article

Ethical Aspects of Susbtance Abuse and Intervention: Reflecting on Methadone Maintenance in New Zealand

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Abstract

Divergent perspectives of the nature of substance use have shaped societal attitudes and legislative action toward management of the implications of drug abuse and addiction at an individual and societal level. When it comes to substance abuse issues, policy and ethical analysis become intertwined. The current review entails an ethical evaluation of drug addiction, involving a comparison of different perspectives of substance use and an assessment of the treatment approaches and legal policies derived from these models. The aims of substance use policy directives will be ethically considered in terms of the balance of harm versus benefit, patient/client autonomy and rights and the duties or role of the health care provider in dealing with the problems of addiction.

During the 19th century, health care witnessed the isolation of several clinically important therapeutic compounds including morphine, which was identified as opium's major active ingredient, and codeine. By the mid 19th century, the hypodermic needle was introduced, enabling large amounts of opioids to be administered intravenously, and their effects to be felt rapidly. The consequences of this were twofold. First, the benefits of the medical relief that opioids provided were embraced extensively by health care communities, essentially revolutionising the effectiveness of treatment. However, operating concurrently to its health care advantages, recreational use became increasingly popular and the number of people who became addicted through the course of medical treatment rose dramatically (Savage, 1996).

Efforts to discover and produce a drug that had morphine's analgesic properties but that was not habit forming ironically resulted in the production of heroin, a semi-synthetic opioid that was in clinical use before it was discovered to be quite addictive. As a consequence of the use of prescription drugs for alternative purposes resulting in potentially destructive outcomes for the user and society, extensive anti-drug regulations have been legislated globally. This sequence of events has generated a social and legal atmosphere that has shaped societal perspectives of substance use and has trapped users in a web of stigmatisation and disdain.

Substance Abuse Intervention in New Zealand

There are currently over 30,000 intravenous drug users in NZ and every year, hundreds of these individuals seek the aid of the country's many treatment centres forming a network of which the Community Alcohol and Drug Service (CADS) in Dunedin is a part. These centres provide methadone maintenance treatment for addicts eager to get their lives back to normal. The form of heroin that consumes addicts in many other parts of the world is somewhat of a scarce commodity in New Zealand such that the majority of these clients are treated for addiction to prescription drugs obtained through the healthcare system or, less commonly, to a domestic form known as 'home bake'. Each centre sets out a list of protocols, which the clients must adhere to, in order to maintain their eligibility for the programme's benefits. Failure to observe these rules generally threatens the client's status in the programme according to the discretion of the treatment team.

Actions that constitute a failure to comply with the Dunedin Centre's programme include: concurrent use of opiates or other illicit substances, dose diversion (selling or maintaining for inappropriate use) failure to produce urine screens as part of the programme's routine checks, which is interpreted and recorded as a dirty screen, among other forms of inappropriate conduct, as specified by the programme. Although such behaviours constitute serious breaches of the methadone programme's safety requirements, the clinical team at CADS may opt to retain clients on the service should they fail to meet these requirements. As part of the treatment services provided by CADS, clients regularly meet with a methadone counsellor to manage their treatment and deal with other problems surrounding their dependency. Based on his or her record of stability and compliance, a client may be allocated take-away doses of methadone under the jurisdiction of his or her counsellor, thus constituting a privilege, which acts as an incentive for programme compliance.

Typical addictive behaviour may result in a situation where a counsellor is not able to trust his or her client, as substance-dependent individuals can be manipulative and deceptive and susceptible to certain actions which constitute breaches of the programme's protocols. One of the most critical and ethically relevant aspects of methadone maintenance programmes involves acting to prevent dose diversion. As noted, diversion of prescribed methadone constitutes a breach of methadone safety requirements and generally merits involuntary withdrawal (involving withdrawal over the course of a month and a three month stand down period) from the programme. As involuntary withdrawal constitutes an issue which merits consideration by other members of the treatment staff, a clinical review team must intervene to review a serious breach and decide the outcome concerning the client's status in the programme.

Looking at methadone maintenance treatment in New Zealand provides an opportunity to explore issues pertaining to drug policy and the aims and effectiveness of interventions such a policy entails. Additionally, it exposes us to a unique perspective of substance use, which prompts us to question the ways in which we perceive and condemn the use of mood altering substances.

