

Ethics and Values in the Prescription of Drugs for ADHD

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Abstract

Although both the diagnosis and treatment of ADHD are well-established, controversy continues to surround the prescription of medication. This article considers the ethical and legal basis for such prescriptions, indicating how other professional and family concerns and values may be explicitly included in giving appropriate advice about the appropriateness of drug prescriptions.

Introduction

The diagnosis and treatment of ADHD remains controversial. There is continuing negative media coverage, especially over the prescription of medication (1). Recent American data suggests that 3.5% of children there are taking medication to treat ADHD (2), which is much higher than the rate in UK children (3). Specialists have to defend their decisions, but much concern is also likely to be expressed to GPs, who often share responsibility for medication management of ADHD; some GP opinion-formers have strongly sceptical views about the prescription of medication for ADHD (4). This may pose considerable problems for GPs when discussing matters with patients, particularly as the initial decision to medicate is usually not their own. The anti-medication argument has two strands. The first, regarding the reliability and validity of the ADHD diagnosis and treatment effectiveness, is discussed in the context of applying the model proposed here. The second involves the value placed upon behaviour of children, particularly in relation to ownership of responsibility for that behaviour.

This strand cannot be answered by a simple appeal to the literature; a different approach is required, which directly addresses the ethical questions it raises.

Medication or Moral Responsibility in ADHD: a false choice

The essence of the moral objection to the use of medication for ADHD is that it implies that the diagnosis may be used to excuse morally repugnant actions by those with it, and those actions may be recruited as evidence for the diagnosis. Impulsive antisocial behaviour, if repeated enough times, may attract an ADHD diagnosis, which then excuses those actions, and the provision of medication confirms that excuse. If the medication is successful in suppressing the behaviour, then the ADHD sufferer obtains full rehabilitation without any apparent mental effort or requirement for remorse. Central to this argument is the ancient concept of “Mens Rea”, or evil intent, which is deemed an essential part of establishing criminal responsibility (5), and the lack of which is understood to be a consequence of mental illnesses and disabilities of all kinds. Arguments may be developed to recruit psychological treatments to programmes of moral improvement (6) but it is hard to see how drugs, which produce behaviour change irrespective of the willed choice of the user, can be deemed to improve morality without undercutting one of the basic tenets of ethical behaviour; freedom of moral choice.

To manage these moral issues, we should begin with who we are in this context: medical practitioners. This implies, as it always has, that our moral judgements should be limited to our own behaviour, not those of our patients. So, irrespective of whether we agree or disagree with the moral position just set out, we have no professional justification to apply our conclusions to our patient. Instead, our duty is to apply ordinary medical ethical principles, and show to our patients and our families we are following them honestly in making our recommendations.

An ethical model for ADHD diagnosis and medication management

If we are to apply ordinary medical ethics, it follows that in the diagnosis of ADHD, and subsequent prescription of medication, ethical medical practice must be consistent with respect to four principles: respect for autonomy, beneficence, non-maleficence (which is better known as “primum non nocere” – first do no harm) and justice (7). Ethical concerns lead to legal processes, the task of which is to ensure ethical practice. So, legal processes should be interpreted—with respect to doctors and as far as possible—as applications of the ethical principles just mentioned, and should be followed accordingly. Finally, we should work to the interests of our patients. Combining these three components allows the development of a working ethical model to provide useful, reliable guidance in ordinary clinical practice (8).

