliban**, an Islamic fundamentalist and Pashtun Nationalist movement, emerged on the scene in mid-1994. Its stated aim was to liberate the country from a corrupt and warring leadership and establish an Islamic-based society. As the Taliban gained substantial territory and popular backing, Rabbani and Hekmatyar joined forces to face the common threat. Yet, despite their efforts the Taliban, now strongly backed and supported by Pakistan, seized Kabul forcing government forces to abandon the capital. Within hours, key government and military installations had fallen into Taliban's hands and Massoud retreated to the north of the country where he organized the main anti-Taliban force.

5. *The rise and fall of the Taliban*

National and international implications. Soon after Islam arrived in Afghanistan in the seventh century, the Taliban established themselves as an important component of the social landscape: running schools, mosques and shrines, and providing social services to the needy. Yet, they could quickly become fierce Mujahideen fighters when needed, as was the case during the Soviet occupation when they fought from their military training bases in Pakistan. They remained loosely connected regional groups for centuries. However, in 1994 the Kandahar-based Taliban were able to capture the city and the surrounding provinces and went on to control 12 of Afghanistan's 34 provinces in a few months. Their commitment to Islamic lifestyle attracted wide public support from a devout Muslim nation weary of the corruption, brutality, and feuding of Mujahideen warlords, enabling their capturing Kabul in the fall of 1996 and winning over 90% of the country shortly thereafter. Yet, the predominantly Sunni and overwhelmingly Pashtun Taliban failed to pacify Northeast Afghanistan where the Northern Alliance, ethnically comprised of Tajiks, Uzbeks, Turkmen, and Hazara of predominantly Shiite affiliation had established their stronghold enabling them to repel repeated military offensives and to reject repeated proposals of settlements offered by the Taliban. Likewise, the international community shunned them and only Saudi Arabia, Pakistan, and the United Arab Emirates recognized the "*Islamic Emirate of Afghanistan*", as they named their regime, as the legitimate government of Afghanistan. Under the leadership of Mullah Muhammad Omar, they established a rigid authoritarian regime based on the strictest interpretation of Islamic "*Sharia*" ***. That interpretation seems to have derived from ancestral tribal customs mixed with a radical "*Deobandi*" **** version of Islam and the influence of indoctrination they received in "*Madrasah*" (a place of learning/teaching)

* Unity party

** Plural of *Talib* or seeker (of knowledge)

*** The legal framework that, based on Islamic principles, regulates public and private life

**** Revivalist Islamic movement first taught at *Darul Uloom Deoband* school in Utar Pradesh, India

schools while exiled in Pakistan during the Soviet occupation of Afghanistan. Many such schools, supported by Saudi Arabia, taught a conservative *Wahhabi** Islamic tradition.

Implementation of this combined Islamic orthodoxy as public policy led to banning any “modern” or “western” activities, such as kite flying, applauding at sports events, shaving, television and movie watching, listening to music, accessing the internet, and to an especially repressive treatment of women. Women were not allowed to attend school after age 8, to work outside the home, to leave home unaccompanied by a male relative, or to wear nail polish or other adornments. These rules, imposed as part of a strict observance of the Taliban’s version of “*Purdha*”** (curtain) custom, also included the wearing of the “*Afghan Chadri*”***; the most concealing style of *Burkha***** still used in North Western Pakistan and in some parts of Afghanistan controlled by unyielding fanatically fundamentalist warlords. Women not in compliance were flogged on site by officers of the “*Ministry for the promotion of virtue and suppression of vice*” patrolling the streets of major cities⁹². In contrast to the Taliban’s interpretation of the *Purdha*, the “*Islamic Dress Code*” is usually described as designed to promote women’s modesty. According to a generally accepted interpretation among Muslims, “*In Islam, both men and women are expected to dress simply, modestly, and with dignity... When leaving the home, a Muslim woman must at least cover her hair and body in loose and unrevealing clothing, obscuring the details of her body from the public; some also choose to cover their face and hands*”⁹³. In fact, Islam does not impose the wearing of the *Burkha* nor does it dictate lengths of skirts, or whether a bit of hair can or cannot show under the scarf. Hair exposure together with using cosmetics or colored dresses often are targeted by restrictive Islamic regimes as exemplified by today’s annual street campaigns conducted by the Iranian police aimed at emancipated women wearing light and short clothing during hot Teheran summers, when 110° F temperatures are not unusual⁹⁴. Some traditional Islamic celebrations were also banned, including *Nowruz* (New Year celebration observed in Iran and other central and western Asian regions) and *Ashura* (Shia day of mourning). Yet, perhaps the gratuitous destruction, in March 2001, of the 125- and 174-foot tall Buddha statues, carved out the cliff-sides of Bamiyan in AD 507 and 554, attracted the most attention and international condemnation. Theft was punished by amputation of the hand. Murder and rape led to capital punishment and adulterers were stoned to death. Punishment, especially executions, was carried out at former soccer stadiums as public events with a high dissuasion value.

Their system of government was unorthodox, to say the least. They did not have or believe in a government per se or head thereof or in institutions of governance, did not hold elections, and did not communicate with the governed who did not know what their leaders looked like for photography was banned. They rejected ancestral tribal and feudal structures that dictated the provenance of leaders designed to avoid sharing power with non-Pashtuns that represented well over 50% of Afghan’s population. In their view, leaders’ legitimacy derived from the ancestral “*Bay’ah*” (oath of allegiance). In the case of Mullah Muhammad Omar it occurred on April 4, 1996, when wrapped in the cloak of Prophet Mohammed he appeared on the roof of a building in Kandahar while hundreds of Pashtuns Mullahs chanted “*Amir al-Mu’minin*” (Commander of the Faithful)

* A conservative view of Islam that originated in Arabia and influenced several reform movements

** Physical segregation of the sexes, including wearing the “*Burkha*” in public

*** A version of *Burkha* that covers the woman’s eyes with a mesh

**** A long, loose, and all enveloping outer garment designed to cloak Muslim women in public

as a pledge of support and submission. Their army was little more than an expanded version of the traditional militia force common to Mujahideen warlords though they maintained training camps that served as recruiting centers. They ruled with a medieval mind and an iron fist. Their brand of radicalism excluded certain ethnic groups as well the Shia branch of Islam. For instance, upon capturing Kabul *“all senior bureaucrats of Tajik, Uzbek, or Hazara stock were replaced by Pashtuns loyal to the Taliban regardless of qualifications.* Likewise, their religious zeal and intolerance led to human rights violations and to massacres of certain non-Pashtun ethnic groups. For instance, immediately following the takeover of the city of Mazar-i-Sharif in August 1998, Mullah Manon Niazi, the new Taliban governor incited violence against the Persian-speaking Hazaras, a Mongol-descendent minority of Shia Muslims, calling them *“kofr”* (infidels) ⁹⁵. This was a precursor of subsequent massacres and human rights violations of the Hazaras and other ethnic groups by the Taliban in reprisal of the 1997 massacre of 2,000 of their own by Hazara fighters. According to eyewitnesses interviewed by news media ⁹⁶⁻⁹⁷, the UN, and human rights organizations ^{98,99}, the Taliban apparently went street-by-street and house-by-house looking for Hazara individuals easy to identify by their Mongolian facial features and went on a frenzy of revenge killings, cutting throats, and raping women. By the end of the week, an estimated 6,000 to 8,000 Hazaras had been massacred. Contrary to Islamic precept that the dead be buried immediately, corpses were left on the spot to rot for several days in the summer heat and be eaten by scavengers. The anti-Hazara hate was such that Mullah Musa, director of public health, is said to have taken a group of gunmen to the military hospital in order to exterminate Mongol-featured patients and their visitors.

After loosing Mazar-i-Sharif, the Northern Alliance was relegated to approximately 10% of the North of the country and on September 9, 2001 its leader, Ahmad Shah Massoud, was assassinated by a suicide bomber posing as a reporter, removing the last obstacle to the Taliban taking control of the entire country. Both, the defeat of Mazar-i-Sharif and the assassination of Massoud was aided by al-Qaeda-trained fighters who had been integrated into the Afghani army shortly after Osama bin Laden moved to Afghanistan from Sudan. The bin Laden-Taliban alliance was one of convenience where al-Qaeda provided financial assistance in exchange for protection. For instance, following the al-Qaeda-blamed August 7, 1998 bombings of American Embassies in Dar es Salaam, Tanzania and in Nairobi, Kenya, bin Laden was indicted in US criminal court and his extradition requested but promptly rejected by Omar on grounds that the US had provided no evidence of his involvement in terrorism. The connection was also personal for one of bin Laden's sons is said to have married Omar's daughter. Then came the worst attack on American soil in US history, on September 11, 2001 referred to a *“9/11”*. An FBI investigation code-named *“Penttbom”** launched the next day, quickly identified 19 hijackers affiliated to al Qaeda as the perpetrators. In his September 20, 2001 address to a joint session of Congress President Bush demanded that the Taliban *“Deliver to United States authorities all of the leaders of Al Qaeda who hide in your land... Release all foreign nationals, including American citizens you have unjustly imprisoned... Protect foreign journalists, diplomats, and aid workers in your country... Close immediately and permanently every terrorist training camp in Afghanistan... hand over every terrorist and every person, and their support structure to appropriate authorities... Give the United States full access to terrorist training camps, so we can make sure their demands are not open to negotiation or discussion”* ¹⁰⁰. Once again, the Taliban's responded that they would turn bin Laden over if the US provided

