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ADDICTION AND AUTONOMY: CAN ADDICTED PEOPLE CONSENT TO THE PRESCRIPTION OF THEIR DRUG OF ADDICTION?

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Keywords: addiction, freedom, desires, will, competence, appetite, coercion

ABSTRACT

It is often claimed that the autonomy of heroin addicts is compromised when they are choosing between taking their drug of addiction and abstaining. This is the basis of claims that they are incompetent to give consent to be prescribed heroin. We reject these claims on a number of empirical and theoretical grounds. First we argue that addicts are likely to be sober, and thus capable of rational thought, when approaching researchers to participate in research. We reject behavioural evidence purported to establish that addicts lack autonomy. We present an argument that extrinsic forces must be irresistible in order to make a choice non-autonomous. We argue that heroin does not present such an irresistible force. We make a case that drug-oriented desires are strong regular appetitive desires, which do not compromise consent. Finally we argue that an addict's apparent desire to engage in a harmful act cannot be construed as evidence of irrational or compulsive thought. On these arguments, a sober heroin addict must be considered competent, autonomous and capable of giving consent. More generally, any argument against legalisation of drugs or supporting infringement of the liberty of those desiring to take drugs of addiction must be based on considerations of harm and paternalism, and not on false claims that addicts lack freedom of the will.

INTRODUCTION

A 1951 police training film proclaims the existence of 'the addict, without a will of his own'¹. In 1999, Pittsburgh's *Post-Gazette* ran the headline 'Heroin holds him in its vicious thrall'². Even the urban folklore of American addicts bears an image of powerlessness before the lure of the drug in the tale of 'King Heroin':

I've captured men's wills, destroyed their minds,
Caused men to commit brutal crimes,
Now I can make a mere schoolboy forget his books,
Make a world-famous beauty neglect her looks,

¹ J. Sandrich, D. Sanders & T. Sanders. 1951. Subject: Narcotics. Los Angeles, Anti-Narcotics League of America.

² Heroin Holds Him in its Vicious Thrall. Pittsburgh Post-Gazette. Pittsburgh. Tuesday 13 April 1999.

Make a good husband forsake his wife³

The addicted individual is portrayed as fundamentally irrational in her choices, which may only be explained by the inexorable power of drugs. Is this view of the addict correct?

In studies of the effects of addictive drugs, it can be difficult (if not impossible) to measure the dosage and frequency of use, if the subjects are using from their own supply of drugs. It becomes necessary for researchers to prescribe a controlled dose of drugs to users, to attempt to control their effects. Doctors, too, sometimes have reason to prescribe drugs to dependent users.⁴ From 1998 to 2001, Dutch researchers prescribed controlled doses of heroin as a treatment for dependent users. They found a substantial increase in the participants' physical and mental health⁵. In such cases, the patients or participants are required to provide informed consent to the prescription of their drug. Such trials raise the question of whether addicts can give valid consent to take part in research. If the folk view of addicts as powerless to resist the irresistible force of heroin is correct, then it is hard to see how they could give free and informed consent.

This issue is not limited to heroin addiction. In 1997, Carl Elliott argued that severely depressed people cannot consent to participate in research, either because they do not care enough about risks to themselves or because the depression changed their values, goals and desires – their personality – into that of 'different person'⁶. This spawned a series of articles in which drug users in general, on the basis of their infamous lack of concern for their health and heightened orientation towards drugs, are viewed as not mentally competent to consent to the prescription of their drug.

For example, a report by the National Bioethics Advisory Commission argued that substance-abuse disorders can cause decisional impairments, and that defects in decision-making capacity can invalidate consent⁷. Peter Cohen's article 'Untreated Addiction Imposes an Ethical Bar to Recruiting Addicts' uses this finding to conclude that an addict entering treatment displays enough rational capacity to enable consent, but that the craving and denial in untreated addicted users 'preclude the degree of rationality at the time of consent demanded in any clinical study of non-therapeutic benefit to the participant'⁸.

Louis Charland's article, 'Cynthia's Dilemma', goes further to argue that addicted drug users are simply unable to refuse their drug. He argues that they cannot consent to its prescription⁹. This claim is inspired by a comment made by the heroin addict Cynthia that 'if you're addicted to heroin, then

³ M.H. Agar. Folklore of the Heroin Addict: Two Examples. *J Am Folk* 1971; 84(332): 182–183.

⁴ C. Wilson. Fixed up: When nothing else works, heroin addicts should be prescribed the drug they crave. *New Sci* 2002; 173(2336): 34.

⁵ F. van Kolfschooten. Dutch investigators recommend prescription of heroin to addicts. *Lancet* 2002; 359(9306): 590.

⁶ C. Elliott. Caring About Risks: Are Severely Depressed Patients Competent to Consent to Research? *Arch Gen Psychiatry* 1997; 54(2): 113–116.

⁷ National Bioethics Advisory Commission (NBAC). 1998. *Research Involving Subjects with Mental Disorders That May Affect Decisionmaking Capacity*. Rockville, MD. National Bioethics Advisory Commission.

⁸ P. Cohen. Untreated Addiction Imposes an Ethical Bar to Recruiting Addicts for Non-Therapeutic Studies of Addictive Drugs. *J Law Med Ethics* 2002; 30: 76.

⁹ L. Charland. Cynthia's Dilemma: Consenting to Heroin Prescription. *Am J Bioeth* 2002; 2(2): 37–47.

by definition you can't say "No" to the stuff"¹⁰. Following Leshner and Koob's conclusion that an addicted heroin user's brain is 'hijacked' by their drug¹¹, Charland argues that a user's decision processes are warped by the drug so that the risks of drug-taking are ignored. Their choices are, allegedly, 'not truly their own'¹². Charland argues that addicts are incompetent to consent because they care too much about heroin's pleasurable effects to be able to refuse it: 'Heroin addicts suffer from a compulsive need to seek and use heroin. As a result, they have an impaired decisional capacity to make choices about heroin.'¹³

Such claims raise several issues which need to be addressed critically:

- Does drug use or withdrawal invalidate consent to participate in research? Do the acute effects of drugs invalidate consent?
- Do the chronic effects of drug addiction invalidate consent? Are drug-oriented behaviours compulsive?
- If not, then are addicted users incompetent to consent on the grounds that their choices are harmful to themselves?

We consider each of these questions in turn.

I. DOES DRUG USE OR WITHDRAWAL INVALIDATE CONSENT TO PARTICIPATE IN RESEARCH?

Let us begin by asking whether the immediate, acute effects of a drug might invalidate consent. Drug use is known to cause incapacitating physical effects of intoxication and, in some cases, withdrawal, so we could plausibly suppose that drug use could render a person incapable of competently giving consent. But we must first ask whether this is likely, *in the usual range of circumstances*, to make a difference to an addict's capacity to consent take part in a clinical trial of heroin.

