The Ethical View
March 2009
Addiction and Responsibility from a Medical Perspective

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Letter from the Editor
Meredith Ashooh, ‘11

The Ethical View is released annually by the Medical Humanities Program of Davidson College in an effort to raise awareness about healthcare issues and their ethical ramifications.

The theme of the publication corresponds to that of the Frederick Womble Speas Symposium (see page 7 for details). The event will bring disciplinary experts together on campus to discuss a particular healthcare theme, which this year is Addiction and Responsibility in Medicine.

The Speas Symposium is a great opportunity to interact with other students and professionals from the medical and bioethical fields. The event will give you an opportunity to hear from various experts and to discuss the topics within this issue, as well as other ethical concerns about addiction.

The articles in this publication have been written by members of the Medical Humanities Program. It is my hope that reading them will give you new insight about just a few of the many problems associated with addiction.

Can a person struggling with addiction consent to their own treatment? What are some concerns with genetic testing for a predisposition to drug and alcohol addiction? Are vaccinations an effective treatment for drug addicts? These questions, along with several others, are addressed within these pages.

To respond to any article or issue presented in this publication, please see the contact information on page 10.

About the Editor...

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Addiction and Responsibility
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What is addiction?

According to the Oxford English Dictionary, addict, addicted and addiction are ancient legal terms that trace their origins to Roman law. For a court or a judge to addict a person is to assign him or to attach him, or formally to make him over to the service of another, by decree or by sentence, imposing a restraint or obligation on him. By extension, in the first-person reflexive case, to addict oneself is to be attached by one’s own act, bound or devoted to another, as a servant, disciple or adherent.

The terms addict, addicted and addiction trace their origins to Roman law, but the concepts predate the terms. Homer’s account of Ulysses and the Sirens uses the concept of addictive desire to illuminate its self-destructive tendency when one wills acting on it. The Ulysses story offers a thought-provoking strategy (pre-commitment/self-binding) for avoiding self-inflicted disaster.

Plato, in The Republic, says that a patient seeking to be made well, attaches himself to the physician, voluntarily subordinating himself to the physician’s regimen. In effect, the physician judgment rules the patient’s sick body, for the purposes of healing it. Plato appreciated that incurring subordination is risky. The patient may mistake a quack for a physician, become subservient to a sooth-sayer, whose true skills lie in recruiting patients and making them chronically dependent on his beliefs and authority. The quack and the physician appear similarly, but in reality are different. The physician is a master of the art medicine who puts the patient’s interests first and will not subordinate the patient longer than curing his illness requires. By contrast, the sooth-saying quack is a master of advancing his own interests, not in making patients well. “…no physician, in so far as he is a physician, considers his own good in what he prescribes, but the good of the patient; for the true physician is also a ruler, having the human body as a subject, and is not a mere money-maker…” (Book I, @ 342). Unfortunately, Plato never solved the problem of enabling someone who is not a true physician himself to distinguish the real-deal from quacks and pretenders. It follows that a person burdened with addictive desire who seeks professional help is doubly challenged. He may only succeed in addicting himself to a quack’s authority. Regaining independence will prove twice as hard. Addiction may be iterative, proliferating misguided choices, ultimately self-defeating.

Addiction implies a condition of servitude, imposed by another or self-imposed, hence a loss of autonomy. The loss of autonomy entailed by addiction may be indeterminate or determinate, for example, as imposed by a judge’s sentence. Addictions resulting from acts of one’s own may also be indeterminate or determinate. One’s autonomy loss may be greater than intended, wanted or anticipated.

Remission of servitude’s disabilities (the recovery of autonomy) may be beyond the addict’s power as it would be when a judge’s authority is required to remove them. But the duration of self-imposed servitude may be somewhat subject to the addict’s own discretion. For example, by a personal service agreement one becomes another’s servant, to do his bidding in some respect. Having addicted oneself, placed oneself in a condition of servitude by one’s own act, one may revoke it, or breach it. Similarly, one may addict oneself to a teacher, to a teaching or school of thought by become an disciple or adherent. Bonds of loyalty, habits of subservience tend to result. One’s person may be transformed in unexpected, even unwanted ways by such attachments. If so, freeing oneself, regaining one’s independence may prove very difficult, even identity-threatening.

