Eric J. Gouvin, COMMENT: Drunk Driving and the Alcoholic Offender: A New Approach to an Old Problem

ABSTRACT

Health laws in every state recognize alcoholism as a treatable disease. State drunk driving laws, however, inadequately provide for alcoholic drunk drivers. Studies show that problem drinkers make up as much as two-thirds of the DWI offender class. Alcoholic drunk drivers cannot fully conform their drinking behavior to the dictates of the law as long as their alcoholism remains untreated. This Note argues that the law should consistently treat alcoholism as a disease. This Note suggests that the most appropriate way for the legal system to deal with alcoholic DWI offenders is to suspend the offender's license until he can show that he has successfully completed an initial alcohol detoxification/rehabilitation program. In addition, because alcoholism requires lifelong treatment, alcoholic drivers should be required to present periodic documentation that their condition is under supervised treatment. Epileptic drivers are handled in a similar manner in most states.

TEXT:

[*99]  I. INTRODUCTION

Man has used alcohol at least since the beginning of recorded history, and it is likely that man has abused alcohol for just as long. n1 Laws attempting to regulate alcohol use have a long history. Hammurabi's code set out regulations for tavern operators and patrons. n2 Ever since that time, the laws of many nations have attempted to eliminate the problem of alcohol abuse through the use of criminal sanctions. In the American colonies, public drunkenness was a criminally punishable offense. n3 Early American attitudes toward alcohol abuse were shaped by the notion that excessive drinking was a sin. n4 During the nineteenth century, the temperance movement, with its strong religious overtones, furthered the idea of drinking as a sin by framing public discussion of alcohol abuse in moral terms. The influence of temperance societies, and the sin theory of alcohol abuse, culminated in 1919 with the passage of the eighteenth amendment to the Constitution prohibiting the manufacture and sale of alcohol in the United States. Prohibition lasted thirteen years, but did little to eradicate the problem of alcohol abuse.

Just as alcohol abuse is as old as alcohol, drunk driving is as old as the automobile. An editorial in a 1904 issue of the Quarterly Journal of Inebriety made the following observations:

We have received a communication containing the history of twenty-five fatal accidents occurring to automobile wagons . . . . A careful inquiry showed that in nineteen of the accidents the drivers had used spirits within an hour or more of the disaster . . . . Inebriates and moderate drinkers are the most incapable of all persons to drive motor wagons. The general palsy and diminished power of both the reason and senses are certain to invite disaster in every attempt to guide such wagons . . . . With the increased popularity of these wagons, accidents of this kind will rapidly multiply, and we invite our readers to make notes of disasters of this kind. n5

It would not be surprising to hear the same editorial on television news broadcasts. Of the 48,069 highway traffic deaths in 1981, 20,658 (43 percent) were known to involve alcohol. n6

Today, Americans again are very concerned about alcohol abuse. Newspapers frequently publish stories about drunk driving laws, n7 the appropriate drinking age, n8 alcohol abuse on college campuses, n9 the creation of alcohol education programs, n10 and the elimination of "happy hours." n11 Public figures such as Betty Ford and
Dick Van Dyke, along with many anonymous volunteers, have raised public awareness of alcohol abuse. Professional groups and unions have also become sensitized to the disease of alcoholism. The ABA, for instance, recognizes that there is an extremely high rate of alcoholism among attorneys. Some state bars have instituted peer counseling and other programs to help alcoholic lawyers.

Yet despite increased public awareness of alcohol abuse, misconceptions about alcoholism persist. Studies show a significant correlation between drunk driving offenders and alcoholism. Many people believe that drunk driving is most appropriately handled by imposing criminal sanctions. To justify the application of criminal sanctions, our legal system requires that an offender perform some voluntary criminal act. The U.S. Constitution and constitutional case law prohibit the punishment of individuals for merely having a certain status or condition, such as heroin addiction. These basic tenets of criminal law have serious implications for the alcoholic who is punished for drunk driving. Although the alcoholic may have been voluntarily driving, the other element of the offense, intoxication, may be involuntary. If both elements of the offense are not voluntary, it is inappropriate to hold the alcoholic driving while intoxicated (DWI) offender completely culpable.

This does not mean that we should allow drunk drivers to careen recklessly down our highways without fear of prosecution. It does mean, however, that we should handle the alcoholic DWI offender as we handle other drivers with diseases that affect their ability to drive. Like epileptic drivers, for example, the alcoholic driver should lose his license until he can prove that he is treating his disease and has it under control. Undoubtedly, those who favor "tough" criminal drunk driving laws will question this approach, but criminal sanctions are only effective against the portion of the drunk driving population that is in control of its drinking. Unfortunately, studies show that the majority of apprehended DWI offenders have serious problems with alcohol abuse and are not deterred by criminal sanctions.

Alcoholism should be handled as a medical, rather than a legal, problem wherever alcoholism and the law interact. Since virtually every state considers alcoholism a disease under its health code, it should be recognized as a disease in the traffic code as well.

This Note begins with a description of the disease concept of alcoholism, and a discussion of the idea of "disease" in general, while focusing on the disease of alcoholism. The Note then discusses the public policy goals of the criminal sanction. After comparing these goals to society's attitudes toward drunk drivers, a disease concept approach to alcoholic drunk drivers is suggested. Under this new approach, the law would handle alcoholic drivers similarly to the way epileptic drivers are currently handled. Finally, the Note addresses anticipated criticisms of this new approach.
medical and legal professions, not everyone accepts the disease concept. \(n\)26 Even those who oppose the disease concept of alcoholism, however, speak in terms of individuals who are "alcoholics." \(n\)27 It seems logically inconsistent for these critics to distinguish between "alcoholics" and "normal" drinkers, without offering some explanation for the distinction between the two groups. Reluctance to accept the disease concept of alcoholism may be based in part on confusion as to the definition of "disease" itself.

A. DEFINITION OF DISEASE?

The concept of "disease" is difficult to define. In 1979, a study conducted by a group of Canadian researchers sought a unifying definition of "disease" by asking doctors to classify 34 different conditions as diseases or non-diseases. \(n\)28 The study found that 100 percent of the general practitioners surveyed considered lung cancer a disease, while 85 percent of that group regarded hypertension, epilepsy, and alcoholism as diseases. \(n\)29 The study also revealed that biological infections are more likely to be considered diseases than are other conditions, such as malnutrition or color blindness, but "disease" as such did not emerge as a crystal-clear concept. \(n\)30 [*105] The study concluded with the observation it began with: "Medical discourse has largely been conducted in terms of 'diseases.' But there is no general agreement on the definition of 'a disease'." \(n\)31

Medical reference books provide little help in clarifying the definition of "disease." *Dorland's Medical Dictionary* defines disease as "any deviation from or interruption of the normal structure or function of any part, organ or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis may be known or unknown." \(n\)32

The study and the dictionary definition draw no bright line distinction between diseases and other conditions. To arrive at a clear concept of disease, this Note will examine hypertension, epilepsy, and alcoholism as diseases. Several possible characteristics of diseases will be considered, such as the presence of an "involuntary victim," specific etiology, predictable treatment, and societal acceptance of the disease label.

1. Lung Cancer

Lung cancer is generally recognized as a disease. \(n\)33 But there are no clear cut reasons for such recognition. Perhaps it is considered a disease because the lung cancer patient is an unwilling victim -- no one "voluntarily" gets lung cancer. However, some lung cancer victims "voluntarily" smoked cigarettes, and others "voluntarily" worked with or near carcinogenic substances. Apparently, "voluntariness" is not a necessary condition for the existence "disease."

Perhaps what makes lung cancer a disease is that it is always caused by certain specific events, always runs the same course, and always responds to a particular treatment. Although this approach may seem appealing, it does not describe the pattern of lung cancer. There are many "causes" of lung cancer. Not everyone exposed to these "causes," however, will develop cancer. The course of the disease varies considerably among patients who develop lung cancer. The effectiveness of treatment also varies significantly from one individual to the next. \(n\)34 Despite these variances, lung cancer is considered a disease. Apparently, the lack of specific etiology, uniform symptoms or completely predictable treatment outcomes does not prevent a condition from being considered a disease.

[*106] 2. Hypertension

Hypertension is another condition with no specific etiology. Hypertension was considered a disease by 85 percent of the doctors interviewed, \(n\)35 yet it defies precise physical definition. \(n\)36 The condition lies on a physiological continuum, at the extremes of which diagnosis can be made conclusively. In the grey area between the extremes, however, accurate diagnosis requires medical judgment. \(n\)37 Despite the fact that the class of all hypertensive people cannot be precisely defined by physical characteristics, hypertension is widely considered a disease.

