1986

The battle for the right to prescribe

Through the 1970s, consultant psychiatrists in the NHS drug clinics had been moving away from prescribing any injectable drug to oral methadone – and also on a reducing dose basis. But there were still doctors in the community (both private and NHS) willing to prescribe more liberally. The 1982 ACMD landmark report on treatment and rehabilitation came out strongly against private prescribing and battle was joined in the right to prescribe.

The first guidelines of good practice were published in 1984, but like the guidelines that followed in 1991, were little more than the collective opinion and experiences of a small group of London-based consultant psychiatrists with virtually no reference to the (admittedly slim) clinical literature.

The 1999 guidelines were a different beast – a wide range of disciplines were represented on the Working Group, not just consultant psychiatrists – and there was an acknowledgement of a wider clinical literature. Inevitably, though, prescribing was the most controversial area to be tackled; a significant departure from previous guidelines was the endorsement of methadone maintenance as an appropriate intervention for primary care, but tied to much stronger recommendations on daily supervised consumption – were still expressed. Some general reservations about the appropriateness of GP prescribing. Like their predecessor, the 1999 Guidelines were intended *de facto* if necessary to have the force of law in cases of medical discipline against those believed to be acting outside the guidelines. So, there was a more liberal view taken on prescribing, but still a pretty restrictive view on who best to carry out the work. The 2007 Guidelines will be considered in the next issue, but at the time of writing these too are under review.

What follows is an edited version of the two articles by **Mike Ashton** which looked at the issues dividing the medical camps in 1986.

DOCTORS AT WAR

Two recent full-page articles in the national press explored the case for legally 'maintaining' addicts on opiate-type drugs (*Guardian*, 12 March 1986; *Observer*, 16 March 1986). As in the '60s, controversy surrounds the idea that providing a cheap, legal supply of heroin or heroin-substitutes on prescription can help some heroin addicts live stable, productive lives and undercut the illicit market. Behind this is the argument about whether doctors should be allowed to prescribe in this manner. It's an argument that reaches to the heart of the British response to opiate addiction – the so-called 'British system'.

Long the envy of liberal-minded observers across the Atlantic, the distinctive element of this system (and the reason why many deny there is a system) is that each doctor can treat their addict patients as they see fit, with minimal interference from the authorities. For 60 years the range of acceptable treatments open to any doctor in Britain has included long-term opiate prescribing if withdrawal was impractical or inadvisable. Because the aim is to keep the addict on an even keel rather than to attempt a cure, this practice is known as 'maintenance' prescribing.

Legislation enacted in the late 1960s and in the 1971 Misuse of Drugs Act eliminated heroin itself from most doctors' addiction treatment armoury and allowed the authorities to stop 'irresponsible' prescribing. By the mid '70s, opinion in the hospital centres for addiction treatment (and elsewhere) had swung away from maintenance prescribing towards short-term prescription of non-injectable opiates. But these legal changes and trends in practice still leave doctors free to prescribe maintenance doses of almost all the opiate-type drugs according to their clinical judgment of what's best for the patient.

Proposals to curtail these freedoms made by the Advisory Council on the Misuse of Drugs (the government's advisory body) in 1982 precipitated a protracted and sometimes bitter battle within the medical profession, one with serious implications for everyone seeking medical help for opiate addiction, and everyone involved in helping them find it. How the 'British system' survived its close shave with the legislators, but the freedoms (some would say, abuses) it entails remain in the balance, is the subject of our story. In this issue we trace events up to the government's response to the proposed curbs.

Curbs recommended

In its 1982 *Treatment and rehabilitation* report, the Advisory Council on the Misuse of Drugs took a hard line on prescribing to addicts. They observed more addicts were turning to GPs and private doctors rather than the specialist hospital-based drug dependency clinics. Through inexperience and lack of expert advice, some of these 'independent' doctors in addiction (a term coined to distinguish them from hospital doctors) were guilty of 'injudicious' prescribing. There was also a strong suggestion that private prescribing for addicts was morally and ethically undesirable – an allusion to the concern that addicts may need to sell prescribed drugs to pay medical fees or, worse, that doctors may be too willing to give fee-paying patients the drugs and the doses they desire.