Competence

What is competence? Consider two influential accounts. The British Medical Association and Law Society have given a useful list of the capacities which define a competent person (Figure 1).

- To demonstrate competence, a patient should be able to:
1. Understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed.
 2. Understand its principal benefits, risks and alternatives.
 3. Understand in broad terms what will be the consequences of not receiving the proposed treatment.
 4. Retain the information for long enough to make an effective decision.
 5. Make a free choice (i.e. free from pressure)

¹⁰ Ibid. p. 37.

¹¹ A.I. Leshner & G.F. Koob. Drugs of abuse and the brain. Proc Assoc Am Physicians 1999; 111(2): 99–108.

¹² Charland, op. cit. note 9, p. 43.

¹³ Ibid. p. 37.

*Figure 1. Capacities that define a Competent Person*¹⁴

Second, consider the widely accepted MacArthur model of competence for consent, which Charland adopts as a benchmark. This model requires that a person display four minimal capacities similar to those given above:¹⁵

- 1) The ability to understand a choice
- 2) The ability to appreciate a choice
- 3) The ability to rationally manipulate information
- 4) The ability to communicate a choice

These two models of competence are very similar, except that only one requires the ability to ‘communicate a choice’, and only one requires the ability to ‘retain information’. To be on the safe side, we will assume both of these capacities are required to demonstrate competence.

Do addicts retain these capacities when acutely intoxicated or withdrawing? It is clear that taking narcotics to the extent that one is rendered stuporose would likely affect all these capacities. Addicts are not predominantly in this state and, moreover, they are not likely to be approached for consent when in this state, as we now argue.

Acute intoxication

It is often claimed that addicts vacillate between states of intoxication and withdrawal. In Wikler’s influential work in the 1940s and 1950s, withdrawal and its behaviour-reinforcing effects were considered to be the only motivation for drug use, and it was only after the rapid increase in cocaine use in the 1980s that this began to seriously be questioned¹⁶.

This, however, is untrue for several reasons. Firstly, as Stewart recounts in her first-hand account of heroin addiction, heroin users typically prefer privacy when they are intoxicated, since severely intoxicating amounts of heroin put the user at risk of detection by police or workmates¹⁷. A large majority of overdoses occur in private homes¹⁸. In particular, they are unlikely to approach a doctor or researcher for prescribed heroin when intoxicated, because when they are high they do not care about getting more heroin, or getting treatment.

Secondly, heroin users spend most of their time neither intoxicated nor withdrawn. They take small doses of heroin to defer withdrawal, and in this state are capable of maintaining professional jobs, caring for children, and driving cars. Neale found that injecting heroin users structured their use

¹⁴ British Medical Association and the Law Society. 1995. *Assessment of mental Capacity: guidance for doctors and lawyers*. London. British Medical Association Professional Division Publications: Chapter 10

¹⁵ T. Grisso & P.S. Appelbaum. The Macarthur Treatment Competence Study. 3. Measures of Patients to Consent to Psychiatric and Medical Treatments. *Law Hum Behav* 1995; 19(2): 149–174.

¹⁶ M. Lyvers. Drug addiction as a physical disease: The role of physical dependence and other chronic drug-induced neurophysiological changes in compulsive drug self-administration. *Exp Clin Psychopharmacol* 1998; 6(1): 107–125.

¹⁷ T. Stewart. 1987. *The Heroin Users*. London. Pandora Press.

¹⁸ M. Warner-Smith et al. 2000. Heroin overdose: Prevalence, correlates, consequences and interventions. Sydney. National Drug & Alcohol Research Centre.

around family commitments, work and hobbies, both to avoid discovery and allow them to remain competent¹⁹. During these times, users are neither desperately sick with withdrawal, nor reckless with craving.

Thirdly, the cost of being intoxicated all the time is large. The average intoxicating dose of heroin lasts 4–6 hours²⁰ during which time the user is unlikely to obtain money. A daily heroin habit costs more than the average wage²¹ – to stay intoxicated all the time addicts would need to double or quadruple this usage, while decreasing their money-earning to make enough time. Most addicts probably cannot *afford* to stay intoxicated.

Withdrawal

Similar arguments apply to withdrawal. It is reported by many users that the monetary cost of withdrawal is equally high²². While withdrawn, users are unable to perform money-earning tasks such as jobs, or even crime.

Even without monetary worries, heroin users do not have time to stay intoxicated or withdrawn – Faupel found that 43% of ‘hard-core’ heroin users in his sample were employed.²³ In order to maintain their heroin supply, and their lifestyles in general, they must stave off withdrawal with small doses of heroin. Addicts are simply unlikely to be severely withdrawn at any given time.

Still, it may turn out that heroin users with severe withdrawal symptoms (rather than acute intoxication) do attempt to obtain heroin by consenting to therapeutic or research-based prescription. We believe that withdrawal does not present a special case of addictive desires – it merely adds extra motivating reasons for an addicted person to use drugs. We will discuss evidence for this position in section III. Nevertheless, it seems that the bulk of heroin users who are willing to take part in research will be neither acutely intoxicated nor withdrawn. At first glance, this would seem to imply that heroin users will indeed be competent to consent to the drug’s prescription.

Sober addicts

It is likely that much of the time addicts will be sober – affected neither by acute intoxication nor withdrawal. Are they capable of giving consent when sober?

The USA’s National Bioethics Advisory Commission reported that drug users may be impaired in decision-making even ‘outside the circumstances of intoxication and certain forms of withdrawal’²⁴. This claim that addicted people are decisionally impaired while sober is echoed in the work of

¹⁹ J. Neale. 2002. *Drug Users in Society*. New York. Palgrave.

²⁰ <http://ysas.org.au>.

²¹ Neale, op. cit. note 19.

²² Stewart, op. cit. note 17.

²³ C.E. Faupel. Heroin Use, Crime and Employment Status. *J Drug Issues* 1988; 18(3): 467–479.

²⁴ NBAC, op. cit. note 7.

Charland and others.²⁵ The validity of this claim is at the core of the question of whether addicted drug users can give valid consent to prescription of their drug.

The only way we can continue to conceive of a sober heroin user as being incompetent is if her desire or decision formation is impaired in a way that invalidates her consent. If the user is sober, and otherwise unimpaired, then this would imply that the urge to take heroin overwhelms her desire and decision-making capacities in an irresistible way. When a person is thus overwhelmed, the decision is termed *compulsive*. Faden, Beauchamp and King argue that the reason we require consent, both historically and theoretically, is to preserve an agent's right to autonomous choice.²⁶ A decision that is compulsive is not free and therefore does not constitute valid consent. To use the MacArthur formulation of competence, we may say that a person with a compulsive behaviour cannot manipulate information rationally with regard to her compulsion, so she must be adjudged incompetent. The BMA's model of competence requires that a decision is made freely. A compulsion renders an agent unfree.