* Pentagon/Twin Towers Bombing Investigation

evidence of his guilt in the 9/11 attack; a refusal used as justification for the US-led attack on Afghanistan. Yet, bin Laden's involvement, he denied initially, was suspected but never confirmed. A bin Laden's videotape surprisingly discovered in a house in Jalalabad and aired in the US on December 9, 2001 suggesting his pre-knowledge of the attack in its English translation has been called a fake. Indeed, experts have questioned the identify of the individual shown on the videotape and experts commissioned by the German TV station *Das Erste* to analyze the videotape challenged the translation. They concluded, "*The American translators who listened to the tapes and transcribed them apparently wrote a lot of what they wanted to hear but that cannot be heard on the tape no matter how many times you listen to it*" ¹⁰¹. However, in a videotape aired on October 29, 2004 and an audiotape broadcasted on May 23, 2006, bin Laden claims responsibility for personally directing the 19 hijackers. In the audiotape, he also asserts that Zacarias Moussaoui, the presumed "*alternate 20th hijacker*" who had been sentenced three weeks earlier to a life sentence for "*conspiring to kill Americans as part of the September 11, 2001, terrorist attacks*", had "*no connection at all with September 11*". Yet, despite his apparent confession the FBI's "*Ten Most Wanted*" lists bin Laden "*in connection with the August 7, 1998 bombings of the United States Embassies in Dar es Salaam, Tanzania, and Nairobi, Kenya... [and as]... a suspect in other terrorist attacks throughout the world*" but no mention is made of 9/11 ¹⁰². When asked why, Rex Tomb of the FBI's public affairs unit explained "*The reason why 9/11 is not mentioned on Usama Bin Laden's Most Wanted page is because the FBI has no hard evidence connecting Bin Laden to 9/11*" ¹⁰³.

The absence of bin Laden's unequivocal involvement in the 9/11 attack together with the unexpected collapse of World Trade Center twin towers and "*tower 7*" along with other disputed events have provided fodder to conspiracy theories. The three most prevalent hypotheses implicate Saudi Arabia, members within the US government, and Israel. As the home country of 15 out of the 19 hijackers and speculations, refuted by the 9/11 Commission*, that the Saudi Embassy in Washington arranged flights out of the US for Saudi nationals including several bin Laden family members while all other civilian flights were grounded, pointed to Saudi Arabia as a prime suspect. Alternatively, based on Arab-Jewish geopolitical considerations a "*false flag*"** operation conducted by members of Israel's Mossad ¹⁰⁴ has been suggested. Finally, the demolition-style collapse of the World Trade Center towers and the dismissal of pre-9/11 warnings of impending attacks on US soil from low-level intelligence officers are interpreted in some quarters as contributing negligence by higher echelon US officers, at best, or their implication in the attack, at worst. The total, sudden, and symmetrical collapse of World Trade Center twin towers is interpreted by "*9/11 Truth Movement organizations*"*** and other conspiracy theorists as evidence of a controlled demolition induced by deliberately placed and sequentially detonated explosive charges rather than by the impact of airplanes on the towers or the resulting fire. The identical collapse of Tower 7 that was not impacted by an airplane is even more problematic as fire alone has never before caused the demolition-style collapse of a building. In fact, the National Institute of Standards and Technology has yet to publish its final report and the Federal Emergency Management Agency's initial investigation reported that its "*best hypothesis has only a low probability of occurrence*". Nevertheless, America invaded Afghanistan and long-

* Official name: *National Commission on Terrorist Attacks Upon the United States*

** A covert operation designed to appear conducted by an entity other than the perpetrator

*** Groups that reject the official version of the 9/11 events such as 911truth.org and Scholars for 9/11 Truth

term consequences are to be expected at the national level of both countries as well as globally, which I will examine briefly as it relates to the opium trade and the Taliban resurgence and their respective role on the *War on Drugs* and the *War on Terror*.

Opium production and the Taliban. While poppy cultivation in Afghanistan is not new, it expanded rapidly when Iran halted its own production in the mid-1970s and again during the Soviet-Afghan war when vast amounts of money destined to support Mujahideen opposition groups were diverted into opium production, which by 1989 reached 800 metric tons. As the flow of foreign money dried out after the withdrawal of the Soviet army, warlords consolidated their regional power by securing a lasting and reliable source of revenue via opium cultivation and cross-border smuggling. It has been observed that during that time *"there was an arms pipeline going in, and a drugs pipeline coming out of Afghanistan"* ¹⁰⁵. By the mid-1990s, Afghanistan's opium production averaged 2,200 to 2,400 tons annually. The Taliban inherited a cultivation and smuggling network they continued to expand so that opium production peaked at 4,565 tons or 79% of the global supply by 1999 ¹⁰⁶. In 2006, Afghanistan's opium business was said to *"sustain a clan-based and crime-ridden society, it impedes Afghanistan's economic growth, hinders reconstruction efforts of the international community, and ultimately fuels instability and terrorism"* ¹⁰⁷. Since then, the situation has further deteriorated as described in UNODC's Opium Survey 2007 ¹⁰⁶, which concluded, *"The Afghan opium situation looks grim, but it is not yet hopeless"*. This somber assessment derived from detailed statistics that showed continued expansion of the opium trade despite massive anti-drug expenditures, notwithstanding official claims to the contrary, uncritically trumpeted by the media.

Under the Taliban (1996–2003), poppy cultivation ranged between 57,000 and 91,000 hectares, which represented 25% to 45% of the global land area dedicated to opium cultivation. The only exception was 2001 when Muhammad Omar ruled poppy cultivation against Islamic principles and only 8,000 hectares, producing 185 tons of opium or 12% of global supply, were poppy-dedicated. Since then, poppy cultivation exploded to 193,000 hectares in 2007, representing 82% of global poppy-dedicated land cultivation; more than the total land set aside for coca cultivation in Colombia, Peru, and Bolivia combined. Five southern provinces along the Pakistani border, that are the richest, most fertile, and the breadbasket of the country, now produce an astounding 70% of Afghanistan's opium harvest with Hilmand province alone producing over 50%. In excess of 3,000,000 Afghans from 509,000 households are involved in opium cultivation, or 14.3% of the country's population though it varies from province to province. In the province of Hilmand, for instance, more than 80% of farming families were involved in opium poppy cultivation in 2007. This is not surprising considering that one hectare of opium generates US \$5,200 gross yearly income against \$546 for one hectare of wheat; a daily wage of approximately \$9.3 versus \$4.0, respectively, which should give food for thought to those advocating alternate crop growing as a solution to the drug problem in Afghanistan and elsewhere. In addition to a surging poppy-growing landmass, opium yield also increased (to 42.5 kg/Ha in 2007). As a result, 8,200 tons of opium were produced in 2007, which amounts to 93% of the global production and exceeded medicinal global demand by approximately 2,000 tons. Hence, under the US' and ISAF's watch Afghanistan has reclaimed its titled as the world's largest drug producer. These statistics demonstrate that poppy crop eradication, the foundation of the international community's efforts to reduce the amount of opium produced, has been an utter failure as has been attempts to rein Colombia's coca harvest. Indeed, only 19,047 hectares of planted poppy were eliminated in 2007, mainly of marginal fields

*“often as the result of corrupt deals between field owners, village elders and eradication teams: as a result poor farmers suffered the brunt of eradication”*¹⁰⁶, and opium production rose 34% between 2006 and 2007. Yet, eradication fueled insecurity and violence resulting in 31 injuries and 19 deaths in 2007 alone.

The value of the 2007 Afghani opium harvest reached US\$ 4 billion or 35% of GDP: \$1 billion going to farmers and \$3 billion to traffickers and laboratories that convert nearly 60% of the native opium into morphine and heroin using chemicals imported from neighboring countries. The Taliban largely control the southern poppy-growing provinces, especially Hilmand province, and use the cash crop revenue to support their insurgency. Hence, while *“opium is undoubtedly a governance problem across the country. In the south and east, however, it is also strongly related to the Kabul government’s most immediate existential threat; the Taliban-led insurgency as well as to the funding of 139 suicide attacks in 2006”*¹⁰⁸. According to a British reporter, *“Russian gangsters who smuggle drugs into Britain are buying cheap heroin from Afghanistan and paying for it with guns”*. The exchange *“occurs at a bazaar near the old Afghan-Soviet border, deep in Tajikistan’s desert where drug traffickers meet their Taliban suppliers”*¹⁰⁹. One kilogram of heroin selling for \$1,000-\$1,200 in Afghanistan will double in price at the border trading posts where an AK-47 assault rifle costs approximately \$100. According to the same report, *“smugglers claimed they are ‘untouchable’ because their bosses include cabinet-level officials in the government”*. In effect, the post-Taliban drug trade has become a highly organized and hierarchical business with different layers of players linking the *“lower world”* that produces, refines, trades, and smuggles opium to the *“upper world”* of warlords-turned-politicians and commanders that protect and control the process and extract the lion’s share of the profits. As a result, *“criminal activities such as trafficking are less overtly the business of political leaders and more the province of an emerging criminal underworld with strong political connections”*¹¹⁰.

