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Resisting the Temptations of Addiction Rhetoric

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I have no argument with Charland's (2002) statement of his main conclusion, that we should not presume that heroin addicts are competent to consent to heroin prescription. Indeed, I would go further: we should not assume that anyone is competent to consent to heroin prescription, since it is a dangerous course of action. This seems to be plain common sense and an unexceptional conclusion. We need to carefully assess the competence of subjects in research studies on heroin prescription. However, much of Charland's paper seems to argue for the much stronger conclusion, which I see as problematic, that heroin addicts *could* not be competent to consent to heroin prescription. For example, in the section on Cynthia's Dilemma, Charland writes that the key to the dilemma is the claim that "because they are heroin dependent, prescription subjects are incapable of competent voluntary consent." Charland may not go so far as to actually endorse this claim himself, but it is clear that he believes it is plausible. Note that if his argument works, it will imply not only that heroin addicts are incompetent to consent to be part of research studies involving heroin prescription, but also, at least if the standards of competence are the same for treatment as they are for research studies, that addicts are incompetent to consent to heroin prescription as a treatment after it has been approved as a treatment.

The main weakness in Charland's argument is in his exaggeration of the nature of heroin addiction. He says that addicts are "completely obsessed" with drugs; that they have, quoting Leshner, an "uncontrollable compulsion to seek and use the drugs;" that their drug taking is a "direct physiological consequence" of changes in their brains caused by the drugs; that the compulsions "nullify any semblance of voluntary choice;" and that "Quite literally, the addict's brain has been hijacked by the drug." If these descriptions of addiction were true, then no addicts would ever end their addiction, while addicts are at least sometimes able to quit taking drugs. Furthermore, there's

a spectrum of addiction, and some people are able to stay in their jobs and maintain relationships while at the same time being dependent on drugs. Even in the most extreme cases of addiction (and this is more a conceptual than an empirical point) no form of complex behavior such as seeking and taking drugs could simply be a "direct physiological consequence" of a change in the brain, since a great deal of planning and thought is required for such behavior, especially when it requires finding ways to get the money to buy the drugs and evasion of the police is required in the process of buying and using the drugs. Certainly, drugs do not literally hijack the brain, and it is unclear what value this description has even as a metaphor. There is a great deal of empirical work on addiction, but far less philosophical work addressing how addiction affects a person's moral agency. I think it is fair to say that these issues are still unresolved (Perring 2001).

If Charland has exaggerated the meaning of addiction for our understanding of an addict's behavior, how does this affect his argument concerning competency? He asks, "how can a person with no minimally stable real values of their own be held accountable for their decision?" and goes on to say, "The set of values that governs their daily decisions and behavior is no longer really theirs." But Charland has not shown that addicts do not have minimally stable values, nor that their values are no longer really theirs. The values of an addict may be quite stable even when he or she relapses into addiction: a standard reading of such weakness of will is that the agent's values remain the same but the agent nevertheless succumbs to temptation. An addict can know that she is acting against her own values in seeking and taking drugs, even while she is doing it; she may be simply unwilling to face the physical and psychological pain that comes with abstaining (Mele 1987). Even if an addict is self-deceived about her motivation for taking the drugs, she may still have insight into her own values. It's certainly a

mistake to conflate a person's overriding desires with her values.

Of course, in assessing an addict's decision-making process, we need to worry whether the addiction biases her choice. It makes a great deal of difference what options the addict is choosing between. Consider:

Choice 1

- A. A place in a study on an unproven heroin-prescription treatment.
- B. A drug-free treatment in a residential treatment center with a good chance of success, but involving a great deal of physical and psychological pain.

Choice 2

- A. A place in a study on an unproven heroin-prescription treatment.
- B. Returning to life on the streets, funding the heroin seeking by petty crime and begging.

In Choice 1, I would worry that the addiction would bias the addict's choice, leading him to overestimate the possible value of the heroin-prescription treatment and to avoid the difficult process of coming off the drug. But in Choice 2, drug taking is in both options, and there's no reason to think that the addiction makes the addict overestimate the possible value of prescribed heroin and underestimate the value of a life on the streets and petty crime.

Charland comes close to recognizing this in his discussion of the "second strategy," which focuses "on the notion

of risk" and the use of a sliding scale of competence. But he quickly dismisses this because "the subjects sought for heroin prescriptions invariably suffer from serious psychiatric disorders other than addiction." But if this is the case, then it is puzzling why he even addressed the original subtle considerations about their competence, since if they have other serious psychiatric disorders, then those conditions are very likely to impair rationality enough to make the subtle considerations of competence beside the point.

I applaud Charland for raising the issue of the competence of heroin addicts to consent to participation on heroin-prescription studies, and for his thoughtful discussion of how addiction affects competence. But he has overplayed some of the empirical characterizations of addiction and underplayed the ability of addicts to think for themselves. I hold more hope than he seems to that it should be possible to find ways in which potential research subjects are not so biased by their addiction in their choices that they are not competent to consent. ■

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Ethics and Heroin Prescription: No More Fuzzy Goals!¹

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Louis C. Charland claims that heroin-prescription trials violate North American standards for clinical research. This may be true, but not necessarily for the reasons he cites. First, without greater attention to the processes and criteria used for subject entry into the trials, Charland does not provide a sufficient basis to determine whether consent was invalid. In this regard we concur with Perring (2002), who notes that Charland has overreached in claiming that heroin addicts can *never* be competent to consent to enrollment into heroin-prescription trials. But perhaps of greater importance, we worry that heroin-prescription trials are especially susceptible to violating ethics and failing informed-consent requirements due to the conflation, con-

fusion, or absence of trial goals. Essential to the ethics of research on heroin prescription, but underappreciated in Charland's article, are the risks of doing research that might primarily benefit society rather than the heroin addict, including research on harm-reduction strategies.

Vulnerability, Exploitation, and Choice

Charland claims that addicts are vulnerable to exploitation if promised free heroin and that this vulnerability negates their capacity to give consent. But vulnerability is most important where individuals are exposed to harm without personal benefit and because of coercion. Exploitation involves placing vulnerable individuals at risk in order to advance goals that the individuals do not share. How vulnerable are addicts and can they share the goals of researchers?

Charland argues that heroin addicts are absolutely vul-

1. The views and opinions contained in this article are those of the authors and should in no way be construed as representing the official policies of the American Medical Association.