CONTROVERSY SURROUNDS THE IDEA THAT PROVIDING A CHEAP, LEGAL SUPPLY OF HEROIN OR HEROIN-SUBSTITUTES ON PRESCRIPTION CAN HELP SOME HEROIN ADDICTS LIVE STABLE, PRODUCTIVE LIVES AND UNDERCUT THE ILLICIT MARKET

For the Advisory Council, the consequence of 'injudicious' or 'ethically questionable' prescribing was a significant rise in the availability of prescribed drugs on the illicit market, as addicts 'recycled' drugs surplus to requirements or bartered their prescriptions for more alluring chemical treats. The end result was more addicts and physical damage from injection of unsuitable preparations prescribed by unwary doctors. To counter these threats, the Advisory Council made their most controversial recommendations – effectively, an end to opiate prescribing for addiction unless the doctor accepted national treatment guidelines and/or local supervision by a more 'experienced' practitioner.

It took little imagination to see the Advisory Council's recommendations as an attempt to legislate the non-hospital doctor out of addiction treatment, unless they toed the line laid down by the clinic psychiatrist – an unprecedented restriction on the autonomy of the GP. As one GP later put it, the grandly-titled 'independent' doctors treating addicts might become little more than "clinical assistants to their local psychiatrist".

If doctors outside the clinics were to toe the clinic's line, what was this likely to be? Each clinic sets their own policy, but the Advisory Council recognised that most clinic doctors had turned away from long-term prescribing. The dominant treatment in the clinics now probably involves a 'fixed-term' prescription reducing to zero over up to six months. A significant number prefer not to prescribe opiates at all, while those that practice maintenance prescribing usually supply only non-injectable (and therefore, for the addict, less attractive) drugs to be taken by mouth. The Advisory Council also observed that in some areas GPs were prepared to prescribe more liberally, in direct conflict with the clinic psychiatrist – with predictable results on their relative pulling power among the local addict population.

Extending clinic policies beyond the hospitals would have seen the legislated erosion of most doctors' remaining clinical freedom in addiction treatment, and, in many areas, the practical restriction of the treatment available to strictly enforced, short-term, non-injectable withdrawal regimes. At the receiving end would be the addicts and drug users – some supplied and some physically damaged by 'injudicious' prescribing, but also some forced into crime and health risks due to difficulties in obtaining a legal supply of the drugs for which they have an "overpowering desire".

Battle commences

The heightening temper of the debate outside and inside the medical profession, and the potentially major impact on addiction treatment, made the Advisory Council's recommendations an unusually hot potato. It took three years for the government to finally reply.

The Council's proposals ended up in the hands of a Medical Working Group on Drug Dependence announced by the DHSS in 1983. It included members from

both sides of the growing divide between the psychiatrists in the drug dependency units and the doctors in general or private practice who – if the proposals were enacted – might be required to accept the psychiatrists' advice/control.

'Good practice' guidelines

After just six months of meetings in the first half of 1984, the Group were able to compose the "authoritative statement of good practice" called for by the Advisory Council. As the Guidelines of good clinical practice in the treatment of drug misuse these were later sent to "every hospital doctor and general medical practitioner" in Britain (though many profess not to have received them).

The Guidelines emphasised drug-free treatment and withdrawal regimes of up to six months duration, for which it gave detailed guidance. Nowhere was longer term prescribing recommended, even for the stable, chronic addicts for whom in earlier days it had been considered appropriate. Instead a few cautionary lines warned maintenance prescribing should never be initiated by general practitioners and undertaken only by, or in conjunction with, an experienced specialist.

But this was the only place where GPs were told they should work with the specialists. Even so, at least one member of the Group later came out against the document and an indignant letter to the British Medical Journal from a Scottish psychiatric consultant complained at the Group's presuming to be able to lay down guidelines for others to follow. But critical comments in the medical press were few.

