Alternatives to licensing doctors

Recent proposals to license doctors who treat drug users with controlled drugs other than oral methadone mixture, will deter doctors from working in this area.[1] This was exactly why a similar licensing proposal was rejected in 1984.[2]

The consequent failure of drug users to access treatment will result in more drug-related deaths, more blood-borne virus infections, deterioration in the health of drug users their families and local communities, and increasing crime.

A major debate on licensing is needed within the drugs field, which has not happened because those involved in this treatment process have not been consulted. Under the 1971 Misuse of Drugs Act licensing can be enacted without parliamentary debate. Is it being pushed through regardless?

Licensing is, apparently, supposed to curb the prescribing habits of a few private doctors in London. It will affect every NHS and private doctor in the UK. Alternatives to licensing have not been discussed. We propose an alternative for NHS doctors, towards which much work has been done and is being done.

The Department of Health (DoH) recently made a sizeable sum available for training all levels of doctors in drug misuse. GP training will be at two levels: generalist and specialised generalist. This will improve care for service users and enhance doctors' understanding. It could remove the need for licensing.

Other components of the proposal are in place in many areas and developing in others: incentives for high quality care, clinical governance, monitoring groups, and disincentives for those who transgress.

NHS doctors' incentives

GPs who treat drug users are disadvantaged financially – drug users attend about ten times more than average, and consultations tend to be complex and time-consuming.[3] Neither the BMA nor the RCGP regard this work as a core General Medical Service (GMS).

In some areas the additional work attracts monies from outside GMS funds. These provide financial and professional resources, and support and training to enable quality shared-care services. Training, specialist clinical support and payment for GPs who treat patients according to good local protocols will enhance professional practice, and increase the availability of treatment.

Ensuring high quality NHS practice

1. Prescribing NHS and private doctors should adhere to minimum standards of care, undertake audits, and attend ongoing training. Each shared-care scheme should have a local monitoring group containing the Director of Public Health (or deputy), representatives from specialist treatment agencies, local scheme GPs, the Local Medical Committee, and others.
2. Regular Prescribing Activity (PACT) analysis of prescribing per Primary Care Group and Primary Care Trust area (preserving individual GP confidentiality) will be available for each shared-care monitoring group.
3. GPs should be encouraged to join their local shared-care scheme. Local NHS doctors who continue outside the scheme can be encouraged to join by funding incentives and shared-care liaison resources.
4. Primary Care Groups and Primary Care Trusts will be involved in developing local protocols and prescribing, through clinical governance mechanisms and the commissioning process.
5. Primary Care Group pharmaceutical advisers can monitor the prescribing of individual NHS GPs through the PACT system. GPs who appear to prescribe outside expected practice will be approached. Cases of persistent prescribing irregularities, in spite of supportive advice, should be referred to an agreed local specialist, with knowledge of primary care, for further assessment and advice.
6. Payments should be withheld from participants in formal shared-care schemes whose work falls outside locally agreed contracts and protocols.
7. If NHS doctors persistently act contrary to good practice, referral to the General Medical Council (GMC) or to a tribunal under the 1971 Misuse of Drugs Act can be threatened.
8. If such a referral occurs, the GMC can suspend a doctor from drug dependence work until the case is heard, while allowing them to continue general practice in all other respects.

This system will encourage, rather than restrict, GP involvement in the treatment of substance misuse, raise standards of care, but still deter bad practice.

Private doctors

Comparable regulation of private doctors is more difficult. PACT data does not cover private prescriptions and there are no clinical governance arrangements. Local police pharmacy inspectors scrutinising pharmacies' controlled drug registers has lapsed in many places. A partnership of the pharmacy inspector, Home Office Drugs Inspectorate and local specialists could audit, advise, and regulate, with the ultimate threat of referral to the GMC or a tribunal.

Summary

We believe that licensing will reduce and potentially stop GP involvement with drug users. Before this is forced on us, with next to no consultation, we urge the Home Office and the DoH to seriously consider our alternative for NHS doctors (passed to them over six months ago).

More robust monitoring is needed for the private sector (only a problem in London) but licensing as proposed is not the best method. The Home Office and the DoH need to give serious thought to what will happen to several thousand users served by the private sector, who will be without care if licensing is introduced.

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If you are concerned about licensing and the lack of consultation e-mail licence.consult@dial.pipex.com with your name, job, and concerns, or write to Bill Nelles, National Organiser, Methadone Alliance, 35 Cavendish Road, London N4 1RP

1. Beaumont B. *et al.* 'Licensing doctors counters the National Strategy.' *Druglink*. 2000; 15(6), p.24.
2. Ashton M. 'Doctors at War.' *Druglink* 1986 1(1), p.13–15.
3. Waller T. *Working With GPs*. London: ISDD, 1993.