3. Epilepsy

Epilepsy was also considered a disease by 85 percent of the doctors surveyed. \(n\)38 Until recently, however, epilepsy has not been treated as a disease. \(n\)39 In the past, epileptics were considered to be possessed by evil spirits. They were classed along with idiots, imbeciles and the insane. \(n\)40 Many epileptics were punished, ridiculed and warehoused in asylums before the medical community adopted the disease concept of epilepsy. Epileptics, however, continue to suffer discrimination in the workplace and on other fronts due to lingering public misconceptions about epilepsy caused by centuries of ignorance. The underlying condition has been the same throughout history whether
society considered epilepsy a disease or not. Societal acceptance of epilepsy as a disease is not crucial to its status as a disease.

4. Alcoholism

Alcoholism, like lung cancer and hypertension, has no known specific etiology. Suspected "causes" of alcoholism include societal, genetic, psychological, and biochemical factors. Again like lung cancer, the course of alcoholism in an individual is not absolutely predictable. As with hypertension, the disease has been linked to societal factors.

Although the lung cancer victim may have knowingly increased his chances of contracting the condition, he is still considered an involuntary victim of the disease. As with the lung cancer patient, the alcoholic is an involuntary victim. No one becomes alcoholic by free choice; nor does the smoker or the asbestos worker voluntarily develop lung cancer. If lung cancer is a disease, then so is alcoholism.

Because the treatment of alcoholism, like that of hypertension, requires a great deal of will power on the part of the patient, the course of treatment is unpredictable. By avoiding salt, monitoring calorie intake, taking medication and avoiding certain stressful social situations, the hypertension patient can cause the disease to go into remission. Although the condition might not be alleviated by a given treatment regime, as with lung cancer, this does not mean alcoholism is not a disease. Unpredictability of treatment is consistent with a disease concept of alcoholism.

As with epilepsy, alcoholism has historically been regarded by public opinion as everything but a medical disorder. Victims of epilepsy and alcoholism are burdened by public misconceptions. When the term "alcoholic" is mentioned, most people think of the skid-row bum, although only 3 percent of all alcoholics fall into that category. Like epilepsy, alcoholism can be meaningfully treated, but lingering public misconceptions hinder an enlightened public health response to the problem.

After examining the Cambell study, a medical dictionary definition, and three conditions widely regarded as "diseases," the concept of "disease" remains elusive. Often the medical community will consider a condition a disease, such as alcoholism, while the general public does not, and sometimes the general public will consider a condition a disease, such as the antiquated view of homosexuality, while the medical community does not. This Note will rely on the medical definition given by Dorland's Medical Dictionary for the basic concept of disease: "any deviation from or interruption of the normal structures or function of any part, organ or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis may be known or unknown."

B. DEFINING THE DISEASE OF ALCOHOLISM

The Harvard Medical School's Study of Adult Development followed a cross-sectional group of 660 young men for forty years, gathering information on many aspects of their lives, including their relationship with alcohol. One of the aims of the study was to determine whether alcoholism is a symptom of underlying problems, or a disease in its own right. The conclusions of the study on this question are as follows:

[...]he number and frequency of alcohol-related problems, rather than the specificity of such problems, best define the clinical phenomenon known as alcoholism. No single set of traits invariably defines alcoholism. Just as light can consist of both waves and particles, just so alcoholism can exist both as one end of a continuum of drinking problems and as a psychological disorder . . . . Thus, alcoholism is a construct of a higher order of complexity than pregnancy or measles.

Although the Harvard Study found no conclusive premorbid differences between alcoholics and non-alcoholics, other studies indicate possible genetic and biochemical links in alcoholism.

In an early study that examined the genetic aspects of alcoholism, a group of researchers studied the development of adopted children raised apart from their alcoholic biological parents. The study found that sons of alcoholics were about four times more likely to become alcoholic than were the sons of non-alcoholics, regardless of whether they were raised by non-alcoholic foster parents or by their alcoholic biological parents. This study strongly suggests that there are genetic factors that affect the development of alcoholism. Subsequent studies have supported this theory.
Other studies have focused on biochemical differences between alcoholics and non-alcoholics. One group of researchers discovered that the body's level of the enzyme gamma-glutamyltransferase increases with chronic heavy alcohol intake. The researchers monitored the level of the enzyme in seventy-eight non-alcoholic subjects before and after acute ethanol administration. The levels in the non-alcoholic men did not rise, suggesting a possible biological difference between alcoholics and non-alcoholics. Another research group has discovered that the chemical 2,3-butanediol is found in the bloodstreams of chronic alcoholics, but not in the blood of non-alcoholics, even after both groups have been drinking. The researchers suggest that the chemical is produced as a by-product of a special metabolizing process that only alcoholics possess. The genetic and biochemical studies present strong evidence that alcoholism is more than just a "bad habit."

While the genetic and biochemical studies concentrate on possible causes of alcoholism, it is important to recognize that we can describe and diagnose alcoholism without knowing its causes. The disease of alcoholism can be broadly defined by the following three points.

First, alcoholism is a disorder characterized by pathological drinking patterns, and the adverse effect of those drinking patterns on the alcoholic's physical, emotional, and mental well-being. Alcoholism has both physiological and psychological dimensions, but is neither a purely physical nor a purely psychological phenomenon.

Second, an individual's relationship with alcohol lies on a continuum. This continuum is delimited by the extremes of total abstinence at one end, and complete physiological and psychological dependence on alcohol at the other. All individuals, whether "alcoholic" or not, will fit into this continuum somewhere. Most people fit into the gray area between the two extremes. At some point along this continuum, drinking behavior becomes disruptive enough to classify the individual as "alcoholic," "alcohol dependent," "alcohol abusive," or some other term to denote a problem with alcohol abuse. This point varies from one individual to the next, and can only be determined on a case by case basis.

Third, sustained consumption of alcohol over a long period of time will cause the alcoholic to develop a physiological dependence on alcohol. This dependence will result in alcohol withdrawal syndrome during detoxification.

C. CRITICISMS OF THE DISEASE CONCEPT OF ALCOHOLISM

A common criticism of the disease concept of alcoholism is that alcoholism appears to be a condition under considerable volitional control. This criticism maintains that alcoholism is not a disease but is rather a mere character flaw. Thomas Szasz, the best known proponent of this view, states that "[e]xcessive drinking is a habit. If we choose to call bad habits 'diseases,' there is no limit to what we may define as a disease." The bad habit view, however, completely ignores the research evidence showing that genetic and biochemical factors may determine an individual's susceptibility to alcoholism.

A second argument against calling alcoholism a disease is that to do so may cause more harm than good. The disease label may give the alcoholic an excuse to drink, since he has been deemed "not responsible" for his acts. Clinical experience shows, however, that once alcoholic patients understand they have a "disease" they become more, not less, concerned with their recovery. The disease designation merely points out, in stark terms, that the alcoholic is not in control of his drinking. Rather than absolving the alcoholic from responsibility, the disease appellation charges him with the responsibility of treating his condition to avoid the damage his alcohol abuse can do to society. Calling alcoholism a disease does not interfere with, but may foster, its treatment.

A third argument is that the disease label carries a societal stigma. To counter this argument, acceptance of the disease concept of epilepsy provides a useful analogy. Both epilepsy and alcoholism are chronic diseases, and both have historically carried a social stigma. Yet over the centuries, as we have gained knowledge of epilepsy, the stigma associated with the disease has lessened. It took many centuries to shake the superstitious view that epileptics were somehow cursed by God. Hopefully, as science better understands alcoholism, the stigma associated with it will disappear as well. The real challenge to the medical profession, therefore, is not to find ways to avoid diagnosing alcoholics as diseased, but rather to make honest diagnoses, and help change society's misconceptions about the disease of alcoholism.
Society employs criminal sanctions to maintain behavioral norms. These sanctions are designed to achieve certain goals, which, in turn, are [*112] supposed to uphold social order. The traditional goals of criminal sanctions are: (1) to deter people from committing crime; (2) to incapacitate criminals so that they cannot commit crime again; (3) to exact retribution from criminals; and (4) to rehabilitate criminals in order to allow them to lead more law-abiding lives.  

A. THE VOLUNTARY ACT REQUIREMENT

The actus reus requirement has always been a basic part of Anglo-American criminal law.  

Convincing arguments have been made that all events, including moral choices, are causally linked to, and determined by, preceding events [*113] and circumstances.  

