The federal government has approved buprenorphine for the office-based treatment of persons who are opioid dependent, whether from heroin or prescription narcotics. Unlike methadone, buprenorphine is an opioid partial agonist, which accounts for its better safety profile and lower (Schedule III) controlled substance rating. Leaders in addiction medicine hope that generalist physicians will volunteer to become certified buprenorphine providers so that more of the millions of untreated opioid-dependent persons in the United States will have access to opioid maintenance therapy.1 To assist physicians who are willing to prescribe buprenorphine, the Substance Abuse and Mental Health Services Administration has even created a network of addiction experts and colleagues, who show that different anthropologies can affect the way substance dependence is framed.2 A “medical” anthropology conceives addiction as a disease that requires medical treatment, not punishment. Within this view, addicted persons are victims of disease and therefore not fully accountable for their addiction, and the goal of treatment is either abstinence or, if relapse persists, palliation. By contrast, a “legal” anthropology conceives addiction as fundamentally connected to freedom and autonomy. Within this view, addicted persons remain morally responsible for choosing their lifestyle, and addiction is a self-inflicted social problem that requires a system of punishments (for those addicted) and protections (for the rest of society). A key distinction in these contrasting anthropologies lies in their competing assessments of free will in the life of an addicted person.

The literature on the treatment of opioid dependence includes a range of statements that juxtapose free will and neurobiology. A report from the World Health Organization on the neuroscience of substance dependence states that “substance dependence is as much a disorder of the brain as any other neurologic or psychiatric disorder,” involving “brain mechanisms and not a failure of will.”7 Other claims about substance dependence are as nuanced, especially when articulated in response to the argument that if substance-dependent persons lack freedom regarding their substance dependence, they should not be allowed to participate in certain research studies owing to their inability to provide informed consent. Accordingly, some researchers acknowledge the need to develop theories of addiction that take neurobiology seriously without depicting addicted persons as mere automatons;8 they also note the need for balanced perspectives that allow partial impairment of volition to coexist with enough capacity for self-determination to satisfy informed consent requirements in research.9 It is instructive to observe how concerns about Institutional Review Board scrutiny have stimulated vigorous dialogue among researchers about the status of free will in the lives of substance-dependent persons.

Why are such philosophic and neurobiologic reflections on free will important for clinicians? I would suggest that how a
physician perceives a substance-dependent person is likely to have an impact on that physician's willingness to provide opioid maintenance therapy. If a patient is believed to be the victim of neuropathic disease or unfortunate social circumstances, the physician may be more inclined to offer treatment. Conversely, if a patient is believed to be a free agent who voluntarily persists in self-destructive behaviors a physician may be less inclined to offer treatment. Such contrasting views remind us of the intimate relationship between a physician's beliefs about a condition and his/her professional response to it.

Another basic question in opioid maintenance therapy has to do with goals. Goals of care are fundamental to clinical practice, and in ethically challenging situations goals need to be made explicit.10 In the treatment of substance dependence, harm reduction and abstinence are central. In the setting of heroin addiction, tensions may exist between these 2 goals, as pointed out by Koutroulis, who argues that harm reduction (the predominant message in this context) prioritizes short-term goals but tends to be less clear about the long-term possibility of abstinence.11 Attention is focused on safer methods (needle exchange programs and avoiding overdose), transition to controlled addiction (opioid maintenance therapy), and decreasing the risk of comorbidities (especially the spread of HIV and hepatitis C). Tensions between alternative goals also may exist in the setting of opioid maintenance therapy, where high relapse rates lead to open-ended recommendations about the duration of treatment—without an expectation of eventual abstinence from illicit and prescribed opioids. For some physicians, the goal of medical and social stabilization through indefinite opioid maintenance therapy may conflict with an expectation of complete opioid abstinence in the future, even if such an outcome is acknowledged to be distant or statistically improbable.

There is another ethical feature of opioid maintenance therapy that relates to goals and has to do with who benefits. Whereas the literature on maintenance treatment focuses mainly on the health of and personal benefits to addicted persons, some authors address the public health and economic benefits that accrue to society when harms associated with substance use are decreased. Though still acknowledged as a person with individual value, the substance-dependent patient may thus be viewed as a source of harm because of the socially disruptive and economically costly effects of "reckless" behavior. As one author expressed, treating such a patient can be seen as a “means to the end of diminishing the damage to society caused by the endemic use of illegal drugs.”

In the midst of such societal assessments, physicians should remember that their primary professional obligation is to the patient, independent of what additional societal benefits may follow. This general professional reminder is particularly important in the context of opioid maintenance therapy because treatment involves strict rules regarding adherence (which may restrict patient autonomy), patients’ options for treatment are usually limited, and treatment effectiveness at the individual level cannot be assured.

There are other ethical issues that arise in opioid maintenance therapy, not least of which are questions of stigmatization and economic discrimination. It is notable that a recent observational cohort study of primary care patients receiving buprenorphine/naloxone excluded patients without means to pay for the medication.12 If applied generally in practice, such economic restrictions would be concerning as only one third of persons entering treatment for opioid dependence in the United States have medical insurance.

Generalist physicians now have the opportunity to consider becoming certified to provide buprenorphine maintenance therapy for opioid dependence. Their decisions will depend on multiple professional factors, including judgments about scope of practice and resources, especially the ability to provide (or refer to) the psychosocial care that must accompany medical management. Along with these practice considerations, willingness to prescribe opioid maintenance therapy will presumably be affected by physicians’ basic beliefs about addiction and the goals of its treatment. Discussions occasioned by the arrival of office-based buprenorphine treatment also serve to remind us how much need there is for substance-dependent patients to have access to medical care in general, whether or not such care includes buprenorphine. Before considering whether to treat or not to treat with buprenorphine, some generalist physicians will first need to gauge their readiness to enhance their accessibility to this particularly needy population of patients.

References