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COMMENTARY

Alcohol and other drugs: the response of the political and medical institutions

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Abstract

Formal and informal social control in shaping individual behaviors toward the use of alcohol and other drugs is discussed. Emphasis is placed on formal social control as it occurs in two major institutions. The state, which embodies the political and legal structures of the society is discussed in terms of the social control of some of the consequences of drinking, such as public drunkenness, alcoholism, operating vehicles with specific blood alcohol levels, and crime and alcohol use. The medical institution's involvement in alcohol and drug control is discussed in terms of the physician's role in diagnosing alcohol and drug dependent individuals. Two contemporary cases, those of pregnant addicts and alcohol-related organ transplant patients, illustrate the significant interactions between the responses of the political and medical institutions, and the broader influences that help shape these responses.

Introduction

Sociologists, psychologists, psychiatrists and economists have largely de-emphasized the importance of drinking and drug taking practices, and people's behaviors while they are ingesting drugs, for understanding the social and cultural context in which pathologies from this activity develop. Behavioral scientists are thus in the same situation as the psychiatrists whose almost exclusive concern with neuroses, psychoses, and other mental disorders allows them to make few generalizations about non-pathological behavior.

Moreover, every culture reflects a general ethos or feeling tone about the use and role of alcoholic beverages and other drugs within its social structure. This ethos may also be conceptualized as the cultural attitudes toward drug use and drug intoxication which exist within any society. Suffice it to say that these attitudes run the gamut from an absolute prohibition on ingesting various types of drugs to attitudes of permissiveness toward their use.

Our contention is that only by obtaining more drug use, and the function and role of drug use in diverse cultures will we begin to understand and explain pathological use of drugs. An approach that begins with a concern for drug taking practices would allow one to specify those occasions and situations which fall within a culture's permitted range, and those which are deviant and may indicate the beginning of a drug pathology. The researcher must be constantly aware that drug usage is affected by and affects the major institutional structures of society—family, economics, religion, politics, medicine, education, etc. Of course, we are making a major plea for re-emphasizing the sociocultural studies of drinking behaviors which were the core of the research of Bales,[1] Snyder,[2] Lolli,[3] Heath,[4] and many others. Some attempt is being made to remedy

that defect with a revised edition of *Society, Culture, and Drinking Patterns Reexamined* to be published by the Rutgers Center of Alcohol Studies in 1991.

Furthermore, there is a historical dimension to the use of alcohol and other drugs in any society. The relationship of humans to drugs is a long one, antedating recorded history. Drugs have been used for religious, medicinal, hedonistic, and social purposes. Cultural and legal attitudes towards drugs vary: a drug, such as alcohol, may be highly exalted by one society (e.g. France) and at the same time prohibited by another (e.g. Saudi Arabia); another drug, such as cannabis, may be widely used by one segment of a community and severely frowned upon by another. Also, over time a community may reverse its attitude toward a drug; opiates were legally accepted in the United States before World War I, but were legally prohibited, except under strict regulation, after the war. The current War on Drugs in the United States is the third major offensive against them in the 20th century. Perhaps the major difference between the previous wars against drugs (1914–25 and 1965–73) and the Reagan–Bush one is that the current war is more complex, given advances in technology and the natural sciences.

The increased complexity of the drug problem is related to the specific scientific discoveries in pharmacology. Society today has at its disposal drugs that cover the whole spectrum of human behavior. Besides the contraceptive pill we have others to sedate us when we are nervous, excite us when we are dull, slim us when we are fat, fatten us when we are thin, awaken us when we are sleepy, put us to sleep when we are awake, cure us when we are sick, and make us sick when we are well. Thus, on one hand drugs can enhance our ability to function more effectively, but on the other they can carry our minds out of the realm of reality into loneliness, despair, and hopelessness.