Only by accepting a world view in which criminal offenders are both the agents of their own free will and the pawns of deterministic forces, can society embrace a meaningful standard of criminal responsibility based on culpability. In H.L.A. Hart's words, "a primary vindication of the principle of responsibility could rest on the simple idea that unless a man has the capacity and a fair opportunity or chance to adjust his behaviour to the law its penalties ought not be applied to him."  

The concept of individual culpability is the most humane approach to resolving the problems of applying criminal sanctions. Because of this principle, society does not punish insane offenders since they are considered either incapable of appreciating the wrongfulness of their conduct or unable to conform their conduct to the dictates of the law. Instead, we use the insanity defense to divert the insane out of the criminal justice system, and into the health care system.  

B. THE CONSTITUTIONAL ACTUS REUS REQUIREMENT

While it is clear that a criminal act by a culpable actor is required before punishment can be meted out, a court must still address the preliminary problem of what constitutes an "act." The Supreme Court obliquely addressed this question in Robinson v. California.  

The holding in Robinson raised questions about the definition of "status or condition." For example, if heroin addiction is a status or condition within the holding of the case, is injection or possession of heroin included in that status?  

Alcoholics successfully raised the Robinson defense to invalidate public inebriation laws.  

The majority reasoned that Powell was not convicted "for being a chronic alcoholic, but for being in public while drunk on a particular occasion."  

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It seems that the reason the Court did not accept Powell's argument was that it did not accept the disease concept of alcoholism. n91 Justice Marshall, who wrote the majority opinion, was not willing to accept the defense until someone could prove unequivocally that Leroy Powell had a compulsion to get drunk and appear in public. n92 Marshall's insistence on this point indicates that he believed it irrelevant whether the act of intoxication was voluntary or not. As a matter of criminal law, however, where the crime consists of two elements, intoxication and appearance in public, it seems logical to extend the voluntary act requirement to both elements.

Because it failed to accept the disease concept of alcoholism, the Powell Court ignored some crucial distinctions. The Court stated that since it feared most states did not have alcohol treatment programs it "would be tragic to return large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities without even the opportunity to sober up adequately which a brief jail term provides." n93 This argument completely disregards the distinction between punishment and treatment. It also blithely glosses over the distinction between "sick" and "guilty," by imagining the jailhouse to be an adequate facility for both conditions. But most critically, the argument fails to make the distinction between intoxication and alcoholism. An alcoholic is an alcoholic whether dry or drunk; "sobering up" is not treatment. n94 Most alcoholics are not intoxicated all the time. What makes them alcoholics is their inability to control their drinking when they do drink, rather than their constant intoxication.

The Court's decision in Powell left the constitutional requirement of actus reus unclear. Under Powell, it is constitutionally impermissible to punish someone for having a "status or condition," but once a person with a status or condition acts in any way, the state may criminalize the act. The boundary between "status or condition" and "act" is indistinct: only heroin addiction has been explicitly recognized as a protected condition. This boundary may remain indistinct until another case challenges the Robinson-Powell doctrine. In the meantime, legal analysis of alcoholism bereft of the disease concept is likely to result in ineffective laws. Such laws include state DWI statutes.

IV. A NEW APPROACH TO THE ALCOHOLIC DWI OFFENDER

Several studies have demonstrated the extensive interrelation between alcohol abuse and drunk driving. n95 One study has shown that almost two-thirds of those charged with DWI, and half the drivers involved in accidents dents after drinking, are either alcoholic or alcohol abusive. n96 Since close to 66 percent of the DWI population suffers from alcohol problems, in contrast to a 10 percent incidence in the general population, n97 there appears to be a significant correlation between alcohol abuse and DWI. Researchers generally agree that alcoholics and alcohol abusers are more likely to be involved in traffic accidents than light drinkers or non-drinkers. n98 Therefore, it appears that drunk driving is symptomatic of the much bigger problem of alcoholism and alcohol abuse. n99

Virtually every state in the union has laws dealing with alcoholism. n100 These state statutes either implicitly or explicitly recognize alcoholism as a treatable disease. n101 At the same time, however, all of the states take a primarily criminal approach to the problem of drunk driving. n102 The problem of DWI, however, seems to implicate medical issues beyond the scope of the criminal law.

Applying criminal sanctions to those not in control of their actions is both counterproductive and ineffective. Herbert Packer's comments concerning the crime of public intoxication apply with equal force to the failure of criminal sanctions to control drunk driving. In Packer's words, such a failure "provides a classic illustration of the twofold evil that results from misusing the criminal sanction: we burden the operations of the criminal process to no avail, and we delude ourselves into believing that we have thereby solved a social problem." n103 Experience shows that public inebriation laws apparently did not affect the incidence of public drunkenness. n104 Experience also shows that the problem of driving while intoxicated is apparently unaffected by the various criminal approaches designed to curtail it. n105 The shortcomings of the criminal sanction in the DWI context are arguably the fault of states failing to recognize that the majority of DWI offenders have serious problems with alcohol abuse.

Because state laws relating to alcohol are internally inconsistent, getting to the root of the DWI problem appears difficult. If alcoholism is a disease under the public health code it should be treated as a disease in other areas of the law. Drafting a DWI law that is sensitive to the disease concept of alcoholism is potentially the most successful way to deal with the alcoholic DWI offender.

One such approach would be to require all DWI offenders to receive detoxification treatment, but this approach would be over-inclusive, since one-third of known DWI offenders are presumably in control of their drinking habits. n106 These "social drinkers" should be able to conform their conduct to the dictates of the law. A criminal sanction is appropriate for these social drinkers who know the consequences of drinking and driving, but decide to drive anyway.
To send social drinkers to a detoxification/rehabilitation program is an inappropriate medical response to a legal problem.

A second approach would be to impose a very severe criminal penalty on all DWI offenders. Although this might deter social drinkers, and although the general public might feel better having a "tough" drunk-driving law, it would do nothing to address the underlying drinking problems of two-thirds of the DWI offender class. Such a myopic approach would be inefficient in the long run.

A more reasonable approach would provide a mixture of punishment and treatment. This would entail testing all DWI offenders to determine their relationship with alcohol; if an offender is diagnosed alcoholic or alcohol abusive, he or she would be regarded as a person with a disease that affects driving ability. Disposition of the alcoholic DWI offender would be patterned after the way epileptic drivers are handled by the motor vehicle law. The alcoholic's license would be suspended until he could produce documented evidence from a doctor certified in the treatment of alcoholism that the offender's condition is being treated and that the offender is abstaining from alcohol. Furthermore, the law would require continued periodic documentation showing that the condition is under control in order to keep the driver's license in good standing. If an offender is diagnosed as a non-alcoholic, he would be sentenced with reasonable fines, community service, imprisonment, or a combination thereof. This new approach does not provide alcoholic DWI offenders with a complete excuse defense. Rather, it charges them with an affirmative duty to take care of their condition.

A. DIAGNOSTIC PROBLEMS

1. Separating Social Drinkers from Problem Drinkers

One criticism of this new approach is that it would be difficult to separate problem drinkers from "social drinkers." In the past fifteen years, the quality of alcoholism diagnosis and classification techniques has improved dramatically. As noted previously, alcohol consumption is defined along a continuum ranging from "healthy" to "chronic alcoholic." At the extremes, the diagnosis is accurate, but since most cases fall somewhere in the middle, professional judgment is required. The majority of police officers and judges do not possess the requisite medical expertise to diagnose alcoholism. In order to separate "alcoholics" from "non-alcoholics" for purposes of disposition under a disease concept DWI law, therefore, all offenders would be required to see a state-certified alcohol clinician for a diagnostic session. Although no one screening test has gained acceptance from all members of the alcohol research community, a clinician using a battery of tests can make a meaningful determination of the individual's relationship with alcohol. This determination would be passed along to the court for appropriate disposition. Several states currently require the screening of all DWI offenders for possible alcohol abuse problems. This is a step in the right direction, but it does not go far enough. Although an offender may be diagnosed alcoholic, judges in most states still have discretion to require treatment or impose a criminal sanction.

A judge should not have the discretion to impose only punishment, and no treatment, on a DWI offender diagnosed as alcoholic. If an offender is diagnosed as having a disease, an appropriate disposition should always include treatment. In some cases, a combination of treatment and punishment may be required, but the treatment aspect should not be omitted. For example, if an epileptic caused an accident because of an uncontrolled seizure, it would be unusual for a court to sentence that person without requiring him to either obtain treatment, or stop driving, or both. The same should hold true for alcoholic drivers. Under a coherent disease concept approach, the judge would have very limited discretion with regard to the alcoholic offender's punishment and treatment.