Now the Group had to tackle the crunch issue. Guidelines, after all, can be 'adapted' by doctors who remain in possession of their clinical freedom. But prohibiting unlicensed doctors from prescribing any opiate for addiction would have the force of law, and could be used to turn 'guidelines' into rules.

Licensed to prescribe?

In 1968 it became necessary for a doctor to hold a special Home Office licence before they could prescribe heroin or cocaine in the treatment of addiction. Licences were (and still are) given to only a few hundred doctors, almost all working in hospital clinics. Not until 1984 was another drug – dipipanone (Diconal) – similarly restricted on the Advisory Council's urgent recommendation, after evidence of serious physical damage from its abuse by injection.

Both moves met remarkably little medical opposition, perhaps partly because doctors still had a wide range of opiate-type drugs with which to attract and treat addict patients. But the proposal now before the Medical Working Group would leave the vast majority of British doctors unable to prescribe any opiate-type drug for addiction.

Without an opiate 'script' to look forward to, addicts might no longer think a visit to the doctor worth the time, effort and the risk involved. Doctors already reluctant to accept addict patients could embrace their unlicensed state as a further excuse for refusing treatment of any kind; the remainder might read increased legal and professional restrictions as a warning not to get involved. Net result – a potentially drastic reduction in the availability of medical care to addicts.

On the plus side the proposals could have meant a virtual end to unsupervised addiction treatment by profit-minded private physicians and inexperienced family doctors, and provide a much more direct means of preventing or eliminating 'injudicious' prescribing.

The issue irreconcilably split the Medical Working Group. Its recommendation to the Minister went in two parts. A majority were for extending licensing to all opiate-type drugs except oral methadone, a non-injectable liquid favoured by the clinics and recommended in the Guidelines, but relatively unattractive to addicts. To prescribe other opiates for addiction, GPs might have to obtain a licence committing them to have regard to the Guidelines.

A dissenting minority opposed extended licensing, primarily because they considered that it would discourage some GPs from treating drug misusers.

Temper

On both sides of the argument, feelings ran high. Speaking to a conference in 1983, a London clinic doctor admitted: "I would certainly find it very difficult to keep my temper in a discussion with some members of my profession" – he was referring to private doctors "abusing their legal rights" by prescribing excessively to addicts.

Later that year two more London clinic psychiatrists, Thomas Bewley and Hamid Ghodse, published a research article uncompromisingly titled "Unacceptable face of private practice: prescription of controlled drugs to addicts". One of the authors served for a time on the Medical Working Group and is known to have been in correspondence with the General Medical Council concerning the behaviour of another member of the group, a private practitioner and president of the Association of Independent Doctors in Addiction, Dr Ann Dally. She had recently been prone to publicise her trenchant criticism of the competence and relevance of the NHS clinics (eg, "Have Drug Clinics Failed", *Sunday Times*, 27 February 1983).

Exasperated by this "ever-present but highly local controversy" between clinics and private doctors in London, Dr Arthur Banks, a provincial GP on the Medical Working Group, nevertheless had strong words to say about the Advisory Council's proposals. Extended licensing would, he said, be a "quite revolutionary step…forcing a major section of the medical profession to become clinical assistants to their local psychiatrist… whether or not they agree with his policies or judgment, and whether or not they have more experience and perhaps a sounder clinical basis for their treatment."

His campaign within the Medical Working Group culminated in a last minute plea to Norman Fowler: "… please, please tell Mr Mellor [minister in charge of coordinating drugs policy]… that if one brings in licensing now… any flicker of interest among general practitioners may be diminished if not snuffed out …".

Government decides

Among the majority for extended licensing were some of the biggest names in addiction treatment in Britain. General practitioners themselves (through the General Medical Services Committee of the BMA) had accepted the need for further restrictions on their right to prescribe. In contrast the medical forces against licensing appeared weak. With them were the civil servants at the Home Office and the DHSS, the former anxious to retain Britain's traditional flexibility and moderation in the treatment of addiction, both departments concerned about the practicalities of monitoring and enforcing extended controls.

