

## Stemming needless deaths: “medicalizing” the problem of injection drug use

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The University of British Columbia, where I am a medical student, introduced its “problem-based learning” curriculum 3 years ago. One component of the new curriculum is a 4-year longitudinal course entitled “Doctor, Patient and Society.” This multidisciplinary course aims to develop students’ ability to address issues critical to the doctor–patient relationship, through such means as increasing sensitivity to cross-cultural perspectives and awareness of new ways to deliver health care advice and service.<sup>1</sup> Rather than providing a simple formula for problem-solving, this course encourages students to develop a framework encompassing the full range of patients’ personal norms, values, life experiences and socioeconomic circumstances.

One of the topics that the course introduced to our second-year class was the controversial subject of harm reduction. This was of particular interest to me, because before entering medical school I had worked with the BC Ambulance Service. A typical night shift in the Vancouver downtown core on a “Mardi Gras weekend” (welfare payday) would entail multiple “man-down” and “OD” emergency responses. One call in particular stands out in my mind. My partner and I had responded to a call to one of the many single-occupancy hotel rooms in the Downtown Eastside. Upon entry, it was apparent that the room was being used as a “shooting gallery” — there were more than 30 syringes, spoons, cookers and other drug paraphernalia scattered about. Lying in the corner between the bed and a side table was an unresponsive young woman in her early 20s. Someone had called 911 after realizing that she could not be roused, but the caller had then left the premises. All revival attempts, including those of the Advanced Life Support crew, were unsuccessful, and the patient was declared dead shortly after our arrival at St. Paul’s hospital. “What a waste — she was someone’s daughter. No one chooses to

die with a needle in their arm,” remarked one of the emergency department nurses as she walked away from the resuscitation room, shaking her head.

Waste: “1. to destroy; devastate; ruin. 2. to wear away; consume gradually; use up.”<sup>2</sup> This young woman’s life was indeed needlessly wasted. Yet how can we prevent this story from continually replaying itself, with different protagonists, each welfare payday?

Reflecting on this tragedy, I sat in the “Doctor, Patient and Society” class, in the safe, warm confines of the B-Hall lecture theatre, and listened to two distinguished physicians debate the pros and cons of harm reduction. There was a great deal of articulate jousting and parrying. The topic range was impressive, touching on fiscal issues, health care infrastructure and our ethical obligations. Despite all this information, I was unable to reconcile the woman who would not reach her 23rd birthday with the detached academic discussion. Too far from the front line, most members of the medical establishment are not attacking the problem with the urgency it merits.

The facts are staggering. Vancouver has the highest levels of overdose deaths in Canada, with more than 300 in 1998 and more than 2000 since 1991.<sup>3</sup> Vancouver also claims the dubious honour of having the highest levels of HIV infection among injection drug users in the Western world.<sup>3</sup> The problem is not improving. Fully 85% of street youth in Vancouver reported using cocaine in 1997, with injection being the method of choice.<sup>4</sup> Injection drug users account for half of new cases of HIV and AIDS in Canada.<sup>5</sup> Furthermore, mental illness occurs all too often in people like the young woman described above. We must recognize that these people may lack the fundamental capacity for personal insight and may be unable to appreciate the ramifications of their actions.

So what is the solution? Clearly, there is not a single

specific answer, but I strongly believe that we must acknowledge that the current system is not working. Such an admission would spur us to visit other possibilities, one of which must be the subject of "harm reduction." Two harm reduction priorities are apparent.

First, there must be an immediate, concerted effort to reach injection drug users and to diminish the grievous injuries they experience through overdose, infection with HIV and hepatitis C virus, and other related problems. Injection drug users are on society's periphery because of factors such as mental illness, lack of safe, affordable housing, and societal judgement. The transience and stigmatization of this population pose a major communication predicament. How can we provide the educational, health promotion and other social programs necessary to enable positive change without direct lines of communication? The few excellent outreach programs that do exist do a commendable job of helping injection drug users to reintegrate into society, but unfortunately the potential candidates vastly outnumber the available program spaces.

Second, we need to reconsider the current criminalization of injection drug use, which follows the path of legal persecution and isolation. Instead, we should try to "medicalize" the problem. Currently, significant resources are spent on law enforcement, court costs and other aspects related to the criminalization of this activity, money that could be spent on prevention and the expansion of treatment facilities for drug users. Within a medicalization model, "specific exemptions can be given to criminal offences for the medical management of drug dependence, such as in the use of methadone for opioid dependence."<sup>5</sup>

Such an approach has been criticized for deeming the addict "recidivist and discardable."<sup>6</sup> Yet I propose that these qualities more accurately reflect our persistent endorsement of the prohibitionist measures that are so obviously ineffective. Our failure to modify our approach sends the message that these people are disposable. If we truly understood and valued injection drug users as individuals we would be doing more to prevent their deaths.

Improved support for people whose life experiences and vulnerabilities have led them to the shooting galleries is necessary. This entails the provision of medications, affordable housing, education and, if necessary, safe, alternative ways of continuing their drug use. Dr. David Roy, author of the ethical component of a report prepared by the Canadian HIV/AIDS Legal Network, explained it this way: "The criminalization of drug use does not achieve the goals it aims for. It causes harms equal to or worse than those it is supposed to prevent.... It is ethically wrong to continue policies and programs that so unilaterally and utopically insist on abstinence from drug use that they ignore the more immediately commanding urgency of reducing the suffering of drug users and assuring their survival, their health, and their growth into liberty and dignity."<sup>5</sup>

As a first step, the medical community must acknowledge that our present approach to, and management of, in-

jection drug use is sadly inadequate. We have a moral obligation to embark on the difficult journey of policy amendment to help mitigate the damage and destruction that are occurring. Clearly, such adjustments will not be without debate and disagreement. However, I suggest that the controversy will be diminished as we witness injection drug users reclaiming their lives and their places as contributing members of our communities.

We have very little to lose and many lives to gain by trying something new.

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Competing interests: None declared.

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