2. Imposters

Critics also raise the concern of an alcoholic posing as a "social drinker." If the balance between the punishment and treatment modes of disposition has been carefully struck, however, there will be no incentive for "social drinkers" to pose as "problem drinkers," or vice versa. A major goal of a mixed disposition approach is to overcome the notion that treatment means "letting the offender off easy." Although past and current court-ordered "treatment" programs have been called, with some justification, a "slap on the wrist," a true recovery program is an arduous journey which would not reward those seeking to avoid criminal sanctions with a pleasant hotel stay.

Differentiating between punishment and treatment is not always easy. The degree of unpleasantness or the severity of the disposition is not the defining characteristic. To use Herbert Packer's example, "thirty days in jail for disorderly conduct is much less unpleasant than a lifetime in the locked ward of a state mental hospital. Yet common usage will
unhesitatingly classify the former as Punishment and the latter (perhaps not quite so unhesitatingly) as Treatment."

The ultimate goal of the disease concept DWI laws will be to treat the alcoholic offender as a sick individual even though he has committed an act which is a crime when committed by a "social drinker." The obvious parallel to the insanity defense is intentional. n113 We do not punish insane offenders, but use the criminal justice system as a screening device to channel these individuals into the health care system. n114 As with the treatment of the insane, alcoholism treatment should be designed to cure the truly ill, not coddle imposters.

B. TREATMENT PROBLEMS

Another difficulty with the proposed DWI approach involves how much treatment to require once an offender has been diagnosed as "alcoholic" [*121] or "alcohol abusive." As a practical matter, this determination largely depends on the attitude of the patient. If he is cooperative and motivated, progress will be his reward. If, however, the patient is recalcitrant and stubborn, it will take a longer time for him to start his recovery. n115 Under a disease concept DWI law, the offender would have to remain under active treatment until an accredited alcohol clinician could certify that his alcoholism was under control, however long that might take.

No one is ever "cured" of alcoholism. n116 Treatment after detoxification/rehabilitation, called "aftercare," is imperative. n117 In the proposed disease concept DWI law, diagnosed alcoholic drivers would be handled as epileptic drivers are currently handled. An epileptic who is not in treatment, and is therefore not in control of his seizures, poses a serious public safety problem when he is behind the wheel of an automobile. Similarly, an alcoholic driver who is not in recovery, and therefore not in control of his drinking, also poses a serious public safety problem.

All states require epileptic drivers to produce evidence that they are in control of their seizures before they can receive a driver's license. n118 These laws usually require proof of a long seizure-free period in order to establish [*122] that the epileptic is in control of his seizures. Additionally, most states require periodic reports from the epileptic's physician to certify that the epileptic is maintaining his treatment. n119 The same requirements should apply to alcoholic drivers, since the broadly-worded driving laws used to reach epileptic drivers grant power to the commissioner of motor vehicles to deny a license to anyone who is medically unfit to drive. n120 Often, the same laws that bar epileptics from driving specifically deny "habitual drunkards" the right to drive as well. n121 Under a disease concept approach, a state could require treatment and an alcohol-free period of a year or more as a prerequisite for return of the driver's license n122 and also require periodic certification from an accredited alcohol clinician that the alcoholic is continuing his treatment and receiving aftercare. n123

To fully implement this proposal, drivers who have been diagnosed alcoholic would have to be reported to a state's department of motor vehicles. Several states require epileptics, doctors, or others to report epileptic drivers to the state motor vehicle department. n124 These reporting laws have come under attack from groups like the Epilepsy Foundation of America as being an invasion of the doctor/patient privilege and for tending to discourage some people from seeking treatment of their condition. n125 These concerns could be met by applying the reporting requirement only to those cases where alcohol treatment is received pursuant to legal proceedings. Moreover, some courts have held that the state's interest in maintaining public safety is compelling enough to override the doctor/patient privilege. n126

[*123] Another controversial issue in the area of treatment is that requiring an offender to check into a treatment facility could amount to involuntary civil commitment. n127 This problem could be avoided by not actually requiring treatment, but rather by making successful completion of a treatment program and continuing aftercare reports a condition for return of his license. The offender has the choice to either undergo treatment voluntarily and get his or her license back, or refuse treatment and give up the driving privilege.

1. Court Ordered Treatment Programs

There is a good deal of controversy as to the effectiveness of DWI rehabilitation programs. n128 Much of the controversy surrounds a program adopted by the federal government in the 1970's called the Alcohol Safety Action Project (ASAP). ASAP had many components, including public education, driver training schools, increased enforcement, and required treatment programs. n129 The most controversial component dealt with the identification and rehabilitation of problem drinkers. The federal government eventually set up pilot programs in thirty-five cities before funds ran out. The ASAP programs could not be adequately evaluated due to design flaws. n130 However, anecdotal evidence and a methodologically suspect follow-up study n131 pronounced the project ineffective.
The biggest problem with the follow-up study was an unstated belief that the goal of the ASAP programs was to reduce alcohol-related traffic fatalities. With that goal in mind, the study "proved" the ineffectiveness of the ASAP programs by finding no significant decrease in the incidence of fatal accidents involving alcohol after the programs were initiated. \[^{n132}\] The study failed to note that in all alcohol-related highway fatalities, 96 percent \[^{n124}\] of alcohol-impaired drivers had never been apprehended for drunk driving before the accident. \[^{n133}\] To label a treatment program aimed at specific deterrence "ineffective" because individuals who have not gone through treatment have continued to engage in the offensive behavior, is simply not a valid criticism.

Alcoholism is a disease. People do not recover from a disease just because a new law has been passed. To evaluate the treatment approach, studies must focus on the effect of the treatment program on those who were treated. The goal of such studies would be to evaluate the public health consequences of more widespread treatment of alcoholism, rather than the treatment program's effect on safety.

Another study of ASAP evaluated its effect on recidivism. \[^{n134}\] The study "provided no overwhelming evidence of program effectiveness as measured by reductions in crash or arrest recidivism" (emphasis added), \[^{n135}\] although some reductions were reported. The report found that education programs had a small positive deterrent effect for social drinkers. Large impersonal lecture classes, however, had either no effect or a negative effect on deterring problem drinkers. \[^{n136}\] A significant, but frequently overlooked finding of the report was that problem drinkers attending smaller, more personalized group therapy programs had lower re-arrest rates than those attending larger, more impersonal programs. \[^{n137}\] The authors of the study, recognizing the methodological problems inherent in trying to evaluate the ASAP program, cautioned against placing too much emphasis on the findings of the evaluation reports.

The allegation that ASAP was ineffective in responding to the problem of alcoholic drivers is based on intrinsically flawed studies. These studies do not show that a treatment approach, like the one advocated in this Note, cannot work. Rather, they show that such a program must be evaluated in terms of its public health consequences and must treat alcoholics as individuals with a disease. The effectiveness of such a program has been neither proved nor disproved.

### 2. Assuring Compliance With Treatment Programs

Critics may argue that it would be extremely difficult to assure compliance with the treatment programs. However, it is constitutionally permissible \[^{n125}\] for a state to impose criminal sanctions on an individual who fails to adhere to a medical program designed to protect public health and safety. \[^{n139}\] As with the epileptic who fails to maintain his treatment, the state is justified in suspending the driver's license of the alcoholic driver who refuses treatment or returns to active alcoholism. \[^{n140}\] If the driver continues to drive without a license, enforcement should be very strict. This two-stage disposition of the alcoholic offender is a carrot and stick approach. The initial treatment program is the carrot, but if that fails, the state may resort to the stick of criminal and civil penalties.

This resort to criminal sanctions against the alcoholic offender is not inconsistent with the proposed approach. The disease concept DWI law operates on the assumption that most offenders are unaware of their alcoholic status at the time of arrest. The diagnosis and court proceedings are medically and legally significant events that put the offender on notice that he is an alcoholic, not merely that he was driving while intoxicated. The sentence creates a duty on his part to take care of the condition. Therefore, punishment of an individual for failure to receive or maintain treatment for a known condition in order to protect public health and safety is not unconstitutional punishment for having the condition.