A condition of servitude implies regularly performing acts of submission. When done habitually, such acts become characteristics – obedience, compliance, subservience or even servility. A servile person has surrendered not only his autonomy, but also dignity and self-respect. His identity and values derive from his attachment. Since servility is contrary to self-respect, a person who suffers from it has a reason to mischaracterize the trait to himself. In other words, he will be motivated to disbelieve that he is servile. Self-deception results – the vice of failing to be honest with oneself. Acknowledging servility invites self-contempt, an attitude towards the self everyone has a reason to avoid, an attitude one would want others not to have towards one.

Addiction implies servitude, a loss of autonomy. It does not rule out responsibility or self-control. Incarcerated criminals, addicted to prison authority, remain capable of mens rea, an element of

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their committing further crimes. Their sentences may also be blameworthy – when outrageously compliant to a quack’s bidding. At the Nuremberg Trials, “superior orders” was not allowed as a defense for war crimes and crimes against humanity. Individuals remained accountable for their killings. Their having addicted themselves to Hitler and Nazism was no excuse. Self-Addiction and Brain-Washing.

On or about November 18, 1978, 909 persons died at Jonestown, Guyana. The adults had previously addicted themselves to James Jones, founder of the People’s Temple, and to his theology, a blend of Marxism and Christianity. Swayed by his apocalyptic teaching, they voluntarily followed him from San Francisco to Jonestown. After a congressman (Leo Ryan) and several newsmen who had come to Jonestown on a fact-finding mission were shot at death at the airfield, Jones ordered, pleaded, and cajoled his followers to kill 276 children first and then themselves by swallowing grape-flavored Flavor-Aid (often mistakenly called Kool-Aid) that had been laced with potassium cyanide and a sedative. An audio tape recording of the event, later transcribed by the FBI and made public on the internet, makes it clear many of the adults were unwilling to kill the children and themselves. But no matter, Jones alternatively harangued and pleaded with them to overcome their hesitancy. He succeeded. Virtually all eventually did his bidding, voluntarily even if reluctantly. They put the cups to their children’s and their own lips and drank as they were told. Jones had primed their obedience by staging rehearsals (“white nights”), deceiving his disciples that they were drinking poison. The rehearsals plus awareness of fellow-believers’ compliance no doubt influenced their decisions.

No one argues that Nazis addicted to Hitler and Fascism should have been allowed to escape responsibility for the killings they committed. If so, we should not deny responsibility to the addicts of Jim Jones. Nor should we withhold blame and disgust from Jones’ addicts for killing their children and throwing their own lives away. Their conduct was purposeful, intentional, and disciplined. Ultimately, their self-control proved sufficient to overcome whatever reservations they may have felt.

It might be objected that Jones’ brain-washing techniques had enabled his supplanting the wills of his disciples with his own. His adherents had ceased to be responsible agents. His charismatic manipulation had reduced them to robots.

This conjecture is false to the facts, as a re-

view of the Jonestown death tape reveals. Jones alternately berated, reassured, pleaded, and begged his unwilling disciples that they should kill their children and themselves. And the adults decided to do it, but not in unison, all at once. Some disciples took much more convincing than others. Only a very few ran away.

Chemical Addiction and Disease of the Brain

At Roman Law, the mechanism of addiction, what explained the addict’s autonomy loss, was a court order or sentence imposed by a judge. In cases of self-addiction discussed so far, one’s own act is the mechanism by which one incurs an autonomy loss. It seems that neither addiction nor the condition of servitude it entails rules out self-control and responsibility.

