

Organization of Public Technology

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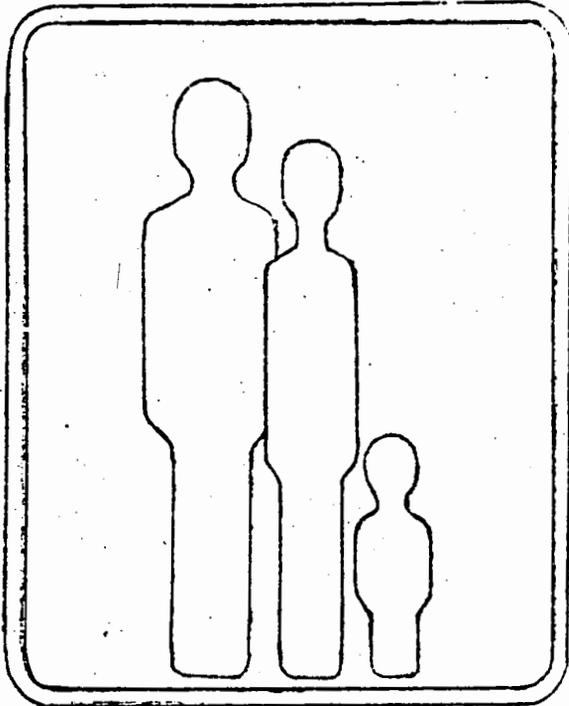
N O T E :

This folder contains excerpts from memoranda constructed for the purposes of the Organization of Political Technology Inc. (OPT) and its formation.

These excerpts are gathered into this folder to serve the purpose given in the accompanying letter dated 29 September, 1976.

Samuel A. Helm

1.



Organization of
Political Technology inc. **OPT**

(MEMO. TWO)

HEROIN MAINTENANCE:

An Alternate Modality

In short, there is no known therapeutic means of inducing the majority of the opiate addict population to become "drug free."

Those programs that have been tried have worked upon a select group of addicts and have generally been potentially effective for less than 15% (optimistically) of the addict population.

Methadone also cannot attract but a minority of the addict population and therefore can only be of limited effectiveness. Furthermore, there is no rational basis for hope that the criminal justice system will be able to make illegal opiate drugs unavailable to the opiate addict or to deter chronic addicts from using such drugs.

Also indications are that professional persons who are in a high socio-economic status represent a large portion of the opiate addict population, (where such persons are under stress, suffer anxiety and have access to such drugs).

Therefore, it would seem that seeking to suppress opiate addiction by raising the socio-economic level of the subject population would have a limited effectiveness where such a population is knowledgeable of the effect of such drugs, "socialized" to their use and capable of acquiring such drugs. In other words, eliminating poverty and racial inequalities will not be an adequate means of inducing the majority of the present opiate addict population to become "drug free" or non-addicts. Furthermore,

such socio-economic progress, even if accompanied by drug education, may not, as indicated by the high numbers of opiate addicts in the medical professions, lead to a great reduction in the incidence of new opiate addicts.

In reiteration, the conclusion is that we do not know how to treat the majority of the addict population for the causes of their addiction, nor, aside from some reducing of the availability of the drug, do we know how to prevent many persons from becoming opiate addicts, nor do we, beyond a certain point, know how to make the opiate drugs (and their substitutes) unavailable to present and potential opiate addicts.

The fact is that we only know one method of treating the majority of the opiate addict population for their addiction, and that method only treats some of the symptoms and indirect effects. That method is heroin maintenance.

Even heroin maintenance would tend to be counterproductive unless it were administered in such a way as to prevent the participant addict from misappropriating the "take-home" dosages of heroin.¹

Therefore, the problem is defined and the question is posed: "How to prevent misappropriation of take-home dosages of opiate drugs (namely Heroin) in a heroin maintenance program."

¹How much of "rush" effect is from mixture or "mix" and is an equally "pleasure" rush effect had from small dosages of high purity heroin?

The problem is finding a method or means of giving the drug to the addict in such a way that the person the drug is given to will be the only person who can use it.

Experience has shown that the honor system with opiate addicts is unreliable therefore that method is ruled out.

Also finding a long lasting, or long acting drug substitute for heroin would not be an adequate solution since such a drug would not have the attractiveness of "rushing" with heroin injections several times a day.

Also finding a heroin substitute that would only provide the opiate-like psychological action to persons treated with another long lasting synergic drug would not be adequate since an illegal market would soon develop to provide the synergic complementary drug.

Experience has also shown that "bargaining" with the participating opiate addict as to the minimum requirement of the addict's present tolerance level or level of addiction is an inadequate method. (Note some of the problems of the so called "British System").

Experience has also shown that providing harsh punishment for misuse of opiate drugs is not an effective means of preventing misappropriation of such drugs.

The alternatives are thus narrowed to the point that the conclusion is drawn by this author that the only apparent method of operating heroin maintenance programs that would be attractive to the majority of the opiate addict population, provide a secure means of preventing the misappropriation of "take-home" dosages of the drug and

allow the individual participating addict to regulate the amount and time sequence of taking the dosages is by the use of some kind of internal reservoir that could be operated by the addicts as they chose and that could be refilled at a secure clinic site.

The internal reservoir would prevent sharing or selling of the prescribed opiate drugs to anyone by any method short of extreme self-surgery, an unlikely action and one quite readily detectable.

Therefore, this paper turns to the problems of some of the design requirements and political and ethical aspects of such a device and such a program.

First of all, the technology of such a device must be designed and tested.

Heroin itself has already been well tested and the design of such an internal reservoir as shown in the accompanying sketches contains no totally new technology. Therefore, the major question is reliability of the design.

Reliability is a factor that becomes more manageable with the simplicity of the design. However, such a device as described here, while relatively simple, still presents great problems on the question of reliability. There are tens of thousands of opiate addicts in the U.S. and many many more around the world. Each of these addicts makes (usually) several injections or takes several dosages of their drug of addiction each day. Furthermore this internal reservoir must be able to remain in operation without repair for several years within the interior of the human body. These are not criteria easily met.

Such a device would need to be tested for a few years upon a sizeable test group before being made available for wide use. Following adequate and acceptable testing results the implementation of a program for making such a device available in a heroin maintenance program would have to be developed.

The results would be a time table of several years, perhaps as many as ten years, before full implementation could be achieved, and only then if major problems are averted.

However, vast numbers of people are suffering greatly from the problems of opiate addiction. Vast sums of money are being used. Addict related crime accounts for a major portion of the urban crime problem. The public and the addicts desire some improvement in the situation. For humanitarian reasons even treating part of the problem, as a maintenance program is largely designed to do, is a very high priority in some of the public's mind.

This is not to belittle the fact that a heroin maintenance program would be somewhat remedial to the root causes and the acerbative self-perpetuatory aspects of opiate addiction by a consequential effect; for such consequential effects would be large plus factors for an opiate maintenance program.

However, for many persons addicted to opiates a heroin maintenance program, with the use of the internal reservoir, would be largely a matter of relieving some of the symptoms and "buying time" for a more effective future solution.

For society at large such a program could also be considered an interim program to reduce the hardships of a large sector of its population, increasing their positive contributions to society, reducing the

inhumane effects of punitive drug laws and reducing addict related crimes. However, there seems to be well established ethical trends in law and of conscious that makes social considerations secondary on questions of severe medical alterations of any individual's body; even where such medical alterations are seemingly to the best interest of the subject individual unless the subject individual so agrees to such alteration, eg. sterilization. In other words, medically (surgically and chemically) altering an individual's body for the benefit of society at large where the subject individual objects and/or does not benefit directly is widely considered unethical.

An opiate maintenance program even with the use of the internal reservoir need not conflict with such ethical guidelines where the subject individual is already a chronic addict and intelligently agrees to enter such a program and where such addicts are continuously allowed to regulate their level of dosages and/or periodic or permanent abstinence.

At the very least an opiate maintenace program would reduce many of the psychological, economic and health deprivations of the addicts' addiction, would allow the addict an improved opportunity to stablize their personal lives, (perhaps to the point of being more inclined to see the need to participate in the "drug free" therapeutic programs) and would tend to remove much of their need to raise money by criminal activities.

In other words the program would relieve some of the symptoms and elements of the self-perpetuating cycle of opiate addiction.

I suggest further research be conducted on this matter in order to further analysis the feasibility of the foregoing ideas.



MEMO

NUMBER THREE

SUBJECT: Highway safety and efficiency

To a very large extent the present 55 m.p.h. speed limit is not enforced, if indeed it is enforceable. For "truckers" the 55 m.p.h. speed limit does not save fuel (in fact may increase fuel consumption) and results in a decrease in the labor and capital-use efficiency of both the truck, the truck driver and the highway system.

The truck driver and indeed the entire driving population seems to be frequently exceeding the 55 m.p.h. speed limit. The result is an increased conditioning to disregard the law and an increased level of anxiety in the lives of vast numbers of drivers, particularly professional truck drivers.

The 55 m.p.h. speed limit does seem to discourage long automobile trips and thus results in some decrease in automobile related injuries? However, travel requires more time on the highway for those that do travel and thus longer exposure to opportunity to be involved in accidents? What are the facts and how important are they?

It is difficult to determine the safety factor of a 55 m.p.h. speed limit and even more difficult to balance that safety factor against the utility of highway-use efficiency that results from higher speed limits.

The ideal solution would be to have both higher speeds and greater safety. To that end a study of the following system is suggested.

Suppose a system or plan were devised whereby all automobiles which had approved air-bag collision restraint devices for all front seat passengers were by law allowed to travel at the old 70 m.p.h.

speed limits (where such a speed limit applied). Such automobiles could be given special highly visible license plate markings as to designate which autos had such air-bag collision restraint devices.

The results might be that within a few years most automobiles would have air-bag collision restraint systems. If so the automobile related injuries at all speeds would be sharply decreased and the inefficiencies of the 55 m.p.h. speed limit would be eliminated to a large extent.

The fuel saving factor of the 55 m.p.h. speed limit would be compensated for by the increased safety of the highways and streets.

Further study could more clearly show one way or the other the feasibility and practicality of such a system and the validity of the above assertions.



MEMO

NUMBER FOUR

SUBJECT: A pneumatic tube, address to address, small item, delivery system

I suggest that a new type of public utility might well be possible and practical. Namely, an automated small item delivery system.

Suppose that each house and business place had a "dumb waiter-like" cabinet door in the wall out of which wheeled, tube-like containers the size of gallon milk bottles could be taken, opened up, filled with mail, or compacted or compressed garbage, or cake for grandmother, or books to or from the library, or papers to a client, or deposits to the bank, or food from the local grocery store or hamburger stand, etc., etc., and then electronically addressed, replaced in the "wall cabinet" and thus via a system of pneumatic tubes and electronically controlled devices be carried off to the designated address.

Such a system could possibly replace the mail man, paper boy, garbage man, and most small item delivery personnel with a more efficient system and also open up many new services and conveniences for the homeowner, apartment dweller and business person.

I suggest that such a system be studied further for feasibility and practicality.

MEMO

NUMBER FIVE

SUBJECT: Interstate highway (four lanes) electric rail auxiliary power system:

With the present shortage of energy particularly energy from fossil fuels perhaps an electric auxiliary power system primarily designed for use by trucks, but adaptable to private passenger cars use, could be devised.

Suppose a guard-rail-like electric power source ran along the right side of interstate expressways. Heavy trucks could be outfitted with auxiliary electric power systems and by means of a contact arm (somewhat like the old street cars) extending out from the side of the truck the individual trucks could draw power from the electric rail to operate their auxiliary electric motors. The trucks' conventional diesel engines could be kept running at an idle speed, ready for use whenever the trucks needed to pull away from the electric rail for any reason.

By such a method, diesel fuel use could be reduced, the air pollution and noise levels abated and the electricity could be cheaply produced at a central location and cabled to and along the rail.

I suggest a study of such a system be undertaken.



MEMO

NUMBER SIX

SUBJECT: Toward a program for survival

Individual survival and good physical health are two very high if not the two very highest values or desirable states of affairs in the minds of happy and rational human beings. However, the irony is that these two values are two elements of human life that are thus far unobtainable for more than several fleeting years.

Thus one might think that relatively large amounts of human and material resources would be being expended toward finding a solution to such problems. But no, relatively large amounts of resources are not being expended on medical research. In fact in 1973, a record year to that date, less than five cents per capita per day (for each U.S. citizen) of government funds were being expended for medical research purposes and private medical research monies were considerably less.

Therefore, the question arises as to why this relatively small expenditure for such an overriding need or problem.

The answer seems to be that there is a widely held belief that science and technology will be and can be of only a very limited efficacy in finding a feasible means of maintaining individual physical health and thus in turn maintaining long term individual survival.

However, since the issue is no less a ponderous matter than that of the wellbeing and survival of many succeeding world populations, whatever our feelings of intimidation over the novelty of the matter may be, some further questioning of such a pessimistic assessment of the efficacy of science and technology and indeed of the future of all humankind would seem to be in order.

To begin with, many people seem to think that bringing about large scale, long term, individual survival would create unmanageable population problems and place unmeetable demands upon the Earth's resources. Therefore, in these peoples' minds even if science and technology were to solve the medical problems of long term individual survival it would all be to little avail, because the non-medical problems would, by themselves, be deadly or intolerable.