### C. PUNISHMENT PROBLEMS

#### 1. Punishing "Social Drinkers"

Critics are concerned with the disposition of the "social drinker" portion of the offender class and how to most effectively penalize that class. Popular thinking on this subject seems to be "the bigger the penalty, the better the deterrence." This simple formula, however, has not been confirmed by empirical data. \[^{n141}\] Although most states that tough drunk driving laws do experience a short-term decline in the number of drunk driving related accidents, the effect is always just a short-term phenomenon. \[^{n142}\] The key to deterrence lies in the enforcement of the laws. \[^{n143}\] The chance of getting caught for DWI in the average American city \[^{n126}\] has been estimated at one in 2000, \[^{n144}\] which is less than the risk of getting in an automobile accident. \[^{n145}\] This enforcement rate is so low that even the heaviest fine is deeply discounted, resulting in a small deterrent effect. Part of the answer to the drunk driving problem
seems to lie in increasing the enforcement rate, or at least the perceived enforcement rate, for DWI. Still, that insight does not tell us how severe DWI penalties should be.

Our legal system requires that the penalty fit the crime. Judges sentence offenders in DWI cases. Some judges see the crime of DWI as so heinous that only a very great penalty will "pay" for it; other judges take a more lenient attitude. Despite these differences, judges in the same jurisdiction must strive to apply the law consistently and fairly.

The state may try to achieve the desired consistency through determinate sentencing. All violators would be treated exactly the same way. What this approach gains in consistency, it sacrifices in fairness. Often there are extenuating circumstances that call for a heavier or lighter penalty than the one mandated.

The disease concept DWI law would strive to ensure consistency, yet also allow flexibility. Under the proposed disease concept DWI law, if the findings of the clinician are not findings of fact but only recommendations, the court would retain its discretion to choose between treatment and punishment for the offenders. Presumably, some judges would sentence all offenders with a criminal sanction, thereby frustrating the goal of treating the medical problem of alcoholism, while other judges would sentence all offenders to treatment, thereby frustrating the goal of holding social drinkers responsible for their acts.

To avoid this problem, either the clinicians' findings must be binding on the court, or there must be a proper balance between the severity of punishment and the rigor of treatment so that judges will dispose of all cases properly. To achieve this balance, the treatment aspect of the law must be rigorous and lengthy enough to convince the "tough" judges (and juries) that the offender is not "getting off scot-free." In the proposed disease concept DWI law, the "treatment" option requires loss of license until documented successful treatment is achieved. Because the "treatment" disposition for the problem drinker may result in permanent loss of license, it is demanding enough "tough" judges would be willing to apply it. On the other hand, the criminal penalty for the social drinker must not be so onerous that lenient judges will be reluctant to apply it. A recurring problem with drunk driving laws is that the penalties are so severe that judges and juries hesitate to apply them.

Therefore, in the disease concept DWI law, the criminal sanctions would be marked by moderate fines, imprisonment, or community service. The treatment aspect would contain a serious alcoholism rehabilitation program (not just a driver's education program) with a rigorous aftercare component, requiring ongoing documentation of continued treatment.

2. Driver Culpability for Resultant Harm

Another argument against the disease concept approach is the problem of resultant harm caused by the drunk driver. The example often used is that of an innocent person killed by the alcoholic driver. A judge who is sensitive to public opinion will find it difficult to stick to the principles of culpability developed by H.L.A. Hart. Groups such as Mothers Against Drunk Drivers (MADD), Students Against Drunk Drivers (SADD) and Remove Intoxicated Drivers (RID) have done an excellent job in promoting public awareness of the drunk driving problem. Unfortunately, since the members of these groups usually have lost a loved one to a drunk driver, they have also done much to suffuse the issue with emotion. Emotionalism and the current penchant for "tough" punishment may unconsciously help society satisfy a need for cathartic retribution, but such primitive impulses are inappropriate in a culpability-based system of criminal justice.

As a logical matter, the problem of how to dispose of the alcoholic DWI offender in this situation is not difficult. The culpability of the alcoholic DWI offender must be evaluated just like any other defendant. If the court or jury determines that the offender had some degree of culpability, then he should be found guilty of some degree of homicide, ranging from vehicular homicide to murder. The mere presence of attendant harm does not make an offender more culpable. It would be appropriate in some cases to revoke the alcoholic defendant's license until successful completion of treatment, without criminal liability. This disposition would be appropriate if the court determined that the offender was involuntarily intoxicated. An argument can be made that a chronic alcoholic is involuntarily intoxicated, even though it appears that he has consumed alcohol voluntarily.

Many analysts determine the culpability of an intoxicated (not necessarily alcoholic) offender by determining the offender's culpability at the time of his first drink. This mens rea, or mental state, is then applied to the crime committed while the offender is intoxicated. While this analysis may be appropriate for the intoxicated offender, it does not work when dealing with the alcoholic offender. An alcoholic is an alcoholic whether he is dry or intoxicated.
n155 Determining an alcoholic's mens rea at the time of the first drink is meaningless. The compulsion to drink is as involuntary at the time of the first drink, as it is at the time of the tenth drink. An involuntary act has no mens rea. On the other hand, the social drinker is not compelled to drink. He has an identifiable mens rea at the time of the first drink, and is therefore appropriately subject to the criminal law in accordance with H.L.A. Hart's culpability principle.

The task of the criminal law is to determine the culpability of the offender. The problem of resultant harm is not the concern of the criminal law. Those aggrieved by a defendant's acts may proceed against him in a civil action if they desire compensation.

D. ADMINISTRATIVE COSTS OF THE NEW APPROACH

Critics are concerned that the disease concept DWI law may cost too much. Since the state can require the defendant to pay for his own treatment at a private treatment facility, however, the actual cost to the state would consist of administrative costs, diagnosis of all DWI offenders and [*129] treatment for the indigent. n156 Currently, some states require health insurance plans to cover the cost of alcohol treatment. n157 Because the disease concept DWI law will increase the use of treatment facilities, it will require insurance companies to pay more benefits, which will probably result in marginally higher premiums for everyone. Coordination between the courts, treatment facilities and the state department of motor vehicles will entail administrative costs. Certification and inspection of alcohol clinicians and treatment facilities will also cost money.

Despite these outlays, it must be remembered that leaving the disease of alcoholism untreated entails significant costs as well. n158 To quote George Vaillant:

alcoholism costs the United States upwards of $50 billion a year. Indeed, if one multiplies the approximately 4 million alcohol-abusing wage earners in the United States by the $8000 annual difference between the income of active [sample group] alcohol abusers and that of asymptomatic drinkers . . . . then the lost earning power alone of alcoholics comes to $30 billion a year. The $100 million a year that the federal government has invested on alcohol treatment programs in the past decade (0.2 percent of the cost of the disease) hardly seems extravagant -- especially when one considers that cost-benefit studies have repeatedly documented that alcohol outpatient clinics are cost-effective. n159

The disease of alcoholism has devastating economic and social effects. A disease concept DWI law could be an economically efficient way to combat this destructive force.

V. CONCLUSION

Alcoholism is a disease and is a major health problem in America. Alcoholics and alcohol abusers make up a disproportionate share of the class of DWI offenders. Drunk driving is a symptom of alcohol abuse. Because Anglo-American criminal law requires that, in order to be punished, a criminal offender commit a criminal act of his own volition, and because it is unconstitutional to criminal "status or condition," DWI laws should not punish alcoholic DWI offenders. Because the offender does not have the ability to control his intoxication, he cannot be held [*130] culpable. Instead, DWI laws should attack the root of the drunk driving problem, by acting as a screening device to channel alcoholics and alcohol abusers out of the criminal justice system and into the health care system. To insure continued safe driving, alcoholic drivers can be handled as are epileptic drivers. An alcoholic driver would lose his license until he successfully fully completed treatment. Thereafter, in order to keep his license, the offender would have to present periodic evidence of continued treatment.

Given modern methods of diagnosis and treatment, this approach could have a significant impact on one of the most misunderstood health problems in America today-alcoholism.

