

Responsibility for Addiction

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Taking as its starting point the characterization of addiction as a “brain disease” by the nation’s leadership in public health and biomedical science, this article explores the implications of recent developments in neuroscience for the concept of responsibility. The terrain is divided into three parts: responsibility for becoming addicted, responsibility for behavior symptomatic of addiction, and responsibility for amelioration of addiction. In general, this paper defends the thesis that recent scientific developments have sharpened but not erased traditional understandings in the first two areas, while recent legal developments have exposed new and intriguing theories of responsibility for managing or ameliorating addiction that may also have implications for other chronic diseases.

The subject of addiction has attracted increasing interest over the past decade among moral philosophers,^{1,2} legal theorists,^{3–5} and, most intriguingly, economists^{6,7} and other social scientists.^{8–10} Among the factors explaining this escalating intellectual interest in addiction are the crack epidemic that began in the mid-1980s and triggered the latest drug war; the Surgeon General’s 1988 report on nicotine addiction; advances in the science of addiction, especially in neuroscience; tobacco litigation predicated on the addictive nature of nicotine; and continuing public debate regarding the premises of national policies toward users of illicit drugs.

The advances in neuroscience serve as my point of departure in this article. Remarkable scientific achievements during the past 25 years, especially in

the past decade, have significantly advanced our understanding of addiction in several respects. First, neuroscientists have identified the neural circuits activated by using addictive drugs—the brain’s common pathways of addiction—and have thereby intensified the search for pharmacological treatments.¹¹ All these drugs affect the dopamine system, although through different mechanisms.¹¹ Second, imaging techniques have revealed the effects on the brain of prolonged administration of psychoactive drugs. Alan Leshner, former Director of the National Institute on Drug Abuse (NIDA), has summarized the evidence as follows:

Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional. The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting brain changes are idiosyncratic to specific drugs, whereas others are common to many different drugs [Ref. 12, p 46].

Third, addiction specialists have demonstrated why addiction is plausibly perceived as a chronic disease similar to other chronic diseases, such as diabetes and hypertension, that are also characterized by intermittent remissions and relapses.^{11,13} There are several important claims embedded in this overall assertion: that the condition should be understood as a chronic disease, characterized by occasional relapse, rather than as an acute condition; that the high rate of relapse is related to the neurobiological changes that accompany addiction; and that the onset, severity, and management of the condition are affected by interactions of biological and behavioral variables

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analogous to those that affect the onset, severity, and management of other chronic diseases.

Is Addiction a “Brain Disease”?

The scientific leadership of the addiction field is waging a broad dissemination campaign to bring these advances to professional and public attention, within medicine, among opinion-makers, and in the general public. This campaign has a motto: “Addiction is a Brain Disease.” The core message is reflected in the following excerpt from Alan Leshner’s standard presentation while he was NIDA Director:

That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease. A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use [Ref. 12, p 46].

The characterization of addiction as a brain disease has been contested.^{5,14} At the present time, I think this claim has to be understood more as a political statement than as a scientific proposition. To say that addiction is a brain disease is useful as a rhetorical tool in a debate about public policy; but, scientifically, it is both incomplete and premature. It is incomplete because it fails to communicate the whole story about the behavioral and contextual components of addiction. (In his standard presentation, Dr. Leshner was always careful to note that addiction is “not just a brain disease.”) Behavioral components are much more substantial in addiction than in Alzheimer’s disease, Parkinson’s disease, or epilepsy or even in schizophrenia. It is premature, because research has not connected the observed changes in the brain to behavior. After all, Dr. Leshner found it necessary to speak metaphorically, because we cannot yet speak scientifically. It is still not possible to explain the physiologic and psychological processes that transform the controlled use of drugs into addiction.¹¹

Notwithstanding its scientific shortcomings, I embrace the characterization of addiction as a brain disease because of its value as a political statement. Medicalization of addiction (as a policy choice) will have salutary effects on the lives of people enmeshed in drug use and on society, whether or not this term captures the full complexity of the condition. Addiction is amenable to treatment, although outcome evaluations of treatment must take into account the

high probability of relapse, and our society should be investing more resources in treatment while reducing its expenditures on incarceration. Moreover, continued investment in research is likely to pay off in therapeutic advances (although there is likely to be no biological “fix” for addiction).