Aided by the civil servants, the

minority carried the day. In its response to yet another call for more prescribing restrictions, the government observed that prescribing of the drugs causing concern had decreased of its own accord, so "any advantage…from extension of licensing restrictions would be slight, and would…be outweighed by the risk that at least some GPs would be discouraged from treating drug misusers". The decision was not to extend licensing restrictions but to "monitor prescribing trends…so that, should the situation alter, further action can be speedily considered".

Battle continues

As one doctor put it, defending the Guidelines against a rare attack in the medical press, "Guidelines are not rules, and any individual doctor can extract from them whatever he thinks is appropriate to his patients and his practice". After the government's refusal to legislate on prescribing, these malleable words of advice were the only extra safeguard standing between the doctors and their addict patients.

To some it would appear that clinical freedom and the availability of medical care for addicts had been preserved from the encroachments of a power-hungry elite; to others, that the inexperienced, incompetent and immoral among the medical profession had been given the green light to continue creating havoc on the streets and in addicts' veins through their virtually unfettered prescription pads.

But the outcome is not quite so clear cut. The powerful tide of medical opinion that wants prescribing more tightly controlled still has two weapons available to it. First is the medical profession's own disciplinary committee, run by the General Medical Council; second, the Misuse of Drugs Act tribunals, organised by the Home Office. Not quite the 'big bang' of blanket licensing, these mechanisms are nevertheless quite capable of eliminating the individual 'injudicious' prescriber.

In the next issue, Mike examined how these mechanisms were oiled-up and put to use, creating more controversy as the leader of the 'independent' doctors felt the weight of the GMC's disapproval.

DOCTORS AT WAR 2

– THEN IT GOT SERIOUS

In 1982, as the Advisory Council's report recommending prescribing controls was being written, an Uxbridge doctor was struck off the medical register for allegedly prescribing Diconal "on demand" to private patients. His unorthodox treatment of addiction had been judged "serious professional misconduct" by the General Medical Council's Professional Conduct Committee, the medical profession's own disciplinary authority. In 1983, two doctors treating addicts privately in central London were similarly dealt with, the first a Harley Street doctor said to have been 'motivated by greed', the second, a Soho practitioner "misled by the enormous financial rewards".

All three cases involved addict patients who had died, reflected in headlines such as 'Doctors Who Trade in Misery', 'Dr Death' and 'Victims of the Pusher Doctor'. Alongside the professional push towards prescribing controls there developed a veritable press campaign against the prescribing doctor – 'How Doctors Feed the Heroin Black Market', a *London Standard* headline in November 1982, typified the theme.

Between 1972 and 1984 the GMC's Professional Conduct Committee acted against 38 doctors for improper prescribing, of whom 17 were in private practice. In July 1983 they made probably their most significant decision, the fallout from which led the GMC's president to defend its actions in the medical press: the leader of the Association of Independent Doctors in Addiction was admonished for serious professional misconduct in her treatment of an addict patient.

'Leading Independent' disciplined

In November 1981, Dr Ann Dally organised the meeting which founded the Association of Independent Doctors in Addiction (AIDA), "a forum for doctors in both NHS and private practice who encounter addicts outside the clinics". A 'Harley Street' (actually, Devonshire Place) doctor specialising in psychiatry, Dr Dally became the Association's first president. In numerous interviews and articles in the medical and national press, she condemned the "drug dependency establishment" for its 'inflexible' and 'restricted' approach to treatment.

From the start AIDA emphasised

its commitment to "high standards of practice" in the treatment of drug dependence. It came as a shock when the treatment offered by the Association's president to a Diconal addict living in Coventry, was condemned by the medical profession's disciplinary panel.

Dr Dally was charged with prescribing "otherwise than in the course of bona fide treatment", amounting to "serious professional misconduct". The fact that the charge was found proved and because of the status of the defendant involved, have been seen as signalling a significant extension of the GMC's role in controlling prescribing.