In discussing such an emotionally charged area as drugs, especially in the United States, it is imperative to maintain a rational perspective. Miracle drugs of the antibiotic family (such as penicillin), insulin, and others have brought a revolution to the treatment of many illnesses. Thus, drugs in a generic sense have achieved widespread acceptance in all countries, whether obtained by prescription or 'over the counter'. The mass media in western society are filled with advertisements of chemical agents which will remedy many of our problems —whether body odor, headache, bad breath, or digestive upset. Yet any drug or chemical agent can be misused, with negative consequences to the individual and society. Fortunately, few drugs out of the thousands available are consistently misused by any significant portion of the population. The major drugs that create problems for individuals in western society are nicotine, alcohol, heroin, barbiturates, tranquilizers, amphetamines, and cocaine and its derivative crack.

Given these general sociohistorical observations on alcohol and other drugs, this article will focus on three major areas:

(1) The role of social control in determining the behaviors of individuals towards the use of alcohol and other drugs;
(2) The social control response of the political institution; and
(3) The social control response of the medical institution.

This is not to deny that alcohol and other drugs are impacted by the other major institutions of society. For example, we could focus on the economic institution; this would involve a discussion of the implications of the globalization of the alcoholic beverage, the cigarette, and the pharmaceutical industries for developing nations in Latin America, Africa and Asia. Economic issues would lead us into questions of taxation and the effect of various tax policies on national revenues, consumption patterns, and drug-related harm. However, for the purpose of illustration we will concentrate on two institutions, and their interaction in the social control of alcohol and other drugs.

Social control

A major function of all human societies is the social control of the behavior of its members. Relatively small segments of human action are governed by instinctive responses embedded in the genetic endowment of individuals. Social control, therefore, begins before birth, for the fetus is dependent for its existence upon the environment that the mother's womb provides. As researchers have shown, the fetus's development can be affected by the types of substances that a pregnant woman is exposed to or consumes, for example the amount of alcohol and/or other drugs which are ingested. Social control comes into play at birth when the socialization process begins and the person learns to become a functioning member of society. In short, social control addresses the fundamental question of the

means by which a screaming, egocentric infant becomes a law abiding member of a community.

Social control is a fundamental concept in the social sciences, but it has different meanings depending on the theorist who is using the term. Robert Meier addressed this issue in his essay on the different ways in which social control is defined.[5] For example, social control is used 'as a mechanism to insure compliance with norms' which define what is appropriate and inappropriate behavior in general, as well as in specific situations. The degree of force involved in applying social control measures may range from minimal, such as the use of threat or presenting an ultimatum—for example, spouses telling their partners that their alcohol consumption or use of a certain drug must be moderated or stopped or the relationship will be terminated. More force is invoked by the social control agents when they institute fines, curfews, or censorship of media in an attempt to stop the drinking or drug behavior considered inappropriate. More force is involved when actually hurting the individual is permitted. This may take the form of direct assaults on the individual, as exemplified by imprisonment, flogging, or torture.[6] In Bush's War on Drugs, the force involved is the denial of public housing to drug offenders or indirectly by making no provision in the health delivery system for treating alcohol- or drug-dependent individuals. The latter form of social policy has characterized the Reagan–Bush years in the United States resulting in the paucity of facilities and staff for lower-income alcohol- and drug-dependent individuals. The ultimate social control force is killing the offending individual—capital punishment. American drug legislation of the 1980s allows execution of major illicit drug dealers. Thus, we conceptualize social control as a means of inducing compliance with norms. We will, however, concentrate only on aspects of formal social control as they occur in two major institutional areas: the state, which embodies the political and legal structures of the society; and the medical institution. In both of these institutions agents exercise institutional power to respond with sanctions to putative conditions. The term putative 'is intentionally, even ostentatiously, careful talk, allowing one to speak of something without commitment to its actuality'.[7] In our case, this refers to alleged alcohol and other drug-related deviance. We choose to use the term putative conditions:

(1) to avoid the implication that there is a normative consensus;
(2) to avoid the value judgement that deviance is always bad and conformity is always good;
(3) to avoid certifying the truth or falsity of institutional agents' beliefs that rationalize their social control actions.