FOOTNOTES:

n1 For a discussion of the history of alcohol use, see Tongue, 5,000 Years of Drinking, in DRINKING: ALCOHOL IN AMERICAN SOCIETY -- ISSUES AND CURRENT RESEARCH 31-38 (J. Ewing & B. Rouse eds. 1978) [hereinafter cited as DRINKING].

n2 In classic Hammurabian style, violations of the law were punishable by death. Id. at 32.
n3 The criminal sanction was rarely applied, however. Howland & Howland, 200 Years of Drinking in the United States: Evolution of the Disease Concept, in DRINKING, supra note 1, at 39, 42-43.


n5 Quoted in Waller, Drinking and Highway Safety, in DRINKING, supra note 1, at 117.

n6 U.S. DEPT. OF HEALTH AND HUMAN SERVICES, FIFTH SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL AND HEALTH 9 (Dec. 1983) [hereinafter cited as ALCOHOL AND HEALTH].

n7 N.Y. Times, Sept. 30, 1984, § 1, at 41.

n8 Id., June 19, 1985, § 1, at 1.

n9 Id., May 21, 1985, § 3, at 9.

n10 Id., April 29, 1984, § 22, at 10.

n11 Id., April 21, 1984, § 1, at 6.


n13 See infra notes 95-96 and accompanying text.

n14 See infra text accompanying notes 72-80.

n15 See infra text accompanying notes 81-100.

n16 The initials "DWI" (driving while intoxicated) are used throughout this Note to designate laws relating to the operation of motor vehicles while intoxicated or under the influence of alcohol, although the specific crime has many different names in the various states. Levine, The Vocabulary of Drunkenness, 42 J. STUD. ALCOHOL 1038 (1981).
n17 See infra text accompanying notes 103-105.


n20 U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *ALCOHOL AND HEALTH*, FOURTH SPECIAL REPORT TO THE U.S. CONGRESS (1981). Alcoholism research terminology is currently undergoing a change. This paper uses the terms "alcohol abuse" and "problem drinking" interchangeably, and also uses "alcoholism" and "alcohol dependence" as synonyms. The third edition of the *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (American Psychiatric Association 1980) [hereinafter DSM III] defines alcohol abuse as a set of symptoms including: (a) a pattern of pathological alcohol use, sometimes evidenced by daily consumption, binge drinking, and continued drinking despite a serious physical disorder that the individual knows is exacerbated by alcohol, etc.; (b) impairment of social or occupational functioning due to alcohol use, sometimes evidenced by violence while intoxicated, absenteeism, legal problems, domestic disturbance, etc.; and (c) duration of disturbance for at least one month. DSM III defines alcohol dependence as all of the above, plus either: (d) tolerance (need for increased amount of alcohol to reach desired result); or (e) withdrawal after cessation or reduction in drinking (morning shakiness, malaise, nausea). See also *ALCOHOL AND HEALTH*, supra note 6, at 100-02.

n21 E. JELLINEK, THE DISEASE CONCEPT OF ALCOHOLISM (1960). Dr. Jellinek had extensive clinical experience in the treatment of alcoholics. His book tried to identify some common denominators characteristic of alcoholism. His clinical experience showed him that not all alcoholics followed the same course. He identified four types of alcoholics, which he called "alpha," "beta," "gamma," and "delta." "Gamma" and "delta" alcoholics had a physiological dependence on alcohol. Jellinek's typology is no longer used, but his major contribution to the field, the initiation of serious discussion of alcoholism as a disease, lives on.

n22 Gitlow, *Alcoholism: A Disease*, in *ALCOHOLISM: PROGRESS IN RESEARCH AND TREATMENT* 3 (P. Bourne ed. 1973) [hereinafter cited as ALCOHOLISM: PROGRESS]. The outward manifestations of alcohol dependence are listed by Gitlow as follows: character disorganization, diminished ability to achieve potential, decreased attention span, diminished ability to concentrate, tremulousness, insomnia, recurrent somatic symptoms (especially headache, bowel dysfunction, muscle spasm, fatigue, palpitations, and exaggerated subjective response to minor local pathology), diminished seizure threshold, and eventually elevated tolerance, amnestic episodes, hallucinations and delirium. The most critical aspect of the patient's history is recurrent use of the sedative agent despite evidence that alcohol adversely affects some aspect of his life (health, work, interpersonal relations, etc.). The progressive nature of this deterioration, usually obscured by an elaborate and powerful denial system, is an almost universal characteristic. Recurrent episodes of increased psychomotor activity, necessitating continued use of some sedative agent in a vain attempt to control the agitation, are regularly noted in and almost limited to the alcoholic population. *Id.*


n24 ALA. CODE § 27-20A (Supp. 1985); ALASKA STAT. § 47.37.010 (1984); ARIZ. REV. STAT. ANN. § 36-2021 (1974 & Supp. 1985); ARK. STAT. ANN. § 83-718 (1976); CAL. WELF. & INST. CODE §


n27 See id., passim.


n29 Id. at 759.

n30 Id.

n31 Id. at 757.


n33 Cambell, Scadding and Roberts, supra note 28, at 759.

n35 Cambell, Scadding and Roberts, supra note 28, at 759.

n36 DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 635 (26th ed. 1985).

n37 Maxwell, A Functional Approach to Screening, in THE HYPERTENSION HANDBOOK 53 (1974); see infra note 61.

n38 Cambell Scadding and Roberts, supra note 28, at 759.

n39 Epileptics do not refer to epilepsy as a "disease": they prefer to call it a "neurological disorder." By doing so, they seek to avoid the negative connotations of the word "disease." Interview with Barbara Walters, Epilepsy Foundation of America, Boston, Mass. (March 8, 1985).


n44 See L. KOLB, MODERN CLINICAL PSYCHIATRY 640 (9th ed. 1977).


n46 See supra note 42.


n48 ALCOHOLISM: PROGRESS, supra note 22, at 6.
n49 Cambell, Scadding, and Roberts, supra note 28.

n50 DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, supra note 32.

n51 Id.

n52 NATURAL HISTORY, supra note 41, at 2. The Harvard Medical School study of Adult Development began in 1940 when researchers Sheldon and Eleanor Glueck at Harvard Law School selected 456 inner city males as a control group for their prospective study on juvenile delinquency. The inner city group males were all junior high school students, and were predominantly in the lower and lower-middle social classes. The Gluecks obtained extensive social service records on the group, allowing the researchers to determine each subject's ethnicity, "alcohol heredity," and childhood strengths and problems. The inner city subjects were interviewed at ages 25, 31, and 47. A second group of subjects in the study was taken from the Harvard College sophomore class of 1940. This group consisted of approximately 200 young men in the upper middle and upper social classes. The background of this group was determined through medical records. The subjects in this group were interviewed every two years until age 55.

Aside from the original medical and social background information, all of the data collected in the study were self-reported by the subjects in interviews with the researchers. Vaillant, Paths Out of Alcoholism, in EVALUATION OF THE ALCOHOLIC: IMPLICATIONS FOR RESEARCH, THEORY AND TREATMENT 383-85 (Meyer ed. 1981) [hereinafter cited as EVALUATION].

n53 NATURAL HISTORY, supra note 41, at 2.

n54 Id. at 311.

n55 Goodwin, supra note 43, at 98.

n56 See, e.g., Cadoret, Cain and Grove, Development of Alcoholism in Adoptees Raised Apart from Biologic Relatives, 37 ARCHIVES OF GENERAL PSYCHIATRY 561-63 (1980).


n58 Schmeck, supra note 45.

n59 Previous studies have also "discovered" traits which are common to alcoholics, although many have turned out to be spurious. For a humorous essay, see Keller, The Oddities of Alcoholics, in EMERGING CONCEPTS OF ALCOHOL DEPENDENCE 63 (E.M. Pattison, M. Sobell and L. Sobell eds. 1977) [hereinafter cited as EMERGING CONCEPTS].

n60 Marlatt, The Drinking History: Problems of Validity and Reliability, in EVALUATION, supra note 52, at 28.
Hypertension provides a helpful analogy. Possible human blood pressures define a continuum from very low blood pressure to very high blood pressure. At the extremes, diagnosis is easy and accurate. For example, a patient with blood pressure of 30 over 20 would have incredibly low blood pressure, while a patient with blood pressure of 250 over 180 would have dangerously high blood pressure. Most people, however, fall somewhere between these two extremes. "Normal" blood pressure is about 120 over 80. R. GRAY, ATTORNEY'S TEXTBOOK OF MEDICINE 180-15, P180.23 (3d ed. 1985). But what about a person with blood pressure of 140 over 100? Is it high? Or is it within range of "normal"? A physician would have to use medical judgment to decide, because blood pressure varies considerably with age, sex, race, climate and weight. Id.; Maxwell, supra note 37. Similarly, alcohol dependence exists on a continuum, and must be evaluated by a trained observer who can consider the many ways that alcohol affects the individual's life -- physically, psychologically, socially, etc. Once the alcohol has an effect on the individual's life different from that of any other beverage, the individual has the beginnings of an alcohol problem. If that problem grows to such a degree that it interferes with the individual's physical health, social, work, or familial relationships, then the individual is an alcoholic.

Some people will think that hypertension is more precise, despite its subjective nature, because doctors can measure blood pressure and assign it a numeric value. What most people fail to appreciate, however, is that a person's blood pressure reading can vary significantly depending on the time of day the reading is taken, the state of mind of the patient, the skill of the person taking the measurement, and the type of measuring device used.