TOLERANCE, FLEXIBILITY, RELIANCE ON THE DOCTOR'S JUDGMENT, QUALITIES AT THE HEART OF TREBACH'S ROMANTIC VISION OF THE 'BRITISH SYSTEM', WERE NOW UNDER THREAT

After the last wave of concern over prescribing in the '60s, it had been established that the GMC had very limited powers. Proof of mistaken, negligent, excessive or even reckless prescribing was not enough. It had to be proved that the doctor did not even believe this was the right treatment ('bad faith'), and that their conduct amounted to serious professional misconduct – issues of interpretation, rather than fact. Dr Dally's case illustrates how far the committee is now prepared to go in interpreting imperfect or risky addiction treatment as professional misconduct. Whether the judgment was 'right' or 'wrong' is not at issue here – it is what the judgment means in the struggle over prescribing controls that concerns us.

Legal advice to the committee hearing Dr Dally's case defined two criteria which, if either were satisfied, would mean prescribing was not bona fide treatment. The first, prescribing without honestly believing this was the right treatment for the patient, was the accepted basis for disciplinary action.

The second criterion for non-bona fide treatment, prescribing in the knowledge that the drugs might be sold on the illicit market, but "not caring" if this happened, was more of an innovation, and appears to have formed the substance of the successful case against Dr Dally. In the words of the prosecuting counsel, the "practitioner owed a duty not merely to the patient who was being treated but also to the public at large, that is to say, those into whose hands such drugs may fall ".

Later *The Lancet* carried a barrister's opinion that the evidence against Dr Dally "seems to fall well short of proof of lack of good faith". In the same issue, an editorial spoke of "bewilderment" among journalists and observers at the hearing's decision to admonish AIDA's leader, commenting that "the evidence did not emerge as compelling".

Britain's other leading medical journal published the views of a well-known GMC member and medical author. His colleagues on the GMC had, he said, stuck to the rules. But observers might understandably have got the impression "that this was a political trial in which the 'establishment' was out to 'get' Dr Dally because of her heretical views…I wonder if without the background political noise a case which in the end the GMC adjudged to amount to 'reckless' prescribing for one patient would have reached the council chamber for the full ritual of a 'public trial'".

It took the Professor of an American School of Justice to draw out the wider implications. Long an admirer of the 'gentle' British approach to addiction, Professor Trebach feared the GMC "may well have cut out a major piece of the heart of the most civilised system of drug abuse treatment in the world". As he saw it, the judgment had interpreted a genuine disagreement over appropriate treatment as 'bad faith' on the part of the dissenting doctor. Tolerance, flexibility, reliance on the doctor's judgment, qualities at the heart of Trebach's romantic vision of the 'British system', were now under threat.

GMC lays down the law

Professor Trebach's prophecy may be premature, but the decision against Dr Dally does represent a tougher line on addiction treatment. The GMC's submission to the recent Commons Social Services Committee investigation confirmed their willingness to act against doctors whose prescriptions find their way on to the illicit market, and added that 'irresponsible' as well as dishonest prescribing could be subject to disciplinary procedures.

What emerges from the controversy and confusion is that the GMC believes doctors treating addicts must have regard, not just to whether the treatment is right for their patient, but whether any drugs of dependence they prescribe may be redistributed and harm other members of the public. In any particular case the issue would be whether the doctor gave due weight to this possibility, a difficult judgment to make.

Since the majority of addicts in treatment sell some of their prescription, a severe interpretation of this criterion might land even clinic doctors in trouble. Chief Inspector Spear of the Home Office Drugs Branch has recalled a time in the '70s when clinic doctors became alarmed at the increasing street availability of injectable methadone, "but their proposal that general practitioners should be advised against prescribing methadone by injection for addicts had to be dropped when a survey by the Home Office…demonstrated beyond doubt that the major sources of the surplus were the clinics themselves and not general practitioners".

