DOCTORS AT WAR

The government's decision not to extend legal curbs on prescribing to addicts leaves two ways of enforcing control on 'errant' doctors. In the second part of a two-part article, Mike Ashton of ISDD describes how these have recently been put into effect, as doctor opposes doctor over proper practice in addiction treatment.

Mike Ashton

In the last issue of *Druglink*, we recounted how recommendations from the Advisory Council on the Misuse of Drugs (in their *Treatment and rehabilitation* report), which would have banned most doctors from prescribing opiates for addiction, were turned down by the government. But there are still at least two ways of 'eliminating' the individual 'injudicious' prescriber.

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.[1] 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:[2] 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 the defendant involved have been seen as signalling a significant extension of the GMC's role in controlling prescribing.

> ***"The practitioner owes a duty not merely to the patient but also to the public into whose hands such drugs may fall"***

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 . . . ".[3]

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".[4] 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'".[5]

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.[6]

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 (see box).

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".[7]

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[8] 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 . . .".[9]

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 "overprescribing" 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.

"The great advantage with this document is that we now have the corporate view of proper practice in this field"

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 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".[10] 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"[11] was the reposte from an AIDA member. Together with Dr Dally's husband,[12] 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.[13] Far from helping to settle the issue with objective facts, the research simply added fuel to the fire.

THE SAME FATE 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

"The Council has hitherto eschewed the promulgation of specific views on the correct regime of treatment for a particular condition . . . Nevertheless, disciplinary inquiries . . . have all too plainly demonstrated the special hazards of medical practice in the field of prescribing to addicts . . . The prescribing of opioid drugs to addicts, unless it is strictly controlled by the practitioner, may foment the growing problem of drug abuse, by increasing supplies to the illicit drug markets, rather than achieve the therapeutic aims of control, alleviation and detoxification. In the public interest, the Committees have felt bound to take a grave view of cases where it was proved that a doctor had undertaken such prescribing irresponsibly or otherwise than in good faith."

The General Medical Council's submission to the Social Services Committee, session 1984-85