In addition to sanctions, prevention and treatment are important mechanisms of social control for alcohol and other drugs.

Informal mechanisms of control exist in society beside formal mechanisms. For instance, Peter Berger describes informal control in primary groups:

> Where human beings live or work in compact groups, in which they are personally known and to which they are tied by feelings of personal loyalty . . . very potent and simultaneously very subtle mechanisms of control are constantly brought to bear . . .[8]

Trice and Beyer discuss some of these mechanisms that occur within institutional settings and include: role expectations and obligations that also evoke the informal controls of others in the group; the development of social distance between those not meeting the obligations of their roles and those who do; and the internalization of values that support role expectations.[9] Thus, while informal systems of control sometimes contradict formal systems, they are integrally intertwined with and reinforce each other. Now let us turn to a discussion of social control in two institutional areas.

The political institution

The political institution as represented in the legal system plays a major role in reflecting society's basic attitudes towards drugs. The decision of whether the manufacture, distribution, and sale of a particular drug will be criminalized, decriminalized, or legalized depends on the governing images held toward that drug, and these differ from culture to culture. Take, for example, cocaine. South Americans living in the Andes have been chewing the leaves of coca plants for centuries, with few efforts to eradicate this custom by their governments. Dutch researchers present papers at international meetings which discuss the recreational use of cocaine by individuals who do not become dependent on the substance.[10] In the United States, however, the governing orientation of the mass public is that cocaine and its smokable form, crack, produce instant addiction and are killer drugs, despite evidence to the contrary. For example,

Freud used cocaine for a time and was then able to stop.[11] Conversely, a drug widely accepted in Western society, alcohol, is criminalized in the fundamentalistic Islam societies of Libya and Iran. Thus, it is essential to analyse the cultural attitudes and practices of any society towards various types of drugs, for they form the backdrop against which legal sanctions will be instituted. Of course, one must be cognizant of the fact that certain laws in reference to drug-taking behavior are only symbolic in nature. To a large extent this is the status of the marihuana use statutes in the United States, which are rarely enforced.

The role that the legal institution plays in the social control of alcohol and other drugs is all-encompassing. First, the legislative bodies decide whether the drug is legal or criminalized. Let us use alcohol as our focus. General areas of state involvement require determining:

(1) *who* may purchase and drink alcohol;
(2) *what* may be purchased and consumed;
(3) *where* it may be purchased and consumed;
(4) *when* it may be purchased and consumed;
(5) the *cost* and form of payment;
(6) the *unacceptable consequences* of drinking.

The state also regulates the acceptable boundaries of social control for other institutions, such as the medical one, in developing systems with sanctions and adopting activities for prevention or treatment. For example, in the United States a person must be 21 years of age to purchase alcohol (the *who* question); fortified wines of more than 17% alcohol content may not be purchased in designated areas of Los Angeles (the *what* question); alcohol may not be purchased from a non-licensed vendor (the *where* question); *in some states* alcohol may be purchased only during certain hours (the *when* question); beer, wine and distilled spirits have differential tax rates, both in terms of ethanol content and locality of sale (the *cost* question).

The legal institution is also concerned with the social control of the consequences of drinking, which may be divided into four parts.

Drunkenness-related consequences

Laws have been enacted to control drunkenness, including prohibitions on public displays of drunkenness, vagrancy, loitering, disorderly conduct, and being drunk and disorderly. Early English common law did not make public intoxication a crime unless it was accompanied by a breach of the peace; however, public intoxication was made a criminal offence by an English statute in 1606, before the founding of the first permanent English settlement in the United States in 1607:

> *An Act for Repressing the Odious and Loathsome Sin of Drunkenness*
>
> Whereas, the loathsome and odious sin of drunkenness is of late grown into common use within this realm, being the root and foundation of many other enormous sins, as bloodshed, stabbing, murder, swearing, fornication, adultery, and such like, the great dishonor of God, and of our nation, the overthrow of many good arts and manual trades, the disabling of divers workmen, and the general impoverishing of many good subjects, abusively wasting the good creatures of God:
>
> II. Be it therefore enacted... That all and every person or persons, which shall be drunk... shall for every such offense forfeit and lose five shillings... to be paid... to the hands of the churchwardens... and if the offender or offenders be not able to pay... shall be committed to the stocks for every offense, there to remain by the space of six hours.[12]

Public intoxication remains a criminal offence in England and parts of the United States despite the social movements in the 1960s and 1970s to decriminalize it in both countries, with the concomitant development of detoxification centers to provide treatment. Research has shown that those individuals who are publicly intoxicated are often chronic alcoholics. Coming from the lower socio-economic classes, they live in transient and skid-row areas in every American city and typically are part of the homeless population. Recent estimates in the United States indicate that about 40% of the homeless have alcohol problems.[13]

In the late 1960s and early 1970s, social scientists and treatment personnel were optimistic that public drunkenness could be decriminalized and treatment centers for affected individuals developed. Despite the 1968 U.S. Supreme Court ruling in Powell *v* Texas that upheld the public drunkenness laws, states were encouraged to decriminalize the offence and use federal grant incentive programs for the lower-income alcoholics; however, several large states, such as California and Pennsylvania, never did.

Great Britain also was characterized by such a movement to alter the patterns of care of chronic alcoholics. The British Home Office's Working Party on Habitual Drunken Offenders, after 3 years of study, made a series of enlightened recommendations in 1970 concerning the problem, the need for a wide array of treatment options, including special arrangements for detoxification for these individuals.

Two decades later it is interesting to note that the Working Party stated:

> One of the clear lessons from its past history is that the problem is unlikely to disappear of its own accord: it has shown itself to be stubbornly resistant to changes in the structure of society itself... over the past 250 years and there is no reason that this pattern will alter unless deliberate steps are taken to eradicate it or at least to reduce its effect.[14]

As a consequence of this committee's recommendation, the British National Health Service established two detoxification centers (in Leeds and Manchester) on an experimental basis for 3 years. A decade ago, in 1979, the London *Daily Telegrraph*, commenting on the imminent termination of these facilities, noted that 'The experiments have not failed; the centres are always full and there have been some success stories. But this kind of rehabilitation work is very slow'.[15]

The profiles of those treated in centers in Great Britain and the United States were similar—middle-aged men at the bottom of the social and economic ladder; typically men who were isolated, uprooted, unattached, disorganized, demoralized and homeless; men beset with major medical problems of liver disease, gastric disorders, and nutritional deficiencies. The major difference between the groups was that in the United States more of them were drawn from a greater diversity of social and ethnic groups.

However, with the dawning of the 'greedy and conservative decade' of the 1980s (the Reagan–Bush years in the United States) a more self-centered age began in which less attention was given to community needs and more emphasis was placed on individual entrepreneurship goals emphasizing personal economic wealth. In this climate, the decriminalization movement ended in the United States, and in Great Britain the health service's detoxification units were allowed to expire. In the United States, detoxification centers continued to operate, but a two-tier system developed—one tier for those with private health insurance, which usually provided medical and social care in a 28-day facility, and another tier that provided social detoxification in a non-medical setting, which at best had medical care as a back-up and at worst none at all. For many there was no medical care at all.