Therefore, the claim that the Taliban now control the bulk of the drug trade business is an oversimplification at best or a fabrication at worst. Like Colombia’s guerilla and counter-guerilla groups, the Taliban exploit their country’s most lucrative export crop as a source of revenue to fund their enterprise. Yet, they are but one set, albeit growing, within a widespread and diverse group of players. The efficiency of the system relies on a sophisticated pyramidal scheme of protection payments that generally flow from the bottom to the top of participants in the drug-trade and on checks and balances that ensure compliance at each level. Farmers pay the local police chief or commander, in currency or as a fraction of their poppy harvest, for the *“right”* to cultivate and to avoid crop eradication. Traffickers pay the district official who bribes the provincial administrator who, in turn, makes payments to one of the 20 to 30 individuals with high-level political connections that keep the system working smoothly, undisturbed by the relevant authorities, and relatively free of competition. It must be emphasized that while players’ wealth is directly proportional to their place in the pyramid. Hence, while top echelon participants are extremely wealthy, farmers at the bottom of the pyramid rely on poppy cultivation simply to survive at a subsistence level. Under these conditions, most Afghans view eradication and other counter-narcotics measures as international policies directed against the poor of the country who benefit the least from the drug trade and, as a result, have lost any hope that foreign intervention will bring a better future. General discontent provoked by crop eradication, insecurity, and frustration for not sharing in the promised economic and social benefits of peacetime paved the way for the Taliban’s return to the poppy-rich south of the country. In fact, it is not ideology what moves Afghans but a combination of an unstable environment where bribes to government

officials and their cronies are a prerequisite for solving problems and a dysfunctional administration unwilling or unable to bring fairness and justice to the ordinary people.

While the central government's record on administering justice is scant or non-existent, the Taliban imposed their brand of justice in areas under their control. In the words of a lowly villager, *"even if it's a minor thing, the Taliban will sort it out. Before (when the government of President Karzai was in control), it was not like that. They did not pay attention to us and the poor people were ignored"*¹¹¹. In addition to having lost confidence in their own government, Afghans increasingly distrust Western intentions and resent their actions. Indeed, Operation Enduring Freedom* and ISAF focus and spend far more on military missions than on rebuilding the country's physical and social infrastructures. In fact, Army Colonel Hy Rothstein, a 20-year veteran of the Army Special Forces, who was commissioned in 2002 by the Pentagon to examine the war in Afghanistan and its outcome, concluded the conflict created conditions that have given *"warlordism, banditry, and opium production a new lease on life"*¹¹². Hence, having lost Afghans' *"hearts and minds"*, the West has contributed to the return of the Taliban that now control nearly half of Afghanistan. Seven years have passed since President Bush declared, only days after 9/11, *"We will find those who did it, we will smoke them out of their holes, we will get them running, and we'll bring them to justice"*. Yet, despite US and ISAF military might and reconstruction aid, Afghanistan is quickly becoming a failed State and a breeding ground for terrorism, Osama bin Laden is alive and hiding in the Afghanistan-Pakistan border region, al Qaeda remains a global threat, and the Taliban continue a relentless advance that will likely spill into Pakistan.

In conclusion, the very fact that certain mind-altering drugs were outlawed and their use criminalized has spawned an extremely lucrative international illicit drug market dominated by criminal elements on both sides of the drug trade divide that has profound economic and social consequences for both, producer and consumer countries. For consumer countries, especially the US, by squandering billions of dollars to enforce misguided policies that attempt to regulate human behavior and restrict the practice of medicine at home, by bullying producer countries into reducing production, and by coercing the international community into pursuing an unwinnable *War on Drugs*. Enforcement of anti-drug laws and of international conventions in consumer countries varies somewhat according to each country's legal traditions and social sensitivities. The US, with the most repressive drug laws in the Western world, impose harsh minimum prison terms on convicts of drug offenses, including marijuana possession, that can be as lengthy as those imposed on rapists and murderers. Additionally, the drug enforcement establishment targets pain-treating physicians as easy and high profile scapegoats with plenty of forfeitable assets to camouflage its failure to curb drug availability on American streets and to generate additional income. As a result, thousands of mostly non-violent drug users and hundreds of pain-managing physicians are arrested, prosecuted, and many are incarcerated each year. In contrast, in certain European countries where drug use is considered a health, not a criminal matter, possession has been de-penalized or is handled as an administrative offense without increasing drug use, which is actually lower than in the US.

The economic and social impact of drugs on consumer countries is the consequence of their societies' insatiable demand for prohibited drugs that created and sustains a highly profitable black-market that in turn fosters crime at home and abroad.

* Code name of the US-led invasion of Afghanistan that launched the *War on Terror*

Yet, while most drug-related crime is committed by traffickers, as creators of demand users must be considered accomplices, albeit unwittingly. In contrast, the economic and social impact of drugs on producer countries is far grater for it involves local military, political, and judicial elites who collude with drug traffickers in the pursuit of riches while trampling on the property, human rights, and lives of the poor and disenfranchised. Such devastating outcomes, and their eventual correction, are directly linked to the economic, social, and political conditions in producer countries, to their democratic institutions, and to the functional adequacy of their civil societies. For instance, over the last 20 years Colombia's drug trade has been the main contributor to crime and corruption that permeates all levels of society resulting in tens of thousands of human rights violations, kidnappings, assassinations, and massive population displacements reaching into the millions. Yet, the country's institutional and social infrastructure and its democratic traditions, albeit imperfect, paved the way for its current President to successfully begin the process of reclaiming control of the country from guerrilla and counter-guerrilla groups by combining US-backed military pressure with extending an olive branch to combatants willing to demobilize and reintegrate civil society. During his tenure, tens of thousands of *paramilitary* combatants have demobilized and the FARC have being weakened and relegated to scarcely populated jungle areas, considerably reducing crimes committed by these groups (table 8). However, despite these successes, much remains to be done for, according to the law of supply and demand, producer countries will continue to supply consumer countries' demand as long as *War on Drugs* policies remain in place, ensuring an unmatched economic bonanza from the illicit drug trade.

Table 8. Violence indicators in Colombia: 2002-2007 ¹¹³.

Year	2002	2003	2004	2005	2006	2007
Homicides	28.837	23.523	20.208	18.111	17.479	13.020 (Sept)
Kidnappings	2.882	2.121	1.440	800	687	393 (Sept)
Displaced	422.394	217.138	202.919	229.655	242.860	150.940 (Oct)

Hence, as long as demand for illicit drugs in consumer countries sustains a lucrative illegal trade, production will follow suit. For instance, should Colombia succeed in reestablishing law and order and drastically reduce cocaine production, both unlikely events in the foreseeable future, cocaine production would simply shift to a different country with its own set of criminals, poor farmers eager to grow in a lucrative crop, and the same overseas accomplices.

In contrast, Afghanistan is a country without democratic traditions, institutional infrastructures, or a well-functioning civil society that is controlled by CIA-trained Mujahideen and nominally governed by a central government that is viewed as powerless, corrupt, and a puppet of "*infidel*" foreign invaders. Indeed, it has proved unable to enforce law-and-order or to hold back the advance of the socially regressive Taliban despite American and ISAF military and economic support. These are propitious grounds and ideal conditions for common criminals and Islamic extremists to fill the vacuum, and so they have. Hence, Afghanistan is unlikely to follow Colombia's footsteps and the country's future looks bleak, as does the goal of instituting a modern, self-sustaining democracy in that part of the world as contemplated by the USA and ISAF. Unlike Colombia, Afghanistan is not likely to gain control over its territory in the foreseeable future and risks becoming a failed State, the breeding ground for terrorism, and center-stage of an equally unending and unwinnable *War on Terror*.

PART VI

REFORMING DRUG POLICY

Chapter 9

REFORM PROPOSALS

1. *Framing the discussion*

Policy changes more often than not are incremental for repeal requires both seldom-achieved consensus on whether goals are being attained or undesirable outcomes are intolerable, and political courage to objectively tackle controversial issues. This is especially true with regards to drug policy where prohibitionists have succeeded in dominating the flow of information and public support, and where being “*tough on drugs*” is risk-free for no politician will ever lose a vote for holding that stance. Additionally, policy discourse is framed by participants’ sets of assumptions, which by remaining concealed from the debate preclude openly considering the motivations of discussants when assessing the evidence cited in support of their point of view¹. This is particularly notorious within drug policy discourse where sets of assumptions including ethical, moral, political, and other considerations emphasize and assign relevance to a certain body of knowledge but not to others. Hence, widely divergent positions exist on drug policy¹ though the literature on the subject suggests polarization of the debate between two opposing viewpoints: prohibitionists vs. reformers.

