LOST BETWEEN THE CRACKS: PAIN PATIENTS DENIED INPATIENT TREATMENT FOR ILLICIT DRUG ADDICTION

There is a growing body of literature that suggests that moderation is a potentially successful therapeutic goal for substance-dependent patients (1). Unfortunately, those who choose moderation as a treatment goal will typically be denied inpatient rehabilitation services. Contrary to scientific findings, many inpatient treatment programs continue to require that patients commit to abstinence. In a paper summarizing the American Psychiatric Association practice guideline for substance use disorders, McCrady confronts this discrepancy between science and practice. “Based on the scientific literature, the guideline also supports views that are not widely accepted in the addictions treatment community, such as the use of nonabstinence goals and the use of harm reduction strategies...” Such perspectives are controversial among policy makers and may appear contrary to an abstinence-only goal for those who attend 12 step meetings” (2).

The philosophical and programmatic dogma of abstinence has gone generally undisturbed, and it should be disputed on the basis of equal access to care. Patients who choose moderation and who meet the criteria for inpatient treatment should not be denied therapeutic advantages unique to the inpatient setting (3). The ethical profundity of this is even more apparent when the patient cannot choose abstinence without negative medical consequences. Such is the case with patients with chronic pain who want treatment for illicit drugs but need to be maintained on chronic pain medications.

A patient brought this ethical dilemma to our attention. Joe was a patient with sickle cell disease with known cocaine dependence. He was caught between the cracks of the currently accepted treatment for chronic pain and the currently accepted protocol for treatment of drug dependence. Staunch believers in abstinence will offer other solutions for this patient. They might ask, why not wait until he is out of sickle cell crisis? Why not treat him in the outpatient setting, perhaps making use of a methadone program? We cannot delay treatment unless there is an evidence-based argument to do so, and we have inpatient rehabilitation programs because some patients need to be removed from enabling environments to succeed in rehabilitation. The final argument might be that programs geared toward abstinence cannot afford to let in people who are “using.” Admittedly, it would be a massive adjustment, but most paradigm shifts require effort and risk. As modern medicine succeeds in extending the lifespan, we have more and more patients living with chronic pain. We believe there is a substantial moral imperative to consider the options.

Instead of looking for patient-based solutions that defer treatment or offer less-than-optimal treatment, we need to consider programmatic change. If moderation is a potential solution for drug-dependent patients, let us design programs flexible enough to accommodate patients who prefer, or, in the case of patients with chronic pain, need a different kind of treatment program. If a drug-dependent patient with chronic pain is willing to abstain from the targeted illicit drug and have his prescription medications dosed by providers in the inpatient setting, then that should be considered adequate commitment to therapy. Asking patients to suffer the pain of one chronic medical condition or go without optimal treatment for another condition is unethical and, in a society that values evidence-based treatment, it is simply bad medicine.

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LETTERS TO THE EDITOR

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PLACEBO RESEARCH AND THE SPIRIT OF INFORMED CONSENT

Lee et al reported important findings from a study designed to investigate the placebo effect on cough (1). From an ethical perspective, however, their research raises significant issues. It illustrates how research subjects can be deceived by truthful information disclosure. A single dose of vitamin E was administered to half the subjects as a placebo treatment. The other half received no treatment. The two groups were compared with respect to cough frequency and cough-suppression time. The subjects were not told that they might receive a placebo. Instead, they were informed that “The treatment to be tested contains vitamin E 300 ui. The study is designed to investigate the effect of vitamin E on cough associated with the common cold.” It is therefore surprising that the authors described this disclosure as “accurate but not misleading.” It may have been accurate in disclosing facts about the study, but it was certainly designed to mislead subjects about the purpose of the research and the use of vitamin E as a placebo. The report states that “All patients gave written informed consent for the study.” However, it is doubtful that subjects who have the opportunity to read this report would regard their consent as informed in light of the deceptive disclosure. There is no mention of debriefing of subjects at the conclusion of the research, which is a standard practice for research that uses deception. The deceptive experimental design might have been presented to the subjects in a way that respected self-determination and the spirit of informed consent by disclosing that aspects of the study are described in a misleading way, but that subjects would be informed accurately about the purpose and methods of the research at the end of the experiment (2).

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RESPONSE

Miller and Wendler raise an important ethical issue regarding the information provided to participants in our recently published study on the effects of placebo treatment on cough (1). The study did involve some deception of subjects because they were told in the informed consent that the aim was to investigate the effects of treatment with vitamin E on cough when the true aim was to obtain new knowledge about the effects of placebo treatment on cough. Vitamin E is not known to have any effects on cough, and the short time allowed for absorption (15 minutes) meant that any pharmacological effect would not be apparent at this time point. In designing the study, the investigators considered that the use of a vitamin would be useful in demonstrating a placebo effect because most people know the term vitamin and associate it with positive therapeutic effects. The ethical problem associated with this study is common to many studies on the placebo effect because the placebo effect is influenced by the belief of the patients that they are receiving a beneficial treatment (2). In retrospect and with the benefit of the letter from Miller and Wendler, it would have been appropriate to debrief the participants at the end of the trial, and this is an important point to be included in any future trials. However, even a debriefing would not have addressed the intended deception in the design of the study. Inclusion of some explanation of the misleading information in the informed consent could have confounded the outcome of the study by destroying any belief in the placebo therapy. The use of any form of placebo therapy must involve some form of deception or misplaced belief in the efficacy of the therapy, and it is difficult to see how one can be completely transparent about the aims of placebo therapy without compromising the patient’s belief in the therapy. This is a dilemma that has confounded much of the research on the placebo effect and that has stimulated much ethical debate on deception and the use of placebo treatments (3).

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