Models of Addiction

The way in which a society conceptualises drug addiction greatly influences the approaches of interventions applied within it. Attempts to understand and explain the principles underlying human action have generated several models for explaining the phenomenon of addiction and its characteristic behaviours.

The first of these, the 'addiction as sin' theory, also known as the moral model of addiction, characterises addiction as a refusal to abide by some ethical or moral code of conduct (Thombs, 1999). Addicts are perceived as autonomous agents, exercising free will and controlling their tendencies to use illicit substances in a way that creates potential harm and suffering for themselves and others. That is, they are in control of their actions, despite the fact that such actions do not remain consistent with shared moral norms. Addictive behaviour, as a product of wilful misconduct by an autonomous agent, thus merits treatment with punishment. Under this model, addicts can justifiably be blamed for their use and held accountable for the consequences of their habit and its associated activities, i.e. crime, etc. The moral model represents the most absolute and clear description of addiction, although it negates the multi-factorial nature of addiction currently embraced by scientists in addiction research.

Although popular opinion rests with the moral model for addictive behaviours, other models, such as the 'addiction as disease', or the medical model are gaining recognition and have thus revolutionised current approaches to substance abuse intervention. The disease model characterises the increasing rate and volume of use of illicit substances as symptoms of an illness (Thombs, 1999). Although the mechanisms for such an illness are not made clear, the disease model emphasises the addict's loss of control over their habit. As a condition that surmounts the individual's free will, addiction is removed from the moral realm and thus merits treatment through compassion, care and medical intervention. Despite there being little empirical evidence to support this model, an addict who is considered to be 'diseased' incurs greater support from the community.

The last major model, the 'addiction as maladaptive

behaviour' or the social model for addiction characterises substance use as a maladaptive behaviour produced though the influence of external social contingencies (Thombs, 1999). The social model stipulates that individuals succumb to passive identification with a deviant role, within which they develop a sense of self-determination (Hamilton, Kelehear and Rumbold, 1998). Again, emphasis is placed on the lack of control of the user over his or her addiction, thus removing addiction from the moral realm. In accordance with this model, the emphasis of treatment is placed on endowing addicts with the skills necessary to prevent relapse and the tools for societal reintegration.

This perspective brings to bear an elusive distinction between the moral 'sin' of *active* identification with substance abuse and the passive identification characteristic of the social model. Separating these models is contingent upon the alleged foundations of the user's individual morals and those of society. Nevertheless, the latter implies an exemption from personal responsibility of the individual for his or her actions. Thus, emphasis is placed on the loss of control over one's will and subsequent actions.

Policies currently in place for managing the impacts of substance abuse differ with respect to the perceptions of addiction on which they are based and thus operate from different concepts of what constitutes the major problem. The major factor, which distinguishes attitudes toward substance use, is whether one attributes this behavioural phenomenon to volition or determinism (Theuerkauf, 2000). According to the former, human actions and decisions are based on a person's free will while according to the latter, they are determined by external contingencies such as inherited genetic factors or social conditions. Clearly, the disease and social models represent manifestations of the latter, and thus the goals of such models are to recuperate and refocus the user's habit rather than to reprimand it.

The perception of substance use as a moral threat to society remains the dominant perspective governing attitudes towards drug addiction and its interventions. However, those holding this perception often cower behind the veil of the disease model. By instituting programmes such as those discussed herein, the goal is to treat addiction as a disease, but in reality there remains a strong tendency to hold addicts morally responsible and accountable for their actions. Only when we move away from this tendency can we begin to optimise the efficacy of the strategies we employ to treat addicts.

Addicts have traditionally been, and are currently being, viewed for the most part as morally bankrupt individuals expressing anti-establishment attitudes and tendencies. Such impressions have instigated the approaches to drug policy involving prohibition, repression and criminalisation. America's 'war on drugs' exemplifies the strength of the moral motivation to institute such approaches, which emphasise the goal of abstinence and the need for the individual to be drug free in order to receive treatment, i.e. through drug rehabilitation. More recently, however, addiction to illicit substances has been recognised as a relevant social and/or biological problem. As victims of environmental, political, social and biological determinism, drug addicts have benefited from interventions directed toward treatment rather than punishment for addiction.