Prohibitionists adopt a “*Paternalistic*” approach based on the premise that the State can and should implement policies that protect individuals from their own actions or behavior, or a “*Preventive*” approach, which is based on the principle that justice demands punishing those who engage in activities that risk harm to others. To *Paternalists*, illicit drugs are illicit because they cause harm: end of discussion. Some extreme Prohibitionist positions often circulate in the Halls of Congress as exemplified by views expressed by members of the Subcommittee on Criminal Justice at its 1999 hearings on “*The Pros and Cons of Drug Legalization, Decriminalization and Harm Reduction*”³. For instance, Benjamin A. Gilman (R-NY), expressed the views of most Subcommittee members stating, “*Legalization is a surrender to despair; It cannot and ought not be any topic of serious discussion in our nation's debate of the challenges of illicit drugs*”. Likewise, Mark Souder (R-IN), expressed his irrational dismay at the very idea of holding hearings on drug legalization arguing, “*We do not have hearings called 'The Pros and Cons of Rape'*”. Bob Barr, (R-GA) inquired “*whether anti-racketeering laws could be used to prosecute people conspiring to legalize drugs*”; a reactionary interpretation of the freedom of expression amendment. To *Preventive justice* advocates, drug use exposes others to potential harm and, like drunk driving, is punishable even if no harm results from it.

Alternatively, reformers can be clustered as supporters of the “*Public Health*”, “*Harm Reduction*”, “*Utilitarian*”, and “*Libertarian*” stance on drug use. *Public Health* and *Harm Reduction* differ mainly in that while the former advocates policies that generally promote public health, the latter includes collateral harm in the equation. Hence, According to the former, drug use should be reduced though minimizing additional public health consequences to the user (e.g. HIV risk to imprisoned drug offenders), the latter advocates minimizing the overall harm to society of both drug use and of drug policy

(e.g. the harm to imprisonment itself). *Utilitarians* take into account the social utility of drugs (e.g. the benefits as well as the harm drugs cause). *Libertarians* espouse the most radical drug reform ethic, which emphasizes maximum individual liberties as long as they do not expose or cause harm or others or violate their civil liberties.

While the above classification stratifies and compartmentalizes, perhaps arbitrarily, the attitudes and mindsets of drug policy debate participants, it nevertheless provides a framework for understanding hidden issues when discussing drug policy, at least in the abstract. I say *at least in the abstract* because a 35-year historical perspective on the meager achievements but devastating consequences of the *War on Drugs*, described in the preceding pages, provide solid bases for assessing the economic, social, and political outcomes of drug policy at home and abroad, at least to unbiased observers. From that perspective it seems clear that, having failed on all counts, the *War on Drugs* should be abandoned and its legal and administrative infrastructures dismantled. Nevertheless, in the next section I will outline the pros and cons of three drug policy reform proposals as a prelude to describing my own. The first proposal tows the official line, the second attempts, unsuccessfully, to solve several opium-related issues at once, and the third follows a strictly libertarian approach.

2. *Illustrative reform proposals and positions.*

The RAND corporation* proposal. In their 2005 drug policy analysis paper for the prestigious RAND Corporation ², the authors began *"From 1985 until 2001, 'drugs' was consistently 1 of the top 10 answers when Americans were asked what they thought was the most important problem facing the nation. In response to such concerns, federal and state legislators and executive-branch officials have enacted and implemented policies that, while diverse in approach, are oriented toward enforcement"*. To pretend that drug policy was enacted in response to public concerns is clearly disingenuous and ignores historical facts. As we have documented in chapter 3, politicians and prominent public figures deliberately and methodically shaped public opinion over many years, portraying drugs as *"evil"*, *"sinful"*, and a *"plague"* that *"infected"* American streets, the workplace, and schools and would destroy entire generations of *innocent children*. For instance, Harry J. Anslinger, a former Commissioner of the US Bureau of Narcotics during *Prohibition*, became a tireless and influential if deceitful anti-drug crusader. In the 1970s, Nelson Rockefeller was elected Governor of New York on an equally deceitful anti-drug campaign against a presumed *"epidemic of addiction"* in New York State he claimed had reached plague proportions and threatened the lives of innocent children. Emulating Rockefeller, Richard Nixon promoted the fear of drugs as a political strategy to win popular support for his Presidential aspirations. Once elected, he made drug policy the centerpiece of his administration and launched the *War on Drugs* by implementing the *Controlled Substances Act* and by creating the DEA. Since then, legions of Anslinger, Rockefeller, and Nixon emulators continue the anti-drug disinformation rhetoric at local and national levels, all cheer led by the DEA.

The RAND Corporation report correctly points out, however, that measures adopted *"have not led to substantial decreases in the severity of America's drug-related problems, prompting strident denunciations of current policy. Many critics argue that the increased toughness of that policy has done more harm than good. Some go so far as to suggest that drugs should simply be legalized"*. It also concedes that *"programs outside U.S. borders... Crop eradication and substitution, in particular, show minimal promise"*, and that *"it is not credible to justify an intervention [by the US] principally on the grounds that it will reduce U.S. drug consumption"*. The authors tackle issues such as *"What the goals have been"* (of the *War on Drugs*) and whether they were achieved (on which they equivocate), *"Why hasn't the Drug War been a greater success?"*, *"What about bonuses and collateral damage?"*, *"Why not course corrections?"*, and *"How might US drug problems and policies evolve?"*. Then, they propose their vision of *"How **should** ** US drug policy evolve"*. They point out that given the fact that *"America is not going to be the world's first drug-free society"*, the drug problem *"must be **managed** ** so as to limit the number of people who use, the frequency or duration of their use, and the damage they do to themselves and others, together with the damage resulting from policy choices"*. This is to be achieved by tailoring current policy levers (enforcement, treatment, and prevention) according to circumstances. That is, emphasizing enforcement during the beginning of an *"epidemic cycle"* when there is a *"contagious spread"* to new users, followed by treatment later in the cycle when *"more heavy users who are generating substantial social costs"*; keeping prevention as a measure applicable at all times. Their second recommendation is to *"Draw strength from cross-State variations in drug policy"*

* *"A nonprofit institution that helps improve policy and decision making through research and analysis"*

** *Emphasis in the original*

under the assumption that “*evaluation of open questions and issues regarding variations within the prohibitionist regime might illuminate profitable directions for national and state policy*”. Finally, the authors make a plea for a “*more dispassionate debate*” over drug policy.

This drug policy quasi-reform proposal is shaped more by its authors’ perceptions and mindsets rather than by facts, some of which they misrepresent especially the roots of current drug policy. The authors assert to be “*interested primarily in choices at the strategic level-choices, for example, among strict prohibition, moderate prohibition, or decriminalization; choices among goals, for example, those focusing on use reduction or those focusing on harm reduction; decisions as to the appropriate roles of supply and demand control*”. Yet, while acknowledging that US-sponsored foreign programs and interventions to curtail drug production and importation have not and will not reduce US drug consumption, they hold fast to the notion that “*measured against its goals, early and more recent, the drug war has had a mixed record, at least superficially*”. This classic prohibitionist stance that requires biased interpretation of the facts not to stray too far from the drug policy official line, inevitably led to a desultory proposal that, at best, would harvest tepid results if implemented.

The SENLIS Council* proposal. The Senlis Council has achieved notoriety through its “*Afghan village-based Poppy for Medicine*” proposal ⁴. In it, it presents a carefully researched, though unworkable counter-narcotics plan with counter-insurgency implications for Afghanistan that, in addition, would address the “*global unmet need for morphine*”. It consists of setting up pilot projects to assess the feasibility of an opium licensing system in Afghanistan for the production of opium-derived painkillers such as morphine and codeine. Under the plan, poppy would be turned into valuable medicinal opiates, produced *in situ*, rather than being diverted to narcotics production destined to supply the illegal drug market. As contemplated, the scheme would give Afghan poppy farmers, and all others involved in the production of medicinal opiates, the opportunity to profit in a legal economy. This presumably would encourage them to cut ties with drug traffickers while addressing what the authors view as a global “*unmet need for opiates*”.

This proposal draws on licensed poppy cultivation programs established in India in 1947 ⁵ and in Turkey in 1971 ⁶ that were designed to break poppy farmers’ reliance on the international illegal heroin market without having to resort to forced crop eradication. With the support of the international community and sustained funding of alternative development programs and effective law enforcement, Turkey switched from production of opium to concentrate of poppy straw to meet legitimate medical demand. This strategy, which is credited to have brought Turkey’s illegal poppy cultivation and illicit trade under satisfactory control within a few short years, remains in place to this day. The underlying rationale of the Senlis council proposal is that abject poverty in Afghanistan and forced crop eradication without a compensatory source of income leaves poor farmers with no alternatives but to rely on drug trafficking and to support the Taliban as survival and self-preservation strategies, respectively. As emphasized in the Senlis report, “*the key feature of the Afghan Poppy for Medicine project model is that village-cultivated poppy would be transformed into morphine tablets in the Afghan villages. The entire production process, from seed to medicine tablet, can thus be controlled by the village in collaboration with government and international actors, and all economic profits from medicine sales would remain in the village, triggering economic*

* “An international policy think tank committed to implementing change at all policy levels”

diversification” free from drug trafficking links.