One prominent rhetorical feature of the campaign needs much more careful scrutiny, however—the question of voluntariness. According to two leading clinical researchers on addiction:

At some point after continued repetition of voluntary drug-taking, the drug “user” loses the voluntary ability to control its use. At that point, the “drug misuser” becomes “drug addicted” and there is a compulsive, often overwhelming *involuntary* aspect to continuing drug use and to relapse after a period of abstinence [Ref. 13, p 237].

Dr. Leshner puts the point this way:

We need to face the fact that even if the condition initially comes about because of a voluntary behavior (drug use), an addict’s brain is different from a nonaddict’s brain, and the addicted individual must be dealt with as if he or she is in a different brain state. We have learned to deal with people in different brain states for schizophrenia and Alzheimer’s disease. Recall that as recently as the beginning of this century we were still putting individuals with schizophrenia in prisonlike asylums, whereas now we know they require medical treatments. We now need to see the addict as someone whose mind [read: brain] has been altered fundamentally by drugs [Ref. 12, p 46].

The emphasis on involuntariness bristles with implication for responsibility. Medicalizing addiction and emphasizing its neurobiological underpinnings is meant to negate the common belief that addiction manifests a moral weakness or a flaw of character and thereby to counteract stigmatization and punishment. Presumably, people should not be held morally and legally accountable for behavior that is involuntary. But we should take a much closer look at these assertions. What is meant by involuntariness in this context? Is an addict’s drug use involuntary after the switch is flipped? In what sense? Is relapse involuntary? In what sense? Do people voluntarily take the risk of becoming an addict when they begin to use drugs? Should this matter? These are very difficult questions, and the answers have a direct bearing on legal issues of responsibility. My goal in this article is to explore ethical and legal concepts of responsibility in these three domains (addiction, relapse, and onset).

The Vocabulary of Voluntariness

After addressing several important conceptual issues about the vocabulary of voluntariness, I will cover the law on each of these issues.

Addiction

What is meant when it is said that drug use becomes involuntary after “the switch is flipped”? Does the disease cause drug use in the way that a brain lesion causes epileptic seizures or loss of cerebral blood flow causes loss of consciousness? This is the language of mechanism, and the language of choice, or voluntariness, has no place in it.⁵ Clearly, however, something more is involved with addiction than mechanism. Addiction is not just a brain disease. The link between brain and behavior is mediated through consciousness. Thus, when we say that the addict’s drug use is “involuntary” and symptomatic of disease, we mean something different from what is meant when we say that having a seizure is involuntary. In terms of responsibility, this is a very important distinction.

Even within the realm of conscious experience, there are situations in which one can properly say that a person has no “real” choice (like grasping the edge of a cliff, when the inevitable effects of muscular fatigue will prevail, no matter how hard the victim chooses to resist). Again, this is the language of mechanism, but this is not what is meant by “loss of control” in addiction. Loss of control means that, due to neurobiological processes deep in the brain over which the addict no longer has control, he or she is experiencing a strong need for or desire for the substance, a desire so great that it is unlikely that he or she will be able to resist it. This is the language of choice and compulsion, not of mechanism and causation.⁵

The addict has the experience of choosing, just as a person under duress (“push the button or I’ll kill you”) has the experience of choosing. Such situations involve a hard choice rather than no choice. Clinically, I am addressing what most accurately might be called “impairments of volition” rather than involuntary behavior. This important conceptual distinction is needed to connect scientific and clinical ideas about addiction (and other pathological conditions involving so-called compulsions, such as obsessive compulsive disorders) to the vocabulary of responsibility.

Relapse

The nature of relapse is another matter too easily blurred by the brain disease rhetoric. Even after detoxification and a period of abstinence, addicts have a strong susceptibility to relapse. In fact, 40 to 60 percent of patients treated for addiction relapse within a year, and the rate is highest for tobacco addiction. It is said that this tendency to relapse is involuntary, because the person has no control over conditioned responses associated with previous drug-taking. For example, McLellan and colleagues explain:

[One neurobiological] explanation for [addicts’] tendency to relapse lies in the integration of the reward circuitry with the motivational, emotional and memory centers that are co-located within the limbic system. These interconnected regions allow the organism not only to experience the pleasure of rewards, but also to learn the signals for them and to respond in an anticipatory manner. Repeated pairing of a person (drug-using friend), place (corner bar), thing (paycheck), or even an emotional state (anger, depression) with drug use can lead to rapid and entrenched learning or conditioning. Thus, previously drug-dependent individuals who have been abstinent for long periods may encounter a person, place or thing that previously was associated with their drug use, producing significant physiologic reactions such as withdrawal-like symptoms and profound subjective desire or craving for the drug. These responses can combine to fuel the “loss of control” that is considered a hallmark of drug dependence [Ref. 11, p 1691].