However, such a belief may be unnecessarily pessimistic. Why should one see the problems of population growth, provision of goods and services, provision of greater space, and etc. that would be needed for caring for a population of long-term surviving human beings as necessarily unmanageable? There are no physical reasons as to why such problems would necessarily be unmanageable. Furthermore the challenge of such problems is surely less frightful than the present realities.

Secondly, many people seem to think of long term individual survival in terms of living long years in a state of decrepit, wrinkled, run-down physical health.

Obviously long term individual survival in a state of poor physical health is not a very desirable state of affairs. But here again, long term individual survival need not mean that physical age must be commensurate with chronological age.

To truly test the value of long term individual survival one should cast the hypothication in the most desirable of conditions. For example, what would be the desireability of long term individual survival with a body healthy in all respects; namely, a body that would be physically youthful irrespective of the individual's chronological age?

One would hardly expect a well adjusted, rational and happy,

one hundred year old person with a body of a contemporary twenty five or thirty five year old person to suddenly one day decide that they had had enough of life and thus do away with themselves.

One would suspect that given continued good health, physical beauty, an intelligent mind and a comfortable environment one would hardly be less than adamantly motivated toward continued personal survival.

Therefore it would seem that as to the question of the desirability of long term individual survival the answer would be and is an overwhelming "yes", given the above conditions.

The question that remains is one of theoretical medical feasibility.

Looking at present typologies of medical modalities, one may see four modes of medical treatment; namely, prevention, repair, substitution and replacement. These modalities either individually or collectively, do not offer a theoretically feasible model for large scale, long-term, individual survival.

Considering each modality successively; obviously, all injury, particularly accidental injury, and the injury of ordinary wear and tear of the human body cannot feasibly be prevented. However, some injury can be prevented and much of that that can't be prevented can be repaired. Yet, just as obviously, some injuries may be so total as to be beyond repair.

Here again some injured parts of the human body that can't be repaired can theoretically be substituted with prosthetic devices. However, eventually, at some point in the progression, a prosthetically repaired human body would become aesthetically and emotionally undesirable.

But here again the use of prosthetic devices could theoretically

be avoided by using actual human donor replacement parts to repair or replace injured or unworkable parts of the body. Obviously in many instances, in order to have a donor transplant, the donor would necessarily be a cadaver. Hardly, an ideal solution or mode of medical treatment since such a mode of treatment could not operate unless some percentage of the population frequently died.

Yet once again, theoretically, transplantable human or human-like body parts could be cloned and grown in laboratory-like organic cultures by artificial means.

However, the replacement modality would still not work in cases of injury or deterioration of some portions or parts of the patient's brain because to replace the patient's brain without replacing the patient's memories from the injured brain into the replacement brain (or portion of the brain) would be the same as replacing the patient with a new or another human being, since the patient's awareness of being alive and being oneself is seemingly a function of memory data operative within a reflective consciousness. Therefore, the result would be the death of one human being or individual and the creation of another. This conclusion makes the reasoned assumption that the identity, the self-personality is the function of a continuity of a memory data set operative within the medium-mechanism of a conscious, reflective brain.

Therefore, if one is to devise a theoretical model of long term individual survival for the entire human population (at some point in the future): one must add another type of medical treatment to the previously mentioned four types, namely, the modality of memory transcription.

Now that one is into the never never land of theoretical medicine, the question that arises is how to take memories from an "old" brain and place them in a "new" brain.

The point to hold in mind is that memories are abstractions. On paper memories can exist in a spatial arrangement of ink; in an electronic computer, memory can exist in an electrical or magnetic charge on a tape or with some minute alterations in the memory core or components of the machine.

This is likewise to say that memories are recorded in the brain by many billions of minute alterations of some substances within the brain (although the precise mechanism is not fully understood as of yet). Therefore one need not physically transplant the substance that contains the billions of minute alterations in order to transplant the patient's memory; rather one would need to but duplicate or transcribe similiar minute alterations into the substances of the "new" brain.

The problem would be to create, that is to clone and artificially grow into a mature or near mature structure a human body, complete with brain, without ever having allowed such a human body or organism to have achieved consciousness and thus memories and an identity of its own.

For, to allow a human brain to have obtained consciousness and thus memories would be to have created another human being or personality worthy in its own right of survival, given the rationale of this modality.

Also, to have duplicated and transcribed a patient's memory set into a new human organism's brain while leaving the original memory set yet in the original brain in a conscious state would be to have created

duplicate human beings; both, given the rationale of this transcription modality, worthy in their own right of survival. The result would be to have accomplished nothing toward the improvement of the health of the original patient.

The transcription process would therefore necessarily require removal of the patient's memory set from the patient's "old" brain before placing or transcribing it into the "new" brain of the "new" body.

In fact, to assure that the individual's memory would be available should the individual be involved in an accidental injury that would result in destroying the brain so totally as to destroy the memory data stored within it; theoretically, a means might be devised for placing a near-current duplicate memory in storage ready for transcription should such an accident occur. The result would be a loss of memory between the time of the duplication and the time of transcription.

Obviously the technological problems of realizing such a model of medical treatment are immense; not only the immediate technology but also problems of providing and organizing the resources necessary to provide and maintain such a model of treatment for use by the entirety of the human population and at the same time maintaining a comfortable environment for all.

One might imagine that such a model would necessitate a vast number of highly skilled and competent persons of all professions. To meet such a necessity the means might very well be found in the basis of the problem. For it would seem to follow that if one could devise

a means of transcribing memory data directly into the human brain by chemical, electronic or some other artificial means, one might likewise be able to devise a means of directly transcribing or inducing into the brain's memory bare technical data, learned co-ordinative sets and methodological ratiocinations necessary to the performance of certain skills and vocations.

Of course, to even the intellectually near-moribund the first mention of medical treatment upon the human brain "brings forth ethical questions that tower and rage like volcanoes upon a bucolic plain," (if you'll forgive the simile). Pictures of potential dangers, abuses and terrible misjudgments seem as formidable as military mine fields in a dust storm. Visions of offal specters stalk the far reaches of one's worst fears and etc."¹ (or so one might imagine such criticism.)

In reaction one might become paralyzed by the horrendous potentialities and prefer to continue to live, suffer and die with present realities,² totally lethal as they are.

¹Prejudice throughout human history against medical science, indeed against all sciences has greatly retarded the development of humankind's ability to cope with the problems of human suffering human achievement and human survival. As a result billions of people have died and will die. Billions suffer the poverty and pain of our civilization's incapacibilities to cope with the problems of life. Science, as primitive as it is even today, has demonstrated again and again that only with knowledge and technology can even the very best of people hope to cope with our problems. Prejudices against science and technology do not account for all scientific controversy and indeed one must be careful not to brow beat all critics with such an implication. However, those persons who suggest submission or surrender to the deprivations of human poverty, illness and death, in my opinion, fully deserve to be brow beaten for the nihilistic, facile, inhumane and pessimistic mentality of such dispositions.

²"Barbarism may return on the wings of science" (Winston Churchill)

On the other hand, if one adheres to a rationale of humanitarian progress, one may see the present real human condition as a poor measure of humanitarian accomplishment when the alternative of universal good physical health and long term individual survival, (as a highly educated and competent civilization) is a possibility but awaiting a correct development of enabling technology.

The ethical questions which are ultimately humanitarian questions are indeed a frightening challenge; so frightening, in fact, that the challenge may go unmet. Our social and political systems and decision makers may be so paralyzed or turned-off by fear of the novelty and controversy of the challenge as to prefer the status quo or an unplanned, gradual, incremental approach of non-decision.

It has been said that we live in a "political mediocracy"; where consistent mediocre achievement is more acceptable and highly rewarded than great but inconsistent achievement. In such a system novelty, creativity and experimentation are greatly inhibited. In the sociological and political professions creativity is viewed with suspicion and, barring considerable success, likely to lead to a reduction in one's credibility or professional reputation. Little wonder that career minded political leaders tend to avoid creativity, for experience shows that inventors have many more failures than successes, that for scientists most experiments do not prove their hypothesis or result in great discoveries, and that for artists, most new ideas or creations are scrapped or greatly altered before completion.

We live in a world where humanitarian problems are so great as to be beyond any person's capacity for empathy, yet we have no greater fear than that of change from the status quo. In this world fear of change is a huge irony. It has been said that the "greatest thing we have to fear is fear itself", fear of change, that is, or the paralysis of fear and distrust of our own abilities.

Nonetheless, we live in a dynamic age where most human knowledge is but a few decades old. Where one hundred years ago our forefathers crossed the plains (to settle the West) in covered, horse-drawn wagons. We can change, and we have. The question is to decide when our fear of change is reasonable caution and when it is blind fright.

To consider the political and social obstacles to change to be too great to overcome would be unnecessarily pessimistic, (as recent history has shown).

Social acceptance often follows or co-extends with creation of technical feasibility rather than feasibility following social acceptance.

Ideas that are otherwise worthy of further study should not be considered stillborn, in my opinion, simply because they are presently politically unfeasible.

Therefore, in my opinion, further study of this foregoing theoretical medical modality deserves consideration.



MEMO

NUMBER SEVEN

SUBJECT: The Development of a Model of Rapid Economic Growth

Simplistically stated this country is pungent with poverty.

The goods and services of housing, education, health, transportation, recreation and personal and environmental aesthetics are neither of adequate quantity or of adequate quality.

Much of our wealth is symbolic and the majority of the people "enjoy" it only or largely out of vicarious empathy with those few persons who do in some respects actually have wealth. The delusion is that we are a wealthy country because some of the country's people in some ways are wealthy; that we are a country of beautiful homes because some people have beautiful homes; that we are a nation of beautiful women and handsome men because some women are beautiful and some men are handsome; that we are an educated people because some of the country's people are in some respects well educated; that we are a people of good health because some of our people have good health for several years etc. etc. The delusion of wealth and accomplishment is perpetuated largely because the "best" of our country receives the highest emphasis and the greatest saliency both in our media and in our minds.

We live in the shadow of those persons and things that are our standard bearers of "excellence". Our selective perception of our social and personal realities allows us some peace of mind and affords us, as human beings in a primitive world, great ability to adapt to the most exigent circumstances in a manner that befits our perception of our limited abilities. In other words, if we perceive that there is no available solution

to our problems, we by a process of rationalization and selective perception perceive that there is no urgency to our circumstances. The result is a combination of delusion, orthodoxy and apathy that is self-realizing and perpetuating of the vapidty and inhumanity of the status quo.

The point to ponder is the erroneous perception of our limitation of our ability to solve our problems; to right our wrongs and to create a better, more humane world for ourselves; both as individuals and as a society of human beings.

Economics is known as the "dismal science", and indeed it is when viewed in the harsh mathematics of the prerequisites of "savings", "capital growth", "labor efficiencies", "raw materials", and etc. Often economic projections are made or concluded with the qualifier "barring institutional and/or technological change", or "everything else being the same." Which, in many ways accounts for the label of "dismal science," for without institutional and technological change the potential for rapid economic growth is indeed dismal.

Thus, the question arises as to why or why not one should bring about institutional and technological change.

To begin with, some kinds of institutional changes are so politically disruptive as to be counterproductive. For instance, the elimination of private capital or the elimination of government capital in some countries would be so disruptive socially, economically and professionally as to retard production for decades.

On the other hand technological change is difficult to plan for or to predict, and expending so many dollars and/or so many hours of human resources does not necessarily result in the invention of the telephone, the automobile, or a cure for cancer, and etc. This

seeming unpredictability of creating technological innovation has resulted in the relegation of scientific and technological innovation to an area of "never never land" in our economic planning.

Yet it is only with institutional and technological change that rapid economic growth can be realized. Obviously the problem is to find a means of acquiring the benefits and avoiding the dangers.

To give an example of the problem; the housing shortage or problem might be approached by a federally funded mortgage interest subsidy. But as a result of the increased demand for construction materials, services and labor, the price of such items (or other consumer goods) might increase sharply, thus offsetting the stimulatory effect of such a mortgage interest subsidy.

The solution would seem to be to tie the mortgage interest subsidy to an increase in production efficiency of new housing and/or housing construction materials production (some general, comprehensive plan would eventually be needed for other items).

Here the problem with the solution is that production efficiency or indeed efficiencies of any kind eventually tend to mean reduction in human labor involved in the production per item, service or product, which in turn may result in unemployment rather than economic growth unless the unemployed persons that resulted from the production efficiencies are reemployed or utilized for other production.

Therefore, a model of rapid economic growth would seem to require an increasing of demand followed by an increase in production and production efficiency followed by an increase in demand followed again by an increase in production and production efficiency and etc. in a rapid and vigorous or high velocity cycle that involves a high level

of utilization of production resources, particularly labor.

Institutional change can provide the stimulus of demand and condition it upon increased production efficiency and balanced social development while technological change can carry the majority of the burden of creating production efficiency opportunity per se. To such an end institutional change may be needed to stimulate technological innovation as well.

The question is can such a model of rapid economic growth be designed; and if designed, can such a model be made manageable and politically feasible?

One could conclude that such a program is little more than simplistic rhapsodizing about the future. On the other hand one could conclude that there is something wrong with the present situation wherein great poverty and technological inability afflicts the entire population while millions of highly capable and eager labors or people, are unemployed and vast resources, both human and material go unused or under utilized. To conclude that our institutions and our systems cannot fully utilize our resources to the highest and most rapid elimination of our impoverishment is to conclude that our systems and institutions should be replaced by others that can. One can hardly justify the status quo. In other words, the rational pursuit of a more humane society would seem to require that we as a country either more fully and efficiently utilize our systems and institutions or acquire some new ones.

