

Taking drugs to help others

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Primaquine is an anti-malarial drug. When someone infected with the falciparum malaria parasite takes the drug, it reduces the risk that the parasite will be transmitted to mosquitoes and so to other people. However, it confers no direct benefit on the individual who takes the drug. Indeed it poses a net risk, since it has side effects and can cause a breakdown of red blood cells in certain genetically susceptible individuals. Nevertheless, primaquine is taken as a single dose by millions of people annually.

Triptorelin is a testosterone-suppressing drug that has been used to ‘chemically castrate’ sex offenders, including paedophiles. It can’t redirect misplaced sexual desires, but it can attenuate them, and there is some evidence that this can reduce the risk of recidivism in a subgroup of offenders. Again, though, it can have serious side effects for the user, including depression and softening of the bones.

Both of these drugs, then, can work in ways that benefit third parties, but confer no net benefit on the user of the drug.¹ This has led some to question whether it is ethical to prescribe them, even when the user freely consents to their use.² For example, Kevin Baird and Claudia Surjadjaja have argued that prescribing single-dose primaquine for third party benefit may be ethical in some cases, but only when the

risks to the patient fall within certain limits. Measured risks can be taken, but significant risks of serious harm cannot.³

The concern here is not that primaquine and triptorelin are being used *in part* for their benefits to third parties. This is the case with many medical interventions, as when an AIDS patient uses anti-retroviral therapy in part to reduce the risk of infecting others. This seems unproblematic. Rather the worry is that, in some cases at least, the use of primaquine and triptorelin may have *no* benefit for the user and indeed may pose a risk of serious harm. It may thus violate the requirement that seriously risky medical interventions should not be provided *solely* to bring about benefits to the third parties, even when their use is voluntary. They should be provided only when they're in the best interests of the individual who undergoes the intervention.

Let us call this the 'best interests requirement'.

The best interests requirement is widely accepted, at least as a rough rule of thumb, both by medical ethicists and medical practitioners (though some might allow an exception for cases in which the third parties are friends or family, as, for example, in cases of sibling-sibling organ donation). But I find it puzzling. It's generally regarded as ethically acceptable for a person to undergo a risky procedure to benefit herself. And surely it's *more* admirable to take a risky drug to benefit others. So why adopt a principle that rules out altruistic treatments while allowing self-interested ones? In many other contexts individuals are encouraged to expose themselves to physical and mental risks for the social good; consider allied efforts to recruit soldiers to fight Nazism during World War II.

Perhaps some think that the best interests requirement is necessary to prevent the misuse of medical technologies. We should accept the requirement since, if we do not, we are likely to subsequently accept seriously immoral uses of medicine to benefit society. Although the consensual provision of risky but socially beneficial medical interventions might be ethically acceptable taken in isolation, we have no way of enabling this without also creating a risk of more extreme, ethically objectionable practices. So we should adopt a moral requirement that rules out all seriously risky interventions that are not in the interests of the user.

This rationale looks superficially persuasive. Humanity does have a bad track record of coercively and misguidedly adopting intrusive and risky medical interventions perceived to have social benefits: think of the past use of frontal lobotomy to control putatively anti-social behaviour and of coercive sterilization to achieve the social benefit of better genes for future generations.

However, it's at least open to question whether concerns about past misuse are sufficiently powerful to justify forgoing the social benefits of interventions like single-dose primaquine and triptorelin-induced chemical castration.

In the wake of diabolical attempts to achieve social goals through medicine in the twentieth century, it may have been reasonable to introduce a strict best interests requirement. But we have since made a good deal of progress in medical ethics; the risk of serious misuse is much lower than before, at least in countries that witnessed a 'medical ethics revolution' in the late twentieth century. And we've acquired greater technological capacity to achieve genuine social benefits through medicine. It's now time to rethink the requirement.

Notes

¹ Vaccines also sometimes share these features when they are used in individuals who stand to benefit little from the vaccination, but whose vaccination will help to confer herd immunity on the population.

² See Don Grubin and Anthony Beech, 'Chemical castration for sex offenders', *British Medical Journal* 340 (2010): 433–4, at p. 434.

³ J. Kevin Baird and Claudia Surjadjaja, 'Consideration of ethics in primaquine therapy against malaria transmission', *Trends in Parasitology* 27, 1 (2011): 11–16, at p. 15.