It has been proposed that chemical addiction (called “drug dependency” in DSM IV) is unlike cases discussed so far with respect to mechanism of action. Nicotine, alcohol, heroin, marijuana, cocaine, amphetamine-type stimulants, barbiturates (or their metabolites), cross the blood-brain barrier, and by mimicking various neurotransmitters, they achieve selective uptake at key receptor sites, activating the mesolimbic reward system deep within the brain. Irreversible changes in the brain result. Receptor sites avid for chemical stimulation proliferate. The brain’s metabolism is altered. Even gene expression response to environmental triggers is affected. Addictive chemicals variously change the brain’s architecture, hijack key neural circuits away from normal human pleasures, such as sex and eating, making them starved for the stimulation that these substances preferentially provide. By his own initial, fateful act, the addict’s autonomy takes an irrevocable hit. However, unlike the cases of obeying a judge’s order, or complying with the commands of a malevolent leader, the addict is victimized by his own sick brain whose commands he is helpless to disregard – “Get High!” In defense of the brain-disease model, it is seemingly impossible for a regular cocaine user or heroin junky to abate her using when the chemicals are ready to hand. She will ignore her infant children, her family, and job to risk lethal infection by injecting her veins with dirty needless. She seems helplessly obedient to the commands of her own brain.

However, neuro-physiology is not uniquely applicable to chemical dependencies. It must apply to Hitler-dependency, Jim Jones-dependency and other irrational attachments too. After all, hearing signature music, associating with like-minded adherents, learning rituals of obedience, regular disciplining, must access and change the brain’s neural pathways.

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Habits must cause brain changes. How could it be otherwise? The indoctrinated brain of a Hitler-addict addict must have ordered him, “join the chorus now, stand up, right-hand raised, – Sieg heil!”

Drs. Satel and Goodwin are skeptics about the brain-disease model of addiction (Is Drug Addiction a Brain Disease, internet available). They point out the addict’s seemingly out-of-control, mindless (but brain-guided) compulsive drug-using behavior changes when her supply runs out. She recognizes what’s happened. She intends to replenish her store and seeks to do so deliberately. She knows where likely sources are to be found, knows how much she must pay, takes steps to obtain the money. She may prostitute herself or steal to get it. But, importantly, she does not routinely proposition uniformed police officers or try to rob them. Plain-clothes vice squad officers may catch her, whereupon the addict may concoct elaborate lies in an attempt to mislead authorities about what’s she has been up to. In short, the addict’s supply-replenishment behavior is not random, is not seizure-like, or out of control, but rather intentional, deliberate. Stretches of the addict’s life are rational and self-controlled, albeit intermittently punctuated by drug binges.

Satel and Goodwin argue that it is fruitless to seek a magic chemical counter-measure for addiction. Chemicals may blunt the addict’s craving but come with sense-dulling side-effects. Vaccines may effectively recruit the immune system to prevent cocaine from crossing the blood-brain barrier. But an effective cocaine-vaccine cannot prevent the addict’s seeking a substitute that evades the immune system’s surveillance.

What is necessary is a multi-pronged response to addiction that recognizes the addict’s distress but does not demote his moral status. Paternalism might say, “yes.” It is what the addict herself would agree to, if she were thinking clearly and using her own best-interest as a guide. Is that sufficient justification? Perhaps, not but the fact that some addicts do respond voluntarily to changes in the contingencies of choice show that addiction, even chemical addiction does not rule out self-control and deliberate conduct.

Is it right to threaten drug addicts with these consequences? Would it be right to commit them (to addict them!) to involuntary treatment in residential treatment program? A theory of libertarian paternalism might say, “yes.”

Notes and Bibliography Available On Request From the Author.

The Medical Humanities Program at Davidson College

The Medical Humanities concentration promotes an interdisciplinary understanding of health and health care. It enables students to appreciate the strengths and limits of the natural sciences, social sciences, and humanities as they seek to explain and to achieve a measure of control over disease, illness, and suffering.

The concentration helps students grasp how legal, economic, and political institutions influence the production, distribution, and delivery of health care services. It also provides students with the analytical and ethical skills necessary to apply the principles of scientific integrity in biomedical research.
**Can a Drug Addict Consent to Prescription of Their Drug of Choice?**
Ross White, Davidson College ’09

Heroin prescription is a research practice in which heroin addicts are provided with medically prescribed heroin in the treatment of their addiction. This method offers the potential for drug addicts to receive their drug of choice in a safe and clean environment, with the hope of decreasing illicit drugs use and criminal behavior. Despite these seemingly positive outcomes, this treatment program raises many important ethical problems, most notably the difficulty of whether these addicts can appropriately consent to such treatment. Two fundamental questions arise: how can an individual who is addicted to heroin voluntarily consent to participate in research that provides the drug of choice free of charge; and, if consent were possible, is a heroin-dependent person mentally competent to make such a decision? Through exploration of these questions, and others, one can conclude that heroin addicts should be presumed to not have mental competency to consent unless proven otherwise.

