Addiction and Consent

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In teaching medical students and residents about substance dependence, I often use the phrase "the addiction takes on a life of its own." This intuitive expression begins to introduce how the severely addicted person becomes merely the "means" for the substance, how the person is displaced within his own body, how there becomes a fundamental separation within the addicted person who himself is diminished as the substance dependence intensifies. Indeed, the addicted person does not, cannot feel "whole" in the absence of the substance. Understanding substance dependence is to see how an addiction resides within the human person but erodes the things that most define his humanity: his sense of self, his aim in life, his actions, his ability to work and love, his capacity to discern and enact choice.

These effects are particularly true for opiate dependence, which includes illicit heroin addiction and licit methadone maintenance treatment and directly affects hundreds of thousands of people in the United States and millions worldwide (Franklin and Frances 1999). Specifically, in 1998 it was estimated that 2.4 million people in the United States had used heroin during their lives, 130,000 had used it in the prior month, and 81,000 had become new heroin users in 1997 (NIDA 1997). Heroin addiction is unusually powerful and tenacious in its hold on affected persons, is associated with serious comorbid conditions (e.g., HIV, hepatitis, head injury, malnutrition), and mortality rates 13 times greater than the general population. Withdrawal signs and symptoms, although extraordinarily uncomfortable, are generally not life threatening, except in affected babies of addicted mothers (Franklin and Frances 1999; Huse 1999). Opiate dependence has grave psychosocial and societal implications, and is perhaps the most stigmatizing of the addictions.

Louis C. Charland's paper, "Cynthia's Dilemma: Consenting to Heroin Prescription" (2002) presents an astute, clear, and courageous analysis of the complexities surrounding informed consent in the context of opiate addiction. Relatively little conceptual work, and no systematic empirical ethics work, has been done in this area, and Charland's paper represents a valuable contribution to an underdeveloped field that is of great importance to public health. I would like to briefly outline strengths of Charland's well-written paper, argue for greater emphasis on "voluntarism capacity" as well as "decisional capacity" considerations (based on my own work on informed consent and serious illness), and conclude with a few words of caution.

The paper has several unique strengths. The historical analysis describing the medicinal use of opiates internationally, for example, is coherently constructed, well researched, and novel. The characterization of the ethical issues in human experiments involving opiates is interesting and certainly deserves to be the subject of its own manuscript in the future. The paper, furthermore, places emphasis on the notion of appreciation, which in my view is the most important dimension of decisional capacity in that it integrates life experience, personal values, and individual character with the more strictly cognitive, reductionistic, and "rational" elements that are necessary but not sufficient for decisional capacity (Roberts 1998; Appelbaum and Grisso 1995). Charland nicely focuses attention on the issue of the valence ("overweighting" or "underweighting") given to certain factors in decisions, as determined by illness phenomena (e.g., "cravings" for an addictive substance). The concept of accountability (i.e., whether "the decision truly belongs to the patient" and whether "he can legitimately be judged accountable" for the decision) is also emphasized, following through on the implications raised by Carl Elliott's superb thinking in psychiatric ethics (Elliott 1996). Though some clinical terms are used incorrectly in a few places (e.g., "addiction is a combination of both compulsion and delirium"), overall Charland's discussion of the nature of addiction is clinically informed and anchored-it conveys the right "gestalt," which is especially important in understanding this clinical topic. Finally, another key strength of this paper is its brief comments on the notion of a "sliding scale" of decisional capacity, as driven by the nature of the choice at hand and its attendant risks and benefits. This conceptualization refrains from all-or-nothing thinking that may be misunderstood, potentially undermining the rights and true strengths of people suffering from serious illnesses.

While I suspect we might agree in substance, I differ with Charland in that I frame the main clinical ethical issues in addiction and consent as related to *both* decisional capacity and the capacity for voluntarism. Voluntarism is widely acknowledged for its centrality, and it is often discussed in the bioethics literature; but voluntarism *as a capacity* has not been adequately examined or empirically studied for its ingredient elements. For this reason, it has become a key focus for my work on informed consent in clinical care or research involving people with serious illness and/or other sources of vulnerability (e.g., poverty, captivity, developmental disabilities, societal powerlessness). Elsewhere I have described how voluntarism encom-

passes the individual's ability to act in accord with one's authentic sense of what is good, right, and best in light of one's situation, values, and prior history (Roberts and Roberts 1999; Roberts 2002a). Voluntarism is an expression of the self; it is a human capacity for discerning and carrying out choice. Voluntarism further entails the capacity to make a choice freely and in the absence of coercion. Intent, deliberateness, genuineness, and congruence with life experience and prior decisions are inherent to this idea.

On conceptual, clinical, and empirical grounds, I have proposed a framework for assessing voluntarism in clinical- and research-consent decisions that centers on four domains:

1. developmental factors (e.g., young children who do not yet possess the ability to clarify or express preferences around major decisions);
2. illness-related features (e.g., amotivation and helplessness associated with major depression; avolition associated with psychotic disorders);
3. psychological issues (e.g., hopelessness and desperation accompanying extreme pain in cancer patients; enduring powerlessness experienced by trauma victims, refugees, and some minority individuals) and cultural, individual, and religious values (e.g., beliefs in cultures characterized by interdependence rather than separateness and in which family elders rather than individuals make important health decisions); and
4. external features and pressures (e.g., situations of captivity or of overlapping roles) (Roberts 2002b).