Consider an ordinary referral for a hyperactive child, who is assessed, diagnosed and treated. We begin by meeting our legal duty to manage the referral to ensure it is treated optimally. We seek consent, aware that assessment or treatment without consent, normally constitutes the legal offence of battery (9). Usually, we seek consent from the parents but try to take the child’s views and wishes into account. Despite concerns about whether this offers children, particularly teenagers, sufficient autonomy, the overwhelming weight of law and guidance is on our side. We undertake a thorough assessment and treat on its basis, ensuring both assessment and treatment are consistent with current professional guidelines (11,12), meeting the legal requirement that our practice should be both reasonable and agreed with peers (13). This process clearly involves respect for autonomy in obtaining appropriate consent, beneficence and non-maleficence in providing appropriate care. Justice is also involved, though less obviously. For example, we consider it just (fair) to be expected to manage the assessment and medical treatment of these cases well, while the legal framework and guidance just outlined tells us what ‘well’ means. Our model tells us that, if we approach ordinary cases of hyperactivity in an ordinary way, we are acting both ethically and legally. There is more to this than reassurance. Despite the controversy surrounding it, the diagnosis of hyperactivity is at least as well established as other medical diagnoses (14,15). So, our model both permits us to use the diagnosis despite doubt, while philosophical or theoretical objections are not sufficient grounds to refuse to make the diagnosis – any objections must be specified in terms of the model e.g., a valid objection would be that the methods used to achieve diagnosis have insufficient validity or reliability to trust it sufficiently. The model similarly makes clear that we should not be swayed by prejudice in treatment. For example, being ‘against medication’ must be justifiable in terms of the individual patient, against the standards set by the model. In both cases, the alternative is to risk ethical criticism or even legal sanction.

Given the safety of the treatments available for hyperactivity (16) and the significant disability the condition imposes (17), beneficence and non-maleficence rarely conflict. Respect for autonomy presents few challenges at initial assessment, as the children are usually so young that one may place the overwhelming responsibility for consent on the parents who have brought the child and still respect the child’s autonomy. As the treatment is over several years, the model suggests that the child’s appreciation of the treatment should be reviewed as time passes, to ensure that the practitioner appreciates how the balance of autonomy is shifting, and can respond to it as necessary. ‘Gillick competence’ i.e., to understand the treatment and its benefits sufficiently to give informed consent, which a child must possess in order to give consent independently without parents, is based on an assessment of the child’s competencies, not age (18). Though a child’s wishes may be overruled until aged eighteen, assessment of autonomy is essential to ensure that sufficient weight is given to the child’s views, as in the case of an older child, they may not be overruled lightly (19,20). Only those with parental responsibility can give consent for more than immediate or emergency treatment, though only one parent is needed to consent (21). People who cannot give full consent include teachers at boarding schools, foster-carers, unmarried fathers or stepfathers who have not been granted parental rights by a court, and social workers, unless the child is under a care order – being ‘accommodated’ or under a supervision order will not do. So, practitioners must be careful that the adult with the child is actually able to give consent, if the child (as is usually the case in hyperactivity) is not ‘Gillick’ competent.

Incorporating the model in everyday practice

Previous descriptions of the application of this model (8) referred largely to circumstances (incorporating the view of agencies bound by different ethical and legal principles) more appropriate to a specialist than a GP. However, the model may be readily incorporated into more medical decision-making systems that explicitly include values e.g., Huninks PROACTIVE model (22). PROACTIVE is an acronym which describes nine stages of good medical decision-making (identify the Problem, Reframe in soluble form, define Objectives, consider Alternative routes to them, reflect on the Consequences of the alternatives, and the Trade-offs between them, then Integrate the evidence with values, maximise the Value obtained, and Experiment to check the best decision has been achieved). The last three stages allow direct engagement of the moral strand of opposition to medication for ADHD-related symptoms, by requiring those holding that position to integrate their views with the ethical practitioner model just detailed, so that the benefit to the child is maximised, and then review the outcome of the resulting course of action in comparison to the alternatives, to ensure that the choice is correct from the perspective of the child. These three stages are examples of, respectively, dialectic, specification and balancing, which Beauchamp and Childress identified as essential to the effective application of ethical principles to practical situations, resolving the conflicts which their application inevitably generates (8).

Conclusion

Despite the ongoing controversy about prescribing medication for ADHD, by ensuring that the process of decision making is based on a firmly grounded ethical framework, it should be possible for the clinician to justify the decision reached for each individual patient.

GP Comment.

What have I learned from this paper?

1. It was useful to be reminded of what we already know, namely that we should do what is in the best interests of our patients and that our moral judgements should be limited to our own behaviour, not those of our patients.
2. Controversy about the medical treatment of ADHD and even about the validity of the diagnosis of ADHD underlines the importance of applying ethical principles to the management of this condition. This was nicely summarised in the statement that ethical practice must be consistent with four principles: respect for autonomy, beneficence, non-maleficence (first do no harm) and justice.
3. There is a considerable body of evidence about the efficacy of treatment of ADHD; we should not be swayed by prejudice but should be guided by the evidence.

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