II. ADDICTIVE BEHAVIOURS ARE NOT COMPULSIVE

Besides the acute effects of heroin addiction, Charland's argument depends on the belief that addicted heroin users are acting in a way which is controlled by the drug, rather than the user. He cites Leshner, who claims that 'what matters most in addiction is often an uncontrollable compulsion to seek and use drugs'.²⁷ This articulates a belief, widespread amongst both addicted and non-addicted people, that addicted drug-users act *compulsively* to contravene their 'true' desires and values. Harry Frankfurt famously characterised our true desires as second order desires: what we desire to desire. He claimed that addicts are not free because they have a first order desire to take heroin but a higher second order desire not to desire to take heroin. Freedom of the will, according to Frankfurt, occurs when our first order desires are in line with our second order desires: we do what we desire to desire to do.²⁸

There are two reasons why it is tempting to label addictive drug use 'compulsive'. First, there is a popular conception that addicted drug users will use no matter what countervailing reasons are present. In Oddie's terms, such drug-oriented desires are not 'reasons responsive'.²⁹ It is popular to cite the case of the cocaine-addicted rat which continues to selfadminister the drug, ignoring the bodily demands of hunger and fatigue, until it dies. As Davies points out, however, this is a terrible metric for compulsion – the rats tested have nothing to do other than selfadminister drugs, and when the same tests are run under more naturalised environments, their behaviour looks much more reasons-responsive, and much less compulsive.³⁰ In fact, as Watson points out, drug-addicted humans are a lot more likely to decide not to use drugs than is popularly believed, especially when

²⁵ Charland, op. cit. note 9; Cohen, op. cit. note 8.

²⁶ R.R. Faden, T.L. Beauchamp & N.M.P. King. 1986. A history and theory of informed consent. New York. Oxford University Press.

²⁷ A.I. Leshner. Science-based views of drug addiction and its treatment. J Am Med Assoc 1999; 282(14): 1314.

²⁸ H. Frankfurt. Freedom of the Will and the Concept of a Person. J Philos 1971; 68, as reprinted in The Inner Citadel: Essays on Individual Autonomy. J. Christman, ed. New York. Oxford University Press: 63–76.

²⁹ G. Oddie. Addiction and the Value of Freedom. Bioethics 1993; 7(5): 373–401.

³⁰ J.B. Davies. 1992. The myth of addiction: an application of the psychological theory of attribution to illicit drug use. Chur, Switzerland. Harwood Academic Publishers.

strong counterincentives are presented. Mothers with dependent children, for example, are much more likely to give up their drug addictions.³¹ Neale reports that less serious reasons are also commonly given by users who decrease their heroin consumption, such as changes in the drug market, or conscious reflection of the drug's pros and cons.³² The evidence that drug users do in fact respond to powerful incentives is a strong indicator that their behaviour is not compulsive. The statistics on drug use also fail to support the idea that drug users will always use. Leshner cites the low number of successful, voluntary drug quitters as evidence that people with addictions are behaving compulsively. 'Once addicted', he claims, 'it is almost impossible for most people to stop the spiralling cycle of addiction'³³. In fact, he is wrong – though in 2001, 18% of US citizens aged 18–24 met criteria for substance dependence, only 5.4% of those over 26 were substance dependent. In the same year, less than 2% received treatment for substance dependence, implying that large numbers of people voluntarily quit.³⁴

The second reason why drug use is claimed to be compulsive is that addicted people may continuously insist that they intend not to use drugs, but then use in spite of their stated intentions. This fits the Frankfurt model of first order desires being in conflict with higher second order desires: the addict is overwhelmed by a brute desire to take heroin despite a reflective second order desire not to desire to take heroin³⁵. This apparent reflective wish to quit is one of the diagnostic criteria for drug dependence in the DSM-IV-TR diagnostic manual³⁶.

However, given the incredible stigma which drug use holds, we should regard an addict's stated wish to abstain with some suspicion. Many authors, such as George Ainslie, have argued that such a claim of inability to control their drug use allows addicted users to defer responsibility for their socially unacceptable actions³⁷. As Neil Levy points out, social forces ask drug users to embrace a false self-image of the addict who cannot control her actions³⁸. Indeed, the first step of Narcotics Anonymous, Alcoholics Anonymous, and related 12-step programs, requires users to admit they are 'powerless over drugs' or 'powerless over alcohol'.³⁹ With this motivation, users may lie about their desires, or even begin to believe that they are powerless over the drugs. With no way to determine whether we should infer the users' desires from their claims or from their actions, it is difficult to decide whether there is a truly *irresistible* compulsion.

In fact, it turns out that drug users do not only consent to research in order to obtain drugs. Fry and Dwyer offered money to drug-using research 34 35 36 37 38 39 participants, with which they could

³¹ 31 G. Watson. 1999. Disordered Appetites: Addiction, Compulsion and Dependence. In *Addiction: Entries and Exits*. J. Elster, ed. New York. Russell Sage Foundation: 3–28.

³² Neale, op. cit. note 19.

³³ Leshner, op. cit. note 27, p. 1315.

³⁴ M. Szalavitz. Trick or Treatment: Teen drug programs turn curious teens into crackheads. *Slate Magazine*. 3 January 3 2002. <http://slate.msn.com/id/2076329>

³⁵ Frankfurt, op. cit. note 28.

³⁶ American Psychiatric Association (APA). 1987. *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, D.C. American Psychiatric Association.

³⁷ G. Ainslie. 1999. Intuitive Explanation of Passionate Mistakes. In *Addictions: Entries and Exits*. J. Elster, ed. New York. Russell Sage Foundation: 209–238.

³⁸ N. Levy. Who's Fooling Who? Self Deception and Addiction. *Res Publica* 2002; 11(1): 6–10.

³⁹ Alcoholics Anonymous World Services. 2002. *The Twelve Steps of Alcoholics Anonymous*. New York. Alcoholics Anonymous World Services Inc.

surely have bought drugs, yet only 46% cited economic gain as the primary reason for their involvement in the study. It was concluded that, even if this result was skewed by users' reluctance to cite economic gain as their primary motivator, participants were not primarily enrolling in the study as a means to access drugs, and multiple motivating forces were certainly present. In heroin trials in Switzerland, in which heroin prescriptions were offered, it was difficult to obtain heroin users as subjects, and only a third of subjects decided to receive a heroin prescription when given the choice.⁴⁰ It seems that they are far from the mindless automata that media portrayals may present.⁴¹

Both of these behavioural phenomena – drug use in spite of countervailing reasons and claims of a desire to abstain from drugs – may seem to indicate that drug use is compulsive, but they ultimately fail to support this conclusion when the evidence is considered. Many will still maintain, however, that consent to prescribed heroin is compulsive, simply because addiction to heroin makes an addict want it very badly.

