February, 2012

Lies, Damned Lies, and Addictions: The Strange Case of the Disappearing Person and the Bogey of Determinism

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The only acceptable point of view appears to be the one that recognizes both sides of reality -- the quantitative and the qualitative, the physical and the psychological -- as compatible with each other, and can embrace them simultaneously.

-- Wolfgang Pauli

Introduction

The issue of addiction has become a paradox in the courthouse. On the criminal side, addiction (e.g., alcohol, cocaine, heroin, etc.) is without exception seen as voluntary action for which the actor is responsible, whereas on the civil side (e.g., tobacco) it is treated as involuntary behavior that somehow shifts responsibility from the user to the provider and merits reward in the form of money damages. Plaintiffs' theory of causation and liability in tobacco litigation, for example, is rooted in the medical model of addiction as a "brain disease" for which the individual is not responsible.

The rebuttal presented here is that reliance upon the medical model of addiction to claim that drug use is pharmacologically compelled (and thus involuntary) behavior is conceptually at odds with the legal view of the person and related rules of conduct, which turn on actions and mental states, as opposed to physiological function. The point bearing emphasis is that classifying drug use as a "disease" for purposes of the information contained in a clinical diagnosis does not mean that those who seek and use drugs cannot be held fully responsible for the consequences of that behavior in terms of the questions of ultimate concern to the law. See Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders xxxiii (4th ed. 2000) (DSM-IV) (discussing "the imperfect fit" between medical and legal decision making).

People do not smoke cigarettes because they are compelled to do so by the pharmacology of nicotine on the brain and body. The life of man includes a mental side, too. Regardless of addiction, people seek and use cigarettes (and other drugs) for their own reasons, on purpose, because they like it, and because the behavior makes sense for them given the choices available. See generally John B. Davies, The Myth of Addiction (Routledge 2010) (1992). In sum, "to characterize addiction as a disease is not morally incompatible with saying

* David Wallace, a partner at Herbert Smith New York LLP with extensive experience in a wide range of products liability litigation, has tried and won a number of politically charged cases. He has represented and advised manufacturers in courts around the world. The epigraph is from W. Pauli, The Influence of Archetypal Ideas on the Scientific Theories of Kepler: The Interpretation of Nature and the Psyche 208 (Routledge & Kegan Paul 1955) (emphasis in original).
that addicts are responsible for yielding to it." Richard Bonnie, "Responsibility for Addiction," 30 J. AM. ACAD. PSYCHIATRY & LAW 405, 413 (Nov. 2002). Addictions do not make us hapless puppets of our brains.

The Medical Model of Addiction as "Brain Disease"

In August, the American Society of Addiction Medicine (ASAM) issued a press release announcing its adoption of a "new definition" of addiction holding that "addiction is a chronic brain disorder and not simply a behavioral problem involving too much alcohol, drugs, gambling or sex." See News Release, ASAM Releases New Definition of Addiction 1 (Aug. 2011) (available at www.asam.org). In introducing it, Dr. Michael Miller, the past president of ASAM, said: "Many behaviors driven by addiction are real problems and sometimes criminal acts. But the disease is about brains, not drugs. It's about underlying neurology, not outward actions." Id. at 2. The plaintiffs' trial bar laps up pseudoscience of this type, but it's nonsense calling to mind Mark Twain's famous quip that "there are three kinds of lies: lies, damned lies, and statistics." Mark Twain, " Chapters from My Autobiography," 1907 N. AM. REV. 465, 471. So it is with addictions, too. It is the strange case of the disappearing person.