Even if there is to be no extended licensing system through which to firm the Guidelines into rules, the GMC has eagerly seized on the advice from the Medical Working Group as a yardstick for deciding what is, or is not, acceptable medical practice. Speaking to the Social Services Committee, the chairman of the GMC's disciplinary committee admitted "there was…a little difficulty in dealing with these cases, that a professional was in a position to argue regarding the validity of the treatment he used… the great advantage with this particular document is that we now have…the corporate view of what constitutes proper practice in this field".

For the GMC, in some respects the Guidelines did not go far enough. Their 1985 annual report commended the Guidelines, but also publicised "the serious view taken by the Professional Conduct Committee of evidence that a doctor has prescribed opioid drugs to addicts in private practice where the financial circumstances of a patient were such that he would have needed to sell part of the drugs prescribed in order to cover his expenses in obtaining them, or where the fees charged have varied according to the amounts of drugs prescribed."

The tribunals

Because the medical profession's disciplinary committee was thought

unable to act without evidence of bad faith, the Misuse of Drugs Act allowed the Home Secretary to withdraw a doctor's authority to prescribe controlled drugs on proof of irresponsible prescribing. The interpretation given to this charge has officially been described as "narrow" and "legalistic", whilst a Home Office drugs inspector has described the procedures as "rusty" and "creaky". Charges of irresponsibility are referred to a tribunal and then (on appeal)to an advisory body, each body consisting of a legal expert plus doctors appointed by the government.

In the years from 1971 to 1984 the tribunals sat just 15 times resulting in 12 doctors losing their right to prescribe all or some controlled drugs. Half these decisions were made by tribunals sitting in 1983 and 1984, evidence for the Home Office's claim that procedures had been streamlined. There is also evidence of greater urgency – the shortcut procedure allowing a temporary prescribing prohibition at short notice was used three times in 1984, but only once in the preceding years.

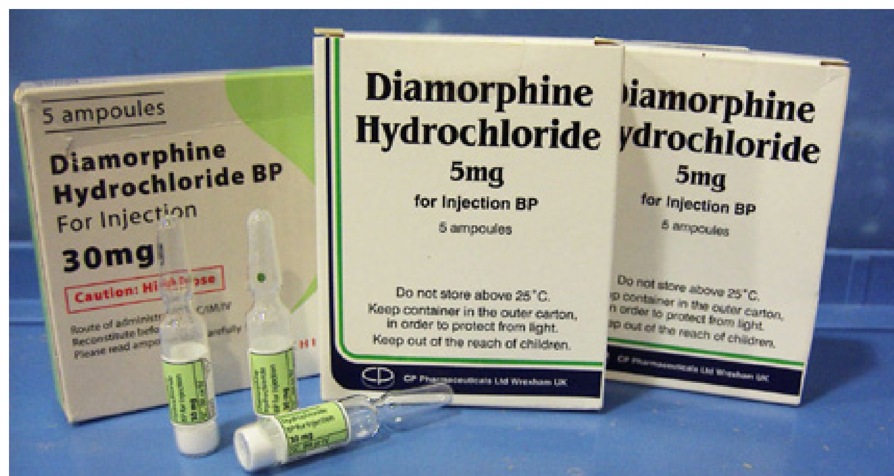
Responsibility for investigating alleged cases of irresponsible prescribing and instigating tribunal hearings lies with the Home Office Drugs Branch. In evidence given during Dr Dally's hearing, the Branch's Chief Inspector emphasised that "over-subscribing" could not be equated with "irresponsible" prescribing. Despite civil service discretion, the Drugs Branch is known to be concerned that addiction treatment in Britain may become counter-productively inflexible.

In an intriguing reversal of roles, the Home Office now opposes the medical establishment's push for blanket restrictions on prescribing, whereas in the 1920s it was the medical establishment that successfully resisted Home Office pressure to outlaw maintenance prescribing, setting ground rules for the 'British system' that lasted unchanged until 1968.

The evidence

With important policy issues and the central medical principle of clinical freedom at stake, medical politics and outraged ethical and moral responsibilities heightening emotions, but little more than uninformative official statistics to go on, research evidence on the medical response to addiction in Britain has become almost as much a subject for dispute as the issues it pertains to.