Does it make sense to characterize relapse as involuntary under these circumstances? The physiologically conditioned feelings may be involuntarily aroused, and relapse may be made more likely by this conditioning and the accompanying neurobiological changes; but the addict is not an automaton, responding mindlessly to environmental cues. What is meant is that the addict has a strong predisposition or vulnerability to the use of drugs. Of course, relapse is not inevitable, and its likelihood can be reduced if the addict chooses to avoid the contexts or environments that trigger relapse.

Note that in what was just said, I have simultaneously used the probabilistic vocabulary of causation and the individual-centered language of choice. Clinically speaking, the experience of compulsion is the experience of feeling that one must choose to do something to avoid pain or dysphoria. Similarly, whether a particular individual can avoid relapse is at least partly affected by whether he or she chooses to take precautions, such as to avoid exposure to predisposing environmental cues.

The central claim of this article is that the concepts of disease and choice are compatible, and that the law

(which is based on our shared moral intuitions) can easily incorporate advances in our understanding of the neural substrates of addiction. These advances amend, but do not displace, the vocabulary of choice.

Onset

The same point is pertinent to the preaddiction phase of drug use. Although O'Brien and McLellan say that drug use is "voluntary" during this phase, they emphasize that the onset of drug use also has many involuntary components:

One reason why many physicians and the general public are unsympathetic toward the addict is that addiction is perceived as being self-[in]flicted: "they brought it on themselves." However, there are numerous involuntary components in the addictive process, even in the early stages. Although the choice to try a drug for the first time is voluntary, whether the drug is taken can be influenced by external factors such as peer pressure, price, and, in particular, availability. . . . Nonetheless, it is true that, despite ready availability, most people exposed to drugs do not go on to become addicts. Heredity is likely to influence the effects of the initial sampling of the drug, and these effects are in turn likely to be influential in modifying the course of continued use. Individuals for whom the initial psychological responses to the drug are extremely pleasurable may be more likely to repeat the drug-taking and some of them will develop an addiction. Some people seem to have an inherited tolerance to alcohol, even without previous exposure [Ref. 13, p 237].

It is important to note that the concept of voluntariness is being used in two different senses in this passage. With regard to any specific act of using drugs, "compulsion" is the relevant sense, and this is what O'Brien and McLellan¹³ mean when they say that drug use is voluntary before the addiction switch is flipped, and involuntary afterward. However, when they refer to the involuntary features of the early phases of the addictive process, O'Brien and McLellan emphasize that certain factors increase the probability that a particular person will be exposed to drugs, will continue to use them, and will become addicted to them. Now they are using the word "involuntary" in the "causation" sense. Note, however, that the vocabulary of causation is not incompatible with the vocabulary of choice in this context. For example, people who are aware of their vulnerability might choose to behave in a way that reduces the risk of addiction or, conversely, might knowingly take that risk.

Addiction and Legal Responsibility

With these preliminary observations in mind, I will explore legal concepts of responsibility that track

the clinical chronology of addiction: the preaddictive phase, period(s) of active addiction, and the period of remission.

Responsibility for Becoming Addicted

I begin with whether people are responsible for becoming addicted. As noted, everyone agrees that people choose (voluntarily) to initiate the use of addictive drugs. The question of ethical and legal interest is whether people who voluntarily choose to use addictive drugs are responsible for the consequences of their actions, including addiction. Should it be said, for example, that people who become addicted have only themselves to blame and that they have no legitimate claim on the society to insulate them from the consequences of their own folly? Assuming that, once addicted, the person has a brain disease—an irreversible pathological process—under what circumstances does the person bear responsibility for becoming addicted? This question has direct relevance for some of the key policy goals of the public campaign now being waged by the scientific leadership of the addiction field: access to addiction treatment and nondiscriminatory access to health care and public economic assistance.