As one commentator notes, ASAM's position on addiction is "a bit like saying that eating is a phenomenon of the stomach. The stomach is an important part of the story. But don't forget the mouth, the intestines, the blood, and don't forget hunger, and also the whole socially-sustained practice of producing, shopping for and cooking food" -- or human preferences, values, choices, and actions for that matter. Posting of Alva Noë to 13.7blog, "Addiction is Not a Disease of the Brain," http://www.npr.org/blogs/13.7/ (Sept. 9, 2011, 11:14 a.m.). In the normatively biased view of ASAM, drugs supposedly "hijack" reward pathways in the brain leading addicts to value "something worthless (like pleasure) over something worthwhile (like one's health)." Bennett Foddy & Julian Sevalescu, "A Liberal Account of Addiction," 17 Phil., PSYCHIATRY & PSYCHOL. 1, 8 (Mar. 2010) (Foddy); see also Oliver R. Goodenough & Micaela Tucker, "Law and Cognitive Neuroscience," 6 ANN. REV. L. SOC. SCI. 61, 79 (2010) (Goodenough). In this regard, ASAM's Dr. Hajela claims that "the disease creates distortions in thinking, feelings and perceptions, which drive people to behave in ways that are not understandable to others around them." ASAM News Release, supra, at 2.

Wielding scientific terms like "nucleus accumbens, anterior cingulate cortex, basal forebrain, and amygdala," ASAM aims to mystify the mundane -- claiming that the chemical effects of drugs on the brain and body alter "motivational hierarchies" to the point that "addictive behaviors, which may or may not include alcohol and other drug use, supplant healthy, self-care related behaviors." ASAM, Public Policy Statement: Definition of Addiction (Long Version) 1 (Apr. 12, 2011) (available at www.asam.org). At bottom, we are witnessing the medicalization of deleterious reward-seeking behavior. Under the medical view, the self-administration of drugs is pharmacologically compelled behavior that is the product of a diseased brain barking commands to smoke, as opposed to voluntary behavior emanating from the seat of human consciousness. See, e.g., Foddy, supra, at 7 ("A strong moral opprobrium exists against the seeking of deleterious pleasures. Health, as popular morality would have it, is worth more than a
good time, and whenever a person makes the reverse valuation, it is assumed that they are disordered, reckless, or wanton.

ASAM's new definition of addiction is simply the latest chapter in a tediously exhausting campaign to moralize, medicalize, and politicize the behavior of people who fail to desire "what they ought to desire," according to the cult of experts. Foddy, supra, at 8. The American Psychiatric Association also takes a value-freighted approach to "substance-related disorders" in the DSM-IV. Its synonym for addiction is "substance dependence," which it describes as "[a] maladaptive pattern of substance use, leading to clinically significant impairment or distress" -- as manifested by a variety of behavioral symptoms, including actions and mental states. Id. at 197 (emphasis added).

By using the prefix "mal" -- as in bad, wrong, or fraudulent -- the APA medicalizes patterns of behavior that do not conform to its membership's "substantive normative claims about what a person's preferences should be." Foddy, supra, at 9. A similar moralizing spirit prompted the APA to use its "disease" flat to classify homosexuality as a mental disorder until 1973, when it changed its mind. Of course, the nature and pattern of homosexual behavior did not change between 1968 and 1973; all that changed were the "values of a professional group empowered to affix labels of deviancy." Stephen J. Morse, "Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law," 51 S. CAL L. REV. 527, 558 (1978) (emphasis in original). None of this is new or novel. A "strong moral opprobrium against particular behavior" also cloaked Dr. Samuel A. Cartwright's claimed "discovery" in 1851 of an affliction among local slaves called "dрапетомания," which he described in the pages of the New Orleans Medical and Surgical Journal as an "addiction" to absconding from service to their owners. Foddy, supra, at 9.

When I raised the "brain disease" theory of addiction with a psychologist-professor friend at dinner recently, he just sniffed at the idea and told me:

Neurons and chemicals do not have desires, opinions, attitudes, feelings, motives, or intentions. They do not fall in love, or worry about where to go on holiday next year. There is a pharmacology and biology behind all behaviors. Indeed, there is a genetic and neurobiological basis at some level for everything we do! But despite these underpinnings, we do not cross the street simply because our brains make our legs walk. We do so because Marks and Spencer's is on the other side, and to the best of my knowledge neurons and chemicals don't have a strong desire to shop there, and don't even go there unless accompanied by an entire human being.