The report optimistically points out “*by triggering economic development in rural communities and integrating these communities within the Afghan legal economy and government system, the Poppy for Medicine projects would decrease insurgents’ recruitment bases*”. It also foresees that taxing a legal opiate industry would create a source of revenue to fund a law enforcement apparatus needed to combat opium diversion into the black market. In turn, this would increase popular support for the central government once it is perceived to look after farmers’ livelihood and economic prosperity. If that came to pass, the implications for government stability and for reconstructing and pacifying the country would be considerable. The report also predicts that the *Poppy for Medicine* plan would “*provide emerging and transitional countries with access to affordable essential painkilling medicines... at a price at least 55 percent lower than the market average*”^{*}. This aspect of the proposal is significant for, as pointed out by the Senlis council, “*In 2005, to meet the pain needs of the end-stage HIV/AIDS and cancer patients in Latin America, 7.1 metric tons of morphine would have been needed, but just 600 kg of morphine was actually used, leaving 91% of these patients’ pain needs un-met... [and] Even in the world’s richest six countries, which include the United States and the Western Europe, only 24% of patients’ pain needs are being met*”⁷.

While cogent, innovative, and “*a winning solution*” according to some of the world press, this proposal remains controversial and is being criticized on several counts. For instance, in a somewhat wordy, inaccurate, and at times contradictory rebuttal the US State Department drew on four counter arguments⁸. First, the licit opium market is not lucrative enough to entice Afghan farmers. Second, there is no *unmet* worldwide need for opiates that could be met by Afghanistan. Third, effectively controlling a legal market in Afghanistan is unrealistic. Fourth, legalizing opium would be detrimental to Afghanistan’s security and economic development. Of these, the second argument is misleading, the fourth is farfetched and unfounded, and only the first and third are objective and cogent. Indeed, even if the *Poppy for Medicine* initiative could be made economically competitive and an “*unmet need for opiates*” resulted from insufficient supply, the lack of effective legal, economic, and political infrastructures, a weak and corrupt central government distrusted by the population, and growing insecurity would make Afghanistan the least suitable country to implement such a drug control program.

An independent analysis⁹ of the *Poppy for Medicine* initiative provides an unbiased and authoritative critique of the project, which it calls “*A rather new, but unrealistic, proposal*”. It criticizes the proposal as “*based on false or inexact premises, on at least two levels: regarding the world market for licit opiates on the one hand, and national and local [Afghan] opium farming communities on the other hand*”. First, it correctly points out that according to the INCB, “*the supply of such opiates has, for years, been ‘at levels well in excess of global demand’*”. This statement and the Senlis council assertion of “*un-met worldwide pain needs*” seem irreconcilable views but in fact are two sides of the same issue. The INCB addresses “*supply*” in response to “*demand*” for opiates estimated by each country, whereas the Senlis council refers to a global “*un-met need*” for opium-derived painkillers due to the fact that “*official measurements of ‘demand’ do not reflect actual morphine ‘needs’*”. Indeed, there is a worldwide pain crisis caused by impediments to pain management rather than by an insufficient supply of

^{*} Emphasis in the original

painkillers. In the US and other rich countries, it is caused mainly by the impact of drug policy on medical practice and by an unfounded fear of addiction nurtured by prohibitionists of various persuasions and affiliations, and trumpeted by an uncritical media. In underdeveloped countries, it stems primarily from poverty and inefficient, unstructured, and under-funded health-care systems unable to provide access to painkillers or even expertise to assess needs. In fact, as acknowledged by the INCB, *“most developing countries lack the resources and expertise required for determining medical needs and adjusting drug supply to meet those needs. Medical practice shows undesirably large variations attributable to chronic shortage of staff and inadequate training and information”*. Given these circumstances, increasing opium supply would have little if any effect on the global pain management crisis in either rich or poor countries. Likewise, out of nearly two-dozen countries that cultivate poppy, only four (China, India, Japan, and South Korea) produce opium and only India exports it. The price paid to Indian farmers in 2004-2005 averaged US \$26 per kilogram of opium. Such a low price encourages diversion to the illegal market. In fact, India’s production and exportation of licit opium has been plagued by diversion and by increasing unlicensed opium cultivation that in 2007 exceeded (7,753 Ha) licensed cultivation (6,300 Ha) despite the country’s Central Bureau of Narcotics’ tight regulations. Hence, it is difficult to foresee how could such low prices succeed in weaning Afghan farmers from the illicit drug trade that fetches 4 to 5 times higher prices that they could possibly expect under the *Poppy for Medicine* project, even without taking into account possible additional restrictions and bottlenecks in the system. Given Afghanistan’s economic, social, and political conditions, a rudimentary and corrupt law enforcement establishment, and a government often in collusion with drug traffickers, much of the licensed opium production would undoubtedly find its way to the illicit drug market without significantly impacting the very problems the *Poppy for Medicine* project seeks to solve.

The CATO Institute’s* stance. Soon after its founding in 1977, the Cato Institute began calling attention to the unintended domestic and international impact of American *Drug War* policies in books and book chapters, articles and newsletters, opinion and commentaries, Cato studies, legal briefs, and events ¹⁰. In an early *“Policy Analysis”*, dated December 9, 1985 ¹¹, its author noted several major negative outcomes of President Regan’s 1981 energetic anti-war *“foreign policy that vigorously seeks to interdict and eradicate illicit drugs, wherever cultivated, processed, or transported”*. *“Despite much rhetorical bravado and a few highly publicized successes”*, he explained *“the U.S. effort [coordinated by the State Department, the DEA, and the CIA] has been a bitter disappointment. There has been virtually no reduction in the aggregate amount of cocaine, heroin, and marijuana coming into the United States”*. Looking for scapegoats, the author observed, *“Congressional conservatives and their ideological brethren in the administration also increasingly identify the narcotics issue with the larger cold war”*. Such a link is now established with the *“War on Terror”*. He also noted, *“they assert that Cuba, Bulgaria, Nicaragua, and other Marxist states are trafficking in drugs as part of a conspiracy to ‘destabilize’ American society”*. Such a ludicrous, politically motivated claim was no more credible than the Temperance movement’s assertion that Germany was attempting to addict the entire American population to heroin during WWI, or Harry Anslinger’s that Japan had unleashed an opium offensive to do likewise during WWII. In a subsequent drug policy analysis ¹² the author observed, *“in spite of the greatest anti-drug enforcement effort in U.S. history, the drug problem is worse than ever”*. Drawing

* *“A non-profit, non-partisan public policy research foundation dedicated to the principles of limited government, individual liberty, free markets, and peace”*

on the Prohibition experience, he proposed drug legalization “as a solution to... end crime, corruption, and AIDS caused not by the biochemical effects of illegal drugs but by the attempt to fight drug use with the criminal justice system”.

Over the ensuing years, Cato experts and staff have also addressed negative global outcomes of the drug war in publications with titles ranging from “*Bad neighbor policy: Washington’s futile War on Drugs in Latin America*”¹³, to “*A society of suspects: The War on Drugs and Civil Liberties*”¹⁴, to “*The Drug War and the homicide rate: A direct correlation?*”¹⁵. Yet, one of their main rationale for opposing this expensive, ineffective, overreaching, and disastrous American government program of global reach rests on its unconstitutionality, as eloquently stated in a book titled “*After Prohibition: An Adult Approach to Drug Policies in the 21st Century*”¹⁶. In it, the author points out that contrary to Prohibition, today’s *War on Drugs* violates the American Constitution. He noted, “*It is more than noteworthy, however, that, when the [Temperance] movement reached fruition in the form of national Prohibition, respect for constitutional limits on federal power was still such that it took an amendment to the Constitution to bring federal Prohibition about. No one thought, that is, that the Constitution authorized Congress, by mere statute, to prohibit the manufacture, sale, or transportation of alcoholic beverages. An amendment to the Constitution was required to give Congress that authority. Today, by contrast, we fight the drug war by statute alone*”. Based on a broad-based series of arguments, Cato Institute drug policy stance was articulated in a recent “*Handbook for Congress*” series titled “*The War on Drugs*”, where domestic and global policy reform recommendations are made¹⁷. In the domestic front, Congress is urged to 1) “*Repeal the Controlled Substances Act of 1970*”; 2) “*Repeal the federal mandatory minimum sentences and the mandatory sentencing guidelines*”; 3) “*Direct the administration not to interfere with the implementation of state initiatives that allow for the medical use of marijuana*”; and 4) “*Shut down the Drug Enforcement Administration*”. At the international level, policy-makers are advised to 1) “*Terminate Plan Colombia and other expensive, counterproductive anti-drug programs in the Andean region of South America*”. 2) “*Not allow anti-drug efforts in Afghanistan to interfere with the far more important effort to destroy the Taliban and Al Qaeda*”. 3) “*Recognize that prohibition creates a huge black-market premium and potential profit from drug trafficking that terrorist groups will exploit*”. 4) “*Remove U.S. trade barriers to the products of developing countries*”. 5) “*Declare an end to the international war on drugs and assure foreign governments that the United States will no longer pressure them to wage war on their own populations*”.