Whether drug users are responsible for becoming addicted connects to a broader question of ethics. When are people responsible for their own disability or disease? Many cases of conscious risk-taking can lead to injury or disease, including riding a motorcycle 100 mph without helmet or engaging in promiscuous, unprotected sexual behavior, not to mention smoking and using other addictive drugs. However, as O'Brien and McLellan¹³ point out, many people have the genetic good fortune to be essentially immune from these conditions, because the effects of tobacco or the hormonal surge associated with risk-taking are aversive to them, whereas others are biologically predisposed to sensation-seeking or to addiction. Again, we have the mixed vocabulary of predisposition and choice.

Judgments of responsibility are not made in the abstract, however; they are contextual. Fundamentally, the underlying issue in any given context is whether the distributive principle is "need" or "fault." A person with an injury or disease is ordinarily no less entitled to rescue, treatment, or continuing support by virtue of having contributed to the onset or severity of the disabling condition. The distributive principle in this context is need, not

fault. However, addicts do not now have equal access to health care and disability benefits: Addiction treatment is often not covered under health insurance plans or is subject to benefit restrictions not applicable to other covered conditions. Addictive disorders are not in themselves a basis for disability benefits under the Supplementary Security Income (SSI) and Supplementary Security Disability Income (SSDI) programs; and addicts have a diminished priority in access to scarce medical resources (e.g., liver transplants). Whether these disadvantages are rooted in judgments of personal responsibility is more ambiguous, because some of these restrictions might be explained or justified on grounds of effectiveness and cost. However, to the extent that they are rooted in controversial judgments of responsibility,¹⁵ the “brain disease” formulation probably strengthens the claim of access.

When the policy issue of concern is compensation for the losses associated with addiction, the distributive principle is fault, and the general rule is personal responsibility based on an informed-choice paradigm. Whatever their vulnerability, and however strong the environmental influences, people knowingly take the risk of becoming addicted when they use drugs with addictive properties that are well known. Smokers know about the risks of addiction, and drinkers of alcohol know about the risks of alcoholism.¹⁶ Undercover drug purchasers know about the risks of using the goods they are buying and are not entitled to compensation under a workers’ compensation program when those risks materialize.¹⁷ Physicians who become addicted to opiates diverted from the hospital pharmacy are responsible for their condition and cannot shift the blame to the hospital’s negligence in allowing access.¹⁸

The law reflects a fairly strong commitment to the rule of personal responsibility for becoming addicted when one knowingly uses addictive substances; and medical use of drugs whose addictive properties are unknown can give rise to manufacturer liability (*Crocker v. Winthrop Laboratories* is illustrative of a series of suits brought successfully in the 1970s against the manufacturer of Talwin, a pain reliever that its users did not know was addictive.).¹⁹ There is but one possible deviation from this rule—the prospect of an industry’s having liability for addicting adolescents to tobacco and alcohol. This would be the exception that reaffirms the rule—by marketing alcohol and tobacco to children and adolescents, who

are unable to appreciate the consequences of their behavior (especially the grip of addiction), the manufacturers could be held liable for causing their addiction.

Responsibility for Behavior Symptomatic of Addiction

According to the standard vocabulary, the hallmark of addiction is loss of control over drug use. I have no doubt that prolonged use of drugs is accompanied by many changes in brain function that are correlated with the experience of loss of control, but what are the implications of this phenomenon for personal responsibility, whether moral or legal? Are addicts responsible for using drugs after the switch has been flipped? If not, are they responsible for other conduct prerequisite to drug use (e.g., theft) or consequent to use (e.g., public drunkenness)? Does the brain disease formulation have a bearing on these questions?

The area of law most clearly relevant to responsibility for addictive behavior is the criminal law. The response of the law to addiction cannot be fully understood without understanding a few general principles of criminal responsibility:

1. Every person over a certain age is thought to have the capability to obey the commands of the law. This is a key postulate of the rule of law—that the law is generally and equally applicable to everyone. Lack of responsibility must be regarded as a begrudging exception to the general rule.

2. A very narrow exception has traditionally been recognized for persons with severe mental illnesses who do not have the capacity to understand or appreciate the moral significance of their conduct.

3. Some states have expanded this exception to cover cases of severe volitional impairment, but this move has been highly controversial, particularly when it is not limited to situations involving psychotic decompensation. That is, the criminal law has been highly resistant to excusing offenders who have impulse disorders, paraphilias, or other conditions that allegedly impair volition.