The collapse of the American decriminalization movement and the current hysteria about illicit drugs must be viewed against the backdrop of increasing social inequality in the United States. For example, the number of Americans living below the poverty line has increased from 11.4% a decade ago to 13.1% in 1988, according to the Census Bureau. The gap between the wealthiest and poorest Americans has reached an all-time high. Complicating the situation is that over half of the poor families are headed by women. In total, the number of poor Americans is 32 million out of a population of over 240 million.[16] Furthermore, the gap in the life expectancy of white and black Americans has increased from 5.6 years in 1984 to 6.2 years in 1987; life expectancy is 75.6 years for the average white child born in 1987 and 69.4 for a black child. Infant mortality rates for blacks have been higher than for whites; black death rates for AIDS, drug overdoses and other drug-related factors (homicides), motor vehicle deaths and chronic liver disease (including alcoholic cirrhosis) have increased more for blacks than whites in the period 1984–87.[17] The social and political climate in the United States is one in which the medical and psychosocial needs of the public inebriate will be assigned low priority; furthermore, many sectors of the public health establishment are interested in pursuing further legal control measures on alcoholic beverages rather than examining the role of poverty, discrimination, violence, alienation, and anomie in exacerbating alcohol and drug related harm.

Alcholism-related consequences

Previous American laws have made it a crime to be a habitual or common drunkard. It was not until 1962 that the US Supreme Court in Robinson *v.* California declared as unconstitutional those statutes which made the condition of being a drug addict a criminal offense. Furthermore, several states prohibit the sale of alcoholic beverages to intoxicated individuals, and it has been illegal to sell alcohol to an alcoholic whose name was on a posted list. The civil code in American states may provide mechanisms by which not only alcoholics, but drug addicts can be forced to undergo treatment. All of

these are ways by which social control mechanisms may be used to control alcoholics.

Vehicular-related consequences

These controls include laws against operating planes, trains, boats, trucks, motorcycles, and cars when blood alcohol is above a specifically defined level. In the transportation field the states also have regulations restricting the consumption of alcohol by transport workers before they report to work, for example the Federal Aviation Agency's restriction on pilots' consumption of alcohol in the hours before flying. The importance of this type of control is illustrated by the government warning placed on all containers of alcoholic beverages in the United States since November 19, 1989:

> (1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects; (2) Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.[18]

Other alcohol-related consequences

Many criminal behaviors—homicides, assaults, rapes, burglaries, etc.—occur when alcohol and/or other drugs are ingested. Two major research approaches have characterized the investigation of the relationship of crime and alcohol use: what is the drinking behavior of the individual when he or she commits a crime and, what is the correlation between long-standing alcohol abuse and criminality?

The closest relationship between intoxication and criminal behavior (except for public intoxication) has been established for criminal categories involving assaultive behavior. This relationship is especially high in the lower socio-economic classes of blacks and whites. Aggression in these groups is often weakly controlled and drinking alcoholic beverages serves as a triggering mechanism for the external release of aggression. In certain types of key situations in lower-class life alcohol is a major factor in assaultive behavior. This often occurs in the tavern, which is an important social institution for this class. Assaultive episodes are precipitated during the drinking situation by quarrels that center around defaming personal honor, threats to masculinity, and questions about the legitimacy of one's birth. Personal quarrels between husband and wife, especially after the husband's drinking, frequently result in assaultive episodes in the families.

American law has typically held that drinking, intoxication, and alcoholism are not defences against the commission of a criminal act. However, sentences have been mitigated by the condition of alcoholism—as part of the sentence the offender is required to receive treatment for his drug and/or alcohol dependency.

The state is extremely active in sanctioning violations of the alcohol and drug laws, and inappropriate behaviors that occur while drinking, as criminal statistics indicate. In the USA in 1988, approximately 30% of the estimated 13 181 000 total arrests were related to alcohol—driving under the influence, the leading cause of arrest, accounted for 1 792 000; public drunkenness for 819 000; disorderly conduct for 761 000; and liquor law violations for 670 000. Another 9%—155 000 arrests —were violations of drug laws.[19]

The medical institution

The 20th century has been characterized by the rise to pre-eminence of the medical institution. Along with this ascendance, medicine has become more involved in the control of deviance that previously was handled by the state or religion. Control of alcohol and other drugs is an important example of this trend toward the medical control of deviance.[20] The medical institution has gained extensive responsibility for social control of alcohol and other drugs in this century. Bakalar and Grinspoon assert that 'although it emerged from a religious background, medicine is obviously more important than religion today as a basis for drug control'. They go on to make an interesting case for the need of medical control of drugs:

> In modern industrial societies the medical profession has to supply the ritual context that makes drug technology relatively safe.... Some control is needed, and... openly religious restrictions are impossible in present social conditions.[21]

For instance, they discuss the 'ritual of prescription' as a form of drug control.

