letters to the editor

Dear Editor

Homology in Vertical Evolution

A few years ago the BBC announced that British scientists had successfully grown headless frogs by genetic manipulation. It went further to discuss the chief possible implication of such a breakthrough: Growing headless human beings to harvest human spare parts for transplantation surgery!

It had long been apparent to me that natural phenomena repeated themselves when components of a certain biological level evolved vertically into higher levels of organization such as when cells evolved into multicellular organisms, or multicellular organisms into multi-human organisms (societies). So where was the homologous counterpart of a headless man of a certain society, among the cells of a multicellular organism?

It immediately struck me that the red blood cell in a multicellular organism was the perfect counterpart of a headless human being in society. The red blood cell is de-nucleated ('decapitated') at an early age to shuttle gases for 120 days and then is disposed of quietly. No 'cell rights organization' raises an eyebrow.

As societies become ever more intricate, such homologies are bound to become more apparent, eventually becoming inevitable as humanity leaves earth in space dwelling colonies. I will name just a few already existing homologies and leave to readers to think up of others including futuristic ones.

Lymphocytes in humans = soldiers in society,
Liver cells = sanitary workers, mast cells releasing Histamine = terrorists, apoptosis = suicide,
Spore formation = hybernation or cryopreservation,
Host-versus-graft reaction = ethnic cleansing.

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Dear Editor

In a series of articles, responses, and letters extending over two issues (October 2001 and February 2002) the *New Zealand Bioethics Journal* has hosted a wide-ranging discussion and debate on the contentious ethical aspects of methadone maintenance treatment. As an alcohol and drug counsellor with a methadone caseload, I believe there are aspects of praxis that should (albeit belatedly) be brought into the discussion.

In the opening article Townshend, Sellman and Coverdale (2001) highlight elements of paternalism in methadone programmes, and discuss their cause-effect relationship with confusion and conflict among and between providers and clients. Paternalism, either intended as a conscious attitude or unintended as an authority-preserving response to conflict that is engendered by faulty programme design (failure to differentiate between acute needs and potential long-term benefits of treatment), is only part of the picture.

The reality is that, regardless of a counsellor's personal outlook, he/she will have to bear the brunt of clients' frustrations and resentments at each and every restriction that is imposed, whatever the reason. Precisely because of the contentious and conflict-producing impositions on client autonomy arising from restricted access to needed substances (in the interests of precluding drug diversion or preventable deaths), treatment decisions are made and mandated by a clinical team to diffuse the onus of accountability. Furthermore, individual treatment provisions are constrained by general guidelines, such as protocols around numbers of take-home doses. Without such guidelines, prescribing 'on a *laissez-faire* basis' tends in the direction of greater diversion and more overdose deaths (p.11), on the one hand, and on the other hand the varying decisions made by more or less cautious or trusting counsellors are seen by clients as arbitrary and unfair, and programme workers become labelled as 'good counsellor'/ 'bad counsellor', with deleterious effects on both individual counsellor and team morale.

Certainly, the challenge remains to have a clinically-defensible rationale (most often in somewhat tenuous terms of relative