It is possible to understand compulsion as a nonbinary property – on such an understanding, one's actions can be more or less compulsive. Considered in this sense, a compulsion may be defined as the influence of some force extrinsic to a person, on that person's behaviour. However, when we are considering consent, not all the possible extrinsic forces vitiate voluntariness. As Faden, Beauchamp and King describe it, coercion is not permitted during the process of consent, because it deprives a person of autonomous choice.⁴² But, according to their account, to deprive a person of choice, a coercive influence must be *irresistible*. As we will now go on to argue, addictive desires are not irresistible, in that they deprive a person of choice.

The classic example of an irresistible coercive influence is of a robber, who demands money from her victim. When the victim refuses, the robber holds a gun to her head, offering a choice between 'your money or your life'. Most people would agree that, if the victim chooses life, this does not count as valid consent, because it is a non-autonomous choice. And yet this influence is *not* irresistible. If the victim had some powerful reason to choose to keep the money – suppose she needed it to save the life of her child – then there is no reason to suggest that she could not just choose to die. So the robber has both harmed the victim, and invalidated her consent, without providing an irresistible coercive influence.

In fact, what the robber has done is to change the terms of her victim's choice. Before the threat, she was choosing between keeping the money and giving it to the robber. It is reasonable to suppose that she prefers to keep the money. With a gun to her head, she is choosing between death and the money, or between giving up the money and life. Since *most* people, in *most* situations, prefer life to any amount of money, holding a gun to their head will cause them to give the money up. Yet the choice is still volitional, and rational, and it does represent the chooser's real preferences toward money, and life.

⁴⁰ T.V. Perneger et al. A randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatment. *Br Med J* 1998; 317: 13–18.

⁴¹ C. Fry & R. Dwyer. For love or money? An exploratory study of why injecting drug users participate in research. *Addiction* 2001; 96: 1319–1325.

⁴² Faden et al., *op. cit.* note 27, p. 339.

The reason it is wrong to hold a gun to a subject's head is not because it is an irresistible coercive influence (it isn't), but because it is wrong to kill, harm, or threaten other people. The reason the robber cannot obtain the subject's valid consent to give up her money, is because the robber is forcing the subject to choose between *life* and money, rather than between giving up the money and refusing to do so. The person is worse off in virtue of being offered the choice; any option she chooses is worse than if she had not been made any offer at all. The gunman forces the person to choose between two harms, where all harm was avoidable but for the free choice of the gunman. The problem here is harm, not irresistibility.

In this case the robber has removed the option of maintaining the status quo from her victim. Normally, decisions which involve consent in medical settings offer the status quo as one option. Offering the status quo as one option ensures that at least one of the options does not make the chooser worse off than she already is. Whenever the status quo is an option, a person offering choice cannot be said to be harming a person or presenting an irresistible choice. The status quo may be unfair, unjust, harmful or in some other way wrong – but that is another issue.

In many cases, choices which differ from the status quo definitely make a person better off. For example, 'Your money or I will give you a million dollars'. In this case, if the person is sufficiently poor, she may choose to keep her money and be given a million dollars by the benevolent gunman. She cannot remain as she was before, just with her money, but provided she views the million dollars as a benefit, she has not been harmed, and her choice can still reflect her real and rational preferences.

The choice to be given a million dollars is resistible. It represents the paradigm of human rational choice: a decision that one option above all others available has the greatest expected utility or benefit. The more favourable the benefit:harm ratio, the stronger the reason to choose that option.

So, we cannot rob a person of their autonomy by offering only choices which will make them worse off, even though they are harmed when we offer them such choices. They are still free to make the choice from available options which best represents their real preferences. In general, we can ensure that we are not harming participants in research if we give them the option of the status quo – in that way, we can ensure that one option open to the person is to be neither harmed nor benefited compared to her current position.

In the case of heroin prescription, the choice is often thought to be between having heroin, and abstaining from heroin. Since the heroin addict has the choice of the presumed status quo – abstaining from heroin – the offer is not harmful.

In reality, the offer of heroin as a part of clinical trial is one of four options open to the addict: to abstain, to take heroin in the trial, to obtain heroin on the street, or to take heroin in the trial *and* from the street. Again, since the status quo is open to the addict, it is difficult to argue that the addict has been harmed by being offered the choice of entering a trial. The strongest argument against a heroin trial is that the addict will continue to use heroin from the street as well as participating in a properly conducted trial. And that this will harm the addict.

Firstly, there are mechanisms to check whether addicts are using street heroin; in the Dutch trial, the dosage prescribed of heroin was dependent on the amount of illicit heroin they were using concurrently.⁴³ Secondly, can obtaining clean heroin in a trial plausibly be said to harm the addict, that is, make him worse off than he would otherwise have been? Most of the health risks associated with heroin use relate to impurities in the heroin, poor nutrition due to the cost of heroin, overdose, and problems with the injecting equipment.⁴⁴ The reliable supply of clean heroin inside a supervised trial is likely to reduce the addict's need for street heroin, and reduce risks associated with overdose and disease, and so reduce the overall health risk to the addict. At very least, it is implausible that it will *add* to the risks of street heroin consumption. So the offer of a clinical trial of heroin to an addict does not harm him.

Since giving an addict the option of prescribed heroin cannot make him worse off, it cannot be wrong in the way that regular coercion typically is, such as in the robber example. There are two other reasons why it might still be claimed that the choice to participate in the trial is not made autonomously.

1. *Addicts' circumstances vitiate autonomous choice – exploitation*

Imagine we offer a starving man the choice of doing nothing (and dying of starvation) or some food but only if he also takes part in sloppily designed clinical trial in which there is a 1% chance of death. Assume that no reasonable person in a reasonable situation would choose to take part in this trial. Though this offer makes the starving man better off, it arguably also exploits his vulnerable situation in an unfair way. His starvation forces him to accept a compensation for the experiment's risk which is unfairly small. The problem in these situations is that the participant is *insufficiently* compensated, and not that the participant is somehow choosing (in his situation) irrationally or unfreely. He gets something but he should get *more*.

In a similar way, it may be argued, the addict 'dying for' heroin is exploited when offered a clinical trial of heroin, if the addict should be receiving more. This argument would only establish that addicts should receive, in addition to trial heroin, their just deserts. What they should also receive is presumably the offer to take part in an appropriate detoxification program.