Cato Institute’s stance on drug policy is fundamentally libertarian and its reform proposals reflect it. Not surprisingly, while acknowledging the multifaceted failure of drug policy at home and abroad, despite enormous expenditures and unacceptable human costs, Cato Institute authors emphasize its unconstitutionality and its assault on civil liberties. However, their arguments overlook prohibitionists’ false claims that led to drug prohibition in the first place and the pain management crisis caused by current drug policy impact on *narcotics* prescriptions.

Chapter 10

A RATIONAL, EVIDENCE-DRIVEN DRUG POLICY

Medical and other scientific evidence reviewed in this book support the view that drug use and addiction, whether to licit or illicit drugs, is a personal choice rather than the result of these agents' alleged addictive properties. Moreover, the much-vilified *narcotics*, far from being dangerous or addictive, are in fact the most potent and safest painkillers on the market today, especially for the treatment of moderate to severe chronic pain. Evidence also confirms that drug-related crime and violence are the result of their criminalization that created and sustain the highly profitable illegal drug trade, and the prior anti-social tendencies of some individuals attracted to drugs, rather than of any inherent drug properties compelling to violence otherwise nonviolent and composed users. Hence, having dispelled the false claims that led to drug prohibition the question is, what arguments do prohibitionists advance to defend and preserve current drug policy? Overwhelmed by evidence that drug prohibition has been an extremely costly failure that causes more harm than good, prohibitionists cling to claims of "*partial*" success in "*some*" areas and to assert that were it not for current drug policy illicit drug use and addiction would be much worse than it is today. Based on these assertions that are rooted in their sets of assumptions and value systems rather than on facts, prohibitionists are unwilling to consider any relaxation of drug laws, much less their depenalization*, legalization**, or de-criminalization***. That being the case, two pivotal questions come to mind: Is there any evidence to support protectionists' view that current drug policy acts as a deterrent? If legalization, depenalization, and de-criminalization are to be discarded outright, what drug policy will redress the abject failure of the current one?

To answer the first question with any degree of certainty would require a head to head comparison of drug use prevalence within two comparable populations in the same time-frame; one free to use drugs at will, the other not. While such a controlled study has never been done, reasonable guidance can be derived and lessons drawn from marijuana prevalence use in places where it is legal and from comparing prevalence use of legal vs. illegal drugs. As mentioned earlier (chapter 3, section 2), the Netherlands considers drug use as a health issue, not a criminal matter, and personal use of cannabis is allowed when purchased by an adult from the country's licensed cannabis cafés (805 in 2002) in amounts up to 5 grams per person per transaction. Yet, despite having being depenalized, cannabis use is not higher in the Netherlands than in most other Western European countries, as revealed by the EMCDDA****. According to that report, in 2005 3.3% of Netherlands aged 15 to 64 consumed cannabis "*in the last 30 days*", which ranks it 9th among 27 EU countries behind Spain (8.7%), the United Kingdom (6.2%), Italy (5.8%), the Czech Republic (4.8%), France (4.8%), Luxembourg (4.0%), Austria (3.8%), and Germany (3.4%)¹⁸; all with more severe anti-drug laws. Moreover, the prevalence use of cocaine, heroin, and other "*hard drugs*" is not higher in

* Relaxation of the penal sanction provided for by law

** Making drugs legal

*** Removal of a conduct or activity from the sphere of criminal law

**** European Monitoring Center for Drugs and Drug Addiction

the Netherlands than in other European countries, dispelling once again the myth that cannabis, marijuana, and other so-called “*soft drugs*” are “*gateways*” to hard drugs. Likewise, Prohibition was an experiment from which to draw inferences based on consumption levels of alcoholic beverages before and after its repeal. Lessons from Prohibition are applicable to today’s drug problem, despite its distance in time and an American society that has evolved since, because drug use is a universal phenomenon that transcends ethnic, cultural, and time barriers. As described in chapter 1, alcohol consumption, especially of the more profitable “*hard*” liquors rose during Prohibition as did the health consequences of adulterated liquors distilled in bootlegged operations. Also, crime and corruption swept the country and tens of thousands of non-violent citizens were incarcerated for activities that were legal before and after Prohibition. Furthermore, multiple user surveys confirm drug availability everywhere and at any time; a circumstance well known to drug enforcement agents. These surveys and two historical experiments decades apart, one involving alcohol the other cannabis, show that contrary to prohibitionists’ assertions, drug prohibition has failed to reduce drug availability and is not a deterrent. In fact, just as alcohol consumption decreased markedly after Prohibition, as did overall crime and corruption, repeal of current drug policy would likely reduce illicit drug consumption and addiction rates and, once the illegal drug trade disappears, crime and violence it fosters at home and abroad would come to a standstill. Such a drug policy paradigm change would also contribute to restoring America’s former standing in the world; a standing compromised in the last thirty years by foreign adventurism at times funded through covert operations conducted in collusion with drug traffickers.

The answer to the second question is straightforward if one is to adhere to evidence rather than to self-serving preconceptions. Indeed, evidence presented throughout this book shows that drug policy has failed to achieve the ultimate goal of reducing drug use and addiction rates in America despite an enormous and growing economic cost and human suffering it causes at home and abroad. In short, current drug policy and drug laws do more harm than good. In fact, they cause indescribable harm wherever they are applied but little if any good; a situation that is as unacceptable as it is intolerable. Hence, protectionists are left with one of two possible options: 1) better application of current laws and statutes, or “*tailoring current policy levers*” in hopes of achieving the unachievable; 2) further tightening drug laws and harsher repression of transgressors. It should be clear to anyone that the first option is a dead-end measure doomed to fail for it doesn’t address the underlying culprit of all economic and social ills caused by drug policy: drug criminalization that in turn created a black market, which given the enormous profits involved, sparks uncontrollable crime and corruption. The alternate option is a classic “*war*” posture where more soldiers, more ammunitions, and more financial resources are deemed necessary to vanquish the “*enemy*”. Yet, that too is doomed to failure if drug policy experience over three decades is to teach us anything. Indeed, the “*drug problem*” has actually gotten progressively worse despite efforts by seven American administrations since the creation of the DEA, including Presidents Nixon’s and Regan’s major drug war escalations, as described in chapter 3. There are several reasons why further escalation would not significantly impact drug use and addiction trends. First, the lure of mind-altering drugs has been with us for millennia and will likely remain so forever. In fact, in recent times abuse behavior has transcended drugs to involve certain activities (e.g. gambling, sex) and even common foodstuff (e.g. coffee, chocolate, compulsive eating). Second, a small segment of the population with impaired self-control is unable to manage use of such drugs, products, or activities and become addicted regardless of potential health or legal consequences of such a

behavior. Third, because the black market is driven by demand, any escalation of the *War on Drugs* that succeeds in reducing the supply to consumers would raise unit price; a circumstance that would further entice producers and traffickers. Fourth, human behavior is not responsive to legislation even under the threat of the harshest of penalties, as shown by decades of increasingly repressive American drug laws. Fifth, criminalizing some mind-altering drugs, and demonizing users as enemies of society are the wrong approach. Indeed, *"The martial rhetoric of a 'Drug War' creates a sense of crisis and urgency that is inimical to rational policy debate... Martial metaphors not only stifle dissent, polarize opinion and limit the policy options that can be discussed"*¹⁹. Finally, drugs and drug users are not enemies to be vanquished, as in a *War*, but manageable societal problems to be quantified, ranked, and compared to other social liabilities as a basis for developing appropriate public prevention and non-punitive interventional policies, and for allocating resources to finance such programs. Yet, while non-punitive interventional policies would handle drug users and addicts outside the penal code, crimes they commit should remain punishable. However, punishment must be equitable, proportionate to the crime and the circumstances, and based on its nature, type, and gravity and not on prejudice, as is too often the case today for drug offenders and was in former times for minority transgressors. Let us not forget that not long ago young white rapists were often rationalized as *"boys will be boys"*, especially if the victim was said to dress or act *"improperly"*, whereas young blacks accused of raping white women were likened to predators, hunted down, and lynched by mobs seeking revenge rather than justice²⁰.