Addiction in the Courtroom (or "Hamlet with the Prince's Part Left Out")

ASAM's definition of addiction is no doubt welcome news to the thousands of individual plaintiffs in the Engle tobacco litigation now clogging the Florida court system at both state and federal levels. These cases follow in the wake of the Florida Supreme Court's post-trial, prospective decertification of the original Engle class action in 2006, on the grounds that
individual issues predominated. See Engle v. Liggett Group, Inc., 945 So.2d 1246 (Fla. 2006). Being "pragmatic," Florida's highest court reasoned that it made sense to recycle some of the jury's general findings of fact -- e.g., that nicotine is addictive, smoking causes lung cancer, etc. - - for res judicata purposes. Id. at 1269-70. To this end, it held that these findings would be entitled to preclusive effect in all individual Engle actions filed by 2008, so long as a plaintiff establishes class membership by proving that: (1) the smoker was addicted to cigarettes containing nicotine; and (2) such addiction was a legal cause of the smoker's injuries -- as if meeting clinical criteria for the diagnosis and treatment of addiction removes an individual's capacity for voluntary behavior.

That medicine classifies addiction as a "mental disorder" or "disease" for clinical purposes, however, is really neither here nor there. It has absolutely no independent legal significance. See U.S. v. Lyons, 731 F.2d 243, 246 (5th Cir. 1984) (en banc) (explaining that the law does not indiscriminately apply "definition[s] of 'mental disease or defect' . . . developed with medical considerations of diagnosis and treatment foremost in mind"); DSM-IV at xxxiii ("[T]he clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder' . . . or 'mental disease'.") Without denying that "[s]cience can surely help legal decision makers resolve legal problems" (see Stephen J. Morse, "An Accurate Diagnosis, But Is There a Cure? An Appreciation of The Role of Science in Law by Robin Feldman," 3 Hastings Sci. & Tech. L.J. 157, 157 (Winter 2010)), the question in the courtroom is not so much whether a person meets criteria for a diagnosis of addiction, but instead what addiction means for purposes of the questions of ultimate concern to the law -- e.g., in terms of decision-making capacity, legal causation, and personal responsibility.

Plaintiffs and their medical experts contend that the chemical effects of nicotine on the brain and body make smoking a "constrained choice" because "[y]ou can't easily put the cigarettes down and walk away from them" -- that is, it's "hard to quit." See Mack v. R.J. Reynolds Tobacco Co., No. 01-2008-CA-3256 (Fl. Civ. Ct.) (Trial Tr. Vol. 16, 1157, Mar. 10, 2011) (testimony of Dr. K. Michael Cummings). In sum and substance, plaintiffs claim that the neurological adaptation of their brains to the release of dopamine caused by smoking on a regular basis constitutes a chronic, relapsing brain disease that leads them to experience "cravings" for nicotine and withdrawal symptoms that "impair" their ability to stop smoking. They claim to seek and use cigarettes unwillingly; that they "can't help themselves" despite a self-reported desire to stop. In an effort to shift responsibility away from themselves, plaintiffs maintain that their brains "make them do it." Foddy, supra, at 9 ("There is enormous social pressure for addicts to provide an alternative explanation for their drug use. This pressure is alleviated when an addict claims that she could not help but use a drug; that she could not control her behavior. When the behavior is characterized as a disease or altered capacity, some of the social responsibility is shifted to the drug provider, instead of the user."). "[O]nly the hardest of hearts, after all, could call a sickness our own damn fault." Carol Sarler, "Addiction: It Can Be a Habit -- The Litigation Industry," The Times (London), Feb. 18, 2008.

This argument would be laughable were it not for the fact that courts are routinely allowing it to go to juries, where plaintiffs' lawyers have so far parlayed claims of nicotine addiction as a "brain disease" into almost a half billion dollars worth of compensatory and
punitive damage awards in some 50 cases tried in Florida state courts since early 2009. It's a classic case of bad facts making bad law. To borrow the words of the pioneering American psychologist and philosopher William James, the medical model of addiction in the courthouse is like "Hamlet with the prince's part left out." Psychology: Briefer Course 367 (Harv. U. Press 1984) (1892). Simply stated, brains don't seek and use drugs, people do. "Constrained choice," moreover, typifies all but abnormal social behavior, and means much the same thing as liking and preference. It is nothing more than an expression of our personality and personal biases.