We also question (but cannot settle here) whether the starving man is exploited. Whether he is turns in part on whether the scientist who offers food plus participation in risky research is responsible for the man's starvation. It also depends on what options are open to the scientist and on his obligations. Part of the problem in this example is that the experiment is sloppily designed. But imagine it were well designed, and promised to make a significant contribution to knowledge, and entailed some risk of death. If the scientist cannot find any participants, and only has a very small amount of food to offer as an inducement, he is not doing anything wrong. What is wrong here is that the man is starving or that the scientist cannot offer more. The scientist is like Sophie in

⁴³ W. van den Brink et al. 2002. Medical co-prescription of heroin: two randomised controlled trials. Utrecht. Central Committee on the Treatment of Heroin Addicts (CCBH): 42.

⁴⁴ D. Riley. 1999. Injection Drug Use and HIV/AIDS: policy issues. Montreal, Quebec. Canadian HIV/AIDS Legal Network.

William Styron's *Sophie's Choice*. A Nazi says to Sophie that she must choose which of her children will go with her to a concentration camp and which will die now, or he will kill both now. It is not Sophie who does wrong by choosing which child will die, but the Nazi who constructs this situation. To take a familiar example, imagine a drug company gives a doctor a supply of a drug to treat AIDS. However, it is only given on condition that a placebo-controlled trial is conducted in which half the participants get tablets which have no direct effect on AIDS. The researcher conducts a trial in the developing world where no AIDS drugs are available on people who are dying of AIDS. Such a researcher is not exploiting these AIDS victims – he is giving them a 50% chance of receiving an effective treatment where the alternative is no chance at all. It is not the doctor who does wrong, but the drug company or governments or rich exploitative nations which cause this to be the situation.

Secondly, there is no exploitation in the case of heroin addicts taking part in heroin trials because the heroin addict, unlike the starving man, can get what he needs in other ways – the heroin addict can obtain heroin as he always has, on the street. This means that the offer of clinical heroin does not expose him to a choice which was previously unavailable. The starving man, meanwhile, is being offered an option – survival – which was previously inaccessible to him. Moreover, the heroin addict has the choice of rehabilitation programs to help him choose the option of abstinence. The heroin addict is not exploited.

2. *The desire for heroin is a chemical compulsion*

Arguably the effects of heroin stem from an extrinsic, chemical force, satisfying Faden, Beauchamp and King's requirements for coercion. Yet, no matter how much a person wants heroin, and no matter how much heroin has changed her, she can still opt for the status quo. For this reason regular appetitive wanting cannot present an irresistible influence. It may be argued, though, that the chemical changes an addictive drug wreaks on the user's brain create choices which do not result from regular volitional processes. One might suppose that the choice to take drugs is not made autonomously because the drugs create a kind of wanting that is somehow different from regular appetitive wanting.

So do drug-oriented desires result from regular volitional processes? Charland quotes Alan Leshner, whose argument in favour of the compulsive nature of addictive behaviour depends on neither reasonsresponsiveness nor failure to quit. Leshner believes that drug addiction results in behaviours that are non-volitional, like reflexes or schizophrenic hallucinations, and that they are caused by drug-induced changes in brain chemistry.⁴⁵ We should not believe Leshner's account.

Leshner's argument is that changes in brain chemistry resulting from the use of drugs create processes which are distinct from our usual decisionmaking processes. These processes dominate one's actions – to use his term, the drugs 'hijack' one's brain, thus producing actions which can be said to be 'compulsive'. Leave aside for a moment the fact that addicts can and do choose not to

⁴⁵ Leshner, op. cit. note 27; A.I. Leshner. Addiction is a brain disease, and it matters. *Science* 1997; 278(5335): 45–47; Leshner & Koob, op. cit. note 11.

take drugs, given strong enough incentives; Leshner's account should be rejected for its claims about brain chemistry as well.

According to Leshner's argument, to believe that a drug user is incompetent to consent, we must believe that drugs are a major determinant of our behaviour. They do not have to be the only force which determines our behaviour. There are two possibilities: either that drugs motivate us in a way which is completely distinct from regular appetitive processes such as those involving food, as Leshner suggests, or that they act in ways which are fundamentally similar to the processes of appetitive wanting. We examine these possibilities.

III. ADDICTIVE DESIRES ARE STRONG APPETITIVE DESIRES

Christian Perring, in his response to Charland, replies that drug use could never be a 'direct physiological consequence' of changes in brain chemistry, since planning and thought are required to take drugs, especially heroin which requires complicated administration skills. In fact, the empirical evidence is that even complex behaviours, which appear to require higher-level functions such as planning, may be the direct physiological consequence of relatively simple changes in brain chemistry. This is because drugs of addiction tend to modulate the 'reward' systems of the brain, which reinforce complex behaviours.⁴⁶ We should therefore take seriously the suggestion that the complexities of drug seeking and use are a 'direct' consequence of changes in brain chemistry. But does this mean that drug-oriented desires are generated in a different way from regular ones?

Compare what is known about desires for strawberries and a desire for heroin. When we eat strawberries, or any palatable food, an *unconditioned* stimulus response is triggered, in which endorphins are released in the brain, which bind to the brain's *opioid receptors*.⁴⁷ This unconditioned response conditions desires and behaviours which procure these bodily effects, especially when sugar levels are low. Secondary behaviours and stimuli which are related to the presence of the bodily effect create a conditioned response, causing dopamine to be released in anticipation of the bodily effect, and eliciting subjective 'wanting' of related stimuli. Hence we have a specific desire for strawberries, instead of for sugar-filled foods which do not contain the related conditioning taste or smell stimuli.

Sometimes, the desire for strawberries may be so strong that we become very likely to indulge ourselves, given the opportunity. The reason we do not describe this process as 'compulsive', is that it is the normal way to make appetitive decisions. Even if I feel I cannot resist the strawberries, this choice represents the actuation of a normally-generated desire, and must therefore be designated autonomous. If this were not the case, *every appetitive decision* would be compulsive.

In the heroin case, exogenous opiates are released into the brain. Though they have a very different molecular structure than the endogenous *opioids*, or *endorphins*, they bind to the brain's opioid

⁴⁶ E.L. Gardner & J. David. 1999. The Neurobiology of Chemical Addiction. In *Getting Hooked: Rationality and Addiction*. J. Elster and O. Skog, eds. Cambridge. Cambridge University Press.