Both arguments reached a high



BUT THE FACT THAT MORE ADDICTS ARE CHOOSING TO TURN TO 'INDEPENDENT' DOCTORS RATHER THAN CLINICS SUGGESTS THE CENTRAL FINDING – THAT SOME PRIVATE DOCTORS ARE MORE 'GENEROUS' PRESCRIBERS – IS ALONG THE RIGHT LINES

point in the summer of 1983, just months before Dr Dally was called to account before the GMC. "For debate …" said the *British Medical Journal*'s lead-in to an article unambiguously titled "Unacceptable face of private practice: prescription of controlled drugs to addicts". A report of a study conducted by two prominent drug dependency unit consultants, the article did indeed provoke supportive and critical comment that ran to greater length than the original.

The two doctors had given 100 of their patients a questionnaire to complete. All 18 questions sought the patients' views or experiences of "private doctors". Two paragraphs in the two page report briefly reported findings from what appears to have been five of these questions, most answered by less than half of the patients in the study. This partial report painted a black picture of some private prescribers' willingness to 'sell' prescriptions for large amounts of injectable drugs, some of which were later resold to help pay doctors' and chemists' fees.

"It is questionable whether it is ever desirable to prescribe controlled drugs to an addict when a fee is paid," was Drs Bewley and Ghodse's comment on their findings. "If neither the General Medical Council nor a tribunal…can stop these practices, then extension of the present licensing system to include all controlled drugs…is probably the only way that this can be achieved."

'Propaganda' accusation

"… the BMJ has published propaganda disguised as a scientific paper"" was the riposte from an AIDA member. Together with Dr Dally's husband, he highlighted the methodological faults in the research.

A glance at the questionnaire shows at least some of the criticism is justified. Large parts are left unreported, there are leading questions, failure in places to ask the same questions about clinic doctors and private doctors, and invitations to respond with hearsay about the actions of private doctors rather than experiences.

But the fact that more addicts are choosing to turn to 'independent' doctors rather than clinics suggests the central finding – that some private doctors are more 'generous' prescribers – is along the right lines. Answers given by Bewley and Ghodse's patients suggest there may be more acceptable reasons too – 16 out of 38 said addicts went to private doctors because they were treated better, whilst 37 out of 41 mentioned avoidance of clinic regulations.

Predictably, conclusions drawn from these facts were at variance. Bewley and Ghodse argued that the private doctors needed to change or be controlled, others argued that the clinics needed to change to become more attractive to

addicts. Far from helping to settle the issue with objective facts, the research simply added fuel to the fire.

The same befell Dr Angela Burr's observations on the illicit market for prescribed opiates in the West End of London. Her admittedly "informal observations" suggested that between 1981 and late 1982, more non-clinic doctors had become prepared to prescribe larger quantities of drugs to addict patients – the result, a "thriving market in pharmaceutical drugs from the overspill from doctors outside drug dependency units…". Her conclusion supported Bewley and Ghodse's urgings: "… the situation gives cause for concern and would appear to need urgent attention".

AIDA members were quick to reply. Without denying some private doctors were overprescribing, their letters to the BMJ ridiculed concentration on the market for prescribed opiates in Piccadilly at a time when "the main black market is in smuggled heroin which surrounds us in every town and is too big to have a centre of exchange". Such 'doctor bashing' – a phrase headlined last year in *Hospital Doctor* to describe the campaign to curb prescribing – was portrayed as an "irrelevance" which "diverts attention from the real issue".

Swings and roundabouts

Concern over prescribing for addiction currently centres on the possibility of surplus supplies being re-sold by the patient, causing physical damage and addiction among other drug users. There remains the issue of which prescribing regime is best for the patient.

Richard Hartnoll and fellow workers at a London drug clinic compared outcomes for a group of heroin addicts prescribed injectable heroin in the early 1970s, as opposed to another group prescribed oral methadone. The study tested a prescribing regime (injectable heroin maintenance) likely to be more common if some of the physicians in AIDA had their way, against one (oral methadone maintenance) favoured by many clinics. How did they compare?