See supra note 20 for a description of these terms.

As with many other medical conditions, diagnosis of alcoholism must be done on a case by case basis. Other conditions requiring individual diagnoses are hypertension and senility. Because of the subjective nature of alcoholism, however, some researchers question whether the "unitary disorder" approach to the disease concept of alcoholism is correct. These researchers favor the notion of "alcohol dependence" to describe this multifaceted problem. Pattison, Sobell & Sobell, Old and New Views of Alcohol Dependence, in EMERGING CONCEPTS, supra note 59, at 3. Their thesis posits that the condition "alcoholism" is a state marked by various symptoms and behaviors for which the "general case" cannot be meaningfully described. In this view, there can be as many alcoholisms as there are alcoholics. NATURAL HISTORY, supra note 41, at 3. Despite their questioning the so-called "unitary disorder" approach to alcoholism, these researchers do not question the idea that alcoholism is a disease. Their point is that it is a more complex disease than measles or chicken pox, for example, which are unitary disorders.

These three points are taken from the eleven-point outline given in EMERGING CONCEPTS, supra note 59, at 4-5.

Szasz, Bad Habits are not Diseases: A Refutation of the Claim That Alcoholism is a Disease, 2 LANCET, 83-84 (1972), quoted in NATURAL HISTORY, supra note 41, at 19.

See supra text accompanying notes 52-56.


NATURAL HISTORY, supra, note 41, at 19.
n69 As Thomas Szasz notes, "The expression 'mental illness' as a convenient term of derogation, denigration or thinly veiled attack has become part of everyday life." T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 20 (1963).


n71 In more detailed form, the goals of the criminal sanction can be described as follows: Deterrence. General deterrence warns the population at large that severe consequences will result from criminal behavior. S. KADISH, S. SCHULHOFER AND M. PAULSEN, CRIMINAL LAW AND ITS PROCESSES 195 (4th ed. 1983).

In theory, people weigh the benefit to be gained from committing the crime against the penalty for the crime discounted by the chance of being caught. If the benefits outweigh the costs, the individual will commit the crime. Specific deterrence seeks to prevent a particular individual from committing a crime. Id. To meet this goal, the penalty for breaking the law must exceed the individual's subjective benefit from breaking the law.

Incapacitation. In some situations, the goal of the criminal sanction is to get a dangerous individual "off the streets." Incapacitation seeks to physically restrain a criminal offender so that he no longer has the capacity to commit crime. H. PACKER, THE LIMITS OF THE CRIMINAL SANCTION 48 (1968).

Retribution. The visceral urge to get revenge runs deep in the law, though it is often an unstated goal. This is especially true where the law-breaker is considered an immoral person. See J. STEPHEN, A HISTORY OF THE CRIMINAL LAW OF ENGLAND 81-82 (1883). Retribution has been justified on the distributive justice grounds that criminals have gained an unfair advantage over the rest of the society by casting off the burdens of self-restraint shouldered by the rest of the law-abiding public. According to this argument, to bring the criminal back into line with the rest of the citizens, restraint must be imposed upon him in the form of punishment. H. MORRIS, ON GUILT AND INNOCENCE 33-34 (1976).

Rehabilitation. Under this theory, society can use the prison system as a way to address an offender's underlying psychological problems and nip his life of crime in the bud. Prisons, however, are ill-suited as "rehabilitation centers." They are places for punishment. See Martinson, What Works? -- Questions and Answers About Prison Reform, 35 PUB. INTEREST 22 (1974). For this reason, the goal of rehabilitation is often given short shrift, although it is important not to dismiss non-prison rehabilitation programs.

n72 W. LAFAVE, A. SCOTT, HANDBOOK ON CRIMINAL LAW 178 (1972).

n73 Id. at 177.


n76 As a practical matter, we must retain at least the will to believe in free will. W. James, The Will to Believe, in THE WILL TO BELIEVE AND OTHER ESSAYS IN POPULAR PHILOSOPHY 24-25 (1896). William James makes a fitting analogy to describe the problem of free will versus determinism. He suggests that we think of a chess match between the reigning world champion and a novice chess player. The outcome of the match is practically predetermined -- the chess master will win. However, the individual moves that the
novice makes are still within his free will to control. In this way, free will and determinism coexist in the same world. See The Dilemma of Determinism, Id. at 181.


n78 Model Penal Code § 4.01 (1962).

n79 W. LAFAVE, Supra note 72, at 268. Although involuntary commitment of an insane offender to a mental institution serves the same goal of incapacitation that imprisonment would serve, the goals of hospitalization differ from the goals of incarceration. H. PACKER, supra note 71, at 25. The goal of hospitalization is treatment; the goal of incarceration is punishment. Generally treatment benefits the person being treated, without regard to past or future conduct. Punishment is meted out, as noted above, to incapacitate, deter, or to exact retribution for previous behavior. Therefore, the justifying purposes of the two processes are divergent. They seem to converge on the fourth goal of the criminal sanction, rehabilitation. This, however, is a false notion. Although society may inflict punishment on someone and say "he will be better off for it" (which looks like a treatment goal), that is not the complete reason why society imposes criminal sanctions. The ultimate aim of the criminal sanction is the prevention of the offending conduct, not the betterment of the offender. Id. at 27-28.

n80 See infra text accompanying notes 151-155.


n82 370 U.S. at 660-61 (quoting CAL. HEALTH & SAFETY CODE § 11721 (repealed 1972)).

n83 370 U.S. at 666.


n85 See generally Wald, Alcohol, Drugs, and Criminal Responsibility, 63 GEO. L.J. 69 (1974); Fingarette, Addiction and Criminal Responsibility, 84 YALE, L.J. 413 (1975).


n87 392 U.S. 514 (1968).

n88 In the period from 1949 to 1966, Powell was convicted of public inebriation approximately 100 times. 392 U.S. at 555 (Fortas, J., dissenting). After testimony by a noted psychiatrist, the trial court made the following findings of fact:
(1) Chronic alcoholism is a disease which destroys the afflicted person's will power to resist the constant, excessive consumption of alcohol;
(2) A chronic alcoholic does not appear in public by his own volition, but under a compulsion symptomatic of the disease of chronic alcoholism; and
(3) Leroy Powell is a chronic alcoholic who is afflicted with the disease of chronic alcoholism. 392 U.S. at 521.

n89 392 U.S. at 532.

n90 Id. at 559 (Fortas, J., dissenting).

n91 Justice Fortas, devoting the largest part of his dissent to a discussion of the disease concept of alcoholism, suggested that the reason Powell's defense failed was because the majority did not accept the disease concept. Id. at 559-65 (Fortas, J., dissenting).

n92 Id. at 535.

n93 Id. at 528.

n94 ALCOHOLISM: PROGRESS supra note 22, at 6-7. In the treatment community, "dryness" refers to abstinence from drinking without further treatment, while "sobriety" refers to arrested drinking accompanied by a treatment program. C. BEPKO, THE RESPONSIBILITY TRAP 80 (1985). A third argument of the majority was the fear that the compulsion argument would be used by all criminals, from vagrants to murderers. 392 U.S. at 534. This argument is a complete non-sequitur. The crux of the argument is that, the Court cannot "draw the line" on Robinson-type defenses. Line-drawing, however, is the Court's job; every case requires that a line be drawn somewhere. To say that the Robinson defense could not be extended to alcoholism because it would be impossible to draw the line on other conditions is, in effect, a line-drawing decision. Since the Court draws the line by saying that it cannot draw a line, its argument is illogical on its face.

n95 Schmidt and Smart, Alcoholics Drinking and Traffic Accidents, 20 Q. J. STUD. ALCOHOL 631 (1959) (compared to the general driving population, alcoholic drivers were found to be involved in a significantly larger number of collisions per year per miles driven. The ratio between the observed and expected number of collisions for the alcoholic group was 1.8: 1); Filkins, Alcohol Abuse and Traffic Safety: A Study of Fatalities, DWI Offenders, Alcoholics and Court-Related Treatment Approaches, summarized by Vingilis, Drinking Drivers and Alcoholics, in RESEARCH ADVANCES IN ALCOHOL AND DRUG PROBLEMS 332 (1983) (study found that 1.9 times as many alcoholics had two or more crashes over a given period of time when compared to a control group); Eelkema, A Statistical Study on the Relationship Between Mental Illness and Traffic Accidents -- A Pilot Study, 60 Am. J. PUBLIC HEALTH 459 (1971) (study showed a 1.6: 1 ratio for alcoholics, which reduced to nearly 1: 1 after alcoholics received treatment).

