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

risk), both for individual variations and for the general guidelines: thus, use of non-dangerous substances such as cannabis should not attract negative sanctions (and in many programmes it doesn't). This still does not eliminate the need (as regards clinical accountability for prescribing a potentially lethal and addictive drug) to maintain procedures such as urine screening that may be experienced by clients as offensive, and to impose restrictions on access that can have the effect of 'liquid handcuffs'. As noted in the Consumer Perspective response (Anonymous, 2001), greater consistency in the guidelines and their application between programmes in different locations would also lessen the appearance from outside of arbitrary moral dictates.

Kermack, in her article (2001), reflects on methadone maintenance treatment's location in the midst of a force-field of powerful and sometimes conflicting political, ethical and moral pressures, and states that: 'the way in which a society conceptualizes drug addiction greatly influences the approaches of interventions applied within it' (p.15). Caution is indicated in further analysis: though challenging, it should nonetheless be logically possible and ethically defensible for 'society' (the body politic) to perceive addiction as a harm and a threat, to be defended against, while also mandating medical treatment ,to alleviate individual suffering, that rejects an ineffective and unscientific moralizing approach.

Kermack's discussion ranges over some problematic areas of overlap: about whether or not addiction as a condition is a moral failing of the addict (and therefore blameworthy as well as treatable); and whether or not medical services should be concerned not only with the risks of treatment to the patient (i.e. methadone's contribution to death by overdose), but also the risks to society of diverted doses. Though valid topics for theoretical debate, they may be less influential as issues in praxis. In the first case, the pragmatics of team delivery of methadone treatment are likely to smooth-out some of the effects of variation between caseworkers in their personal beliefs on addiction and their attitudes to addicts; and in the second case, dose diversion is an enduring clinical concern not just in the secondary spread of drugs to people outside the programme but with primary regard to the clients themselves, who can take double the normal dose and suffer harm as a result.

Where Kermack has described the challenge posed to health professionals by clients' 'manipulation, deception and lack of reliability', which she controversially categorizes as 'addictive behaviours' (p.21), the subsequent consumer reply reasonably attributes such behaviours to 'self preservation, and trying to maintain what freedoms the individual has managed to achieve within clinic guidelines' (p.27). A similar insight is, I believe, owed to methadone caseworkers, whose supposed paternalism and moralistic stance can often be more aptly attributed to the pragmatics of a team-based treatment regime.

As already noted, at team level there is the tension between staying within general guidelines to avoid appearing arbitrary and inconsistent versus making constant individual exceptions in order to be fully supportive of individual clients. Then at the level of each individual client-counsellor relationship, the dilemmas of uncertainty and trust (in a context of professional accountability) must be managed. In this setting, decisions that appear to reflect Nixon's 'balance of moral model and harm reduction' (Nixon, 2002, p.35) – i.e. what the client either 'deserves' or should be given 'in their best interests' – may be more plausibly explained by a personal emotional rather than ideational calculus. Relevant here is the counsellor's experiencing of a few clients' repeated 'manipulation, deception and unreliability' (however justified from the client's position) that will have produced a deep-seated uncertainty, complicated by the normal aversion to conflict on the one hand and on the other hand professional anxiety over taking the conflict-avoiding but ultimately more risky 'flexible approach'. Reversion to a less uncertain stance that errs on the side of caution can easily be misconstrued as moralistic or authoritarian rigidity.

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