⁴⁷ G.L. Tanda & G. Di Chiara. A dopamine mu(1) opioid link in the rat ventral tegmentum shared by palatable food (Fonzies) and nonpsychostimulant drugs of abuse. *Eur J Neurosci* 1998; 10(3): 1179–1187.

receptors in the exact same way⁴⁸. This means that essentially there is an unconditioned response to heroin which, despite being stronger and resulting from exogenous chemicals, affects the same processes as sugar. In any case, a desire for heroin can be developed just as a desire for food, sex, or exercise can be developed, through repeated intake and the development of associated cues. Hernandez and Hoebel found that wanting for addictive drugs triggered dopamine release through the mechanisms normally activated by eating⁴⁹. It should be noted that this argument holds for all addictive drugs. All addictive drugs are dopaminergic through one mechanism or another, meaning that they elicit dopamine release in the brain. Heroin and sugar are no different, because activation of the opioid systems results in dopamine release.⁵⁰ Colantuoni et al. found that sugar sensitises dopamine and opioid receptors in much the same way as drugs of abuse.⁵¹ Through these mechanisms, people have formed serious addictions to hundreds of ‘harmless’ substances, from carrots to drinking water.⁵²

All this should really be unsurprising – brains need mechanisms to reinforce complex behaviours that satisfy bodily needs, or else bodily appetites which require complex behaviours would never be satisfied. To take drugs, we need to engage administration behaviours which are easily as complex as those for obtaining food. It makes sense, and experimental results suggest, that all behaviours which result in such reinforcement will make use of the same reward pathways in the brain. It is much more likely that we would find drugs that make use of existing reward pathways, than try to find drugs which generate new ones. For this reason we should believe that drug-oriented desires are the same as food-oriented desires or other appetitive desires. Even the element of withdrawal has been observed in rats withdrawing from palatable food.⁵³

The only relevant difference, then, between addictive desires and regular desires is the fact that drugs operate directly on the motivational system without using only endogenous chemicals, so that their motivational power is directly dose-dependent (and may thus be very strong). There is *no other difference* between the brain mechanisms of addiction, and of regular strong appetitive liking. Consider the following: not all addictive drugs directly bind to brain receptors as heroin does. Alcohol, for example, activates dopamine receptor neurons by making them more excitable, due to its interaction with neuronal ion channels.⁵⁴ Given that we think of various drug addictions as relevantly similar, we cannot ascribe much significance to heroin’s ability to bind directly to brain receptors. If we do not privilege the directness of the process, then we cannot privilege the exogenous nature of the chemical – after all, any consumptive desire involves the activation of the

⁴⁸ W.R. Clark & M. Grunstein. 2000. *Are We Hardwired? The Role of Genes in Human Behavior*. Oxford. Oxford University Press.

⁴⁹ L. Hernandez & B.G. Hoebel. Food Reward and Cocaine Increase Extracellular Dopamine in the Nucleus Accumbens as Measured by Microdialysis. *Life Sci* 1988; 42(18): 1705–1712.

⁵⁰ Wise. *Neurobiology of Addiction*. *Curr Opin Neurobiol* 1996; 6: 243–251.

⁵¹ C. Colantuoni et al. Evidence that Intermittent, Excessive Sugar Intake Causes Endogenous Opioid Dependence. *Obes Res* 2002; 10(6): 478–488.

⁵² R. Kaplan. Carrot addiction. *Aust N Z J Psychiatry* 1996; 30(5): 698–700; E.L. Edelstein. A case of water dependence. *Br J Addict Alcohol Other Drugs* 1973; 68(4): 365–367.

⁵³ J. Le Magnen. 1990. A role of opiates in food reward and food addiction. In *Taste, Experience, and Feeding*. E.D. Capaldi and T.L. Powley, eds. Washington, DC. American Psychological Association: 241–254.

⁵⁴ F.P. Weiss & L.J. Porrino. Behavioral neurobiology of alcohol addiction: recent advances and challenges. *J Neurosci* 2002; 22(9): 3332–3337.

brain by some exogenous chemical such as sugars or odours. We should therefore conclude that there is no relevant difference at all between drug-oriented and other appetitive desires.

Finally, there is a strong tendency for chemical addictions, and behavioural addictions such as overeating or problem gambling, to coexist⁵⁵. This is supported by a comorbidity between different chemical addictions⁵⁶, as well as between different behavioural addictions.⁵⁷ There is an increasing body of evidence that suggests that addictions to regular appetitive behaviours are similar to drug-oriented behaviours, and this in turn suggests that drug-oriented desires are similar to regular appetitive desires.

There is no point in trying to distinguish desires for drugs from other appetitive desires. Appetitive desires, therefore, must be considered valid sources of rational, volitional choice. Moreover, we cannot use the mere risk or harm associated with drug-oriented desires to distinguish them from 'rational' desires. Many rational desires, such as the desire to engage in risky sexual acts or sports or to drive a motor cycle, involve risk or even self-harm.

In short, if we understand addictive desires to be nothing other than normal, but very strong, desires, then addictive behaviours make sense as volitional, autonomous behaviours. Drug users may decide to pursue the behaviours which they most strongly desire. Drugs may make it possible to develop dangerously strong desires, and that may make drugs harmful, but it does not render choice either irresistible or non-autonomous.

It may trouble some readers that these arguments could apply equally to cases of obsessive-compulsive disorder (OCD). But imagine that we offer an obsessive compulsive who is about to engage in ritual handwashing a billion dollars if he does not wash his hands. Imagine that, like the addict, he is able to control his behaviour when the rewards are sufficiently high. If it turns out that people with OCD will respond to strong counterincentives, as addicts do, then it follows from these arguments that obsessive-compulsive people are not behaving compulsively. This does not trouble us. It is a necessary result of these arguments, that if obsessive-compulsive people can respond to strong countervailing reasons, then the disorder is wrongly named. This would place OCD amongst hundreds of other scientific misnomers, such as koala bears which are now known not to be bears. If it were true that obsessive-compulsive people would prefer to continue some behaviour rather than accept a billion dollars, or protect the lives of their children, then we can accept that their behaviour is truly and completely compulsive, since they differ in this respect from addicts.

Nothing about the facts presented thus far should lead us to conclude that sober heroin users are incompetent to consent, on the MacArthur model, or on Faden, Beauchamp and King's model of autonomy. Given that addictive desires operate the same way as regular desires – since none of the reasons for viewing them as compulsive turned out to be true – we can view the addictive desires as

⁵⁵ M. Dickerson et al. 2001. *Problem Drinking / Problem Gambling: A Study of Co-morbid Individuals in N.S.W.* Sydney. University of Western Sydney.

⁵⁶ R. Caetano & C. Weisner. The Association between Dsm-III-R Alcohol Dependence, Psychological Distress and Drug-Use. *Addiction* 1995; 90(3): 351–359.