4. Setting aside the insanity defense, the criminal law has also been resistant to excusing people who claim to have committed offenses because their will was overborne by strong emotions or pressures. The best illustration is the defense of duress. A narrow defense has been recognized for the extraordinary circumstances in which a person is threatened with

imminent death or serious bodily harm but not other kinds of threats, including financial or social ruin (even though these threats would render the threatening party guilty of extortion if he or she were seeking the victim's money rather than his assistance in committing a crime).

Given this strong general resistance to volitional grounds of excuse, it should come as no surprise that addiction has not been recognized as a defense in prosecutions for using drugs, for being drunk, or for other conduct symptomatic of loss of control. Yet, at the same time, many judges probably share the moral intuition that addiction should be an occasion for compassion and mitigation, even if it does not qualify as an excuse. Moreover, aside from the issue of responsibility, the wisdom of using criminal prosecution as a means of dealing with problems of addiction has been controversial for more than a century, with fluctuating cycles of support for criminalization and decriminalization.

This long-standing ambivalence was reflected in two cases decided by the U.S. Supreme Court in the 1960s in which the Court was asked to use constitutional rulings to push the states in the direction of decriminalization. In *Robinson v. California*,²⁰ the Court held that convicting a person for being an addict punishes a person for having a disease and therefore amounts to cruel and unusual punishment banned by the Eighth Amendment. Yet, as legal commentators pointed out immediately, the decision seemed to imply that an addict could not be punished for the symptoms of the disease, including using drugs or possessing them for this purpose. Thus, the Court's ruling in *Robinson* raised the possibility that the Constitution forecloses criminalization of drug offenses committed by addicts.

However, six years later, the Court receded from this position in *Powell v. Texas*.²¹ Powell, an alcoholic, was convicted of public drunkenness. He argued that *Robinson* stands for a broad principle of excuse: an addict cannot be punished for conduct symptomatic of disease (a condition he is powerless to change). The Court declined to embrace this principle and read *Robinson* narrowly. According to the prevailing view in *Powell*, although an addict, like Robinson, cannot be punished for the status of being an addict, he or she can be punished for conduct, such as possession or use. Similarly, Powell could not be punished for being an alcoholic, but he could be punished for appearing in public while drunk.

In the course of its opinion, the Court mentioned two reasons for refusing to take the law down the path of excuse. First, the prevailing justices pointed out, tools are unavailable to measure volitional impairment and thereby to differentiate between offenders who were "compelled" by their addictions to use drugs and others who could have chosen not to violate the law. Second, the Court was concerned about the implications of such a ruling for the fabric of legal rules governing criminal responsibility: If an addict cannot be punished for using drugs, what about conduct symptomatic of all other volitional disorders (now called impulse disorders in DSM-IV) such as pyromania and kleptomania? Also, constitutionalizing an excuse for volitional impairment would require all the states to recognize a defense for what was then called an "irresistible impulse" under laws governing the insanity defense. The Court did not want to unsettle the law of criminal responsibility.

These concerns are still pertinent today. The advances in neuroscience that have begun to elucidate the neural substrates of addiction reinforce the argument for an excuse based on compulsion, but they have not yet begun to answer these operational questions. Science has not yet connected the dots between brain and behavior, between synaptic changes and the experience of craving and compulsion. We still have no validated behavioral models of craving.

The effect of *Robinson* and *Powell* was to ratify the traditional reluctance of courts and legislatures to excuse addictive behavior. It is important to emphasize, however, that these decisions are not incompatible with the characterization of addiction as a "disease," or even as a "brain disease." What they stand for is the proposition that, even if addiction is a disease, the Constitution does not preclude punishment of addicts for their unlawful conduct. Symptoms actually caused by disease are not punishable, but conduct said to be compelled does not have to be excused. Compulsion may diminish responsibility, but it does not erase it.

Quite apart from the question of excuse, the wisdom of criminalization may be questioned. In my opinion, it is sensible to forgo punishment in favor of treating addicted offenders, not only for consumption-related offenses but also for other criminal conduct that may be linked to their addiction. However, I do not favor repealing criminal sanctions. The strongest justification—if not the sole one—for re-

taining criminal sanctions against drug use is that they provide therapeutic leverage for engaging people in treatment and facilitating compliance. Indeed, despite their emphasis on destigmatization, I suspect that Drs. Leshner, O'Brien, and McLellan and other proponents of a medical approach would resist decriminalization of addictive behavior for the same reason.

