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Editorial

Heroin, health and disease

Is medical practice in relation to drugs of addiction 'diverting criticism away from cultural values by individualising social problems'? This is the claim made in this issue of the journal by Dr Henk ten Have, a physician-philosopher and Professor Paul Sporken, professor of medical ethics, both at Limburg University in the Netherlands. And they add, equally challengingly, critical analysis of this process 'can help to throw more light on the philosophical basis of medical practice'.

The central assumption in their paper is that because, according to their analysis, heroin addiction is a socio-cultural problem, therefore it is not a medical problem, or at least not only a medical problem: '. . . heroin addiction and the treatment offered cannot be reduced to a medical problem: the medical aspects are deeply embedded in socio-cultural values'. But even if the premise is granted (and it seems difficult to deny that drug addiction in general is a socio-cultural problem, or rather a set of such problems, whose characteristics vary from society to society) it remains questionable whether the conclusion follows, though the claim reminds us of some important issues.

The first is that the institution of medicine is based on value-laden presuppositions – especially that health is a good state and that it is good to promote it, while diseases are bad states which it is good to eliminate. There is of course continuing debate about this, with a few stalwarts arguing that health and disease are concepts which can be defined in value-free descriptive terms, either much as a car can be said to be in perfect working order or not by reference to the manufacturer's specifications (1) or by reference to whether or not a condition places a living organism at a 'biological disadvantage' (2). The overwhelming weight of the argument however (it is here merely asserted) favours the opposing position whereby health and disease are essentially value-laden concepts (3,4,5,6,7).

The second important reminder is that diseases are not independent entities that somehow 'possess' people, but are usually multifactorial in their causation, with psychological, social and cultural factors often having causal roles.

The third important issue to which the authors draw attention is that there may be disagreement about whether or not a particular condition or a particular individual is healthy or diseased. When such disagreement concerns conditions perceived by society to be dangerous the resulting tensions can become severe and doctors may find themselves caught up in them. In this context Drs Have and Sporken draw attention to Foucault's thesis that institutional medicine tends typically to adopt bourgeois norms and thus tends to line up against those who do not share these norms – a point, they suggest, which is of particular relevance in the context of heroin addiction. In passing, one may doubt that social disapproval of heroin addiction is a specifically bourgeois phenomenon, or indeed that doctors are particularly prone to adopt bourgeois standards. Rather, and perhaps more worryingly, they seem more likely as a group to reflect the prevailing power structure of which in most societies they form a part. Complaints about Soviet psychiatrists who comply with the regime and incarcerate political dissidents in mental hospitals certainly don't rely on claims that doctors adopt the norms of the bourgeoisie!

The general message however is surely important for medical ethics: doctors are likely to be heavily imbued with the social norms of the social subgroup of which they are a part, and this is likely to affect among other things their evaluations of which states are good and healthy, which states bad and diseased. There are well known examples of excessive medical acculturation of this sort. Masturbation was a classified disease in the not so distant past and indeed still appears in the 'International Classification of Diseases' (ICD), under the general category of mental disorders, though with the stern admonition that 'the use of this category should be discouraged' (8). Homosexuality was classed as a disease by American psychiatrists until 1974 when they voted that it should no longer be so classified (9) (it, too, still appears in the ICD, coded under the general category of mental disorders, 'whether or not it is considered as a mental disorder') (10). Professor Engelhardt tells us that American doctors once classified as a disease 'drapetomania' – a disorder of

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certain slaves who repeatedly ran away from their masters (6).

To accept the importance of such warnings is not however to agree that if a problem can be shown to be socio-cultural then it cannot be medical. Nor is it to accept that where there is conflict between societal norms and an individual's norms the doctor must reject societal norms in favour of his patient's. Normally of course the doctor does lean heavily towards respecting his individual patient's autonomous preferences and it is in this context that Drs Have and Sporken's reference to medical ambivalence about the objectives of treating heroin addicts has most grip. In standard medical practice the patient has some dysfunction which displeases him and he consults a doctor whom he believes to have some special skill in ameliorating such dysfunctions. The doctor having ascertained that the dysfunction is of the sort for which he as a doctor can offer some reasonable hope of benefit, agrees to do what he can to help. In such normal cases it is the patient's therapeutic objectives which determine the direction of medical intervention. Now undoubtedly *some* cases of heroin addiction fall within this model, with addicts voluntarily and deliberately seeking medical help to overcome their compulsion to take heroin.

This standard model does not however apply to all addicts, and perhaps applies to only a small minority. Many other addicts are primarily or only interested in doctors as suppliers of the drug they wish to take. It is in these circumstances that the conflict to which Have and Sporken allude is most obvious. On the one hand is the view of this sort of addict who is quite ready to take heroin regularly in response to the compulsion to do so, and to 'drop out' of the mainstream of society which he often despises. On the other hand is society's prevailing view that such people are fundamentally disordered and that serious efforts should be made to 'rehabilitate' them back to the active participating norms of the majority. In between, so far as one can tell, is a third position, apparently shared by Drs Have and Sporken, which accepts neither the prevailing norms of the 'bourgeois' majority nor the expressed wishes of the addicts who simply wish to take their drugs and be left alone. But while Drs Have and Sporken wisely point out from their third perspective the dangers of each of these conflicting views, they have nothing, as they say, to replace them.