The latter alternative is hardly attractive to many people and is not necessary, in my opinion. Specific technological innovations can

be designed, as stated above, to fit such an economic framework into our present system, once such a framework is understood and receives the political commitment of the federal government's legislative and executive branches and the general public.

The first task is to design and study such an economic framework of rapid growth and distribution of goods and services.

I suggest that a study of such an economic model (and framework) of rapid economic growth be undertaken and reported upon.



A P P E N D E X

Technological Change by E.G. Mesthene

"Thus much potentially valuable technology goes unused, because the public at large is insufficiently informed about the possibilities and their costs to provide support for appropriate political action." page 37

"The general point is that political action in a democracy depends on the availability of abundant, accurate, and widely disseminated political information." page 37

"Business corporations finally, which are organized around the expectation of private profit, are insufficiently motivated to bring new technology and management know how to bear on urban projects where the benefits appear to be largely social." page 36

"Where technological possibility continues to lie fallow, it is to improve political information and to innovation in political institutions that society must attend if it is to use its tools to their full effectiveness." page 38

"Technological innovation therefore leads ultimately to a need for social and political innovation if its benefits are to be fully realized and its negative effects kept to a minimum." Preface page viii

"If the expected benefit to himself is greater than the cost he will have to pay, he goes ahead. In making this calculation, the individual decision maker does not pay very much attention to the probable benefits and costs of development to others than himself or to society generally... These latter benefits and costs are characterized by economists as external." page 39

"What we mean when we say that a society is committed to certain values is that the people in that society will typically make judgments and choose to act in ways that reveal and reinforce those values. It is equally clear that choice behavior is determined, or at least circumscribed, by the options available to choose from at the time the choice is made." page 49

"Technology has a direct impact on values by virtue of bringing about just such changes in our available options. By literally creating new opportunities for action, it offers individuals and society new options to choose from." page 50

"When technology brings about social changes...that impinge on our values..., it poses for society a number of problems that are ultimately political in nature." page 63

* "The term 'political' is used here in the broadest sense: It encompasses all the decision making structures and procedures that have to do with the allocation and distribution of wealth and power in society." page 63

"Galbraith concludes that there is a bias in the economy generally in favor of development and satisfaction of private needs to the neglect of public needs and, therefore, a relatively slow rate of innovation in the public sector.²¹" page 72

"By contrast, there exist only relatively inadequate institutional mechanisms devoted to exploring technological possibilities for socially desirable public goods and services." page 74

"They have not been motivated to invent "new dishes" for the social menu" page 73

"...the incommensurability of individual incentive and public will..." page 75

"In the end, therefore, the problems that technology poses (and the opportunities it offers) will be resolved (and realized) in the political arena..." page viii of Preface (parentheses added S.A.H.)

"great faith in the social efficacy of scientific methods and tools..." page 17

"Technology may be the motor of all progress, but institutional sluggishness will most often turn out to be a very effective brake." page 22

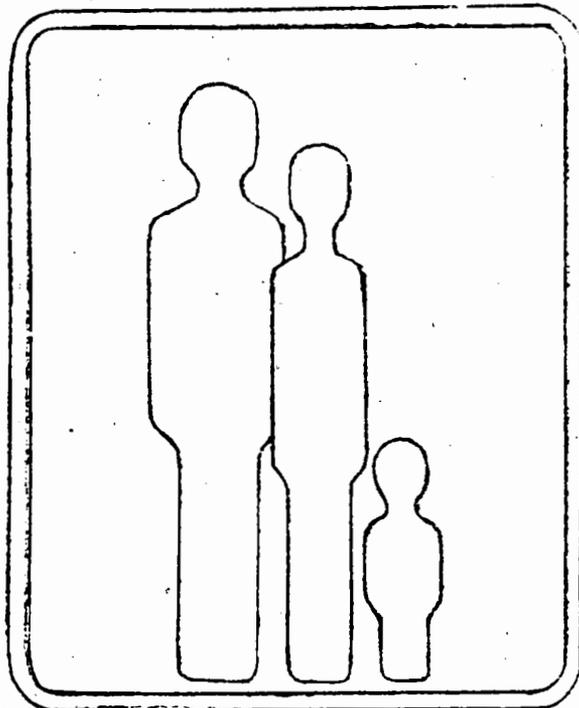
"...we define technology as the organization of knowledge for the achievement of practical purposes." page 25

"... our society is coming to a deliberate decision to understand and control technology, and is therefore devoting significant effort to the search for ways and means to measure the full range of its effects." page 25

"... any given technological development is likely to combine positive and negative effects." page 28

" Some previously distant aspiration may thus be converted into an achievable goal." page 28

2.



Organization of
Political Technology inc. **CPT**

HYPOTHETICAL

PROSTHETIC-LIKE DEVICE NECESSARY
TO FULFILL ONE OF THE PREREQUISITES
OF THE HYPOTHETICAL LEGISLATION FOR
A HEROIN MAINTENANCE PROGRAM:

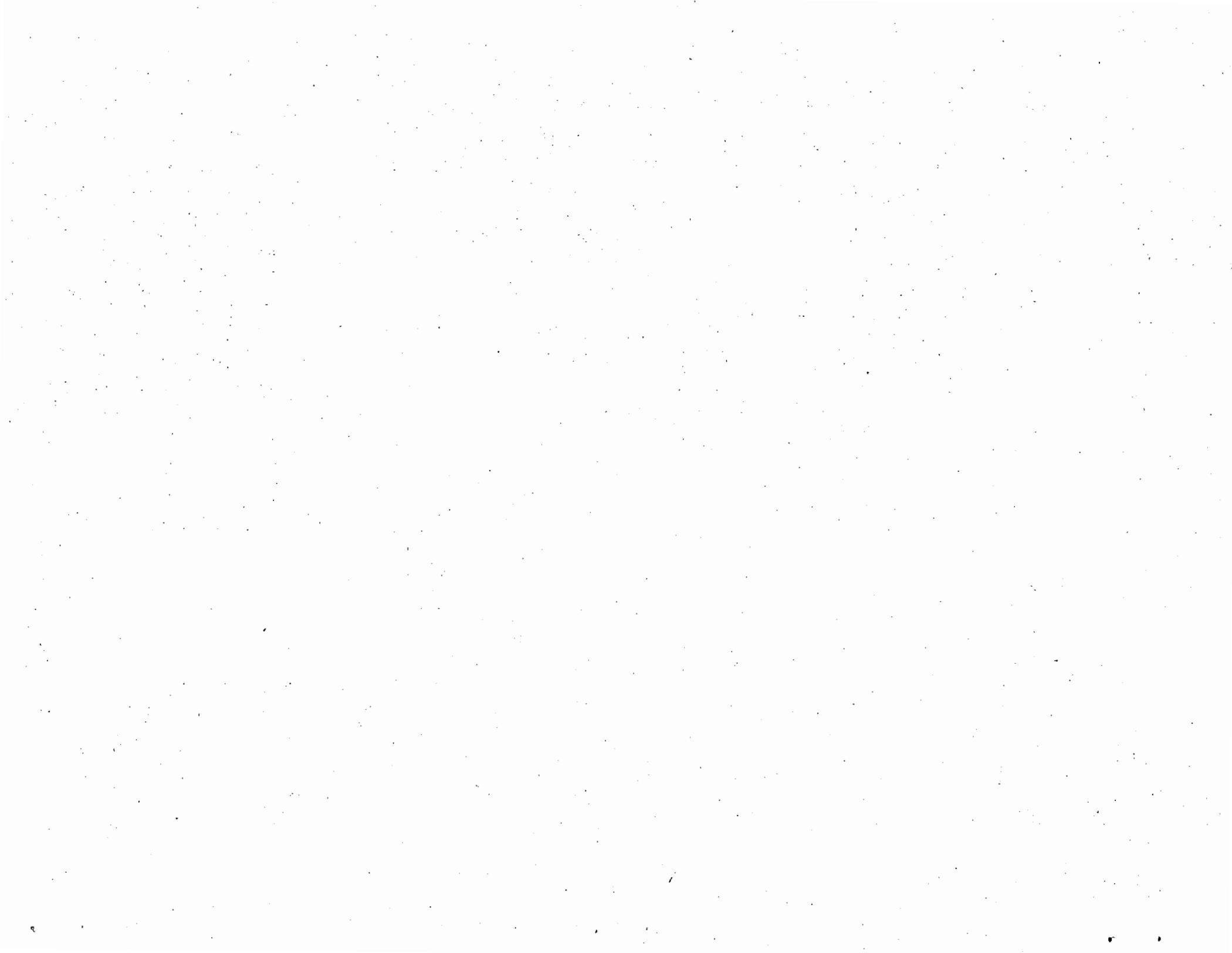
NOTE:

This device is not intended as an actual working model but as a laboratory model designed to show the principles and demonstrate the prerequisites of such a functional mechanism. It is from the demonstration of the principles of such a mechanism that further analysis of the hypothetical legislation is made possible.

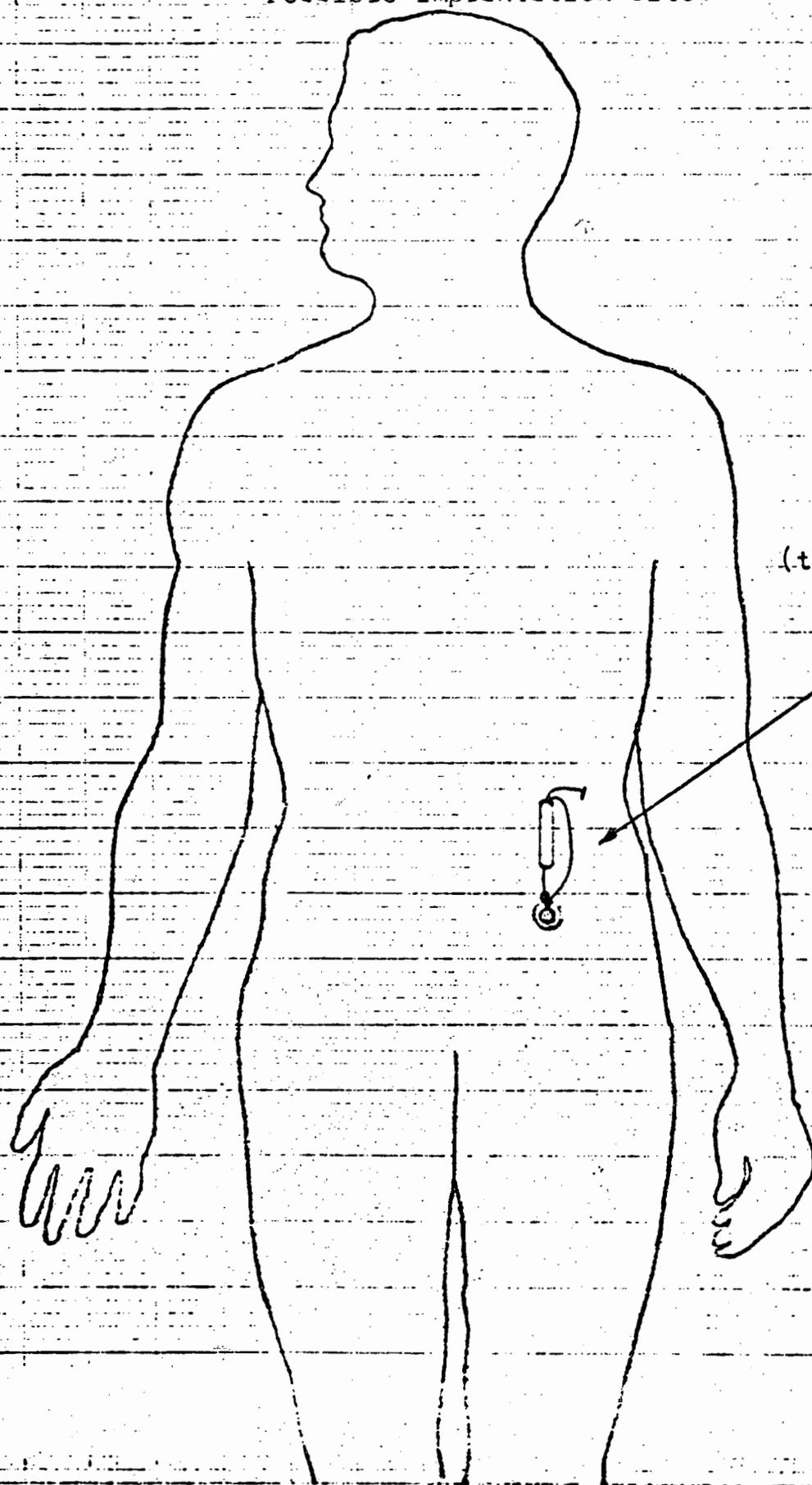
OPERATIONAL PROCEDURE OF HEROIN MAINTENANCE
PROGRAM:

Sequence of procedure:

1. Addict makes application to enter program
2. Applicant is identified and addiction determined
3. Addict is familiarized with operation of program
4. Addict decides to enter program
5. Addict's health is determined as to fitness for program
6. Reservoir device is surgically implanted in addict
7. Addict is familiarized with proper operation of reservoir device
8. Clinic technician fills reservoir device with drug solution and issues H₂O syringe (s) to addict
9. Addict returns to whatever out-patient life style he or she may arrange
10. Addict injects H₂O into reservoir mechanism with use of syringe as addict would the actual drug otherwise. Injection of H₂O into reservoir device (as per sketches) will result in a small amount of concentrated heroin being injected into the vein or muscle of the patient.
11. The addict continues periodic injections of H₂O (as per sketches) until the reservoir is near empty (as level of addiction demands)
12. Addict returns to the dispensing clinic (local hospital) and a clinic technician refills the internal reservoir
13. Addict returns to out-patient life and repeats procedure "11."