A Legal Model of Addiction and Plea for Personal Responsibility

Plaintiffs' addiction-based theory of legal causation and liability is conceptually flawed at multiple levels. Preliminarily, characterizing nicotine addiction as a disease for purposes of medical decision making does not ipso facto strip a smoker of moral agency (i.e., causal power) or trump any other legal rules of conduct. There is no evidence, for example, that regular nicotine use impairs mental functioning. See DSM-IV, supra, at 269. Further, a diagnosis of nicotine addiction "does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time." Id. at xxxiii. There's more to the story, though.

First, the medical model of addiction as pharmacologically compelled behavior amounts to an assertion of physiological determinism that is alien to the law. See Kerri Smith, "Taking Aim at Free Will," 477 NATURE 23, 25 (Sept. 2011) ("Biological determinism doesn't hold up as a defense in law . . . The law has to be based on the idea that people are responsible for their actions, except in exceptional circumstances.") (quoting Nicholas MacKintosh); see also Goodenough, supra, at 74 ("The bogey of determinism cannot be used as an argument against the ascription and assessment of responsibility."). Human agency is at the heart of the law. The legal model of the person is as "an acting, conscious, potentially rational and well-controlled agent who can be responsive to reason" -- including legal rules and requirements. Stephen J. Morse, "Addiction and Criminal Responsibility," in Addiction and Responsibility 159, 172 (Jeffrey Pollard & George Graham eds., 2011). Critically, the criteria for legal liability are all based on mental states and actions, not "underlying psychological variables, brains, or nervous systems." Id.; see also Goodenough, supra, at 65.

Second, the legal concept of human agency is procedural, not substantive (as with the medical model). At law there is no idealized notion of agency in the sense that certain subjective desires or preferences are a priori ruled out as being incompatible with autonomy. Subject to the reasonably prudent person standard, and the presumption of cognitive and control capacity that it incorporates, we are free (if we choose) to prioritize behaviors that might damage our health -- notwithstanding medical advice to the contrary. In this sense, addicts are no less "free" than non-addicts. In different words, failing to make choices that produce the best or most prudent outcomes is not evidence of incapacity or a non-responsibility condition; it is part of being human. See, e.g., G. Heyman, Addiction: A Disorder of Choice 173 (Harv. U. Press 2009) ("[P]opulation trends and lever-pressing rates [in animal studies] tell the same story: choice tends to produce less than optimal outcomes.").
Third, plaintiffs' emphasis on neuroadaptation (i.e., "brain changes") is a red herring. Pleasurable experiences in general activate neural substrates in the brain commonly referred to as reward pathways, causing the release of dopamine and other hormones. This biological phenomenon is not unique to seeking and using drugs. The same effect can be produced by eating sugar or carrots, drinking milk or water, as well as gambling or having sex: our brains adapt the same way whether we are having too much sex or taking too many drugs. Foddy, supra, at 4-6 ("[E]very major effect of drug use -- pleasure, intoxication, habituation, and even addiction -- can be produced for a normal pleasurable behavior such as eating sweet food."). Chemically mediated "brain changes" are not "exotic or different in kind from everyday limitations on a person's ability to choose." Id. at 14. This adaptive process is part of the human condition that has enabled our species to evolve and survive over thousands of years. The truth is that “[l]iving our lives changes our brains," which "adapt when we take drugs or eat sugar or have sex." Id. at 6; see also James, supra, at 143 ("to every brain modification, however small, we suppose that there must correspond a change of equal amount in the consciousness which the brain serves"). If these adaptations are evidence of "disease," then so are the calluses on a violinist’s fingers. Like grooves in a vinyl record, they lead us to repeat certain activities over and over -- the name for it is "learning." Id.

The last bogey in plaintiffs' medically grounded assault on personal responsibility and the rule of law is the assertion that the chemically mediated brain changes associated with addiction to tobacco use make it "too hard," as in unreasonably difficult, for them to avoid smoking cigarettes. For legal purposes, however, avoiding or controlling the use of cigarettes is not anything like duress or coercion. Save the smoker's naked, self-interested assertion to the contrary, the evidence is all the other way. Every day, for reasons great and small, millions of people of reasonable firmness use tobacco non-habitually or otherwise exert control over temptations to smoke. They routinely do so in response to an array of commonplace factors, including health problems, price considerations, and increasingly prevalent legal bans or restrictions on public smoking (e.g., restaurants, workplaces, schools, airplanes, etc.), among a host of other factors.