n96 DRINKING, supra note 1, at 127. In this study, the researcher based his evaluation on driving records and materials available through public agencies, such as the county welfare and probation departments, rehabilitation clinics, state mental hospital and family service agencies. On his scale, "alcoholic" was determined by the number of contacts the DWI offender had with various government agencies. Since most of these governmental services are geared to the lower end of the socio-economic scale, this study is probably underinclusive, in that the estimate that two-thirds of the DWI population is alcoholic or alcohol abusive is probably too low.
n97 ALCOHOL AND HEALTH, supra note 6.

n98 Fell, Alcohol Involvement in Traffic Accidents: Recent Estimates from the National Center for Statistics and Analyses, NHTSA TECHNICAL REPORT NO. DOT HS 806-269 (1982).

n99 Every state attacks the problem of drunk driving through its criminal law as if it is unconnected to the larger problem of alcohol abuse, but few states effectively combat the underlying problem. When viewed in this light, the drunk driving laws in most states seem to illustrate Thoreau's observation that "[t]here are a thousand hacking at the branches of evil to one who is striking at the root." H. THOREAU, WALDEN 68 (Modern Library Edition 1937).

n100 See supra note 24.

n101 See supra note 25.


n103 H. PACKER, supra note 71, at, 345.


n106 Waller found that two-thirds of those charged with DWI had drinking problems. See DRINKING, supra note 5.

n107 Ludwig, Treatment and Sentencing: The Power of the Court, the Rights of the Defendant, and the Legal and Ethical Implications of Sentencing Alternatives, 8 CONT. DRUG PROB. 381, 382 (1979).

n108 See supra text accompanying notes 60-63.

n109 This can be determined by looking for correlations in several tests instead of placing all of the diagnostic burden on one screening device. For a tidy summary of the leading clinical tests for alcoholism, see G. JACOBSEN, THE ALCOHOLISMS (1976).


n112 H. PACKER, supra note 71, at 25.

n113 Some courts have recognized that long continued drinking can lead to actual insanity. See, e.g., Rucker v. State, 119 Ohio St. 189, 162 N.E. 802 (1928); Britts v. State, 158 Fla. 839, 30 So. 2d 363 (1947); Meyers v. State, 83 Okla. Crim. 177, 174 P.2d 395 (1946).

n114 W. LAFAVE, supra note 72, at 208.

n115 Treating the Unwilling Patient, in ALCOHOLISM: PROGRESS, supra note 22.

n116 Id. at 6-7.


n119 See, e.g., KY. REV. STAT. § 186.411 (1980) (requires signed letter from physician each time license is renewed stating that condition is under control and that medication is being taken); WIS. STAT. ANN. § 343.09 (West Supp. 1985) (requires certification every six months for two years, then every two years for ten years; after a ten year seizure-free period, certification is no longer required).

n120 R. BARROW AND H. FABING, supra note 40, at 41.

n121 See, e.g., KAN. STAT. ANN. § 8-237(e) (1982); N.M. STAT. ANN. § 66-5-5(G) (1984); R.I. GEN. LAWS § 31-10-3(4) (Supp. 1984). California, Ohio and Washington have laws that allow the Department of Motor Vehicles to deny licenses to "alcoholics:" GAL. VEH. CODE § 12800(b) (West Supp. 1985); OHIO REV. CODE ANN. § 4507.08(A) (Page 1982); WASH. REV. CODE ANN. § 46.20.031(5) (Supp. 1985).

n122 Vermont's current law allows the court to make abstinence a prerequisite for reinstatement of driving privileges. VT. STAT. ANN. tit. 23, § 1208(e) (Supp. 1984).

n123 This follows from the way epileptic drivers are treated, see supra notes 118-120 and accompanying text.


n126 E.g., Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
n127 Ludwig, supra note 107, at 384-85.

n128 See generally Cameron, supra note 105.


n130 There were many flaws in the program's design, including: (a) the sites selected for pilot programs were not comparable to each other; (b) there were inadequate control sites; (c) there were too many countermeasure programs going on at the same time to establish a causal link between any one of them and a change in drunk driving behavior; (d) the projects were phased in too quickly -- new sites were added before data gathered from the original projects were evaluated; and (e) the programs were over-politicized. Reed, Reducing the Costs of Drinking and Driving, in ALCOHOL AND PUBLIC POLICY: BEYOND THE SHADOW OF PROHIBITION 368-70 (M. Moore & D. Gerstein eds. 1981).

n131 The study was methodologically weak for several reasons: (1) lack of sufficient data (3 years of baseline data and only 1 or 2 years of ASAP operational data); (2) insufficient statistical analysis; (3) obvious anti-ASAP bias; and (4) the design problems discussed in the text. See Johnson, Levy, and Voas, A Critique of the Paper "Statistical Evaluation of the Effectiveness of 'Alcohol Safety Action,'" 8 ACCIDENT ANALYSIS AND PREVENTION 67, 76 (1976).


n133 ALCOHOL AND HEALTH, supra note 105, at 533.

n134 Nichols, Weinstein, Ellingstad & Struckman-Johnson, The Specific Deterrent Effect of ASAP Education and Rehabilitation Programs, 10 J. SAFETY RESEARCH 177 (1978). Unfortunately, this study was also beset by methodological problems. Cameron, supra note 105, at 533. Serious methodological problems included lack of sufficient data and lack of a statistically rigorous control group.

n135 Quoted in Cameron, supra note 105, at 533.

n136 Nichols, supra note 134, at 185-86.

n137 Id. at 183.

n138 Id. at 186.

n139 Jacobsen, v. Massachusetts, 197 U.S. 11 (1905) (compulsory smallpox vaccination law calling for punishment by fine upheld as constitutional).
n140 Several states use alcohol education or treatment programs as conditions for suspending fines or fail sentences. See Treney, *DWI Laws: Getting Tough on Drunks*, 28 S.D.L. REV, 492, 496 n.26 (1983). Delaware requires successful completion of an alcoholic treatment program in order for a DWI offender to get his license back. DEL. CODE ANN. tit. 21, § 4177C (Supp. 1984).

n141 Cameron, *supra* note 105, at 524-525.

n142 Reed, *supra* note 130, at 343-44.

n143 The following equation illustrates the relationship between penalty, enforcement and deterrence:

where P = penalty for drunk driving;  
A = chance of being apprehended;  
C = cost to driver of being drunk;  
u = subjective utility to driver of driving drunk  

P x A = C

if C > u, then deterrence will be achieved  
if C < u, then driver will drive drunk  
if C = u, driver will be indifferent

In simple terms, the cost to the driver of driving drunk must exceed the value to him of driving drunk. The size of the penalty is only one component of the equation. If the penalty is very onerous, but the chance of getting caught is infinitely small, no one will be deterred from the behavior.


n145 Lecture by Ralph Hingson at Boston University School of Law, March 14, 1985.

n146 Cameron, *supra* note 105, at 542.

n147 S. KADISH, *supra* note 71, at 340; U.S. CONST. amend. VIII.


n151 *See supra* text accompanying notes 77-78.

n152 The MADD and SADD groups, while opposed to drunk driving, apparently do not view alcohol itself as a problem. "We aren't against drinking," notes the executive director of MADD, Donald Schaett. "We are just trying to encourage responsible behavior." Some critics say MADD and SADD are reluctant to attack alcohol abuse because the alcohol industry has co-opted these groups. Anheuser-Busch has given at least $70,000 to MADD and at least $200,000 to SADD. Seagrams and Sons is also a supporter of MADD. RID refuses to accept alcohol industry money. Conte, *Crusaders Against Drunk Driving Split Over Whether to Fight Alcohol Broadly*, Wall Street Journal, Nov. 6, 1985, at 35, col. 3.


n154 W. LAFAVE, *supra* note 72, at 342-45.

n155 *See* ALCOHOLISM: PROGRESS, *supra* note 22, at 6-7.

n156 Several states that have a treatment option in their DWI laws require the offender to pay the cost of treatment. *See, e.g.*, MICH. COMP. LAWS ANN. § 257.625(8) (West Supp. 1985); NEB. REV. STAT. § 39-669.07(3) (1984).

n157 *See, e.g.*, MASS. GEN. LAWS ANN. ch. 175, § 110(h) (West Supp. 1985); N.D. CENT. CODE § 26-39 (Supp. 1983).

n158 ALCOHOL AND HEALTH, *supra* note 6, at 93.

n159 NATURAL HISTORY, *supra* note 41, at 316.