The physician has become the major gatekeeper for conferring through diagnosis the status of alcoholic or drug dependent. Physicians in the United States may even, through civil commitment legislation, mandate treatment for alcoholics or drug addicts. In many areas individuals found publicly

intoxicated may be referred to hospitals, clinics or social centers for possible detoxification instead of being sent to jail. Hospital-based in-patient and out-patient treatment has expanded greatly for both alcoholism and drug dependence and is now the predominant institutional treatment in the United States for those individuals dependent on alcohol and other drugs who have health insurance.

In Great Britain, the situation appears to be dissimilar in that, under the National Health Service, the number of distinct units for alcoholic patients has been reduced and certainly not expanded. The emphasis seems to be on early intervention with those who have problems. Of course, the danger with this approach is that those individuals with more severe alcohol problems may be neglected. Great Britain has not witnessed a massive explosion of private for-profit alcohol and drug treatment facilities, as has been the case in the United States; nevertheless, some are in existence, for example, in London and Manchester.

Interactions between the medical and the political institution

Neither the medical nor the political institution exists in a social vacuum, for there are issues in which the two not only intersect, but collide. Two issues illustrate this point.

Pregnant addicts

In the United States a court in Florida in July 1989 convicted a woman of child abuse because she used cocaine during her pregnancy. In Washington, DC, Brenda V., a pregnant addict, spent approximately 4 months in jail because the judge wished to protect her unborn child from drugs.[22] Given the significant number of female alcoholics on American Indian reservations, proposals have been made by tribal leaders to incarcerate pregnant alcoholics in order to reduce the incidence of fetal alcohol syndrome. Furthermore, the New York State Health Department reported that in the period July 1986 to June 1987 almost 3000 babies born in that state were affected by illicit drug use, chiefly cocaine; it estimated that by 1995, if current trends are not reversed, 5% of newborns in New York could require admission to intensive care facilities.[23] The issue thus becomes: to what extent should the state regulate the lives of pregnant women who are alcohol- or drug-dependent? However, the question is complicated by the fact that the women who are most likely to have babies affected by alcohol and cocaine are non-white, poor, and have received limited prenatal care. There is no question that the absence of a national health insurance plan in the United States has made the situation worse. In Bush's current War on Drugs, approximately 70% of the funds are to be allocated to supply interdiction and only 30% for demand reduction, which includes the treatment component. Drug treatment facilities in the inner cities of America have waiting lists and treatment on demand is far from being realized. However, of major interest is that some law enforcement officials are now strong advocates of criminalizing the pregnant addict—sending her to jail instead of to the hospital.[24]

Organ transplantation

Major research and clinical advances in medicine now allow physicians to successfully transplant major organs—kidneys, hearts, and livers—to terminally ill patients; the development of cyclosporine has enabled patients to successfully thwart the rejection of these tissues. Given both the expense of the procedure and the shortage of organs, medical centers must develop criteria for selecting individuals for these procedures. Research indicates that psychosocial factors play a significant role in the decision-making process. In 1972 the US Congress provided funding for kidney dialysis and kidney transplants, but such funding is not available for heart and liver transplants.