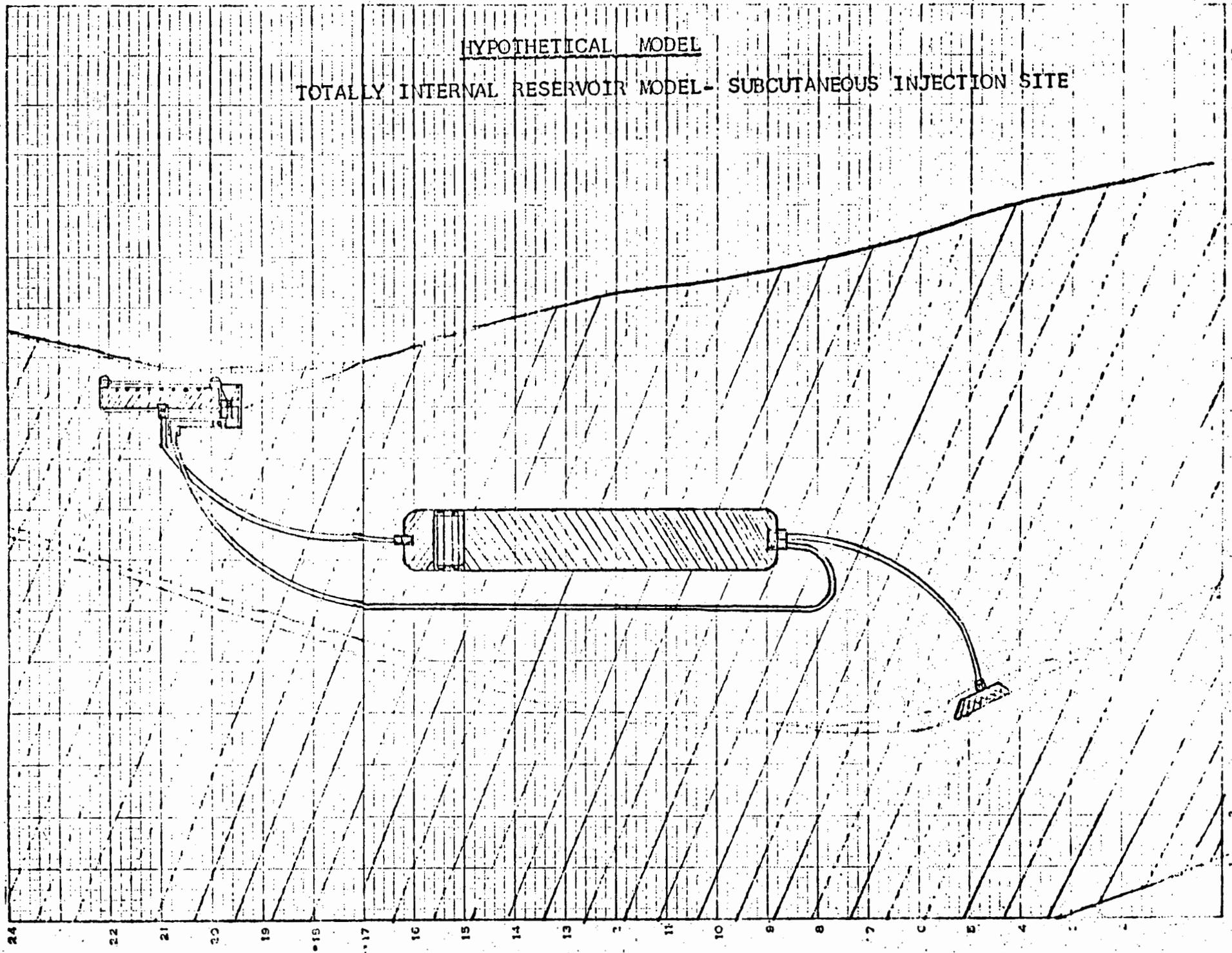
Possible Implantation Sites



surgically
implanted device
(totally internal)

HYPOTHETICAL MODEL

TOTALLY INTERNAL RESERVOIR MODEL - SUBCUTANEOUS INJECTION SITE

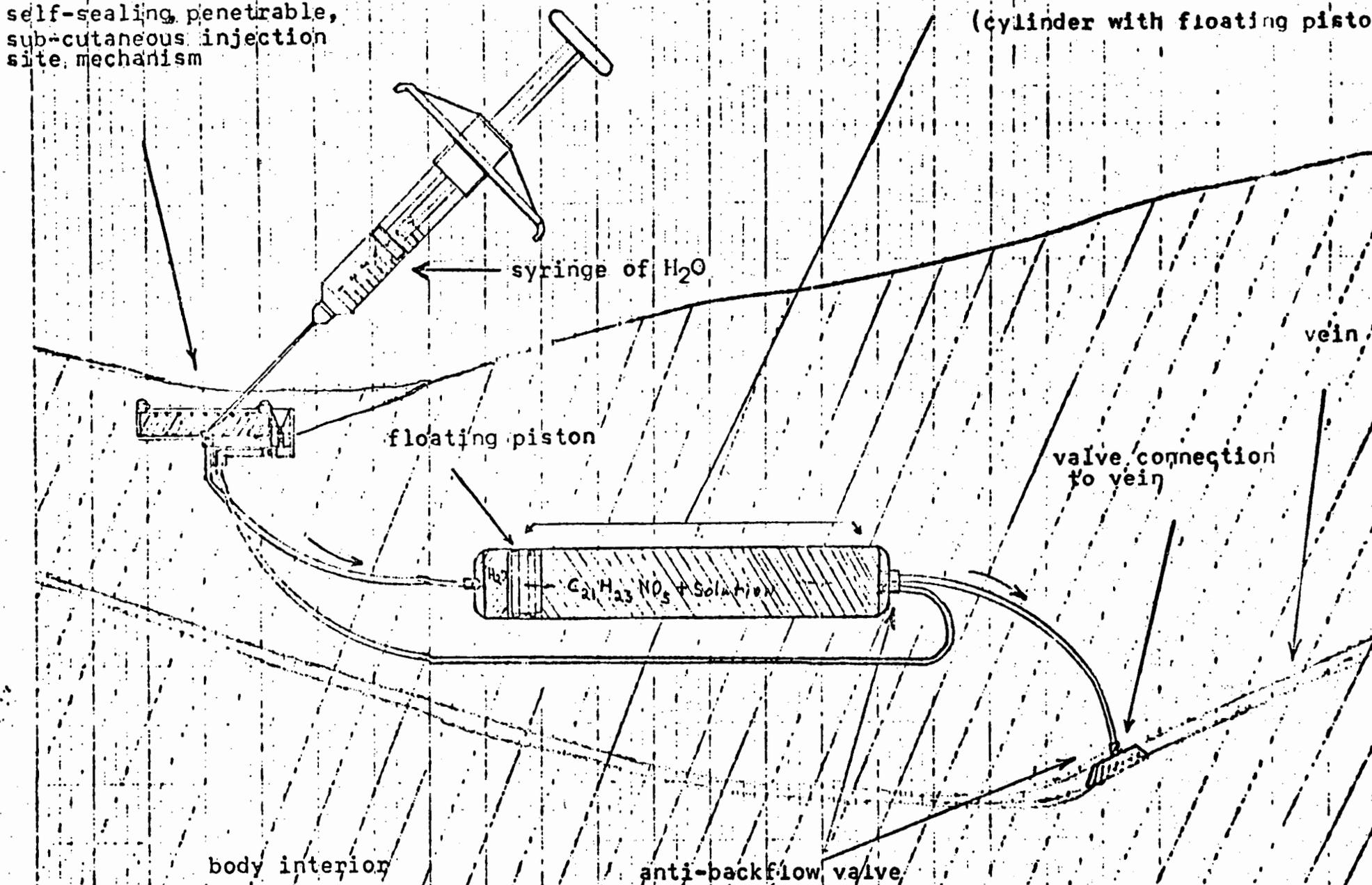


HYPOTHETICAL MODEL

(surgically implanted reservoir of $C_{21}H_{23}NO_5$ in solution)

self-sealing, penetrable,
sub-cutaneous injection
site mechanism

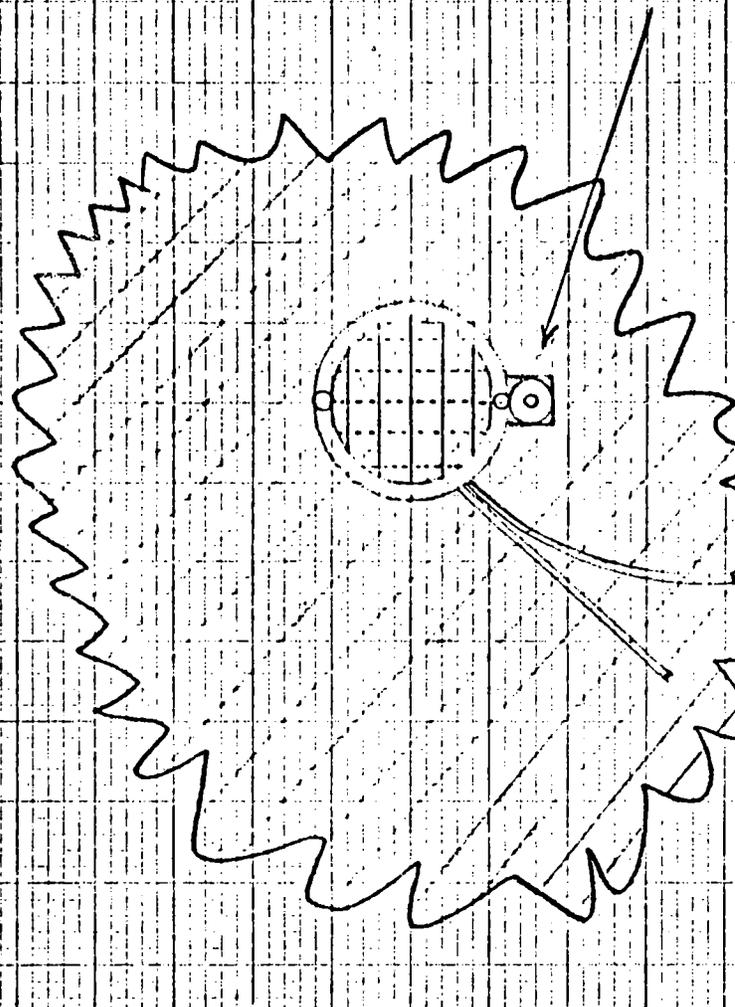
(cylinder with floating piston)



