DOCTORS AT WAR

Should doctors be allowed to prescribe whatever drugs in whatever quantities they think best for addict patients? Or should the government ban all but the 'experts' from the minefield of prescribing addictive drugs to drug addicts? It's an issue that has recently riven parts of the medical profession into bitterly opposed camps. In the first half of a two-part article, Mike Ashton from ISDD's library looks at the arguments, the events and the evidence.

Mike Ashton

Two recent full-page articles in the national press explored the case for legally 'maintaining' addicts on opiate-type[1] 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.[2] 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.

> ► **Extend licensing**
> Only doctors licensed by the government should be allowed to prescribe any opiate-type drug for the treatment of addiction.
>
> ► **Enforce guidelines**
> As a condition of obtaining (and maintaining) a licence, doctors would have to adhere to certain of the "guidelines" to be contained in an "authoritative statement of good practice" in the treatment of addiction.
>
> ► **Supervise 'independent' doctors?**
> The guidelines would stipulate that non-hospital doctors should operate in "close liaison" with the nearest hospital specialist, possibly amounting to supervision by the specialist. This in particular may be made a condition of obtaining a licence.
>
> Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation report*. 1982

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[3] (see box for details).

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.[4] 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".[5]

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*[6] 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 (see box for details). 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 'scrip' to look forward to, addicts might no longer think a visit to the doctor worth the time, effort and the risk involved.[7] 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".[8]

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 published a research article uncompromisingly titled "Unacceptable face of private practice: prescription of controlled drugs to addicts".[9] 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. This latter doctor 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).

► "All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems."

► "The aim of treatment should be to deal with problems related to his or her drug misuse and eventually to achieve a drug-free life."

► "Doctors are advised not to undertake long-term prescription of opioids [natural and synthetic opiates] unless in consultation and conjunction with a specialist in a drug treatment unit or elsewhere who has experience of this approach."

► "We strongly recommend that the general practitioner should explain clearly and sympathetically at the first interview [with a drug misusing patient] that treatment ... will certainly not involve long-term maintenance prescribing."

Medical Working Group on Drug Dependence. *Guidelines of good clinical practice in the treatment of drug misuse*. 1984

Exasperated by this "ever-present but highly local controversy" between clinics and private doctors in London, Dr 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."

"please, please tell Mr Mellor that if one brings in licensing now any flicker of interest among GPs may be snuffed out"

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".[10] 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".[11]

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. ►