Responsibility for Relapse

To incarcerate a severely addicted person for using drugs before detoxification and short-term withdrawal is inhumane and unwise, but what about revoking a defendant's pretrial release for failing a periodic urine screen? Or revoking an offender's probation for failing to remain dry or clean after agreeing to do so or after signing a so-called last-chance agreement (LCA)? Is requiring abstinence as a condition of probation for an addict reasonable? Courts have held that it is, at least when the offender's drug use was connected to the offense.²² Using probation as a tool for keeping the addict engaged in treatment and for prolonging the period of abstinence seems ethically permissible because it is intended to help the addict achieve personal responsibility for managing his or her condition. To put it another way, it eschews punishment for addiction while holding the offender responsible for relapse. In this section, I explore the notion of responsibility for relapse, first as an axiom of clinical practice and then as a basis for a legal principle.

As was mentioned earlier, one of the major challenges faced by addiction treatment researchers is to relate the positive effects of treatment to the changes in the brain caused by chronic drug addiction—that is, to begin the task of connecting the dots between brain and behavior. A recent study by Gottschalk and colleagues²³ responds to this challenge in an intriguing way. They point out that one of the known effects of chronic cocaine administration is multiple focal decreases in cerebral blood flow. Hypothesizing that abstinence would be associated with increases in cerebral blood flow, that these increases would be a good measure of improvement in cognitive function, and that such increases would be correlated with responsiveness to cognitive behavior therapy (CBT), they presented several case reports highlighting this relationship. For our purposes, the most important feature of this preliminary study is that responsiveness to CBT is defined as improvement in the pa-

tient's capacity to learn new behavior and readiness for behavioral change (cognitive flexibility)—a concept that is more or less equivalent to a capacity (willingness) to assume personal responsibility for managing one's addiction.

From a clinical standpoint, then, we are trying to help people in recovery take responsibility for their situations, and, if we mean it, this also implies that they should accept responsibility when they fail. Aside from its purely moral connotations, the language of responsibility plays an integral part in all clinical encounters in chronic disease management, including treatment of asthma, diabetes, addiction, and many psychiatric disorders. Physicians and other therapists implicitly balance compassion for patients whose self-defeating behavior is driven by pathological processes with an effort to help them improve their capacity to exercise self-control. Indeed, assessment of capacity for taking responsibility has been characterized by Halleck as "an inherent part of medical practice" (Ref. 24, p 338). Shaping incentives for self-control and disincentives for self-destructive or noncompliant behavior are often important elements of therapy.

In the context of addiction, the clinician must balance an understanding of the difficulty of achieving and sustaining abstinence with some form of therapeutic pressure or leverage to reduce the risk of relapse. Contingency management can provide positive reinforcers for compliance with the treatment contract,²⁵ but failure to earn the reinforcers does not necessarily lead to a strong attribution of responsibility. However, addiction treatment specialists also often rely on threats of negative consequences, including family discord, suspension of professional privileges, or revocation of probation, to deter relapse.

The explicit use of threatened sanctions for their clinical utility inevitably exposes the issue of responsibility. Clinicians share a common-sense moral intuition that people should not be punished (or be deprived of something to which they are otherwise entitled), unless they can properly be said to be responsible for their choices. If they lack substantial control over their behavior (under the hard-choice paradigm), compassion and assistance, rather than punishment, are indicated. However, at a suitable stage in the clinical course of treatment, blame for failure is not only useful as a clinical stratagem but is also a fair professional response. Defining the line

between compassionate understanding and personal accountability is a complex, morally textured clinical task. According to one addiction specialist with whom I discussed this problem, it is necessary to excuse occasional “slip-ups” by patients who remain engaged in the therapeutic process (because, after all, occasional “slip-ups” are expected); however, imposing treatment sanctions (e.g., license suspension, or probation revocation) on a patient who has dropped out of the treatment program or has been persistently noncompliant is both fair and efficacious (because it preserves the deterrent value of the threat).

Do, or should, attributions of responsibility in the clinical setting have any bearing on moral or legal responsibility? I will explore this question in the context of modern disability law, specifically the employment provisions of the Americans with Disabilities Act (ADA).²⁶ The ADA embodies the distinction between disease and conduct that, as we have seen, defines the boundaries of responsibility under the penal law. Specifically, an employer is permitted to establish generally applicable rules of conduct (if they are justified by business necessity) and to hold all employees accountable for violations, even when the violation may be attributable to the employee’s disability—for example, threats against co-workers that might be symptomatic of a severe psychiatric disorder.