Medical centers use psychosocial factors in deciding who obtains various organs; the patient's status in reference to alcohol and drug dependency plays an important role. For example, of the 40 candidates at the University of Louisville who were not recommended for heart transplants, 13 were rejected for psychosocial reasons, the chief one being abuse of alcohol and/or drugs.[25]

In liver transplants, the role of alcohol dependency becomes a key issue. In June 1983 the US National Institute of Health convened a Consensus Development Conference on Liver Transplantation composed of medical scientists, biostatisticians, ethicists, and public representatives. In their report, they stated:

> Alcohol related liver cirrhosis and alcoholic hepatitis are the most common forms of fatal liver disease in America. Patients who are judged *likely to abstain* from alcohol and who have established clinical indicators of fatal

> outcomes *may* be candidates for transplantation. Only a small proportion of alcoholic patients with liver disease would be expected to meet these rigorous criteria.[26]

Some centers will not perform a liver transplant unless the patient has been abstinent for a period of time. In a landmark case, the Michigan Department of Social Services required a patient to abstain for 2 years before it would pay for the medical costs required for the transplant. The court found the regulation discriminatory, but the man died of liver failure before surgery could be completed.[27]

The requirement for a mandatory period of abstinence for alcohol-dependent patients requiring transplants is based on a history of pejorative opinions towards alcoholics. However, the recent study by Starzl and associates of 41 patients with alcoholic liver cirrhosis who had transplants between 1980 and 1987 seems to contradict the negative judgement of the cirrhosis patient's ability to abstain. When this group was compared with the 625 adult patients whose livers failed for reasons not related to alcohol dependency, the survival rates were not significantly different. Therefore Starzyl concluded:

> The fact that relapses of alcoholism have been uncommon after hepatic transplantation weakens the potential objection that provision of a new liver is a futile gesture as well as the waste of an organ. Going through a trauma of such magnitude as liver transplantation seemingly has been the starting point almost invariably for long or permanent abstention and usually for rehabilitation.[28]

If the work of Starzyl and his associates is replicated in further studies, then there can be no medical reason for not viewing alcoholic cirrhotic patients as excellent candidates for transplants. Therefore, legal strictures, such as those noted in Michigan, would be not only inappropriate, but discriminatory.

Conclusion

Over time, culture and society change and there are parallel changes in the relative power of the various social institutions to control behavior. In American society we have seen the trend towards the medical control of alcohol problems in the last generation, with a corresponding shift in the controlling authority to the medical institution. However, when illicit drugs such as cocaine, crack, and heroin are involved the legal institution is still the major source of social control. Even with these substances a trend towards medical control has occurred with the establishment of drug treatment facilities and methadone maintenance clinics. However, at the same time there is an increasing acceptance of privatized social control, reflected originally in the federal government's promotion of employee assistance programs by private industry and, in the last few years, with emphasis on the testing of employees' urine for traces of drugs. However, it is not just these shifts in institutional power that lead to changes in social control, for there is no consensus in American society over the nature of alcohol and other drug problems. The most obvious examples are found in the basic disagreement over whether these problems are caused by the agents or the hosts. Even where there is agreement on the nature of the problem, there is considerable disagreement on what would be the most effective and/or appropriate response. This conflict leads to change. This, in turn, creates a dynamic, often internally contradictory, social control system as our society grapples with age-old and new problems arising from alcohol and other drugs.

Alcohol and drug problems in America and Great Britain are cyclical, and a review of their history would be worthwhile. As Santayana has noted, 'Those who cannot remember the past are condemned to repeat it'.[29]

