

## **The Need For Scientifically Based Ethical Principles In Dealing With Drug-addicted Persons**

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In a treatment setting for an addictive disorder, the relationship between physician and patient may be hindered by the nature of the disease itself. Insufficient knowledge of the dynamics of the disease may lead to interpreting some typical features or behaviours as an abnormal and unacceptable limitation on treatment feasibility. In some ways, raising obstacles to certain kinds of interactions between the patient and treatment facilities may serve as a way of shifting patients towards a perspective of cure rather than a self-wise manipulation of resources. On the other hand, obstacles to treatment itself, especially if justified in terms of the presence of expected symptoms, simply mean treatment omission. Besides, patients often end up feeling guilty, or at least responsible, for the failure of a therapeutic attempt, no matter whether it is inappropriate or clumsy. As a rule, treatment programmes which require the patient's involvement in "stopping having the symptoms" have no effect other than discouraging the patient from making future attempts, while inculcating the idea of incurability. The following ethical issues need to be accounted for when dealing with addicted patients.

- 1) **Choice of treatment modality.** In the patient's interest, it is up to the physician to make therapeutic choices. If the patient shows he or she is compliant with one treatment perspective, but not others, the decision to be made by the physician should take the patient's preferences into account. A doctor-patient relationship has a therapeutic basis, and it is bound to fail as long as it brings no therapeutic benefits. The first-line choice is the same for most patients, and corresponds to an agonist maintenance programme. Even if some patients, due to a lower degree of

disease severity, may draw additional benefits from environmental interventions, or antagonist maintenance, the choice of a broader-spectrum treatment modality will certainly give them the advantage of a lower likelihood of relapse, without excluding them from the most effective options. The trend of matching less severely impaired patients with less effective treatment options has, over the years, made most such cases increase in severity due to treatment failure. In no case can the choice be restricted to “no treatment” or “waiting”, in the hope that the patient will not relapse or will stop autonomously, after hitting the bottom. When choosing between therapeutic options, it should be remembered that effectiveness is not influenced by expectations of applicants or the intentions of promoters, but by scientifically documented properties. So far, at least, any therapeutic programme which does not employ opiate-modulating drugs cannot be considered a reasonable option in the treatment of narcotic addiction.

- 2) **Availability of treatment options.** Since many treatment options exist, the actual availability of the most effective (agonist-based) programmes should be kept at the highest level; availability should be lower for less effective (antagonist-based) ones, and still lower for harm reduction. Harm reduction is characterized by a low threshold in terms of behavioural requirements, which means that almost anyone qualifies for admission to it, but high-threshold facilities should be those that are made most available, meaning that anyone may apply for them. The Centre should keep high threshold treatment as the final goal, while continuing to run harm reduction programmes, in the attempt to make patients fit to be admitted to higher threshold programmes. Physicians should clearly reject any request that is not inspired by therapeutic purposes, or is inspired by unrealistic expectations about achievable results (e.g. results expected from detoxification, drug-free interventions and agonist-free interventions). The goal and the principles of any treatment must be clear from the beginning, whereas details and related explanations can be discussed later on. Whenever a centre can only provide applicants with one treatment option, agonist maintenance should be the choice, due to its broader spectrum. In this case, the threshold and waiting lists must be such as to allow patients to be followed up individually.
- 3) **Therapeutic Deal.** While dealing with a disease which basically consists of the loss of behavioural control, it is paradoxical if behavioural control is made a requirement for staying within the programme. No physician should ever regard the persistence or recurrence of addictive symptoms as a valid reason for a patient to be terminated. Patients applying for treatment are not in a position to make promises about how much they will “use”, how strictly they will comply with the rules, or how sincere they will be in reporting their behaviours. All this may change in the case of stabilized patients, who have made room within their brain for self-aware choices, and can actually choose, day by day, whether to comply or not with the

treatment regimen. It follows that the achievement or maintenance of abstinence as a requirement for beginning or continuing any treatment programme, respectively, are examples of inadmissible therapeutic deals. As long as addictive behaviours endure, therapies must be handled promptly and meaningfully with respect to the final goal. Only patients who refuse the physician's prescriptions, including attendance and sample delivery, can reasonably be terminated, or referred to a lower threshold programme. The patient is only responsible for compliance with treatment rules, not for substance use, and the physician is not there to prescribe a behaviour, but a therapeutic agent.

- 4) **Negotiation.** At first, allowing the patient to participate in therapeutic decisions may turn out to be helpful in establishing a good relationship. Addicts usually try to manipulate the therapeutic setting, in a stereotyped way, and show apparent gratitude to those who allow them to do so. In reality, stabilized patients approve of physicians who refrain from involving them in therapeutic responsibilities, and are not influenced by their requests. A treatment which is founded, even if partially, on an addicted patient's decision, is bound to be a failure, and this can only be to the patient's detriment. Moreover, as long as patients directly interact with their symptoms, without the autonomous mediation of a sensible physician, they will stay convinced that a possible change in the course of addiction may depend on a variety of factors pertinent to the environmental sphere or to a paradoxical idea of motivation (the ability to resist one's drive towards the substance).
- 5) **Refusal or interruption of treatment.** Addicted patients are ambiguous by nature. However, the crucial factor which allows methadone treatment to be successful, is not of a motivational kind, but behavioural: the administration of certain doses for a certain time can make treatment effective, beyond the subject's intentions to stay off drugs. It is unethical to regard motivations, intentions or self-criticism as crucial for enrolment. The presence of addictive symptoms, no matter how severe, is never a good reason to terminate a patient, unless they actually make it impossible for that patient to comply with the minimal rules of the programme. Minimal rules correspond to the features for effectiveness, that is, dosage and duration and registration of parameters. On the other hand, attendance of ancillary or higher threshold facilities cannot be considered as rules for any kind of patient in any kind of programme. In a way different from basic anticraving treatments, such facilities are optional and require the patient's active request to be regarded as viable. On clinical grounds, the stabilization obtained through anticraving treatment usually causes patients to become spontaneously willing to engage in higher threshold facilities for addiction, and capable of satisfying the corresponding requirements.
- 6) **Change of treatment modality.** The flow of patients' thoughts is spontaneously oriented towards cutting out medications, due to cultural bias. Sometimes, any such

trend is favoured by suggesting or supporting the idea that a drug-free state is the gold standard, and indicative of therapeutic success. The result of following this line of reasoning is that potentially effective programmes may be prematurely aborted, so upsetting the therapeutic balance in favour of a fake perspective of healing. This revolving door mechanism is, sometimes, all that patients are offered at every stage of their addiction history, until death puts an end to it all. Lastly, it is risky and unjustified to shift to a newer treatment modality just for the novelty factor, once another modality has been tried and proved to be effective (e.g. abandoning methadone for buprenorphine, or an agonist for an antagonist).

In conclusion, a physician who acts in accordance with intuition and common judgement, runs the risk of paving the road to hell with good intentions. The fact is that handling a request for treatment by a patient implies a fundamental question for any physician to ask themselves: "In what way and to what extent are my actions supposed to change the course of this disease?". The answer to this key question is often, to one's great surprise, far different from any common judgement.

*Received and Accepted April 20, 2007*