The warnings they give are well taken, for it seems clear that when doctors do participate in addiction treatment programmes they accept a role in which protection and reinforcement of societal norms plays a major part, overriding the normal medical concern to try to accommodate the preferences of patients. In this respect such medical involvement is perhaps more akin to the compulsory treatment of mentally disordered dangerous patients, or to the compulsory treatment of patients under quarantine orders, or to the medical treatment of prisoners by prison doctors. In all such cases the norms of society are imposed, to a greater or lesser extent, upon the patient via a coercive social structure of which the doctor is a part. In each case that coercive structure is established primarily in order to protect society from a perceived danger – dangerous madmen, dangerously infected members of society, and criminals.

Similarly the treatment of drug addicts is carried out within social structures which are to some degree coercive, for societies, bourgeois or otherwise, tend to perceive those drug addictions which radically undermine social participation to be socially destructive and thus a social threat. Decisions about how to treat those drug addictions perceived to be socially destructive are surely quite properly political, not medical, decisions. Of course doctors are as entitled as any other citizen to participate in this political decision-making, but the decisions having been made they then have to decide what if any their specifically medical role should be.

Given a socially determined and democractically accepted decision to try to coerce heroin addicts into accepting the majority's social norms and making efforts to overcome their addiction, should doctors participate in their medical care within the constraints of that socially determined coercion or not? In the bad old days (as most doctors at least would see them) the option did not arise – those who offended sufficiently against social norms, be they mentally ill, drug addicts, or criminals, were incarcerated in non-medical institutions where their 'treatment' was forcible isolation from society, and punishment. Medical non-involvement with such people seems likely to encourage a return to something similar, and it is against that background that some doctors are prepared to try to help criminals, the dangerously mentally ill and heroin addicts, despite the fact that such help must to some extent override their individual patients' preferences.

This is in no way to deny that such problems may have at least part of their origins in socio-cultural factors nor to deny that it may be desirable to try to change these socio-cultural factors. But in the meantime there seems little reason to prevent doctors from trying to treat addicts who *have* succumbed to these socio-cultural factors (if that is what has happened). Equally it is difficult to see how doctors *can* treat heroin addicts except by 'individualising' their treatment, and continuing their present admittedly fairly unsuccessful efforts to rehabilitate heroin addicts. These efforts include provision of the drug they crave (or an equivalent) in return for the addicts' efforts to conform to the socially determined objective of ridding themselves of that very craving. There seems no reason in principle to reject such medical 'individualising [of] social problems', and no reason why it should divert 'criticism away from cultural values'. It would however seem unrealistic, partly for the reasons given by Drs Have and Sporken, to expect doctors to be in the vanguard of such criticism.

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relationships. However, there is evidence to suggest that at least some of the higher animals, like primates, do indeed have a network of social connections. Ethologists and others who study animals in their natural environments are far more likely, for just this reason, than laboratory researchers to support restrictions on animal use. See, for example, Goodall J. *In the shadow of man: Boston, Ma:* Houghton Mifflin, 1971. Because of this documentation we urge researchers to *assume* a network of animal inter-relationships in the calculus.

(8) Other kinds of consequences could also be postulated in order to argue in favour of one or the other.

(9) See, for example, reference (4): Singer: 99–103.

(10) In addition to the Singer and Rachels works already cited, see also, Sechzer J A, ed. *The role of animals in biomedical research*. Cornell Medical College: New York, 1983.

(11) For discussions of related issues see Gaylin W. Harvesting the dead. *Harper's magazine* 1974 Sept and Feinberg J. Sentiment and sentimentality in practical ethics. *Proceedings and addresses of the American Philosophical Association* Sept 1982 56, 1: 32–42.

(12) A very legitimate point could be raised as to whether anencephalics might not be subject to thalmic pain such as that experienced by individuals who have cortical lesions, but with the thalamus intact. This has been particularly well known in individuals who have had a cortical resection for the treatment of intractable pain but who unfortunately as a result suffer from pain even more diffuse and agonising. In response, Walter Freeman, MD, Professor of Physiology, University of California, Berkeley, points out that in the case of anencephalics, the neothalamus is as underdeveloped, or nonexistent, as is the neocortex; therefore, the 'pain centre' in the thalamus is no more likely to exist than those cortical centres which are responsible for pain perception. Consequently, it is quite likely that the kind of pain experience that would be accessible to anencephalics is that of the decerebrate animal or human as distinct from the decorticate animal or human. In the decerebrate state, it is very common to see reactions to painful stimuli which are in the nature of reflex responses which can suggest to an uninformed observer that there is an experiencing of pain but there is no evidence that such experiences actually exist.

(13) Donald Buckner, MD Chief of Pediatric Surgery, University of Miami School of Medicine. Personal Communication.

(14) This is likely because the advantaged segments of society undoubtedly would be more aware of the possibility and procedure for registering consent to this State programme.

(15) No doubt slippery slope arguments will be brought forward to charge that this suggestion opens the flood gates for physicians to commit all sorts of atrocities in the use of infants and others *not* beyond the hope of consciousness. While all slippery slope arguments should be duly considered, they are extremely speculative and only illustrate that wrong decisions can be made either intentionally or unintentionally. It should also be mentioned that the force of slippery slope arguments alone is almost never conclusive in ruling against the legitimacy of a moral principle.

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(9) Cited by Kennedy I. See reference (3): 1.

(10) See reference (8): 196.