These newer interventions are directed more towards the so-called secondary problems of substance use such as infection, malnutrition, crime and prostitution, and less at the primary problems of substance abuse, which entail the pharmacological effects of the drug. Such interventions, which include methadone maintenance treatment and needle exchange programmes, among others, constitute the harm reduction model which aims to reduce the harms resulting from substance use and abuse inflicted upon society and the individual, the so-called "external costs" (Wagstaff, 1989, p.1175) of substance use.

The health care profession plays an integral role in the social control of substance abuse through the provision of such treatment facilities, which reduce the incidence of mortality and disease transmission while enhancing the productivity of drug users and addicts. These facilities demonstrate a convergence of the medical and social paradigms for addiction. That is, rather than trying to treat the addiction, and remove the user from dependency, the health care profession contributes to elimination and neutralisation of societal consequences of drug use (Have, 1994). In this

sense, harm reduction, as a model for treatment and control of substance abuse, calls into question the nature and goals of medical practice and intervention.

Current models used to describe addiction are useful to the extent that they guide the formulation of drug policy and prevention strategies. However, adhering closely to such standards may in fact hinder progress. Forcing addiction into a mould becomes restrictive, as a single model may not apply to all addicts. When treating a condition as elusive and poorly understood as addiction, it is critical that the addict be aided in discovering the specific causes of his or her addiction in order to find the appropriate path to treatment.

Harm Minimization in New Zealand: Establishing and Optimising Treatment

In New Zealand, methadone maintenance treatment allows opiate dependent persons to lead a normal lifestyle on a stable legal source of synthetic opiates without the pressure of ever having to come off the treatment, so long as the safety standards of the programme are met. Currently, in other parts of the world, namely the western world, methadone maintenance treatment retains the goal of eventual abstinence from the substance as part of the harm reduction strategy. Such was initially the case for methadone maintenance treatment in New Zealand, however this strategy proved to be ineffective.

With knowledge that their access to methadone was limited, clients of the programme were more inclined to exploit the system. They could easily 'put across the story', 'play the clinic game' by faking pain and withdrawal, negotiating to get what they wanted, thus providing themselves with a free, consistent source of opiates as sustenance or to be filtered and injected (producing a bigger rush) or sold. Of no less significance, the rate of relapse proved to be substantially high. Such instances are demonstrative of the fact that, unless they are implemented appropriately, harm reduction strategies may be deemed ineffective.

Although many treatment communities in the western world have implemented strategies that reflect the 'addiction as disease' approach, treatment providers often have difficulty eliminating the moral undertones which either consciously or subconsciously permeate one's perception of substance use, thus compromising the effectiveness of these strategies.

It seems evident that the outwardly more liberal aspects of New Zealand's drug policy optimise the use of harm reduction paradigms. That being said, even in New Zealand, drug treatment practices are not completely unfettered from their moral roots. Since they are government funded, drug treatment services, which offer methadone maintenance programmes, are required to place limitations on the number of clients they serve at any given time. Interestingly however, the use of methadone maintenance has proven to be much more economically viable than the government funded repressive policies and /or health care costs incurred by the treatment of substance misuse. Such an economic discrepancy would suggest that, under the premise of the disease model, services provided to addicts should be unlimited.

For methadone maintenance programmes, lengthy waiting lists persistently bear down on the conscience of the staff, as a long wait acts as a powerful deterrent to the addict who is considering enlisting in the programme. Furthermore, the presence of a waiting list may influence the team's decision to stand down a client, as the chances of a client re-enlisting after the stand down period weakens as the list lengthens. The only logic that can be inferred from government restrictions on methadone services is the presumed moral implications of offering unlimited services.

Harm Minimization for Whom? The Case of Dose Diversion

Utilitarian principles are strongest among those that govern the analysis of ethical issues, and hence policy decisions, in the field of addiction. From the perspective of the moral model, abstinence from substance abuse is the ideal. Although advocates of this model are willing to concede to harm reduction strategies to the extent that they reduce the harms of substance abuse, methadone maintenance absent from eventual complete withdrawal from substance use does not fall within their ideal. For the reasons discussed above, such morally influenced restrictions undermine the utility of the harm reduction paradigm.

