Commentary: Cynthia's Dilemma

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Louis C. Charland’s (2002) paper arguing that heroin prescription to heroin addicts violates ethical standards lacks basic information that should be weighed in determining whether true consent is possible and, indeed, what the risks and benefits to the prospective participant. First, the definition of heroin prescription cited in the article is incomplete. Heroin is also prescribed for severe pain in the United Kingdom and other countries, and many physicians feel that it is a superior analgesic to medications available in North America. Thus heroin is not an experimental drug with unknown side effects. Second, the standard treatment for heroin addiction is methadone. While there are numerous clinical trials showing that methadone is effective in saving lives, there are so far no randomized clinical trials showing efficacy for heroin maintenance. It is not correct to say that it may be a “violation of justice” for North American addicts to not have heroin maintenance available because heroin has not been proven effective. There are numerous patently ineffective medications prescribed in other countries that are not permitted in countries with a high standard of science. The Dutch heroin trial does meet scientific standards, but it is not yet complete and published. Little can be concluded from the Swiss experience, because it was uncontrolled. A relevant fact is that heroin could be legally studied in the United States if an appropriate experiment were proposed and approved. At one time the National Institute on Drug Abuse issued a request for research proposals on heroin maintenance, but none of the applications met scientific standards and thus none received a high enough priority score to be funded.

The Swiss were concerned about the number of HIV infections and deaths from heroin overdose among addicts. Since many of the addicts refused to enter standard treatment, a group of clinicians were motivated by humanitarian concerns to induce more addicts into treatment. They offered them the same drug that they were currently using on the street without the attendant risks of impurities, infections, and overdoses. There is no evidence that the subjects taken into the Swiss heroin study were put at any increased risk as a result of the program. They were safer, not exposed to infections and overdose, given medical care and counseling, and given help with an abstinence program if they desired. On the other hand, the Swiss study produced no evidence that heroin maintenance is effective in leading to rehabilitation. This requires a randomized control group. They did demonstrate feasibility. From a pharmacological perspective, methadone is superior to heroin because one dose per day is compatible with normal function. Methadone patients can function in demanding jobs such as teaching school, practicing law or medicine, or driving long-distance trucks. Heroin has a short duration of action, requires injection rather than oral dosing, and thus interferes with normal activities.

While there was no designated control group, a number of applicants for the Geneva section of the Swiss study were put on a waiting list when heroin slots were not available. When they were contacted six months later, most had started on methadone and were no longer interested in the heroin program. It may turn out that the greatest benefit of heroin availability is attracting into the treatment system those heroin users who would not consider methadone. Some of them could later be moved to methadone as a transition and perhaps later to abstinence and naltrexone to block relapse.

Heroin prescription is not at all analogous to the alcohol example used by Charland. There the potential research subjects are abstinent, and the alcohol used experimentally could theoretically increase the risk of relapse. None of the heroin users offered heroin had achieved abstinence, and thus risk of relapse was not an issue.

Note that I have not addressed the issue of whether or not drug craving can influence decisional capacity. Clearly it can, depending on the state of the patient, the time since the last dose, and the presence of other drugs or illnesses affecting mental status. This question, however, is not relevant to the studies of heroin maintenance reviewed in the article where the “choice” is between street heroin of unknown quality with high known risk and medically supervised heroin in a comprehensive treatment program.

In summary, the conclusion that heroin maintenance studies violate ethical standards is simply incorrect. It would be completely different if the research involved offering heroin to former heroin addicts who might then be harmed. In the context of the studies conducted in Europe, I can see nothing but reduction of harm to vulnerable individuals already at great risk and in many cases already infected. My main concern about the studies is that they will divert resources from more definitive and proven treatments that are pharmacologically superior to heroin such as methadone, LAAM, buprenorphine, and naltrexone in combination with appropriate counseling and rehabilitation programs. Since many heroin users refuse these standard treatments, attracting them to the treatment system through heroin availability may save their lives.
Louis C. Charland’s paper “Cynthia’s Dilemma” (2002) opens with a recovering addict’s remark, but the basis for the argument is the Swiss heroin trial. “Cynthia’s dilemma,” according to the author, is that heroin addicts cannot adequately consent to participate in research where heroin is provided. The source of the dilemma, as the author sees it, is the nature of heroin addiction itself. Two points are offered to buttress this argument. First is that the offer of free heroin makes it impossible for addicts to give consent because they love the drug too much and this love so impairs their judgment that they cannot give voluntary consent. The compulsive need to seek and use heroin, the author says, impairs the addict’s decisional capacity to make choices about it. Second, the author contends that even if voluntary consent were possible, heroin addicts are mentally incompetent to make such a decision. Since competence, as the author sees it, must involve some sort of accountability, or value set, a competent choice must minimally reflect a person’s real likes and dislikes (what the addict likes is to get high, and what he dislikes is to get sick).

To the author, being dependent means that every fiber of an addict’s being is bent on seeking heroin. Addicts no longer seek heroin to get high but rather to avoid withdrawal; therefore an addict cannot “just say no” to heroin. The author equates inability to say “no” with being incompetent. This misses the point. Compulsion is a matter of degree and so is its influence on an addict’s decision. Few heroin addicts would attempt to take heroin from an armed dealer without the means to pay for it, and most would readily give up their “stash” to a law enforcement officer rather than risk getting shot. Surely they are not giving it up incompetently. And so the argument that a strong desire, or loving too much, renders one incompetent to make a decision with respect to an object of desire simply does not hold. If it did, all marriages would have to be considered for annulment because they involve persons who are incompetent at the time of proposal. True enough, there are instances where wrongly proposed marriages have led later to murder, but it cannot be said as a general statement that people who are too much in love make marriage proposals incompetently.

The Swiss trial is used as a substrate for the author’s second argument that even if voluntary consent is possible, addicts are mentally incompetent to give it. The adequacy of the consent procedure in the Swiss trial is not the issue here, however, but rather it is the general competency of those who gave consent. The author points to concerns about the competence of alcoholic subjects giving consent in alcohol trials and laments that similar reservations have not been expressed in heroin studies. In his view heroin and alcohol are alike, but of course they are not. Here the author confuses heroin intoxication and withdrawal with delirium from alcohol withdrawal; but whereas delirium may be a feature of alcohol intoxication and withdrawal, it is not with heroin.

The author asserts that heroin addicts vacillate between a state of intoxication and withdrawal and that the state of physiological and psychological compulsion nullifies voluntary choices. He takes literally Alan Leshner’s metaphoric comments that an “addicted brain is a hijacked brain” and that “addicts are no longer themselves” to support his argument that chronic heroin addiction results in radical changes in personal values. Such values are related to a person’s genuine likes and dislikes, which give rise to accountability, which in turn relates to competence. A competent choice, he argues, must reflect a persons’ real likes and dislikes, based on his or her set of personal values. A choice that does not reflect a person’s real likes or dislikes, according to the author, cannot be said to be a real choice. But do addicts under the influence of heroin or in withdrawal know what they like or dislike? Of course they do. Every heroin addict knows that without heroin he will get sick and that an injection of heroin will offer relief.

As noted earlier, an overriding desire for something neither excuses a person from being accountable nor renders his decision incompetent. If addicts are considered incompetent, then virtually all addicts who are arrested cannot offer pleas of guilt or innocence, make decisions about their own future, or conduct any other form of business,