⁵⁷ S.M. Specker et al. Impulse Control Disorders and Attention Deficit Disorder in Pathological Gamblers. *Ann Clin Psychiatry* 1995; 7: 175– 179.

reasons for the addict to consent to the prescription of the drug, at least in the same way as other appetitive desires provide reasons for action. At her worst, a heroin user may have strong reasons (withdrawal symptoms, cravings) to consent to the drug's prescription. At her best, when she has a small amount of heroin in her system, the addictive desires are not likely to modify her choice at all. If we are to deny a dependent drug user the right to consent, it must therefore be because we deny everyone the right to consent to treatments they desire.

Of course, it would be a less than ideal time to attempt to recruit volunteers to a research study during heroin withdrawal. While they are capable of autonomous action even at this point, there are better times for them to make decisions. One might argue that during acute withdrawal, an addict is actually choosing between drugs and suffering, and though we have not caused this change in the choice, it could be argued that we exploit the addict by capitalising on her biological position in this way. But all this implies is that consent for drug trials should not immediately precede the obtaining of a drug or at a time when the addict is obviously in withdrawal. Participation and consent should be separated in time.

IV. CAN DESIRES INTERFERE WITH CONSENT?

We have established that the desire for drugs is not an atypical appetitive desire. We have also established that appetitive desires in general cannot comprise compulsions or irresistible coercions. But does the presence of such appetitive desires, of any kind, preclude autonomous consent? Consent in medical practice is, after all, an expression of a desire to participate in an act initiated by another person. In essence, to consent is to *choose*.

People always have a reason for consenting to the prescription of a drug. A man with a broken leg consents to morphine administration because he desires the analgesic effects of morphine. His desire for pain-relief does not invalidate his consent – if he had no reason to accept treatment, yet consented, we would have to rule him incompetent on the MacArthur model, on the basis of an inability to rationally manipulate information. When we offer research subjects money, we know that it may give them an incentive to participate – should we conclude that the money is *forcing* them to participate? No – people can make rational autonomous decisions to take part in even very risky research for large amounts of money.⁵⁸

If we required that consenters did not desire what they were consenting to, then we could never consider anyone capable of consent. Desire for treatment, therefore, cannot invalidate consent.

An addicted heroin user may consent to heroin prescription because she desires the pharmacological effects of the drug, or because she desires the relative safety of a regulated supply. Addicts probably desire both. If we accept that a person can consent to that which they desire, and also that to be addicted to heroin is to strongly desire heroin, and if we continue to insist that an addicted person's consent is invalid, then we must think that there is something special about addictive desires that makes them *inauthentic*.

⁵⁸ For a discussion of the ethics of paying participants in medical research see J. Savulescu. Taking the plunge. *New Sci* 2001; 169: 50.

V. ARE ADDICTIVE DESIRES INAUTHENTIC?

Charland claims that a competent choice must reflect a person's 'real' likes and dislikes, based on her set of values. He claims that addictive choices do not meet this criterion, and so the heroin user's consent is invalid.

Let us examine Charland's assumption that addictive desires and values are somehow inauthentic. How might we determine whether this is true? Faden, Beauchamp and King claim that, for a behaviour to be authentically autonomous, it must 'be consistent with a person's reflectively accepted values and behavior'⁵⁹. Since Faden, Beauchamp and King, and Charland all conclude that drug-oriented behaviours are inauthentic, they must be making the assumption that drug users would reflectively prefer not to take drugs. This is the analysis that Harry Frankfurt offered of addiction⁶⁰.

This is obviously in conflict with our argument above that addictions are just strong appetitive desires – and therefore at least as authentic as desires for sex and food. The reason that they make this assumption is no mystery: as outlined above, addicted drug users characteristically claim that they would prefer to, or are trying to abstain. As outlined above, this leads many to assume that they are behaving compulsively. But as we argued in section II, we cannot infer compulsion from the user's *claim* that they wish to abstain. In this case we must ask why we would assume that the claim of a wish to abstain is necessarily authentic, and assume that the behaviour of continued drug use is inauthentic.

Buchanan and Brock identify inauthentic desires as desires which are inconsistent with a longstanding set of values – when a person behaves in ways which contravene previously stated beliefs and desires⁶¹. This is also reflected in Elliott's related claims about depression: when a person is caught in the grip of depression, his values, beliefs, desires and dispositions are dramatically different from when he is healthy.⁶²

There is little agreement on whether drug addiction should be characterised as an illness, as severe depression is⁶³. Nevertheless the idea of longstanding values as a measure of who a person 'really is' is coherent in the addiction case. On this argument, a radical sudden change in a person's desires signals that these desires are inauthentic.

There are two responses to this objection that desires for drugs are inauthentic. Firstly, authentic desires and values can radically change rapidly. Religious experiences are examples. Secondly, even if we claim that those previously stated, longstanding values were necessarily authentic, and even if

⁵⁹ Faden et al., op. cit. note 26.

⁶⁰ Frankfurt, op. cit. note 28.

⁶¹ D. Brock & A. Buchanan. 1982. *Deciding for Others: The Ethics of Surrogate Decision-Making*. Cambridge, MA. Cambridge University Press.

⁶² Elliott, op. cit. note 6.

⁶³ Lyvers. op. cit. note 16; J. Orford. *Addiction as Excessive Appetite*. *Addiction* 2001; 96(1): 15–31.

we allow that such a personality change is evidence of an inauthentic desire, researchers do not have the luxury of using this definition of authenticity when evaluating competence. Drug users present to researchers in an already dependent state. Researchers cannot know what their past authentic values were, if they are different to the current values.

In fact the only way for us to be sure that the drug-oriented desires are inauthentic is to decide, on their behalf, what their desires *ought* to be; if their new desires appear to be inconsistent with what we consider an appropriate system of values, then we may label them inauthentic, and oppose them to the person's 'real' likes and dislikes. Typically, addictive choices are harmful to the addict's self and to their social relationships, and we assume that the addict doesn't 'really' want to cause these harms.

Isaiah Berlin warned of the dangers of making judgements about a person's real values. In his essay, 'Two Concepts of Liberty',⁶⁴ he resists this splitting of the self into rational and non-rational parts. This notion of autonomy which identifies a person's 'real' preferences is represented in Berlin's essay in the concept of 'positive liberty'. Negative liberty consists in not being prevented by others to do as one chooses.⁶⁵ Berlin objects that there is a danger of a two-stage slide if positive conceptions of liberty are used. In the first stage, it is often possible and justifiable to coerce men to pursue some worthwhile end (like justice or public health), which they would themselves pursue if they were not 'blind or ignorant or corrupt'.⁶⁶ It is a short step from this to the next stage.

