

**Eduardo Viana
Vargas**

Faculdade de Filosofia
e Ciências Humanas,
Universidade Federal
de Minas Gerais,
Belo Horizonte, Brasil.
evvargas@fafich.ufmg.br

The article under consideration is synthetic, but (and as otherwise can be said of the drugs it deals with, medical and others) this does not make it any less potent or provocative.

As far as I can determine, not being in the medical area and therefore having acquired other academic habits, the article appears careful and up-to-date with respect to its revision of the subject's bibliography. In addition, it is a provocative article, principally where it concludes that "*while there is significant reluctance among medical care providers to begin HAART therapy with active drug users, the evidence base supporting this decision is quite limited*" (p. 712); that "*overcoming residual stigma and discrimination towards drug users by the medical community is essential for optimal treatment to occur*" (p. 712), and so "*data to date suggest that drug use is not an automatic exclusion criterion for prescribing HAART*" (p. 712).

However, the authors do not arrive at this conclusion without first recognizing, among other things, that there is relatively consistent evidence that IDUs present problems, whether they be with adherence and/or resistance to anti-AIDS treatment(s) (which would compromise effective treatment), relapse to high risk behaviors, and above all, taking account of the eventual efficacy of anti-AIDS treatments.

In fact, the problem is a thorny one, and, besides providing an updated revision to the bibliography of the subject (albeit restricted to the biomedical field and the English language), the article has the merit of affirming that there is no reason to prematurely exclude HIV-infected IDUs from the benefits of HAART.

The comments I make below involve three points: the first refers to IDUs adherence and/or resistance to anti-AIDS therapies and to relapse to high risk behaviors; the second, to the assumptions of biomedicine; and the third, to the paradoxes of biomedical development.

As for the first point, it is appropriate to note that these problems are not prerogatives exclusive to IDUs: few are the biomedical therapies that do not address more or less critical problems of adherence and resistance; in addition, relapse stemming from risk behaviors is reported, as the article itself indicates, in populations other than that of IDUs. This point does not make the situation of IDUs less grave. In any event, it is possible to show, for example, refutations, designed to explain these problems, by some representative psychologist (refusal to admit the existence of the disease and thus refusal to adhere to treatment) or educa-

tor (disinformation or superstitions). However, I believe there are also other things at play, which take us to the second point.

There is a general assumption in the exercise of biomedicine, which is difficult to call into question, perhaps because it operates as an implicit motive that legitimates the exercise of these practices, or perhaps because, when identified and threatened, the usual response met by the critic (or the "not adherent" or the "resistant") is that "no one can refuse it" without jeopardizing his own health. As Max Weber well remembered in a classic passage from *Science as a Vocation*¹, while reasoning about the impossibility of the existence of a science "free of all suppositions," "*the general 'presupposition' of the medical enterprise is stated trivially in the assertion that medical science has the task of maintaining life as such and of diminishing suffering. [...] Yet the presuppositions of medicine, and the penal code, prevent the physician from relinquishing his therapeutic efforts. Whether life is worth while living and when – this question is not asked by Medicine. Natural science gives us an answer to the question of what we must do if we wish to master life technically. It leaves quite aside, or assumes for its purposes, whether we should and do wish to master life technically and whether it ultimately makes sense to do so*".

There is, certainly, something relevant in Weber's formulation: in the current conditions of biomedical practice, it is, at minimum, an exaggeration to say that doctors and their peers are not insensitive to the complaints of patients, in part because the latter never act, completely, as mere "patients". The fiery discussions around euthanasia, as well as and especially the medical forces in search of less aggressive or invasive therapies and/or diagnostic exams, in my view, point in this direction.

Nevertheless, Weber's formulation leaves untouched a sensitive point, that speaks directly to what I have called particular modes of engaging the world, which involve different criteria for evaluating life. I would say that in general terms the common assumption of medicine is the appreciation of extended life or, more precisely, the idea that a life that merits being lived is that which endures in time, an idea expressed in the usual formula "the longer the life, the better". Even if legitimate and worthy of respect, this assumption, underlying the exercise of scientific medicine, does not have, as Weber well shows, scientific basis: it deals with values. Notwithstanding, this value is not exclusive, nor universal: the studies that I have conducted among licit and illicit drug users

have systematically pointed, particularly in the case of illicit drug users, to the existence, not without tensions or ambiguities, not without risks or consequences, of other modes of engaging the world, of other criteria for evaluating the world. Such criteria are not in play only among illicit drug users, but also among many others that assume risk behaviors. They would align themselves through modes of engaging the world in which life would be valued not more (or scarcely) in duration, but in intensity, as expressed in the formula “the more intense the life, the better”.

The problem, in my view, arises when the value that serves as presupposition to the medical practices is taken as an absolute and, as such, comes to be used to disqualify other modes of engaging the world, or to justify in an unproblematic manner any initiative taken in the name of biomedicine, or to justify the denial of access to those initiatives if they are demanded by practitioners of risk behaviors. In other words, the problem arises when problematic ethics are reduced to moral precepts or when, rather than ethically insisting on the qualitative diversity of modes of existence, we content ourselves with opposed moral values, good and bad.

At this point, it is incumbent to state that I do not believe the article under consideration takes such values as absolute. It perhaps does not emphasize the point and maintains it as presupposition... Which brings us to the final point.

In the history of biomedicine, there is virtually no positive development (and developments are many, as appears to be the case of HAART) that has resulted in real change, save in the morbid-mortality tables, at least of symptomatic suffering, that also has not produced numerous wicked effects. Sticking to the context of the article, it suffices to remember that drugs, which today are consumed illicitly and cause ample problems, were, in almost all cases, developed in pharmaceutical laboratories and/or in the name of biomedical presumptions (as was the case for heroin, morphine, cocaine, amphetamines...). It is therefore no mystery that the advent of modern anti-AIDS therapies should result in increased risk behaviors...

1. Weber M. *Ensaios de sociologia*. Rio de Janeiro: Editora Guanabara; 1982.

*Dirce Bonfim
de Lima*

*Centro Biomédico,
Universidade do Estado
do Rio de Janeiro,
Rio de Janeiro, Brasil.
dircebonfim@alternex.
com.br*

With regard to the use of anti-retroviral medicines (ARV) among illicit drug users, two aspects should be elaborated: adherence to treatment and medication toxicity. With regard to the problem of adherence, given the gravity of this application, it calls attention to the enormous difficulty of patients returning for consultations. If we admit that return is difficult, adherence to treatment becomes unviable. It thus appears impossible for whatever type of user to abide hours and norms of therapeutic conduct (fasting, medicine interaction, number of pills, etc.).

With regard to medication toxicity, the majority of ARV medications are hepatotoxic to a greater or lesser degree. Cocaine and amphetamines have hepatic toxicity, being able to induce fulminant hepatitis with renal insufficiency and rhabdomyolysis. Because of cardiovascular toxicity, it induces hepatic alterations associated with cardiac insufficiency, rendering other medications hepatotoxic ¹.

Chronic consumption of alcohol, which frequently accompanies the use of illicit drugs, can result in alcoholic hepatitis, which induces hepatic deterioration. As such, alterations of the hepatic enzymes in people infected with HIV are frequent, especially with the most potent therapeutic schemes and under the influence of alcohol and other drugs. The prescription of the ARV scheme for this and other special clientele should be considered case by case.

1. Mallat A, Dhumeaux D. Cocaine and the liver. *J Hepatol* 1991; 12:275-8.