peter mcdermott
pure and uncut

Privates on parade

OVER the last twelve months, we've witnessed what may be the General Medical Council's largest cull of doctors practicing addiction treatment in the private sector. Although I'm not familiar with the details of these cases, I think we can safely assume that these doctors weren't practicing some dangerous fringe medicine of dubious effectiveness. Many would have been providing mainstream methadone maintenance treatment to patients who were unable to find a treatment provider who could meet their needs within the NHS.

As a lifelong socialist, I find it difficult to defend the principle of private medicine, but in the area of addiction treatment, I find myself uncomfortably forced to be one of its staunchest defenders – primarily because of the way it successfully addresses so many of the failings of many of the NHS and voluntary sector treatment providers.

Almost nobody would voluntarily opt to pay significant sums of money for a service that they are entitled to receive for free, unless the free services were somehow failing to meet their needs in some significant manner. Talking to people who use private treatment facilities, you hear the same complaints over and over again: their local provider just isn't sufficiently flexible to meet their needs.

This lack of flexibility can take many forms. Sometimes it's about dose, with services having a ceiling that the patient (and the research evidence) considers far too low. Sometimes it's about modality – when a patient just doesn't do very well on oral methadone, but thrives on an injectable preparation, but his particular specialist service refuses to consider it. And sometimes it's about other aspects of the regimented and inflexible nature of the treatment regime. For example, if your work requires you to travel a lot, but your clinic insists that you participate in daily pick-ups, weekly group therapy sessions and supervised consumption, then access to a private treatment facility can mean the difference between having a career, and being unemployed, between being a productive member of society, and being socially excluded.

As I've said, I'm not familiar with the finer detail of the recent GMC show trials. It seems fairly clear to me that at least some of those doctors working in the private sector have been unjustly disciplined by the GMC. Had they been practicing within the NHS, the doctrine of clinical autonomy would have prevented any challenge to their practice. Yet working in the private sector seems to be more than sufficient reason to launch an investigation. And once the investigation begins, it's easy enough to find some procedural irregularity – patients from outside the local catchment area, or case notes not kept as up to date as they might be. Any minor error seems to be sufficient to convince the GMC that the charges of professional misconduct are well founded.

One has to wonder how well any clinician's practice could stand up to such scrutiny? I rather suspect that there isn't a single DDC or CDT that would survive if they were held to similar standards.

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It is unquestionable that high quality drug treatment should be available to all that need it, free at the point of delivery. Unfortunately, we have still to reach that point, but even if we had, it still seems unclear to me that there is sufficient commitment to the provision of flexible, user-friendly treatment whose primary goal is meeting the needs of the patient when they conflict with the bureaucratic requirements of treatment providers.

Until these conflicts are resolved, there will always be a need for a private sector in drug treatment provision, and those who attack such providers on principle do a disservice to both the many principled and well-intentioned people who are employed in that sector, and to the patients whose continued well-being depends so much on their continued existence. ■

Peter McDermott is a freelance writer and consultant on user involvement in services. His autobiography *The Dark Side of the Spoon* is due to be published by Canongate