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References

1. BALES, R. (1962) Attitudes toward drinking in the Irish culture, in: D. J. PITTMAN & C. R. SNYDER (Eds) *Society, culture, and drinking patterns*, pp. 157–187 (New York, John Wiley and Sons).
2. SNYDER, C. R. (1958) *Alcohol and the Jews: a cultural study of drinking and sobriety* (Glencoe, IL, Free Press).
3. LOLLI, G., SERIANNI, E., GOLDER, G. & LUZZATTO-FEGIZ, P. (1958) *Alcohol and Italian Culture* (Glencoe, IL, Free Press).
4. HEATH, D. B., WADDELL, J. O. & TOPPER, M. D. (Eds) (1981) *Cultural Factors in Alcohol Research and Treatment of Drinking Problems* (special issue of *Journal of Studies on Alcohol*, Center for Alcohol Studies, Rutgers University in cooperation with the Smithsonian Institution).
5. MEIER, R. (1982) Perspectives in the concept of social control, *Annual Review of Sociology* (Palo Alto, CA, Annual Reviews Inc.).
6. WILLETT, T. C. (1980) Social control and the military in Canada, in: R. OSSENBERG (Ed.) *Power and change in Canada* (Toronto, McClelland and Stewart).
7. RAINS, P. (1975) Imputations of deviance: a retrospective essay on the labeling perspective, *Social Problems*, 23, p. 3.
8. BERGER, P. (1963) *Invitation to sociology: a humanistic perspective*, p. 71 (New York, Anchor).
9. TRICE, H. M. & BEYER, J. M. (1982) Social control in worksettings: using the constructive confrontation strategy with problem-drinking employees, *Journal of Drug Issues*, 12, pp. 21–49.
10. COHEN, P. (1988) *Cocaine use in Amsterdam in nondeviant subcultures* (Amsterdam, University of Amsterdam).
11. SZASZ, T. (1975) *Ceremonial chemistry: the ritual persecution of drugs, addicts, and pushers* (Garden City, NY, Anchor Press/Doubleday).
12. HUTT, P. B. (1967) The legal control of alcoholism: toward a public health concept, in: D. J. PITTMAN (Ed.) *Alcoholism*, pp. 124–128 (New York, Harper and Row).
13. ROSSI, P. (1989) *Without shelter: homelessness in the 1980s* (New York, Priority Press).
14. HOME OFFICE (1971) *Habitual drunken offenders: report of the working party*, p. 192 (London, HMSO).
15. MOORMAN, J. (1979) Problem that can't be locked away, *Daily Telegraph*, p. 8, August 13.
16. BARRINGER, F. (1989) 32 million lived in poverty in '88, a figure unchanged, *New York Times National*, October 19.
17. HILTS, P. J. (1989) Growing gap in life expectancies of blacks and whites is emerging, *New York Times*, October 9.
18. WATER, J. V. (1989) Label law: drinkers to see new warnings, *St Louis Post-Dispatch*, p. 1, Section E, October 22.
19. UNIFORM CRIME REPORTS FOR THE UNITED STATES (1989) (Washington, DC, Federal Bureau of Investigation, US Department of Justice).
20. CONRAD, P. & SCHNEIDER, J. (1980) *Deviance and medicalization: from badness to sickness* (St Louis, Mosby).
21. BAKALAR, J. B. & GRINSPOON, L. (1984) *Drug control in a free society*, p. 124 (New York, Cambridge University Press).
22. GEST, T. (1989) The pregnancy police on patrol, *US News and World Report*, P. 50, February 6.
23. FRENCH, H. W. (1989) New York City babies face drug crisis, *New York Times*, October 18.
24. O'MALLEY, W. C. (1989) We've had nothing but failures, *New York Times*, September 10.
25. FRIERSON, D. K. & LIPPMANN, S. B. (1987) Heart transplant candidates rejected on psychiatric indications, *Psychosomatics*, 37, pp. 347–352, 355.
26. NATIONAL INSTITUTES OF HEALTH (1984) Liver transplantation—June 20–23, 1983, *Hepatology*, 4, pp. 107–110.
27. FLAVIN, D. K., NEVIN, R. G. & KELSEY, J. E. (1988) Alcoholism and orthotopic liver transplantation, *Journal of the American Medical Association*, 259, pp. 1546–1547.
28. STARZL, T. E., VAN THIEL, D., IZAKIS, A. G., IWATSUKI, S., TODO, S., MARSH, J. W., KONERU, B., STASCHAK, S., STIEBER, A., & GORDON, R. D. (1988) Orthotopic liver transplantation for alcoholic cirrhosis, *Journal of the American Medical Association*, 260, pp. 2542–2544.
29. SANTAYANA, G. (1952) *FBA book of quotations* (New York, Funk and Wagnalls).