Traditionally, the moral model has emphasised the role of drug policy as punishment for moral misconduct and as a deterrent for the rest of society. Surrendering to the moral leniency of harm reduction strategies instigated a fear of unintentional approval and endorsement of substance use. Evidently, however, striving for the ideals of the moral model does not justify sacrificing the potential benefits of harm minimization strategies for society and the individual. Perhaps the greatest benefit would result from universal abstinence from substance abuse. Experience shows, however, that this ideal is far from attainable. Although methadone maintenance in New Zealand permits the prospect of lifelong opiate dependence, its effectiveness in reducing the implications of substance abuse and its associated activities at individual and societal levels is paramount.

Methadone maintenance treatment as it is applied in New Zealand seemingly exemplifies utilitarian ideals by providing a system that maximizes benefit and minimizes the harms of drug abuse in society. However, situations often arise which call into question the merits of the harm minimization paradigm and its allocation of priorities toward societal versus individual well-being.

As mentioned, of particular ethical relevance are the programme's efforts to prevent the diversion of prescribed methadone. Diverting methadone poses a threat to society in that it may result in the harm or even death of a drug naïve individual to whom it may be sold. When such a situation arises, constituting a breach of the programme's safety requirements, the programme policy denotes that one should be stood down from the programme, thus preventing the service from potentially contributing to societal harm. However, should the client under suspicion be stood down, the possibility remains that he or she will begin to use illicitly again, thus increasing his or her prospects for premature death. On the other hand, if the client is kept on and continues to divert, the client is apt to use his or her dose in an illicit manner, by injecting it, for example, thus perpetuating the cycle of crime and societal unrest that typically ensues. In deciding as to whether a client should be withdrawn from the programme, the members of the treatment team must decide on placing the priority with either a particular individual or with the potential victims in society.

With methadone, addicts are afforded the opportunity to abandon a life of crime, disease, theft, prostitution and deceit, for one that promotes steady employment, family life, health, and hopefully, a renewed sense of autonomy. Nevertheless, despite its perceived benefits health care workers at methadone clinics operate under the assumption that some of their clients do abuse the system in such a manner. However, attempts to weed such clients out would presumably compromise the effectiveness of the system. Keeping in tandem with utilitarian ideals, the system deemed to be most effective should be embraced and instituted in the appropriate manner. Presumably, however, the major impediment to widespread recognition and adoption of policies which reflect utilitarian ideals, can be attributed to the alleged moral implication, of the policies. these implications are not spelled out by policy makes so the source of the impediment is hidden and their worth difficult to assess.

Weakness of the Will: Treatment's Major Paradox

One of the major impediments to the success of methadone maintenance involves a conundrum, which if anything, encumbers morally driven policies more so than any other. Methadone maintenance programmes in New Zealand base their aims and protocols on the so-called 'deterministic' models for drug addiction in an attempt to provide aid to those who are afflicted with a loss of control over substance abuse. These programmes emphasise societal integration and client normalisation by providing opportunities for addicts to explore lifestyle options away from the drug scene.

A difficulty arises because, as addicts are characterised in the deterministic model by a weakness of will, that is, they fail to do what they believe to be in their best interest, it is perhaps unreasonable to expect them to overcome the 'disease' of addiction and gain autonomy of will. The success of methadone maintenance treatment insists that its clients be motivated toward treatment. That is, in order for the service to be of help to them, they are required to satisfy conditions that are incompatible with addictive behaviours (Have and Sporken, 1985). The behaviours we demand from addicts to work toward controlling their problem are the very

elements that are essentially absent by virtue of the state that encompasses addiction.

The Right To Be Treated: The Case of Substance Abuse

Repressive drug policies based on the moral model assume that the addict operates from autonomous choice, nevertheless from a concept of autonomy that is based on an unacceptable notion of what is right and best. Therefore, the addict's autonomous choice should be morally condemned. It may be reasonable to conceive of substance use as a wilful, autonomous action, however more difficulty comes with regarding addiction to be, in itself, a wilful action. More accurately, addiction and its accompanying desperation and dependence are not wilful actions, but rather, indirect consequences of these actions.

Alternatively, normalisation policies regard addicts as possessing an impaired autonomy of will. Accordingly, addicts differ from non-addicts in that their will is derived, not from choice, but from impulses and desires (Have, 1994). Given this perception of addiction, one should question whether treatment should be provided to addicts on demand, thus requiring that one determine whether treatment constitutes a right or a privilege for the addict. Pragmatic policies such as methadone maintenance treatment deal with users as 'normal' people with 'normal' responsibilities. By according clients such privileges as take-away methadone doses, these treatment services work on improving the addict's autonomy of will. The client is able to discover new goals and focus on regaining control of his or her life.