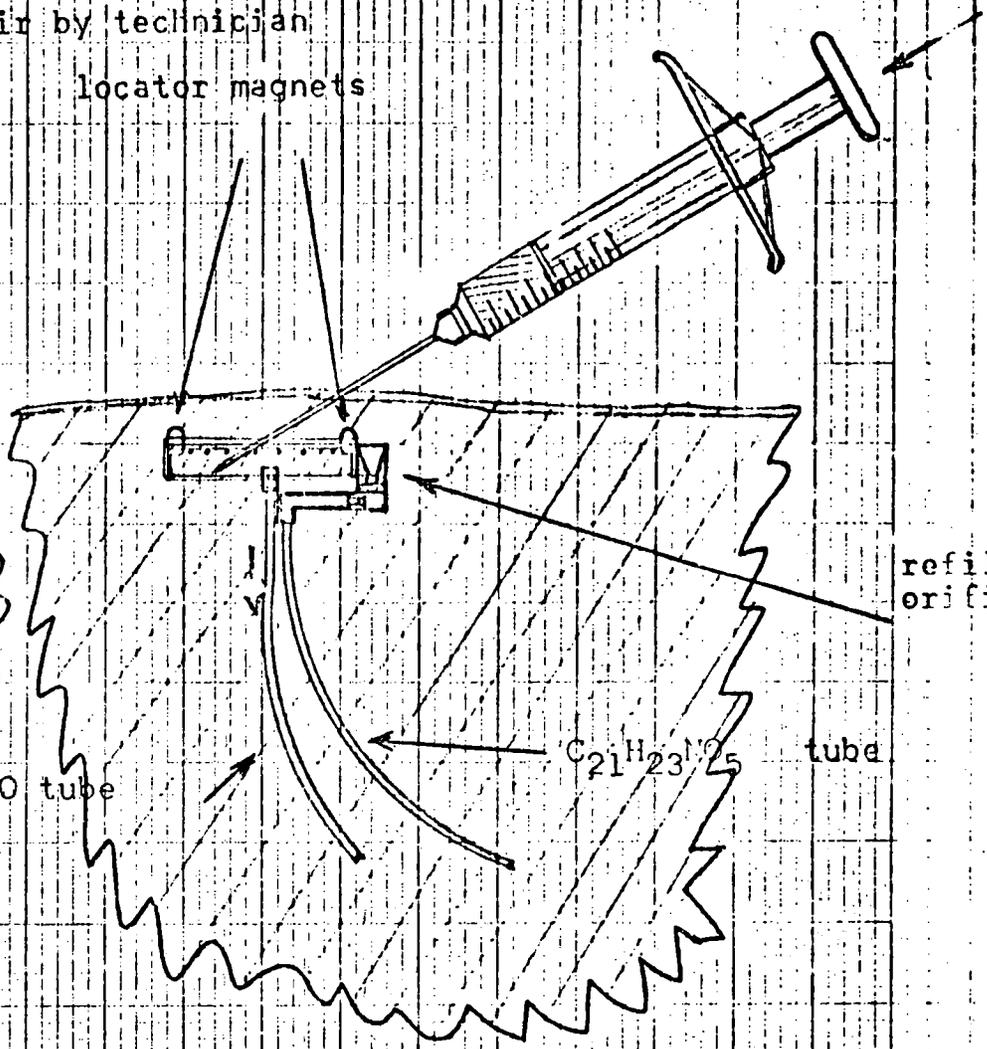
DETAILS SKETCH

funnel shaped guide with threaded orifice for refilling reservoir by technician

locator magnets



Top View

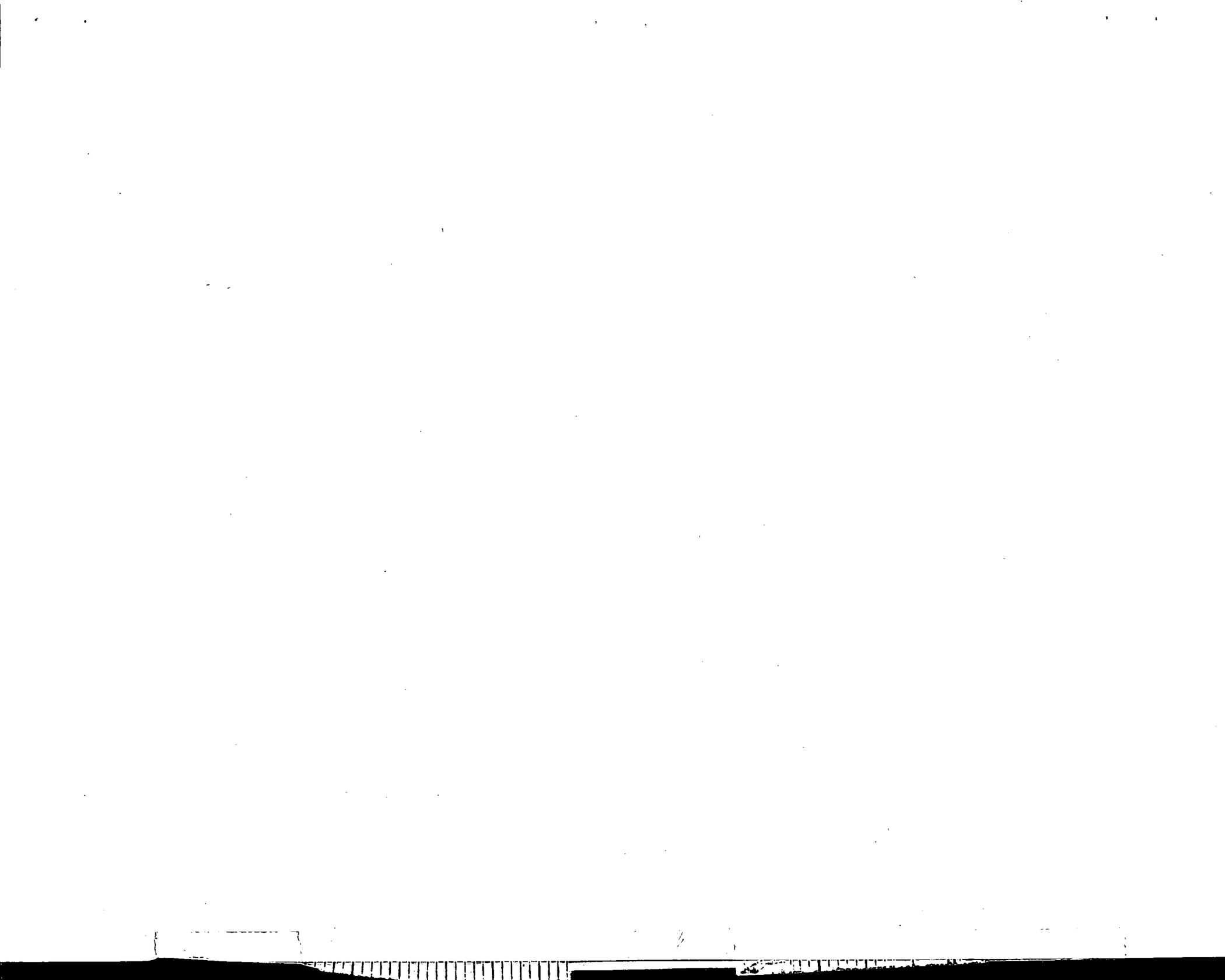


Side View

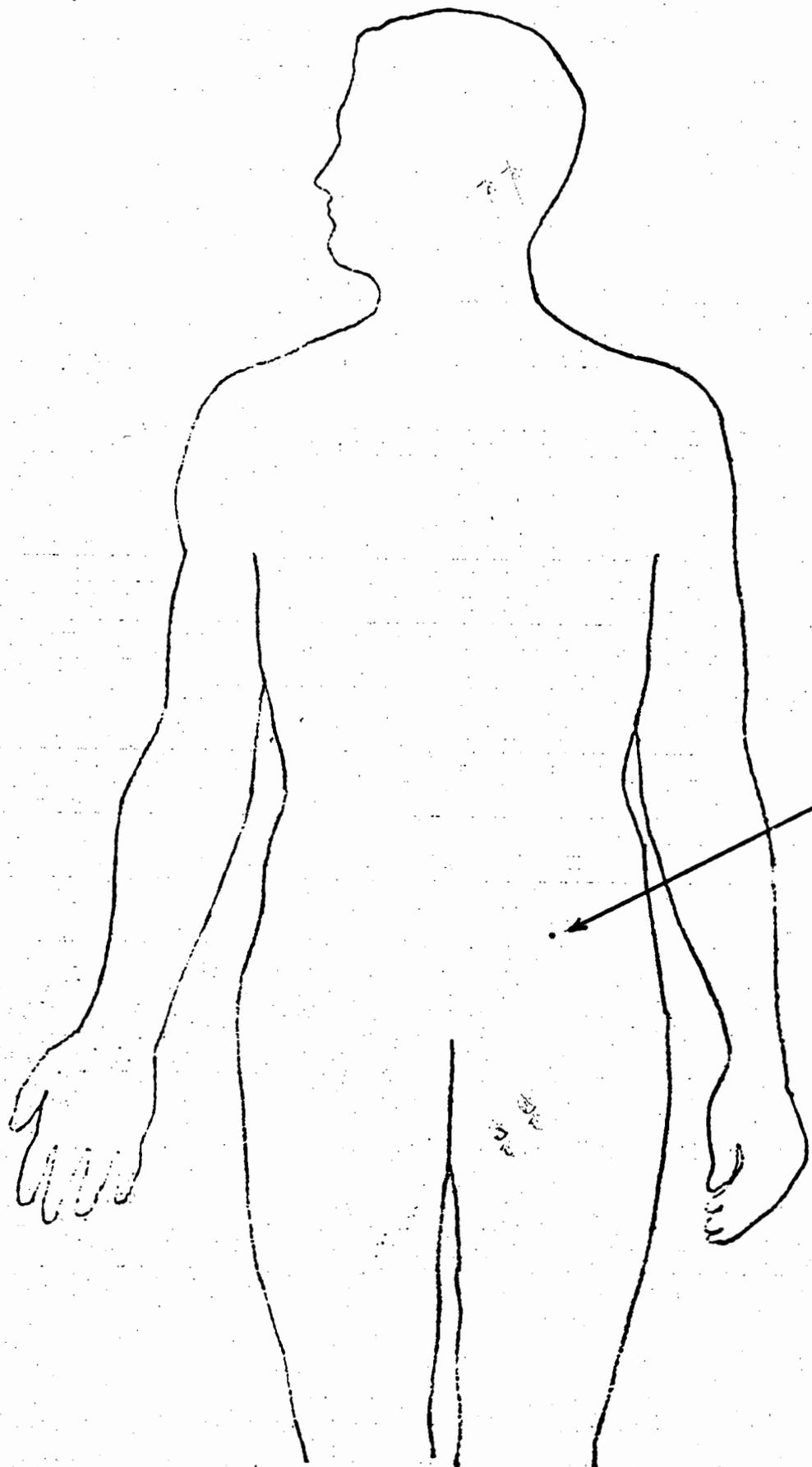
refill orifice

C₂₁H₂₃N₅ tube

H₂O tube



Possible Location of Pyrolytic Carbon Button Valve



Exterior
valve site

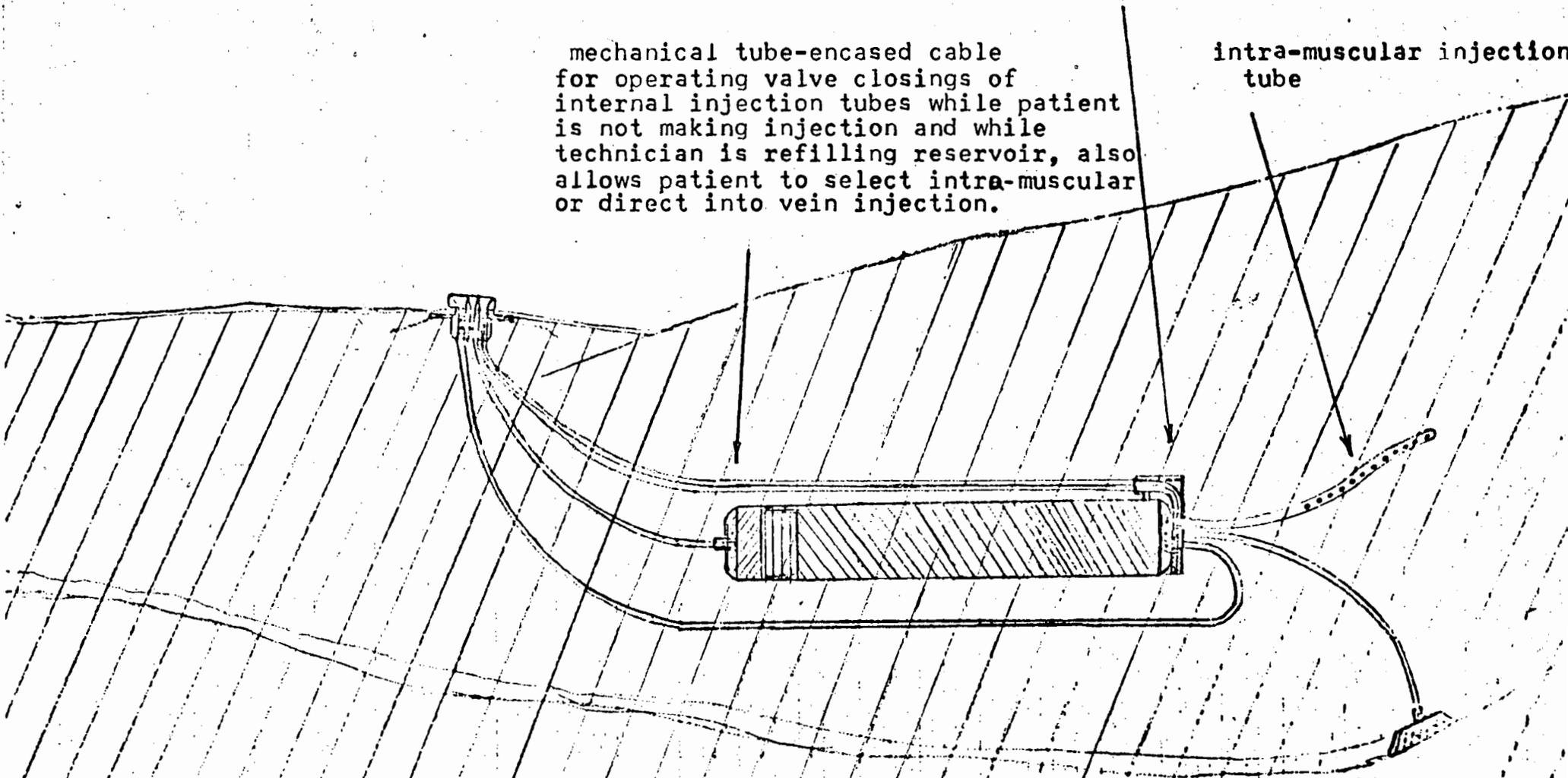
MODIFIED DESIGN OF THE PYROLYTIC CARBON, EXTERNAL, BUTTON, VALVE MODEL

(safety valve is added and intramuscular injection option included)