Many of the considerations that Charland attributes to decisional capacity (e.g., "loss of control," "compulsion," and addiction-related "motivation"; "ambivalence" and "fluctuating" values) may more properly reside within the capacity for voluntarism, which is distorted and may be profoundly compromised in illnesses of addiction. The most powerful explanatory model may, in fact, be that these dimensions of addiction influence the values governing the appreciation component of decisional capacity (i.e., the notion of "overweighting" certain factors in the integrative, synthetic process of appreciating the nature, personal relevance, and implications of a consent decision) as well as the latter three of the four potential contributing elements of the capacity for voluntarism.

In conclusion, Charland's paper is excellent and will certainly stimulate valuable dialogue in a neglected but important area of international health. More conceptual and empirical work is needed to clarify the effects of various illnesses upon the ability to give informed consent, especially in the context of innovative clinical treatments such as opiate (heroin, methadone, or others) prescription, as well as in clinical research.

Some words of caution about Charland's paper are nevertheless warranted. First, his paper does not take on the knotty problem of the medical profession "enabling" substance dependence through the prescription of addictive substances; this requires our consideration. Second, the argument advanced in the paper about "presuming the incompetence" rather than the "competence" of addicted individuals is very radical. Moreover, this is an empirical question needing diligent and long-term study, especially as it may be misconstrued to erode the rights and devalue the true strengths of people struggling with substance dependence. Finally, there is broad international debate on the capacities of people with various psychiatric disorders to consent. This has further stigmatized the mentally ill and, interestingly, the professionals who study and treat mental illness. Some policy makers have moved to implement strategies that may undermine the rights of people with illnesses ranging from depression to schizophrenia, thus adding insult to injury. It is important that we, as scholars in this field, proceed in a manner that fulfills the bioethics imperatives of respect for persons and nonmaleficence by studying and truthfully characterizing informed-consent-related phenomena while also working carefully to provide a balanced perspective on the strengths and gifts that ill individuals bring to the consent situation. ■

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Choice, Rationality, and Substance Dependence

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One of the difficult issues that emerges from Louis C. Charland's (2002) article is the nature of "addiction." The author cites Leshner on a number of occasions in relation to the effects of addiction—to say that heroin users suffer from an "uncontrollable compulsion to seek and use drugs" (Leshner 1999, 3) and to state that the heroin user's mind "is hijacked" by the drug. Charland summarizes by saying that "addicts are no longer themselves and in that sense can no longer be considered accountable for their decision to use heroin."

I would like to question the legitimacy of the employment of such emotive language in relation to regular users of opiates. I do not suggest that frequent heroin use does not induce physical and psychological dependence, including cravings for the drug. Heroin has major lifestyle impacts for many, but to what extent is its use incompatible with rational decision making in such questions as whether to give up the drug, whether to enter a methadone program, or whether to receive prescribed heroin? Even the extent to which addiction is a useful concept in this context is questionable. As Blau (1996) has argued, addiction is for the most part a lay term and generally a nebulous one:

> Although several generations of extensive study have been applied to this area, researchers and practitioners attempting to clarify the concept of addiction do not share a unitary set of rules or standards for understanding or treating the condition. . . . Various definitions have been subject to change and modification, but not to verification. . . . Drug-related research is often inconclusive and frequently contradictory." (90)

The populist notion of addiction encompasses the Leshner notion that a drug takes over a person, depriving them of the capacity for choice and autonomous decision making. Similar unhelpful rhetoric was used for a time in relation to new religious movements "brainwashing" converts and "controlling" their minds. Scientific literature is not so clear on the effects of addiction. Erlich (2001, 40), for instance, recognizes that there is no medically agreed upon definition for addiction. DSM-IV-TR (American Psychiatric Association 2000) also eschews the term, preferring the concepts of substance abuse and substance dependence. This is because the extent to which dependence upon a substance such as an opiate impacts comprehension, decision making, ability to manipulate information rationally, and ability to communicate choice is variable and unfalsifiable. Charland usefully draws attention to the MacArthur model of competence, which addresses each of these indicia. Not surprisingly, he concedes that heroin "addicts" will generally be competent under the MacArthur indicia, but he contends they may not be able to manipulate information rationally.

In this regard his analysis is open to serious doubt. The question perhaps comes down to interpretation of rationality, a matter upon which reasonable people, whoever they are, can and do disagree with a disturbing frequency. Does it really assist the analysis to assert, as Charland does, that everything that addicts decide and do eventually reduces to seeking and using their drug of choice, and that the drug doesn't always have the first say but always has the last say, that decisions are not truly those of addicts and so they cannot be held accountable for them? Interestingly, the law has never subscribed to such notions. The typical response of the courts in most countries has been to acknowledge that drug addiction and substance dependence can explain offending behavior, but they do not excuse it. Addicts make choices. They do not have to buy drugs. They do not have to steal to buy drugs. They do not have to attack people whose houses they break into to get money to sell drugs. They make a range of decisions in relation to their addictions, often bad ones. However, for all those who make dangerous or self-harming choices, there are others who decide to stop using and do so successfully without professional intervention. There are others too who make the choice to enroll in rehabilitation programs.

What impact then can substance dependence be said to have upon the capacity to make choices? First, it is clear that there are dependencies and dependencies, addictions and addictions. There are dependencies that involve only usage that is erratic and not of major proportion. There are dependencies that are intensely physically experienced, and there are others that are principally psychologically