In order to better understand this issue, one must decide if heroin-dependence precludes one’s ability to make a fully competent and voluntary decision. The Diagnostic Statistical Manual of Mental Disorders defines substance dependence as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite negative consequences…a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug taking behavior.” Compulsion would necessarily seem to preclude an individual’s ability to make a voluntary choice about whether or not to participate in a trial offering the drug of choice. Thus arises a dilemma in heroin prescription. If the subjects are heroin dependent, they cannot participate in the trial since they are incapable of competent decision making. Alternatively, if they are not heroin dependent they cannot participate in the trial because they do not qualify. Even if they can participate, we must ensure that they have the mental competence to adequately consent to the research.

The issue of mental competence is better fleshed out by looking at the MacArthur model of competence, comprised of four distinct components.
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.

In the case of heroin prescription, subjects may well understand the choice (whether to participate or not), but that does not mean that they appreciate that choice. One can understand and appreciate that heroin addiction is a serious problem, but that does not mean that they recognize those facts as applied to oneself. Even if a heroin addict were to acknowledge the fact that he or she is addicted, there may still be a resistance or refusal to admit that the addiction may have deleterious effects.

Even more problematic is the third criteria. In order to rationally manipulate information, one must be able to reason logically from premises to conclusions and evaluate the risks and benefits of prospective decisions. This requires assigning preferences to each possible decisions and the capacity to compare the relative merits of each decision’s subsequent outcome. If in fact an individual is clinically addicted to a drug, his or her value and decisional making system will inevitably be influenced by a need for that drug. If this is true, the subject would be inclined to prefer the outcome that results in him or her receiving the drug of choice. While the drug may be procured by other means (such as their normal provider), the financial incentive of receiving the drug with “no strings attached” would likely cloud their judgment and decision making capacity.

In order for true competence to exist, there must exist some sort of enduring set of values upon which that decision can be based. An individual who is truly addicted to a drug will experience daily fluctuations of desire based on their cyclic state of craving and withdrawal. This is especially problematic with a drug such as heroin, which has such a short half-life requiring heroin injections up to two or three times a day in order to fulfill a craving. This leads to a perpetual state of fluctuation, whereby the addict wants badly to quit as a long-term goal, but becomes a slave to the drug under constant craving and compulsion. By enrolling addicts in any prescription program we are only enforcing, and possibly exacerbating, these symptoms of addiction. Knowingly causing harm to research subjects is a clear violation of any research ethics code.

While some may be inclined to say that heroin prescription has value as research and the potential for treatment of addiction, little evidence exists to support this assertion. No trial thus far has substantively shown a causal relationship between the regulated administration of heroin and

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improvements in health and social status. Any such progress is more likely the result of the overall treatment program, which provides social support to those of extremely poor mental and physical health.\footnote{Uchtenhagen, A, F Gutzwiller and A Dobler-Mikola. 1997. Programme for a medical prescription of narcotics: Final report of the research representatives. Berne: Swiss Federal Office of Public Health.}

Rather than perpetuating bad behaviors of addicts by giving them their drugs of choice, we can better invest our time and resources in programs that seek to address some of the social factors that lead to drug addiction: poverty, lack of education, poor mental health care, abuse, and discrimination.

References


\textbf{Ross White ’09 is a political science major, with a concentration in medical humanities. He is the President of the Bioethics Society and plans to study and research health care policy and bioethics in the fall.}

### Is Ignorance Bliss? The Ethical Implications of Genetic Testing for Predisposition to Addiction

Matthew Lotz, ’11

If you were offered a test that would tell you whether you or your child had an above average risk of becoming a drug addict or alcoholic, would you accept? At first thought, the answer may seem obvious. Of course you would want to know if you had a predisposition, because it would allow you to better govern your behavior and seek out the appropriate help. However, with the development of genetic screening, there are deeper ethical concerns that must be addressed.