A year after coming to the clinic, nearly three-quarters of the group given heroin were still in treatment. In contrast, the attractions of oral methadone retained less than a third. But although the heroin group remained in treatment, for most the effect of this treatment seemed minimal. They continued to obtain illicit drugs, remained unemployed and generally maintained a 'junkie' life style, though perhaps less extreme than before.

The group offered only oral methadone tended to react either by becoming very deeply involved with the illicit drug scene, or by abandoning opiate addiction altogether. Most decided to continue their habit, and inevitably had to remain more deeply immersed in the drug subculture than they might have been had the clinic agreed to provide heroin on prescription.

The study indicated that the choice between methadone and heroin must be made more on a 'swings and roundabouts' basis, rather than on the basis of any definite overall advantage. In turn this means that the decision will be influenced by the priorities assigned by prescribers to various outcomes.

This kind of trade-off led the authors to comment that "a decision to prescribe intravenous heroin for maintenance involves clinical, ethical, and political judgments".

Limited gains

Now the dust has settled, what has been the impact of the original 1982 Advisory Council recommendations and subsequent events on prescribing controls? The answer must be, not nearly as much as many Council members would have wished.

Licensing restrictions have been extended, but only to dipipanone, not to all opiate-type drugs as recommended. Now only licensed doctors can prescribe heroin, cocaine or dipipanone in addiction treatment, but any doctor can prescribe other heroin-substitutes, such as injectable methadone.

Guidelines on good practice have been produced and disseminated, a notable achievement in itself. But they have not been universally accepted, nor do they stipulate that non-specialists should always work with specialist services before prescribing controlled drugs to addicts. Liaison is advised only with respect to long-term prescribing.

Without extended licensing, there is no direct means of enforcing the guidelines or of obliging GPs to work under the supervision of specialist doctors. Nevertheless (as hoped for by the Advisory Council) the General Medical Council appears willing to use the guidelines as a yardstick in disciplining doctors, though their powers to do so are limited.

The Misuse of Drugs Act tribunals and the General Medical Council's Professional Conduct Committee have become more active in disciplining 'injudicious' prescribers. The GMC in particular is keeping a close eye on the ethics of private prescribing in addiction. But neither body is constituted in a way that would allow action against those whose prescribing appears excessive, unwise or mistaken, but not irresponsible or unethical.

The 'climate of opinion' in the country is not decisively against maintenance prescribing, even of injectable heroin – the debate is still alive. Short-term prescribing of oral drugs may have gained favour in the clinics, but it has not yet become a secure and universally accepted feature of addiction treatment policy in Britain.

Since the 1970s, a smaller proportion of addicts (estimated at one fifth or less) are seeing any doctor in the treatment of their addiction, and a smaller proportion of these are being seen by the specialists in the clinics (just 31 per cent of addicts notified during 1984). At the same time the major source of illicit opiates in Britain has overwhelmingly become the illegal importation of heroin rather than overspill from the prescribing doctor – nearly 90 per cent of addicts notified during 1984 were addicted to heroin, as opposed to less than 60 per cent ten years before.

These facts make whatever doctors decide to do with addict patients less significant in the overall sweep of drugs policy than in the days when most addicts were in treatment, and doctors' prescriptions fuelled an alarming escalation of addiction. But the symbolic significance of how Britain allows and/or encourages its doctors to treat addicts remains potent, as does the impact of that treatment on the individuals involved.

Should Britain's doctors practice 'tough love' policies on addicts who won't stop taking drugs, and should addiction treatment be taken out of the hands of doctors who refuse to toe the line? Should a lifetime opiate prescription be available to any addict who can persuade an inexperienced family doctor this is the only way they can be helped? Thanks to the government's decision not to extend licensing, these kinds of question are very much alive. After all the battles, it is still up to the individual doctor to decide to a degree unknown and unacceptable in many other countries. Even if the natives like to deny there is (or ever was) a 'British system', it must still seem almost intact to observers from more regulated lands.