valve closing switching mechanism

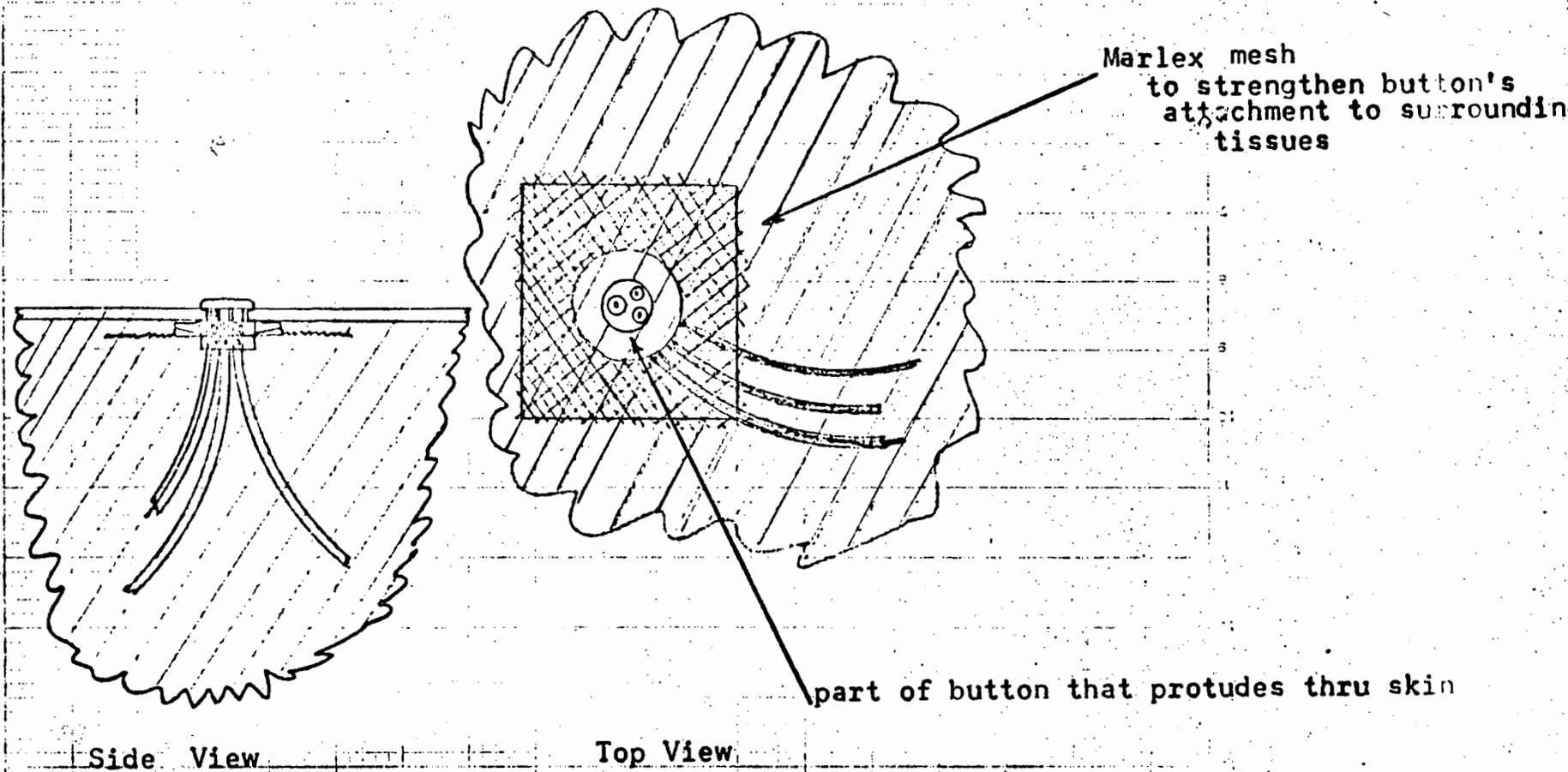
mechanical tube-encased cable
for operating valve closings of
internal injection tubes while patient
is not making injection and while
technician is refilling reservoir, also
allows patient to select intra-muscular
or direct into vein injection.

intra-muscular injection
tube



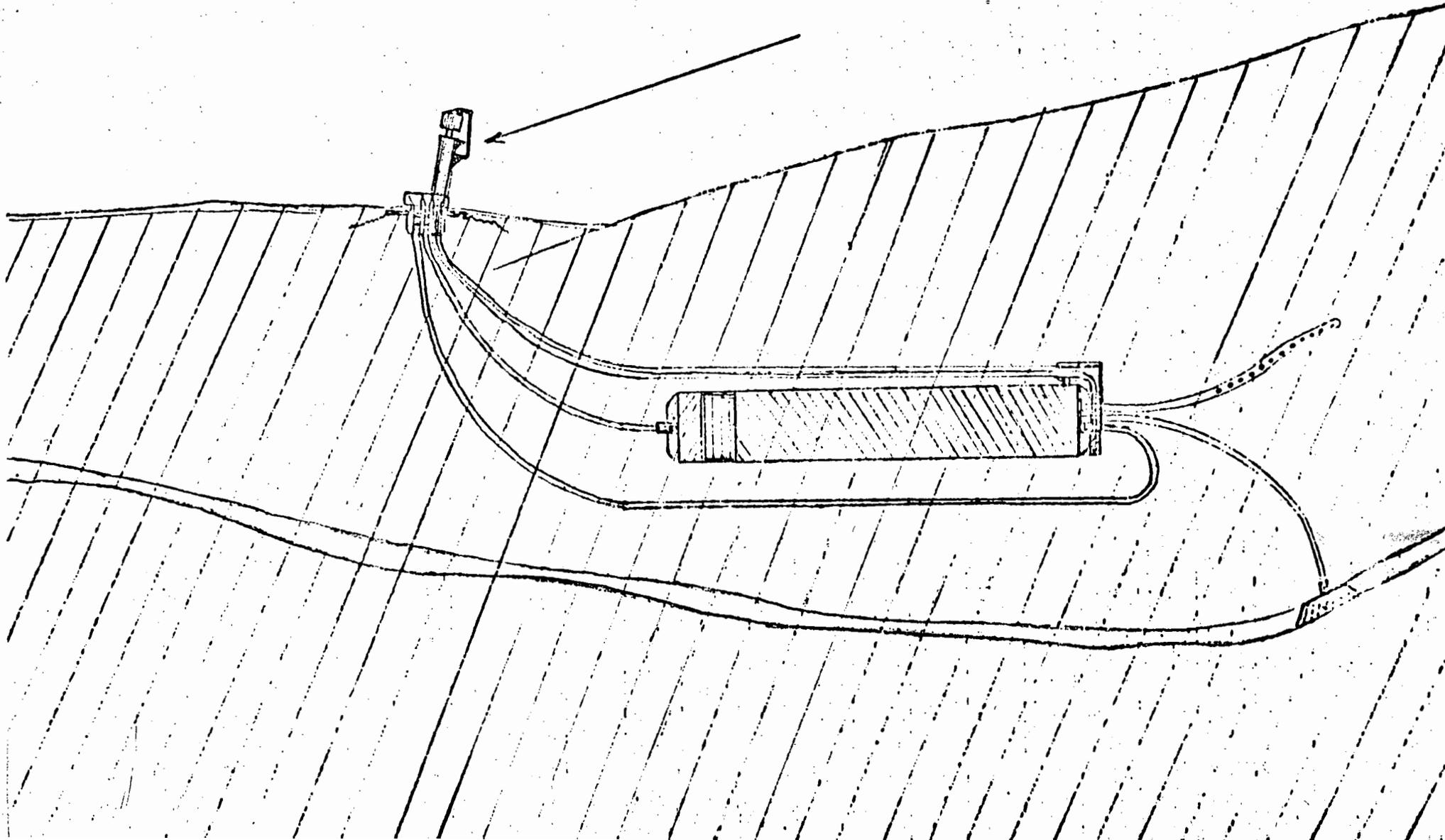
NOTE: Question of blood clotting to be discussed
on feasibility factor

SKETCHES OF DETAILS OF MODIFIED DESIGN OF THE PYROLYTIC CARBON
EXTERNAL BUTTON VALVE MODEL

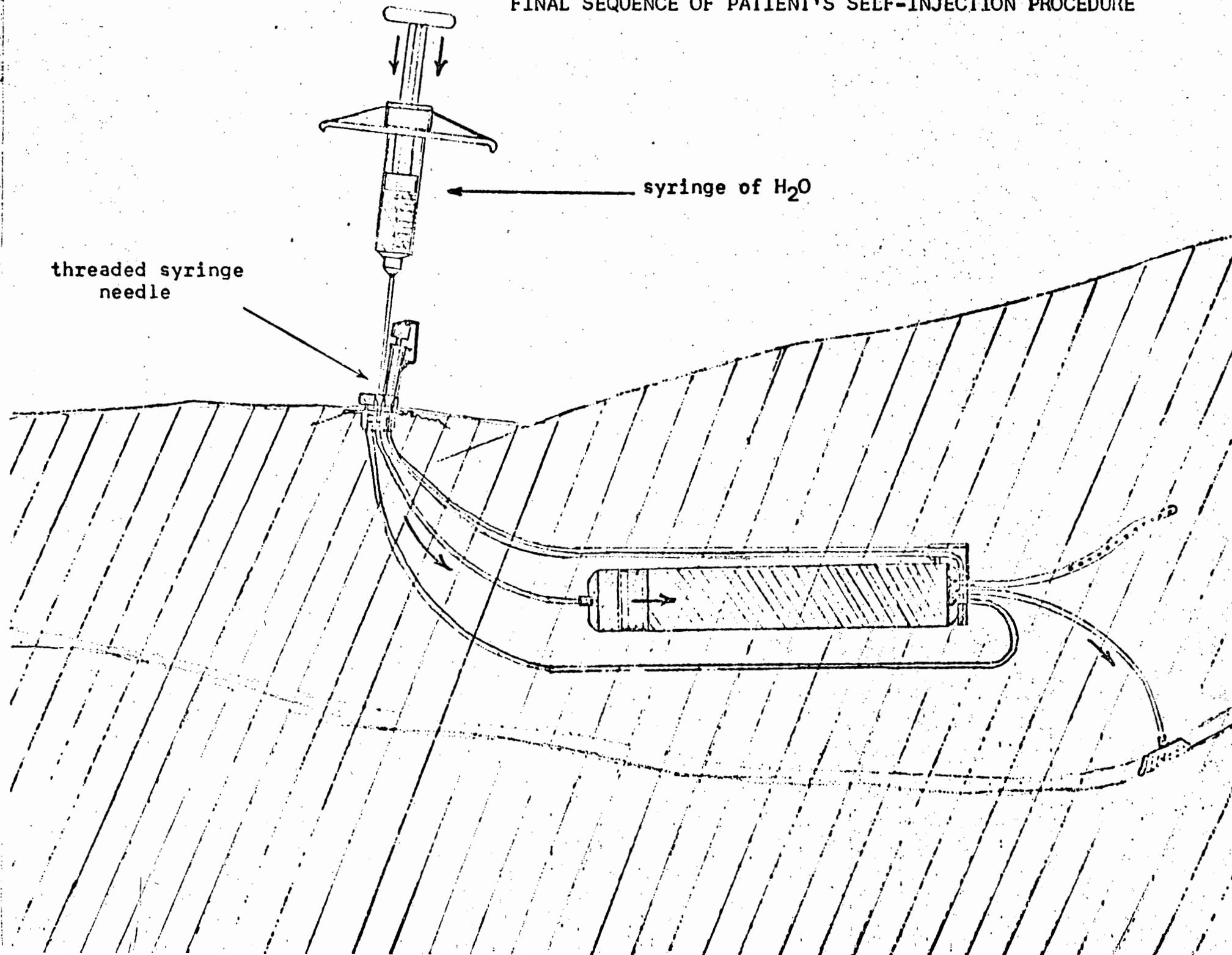


FIRST SEQUENCE OF PATIENT'S SELF-INJECTION PROCEDURE

threaded device for attaching to tube-encased mechanical cab
to open and close injection tubes or to select intramuscular
vein injection