Notably, there are no exceptions to public-smoking restrictions; non-addicts and addicts alike are expected to comply with these laws -- and the empirical data is that they do so in overwhelming numbers. If smoking were a physiological compulsion accompanied by a truly serious withdrawal syndrome, legal prohibitions against public smoking and "stop smoking" campaigns would be pointless and cruel -- like prohibiting diabetics from injecting their insulin. In fact, "drug addicts mostly just stop using as they get older" (Foddy, supra, at 12), "just because the price of their drug rises, or just because they sat down and weighed the pros and cons of continued use" (id. at 14). See also U.S. Dept of Health and Human Services, Monograph 15: Those Who Continue to Smoke: Is Achieving Abstinence Harder or Do We Need to Change Our Interventions? (2003) (reporting higher quit rates among older smokers).

Finally, from a physical-effort perspective, it is as easy (if not easier) to avoid smoking as it is to smoke cigarettes. The whole drama that plaintiffs spin in regard to difficulty quitting is a mental one. The claim that the brain is "hijacked" by nicotine effects is a metaphor. See Alan I. Leshner, "Addiction is a Brain Disease, and It Matters," 278 SCIENCE 45, 46 (Oct. 3,
1997) ("A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use."). There is no "gun-to-the-head," no "do-it-or-else" threat of immediate death or grave physical harm involved. There is only consciousness of a tension in the mind between competing motives and reasons for actions, and the need to make a choice between immediate gratification (continued smoking now) or delayed gratification (abstinence for the prospect of better health in the future). Like so many other things in life, "[t]he difficulty is mental; it is that of getting the wise action to stay before our mind at all." James, supra, at 386. The upshot is that what plaintiffs call "difficulty quitting" is no more than the phenomenon of mental effort that complicates all voluntary acts whenever strong tendencies must be checked or strong obstructive conditions surmounted. Id. at 380.

This is all strong evidence that nicotine addiction does not rob smokers of the capacity for exercising choice and control over their behavior in response to motivational change or the need to conform their behavior to legal requirements. In sum, for legal purposes, the pursuit of rewarding (or otherwise stimulating) activity is treated as a motive or reason for action, not a pathogen giving rise to an excuse or non-responsibility condition.

Evidentiary Support from the Principles of Quantum Physics

Using the medical model of addiction-as-disease, plaintiffs are trying to bury human agency -- basically mind/consciousness and (with it) personal responsibility -- under the anatomical structure and function of brain biology. Their "disappearing person" act is staged for purposes of avoiding liability for the health consequences of smoking cigarettes on a regular, long-term basis despite good reasons for stopping. The deterministic, medical model of addiction behind which they advance has much in common with the classic model of physics, which views "all actions in the physical world as being ultimately the result of the movements of particles," and it is "seriously out of date." Jeffrey Schwartz et al., "Quantum Physics in Neuroscience and Psychology: A Neurophysical Model of Mind-Brain Interaction," 360 PHIL. TRANS. R. SOC. B. 1309, 1313 (June 29, 2005).

According to classic physics, "you are a mechanical automaton: your every physical action was predetermined before you were born solely by mechanical interactions between tiny mindless entities," namely the microscopic bits of proteins and chemicals that comprise the physical brain. Id. (emphasis in original). "Your mental aspects are causally redundant: everything you do is completely determined by mechanical conditions alone, without any mention of your thoughts, ideas, feelings, and intentions. Your intuitive feeling that your conscious intentions make a difference in what you do is . . . a false and misleading illusion." Id. (emphasis in original). The same mindset can be seen tobacco litigation, where plaintiffs essentially deny the existence of a seat of consciousness in the brain. To them, mind/consciousness "is the very same thing as some activity in your brain. Id. at 1314 (emphasis in original). Under this microscopic anatomical view of personhood, we are passive observers of life without the functional power of choice -- that is, agency -- over how we "will act at a macroscopic level." Id. at 1315. Put differently, we are essentially prisoners of neural circumstances lacking the "important element of conscious free choice." Id. at 1316.