As we enter into an age of increasing understanding through research in the fields of genomics, genetics, and neuroscience, a forefront of medical advancement is the development of tests to detect identifiers for disease and treatment of disease through knowledge of an individual’s genetic make-up. Research has been conducted to find a genetic marker for addiction, and other diseases, including cancers. Although some tests have been developed (e.g. the A1 allele test), there are currently no widely accepted effective tests to test for genetic-based addiction risk. However, it is likely that there is some genetic basis behind addiction, because risk can often be traced through family history and more genetic markers are being discovered.

Ethical concerns for the development of an effective genetic test for addiction begin at prenatal testing. As with other prenatal testing, the existence of such a test would force parents to choose whether to know if their child will be predisposed to addictions to drugs and alcohol. A predisposition would then lead to the parents having to make more decisions, and undoubtedly affect how they raise their child – for better or worse. Those parents with the appropriate resources may be able to provide their children with effective education and counseling to decrease risk of addiction.\footnote{Elster, J. 1999. Strong Feelings: Emotion addiction, and human behavior. Cambridge, MA: MIT Press.} What about less fortunate parents? The parent may be able to provide effective parenting to their child, which can override the predisposition to addiction.\footnote{World Health Organization. 1999. Report of the external panel on the evaluation of the Swiss scientific studies of medically prescribed narcotics to drug addicts. Geneva: World Health Organization.} However, the knowledge may lead unprepared parents to give their child up to foster care, which leads to different problems. In short, with the right resources, a parent can use this information to their advantage, but without resources, the future child’s disadvantageous position may be exacerbated.

In addition, there is the issue concerning confidentiality and third parties. That is, will this medical information be kept confidential and out of the hands of employers and insurers? Knowledge of an individual’s genetic predisposition may lead to difficulty in job security and higher insurance premiums. Therefore, there must be mechanisms to prevent “genetic discrimination” by keeping this information confidential. Likely, this would need to come from legislation.\footnote{World Health Organization. 1999. Report of the external panel on the evaluation of the Swiss scientific studies of medically prescribed narcotics to drug addicts. Geneva: World Health Organization.}

All in all, the prospect of genetic screening for diseases is very exciting and can lead to better quality of life for many people. However, there are foreseeable ethical consequences that must be addressed before these tests can be effectively used. We must make sure we can effectively treat those with genetic disadvantages, and prevent genetic discrimination. We must also guard against eugenics, which will likely become a concern in treating genetic problems. These are obstacles, but they can be overcome to effectively implement genetic screening to improve medical treatment.

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References


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The Modern Hippocratic Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:
I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.
I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.
I will not be ashamed to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.
I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
I will prevent disease whenever I can, for prevention is preferable to cure.
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm. If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

http://www.pbs.org/wgbh/nova/doctors/oath_modern.html

Since 1988 Davidson College and the Carolinas Health Care System have jointly sponsored the Frederick Womble Speas Symposium funded through the generosity of the R. Dixon Speas Family.

The goals of the 22nd Annual Speas Symposium are to:

- Describe how psychologists, economists, political scientists, and health care providers view addiction.
- Analyze the public policy implications of addiction research and practice.
- Consider the ethical issues associated with addiction research, practice, and policy.

March 30th, 4:30-8pm in the 900 Room of the Knobloch Campus Center

Schedule of Events

4:30-6:00pm—Disciplinary experts, including Mark Smith, PhD (Davidson College), Alison Snow Jones, PhD (Wake Forest University), and Russell Crandall, PhD (Davidson College), will discuss addiction and responsibility from a medical perspective.

6:00-6:45pm—Conference attendees are invited to a buffet dinner and roundtable discussion.

7:00-8:00pm—Sally Satel, M.D., W.H. Brady Fellow (at the American Enterprise Institute) and a practicing psychiatrist specializing in addiction treatment, will give a physician’s perspective about addiction and authority.