Clearly, solving the drug problem and alleviating crime, corruption, and human rights violations linked to the illegal drug trade caused by current drug policy, require ending drug prohibition. That is, the de-criminalization of all illicit drugs, the dismantlement of drug enforcement agencies along with their infrastructures, and the repeal of all related laws. Only such a radical change in direction is capable of ending the economic and social ills it causes. Indeed, de-criminalizing illicit drugs would eliminate their plus-value abruptly thus ending the black market. In turn, this would result in two major consequences:

1. Removing traffickers' main source of revenue, whether within the US or overseas. In the US, this would end all drug-related street crime, restoring peace to neighborhoods taken over by drug pushers and dignity to its inhabitants. In producer countries, it would sharply reduce crime, corruption, and human rights violations linked to the drug industry. However, one should be under no illusion that crime, violence, and human rights violations ingrained in the societies of certain producer countries would be solved by drug de-criminalization. In Colombia, for instance, the loss of drug revenues by traffickers linked to guerrilla and counter-guerrilla groups, and to common criminals would likely be substituted, at least in part, by a recrudescence of kidnappings for ransom and of extortion. Nevertheless, while such societal problems preceded the drug trade and require adapted local solutions independently of and in addition to drug policy reform, ending drug prohibition would be one major step towards to render these problems more manageable.

2. Enabling Federal, State, and local governments to regulate and tax the production and sale of all de-criminalized drugs providing a new source of revenue that could be earmarked for drug prevention and education, and to put into effect socially responsible, non-punitive interventional policies.

3. Additional benefits include eliminating diversion of medical narcotics, the *"forbidden fruit"* factor that entices many youth to *"experiment"* with illicit drugs, and the health consequences of adulterated drugs and of contaminated needles.

Having being rendered obsolete by the de-criminalization of drugs, the DEA, State, and local drug enforcement agencies along with their respective infrastructures would be dismantled and all related laws repealed. In turn, this would:

1. End the harassment and yearly arrest and prosecution of hundreds of physicians for issuing prescriptions capriciously deemed "*outside the scope of legitimate practice*" by untrained drug enforcement agents. In turn, this would empower physicians to prescribe narcotics according to medical criteria rather than as dictated by the DEA thus ending the pain management crisis in the US that penalizes tens of millions of chronic pain sufferers and terminally ill patients.

2. End the yearly arrest of hundreds of thousands of petty drug offenders and the incarceration of many thousands, restoring the proper role of prisons as institutions of confinement for criminals and perpetrators of violent crimes.

3. Enable reallocation of the billions of dollars wasted each year on the *War on Drugs* towards social programs designed to assist needy Americans and aid producer countries educate and retool their illegal crop-producing farmers towards profitable alternate crops and develop the means to market such crops.

PART VII

CONCLUSIONS

The *War on Drugs* is a replay of *Prohibition* at a global scale. While they differ in some important respects, similarities outweigh differences including their origins that can be traced back to human nature, in terms of both the attraction and opposition to drugs, whether yesterday's prohibited alcohol or today's forbidden drugs. Indeed, the lure of mind-altering drugs has been with us since antiquity and represents a human behavior that cannot be legislated or repressed successfully. Hence, it is not surprising that no amount of intimidation, coercion, or punishment has deterred experimentation with drugs. This is especially the case for adolescents and young adults, most of who indulge sporadically rather than regularly, few become addicted, and most who do and choose to quit can do so more often than not without third-party assistance. These facts alone render current repressive drug policy entirely unjustifiable. Another similarity is the cynicism and intellectual dishonesty of many promoters of the *War on Drugs* to achieve their goal of imposing on others their value system, as did *Prohibitionists*, however well intentioned. Both adroitly have used manipulation, disinformation, and outright falsehoods to hold the public hostage to the myths of the dangers of targeted drugs. The modus operandi includes appealing to prejudice, latent racism, and xenophobia to promote a sentiment of "*them vs. us*" in the population. This was the case of the *Temperance* movement, well-known for its prejudice against immigrants of the early 1900s', especially Catholics, and of Harry J. Anslinger's, Commissioner of the US Bureau of Narcotics (1930-1962), who waged an unabashed press campaign during WWII to convince the American public that Japan had embarked on an "*Opium Offensive*" to addict the entire nation. Advocates of the *War on Drugs* demonize drugs and drug users, instigate in the population a fear of the alleged "*perils*" of drugs to self and society, and promote a sense of self-righteousness among drug policy supporters.

Today, the approach includes well-orchestrated and widely publicized DEA campaigns against the "*drug du jour*", as exemplified by its "*OxyContin Action Plan*" launched in 2001 that targeted OxyContin-prescribing physicians. As is frequently the case, such operations are over dramatized by an unquestioning and acquiescing media and applauded by a duped public; two essential conditions that ensure the DEA's longevity despite its lack of success in achieving its mandate of reducing drug smuggling into our country and the amount of drugs available on American streets. Another glaring similarity between the two prohibitionist policies is false claims that drugs, whether alcohol or illicit drugs, are inherently addictive and lead users into a life of crime. For instance, the *War on Drugs*' underpinning is an alleged addictive nature of illicit drugs, now called "*drugs of addiction*", which is presumably caused by a genetic "*disease*". According to this claim, *drugs of addiction* act on neurocircuitry reward pathways as pleasure reinforcers and, as if to strengthen the notion of their wickedness, incite users to a criminal behavior. Yet, both claims are without foundation. Indeed, scientific and clinical evidence show that drug abuse is a choice as is abusing either chocolate or coffee, uncontrolled betting at the races, or unrestrained web browsing.

Addiction, whether to drugs or activities, typifies impaired self-control over use related to the user's personality traits contributed to by education and life experiences, and his/her intent (e.g. taking narcotics or food for pleasure rather than for pain relief or nourishment, respectively), influenced by environmental and non-specific genetic factors, rather than a disease or an indication of moral turpitude. For confirmation of this

viewpoint, look no further than the extreme rarity of addiction among the millions of pain sufferers, whether from cancer or non-cancer illnesses, who take narcotics daily for months to years, not for pleasure, but to attain relief from intractable pain and a return to a more functional lifestyle. Likewise, numerous studies over several decades have shown that drugs do not incite violence or criminal behavior in otherwise law-abiding persons. Examples include crime statistics before, during, and after *Prohibition*, and the fact that most crimes attributed to drugs are committed by international traffickers and by domestic dealers and pushers protecting their lucrative turfs, and by some drug addicts with pre-existing delinquent tendencies, as revealed by carefully conducted longitudinal studies of drug-addicted American servicemen during and after the Vietnam War.

Despite these similarities, *Prohibition* and the *War on Drugs* differ in many important respects. The former was spearheaded mainly by self-righteous rural middle class activists and by conservative religious leaders, was limited to alcoholic beverages, and was implemented within our borders where most of these products were manufactured, sold, and consumed. In contrast, the *War on Drugs* was created and launched by President Richard Nixon in his quest for power and promptly adopted by every self-serving politician since, covers a wide range of psychotropic drugs, and is fought at home and in foreign lands where much of these agents are produced. "*Our uncontrollable heroin epidemic... is, in other words, a foreign import...*" was Nixon's justification to expand his anti-drug crusade beyond our borders. More importantly, the *War on Drugs* and *Prohibition* are poles apart from a civil liberties standpoint. Indeed, American policymakers of the 1920s' and 1930s' felt compelled to seek constitutional amendments to both implement *Prohibition* as the law of the land and to repeal it when confronted with having "*prohibition in law but not in fact*" and with the social decay it caused. In contrast, President Nixon dispensed of such a "*formality*" and created the DEA by executive order, which was followed by an ever-expanding legal and brick-and-mortar infrastructure, and funding to match, reaching \$13 billion distributed among 11 government Departments and Agencies involved in the drug enforcement ban in 2006.

More importantly, drug policy has had devastating if unintended consequences far exceeding *Prohibition's*. During *Prohibition*, much of the illegal alcohol industry was taken over by home-grown organized criminal groups, often combined with gambling and prostitution, which led to street gangs, "*a criminal element that first surfaced during Prohibition*", and to a wave of crime and corruption that cluttered courts and overcrowded prisons. Criminalization of today's mind-altering drugs dictates the arrest of hundreds of thousands of mostly non-violent drug offenders each year and causes crime and corruption that far exceeds *Prohibition's*. More ominously, the DEA's unrestrained enforcement tactics have had a chilling effect on legitimate narcotics prescriptions that interferes with optimal pain management, causing a national pain management crisis where tens of millions of Americans with chronic and terminal illnesses "*receive inadequate care because of barriers to pain treatment*". In contrast to alcohol *Prohibition* that affected American consumers and American suppliers, the *War on Drugs* fostered the emergence of a highly profitable international black market to supply an insatiable global demand for illicit drugs that entices both foreign traffickers, affiliated with insurgent or guerilla armies, or with common criminals in producer countries, and their accomplices in consumer countries. Involvement of these players in underdeveloped countries and the sheer size of the illicit drug market have enormous geopolitical repercussions not seen during *Prohibition*. Indeed, whereas the America of the 1920s' had already developed a well functioning society governed by the rule of law capable of confronting *Prohibition's* challenges, most producer countries, wanting in both, are

overwhelmed by their illegal drug industry. The consequences are high levels of crime and corruption at all levels of their societies plus massive human rights violations against the poor and disenfranchised perpetrated mostly by drug-funded guerrilla and counter-guerrilla groups as is the case of Colombia, or international terrorism as seems to be the case in Afghanistan. Additionally, because the black market is driven by demand and the US is both a high demand consumer country and the driver of the worldwide *War on Drugs*, the US government is blamed in some quarters for the ravages drug policy causes on the societies of producer countries, adding one extra element that contributes to America's loss of prestige abroad.