The aims of the service state that methadone treatment is useful in some cases, and that it is committed to providing methadone within the means of its resources to those people who will benefit from it. In this sense, those clients benefiting from the service in a lawful manner are exercising the right to be treated. These are noble intentions indeed, however, difficulty comes with attempting to determine who will benefit from the services and its treatment.

The argument can be made that opiate addicts have just as much of a right to be treated as patients with other self-induced conditions, whether they be users of alcohol and tobacco or perhaps victims of anorexia or injury through sport. However, although chronic smokers, for example, may demonstrate a weakness of will, what sets them apart from opiate addicts is their relationship with their physician or health care worker. The illicit status of opiate abuse is such that addicts make a living of being manipulative and deceitful. More often than not, methadone counsellors are reluctant to trust their clients. It is unreasonable for them to expect anything from their clients in any given circumstances. Members of the treatment team are constantly working to benefit their clients while maintaining risk at a reasonable level.

Often, members of the treatment team at Dunedin CADS must make significant long-term efforts to stabilise a client's addiction and direct his or her life away from the drug scene. However, despite demonstrating apparent consistent compliance with the programme's safety requirements, some clients continue to act in ways which give the treatment team reason to doubt that they are benefiting appropriately from the treatment. It may be reasonable to assume that such clients continue to be maintained on the programme with their safety, more so than their right to treatment, in mind.

Duties of the Health Care Professional: Deviating From Traditional Goals

Alongside the issue of the addict's right to receive treatment, also of ethical concern are the duties of the health care professional in provision of that treatment. Perspectives on the nature of the problem of drug addiction and user autonomy create uncertainties regarding the duties of health care workers. As mentioned earlier, the health care provider's role in directing treatment efforts toward the social control of substance abuse harms appears to deviate from the nature and goals of conventional health care practice and intervention. The problem becomes deciding how one must balance the requirements of social order, safety and public health versus the health and freedom of the individual. That is, whether one must focus the aims of treatment on the rights of the individual addict or the rights of society.

The aims of repressive policies derived from the moral

model focus on containment of the drug problems at the societal level. Treatment for drug addiction becomes part of a series of legal strategies geared to repress, control and prohibit use and its associated activities (Have, 1994). Duties of the health care worker are thus directed at the protection of societal norms rather than individual patient's preferences. Alternatively, harm reduction strategies involve medical intervention as distinct from a socio-cultural strategy. That is, the health care worker operates on two fronts. In this sense, the health care worker maintains a more holistic approach, which encompasses duties as an agent of the individual patient and furthermore as an agent of society.

The nature of conventional medicine normally requires that the health care workers, duties to the individual patient override those to society. However, in the context of drug addiction, harm reduction involves a complex, non-reductionist strategy, which aims to support the individual client through an enhancement of physical and social function, in the interest of greater societal benefit (Have, 1994). Nevertheless, the primary obligation remains in the interest of the patient.

The principle of beneficence requires that a concerted effort be made to relieve the client of the primary ills of drug addiction. Despite the social consequences of their actions, it is not enough to reinforce legal and social norms in order to deter use. As for any individual afflicted with a physical illness, the health care provider has a duty to attempt to remedy the ills of the addict. Often, however, some societal impacts are remedied through protection of the individual's physical well-being, while the threat of others becomes enhanced. In the example of dose diversion, retaining a client who has committed such a breach will enhance the client's probability for survival and reduce the potential for societal unrest should the individual relapse, while at the same time increasing the societal impacts of dose diversion.

It should be reinforced here that the balance of harm versus benefit is integral to the aims of methadone treatment, occasionally even at the expense of justice. For example, the team's motivation to keep a client on methadone may be influenced by the relative threat the client poses to him/herself or to the community in the event that he or she is withdrawn from treatment. As a result, those who pose a greater threat to the community are apt to be kept on the treatment in the event of a breach of protocol, over a client that is less threatening but equally disloyal, following the priority of community protection.