The event is free and open to the public.
The Ethics of a Vaccination Against Addiction
Molly Palilonis, ‘09

Drug companies in the United States and Great Britain have begun to develop vaccines against drugs like cocaine, nicotine, methamphetamine, phencyclidine, and heroin. The vaccines use antibodies that bind to the drug molecules and prevent them from crossing the blood-brain barrier. In the fast-acting vaccine monoclonal antibodies are injected and can clear the drug from the body quickly but have a short half-life. The second type depends on the body’s immune response to a drug-protein complex to create long lasting antibodies. The vaccines for nicotine and cocaine have begun human clinical trials and could be on the market soon. These vaccines raise ethical questions about their use in addiction treatment and prevention.

The most immediate use of these vaccines is in the treatment of addiction in current or past drug users. The fast-acting, monoclonal antibody vaccine has indications as an emergent treatment for drug overdoses. As long as the treatment proves safe and effective its short half-life removes most ethical concerns that come with irreversible altering a person’s body. In using the longer lasting vaccine to treat addicts or prevent relapse for former addicts creates more problems. This scenario has addicts use the vaccine to assist abstinence by removing the psychoactive effects of the drugs. However, the vaccine may not be 100% effective and allow some molecules to cross into the brain. This could lead to drug users consuming larger amounts of drugs to get an effect and lead to even more physical harm to the person. The increase risk of harm might prevent vaccines from being used in court mandated treatment. Clinical trials will provide information about the risks and effectiveness for drug treatment. In addition, the vaccine would need regular boosters to maintain effectiveness. This means the vaccine will need significant participation on behalf of the drug user, similar to other treatments like cognitive therapy.

Prevention of possible addiction is another use for the drug vaccines. In this case the ethical concerns revolve around the right of children to an “open future.” The idea that drug use, especially nicotine, is a lifestyle choice and not a disease leads some to believe preventative vaccinations unnecessarily limit child’s choices. On the other hand, many

Personal Responsibility and Addictive Behavior: A Look at Alcoholics and Liver Transplants
Ross White, ‘09

One of the greatest problems facing the American health care system is the scarcity of valuable resources, such as organs for transplant. With any scarce, valuable resource comes the difficulty of finding fair and just allocation systems. This requires raising important questions about the role of personal responsibility in determining the level of care that one should receive. One study found that people were 10 to 17 times more likely to allocate a liver transplant to patients they deemed not responsible for their illness than to patients they deemed responsible for their condition. Such a claim raises two important questions: When, if ever, is it morally appropriate to make some individuals pay extra cost of medical care for illness that is due to their voluntary health-risky conduct; and, when, if ever, is it morally appropriate to make it more difficult to gain access to medical resources—thereby denying access—for illness due to an agent’s voluntary health-risky behavior? An examination of alcoholics and liver transplants can begin to shed some light on these questions.

It can be contended that in order for an individual to have moral culpability and thus subjected to differential treatment based upon their behavior, it must be shown that the agent consciously chose that course of action with all known consequences fully understood. If and when an agent is determined to have chosen risky behaviors with disregard for consequences, that individual’s claim to resources may be affected. While one is free as an autonomous being to knowingly pursue risky behaviors, Robert Veatch asserts that “one must be prepared to take the consequences, even if that should happen to result in a lower position on the organ waiting list.”

The driving principle for this line of reasoning is that “an agent [who]... knowingly, voluntarily, and repeatedly engage[s] in...conduct that might significantly contribute to that agent’s needing a scarce, lifesaving resource....may legitimately be given a weaker claim on scarce, lifesaving resources.” By this argument, an individual who constantly abuses alcohol may have a less legitimate claim to a liver because he has brought the disease upon himself. By doing so however, we are increasing the likelihood

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feel that a vaccine to prevent addiction is similar to vaccines that prevent infectious diseases and parents have a similar right to protect their children. However, because of the need for multiple boosters to create long term efficacy a federally funded vaccination program seems out of the question. The costliness of the vaccine may prevent access for those at the highest risk of drug use. In addition, drug vaccines might open the door to coerced, legal vaccination.