Faced with overwhelming evidence that claims that launched the *War on Drugs* were flawed at best, or false at worst, and that drug policy enforcement has had devastating consequences at home and abroad without achieving its primary goal, the question is: what gives it staying power? The answer is three-fold: the mindset and value systems of promoters, the built-in interests, moral, financial, and otherwise, of supporters, and the acquiescence of a duped public. Hard-core prohibitionists reject the undisputable evidence presented in this book and elsewhere on ideological grounds as illustrated in President Reagan's dismissal of the National Academy of Sciences' *An Analysis of Marijuana Policy* 1982 report, "*We are making no excuses for [the ban on] drugs - hard, soft, or otherwise*". Drug policy reformers of most persuasions reluctantly accept the notion of relaxing some of its provisions but exclude depenalization, legalization, or decriminalization of drugs pointing to dubious "*partial successes*" and asserting that were it not for drug policy illicit drug use and addiction would be much worse than it is today. This latter claim also ignores the facts. Indeed, alcohol consumption rose steadily during *Prohibition* only to fall back to pre-*Prohibition* levels after its repeal. More germane to drug policy and to our time, legalization of "*medical marijuana*" in a number of American States has not increased overall marijuana use in any of them. Likewise, depenalization of cannabis in the Netherlands that made it available in hundreds of street cafés since 2000, did not cause an increase in consumption. In fact, in 2005 the Netherlands' ranked 9th among 27 European countries in cannabis consumption well behind some with strict penal laws even for simple possession, nor has it caused an increased consumption of "*hard drugs*". On the other hand, proponents of a more liberal drug policy are frequently hindered by arguments soft on the evidence or influenced by intellectual bias.

Any reflective drug policy reform proposal must be anchored on three incontrovertible facts that redefine the landscape: 1) "*Drugs of addiction*" are not intrinsically addictive. 2) Crime and corruption attributed to drugs are caused primarily by a colossal black market caused and sustained by their criminalization. 3) Attempts to legislate human behavior are doomed to failure regardless of the penalties involved. Accordingly, any halfway reform measure that disregards or dismisses these facts and fails to address them as the roots of today's failed drug policy, will inevitably fail. In contrast, de-criminalization of all illicit drugs would eliminate the huge profits associated with their illegal trade within and between producer and consumer countries, which in turn would end the black market for all such drugs and do so overnight. Having being rendered obsolete, the DEA and other drug enforcement agencies along with their supporting infrastructures would be dismantled and all drug laws would be repealed. Only such a radical change in direction is capable of ending social disruptions caused by today's drug policy at home and abroad. At home, such a progressive drug policy paradigm would end the persecution, arrest, and incarceration of hundreds of physicians for issuing prescriptions judged "*outside the scope of legitimate practice*" by the DEA,

empowering physicians to prescribe narcotics according to medical criteria, which in turn would end the pain management crisis that penalizes tens of millions of innocent American pain sufferers. Additionally, it would 1) End drug-related street crime, restoring peace to many American streets and dignity to its inhabitants. 2) Eliminate the "*forbidden fruit*" aspect that entices many youth to "*experiment*" with illicit drugs, probably reducing drug use. 3) End the yearly arrest of hundreds of thousands of non-violent drug offenders and the incarceration of many thousands. 4) End the health consequences of adulterated drugs and of contaminated needles. 5) Enable Federal, State, and local governments to control and tax the sale of all de-criminalized drugs, creating a substantial new source of revenue that could be earmarked for drug education, prevention, and treatment. 6) Reallocate the billions of dollars, wasted on the *War on Drugs*, towards social programs designed to improve the living standards of needy Americans and protect the country from real threats, and to assist producer countries educate and retool their illegal crop-producing farmers towards the production of profitable and marketable alternate crops. For producer countries, the major benefit undoubtedly would be the elimination of a major source of revenue for traffickers and their guerilla, terrorist, or criminal associates, which in turn would reduce crime, corruption, and massive human rights abuses perpetrated by these groups. However, such groups preceded the illegal drug trade and drug decriminalization will neither make them disappear nor eradicate crimes that seem deep-seated in the societies in which they thrive. Nevertheless, drug decriminalization is the only evidence-driven way forward that would accrue an abundance of social and economic benefits at home and abroad that cannot be matched by less sweeping drug policy reform measures. Indeed, if we acknowledge the falsehood of the claims that launched and sustain the *War on Drugs*, that drug criminalization created an immensely profitable black market that fosters crime and corruption at home and abroad, and the colossal failure of current drug policy in economic and human terms, partial reform measures are hopelessly inappropriate and will prove woefully inadequate.

Implementing the radical non-punitive, socially responsible, and enlightened drug policy reform I propose entails an uphill battle given the lack of political will among today's policy-makers, the entrenched public misconceptions about the perils of drugs continuously reinforced by detractors' unending disinformation campaigns, and the expected resistance from those who one way or another benefit from the status quo. Such a difficult undertaking will necessitate a new breed of legislators acting according to society's best interest rather than their own, willing and able to match the wisdom exhibited by policy-makers of the 1930s, and capable of mustering the necessary political courage to repeal the far more egregious and socially pernicious *War on Drugs*. Yet, a glimmer of hope seems to arise on the horizon. Indeed, Secretary of State, Hillary Clinton recently acknowledged, "our insatiable demand for illegal drugs fuels the drug trade", adding that our three-decade-long war on drugs has simply "not worked"; a first for the US administration. Concomitantly, US Senator Jim Webb, D-Virginia, introduced the "National Criminal Justice Commission Act of 2009" designed to establish a national commission to examine and reshape America's entire criminal justice system that might be a precursor to meaningful drug reform laws. Only then, will the US enjoy a drug policy worthy of its Constitutional principles and world governments be at peace with their own citizens.

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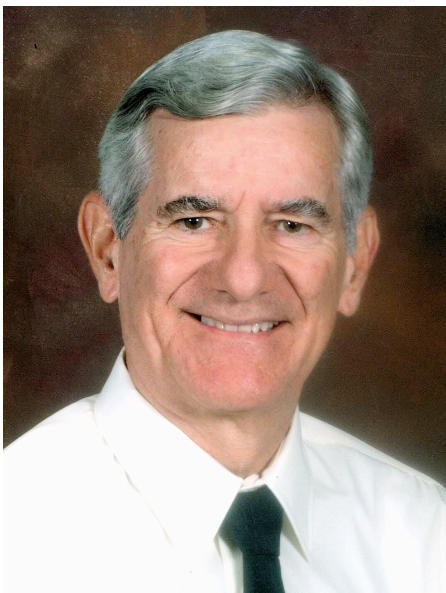
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BACK COVER

Pain Control and Drug Policy: A time for change

This book reviews the abject failure of drug policy and its devastating consequences at home and abroad. At home, it has caused a national pain management crisis that penalizes tens of millions of American pain sufferers, fosters crime and corruption, and compels the incarceration of tens of thousands of petty offenders each year. Overseas, it entices criminal elements to engage in the highly profitable illicit drug trade both wrecking their societies' fragile legal, political, and legislative infrastructures and trampling on the human rights of the poor and disenfranchised. It also shows that addiction is caused by impaired self-control rather than to alleged addictive properties of drugs, a disease, or moral turpitude, and that crime and corruption attributed to drugs are caused, not by the drugs themselves, but by their criminalization. Hence, launching the War on Drugs under such false pretenses was deceptive at best and dishonest at worst. Maintaining a failed policy with such intolerable consequences should be objectionable to anyone with judgment not clouded by emotions, preconceptions, or self-interest. Faced with these indisputable facts, today's prohibitionists look the other way or propose to further increase penalties for transgressors, oblivious of the fact that such an approach has been tried and failed. Alternatively, most drug policy reformers offer halfway measures that, failing to address the causes of addiction and of drug-related crime, will not improve drug policy outcomes including the flow of drugs on American streets, which only drug decriminalization can achieve. If American policy-makers of the 1930s exhibited wisdom and courage to repeal Prohibition, today's legislators cannot be justified or excused for acting less boldly when facing the more egregious and socially pernicious War on Drugs.



About the author.

Dr. Faguet is a retired clinician and researcher funded by the National Cancer Institute and the Department of Veterans Affairs. He was a member of numerous professional organizations and a reviewer for Federal and private granting agencies and for prestigious medical journals. He published many peer-reviewed articles, several book chapters, and three previous books including the acclaimed *War on Cancer: An Anatomy of Failure; A Blueprint for the Future*. His medical background and his insightful knowledge of Colombian society enabled him to assess and monitor both the impact of drug policy on medical practice in the US and on illegal crop-producing countries, especially Colombia. This book presents his reflections and recommendations for an overdue change in drug policy.