Although addiction counts as a disability under the ADA and an employer may not discriminate against an otherwise qualified person on grounds of disability, rules of conduct basically trump the non-discrimination requirement of the ADA in this context. Use of an illegal drug, even off the job, is itself a lawful basis for exclusion or termination of employment, even without any documented effect on performance. Employers are permitted to prescribe random drug tests and to fire people who are “currently engaging in the illegal use of drugs” regardless of whether their drug use is symptomatic of addiction. Even though use of alcohol off the job is not illegal and does not ordinarily implicate any rule of conduct for employees, most employers have sound business reasons to ban intoxication on the job or even to ban use of alcohol at the workplace and would be permitted to enforce such rules against everyone, including alcoholic employees.

What an employer cannot do is discriminate, on the basis of disability, against a person who has com-

pleted or is participating in an addiction rehabilitation program. Enrolling in treatment provides a safe harbor for addicted employees as long as they comply with the conditions of treatment.²⁷ This may require employers to accommodate the demands of treatment. The effect of the ADA, then, is to promote self-identification by addicts, grant a safe harbor for treatment, and use continued employment as a lever to promote therapeutic compliance. By creating the safe harbor, the law invites addicted employees to take responsibility for ameliorating their addictions. Negotiations regarding the conditions of treatment occur within the shadow of the ADA, but once the conditions are set, the employee bears the risk of noncompliance.

This process is illustrated in the case of William Mararri, a steelworker whose alcoholism was accommodated by allowing him to enter into an LCA after he twice violated bans against workplace intoxication. The LCA required him to submit urine samples on request for five years and specified that a positive result at any level would be sufficient cause for termination, as would reporting for work after having consumed alcohol. After he was fired for failing a urine screen, Mararri sued under the ADA. The Sixth Circuit Court of Appeals held that firing Mararri for failing a urine test administered pursuant to a valid LCA did not violate the ADA, even though it was not a company-wide policy.²⁸

Mararri’s company had chosen to accommodate his alcoholism when it might have lawfully discharged him from the outset for being intoxicated on the job. In other cases, however, the LCA might itself be a reasonable accommodation of employees with a history of relapse. Either way, once the LCA is signed, the employee’s job is hostage to his or her compliance with its terms. Some disability rights advocates might regard this arrangement as unduly paternalistic, arguing that employers should not have the authority to prescribe conditions of treatment. However, whether or not this approach is ethically appropriate, it seems to represent the prevailing understanding of the ADA. It also casts the characterization of addiction as a chronic relapsing disorder in a somewhat different light: it emphasizes responsibility rather than excuse, and it also raises questions about the generalizability of the principle embedded in the addiction cases. Is this a special rule for addicted employees or does it represent a more general principle of disability employment discrimination law?

Several recent cases involving diabetes,²⁹ bipolar disorder,³⁰ and asthma³¹ strongly suggest that a more general principle is emerging. These cases suggest that people have a responsibility to ameliorate and manage their own disabilities. This means seeking treatment when the disorder is identified and complying with medical direction, including taking prescribed medication. An employer has an obligation under the ADA to accommodate such an employee only to the extent that the residual impairments lie outside the employee's control. Only then is it fair to shift the costs of accommodation to the employer.

Summary

In summary, to characterize addiction as a disease is not necessarily morally incompatible with saying that addicts are responsible for yielding to it. This is admittedly a demanding approach to responsibility, but our criminal law has always set the bar pretty high. Holding addicts responsible is also strongly supported on utilitarian grounds because the threat of sanctions provides leverage to press them into treatment and to keep them engaged while therapeutic efforts are undertaken. Such a stern approach may be thought to be both unfair and unduly paternalistic. However, focusing on relapse suggests a more gentle, less jarring way of thinking about the addict's responsibility: After the period of detoxification and acute treatment, the addict is responsible for taking steps to manage the addiction.

In this connection, the similarity between addiction and other chronic diseases, which lies at the heart of the brain disease claim, becomes particularly pertinent. Yes, addiction is best understood as a chronic relapsing disorder. This helps to establish realistic expectations for the benefits of treatment, but it also emphasizes the important role of behavior in disease management and points in the direction of a theory of responsibility for managing one's own illness.

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