For example, a pregnant woman with a history of drug use could be ordered to get the vaccine to prevent fetal harm. Assuming the vaccine itself is safe, this raises questions about privacy and the court’s duty to protect fetuses. As a form of addiction prevention, the drug vaccine raises several ethical issues. Finally, drug vaccines affect the perception of addiction within society. The idea that drug use is a disease that can be vaccinated against may decrease concern about the social factors of addiction. Also, the ability to test for drug antibodies may lead to discrimination against drug users and former drug users. The information that a person has drug antibodies can lead to generalizations about their character and abilities. For many people the word “vaccine” equates to the eradication of drug use. However, the mechanism of the vaccine, as well as the complexity of addiction proves that no such cure is imminent. As the vaccines develop and we gather more information about safety and effectiveness, the ethical issues in treatment and in prevention will continue to evolve.

References


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that that individual will die because of their liver disease. This raises the important question of whether or not this response is proportional to the decision to drink on the part of the individual. Refusing a liver transplant to an alcoholic can become a draconian penalty. Before we decide upon this course of action we must examine the individual’s actions through an ethical framework.

In order to hold an individual morally culpable, and therefore use their behavior as determinant for listing, it must be determined that that individual knew certain things: if he destroys his liver, he will need a transplant; that donor livers are scarce; and that providing him with a liver will deny one to someone else, who will be more likely to die. Although hard to objectively determine, an alcoholic with knowledge of the basic facts about liver scarcity and transplant lists must be readily prepared to face a “disadvantage” when it comes to preference for transplants. Knowing drinking away one’s liver and then asking for a transplant is to act with reckless disregard for the consequences that one’s conduct has on the life chances of others. If this is the case, that individual can be considered morally culpable.

References

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Ross White ’09 is a political science major, with a concentration in medical humanities. He is the President of the Bioethics Society and plans to study and research health care policy and bioethics in the fall.
Exercise Addiction: Too Much of A Good Thing
Meredith Ashooh, ‘11

When you are asked to think about addiction, I doubt that an image of a treadmill and weight machine come to mind. More likely, you envision alcoholic beverages, illicit substances, or even slot machines.

We all know that exercise is extraordinarily beneficial for our bodies and brains, yet most of us don’t get enough of it. For starters, exercise reduces your risk of developing some chronic diseases, relieves stress and anxiety, increases energy, and helps you get a better night’s sleep. So is it really possible that there is such a thing as too much exercise?

Yes, according to some sports medicine experts. Injuries, exhaustion, depression, suicide, and lasting physical harm are some of the consequences that face so-called obligatory athletes. One study concluded that approximately 8% of gym-users meet the criteria for over-exercising. Exercise addiction is often co-morbid with perfectionism, anxiety, and eating disorders. Obligatory athletes may exercise to gain a sense of discipline and control over their bodies, but they quickly lose the ability to stop physical activity, even when they are injured. Exercise becomes a maladaptive obsession that limits the person’s functioning and ability to live a normal life.

Unlike drug or alcohol addictions, exercise addiction is positively reinforced by society. Fitness is a desirable characteristic, which makes it even harder for an addict to recognize that they have a problem. Even worse, exercise addiction is not presently included in the Diagnostic and Statistics Manual of Mental Disorders (DSM-IV), although some authors are trying to change that. Consequently, many people are hesitant to recognize exercise addiction as a real disorder.

Like drug addicts, exercise addicts can experience mood changes, tolerance, and withdrawal. Neurotransmitters are at the root of addiction, as dopamine is known to contribute to a “runner’s high.” Should exercise addiction be included in the newest edition of DSM-IV? Excluding it would reject its classification as a real disorder, and as a result, those who suffer from it will be less likely to seek treatment. But those who argue to include it will be criticized for “inventing” disorders for self-advancement purposes.

Above all else, it is important to take caution before labeling exercise as a bad thing, because for the vast majority of us, it is certainly far from that. Perhaps exercise addiction should remain as a symptom of those disorders already recognized by DSM-IV, such as bulimia nervosa and general anxiety disorder.

References


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