Pervasive and Dominant Moral Reprehension of Chemical Consumption for Pleasure

The health care profession plays an essential role in defining and managing the impacts of substance abuse and its associated activities on the individual and society. Harm reduction strategies offer a pragmatic approach to the problem of drug addiction that emphasises diverting criticism away from cultural values, while individualising social problems. Such strategies employ health care professionals to provide medical support to the individual to improve his or her physical well being as a means of improving his or her ability to function in society.

Still, moral perspectives continue to dominate, or at least influence, modern views of drug addiction and prevail in restricting the efficacy with which many strategies for intervention of opiate addiction operate. Such is the case even in New Zealand, which exemplifies the apparently more liberal aspects of drug policy. Stringent, morally driven drug policies and treatment protocols are not, at least not directly, instituted to remedy the social effects of drug addiction such as crime, theft, disease transmission and prostitution. Alternatively, such policies are driven by the perception of drug addiction as a morally reprehensible act and are established with the intention of punishing addicts and deterring others from engaging in such behaviours.

Normally, society does not disapprove of the pursuit of pleasure, so long as it does not represent an impediment to function in society. A common perception is that, substance abuse represents an affront to basic values of society. It contributes to loss of production, disruption of personal relationships, irrational behaviours and illness through the disturbance of the body's homeostatic mechanisms. Thus, it is believed that persons engaging in substance abuse are regarded as living an inauthentic existence. Many people consider life to be a task, which may be accompanied by perhaps temporary, but not total withdrawal from reality

(Have, 1985). Such a view considers drug addiction to be an anti-establishment act that exploits other people's sense of social obligations.

Death of the Moral Model: Towards a Balance of Perspective and Progress.

The moral motivation that has given rise to and currently sustains the war on drugs in North America is so strong that its repressive policies are not often critically or ethically evaluated. The moral model seems somewhat justified in upholding its standards. However, on a more practical level, the ends do not justify the means. Not only is abstinence an impossible ideal, policies aimed at achieving this ideal have been shown to actually perpetuate criminal activity in society.

It is beyond the scope of this paper to discuss in detail the specifics of the research in this area, however, such studies show that supply-side enforcement is not only completely ineffective when demand is price elastic (i.e. remains consistent when prices increase), it is also counter-productive. Repressive measures often result in an increase in total expenditure on drugs and therefore drug related crime. Moreover, even in the event that control measures are enhanced to a point where demand is inelastic, drug substitution may result (Wagstaff, 1989). In the end, intensification of law enforcement may either be ineffective or result in a shift to analogous predicaments in other markets. Not only will intensified crime management lead to increases in narcotic prices and subsequent crime, it may also serve to further marginalize lower social classes and minority communities, which are associated with substance abuse, further perpetuating the problem.

Conclusions

Harm minimization strategies, such as methadone maintenance treatment, aim to achieve a balance between stopping use and neutralising social consequences of use. Methadone treatment focuses on the individual, stimulating him or her towards lifestyle adjustment and positive integration, thus constituting a means of repairing societal unrest. Victims of substance abuse who comply with the requirements of the programme exchange their dependence on drugs for a dependence on the therapeutic community. Through the process of normalisation, these programmes enable the addicts to re-establish a sense of autonomy and thus a strengthening of the will.

Inevitably, however, exploitation of such strategies remains. Health care professionals who work in these services must constantly be wary of the manipulation, deception and lack of reliability that constitute addictive behaviours. It is critical that such programmes work to minimise the risk of becoming a baseline opiate source for addicts or contributing to harm in society in some other way. This means achieving the appropriate balance between addressing the needs of individual and societal harms may sometimes override the needs and demands of individual clients.

Furthermore, as with any medical intervention, treatment should not be provided according to the demands of the client but requires that there be evidence that the treatment would be effective and incur benefit to the client. The moral model raises doubts concerning the ethical viability of harm reduction policies. However, if someone endeavours to maintain the moral perspective on drug addiction, then he or she is forced to deny the benefits to individuals and society which acrue from harm reduction strategies.

All this being said, upon evaluating and treating the ills of addiction, it is critical to bear in mind that the phenomenon of addiction is an elusive and variable condition whose aetiology is vaguely understood at best. Those attempting to understand and/or treat addiction must be aware that any models which inspire drug policy should be embraced and employed as loose guides rather than fixed constructs. Furthermore, one must remain wary of the unconscious moral motives which suffuse even the seemingly most broad-minded of these policies, in order to question their validity and their effects on the progress of treatment.

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