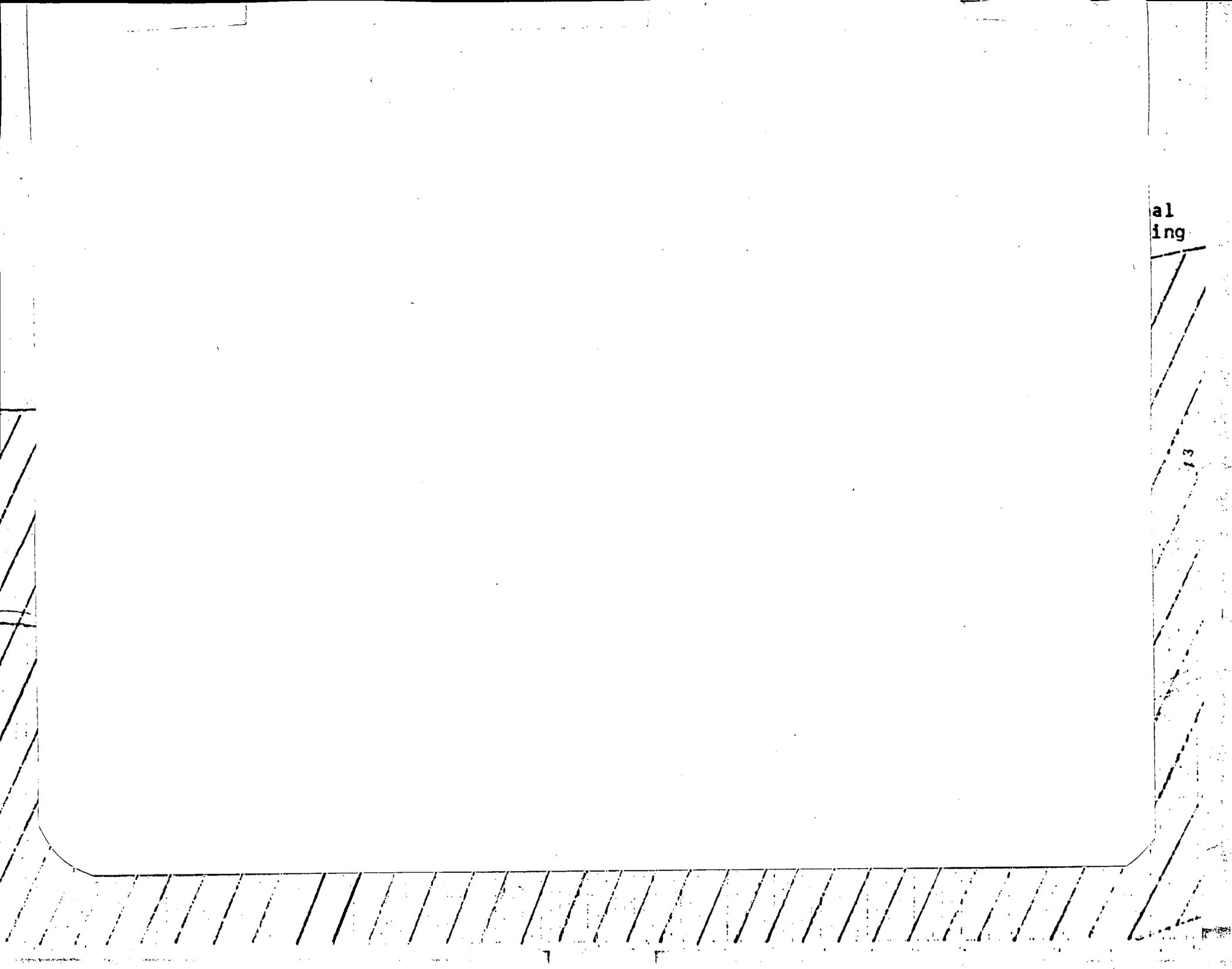


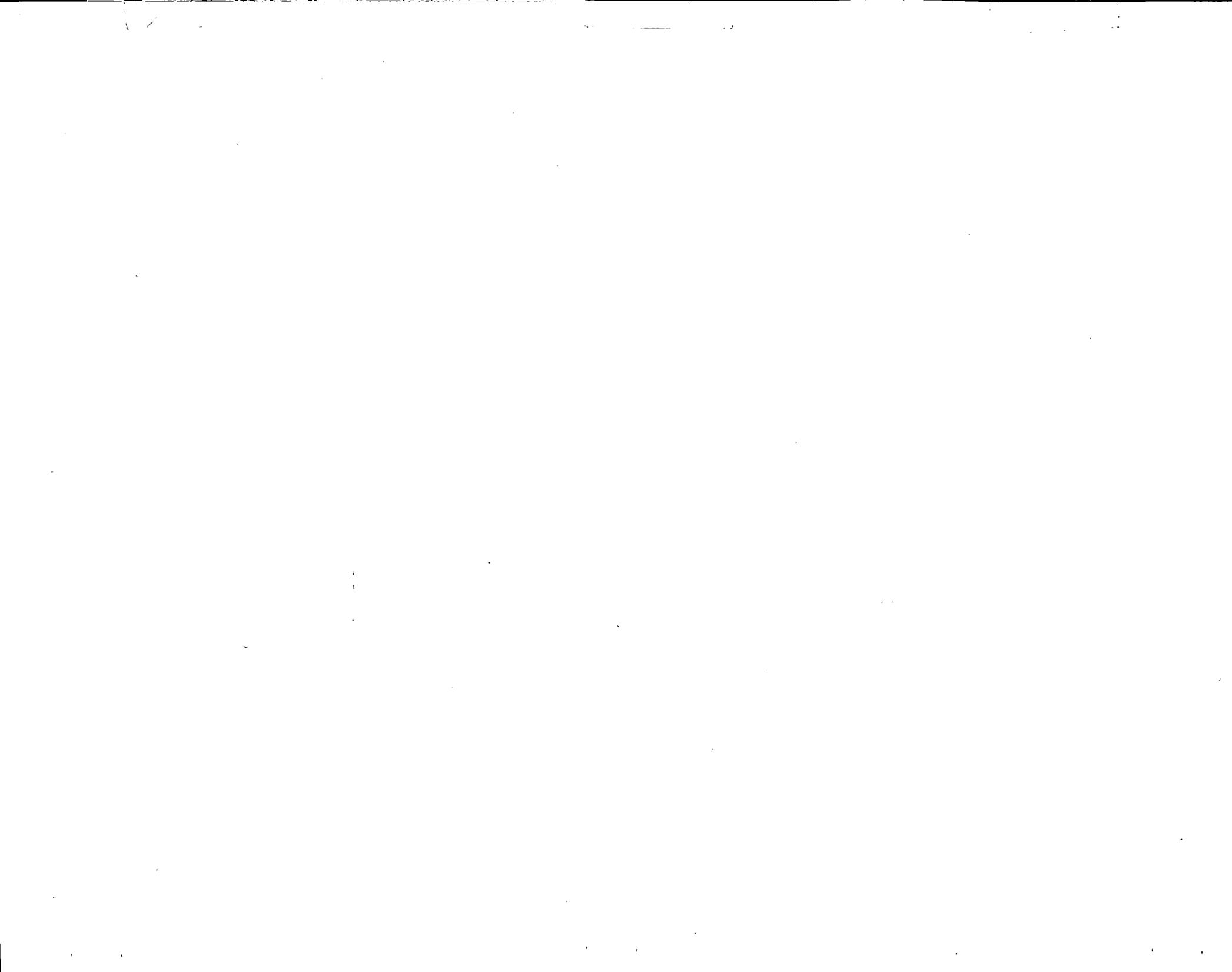
FINAL SEQUENCE OF PATIENT'S SELF-INJECTION PROCEDURE



al
ing

13







THE INTERIM ANTI-NARCOTIC DISEASE PROGRAM

(hypothetical legislation)

Whereas:

It is considered that it is in the public interest to more effectively, economically, humanely and justly exercise the rule of law and,

Whereas:

It is considered that the rule of law has not been in the past nor is at the present most effectively, economically, humanely and justly exercised in the matter of controlling narcotic drugs,

The following is thus enacted:

1. That physical addiction to opiate drugs shall be considered by law to be a disease and that designated medical personnel shall be recruited, trained, authorized and directed to prescribe at a nominal fee dosages of the addictive opiate drugs to those persons medically certified to be physically addicted to such drugs
2. That this program be administered and regulated under the authority of the Department of Health, Education and Welfare
3. That this program be administered under rules and regulations as may be provided by the Department of HEW to assure this

- continuation -

page two

program's effectiveness and as to assure that such opiate drugs as may be prescribed are used by no person other than the person to whom such opiate drugs are prescribed to by this program (see sketches for hypothetical model)

4. That this program shall be operated with the prerequisite that extreme security shall be provided for the prevention of misuse and misappropriation of any of the opiate drugs used in this program

5. That persons in possession of lawfully prescribed devices and equipment for administering opiate drugs or in possession of opiate drugs prescribed to them by this program or intoxicated by such drugs prescribed to them by this program, except where such persons are otherwise disorderly or driving an automobile while intoxicated, shall be free from arrest for such possession and or intoxication

6. That application and or participation by any person to or in this Interim Anti-Narcotic Disease Program shall be regarded by law as a privileged communication

7. That any person applying to enter or having entered this Program shall not as a condition to participation in this program be required to enter any activity or program of rehabilitation or to undergo psychological testing or to provide any information other than that strictly essential to the determination of their addiction, their age, their identity, their physical health, their address and such other requirements physically necessary to participation

- continuation -

page three

8. That minors who are sixteen years of age or older may enter this program with the consent of their parents or guardians

9. That any person where an applicant to this program shall where shown not to have the ability to pay such fees as may be charged for participation in this program will be where otherwise qualified allowed to participate without any charge or at a lesser charge

10. That any resident alien, any illegal resident alien or any fugitive from the law where otherwise qualified shall be allowed with the strictest privileged communication to participate in this program

11. That the identity of the participants (addicts) in this program shall not be given to any other agency or to any other person outside of this program

12. That it shall be a policy of this program to accept only voluntary participation of any addict in this program and to that end means will be devised to assure that persons are not forced to participate in this program as a bargain with law enforcement officials in order to avoid criminal charges or to avoid prosecution for past actions

13. That the Department of HEW shall authorize the implementation of this program on a schedule that corresponds to the availability of adequate funds, systems, materials, personnel, organization and knowledge necessary to orderly, adequately and safely operate such a program

- continuation -
page four

14. That all states shall have the corporate income of the corporations within the respective states assessed a Federal corporate income surtax of two percent (2%) upon all corporate net profit income but that such states that shall pass such legislation allowing by statute participation of such state's residents as shall qualify to enter this Anti-Narcotic Disease Program to enter as per requirements as stipulated heretofore in this Act shall be allowed to waiver such a tax. Those states that do not pass such legislation as to enable this Act to be able to establish its Anti-Narcotic Disease Program within the respective state's boundaries shall pay such afore-said corporate income surtax in order that the Federal government shall have greater funds to aid the participating states to better absorb into this Anti-Narcotic Disease Program such residents of non-participating states as shall migrate to such participating states to become participants as addicts in the treatment offered by the programs that shall be instituted as stipulated in this Act.

END

DISCUSSION

John Doe: Are you proposing or recommending that this country implement a heroin maintenance program?

Author: No, that would be too facile and presumptuous at this stage. What is proposed, if anything, in this writing is that heroin maintenance is deserving of further study and consideration. With the use of the internal reservoir method, such a program might contribute in a very meaningful way to an increase in the well being of the majority of the opiate addict population, whereas no other program as of present can or promises to.

John Doe: Wouldn't giving heroin to an opiate addict be like treating an alcoholic with whisky or free liquor?

Author: The situation with alcoholism is much different. First of all, intoxication with alcohol tends to cause destructive, violent and anti-social behavior much much more often than intoxication with heroin, and is also destructive to the body tissue. However if the majority of alcoholics were otherwise unsusceptible to other forms of treatment and if they were in most cases committing crimes to raise the money to pay for their illegal alcohol, and if the alcohol they were getting was often poisonous and resulted in many deaths of alcoholics, and if the cost of the illegal alcohol was destroying the alcoholic and his or her family economically, I could see where an alcoholic maintenance program would make some sense from a humanitarian point of view. However alcohol

is destructive, particularly in regard to the physical health of the chronic alcoholic and also tends to be more incapacitating in regard to physical coordination. One of alcoholism's major sources of destructiveness is in regard to the automobile. Driving while intoxicated with alcohol has accounted for hundreds of thousands of deaths and millions of injuries in this country alone. The intoxicating effect of heroin does not tend to cause such physical coordination problems with driving as does alcohol. That, among other reasons, is why comparing heroin maintenance with other intoxicating drug maintenance programs is unreasonable and misleading.

Jane Doe: Wouldn't heroin maintenance be creating a population of zombie-like creatures roaming the streets and hiding away in the ghetto tenements?

Author: Heroin maintenance would only be treating those persons that were already chronic opiate addicts and would only be used where the addicts themselves were voluntarily coming into the program. Therefore, we are talking of taking a bad situation and making it only less bad, not ideal or even good. As to whether the participants in a heroin maintenance program would overdose themselves to the point of becoming zombie-like or near unconscious, the answer is that some of every kind of behavior would result as it does with the present prohibition effort. However, indications are that opiate addicts tend to

stabilize their dosages of heroin after reaching certain levels and even detoxing themselves to lower levels periodically. Heroin addicts are not generally "stumble-bum drunks". In fact, heroin addicts can if they wish conceal their addiction from even their most intimate acquaintances. When an opiate addict is detectable by casual observation the reason is generally because the addict is suffering from the withdrawal syndrome or is "on the nod". The "nod" is characterized by a napping or drowsy-type behavior. The restfulness of the "nod" is quite desirable to the addict in many cases and is sometimes manifested in a public setting. However, except in extremely high dosages over the addict's current tolerance level the "nod" appearance can generally be avoided by the opiate addict during his or her working day. Many addicts have jobs, either professional or menial and while many don't have steady jobs, they nonetheless have to "hustle" long hours of the day in criminal activities to raise the money to acquire the drug of their addiction and also to make the "connection" with their "pusher" or source of supply of the day. In a word, the heroin addict tends to be busier than the proverbial bee.

Jane Doe: Wouldn't a heroin maintenance program particularly with an Orwellian-like device like the "internal reservoir" be a form of government mind control of a large portion of the public and create a large population of subhuman automaton-like creatures?

Author: No, the maintenance program and the internal reservoir device would be dealing only with pre-existing, chronic and at present overwhelmingly incurable opiate addicts. The maintenance program would be giving the opiate addict more, not less, control over his or her own life and life-style. Furthermore, the internal reservoir would extend even greater freedom of self control to the participating addict. Remember the program does not include any inducement of drugs into the addict's nervous system by any government or private enterprise employee, technician, or physician. The program simply makes the opiate drug available for self injection by the addict for themselves. The program allows maximum self regulation and control of the individual's choice of level of addiction, time sequence of injection and option to become abstinent intermittently or permanently. This maintenance program places the maximum emphasis upon the right of privacy of the addict and the right of the addict to control his or her own life in regard to opiate consumption as well as to all other aspects of their lives that have been disrupted by the economic and criminal deprivation of opiate addiction. In a word, the maintenance program with the internal reservoir provides the very least threat to the addict's civil liberties of any program yet conceived or readily imaginable.

John Doe: Let's make this personal. Would you want your sister or a member of your family to participate in a heroin maintenance program and be "fitted" with an "internal reservoir"?