I may declare that they are actually aiming at what in their benighted state they consciously resist, because there exists within them an occult entity – their latent will, or their 'true' purpose – and that this entity, although it is belied by all that they overtly do and say, is their 'real' self, of which the poor empirical self in space and time may know nothing or little; and that this inner spirit is the only self that deserves to have its wishes taken into account. Once I take this view, I am in the position to ignore the actual wishes of men and societies, to bully, oppress, torture them in the name, and on behalf, of their 'real' selves, in the secure knowledge that whatever is the true goal of man (happiness, performance of duty, wisdom, a just society, self-fulfilment) must be identical with his freedom – the free choice of his 'true', albeit often submerged and inarticulate, self. This paradox has often been exposed. It is one thing to say that I know what is good for X, while he himself does not; and even to ignore his wishes for its – and his – sake; and a very different one to say that he has eo ipso chosen it, not indeed consciously, not as he seems in everyday life, but in his role as a rational self which his empirical self may not know – the 'real' self which discerns the good, and cannot help choosing it once it is revealed. This monstrous impersonation, which consists in equating what X would choose if he were something he is not, or at least not yet, with what X actually seeks and chooses, is at the heart of all political theories of self-realization. It is one thing to say that I may be coerced for my own good which I am too blind to see: this may, on occasion, be for my benefit; indeed it may enlarge the scope of my liberty. It is another to say that if it is my good, then I am not being coerced, for I have willed it, whether I know this or not, and am free (or 'truly' free) even while more poor earthly

⁶⁴ I. Berlin. 1969. *Four Essays on Liberty*. Oxford. Oxford University Press: 118–172.

⁶⁵ *Ibid.* p. 131.

⁶⁶ *Ibid.* p. 133.

body and foolish mind bitterly reject it, and struggle against those who seek however benevolently to impose it, with the greatest desperation.⁶⁷

Elliott claims that, to be competent for consent, a person must display a 'minimal degree of concern for their own well-being'⁶⁸. His argument is that 'our ordinary relationships with other people are based on certain assumptions about their thoughts and behavior', including 'the assumption that other people ordinarily both have some minimal degree of self-interest and are best positioned to judge their own interests'. Elliott's claims are the basis of the National Bioethics Advisory Commission's decision in their report, wherein these arguments are cited.⁶⁹ Cohen argues that the only way to guarantee that addicts are autonomous and competent is if they have voluntarily entered treatment for addiction.⁷⁰ Perhaps it is true that rational people must have at least some minimal desire for self-preservation. However, given that addictive desires are just appetitive desires, we do not know that an addict who fails to enter treatment has no desire for self-preservation – we only that they have a stronger desire to use drugs. Cohen's argument assumes that a drug user must act on their desire for self-preservation in order to display a 'minimal degree of concern for their own well-being'. This assumption betrays either a belief that such a 'minimal' concern must always outweigh a user's desire for drugs, or that no desire for drugs is ever rational, or that drug-oriented desires are not desires.

We should reject these assumptions because they have slipped into the second stage outlined by Berlin. It may be that desire for drugs harms a person or leads a person to do what he has good reason not to do, but we should not say these desires are unreal or inauthentic. More controversially, we cannot assume that decisions that place a higher value on drug use than medical self-preservation are necessarily irrational. This would represent an anaemic, narrow medical or sanctity of life model for rationality. There is a wide range of experiences which may cause us to elevate the value of some experience above the value of our own health. There is also a wide range of situations in which people may rationally prefer choices which harm themselves, and in which concern for their own well-being may rationally be minimised. Consider the case of a woman who is nine months pregnant, suffering complications. The doctor informs her that she must choose between her life and the life of the baby. Expressing a powerful desire for her child to live, she may rationally elect to receive no treatment and die, even though this clearly fails to promote her own wellbeing. Or consider the man who wants to donate both his kidneys to his two sons who have renal failure. Such a desire is not only altruistic but it can be rational.

It may be true that the nature or extent of the addict's desire for pleasure frustrates the pursuit of the good life, or the best life. However imprudent desires do not render a person non-autonomous or necessarily irrational. Indeed, many of us have, at one time or another, imprudent desires. Partly by making mistakes we can discover the good life. Moreover, imprudent desires do not render a person incompetent.

⁶⁷ Ibid. pp. 133–134.

⁶⁸ Elliott, op. cit. note 6.

⁶⁹ NBAC, op. cit. note 7.

⁷⁰ Cohen, op. cit. note 8.

CONCLUSION

We have argued that addictive behaviour is not compulsive, in any of the senses which would render the drug user non-autonomous. We have argued that the decision to take drugs is in fact an autonomous decision. We have run out of hiding places – we must now conclude that addicted drug users may competently consent to the use of their drug and in particular to its administration in a research trial.

Doctors are legally forbidden from prescribing treatments which will harm a patient, whether they consent or not; researchers should follow a similar ethical course. However, there is evidence that the user is ultimately better or no worse off with uncontaminated, regular clinical doses than with the illegal supply they would have used instead.⁷¹ If we decide we can ethically prescribe drugs such as heroin to addicted users, then we should believe that they can consent.

The evidence is strong – we should not believe that drug users are behaving compulsively. We have argued that addicts act on the basis of normative reasons. They may be mistaken about what they have good reason to do, but they act as rational animals and not as mere automata in response to irresistible physiological or psychological impulses. We should believe that they have strong drug-oriented desires, which cause them to autonomously choose actions which we believe are harmful to them.

Drug addicts should not be treated differently from other addicts or other members of society. Alcoholics, food addicts, exercise and sex addicts can and should take part in research. They can make autonomous decisions about the regulation of their appetitive desires.

Drug addicts are not involuntarily treated for the addiction – they function as other citizens in society. They can vote, make wills, get married and are held responsible for crimes. Taking part in research should be no different. Perhaps narcotic addiction has been singled out because many people in society disapprove of it. But it is a form of behaviour that is not different in kind to many other more socially acceptable, appetitive behaviours.

As with other kinds of research, we can promote more autonomous participation and better consent processes. Separation of the provision of information consent from participation is a good idea for all kinds of research to prevent contemporaneous influences (including the persuasion of researchers) from effecting consent. Addicted drug users should not be approached for consent at times of severe intoxication or withdrawal, just as other participants should not be approached at times when their decision-making may be less robust than it could be. But with these and other caveats, addicts should be encouraged to take part in beneficial research.

The arguments have broad ranging implications for the legalisation of drugs and for the respect we show to the choices of addicts about their own lives. Any argument against legalisation of drugs or supporting infringement of the liberty of those desiring to take drugs of addiction must be based on considerations of harm and paternalism, and not on false claims that addicts lack freedom of will.

⁷¹ Riley, *op. cit.* note 44.

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