Author: That is a very meaningfully constructed question. Discovery

that a member of one's family was an opiate drug addict would be "heart breaking". One would hope for the person to become abstinent or drug-free and that the felt-need or cause(s) of the addiction could be found and more constructively coped with. However, if confronted with a situation where continual use of opiate drugs was not going to cease, participation in a safe and legal heroin maintenance program would be a relatively very positive and humanitarian alternative. Furthermore, one could still have hope for eventual abstinence as the use of the maintenance program and the internal reservoir could be intermittently or permanently discontinued by the participating addict at any time of his choice.

Jane Doe: Wouldn't a heroin maintenance program meet stiff political resistance?

Author: Enclosed is a hypothetical rough draft or vehicle draft of national legislation that would allow a heroin maintenance program to be developed. The legislation contains a national compliance clause which makes use of the Federal Government's constitutional tax powers.

However, it is within the medical professions that a major portion of the opiate addict population exists, but such persons are generally of sufficient and substantial economic capability to function with a less severe need for a public opiate maintenance program. Furthermore, such persons are not as conspicuous as the urban ghetto addict. Therefore, the major political saliency of a heroin

maintenance issue may tend to grow out of the ethnic political milieu of the urban areas or the ghettos.*

This brings up the issues of related political concerns. First of all a great amount of anxiety, stress, and personal hopelessness tends to accompany the poverty and racial and social inequalities that characterize the urban ghettos. Stress, anxiety and hopelessness are seen as creating felt-needs for chronic heroin use. Therefore, the great prevalence of heroin addiction in the urban ghettos is seen as a force showing the need for socio-economic reform. Several political leaders who draw their support from the ghetto population are thus essentially opposed to treating ghetto drug-addiction in any manner that might reduce the presence of a force for socio-economic reform.

The political leaders of the ethnic minorities of the urban poor are suspicious that the non-ghetto political elite of the middle class are or will be willing to seek to control and contain the drug problems within the ghetto by means that are not in the best interest of the ghetto population. In some ways the political leaders of the ghetto poor expect the prevalence of the ghetto addict and their criminal activities to serve as an embarrassment and thorn in the side of the non-ghetto middle class to the point that the non-ghetto middle class will be prodded into political action to correct the socio-economic inequalities of the urban ghetto.

*The persons holding to rigid, moralistic "puritan" ethics of the Temperance League type may also be a source of political saliency i.e. opposition of heroin maintenance.

Political leaders see the anxiety reducing effect of opiate and opiate-like drugs as sapping the energies of persons who might otherwise be demanding socio-economic reform. In a word, political leaders of the urban ghetto are often of the opinion that methadone maintenance programs are serving as a means to chemically control the ghetto dissidents. Likewise a heroin maintenance program would be criticized and likely characterized as "chemical slavery" or "chemical chains", or "chemical control".

On the other side of the argument is the point of view that heroin maintenance would free the ghetto communities' energies from the distractions of "hustling" for heroin and create a more politically peaceful and humane life style within the ghetto community. Experience seems to demonstrate that change or reform seem to accelerate the demand for greater change and reform. Certainly an effective heroin maintenance program would have a dynamic effect upon the ghetto community. The result likely would be a new era of increased demand for economic change. With these things in mind it would seem that the belief that a heroin maintenance program would serve to increase political subjugation (resulting in the de-emphasis of demand for socio-economic change) in the urban ghetto is a diametrically incorrect conclusion. A heroin maintenance program would likely create and fuel a very potent political force that would be centered in the urban ghetto, that would have great

political saliency in the minds of the middle class and that would create demand for better therapeutic programs and correction of socio-economic inequalities. In a word, a heroin maintenance program might well bring the socio-economic problems of the urban ghetto into a more humanely managable focus for all parties to the issues.

John Doe: Isn't a heroin maintenance program essentially a nihilistic approach to the problem of opiate addiction?

Author: Given the present effectiveness of other programs the answer is no. True, a heroin maintenance program is basically a program to treat the symptoms and indirect consequences of opiate addiction. However, the symptoms and consequences of illegal opiate addiction tend to be self-perpetuating to chronic opiate addiction. Therefore, the objectives of a heroin maintenance program by an indirect approach should be to reduce the incidence of new opiate addicts and create greater inclination toward coping with the root cause(s) prerequisite to rehabilitation into a "drug free" life style.

Jane Doe: Wouldn't a heroin maintenance program provide a disincentive for the addict to participate in "drug free" therapeutic programs or methadone programs?

Author: For some addicts, yes. However, the overall effect would be to bring a much larger portion of the addict population into contact with therapeutic programs of all kinds because the heroin maintenance program would be very flexible in every regard. Some would argue that removing many of the hardships of opiate addiction as would a heroin maintenance

program would provide a disincentive for abstinence.

The point is that at present the hardship(s) of opiate addiction are not an effective means of causing abstinence among chronic addicts. Because it is of such small effectiveness it is inhumane. The physical suffering and the death rate is appalling.

It would seem that stabilizing the lives of the opiate addict economically and into a more legal and healthy life style, as a heroin maintenance program could, would result in an addict population more susceptible to the rationale and reasonableness of other therapeutic programs.

John Doe: Would a legal heroin maintenance program eliminate the illegal market for heroin?

Author: To some extent. There would still be a few addicts who would not participate in a heroin maintenance program. Also there would be the occasional use of opiate drugs by non-addicts. However, selling opiate drugs to the non-addict is highly risky for the drug "pusher".

Some non-addicts would still be interested in "experimenting" with heroin or intravenous drug injections. However injecting heroin into the veins requires some skill and without the addict to provide the drug and to teach the non-addict occasional use of heroin would likely greatly decrease and thus so would the incidence of new opiate addiction.

Frankly, completely removing heroin from the streets while leaving other more dangerous drugs would not be good. Heroin is better suited to self-medication for treatment

of anxiety and pain than most, if not all, of the other illegal "hard" drugs.

When it comes to enforcing the prohibition of illegal drugs, heroin should not be the first in line to be eliminated. A balanced enforcement policy or poly-drug enforcement policy should be the rule.

Jane Doe: How would a heroin maintenance program deal with the problem of parental consent for minors attempting to participate in such a program?

Author: Joanne B. Stern in Discrimination And The Addict (page 199) presents a very enlightening discussion of the problem of parental consent for the minor as regards medical treatment and participation and treatment in drug abuse rehabilitation programs.

The position this paper could take is that in regard to medical treatment provided by a heroin maintenance program the sixteen year old addict is considered an emancipated minor or mature minor.

This is a very delicate problem that should be inclined toward judgment of individual cases. It may well be the effective consent or informed consent as well as determining the maturity of the applicant minor should include sessions with an expert counselor and referral to the judiciary for determination of individual cases.

One thing that is apparent is the need to maintain the strict confidentiality of a minor's application to enter a heroin maintenance program regardless of the eventual determination of admissibility.

It may well be that the problem, both socially and politically, of allowing any minor to participate in a heroin maintenance program will be so difficult that all addict minors will be excluded or sacrificed on the horns of the dilemma for the purpose of political expediency.

Jane Doe: Isn't the heroin maintenance program just a "technological quick fix" for a much deeper problem?

Author: A heroin maintenance program would be a humane and rational means of treating some of the problems of opiate addiction. Such a program does not rule out other more comprehensive programs. Furthermore, the program can possibly be developed and implemented in time to help the present addict population and prevent other susceptible persons from becoming heroin addicts.

In the long run other programs may be created that will be more effective. However, "in the long run we'll all be dead" and the addict population is in the front of that line.

If we as a society are going to be so biased and paralyzed by our fear of technology and change that we cease to try to use our knowledge to seek out new and or better ways of coping with our problems, we are soon to learn the very special and painful meaning of the expression that "the greatest thing we have to fear is fear itself."

John Doe: Wouldn't the level of addiction or volume of opiate drugs taken per day increase if the individual addict had ready access to a cheap supply of the drug, as they would with the internal reservoir. And would not the result be an increase in the difficulty of the addict to detoxify himself and thus become abstinent?

Author: In some cases the addiction level would go up and detoxification without medical care would be more uncomfortable. However, seemingly, from experience with the Vietnam veteran returnees who had very high levels of addiction or opiate drug tolerance, the problem was not a large determining factor in detoxification.

Jane Doe: Wouldn't having a ready access to larger amounts of heroin or opiate drugs result in some addicts "shooting up" constantly to the point of "nodding" day in and day out to the point of living in a state of near unconsciousness constantly?

Author: Many addicts would likely increase their dosages to higher tolerance levels. Some would stabilize and others would increase gradually then partially detoxify themselves and start over again. However, even at the very highest levels of tolerance the amount of heroin is only a matter of a very few drops in volume.

Some addicts would likely use the increased supply of the drug to try and retreat totally or near totally into a comatose-like state. Some would use the drug to commit suicide, as is done with the present illegally gotten drug in some cases.

Some modifications of the internal reservoir, such as a timing device and an injection volume limiting device might allow some of these persons to stay in or to enter an opiate maintenance program. However, some addicts will quite simply not be suited to participation in an opiate drug maintenance program for reasons of extreme psychological problems.

A thought to keep in mind is that there is seemingly always a degree of pathological behavior and practically an unavoidable incidence of accidental injury, abuse and misuse in any human activity that involves large numbers of people. The objective is to limit such injury and incidences of such behavior as much as feasible. However, even something as innocent as the family picnic results in several deaths and injuries each year.

Any state of human affairs, whether new or of long standing, where large numbers of people are involved will result in considerable injury and death of some participants. Therefore the question or issue of incidence of injury and death is always relative to the alternative, none of which deal with the absolute of zero.

John Doe: Can any opiate addict be considered a genuine "volunteer" in any maintenance program since by definition of addiction such a person is under the coercion of the addictive power of the drug?

Author: "Free choice", "free will", "voluntary behavior", and other such concepts are relative. One always makes choices based on the "coercion" of felt-need or necessity, whether

The question of "coercion" turns on degree of need, alternatives, intelligence of choice and the artifice by which one creates needs and limits available alternative of others.

It is probably true that some opiate addicts would literally trade their right arm for a lifetime supply of their drug of addiction. Therefore, the fact that addicts may participate in a maintenance program "willingly" or by "choice" does not eliminate the ethical questions; no more so than if a physician acted on a patient's request to amputate the patient's perfectly healthy right arm so that the person would cease to be a compulsive pick-pocket or something of the kind.

If an addict's participation in an opiate drug maintenance program is an "informed" and "intelligent" choice, one that benefits the addict and does not permanently deprive the addict of future alternatives the ethical question is largely narrowed to the question of the psychological action of the drug and the right of society to prohibit certain uses and transfers of opiate drugs. This latter issue turns on the question of sumptuary law, public health and control of commerce. Whether one is inclined or not inclined to think that the state should have the power to prohibit partly or completely the use and or sale of opiate drugs one has little to protest about the consequences of an opiate maintenance program per se on that basis (setting aside the question of whether the program is privately or publicly operated)

Others might argue that any form of intoxication is "wrong" and regardless of the alternatives or choices or humanitarian results any such program or drugs should be absolutely opposed, particularly by the government, for the purpose of "moral and ethical leadership" and an example to all people, etc.

Ultimately such issues have often turned on the pragmatic question of what "society" can and can't "live with", i.e. the real humanitarian consequences. Even highly "normative" or moralistic persons tend to eventually try to justify their point of view on humanitarian results when the issue is before a democratic polity. Therefore, if the maintenance program is good for the addict, good for society at large and if the choice of participation on the addict's part is "intelligent" and continuously revokable the question of the "voluntariness" or civil liberties of the participants could be largely resolved in favor of the maintenance program.

Jane Doe: How much would an opiate maintenance program cost?

Author: Already billions of dollars of public monies have been expended in narcotics control and control of the property crime that results. Billions of dollars are expended in the illegal market for opiate drugs. Billions of dollars in property crimes are inflicted upon the public. The productivity of hundreds of thousands of persons has been destroyed by opiate addiction and the socio-economic progress

(despite the "private Marshall Plan" of addict-stolen goods that are sold and traded in the urban ghetto) of the urban poor has been repressed by the deprivations of opiate addiction and central-city or urban crime that results. The economic and humanitarian improvements that are to be gained by society from partly correcting the deprivations of opiate addiction are immense. These factors will off-set costs of implementing an opiate maintenance program(s),

As to statistical dollar costs placed directly into such a program, the figure would be billions over a period of several years. The program could be largely self-funded generating from fees charged to some participants. However, a multitude of counseling and service programs might absorb such funds (under pressure from some political forces).

The maintenance program as to clinical dispensing costs and administering costs, that is provision of the opiate dispensing program per se, would not seem to be potentially a very conspicuously large budgetary item, in fact, the "cheapness" of a maintenance program might well become a criticism used to impugn the motives of such a program's proponents. It would not take a very imaginative demagogue to characterize the limited objectives of a maintenance program, particularly with the internal reservoir device, as a "cheap, facile, technological fix; designed to sweep the addict and the socio-economic inequalities of the black ghetto under the carpet, and place the ethnic

dissidents under the chemical chains of powerfully addictive drugs. The white, middle class government is going to become the 'pusher'. The 'man' is going to come out from behind the corrupt police and tell our youth that they are hopeless and that white America is going to see that they remain harmless by keeping them sedated with Heroin."

One can easily see that the problem of drug addiction, particularly opiate addiction, is not a social problem that is easily contained within a rational perspective. The result is that the addict is the first and last one to be sacrificed on the horns of the controversy.